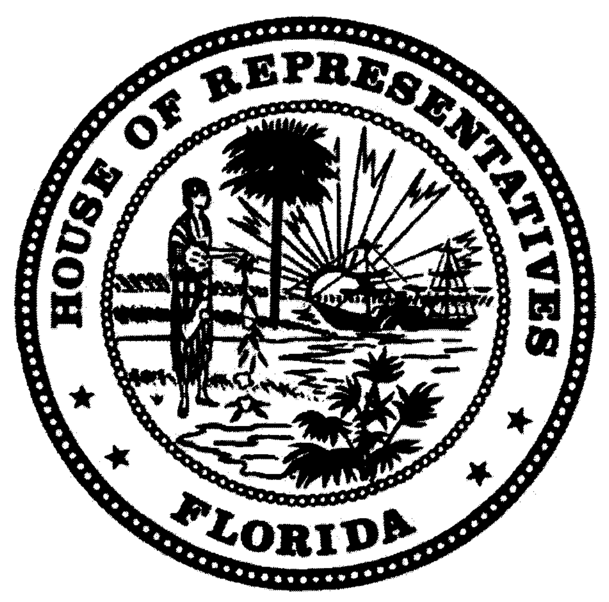

Health Innovation Subcommittee

Meeting Packet

Tuesday, March 25, 2014
9:00 AM - 11:00 AM
306 HOB

Will Weatherford
Speaker

Jason T. Brodeur
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, March 25, 2014 09:00 am
End Date and Time:	Tuesday, March 25, 2014 11:00 am
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 745 Pharmacy Audit Bill of Rights by Cummings
HB 799 Transitional Living Facilities by Magar

Consideration of the following proposed committee substitute(s):

PCS for HB 1179 -- Licensure of Nurse Registries

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, March 24, 2014.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, March 24, 2014.

NOTICE FINALIZED on 03/21/2014 16:07 by Iseminger.Bobbye

HB 745

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 745 Pharmacy Audit Bill of Rights
SPONSOR(S): Cummings and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 702

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Advances in pharmaceuticals have transformed health care over the last several decades. Many health care problems are prevented, cured, or managed effectively for years through the use of prescription drugs. As a result, national expenditures for retail prescription drugs have grown from $120.9 billion in 2000 to $263.3 billion in 2012. This has brought about increased scrutiny of pharmaceutical dispensing and reimbursement processes. As expenditures for drugs have increased, insurers have looked for ways to control that spending. Among other things, they have turned to pharmacy benefit managers (PBMs), which are third party administrators of prescription drug programs.

PBMs process prescriptions for the groups that pay for drugs, usually insurance companies or corporations, and use their size to negotiate with drug makers and pharmacies. They are primarily responsible for processing and paying prescription drug claims. They are also responsible for maintaining the formulary of covered drugs, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. Pharmacies have increasingly complained about the onerous and burdensome nature of these audits. In Florida, the primary concerns of pharmacies regarding audits by PBMs are fairness and lack of consistency in many audit areas.

House Bill 745 creates a "bill of rights" in chapter 465, F.S., for a pharmacy that applies during an audit by a managed care company, an insurance company, a third-party payor, a PBM, or any entity that represents a party that is responsible for payment of pharmacy benefits. The bill imposes notice, timing, and procedural requirements on entities conducting pharmacy audits. The bill appears to address many of the complaints expressed by pharmacies in relation to perceived inequity, unfairness, or burdensome practices of third-party payor audits or third-party administrator audits.

The bill creates a new civil cause of action for an injured pharmacy when an entity willfully violates the provisions of the bill. A prevailing pharmacy will be entitled to treble damages, attorney fees, and costs.

The provisions of the bill do not apply to audits in which fraud or fraudulent activity is suspected. The bill also does not apply to audits related to Medicaid fee-for-service claim; however, the bill would apply to managed care plans under contract with the state to provide Medicaid services.

The bill has an indeterminate negative fiscal impact on state government.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Third-Party Payor/Third-Party Administrator Pharmacy Audits

Advances in pharmaceuticals have transformed health care over the last several decades. Many health care problems are prevented, cured, or managed effectively for years through the use of prescription drugs. As a result, national expenditures for retail prescription drugs have grown from $120.9 billion in 2000 to $263.3 billion in 2012.[1] This has brought about increased scrutiny of pharmaceutical dispensing and reimbursement processes.

Health insurers, including Medicare and Medicaid, and other third party payers spent $214 billion on prescription drugs in 2011 and consumers paid $46.8 billion out of pocket for prescription drugs that year.[2] As expenditures for drugs have increased, insurers have looked for ways to control that spending. Among other things, they have turned to pharmacy benefit managers (PBMs), which are third party administrators of prescription drug programs. PBMs process prescriptions for the groups that pay for drugs, usually insurance companies or corporations, and use their size to negotiate with drug makers and pharmacies. They are primarily responsible for processing and paying prescription drug claims. They are also responsible for maintaining the formulary of covered drugs, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. PBMs currently administer prescription drug plans for more than 210 million people in the U.S. with employer sponsored health care coverage, individual health care coverage, health care coverage through a union, and coverage for prescription drugs through Medicare Part D.[3] Two large PBMs, Express Scripts and CVS/Caremark, control 60 percent of the market and administer prescription drug plans for approximately 240 million people.[4]

Pharmacy benefit managers build networks of retail pharmacies to provide consumers convenient access to prescriptions at discounted rates. The audit process is one means used by pharmacy benefit managers and third-party payors to review pharmacy programs. The audits ensure that procedures and reimbursement mechanisms are consistent with contractual and regulatory requirements. PBMs conduct different types of audits, depending on client and contractual requirements, including:

- Claims analyses to identify payment anomalies;
- Desk audit using documents received from a pharmacy; and
- On-site audit of a pharmacy.[5]

Audit practices, protocols, and requirements vary by PBM and by the client.

Pharmacies have increasingly complained about the perceived onerous and burdensome nature of these audits.[6] In Florida, the primary concerns of pharmacies regarding audits by PBMs are fairness

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[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution, by Type of Expenditure: Selected Calendar Years 1960-2012*, Table 2, available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf (last viewed on March 22, 2014).
[2] Id. at Table 4.
[3] Pharmaceutical Care Management Association, *About PCMA*, available at www.pcmanet.org/about-pcma/about-pcma (last viewed on March 19, 2014).
[4] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Pharmacy Benefit Managers*, December 20, 2013, page 1 (on file with Health Innovation Subcommittee staff).
[5] Id. at page 2.

and lack of consistency in areas such as prior notification, extrapolation,[7] and look-back period of the audit.[8]

Statewide Medicaid Managed Care

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC requires the Agency for Healthcare Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care. Each Medicaid recipient will have one managed care organization to coordinate all health care services, rather than various entities as in the current Medicaid program. This comprehensive coordinated system of care was successfully implemented in a 5-county Medicaid reform pilot program which began in 2006.

The SMMC program has two components: the Long-term Care Managed Care Program and the Managed Medical Assistance (MMA) Program. The MMA program provides primary and acute medical assistance and related services, including pharmacy. On December 28, 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis for the MMA program.[9] AHCA subsequently selected health maintenance organizations and provider service networks via the competitive procurement. On February 6, 2014, AHCA executed contracts with the MMA managed care plans.[10]

AHCA will begin implementing the MMA program in selected regions on May 1, 2014 with the last regions being implemented on August 1, 2014. The program must be fully implemented in all regions by October, 2014, as directed in s. 409.971, F.S.

Once the MMA program is fully implemented, most Medicaid recipients will receive services through managed care rather than fee-for-service.

Medicaid Pharmacy Audits

Section 465.188, F.S., establishes requirements for AHCA and other state agencies when conducting an audit of the Medicaid-related records of a pharmacy licensed under ch. 465, F.S. The audit must meet the following requirements:

- The agency conducting the audit must give the pharmacist at least one week's prior notice of the initial audit for each audit cycle.[11]
- An audit must be conducted by a pharmacist licensed in Florida.[12]
- Any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation and is not subject to criminal penalties without proof of intent to commit fraud.[13]
- A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.[14]

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[6] National Community Pharmacists Association, *Survey: Pharmacists Say Patient Care Undermined by Auditing, Payment Practices*, available at www.ncpanet.org/pdf/leg/sep12/pbmsurvey0912final.pdf (last viewed on March 22, 2014).
[7] A PBM audit usually looks at a small sample of the large volume of prescriptions filled by a pharmacy during a certain time period. Some audit practices allow the PBM to apply the error rate found in the sample to the entire volume of prescriptions in order to calculate the repayment.
[8] See supra, FN 4 at page 3.
[9] Id.
[10] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: AHCA ITN 017-12/13; Feb. 26, 2013, available at: http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 22, 2014); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13, Dec. 28, 2012, available at: http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 22, 2014).
[11] S. 465.188(1)(a), F.S.
[12] S. 465.188(1)(b), F.S.
[13] S. 465.188(1)(c), F.S.

- A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.[15]
- Each pharmacy shall be audited under the same standards and parameters.[16]
- A pharmacist must be allowed at least 10 days in which to produce documentation to address any discrepancy found during an audit.[17]
- The period covered by an audit may not exceed one calendar year.[18]
- An audit may not be scheduled during the first five days of any month due to the high volume of prescriptions filled during that time.[19]
- The audit report must be delivered to the pharmacist within ninety days after conclusion of the audit.[20]
- A final audit report must be delivered to the pharmacist within six months after receipt of the preliminary audit report or final appeal, whichever is later.[21]
- The agency conducting the audit may not use the accounting practice of extrapolation in calculating penalties for Medicaid audits.[22]

The law requires the AHCA to establish a process that allows a pharmacist to obtain a preliminary review of an audit report and to appeal an unfavorable audit report without the necessity of obtaining legal counsel.[23] The preliminary review and appeal may be conducted by an ad hoc peer review panel, appointed by the AHCA, which consists of pharmacists who maintain an active practice.[24] If, following the preliminary review, the AHCA or the review panel finds that an unfavorable audit report is unsubstantiated, the AHCA must dismiss the audit report without the necessity of any further proceedings.[25]

These requirements do not apply to investigative audits conducted by the Medicaid Fraud Control Unit of the Department of Legal Affairs or to investigative audits conducted by the AHCA when there is reliable evidence that the claim that is the subject of the audit involves fraud, willful misrepresentation, or abuse under the Medicaid program.[26]

Effect of Proposed Changes

House Bill 745 creates a "bill of rights" in chapter 465, F.S., for a pharmacy that applies during an audit by a managed care company, an insurance company, a third-party payor, a PBM, or any entity that represents a party that is responsible for payment of pharmacy benefits. The "bill of rights" addresses many of the complaints expressed by pharmacies in relation to perceived inequity, unfairness, or burdensome practices of third-party payor audits or third-party administrator audits.

The bill provides the following rights to a pharmacy regarding an audit:

- To be given 7 days of notice prior to the initial onsite audit of each audit cycle.
- To have an onsite audit scheduled after the first 5 days of the month, unless the pharmacist consents to an earlier audit date.

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[14] S. 465.188(1)(d), F.S.
[15] S. 465.188(1)(e), F.S.
[16] S. 465.188(1)(f), F.S.
[17] S. 465.188(1)(g), F.S.
[18] S. 465.188(1)(h), F.S.
[19] S. 465.188(1)(i), F.S.
[20] S. 465.188(1)(j), F.S.
[21] Id.
[22] S. 465.188(1)(k), F.S.
[23] S. 465.188(2), F.S.
[24] Id.
[25] Id.
[26] S. 465.188(3) and (4), F.S.

- To limit the audit period to 24 months from the date a claim was submitted to or adjudicated by the entity conducting the audit.
- To have an audit which requires clinical or professional judgment conducted by or in consultation with a pharmacist.
- To use the records of a hospital or authorized practitioner to validate a pharmacy record.
- To be reimbursed for a claim that was retroactively denied for a clerical, scrivener's, typographical, or computer error if the patient received the correct medication, dose, and instructions for administration, unless a pattern of errors exists or fraud is alleged.
- To receive a preliminary audit report within 90 days after completion of the audit.
- To produce documentation to challenge a discrepancy or finding within 10 days after the preliminary audit report is delivered to the pharmacy.
- To receive the final audit report within 6 months of receiving the preliminary audit report.
- To have penalties and recoupments based on actual overpayments.

The bill provides a civil cause of action to a pharmacy that is injured as a result of a willful violation of the "bill of right" outlined in the bill. In addition, the pharmacy may seek treble damages and reasonable attorney fees and costs through the civil cause of action.

The "bill of rights" does not apply to audits in which fraud is suspected or to audits of Medicaid fee-for-service claims, which are governed by s. 465.188, F.S. The bill will apply to managed care plans under contract with the state to provide Medicaid services.

The bill provides an effective date of July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Creates s. 465.1885, F.S., relating to pharmacy audit bill of right.
Section 2: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

The bill may limit the ability of managed care organizations, insurance companies, and other third party payors to recoup funds that may have been paid in error to pharmacies.

AHCA is required to pay actuarially sound, risk-adjusted rates[27] to the managed care plans participating in the MMA program. To the extent the provisions of the bill increase the cost of the prescription drug benefit to the MMA plans, these costs will be passed on to the state through required increases in the rates paid to the plans.

The State Group Insurance Program is projected to spend $487 million on pharmacy claims in FY 2014-15.[28] Costs for the HMO pharmacy benefit are projected to increase 8.6% in FY 2014-15 and 10.5% in FY 2015-2016. Costs for the PPO pharmacy benefit are projected to increase 6.3% for FY 2014-2015 and 10.5% for FY 2015-16. To the extent the provisions of the bill increase the cost of prescription drug benefits, the State Group Insurance Program will have increased costs.

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:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. The bill does not require rule-making.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[27] S. 409.968, F.S. and 42 CFR §438.6(c)(2).

[28] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, March 4, 2014. Available at: http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf

1 A bill to be entitled
2 An act relating to pharmacy audits; creating s.
3 465.1885, F.S.; providing rights to which a licensed
4 pharmacy is entitled during certain audits of its
5 records; providing for civil damages; providing for
6 applicability; providing an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Section 465.1885, Florida Statutes, is created
11 to read:
12 465.1885 Pharmacy audit bill of rights.—
13 (1) When an audit of the records of a pharmacy licensed
14 under this chapter is conducted either directly or indirectly by
15 a managed care company, an insurance company, a third-party
16 payor, a pharmacy benefit manager, or any entity that represents
17 responsible parties such as companies or groups, the pharmacy
18 has the following rights:
19 (a) To be notified at least 7 calendar days before the
20 initial onsite audit for each audit cycle.
21 (b) To have the onsite audit scheduled after the first 5
22 calendar days of a month, unless the pharmacist otherwise
23 consents.
24 (c) To have the audit period limited to 24 months from the
25 date that a claim was submitted to or adjudicated by the entity
26 conducting the audit.

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

27 (d) To have an audit that requires clinical or
28 professional judgment conducted by or in consultation with a
29 pharmacist.
30 (e) To use records of a hospital, physician, or other
31 authorized practitioner, which are transmitted by any means of
32 communication, to validate the pharmacy record.
33 (f) To be reimbursed for a claim that is retroactively
34 denied for a clerical error, typographical error, scrivener's
35 error, or computer error if the prescription was properly and
36 correctly dispensed, unless a pattern of such errors exists or
37 fraudulent billing is alleged.
38 (g) To receive the preliminary audit report within 90 days
39 after the audit is completed.
40 (h) To produce documentation to address a discrepancy or
41 finding in an audit within 10 business days after the
42 preliminary audit report is delivered to the pharmacy.
43 (i) To receive the final audit report within 6 months
44 after receiving the preliminary audit report.
45 (j) To have recoupment or penalties based on actual
46 overpayments.
47 (2) A pharmacy injured as a result of a willful violation
48 of subsection (1) shall have a civil cause of action for treble
49 damages, reasonable attorney fees, and costs.
50 (3) The rights contained in this section do not apply to
51 audits in which fraudulent activity is suspected or to audits
52 related to Medicaid fee-for-service claims.

53 Section 2. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 799 Transitional Living Facilities
SPONSOR(S): Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Transitional Living Facilities (TLFs) provide specialized health care services including, but not limited to, rehabilitative services, community re-entry training, aids for independent living, and counseling to individuals who sustain brain or spinal cord injuries. The bill consolidates the oversight, care and services of clients of TLFs under specific licensure requirements of the Agency for Health Care Administration (AHCA).

The bill promotes coordination between various state agencies involved in the regulation of TLFs by requiring AHCA, the Department of Health, the Agency for Persons with Disabilities, and the Department of Children and Families to develop an electronic database to ensure relevant client data is communicated timely and effectively.

Specifically, the bill makes the following changes:

- Requires TLFs to maintain accreditation by an accrediting organization specializing in evaluating rehabilitation facilities;
- Adds specific admission requirements and requires a client to be admitted by a licensed physician, physician assistant, or advanced registered nurse practitioner;
- Adds specific discharge requirements and clarifies the conditions that a client must meet to be eligible for discharge;
- Adds care and service plan requirements 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;
- Enables TLF clients to manage their funds and personal possessions, have visitors;
- Requires TLFs to establish grievance procedures and a system for investigating, tracking, managing, and responding to complaints, which must include an appeals process;
- 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;
- Provides AHCA the authority to develop rules for physical plant standards, personnel, and services to clients;
- Provides standard licensure criteria, including compliance with local zoning, liability insurance, fire-safety inspection, and sanitation requirements;
- Creates sanctions for violations and provides authority to place a court-ordered receiver if the licensee fails to take responsibility for the facility and places clients at risk;
- Clarifies that providers already licensed by AHCA, who serve brain and spinal-cord injured persons, are not required to obtain a separate license as a TLF; and
- Revises the Brain and Spinal Cord Injury Advisory Council's rights to entry and inspection of TLFs.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Transitional living facilities 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.[1] There are currently thirteen transitional living facilities licensed in Florida.[2] The Agency is the licensing authority and one of the regulatory authorities that oversee transitional living facilities pursuant to chapter 408, part II, chapter 400, part V, F.S., and Rule 59A-17, F.A.C. The current licensure fee is $4,588.00 with a $90 per bed fee per biennium.[3]

AHCA governs the physical plant and fiscal management of these facilities and adopts rules, along with DOH, which monitors services for persons with traumatic brain and spinal cord injuries. Investigations concerning allegations of abuse and neglect of children and vulnerable adults are performed by DCF.

Section 400.805, F.S., mandates requirements for transitional living facilities. Section 400.805(2), F.S., provides the licensure requirements and fees for operation of a transitional living facility as well as level 2 background screening requirements for all TLF personnel. Section 400.805(3)(a) requires AHCA, in consultation with DOH, to adopt rules governing the physical plant and the fiscal management of transitional living facilities.

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

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 was based on information from 20 current and former clients and their family members, criminal charging documents, civil complaints and advocates for the disabled.[4] 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.[5]

State agencies involved in the regulation of TLFs strive to maintain a level of coordination sufficient to provide quality care to clients of TLFs. 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 children and vulnerable adults. In working together during the investigations, gaps and deficiencies were discovered in the TLF regulatory structure.

The Brain and Spinal Cord Injury Program (BSCIP) is administered through DOH. Services provided by the BSCIP include:

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[1] Section 400.805(1)(c), F.S.

[2] HB 799, Agency Legislative Bill Analysis, Agency For Health Care Administration, February 7, 2014 (on file with the Health Innovation subcommittee).

[3] *Id.*

[4] 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 March 22, 2014).

[5] 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 March 22, 2014).

- 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."[6] 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 has rights to entry and inspection of transitional living facilities granted under section 400.805(4), F.S.

Effect of Proposed Changes

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, APD, DCF, and the Brain and Spinal Cord Injury Program.

This 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.

This bill creates s. 400.997, F.S., and states the intent of the legislation is 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 is created to define 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., is created to provide 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 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.

[6] Section 381.745(2), F.S.

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 creates s. 400.9974, F.S., to require 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 creates s. 400.9975, F.S., to require 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 creates s. 400.9976, F.S., to require 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 creates s. 400.9977, F.S., which provides that notwithstanding the Nurse Practice Act, 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 creates s. 400.9977, F.S., to establish provisions relating to the protection of clients from abuse, neglect, mistreatment, and exploitation. The bill provides that 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 creates s. 400.9979, F.S., to require 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 bill provides that the use of chemical restraints is limited to the prescribed dosage of medications by the client's physician, PA, or ARNP. The use of physical restraint and seclusion 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

Background Screening and Administration/Management

The bill creates s. 400.998, F.S., to require all facility personnel to complete a level 2 background screening as required in s. 408.809(1)(e), F.S. pursuant to Chapter 435. The facility must maintain personnel records which contain the staff's background screening, job description, documentation of compliance with training requirements, and a copy of all licenses or certifications held by staff who perform services for which licensure or certification is required. The record must also include a copy of all job performance evaluations.

The bill requires the facility 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 creates s. 400.9981, F.S., to require facilities to give clients options of using their own personal belongings, and to choose their own roommate whenever possible. The bill provides that 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. The licensee, administrator, employee or representative 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 creates s. 400.9981, F.S., to authorize AHCA to publish and enforce rules, which include criteria to ensure reasonable and consistent quality of care and client safety. Further, the bill authorizes AHCA to adopt and enforce rules which must include reasonable and fair criteria 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 creates s. 400.9983, F.S., to authorize AHCA to adopt rules to enforce penalties, and require 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, as defined in s. 408.813, F.S., 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 creates s. 400.9984, F.S., to authorize AHCA access the provisions of s. 429.22, F.S., regarding receivership proceedings for TLFs. As a result, AHCA is authorized to petition a court for the appointment of a receiver when any of the following conditions exist:

- The facility is closing or has informed the Agency that it intends to close;
- The Agency determines the conditions exit in the facility that presents danger to the health, safety or welfare of the clients of the facility; 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 creates s. 400.9985, F.S., to require 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. The bill requires the system to include a brain and spinal cord injury registry and a client abuse registry.

B. SECTION DIRECTORY:

Section 1: Creates ss. 400.997 through 400.9985, F.S., as part XI of chapter 400, to be entitled "Transitional Living Facilities.
Section 2: Creates s. 400.9978, F.S., relating to protection of clients from abuse, neglect, mistreatment, and exploitation.
Section 3: Repeals s. 400.805, F.S., relating to transitional living facilities.
Section 4: Redesignates the title of part V of chapter 400, F.S., as "Intermediate Care Facilities".
Section 5: Amends s. 381.745, F.S., relating to definitions.
Section 6: Amends s. 381.75, F.S., relating to duties and responsibilities of the department.
Section 7: Amends s. 381.78, F.S., relating to the advisory council on brain and spinal cord injuries.
Section 8: Amends s. 400.93, F.S., relating to licensure required; exemptions; unlawful act; penalties.
Section 9: Amends s. 408.802, F.S., relating to applicability.

Section 10: Amends s. 408.820, F.S., relating to exemptions.
Section 11: Provides that effective July1, 2015, a TLF licensed before the effective date of this act pursuant to s. 400.805, F.S., must be licensed under part XI of chapter 400, F.S., as created by this act.
Section 12: Provides an effective date of July1, 2014, except as otherwise expressly provided in this act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to transitional living facilities;
3 creating part XI of chapter 400, F.S.; providing
4 legislative intent; providing definitions; requiring
5 the licensure of transitional living facilities;
6 providing license fees and application requirements;
7 requiring accreditation of licensed facilities;
8 providing requirements for transitional living
9 facility policies and procedures governing client
10 admission, transfer, and discharge; requiring a
11 comprehensive treatment plan to be developed for each
12 client; providing plan and staffing requirements;
13 requiring certain consent for continued treatment in a
14 transitional living facility; providing licensee
15 responsibilities; providing notice requirements;
16 prohibiting a licensee or employee of a facility from
17 serving notice upon a client to leave the premises or
18 take other retaliatory action under certain
19 circumstances; requiring the client and client's
20 representative to be provided with certain
21 information; requiring the licensee to develop and
22 implement certain policies and procedures; providing
23 licensee requirements relating to administration of
24 medication; requiring maintenance of medication
25 administration records; providing requirements for
26 administration of medications by unlicensed staff;

27 specifying who may conduct training of staff;
28 requiring licensees to adopt policies and procedures
29 for administration of medications by trained staff;
30 requiring the Agency for Health Care Administration to
31 adopt rules; providing requirements for the screening
32 of potential employees and training and monitoring of
33 employees for the protection of clients; requiring
34 licensees to implement certain policies and procedures
35 to protect clients; providing conditions for
36 investigating and reporting incidents of abuse,
37 neglect, mistreatment, or exploitation of clients;
38 providing requirements and limitations for the use of
39 physical restraints, seclusion, and chemical restraint
40 medication on clients; providing a limitation on the
41 duration of an emergency treatment order; requiring
42 notification of certain persons when restraint or
43 seclusion is imposed; authorizing the agency to adopt
44 rules; providing background screening requirements;
45 requiring the licensee to maintain certain personnel
46 records; providing administrative responsibilities for
47 licensees; providing recordkeeping requirements;
48 providing licensee responsibilities with respect to
49 the property and personal affairs of clients;
50 providing requirements for a licensee with respect to
51 obtaining surety bonds; providing recordkeeping
52 requirements relating to the safekeeping of personal

53 effects; providing requirements for trust funds or
54 other property received by a licensee and credited to
55 the client; providing a penalty for certain misuse of
56 a client's personal funds, property, or personal needs
57 allowance; providing criminal penalties for
58 violations; providing for the disposition of property
59 in the event of the death of a client; authorizing the
60 agency to adopt rules; providing legislative intent;
61 authorizing the agency to adopt and enforce rules
62 establishing standards for transitional living
63 facilities and personnel thereof; classifying
64 violations and providing penalties therefor; providing
65 administrative fines for specified classes of
66 violations; authorizing the agency to apply certain
67 provisions with regard to receivership proceedings;
68 requiring the agency, the Department of Health, the
69 Agency for Persons with Disabilities, and the
70 Department of Children and Families to develop
71 electronic information systems for certain purposes;
72 repealing s. 400.805, F.S., relating to transitional
73 living facilities; revising the title of part V of
74 chapter 400, F.S.; amending s. 381.745, F.S.; revising
75 the definition of the term "transitional living
76 facility," to conform; amending s. 381.75, F.S.;
77 revising the duties of the Department of Health and
78 the agency relating to transitional living facilities;

79 amending ss. 381.78, 400.93, 408.802, and 408.820,
80 F.S.; conforming provisions to changes made by the
81 act; providing applicability with respect to
82 transitional living facilities licensed before a
83 specified date; providing effective dates.
84
85 Be It Enacted by the Legislature of the State of Florida:
86
87 Section 1. Part XI of chapter 400, Florida Statutes,
88 consisting of sections 400.997 through 400.9985, is created to
89 read:
90 PART XI
91 TRANSITIONAL LIVING FACILITIES
92 400.997 Legislative intent.—It is the intent of the
93 Legislature to provide for the licensure of transitional living
94 facilities and require the development, establishment, and
95 enforcement of basic standards by the Agency for Health Care
96 Administration to ensure quality of care and services to clients
97 in transitional living facilities. It is the policy of the state
98 that the least restrictive appropriate available treatment be
99 used based on the individual needs and best interest of the
100 client, consistent with optimum improvement of the client's
101 condition. The goal of a transitional living program for persons
102 who have brain or spinal cord injuries is to assist each person
103 who has such an injury to achieve a higher level of independent
104 functioning and to enable the person to reenter the community.

105 It is also the policy of the state that the restraint or
106 seclusion of a client is justified only as an emergency safety
107 measure used in response to danger to the client or others. It
108 is therefore the intent of the Legislature to achieve an ongoing
109 reduction in the use of restraint or seclusion in programs and
110 facilities that serve persons who have brain or spinal cord
111 injuries.
112 400.9971 Definitions.—As used in this part, the term:
113 (1) "Agency" means the Agency for Health Care
114 Administration.
115 (2) "Chemical restraint" means a pharmacologic drug that
116 physically limits, restricts, or deprives a person of movement
117 or mobility, is used for client protection or safety, and is not
118 required for the treatment of medical conditions or symptoms.
119 (3) "Client's representative" means the parent of a child
120 client or the client's guardian, designated representative,
121 designee, surrogate, or attorney in fact.
122 (4) "Department" means the Department of Health.
123 (5) "Physical restraint" means a manual method to restrict
124 freedom of movement of or normal access to a person's body, or a
125 physical or mechanical device, material, or equipment attached
126 or adjacent to the person's body that the person cannot easily
127 remove and that restricts freedom of movement of or normal
128 access to the person's body, including, but not limited to, a
129 half-bed rail, a full-bed rail, a geriatric chair, or a Posey
130 restraint. The term includes any device that is not specifically

131 manufactured as a restraint but is altered, arranged, or
132 otherwise used for this purpose. The term does not include
133 bandage material used for the purpose of binding a wound or
134 injury.
135 (6) "Seclusion" means the physical segregation of a person
136 in any fashion or the involuntary isolation of a person in a
137 room or area from which the person is prevented from leaving.
138 Such prevention may be accomplished by imposition of a physical
139 barrier or by action of a staff member to prevent the person
140 from leaving the room or area. For purposes of this part, the
141 term does not mean isolation due to a person's medical condition
142 or symptoms.
143 (7) "Transitional living facility" means a site where
144 specialized health care services are provided to persons who
145 have brain or spinal cord injuries, including, but not limited
146 to, rehabilitative services, behavior modification, community
147 reentry training, aids for independent living, and counseling.
148 400.9972 License required; fee; application.—
149 (1) The requirements of part II of chapter 408 apply to
150 the provision of services that require licensure pursuant to
151 this part and part II of chapter 408 and to entities licensed by
152 or applying for licensure from the agency pursuant to this part.
153 A license issued by the agency is required for the operation of
154 a transitional living facility in this state. However, this part
155 does not require a provider licensed by the agency to obtain a
156 separate transitional living facility license to serve persons

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

157 who have brain or spinal cord injuries as long as the services
158 provided are within the scope of the provider's license.
159 (2) In accordance with this part, an applicant or a
160 licensee shall pay a fee for each license application submitted
161 under this part. The license fee shall consist of a $4,588
162 license fee and a $90 per-bed fee per biennium and shall conform
163 to the annual adjustment authorized in s. 408.805.
164 (3) An applicant for licensure must provide:
165 (a) The location of the facility for which the license is
166 sought and documentation, signed by the appropriate local
167 government official, which states that the applicant has met
168 local zoning requirements.
169 (b) Proof of liability insurance as provided in s.
170 624.605(1)(b).
171 (c) Proof of compliance with local zoning requirements,
172 including compliance with the requirements of chapter 419 if the
173 proposed facility is a community residential home.
174 (d) Proof that the facility has received a satisfactory
175 firesafety inspection.
176 (e) Documentation that the facility has received a
177 satisfactory sanitation inspection by the county health
178 department.
179 (4) The applicant's proposed facility must attain and
180 continuously maintain accreditation by an accrediting
181 organization that specializes in evaluating rehabilitation
182 facilities whose standards incorporate licensure regulations

183 comparable to those required by the state. An applicant for
184 licensure as a transitional living facility must acquire
185 accreditation within 12 months after issuance of an initial
186 license. The agency shall accept the accreditation survey report
187 of the accrediting organization in lieu of conducting a
188 licensure inspection if the standards included in the survey
189 report are determined by the agency to document that the
190 facility substantially complies with state licensure
191 requirements. Within 10 days after receiving the accreditation
192 survey report, the applicant shall submit to the agency a copy
193 of the report and evidence of the accreditation decision as a
194 result of the report. The agency may conduct an inspection of a
195 transitional living facility to ensure compliance with the
196 licensure requirements of this part, to validate the inspection
197 process of the accrediting organization, to respond to licensure
198 complaints, or to protect the public health and safety.
199 400.9973 Client admission, transfer, and discharge.—
200 (1) A transitional living facility shall have written
201 policies and procedures governing the admission, transfer, and
202 discharge of clients.
203 (2) The admission of a client to a transitional living
204 facility must be in accordance with the licensee's policies and
205 procedures.
206 (3) A client admitted to a transitional living facility
207 must have a brain or spinal cord injury, such as a lesion to the
208 spinal cord or cauda equina syndrome, with evidence of

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209 significant involvement of at least two of the following
210 deficits or dysfunctions:
211 (a) A motor deficit.
212 (b) A sensory deficit.
213 (c) Bowel and bladder dysfunction.
214 (d) An acquired internal or external injury to the skull,
215 the brain, or the brain's covering, whether caused by a
216 traumatic or nontraumatic event, which produces an altered state
217 of consciousness or an anatomic motor, sensory, cognitive, or
218 behavioral deficit.
219 (4) A client whose medical condition and diagnosis do not
220 positively identify a cause of the client's condition, whose
221 symptoms are inconsistent with the known cause of injury, or
222 whose recovery is inconsistent with the known medical condition
223 may be admitted to a transitional living facility for evaluation
224 for a period not to exceed 90 days.
225 (5) A client admitted to a transitional living facility
226 must be admitted upon prescription by a licensed physician,
227 physician assistant, or advanced registered nurse practitioner
228 and must remain under the care of a licensed physician,
229 physician assistant, or advanced registered nurse practitioner
230 for the duration of the client's stay in the facility.
231 (6) A transitional living facility may not admit a person
232 whose primary admitting diagnosis is mental illness or an
233 intellectual or developmental disability.
234 (7) A person may not be admitted to a transitional living

235 facility if the person:
236 (a) Presents significant risk of infection to other
237 clients or personnel. A health care practitioner must provide
238 documentation that the person is free of apparent signs and
239 symptoms of communicable disease;
240 (b) Is a danger to himself or herself or others as
241 determined by a physician, physician assistant, or advanced
242 registered nurse practitioner or a mental health practitioner
243 licensed under chapter 490 or chapter 491, unless the facility
244 provides adequate staffing and support to ensure patient safety;
245 (c) Is bedridden; or
246 (d) Requires 24-hour nursing supervision.
247 (8) If the client meets the admission criteria, the
248 medical or nursing director of the facility must complete an
249 initial evaluation of the client's functional skills, behavioral
250 status, cognitive status, educational or vocational potential,
251 medical status, psychosocial status, sensorimotor capacity, and
252 other related skills and abilities within the first 72 hours
253 after the client's admission to the facility. An initial
254 comprehensive treatment plan that delineates services to be
255 provided and appropriate sources for such services must be
256 implemented within the first 4 days after admission.
257 (9) A transitional living facility shall develop a
258 discharge plan for each client before or upon admission to the
259 facility. The discharge plan must identify the intended
260 discharge site and possible alternative discharge sites. For

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261 each discharge site identified, the discharge plan must identify
262 the skills, behaviors, and other conditions that the client must
263 achieve to be eligible for discharge. A discharge plan must be
264 reviewed and updated as necessary but at least once monthly.
265 (10) A transitional living facility shall discharge a
266 client as soon as practicable when the client no longer requires
267 the specialized services described in s. 400.9971(7), when the
268 client is not making measurable progress in accordance with the
269 client's comprehensive treatment plan, or when the transitional
270 living facility is no longer the most appropriate and least
271 restrictive treatment option.
272 (11) A transitional living facility shall provide at least
273 30 days' notice to a client of transfer or discharge plans,
274 including the location of an acceptable transfer location if the
275 client is unable to live independently. This subsection does not
276 apply if a client voluntarily terminates residency.
277 400.9974 Client comprehensive treatment plans; client
278 services.—
279 (1) A transitional living facility shall develop a
280 comprehensive treatment plan for each client as soon as
281 practicable but no later than 30 days after the initial
282 comprehensive treatment plan is developed. The comprehensive
283 treatment plan must be developed by an interdisciplinary team
284 consisting of the case manager, the program director, the
285 advanced registered nurse practitioner, and appropriate
286 therapists. The client or, if appropriate, the client's

287 representative must be included in developing the comprehensive
288 treatment plan. The comprehensive treatment plan must be
289 reviewed and updated if the client fails to meet projected
290 improvements outlined in the plan or if a significant change in
291 the client's condition occurs. The comprehensive treatment plan
292 must be reviewed and updated at least once monthly.
293 (2) The comprehensive treatment plan must include:
294 (a) Orders obtained from the physician, physician
295 assistant, or advanced registered nurse practitioner and the
296 client's diagnosis, medical history, physical examination, and
297 rehabilitative or restorative needs.
298 (b) A preliminary nursing evaluation, including orders for
299 immediate care provided by the physician, physician assistant,
300 or advanced registered nurse practitioner, which shall be
301 completed when the client is admitted.
302 (c) A comprehensive, accurate, reproducible, and
303 standardized assessment of the client's functional capability;
304 the treatments designed to achieve skills, behaviors, and other
305 conditions necessary for the client to return to the community;
306 and specific measurable goals.
307 (d) Steps necessary for the client to achieve transition
308 into the community and estimated length of time to achieve those
309 goals.
310 (3) The client or, if appropriate, the client's
311 representative must consent to the continued treatment at the
312 transitional living facility. Consent may be for a period of up

313 to 3 months. If such consent is not given, the transitional
314 living facility shall discharge the client as soon as
315 practicable.
316 (4) A client must receive the professional program
317 services needed to implement the client's comprehensive
318 treatment plan.
319 (5) The licensee must employ qualified professional staff
320 to carry out and monitor the various professional interventions
321 in accordance with the stated goals and objectives of the
322 client's comprehensive treatment plan.
323 (6) A client must receive a continuous treatment program
324 that includes appropriate, consistent implementation of
325 specialized and general training, treatment, health services,
326 and related services and that is directed toward:
327 (a) The acquisition of the behaviors and skills necessary
328 for the client to function with as much self-determination and
329 independence as possible.
330 (b) The prevention or deceleration of regression or loss
331 of current optimal functional status.
332 (c) The management of behavioral issues that preclude
333 independent functioning in the community.
334 400.9975 Licensee responsibilities.—
335 (1) The licensee shall ensure that each client:
336 (a) Lives in a safe environment free from abuse, neglect,
337 and exploitation.
338 (b) Is treated with consideration and respect and with due

339 recognition of personal dignity, individuality, and the need for
340 privacy.
341 (c) Retains and uses his or her own clothes and other
342 personal property in his or her immediate living quarters to
343 maintain individuality and personal dignity, except when the
344 licensee demonstrates that such retention and use would be
345 unsafe, impractical, or an infringement upon the rights of other
346 clients.
347 (d) Has unrestricted private communication, including
348 receiving and sending unopened correspondence, access to a
349 telephone, and visits with any person of his or her choice. Upon
350 request, the licensee shall modify visiting hours for caregivers
351 and guests. The facility shall restrict communication in
352 accordance with any court order or written instruction of a
353 client's representative. Any restriction on a client's
354 communication for therapeutic reasons shall be documented and
355 reviewed at least weekly and shall be removed as soon as no
356 longer clinically indicated. The basis for the restriction shall
357 be explained to the client and, if applicable, the client's
358 representative. The client shall retain the right to call the
359 central abuse hotline, the agency, and Disability Rights Florida
360 at any time.
361 (e) Has the opportunity to participate in and benefit from
362 community services and activities to achieve the highest
363 possible level of independence, autonomy, and interaction within
364 the community.

365 (f) Has the opportunity to manage his or her financial
366 affairs unless the client or, if applicable, the client's
367 representative authorizes the administrator of the facility to
368 provide safekeeping for funds as provided under this part.
369 (g) Has reasonable opportunity for regular exercise more
370 than once per week and to be outdoors at regular and frequent
371 intervals except when prevented by inclement weather.
372 (h) Has the opportunity to exercise civil and religious
373 liberties, including the right to independent personal
374 decisions. However, a religious belief or practice, including
375 attendance at religious services, may not be imposed upon any
376 client.
377 (i) Has access to adequate and appropriate health care
378 consistent with established and recognized community standards.
379 (j) Has the opportunity to present grievances and
380 recommend changes in policies, procedures, and services to the
381 staff of the licensee, governing officials, or any other person
382 without restraint, interference, coercion, discrimination, or
383 reprisal. A licensee shall establish a grievance procedure to
384 facilitate a client's ability to present grievances, including a
385 system for investigating, tracking, managing, and responding to
386 complaints by a client or, if applicable, the client's
387 representative and an appeals process. The appeals process must
388 include access to Disability Rights Florida and other advocates
389 and the right to be a member of, be active in, and associate
390 with advocacy or special interest groups.

391 (2) The licensee shall:
392 (a) Promote participation of the client's representative
393 in the process of providing treatment to the client unless the
394 representative's participation is unobtainable or inappropriate.
395 (b) Answer communications from the client's family,
396 guardians, and friends promptly and appropriately.
397 (c) Promote visits by persons with a relationship to the
398 client at any reasonable hour, without requiring prior notice,
399 in any area of the facility that provides direct care services
400 to the client, consistent with the client's and other clients'
401 privacy, unless the interdisciplinary team determines that such
402 a visit would not be appropriate.
403 (d) Promote opportunities for the client to leave the
404 facility for visits, trips, or vacations.
405 (e) Promptly notify the client's representative of a
406 significant incident or change in the client's condition,
407 including, but not limited to, serious illness, accident, abuse,
408 unauthorized absence, or death.
409 (3) The administrator of a facility shall ensure that a
410 written notice of licensee responsibilities is posted in a
411 prominent place in each building where clients reside and is
412 read or explained to clients who cannot read. This notice shall
413 be provided to clients in a manner that is clearly legible,
414 shall include the statewide toll-free telephone number for
415 reporting complaints to the agency, and shall include the words:
416 "To report a complaint regarding the services you receive,

417 please call toll-free ...[telephone number]... or Disability
418 Rights Florida ...[telephone number]...." The statewide toll-
419 free telephone number for the central abuse hotline shall be
420 provided to clients in a manner that is clearly legible and
421 shall include the words: "To report abuse, neglect, or
422 exploitation, please call toll-free ...[telephone number]...."
423 The licensee shall ensure a client's access to a telephone where
424 telephone numbers are posted as required by this subsection.
425 (4) A licensee or employee of a facility may not serve
426 notice upon a client to leave the premises or take any other
427 retaliatory action against another person solely because of the
428 following:
429 (a) The client or other person files an internal or
430 external complaint or grievance regarding the facility.
431 (b) The client or other person appears as a witness in a
432 hearing inside or outside the facility.
433 (5) Before or at the time of admission, the client and, if
434 applicable, the client's representative shall receive a copy of
435 the licensee's responsibilities, including grievance procedures
436 and telephone numbers, as provided in this section.
437 (6) The licensee must develop and implement policies and
438 procedures governing the release of client information,
439 including consent necessary from the client or, if applicable,
440 the client's representative.
441 400.9976 Administration of medication.—
442 (1) An individual medication administration record must be

443 maintained for each client. A dose of medication, including a
444 self-administered dose, shall be properly recorded in the
445 client's record. A client who self-administers medication shall
446 be given a pill organizer. Medication must be placed in the pill
447 organizer by a nurse. A nurse shall document the date and time
448 that medication is placed into each client's pill organizer. All
449 medications must be administered in compliance with orders of a
450 physician, physician assistant, or advanced registered nurse
451 practitioner.
452 (2) If an interdisciplinary team determines that self-
453 administration of medication is an appropriate objective, and if
454 the physician, physician assistant, or advanced registered nurse
455 practitioner does not specify otherwise, the client must be
456 instructed by the physician, physician assistant, or advanced
457 registered nurse practitioner to self-administer his or her
458 medication without the assistance of a staff person. All forms
459 of self-administration of medication, including administration
460 orally, by injection, and by suppository, shall be included in
461 the training. The client's physician, physician assistant, or
462 advanced registered nurse practitioner must be informed of the
463 interdisciplinary team's decision that self-administration of
464 medication is an objective for the client. A client may not
465 self-administer medication until he or she demonstrates the
466 competency to take the correct medication in the correct dosage
467 at the correct time, to respond to missed doses, and to contact
468 the appropriate person with questions.

469 (3) Medication administration discrepancies and adverse
470 drug reactions must be recorded and reported immediately to a
471 physician, physician assistant, or advanced registered nurse
472 practitioner.
473 400.9977 Assistance with medication.—
474 (1) Notwithstanding any provision of part I of chapter
475 464, the Nurse Practice Act, unlicensed direct care services
476 staff who provide services to clients in a facility licensed
477 under chapter 400 or chapter 429 may administer prescribed,
478 prepackaged, and premeasured medications under the general
479 supervision of a registered nurse as provided under this section
480 and applicable rules.
481 (2) Training required by this section and applicable rules
482 shall be conducted by a registered nurse licensed under chapter
483 464, a physician licensed under chapter 458 or chapter 459, or a
484 pharmacist licensed under chapter 465.
485 (3) A facility that allows unlicensed direct care service
486 staff to administer medications pursuant to this section shall:
487 (a) Develop and implement policies and procedures that
488 include a plan to ensure the safe handling, storage, and
489 administration of prescription medications.
490 (b) Maintain written evidence of the expressed and
491 informed consent for each client.
492 (c) Maintain a copy of the written prescription, including
493 the name of the medication, the dosage, and the administration
494 schedule and termination date.

495 (d) Maintain documentation of compliance with required
496 training.
497 (4) The agency shall adopt rules to implement this
498 section.
499 Section 2. Section 400.9978, Florida Statutes, is created
500 to read:
501 400.9978 Protection of clients from abuse, neglect,
502 mistreatment, and exploitation.—The licensee shall develop and
503 implement policies and procedures for the screening and training
504 of employees; the protection of clients; and the prevention,
505 identification, investigation, and reporting of abuse, neglect,
506 mistreatment, and exploitation. The licensee shall identify
507 clients whose personal histories render them at risk for abusing
508 other clients, develop intervention strategies to prevent
509 occurrences of abuse, monitor clients for changes that would
510 trigger abusive behavior, and reassess the interventions on a
511 regular basis. A licensee shall:
512 (1) Screen each potential employee for a history of abuse,
513 neglect, mistreatment, or exploitation of clients. The screening
514 shall include an attempt to obtain information from previous and
515 current employers and verification of screening information by
516 the appropriate licensing boards.
517 (2) Train employees through orientation and ongoing
518 sessions regarding issues related to abuse prohibition
519 practices, including identification of abuse, neglect,
520 mistreatment, and exploitation; appropriate interventions to

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521 address aggressive or catastrophic reactions of clients; the
522 process for reporting allegations without fear of reprisal; and
523 recognition of signs of frustration and stress that may lead to
524 abuse.
525 (3) Provide clients, families, and staff with information
526 regarding how and to whom they may report concerns, incidents,
527 and grievances without fear of retribution and provide feedback
528 regarding the concerns that are expressed. A licensee shall
529 identify, correct, and intervene in situations in which abuse,
530 neglect, mistreatment, or exploitation is likely to occur,
531 including:
532 (a) Evaluating the physical environment of the facility to
533 identify characteristics that may make abuse or neglect more
534 likely to occur, such as secluded areas.
535 (b) Providing sufficient staff on each shift to meet the
536 needs of the clients and ensuring that the assigned staff have
537 knowledge of each client's care needs.
538 (c) Identifying inappropriate staff behaviors, such as
539 using derogatory language, rough handling of clients, ignoring
540 clients while giving care, and directing clients who need
541 toileting assistance to urinate or defecate in their beds.
542 (d) Assessing, monitoring, and planning care for clients
543 with needs and behaviors that might lead to conflict or neglect,
544 such as a history of aggressive behaviors including entering
545 other clients' rooms without permission, exhibiting self-
546 injurious behaviors or communication disorders, requiring

547 intensive nursing care, or being totally dependent on staff.
548 (4) Identify events, such as suspicious bruising of
549 clients, occurrences, patterns, and trends that may constitute
550 abuse and determine the direction of the investigation.
551 (5) Investigate alleged violations and different types of
552 incidents, identify the staff member responsible for initial
553 reporting, and report results to the proper authorities. The
554 licensee shall analyze the incidents to determine whether
555 policies and procedures need to be changed to prevent further
556 incidents and take necessary corrective actions.
557 (6) Protect clients from harm during an investigation.
558 (7) Report alleged violations and substantiated incidents,
559 as required under chapters 39 and 415, to the licensing
560 authorities and all other agencies, as required, and report any
561 knowledge of actions by a court of law that would indicate an
562 employee is unfit for service.
563 400.9979 Restraint and seclusion; client safety.—
564 (1) A facility shall provide a therapeutic milieu that
565 supports a culture of individual empowerment and responsibility.
566 The health and safety of the client shall be the facility's
567 primary concern at all times.
568 (2) The use of physical restraints must be ordered and
569 documented by a physician, physician assistant, or advanced
570 registered nurse practitioner and must be consistent with the
571 policies and procedures adopted by the facility. The client or,
572 if applicable, the client's representative shall be informed of

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573 the facility's physical restraint policies and procedures when
574 the client is admitted.
575 (3) The use of chemical restraints shall be limited to
576 prescribed dosages of medications as ordered by a physician,
577 physician assistant, or advanced registered nurse practitioner
578 and must be consistent with the client's diagnosis and the
579 policies and procedures adopted by the facility. The client and,
580 if applicable, the client's representative shall be informed of
581 the facility's chemical restraint policies and procedures when
582 the client is admitted.
583 (4) Based on the assessment by a physician, physician
584 assistant, or advanced registered nurse practitioner, if a
585 client exhibits symptoms that present an immediate risk of
586 injury or death to himself or herself or others, a physician,
587 physician assistant, or advanced registered nurse practitioner
588 may issue an emergency treatment order to immediately administer
589 rapid-response psychotropic medications or other chemical
590 restraints. Each emergency treatment order must be documented
591 and maintained in the client's record.
592 (a) An emergency treatment order is not effective for more
593 than 24 hours.
594 (b) Whenever a client is medicated under this subsection,
595 the client's representative or a responsible party and the
596 client's physician, physician assistant, or advanced registered
597 nurse practitioner shall be notified as soon as practicable.
598 (5) A client who is prescribed and receives a medication

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599 that can serve as a chemical restraint for a purpose other than
600 an emergency treatment order must be evaluated by his or her
601 physician, physician assistant, or advanced registered nurse
602 practitioner at least monthly to assess:
603 (a) The continued need for the medication.
604 (b) The level of the medication in the client's blood.
605 (c) The need for adjustments to the prescription.
606 (6) The licensee shall ensure that clients are free from
607 unnecessary drugs and physical restraints and are provided
608 treatment to reduce dependency on drugs and physical restraints.
609 (7) The licensee may only employ physical restraints and
610 seclusion as authorized by the facility's written policies,
611 which shall comply with this section and applicable rules.
612 (8) Interventions to manage dangerous client behavior
613 shall be employed with sufficient safeguards and supervision to
614 ensure that the safety, welfare, and civil and human rights of a
615 client are adequately protected.
616 (9) A facility shall notify the parent, guardian, or, if
617 applicable, the client's representative when restraint or
618 seclusion is employed. The facility must provide the
619 notification within 24 hours after the restraint or seclusion is
620 employed. Reasonable efforts must be taken to notify the parent,
621 guardian, or, if applicable, the client's representative by
622 telephone or e-mail, or both, and these efforts must be
623 documented.
624 (10) The agency may adopt rules that establish standards

625 and procedures for the use of restraints, restraint positioning,
626 seclusion, and emergency treatment orders for psychotropic
627 medications, restraint, and seclusion. These rules must include
628 duration of restraint, staff training, observation of the client
629 during restraint, and documentation and reporting standards.
630 400.998 Personnel background screening; administration and
631 management procedures.—
632 (1) The agency shall require level 2 background screening
633 for licensee personnel as required in s. 408.809(1)(e) and
634 pursuant to chapter 435 and s. 408.809.
635 (2) The licensee shall maintain personnel records for each
636 staff member that contain, at a minimum, documentation of
637 background screening, a job description, documentation of
638 compliance with the training requirements of this part and
639 applicable rules, the employment application, references, a copy
640 of each job performance evaluation, and, for each staff member
641 who performs services for which licensure or certification is
642 required, a copy of all licenses or certification held by that
643 staff member.
644 (3) The licensee must:
645 (a) Develop and implement infection control policies and
646 procedures and include the policies and procedures in the
647 licensee's policy manual.
648 (b) Maintain liability insurance as defined in s.
649 624.605(1)(b).
650 (c) Designate one person as an administrator to be

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651 responsible and accountable for the overall management of the
652 facility.
653 (d) Designate in writing a person to be responsible for
654 the facility when the administrator is absent from the facility
655 for more than 24 hours.
656 (e) Designate in writing a program director to be
657 responsible for supervising the therapeutic and behavioral
658 staff, determining the levels of supervision, and determining
659 room placement for each client.
660 (f) Designate in writing a person to be responsible when
661 the program director is absent from the facility for more than
662 24 hours.
663 (g) Obtain approval of the comprehensive emergency
664 management plan, pursuant to s. 400.9982(2)(e), from the local
665 emergency management agency. Pending the approval of the plan,
666 the local emergency management agency shall ensure that the
667 following agencies, at a minimum, are given the opportunity to
668 review the plan: the Department of Health, the Agency for Health
669 Care Administration, and the Division of Emergency Management.
670 Appropriate volunteer organizations shall also be given the
671 opportunity to review the plan. The local emergency management
672 agency shall complete its review within 60 days after receipt of
673 the plan and either approve the plan or advise the licensee of
674 necessary revisions.
675 (h) Maintain written records in a form and system that
676 comply with medical and business practices and make the records

677 available by the facility for review or submission to the agency
678 upon request. The records shall include:
679 1. A daily census record that indicates the number of
680 clients currently receiving services in the facility, including
681 information regarding any public funding of such clients.
682 2. A record of each accident or unusual incident involving
683 a client or staff member that caused, or had the potential to
684 cause, injury or harm to any person or property within the
685 facility. The record shall contain a clear description of each
686 accident or incident; the names of the persons involved; a
687 description of medical or other services provided to these
688 persons, including the provider of the services; and the steps
689 taken to prevent recurrence of such accident or incident.
690 3. A copy of current agreements with third-party
691 providers.
692 4. A copy of current agreements with each consultant
693 employed by the licensee and documentation of a consultant's
694 visits and required written and dated reports.
695 400.9981 Property and personal affairs of clients.—
696 (1) A client shall be given the option of using his or her
697 own belongings, as space permits; choosing a roommate if
698 practical and not clinically contraindicated; and, whenever
699 possible, unless the client is adjudicated incompetent or
700 incapacitated under state law, managing his or her own affairs.
701 (2) The admission of a client to a facility and his or her
702 presence therein does not confer on a licensee or administrator,

703 or an employee or representative thereof, any authority to
704 manage, use, or dispose of the property of the client, and the
705 admission or presence of a client does not confer on such person
706 any authority or responsibility for the personal affairs of the
707 client except that which may be necessary for the safe
708 management of the facility or for the safety of the client.
709 (3) A licensee or administrator, or an employee or
710 representative thereof, may:
711 (a) Not act as the guardian, trustee, or conservator for a
712 client or a client's property.
713 (b) Act as a competent client's payee for social security,
714 veteran's, or railroad benefits if the client provides consent
715 and the licensee files a surety bond with the agency in an
716 amount equal to twice the average monthly aggregate income or
717 personal funds due to the client, or expendable for the client's
718 account, that are received by a licensee.
719 (c) Act as the attorney in fact for a client if the
720 licensee files a surety bond with the agency in an amount equal
721 to twice the average monthly income of the client, plus the
722 value of a client's property under the control of the attorney
723 in fact.
724
725 The surety bond required under paragraph (b) or paragraph (c)
726 shall be executed by the licensee as principal and a licensed
727 surety company. The bond shall be conditioned upon the faithful
728 compliance of the licensee with the requirements of licensure

729 and is payable to the agency for the benefit of a client who
730 suffers a financial loss as a result of the misuse or
731 misappropriation of funds held pursuant to this subsection. A
732 surety company that cancels or does not renew the bond of a
733 licensee shall notify the agency in writing at least 30 days
734 before the action, giving the reason for cancellation or
735 nonrenewal. A licensee or administrator, or an employee or
736 representative thereof, who is granted power of attorney for a
737 client of the facility shall, on a monthly basis, notify the
738 client in writing of any transaction made on behalf of the
739 client pursuant to this subsection, and a copy of the
740 notification given to the client shall be retained in the
741 client's file and available for agency inspection.
742 (4) A licensee, with the consent of the client, shall
743 provide for safekeeping in the facility of the client's personal
744 effects of a value not in excess of $1,000 and the client's
745 funds not in excess of $500 cash and shall keep complete and
746 accurate records of the funds and personal effects received. If
747 a client is absent from a facility for 24 hours or more, the
748 licensee may provide for safekeeping of the client's personal
749 effects of a value in excess of $1,000.
750 (5) Funds or other property belonging to or due to a
751 client or expendable for the client's account that are received
752 by a licensee shall be regarded as funds held in trust and shall
753 be kept separate from the funds and property of the licensee and
754 other clients or shall be specifically credited to the client.

755 The funds held in trust shall be used or otherwise expended only
756 for the account of the client. At least once every month, except
757 pursuant to an order of a court of competent jurisdiction, the
758 licensee shall furnish the client and, if applicable, the
759 client's representative with a complete and verified statement
760 of all funds and other property to which this subsection
761 applies, detailing the amount and items received, together with
762 their sources and disposition. The licensee shall furnish the
763 statement annually and upon discharge or transfer of a client. A
764 governmental agency or private charitable agency contributing
765 funds or other property to the account of a client is also
766 entitled to receive a statement monthly and upon the discharge
767 or transfer of the client.
768 (6)(a) In addition to any damages or civil penalties to
769 which a person is subject, a person who:
770 1. Intentionally withholds a client's personal funds,
771 personal property, or personal needs allowance;
772 2. Demands, beneficially receives, or contracts for
773 payment of all or any part of a client's personal property or
774 personal needs allowance in satisfaction of the facility rate
775 for supplies and services; or
776 3. Borrows from or pledges any personal funds of a client,
777 other than the amount agreed to by written contract under s.
778 429.24,
779
780 commits a misdemeanor of the first degree, punishable as

781 provided in s. 775.082 or s. 775.083.
782 (b) A licensee or administrator, or an employee, or
783 representative thereof, who is granted power of attorney for a
784 client and who misuses or misappropriates funds obtained through
785 this power commits a felony of the third degree, punishable as
786 provided in s. 775.082, s. 775.083, or s. 775.084.
787 (7) In the event of the death of a client, a licensee
788 shall return all refunds, funds, and property held in trust to
789 the client's personal representative, if one has been appointed
790 at the time the licensee disburses such funds, or, if not, to
791 the client's spouse or adult next of kin named in a beneficiary
792 designation form provided by the licensee to the client. If the
793 client does not have a spouse or adult next of kin or such
794 person cannot be located, funds due to be returned to the client
795 shall be placed in an interest-bearing account, and all property
796 held in trust by the licensee shall be safeguarded until such
797 time as the funds and property are disbursed pursuant to the
798 Florida Probate Code. The funds shall be kept separate from the
799 funds and property of the licensee and other clients of the
800 facility. If the funds of the deceased client are not disbursed
801 pursuant to the Florida Probate Code within 2 years after the
802 client's death, the funds shall be deposited in the Health Care
803 Trust Fund administered by the agency.
804 (8) The agency, by rule, may clarify terms and specify
805 procedures and documentation necessary to administer the
806 provisions of this section relating to the proper management of

807 clients' funds and personal property and the execution of surety
808 bonds.
809 400.9982 Rules establishing standards.—
810 (1) It is the intent of the Legislature that rules adopted
811 and enforced pursuant to this part and part II of chapter 408
812 include criteria to ensure reasonable and consistent quality of
813 care and client safety. The rules should make reasonable efforts
814 to accommodate the needs and preferences of the client to
815 enhance the client's quality of life while residing in a
816 transitional living facility.
817 (2) The agency may adopt and enforce rules to implement
818 this part and part II of chapter 408, which shall include
819 reasonable and fair criteria with respect to:
820 (a) The location of transitional living facilities.
821 (b) The qualifications of personnel, including management,
822 medical, nursing, and other professional personnel and nursing
823 assistants and support staff, who are responsible for client
824 care. The licensee must employ enough qualified professional
825 staff to carry out and monitor interventions in accordance with
826 the stated goals and objectives of each comprehensive treatment
827 plan.
828 (c) Requirements for personnel procedures, reporting
829 procedures, and documentation necessary to implement this part.
830 (d) Services provided to clients of transitional living
831 facilities.
832 (e) The preparation and annual update of a comprehensive

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833 emergency management plan in consultation with the Division of
834 Emergency Management. At a minimum, the rules must provide for
835 plan components that address emergency evacuation
836 transportation; adequate sheltering arrangements; postdisaster
837 activities, including provision of emergency power, food, and
838 water; postdisaster transportation; supplies; staffing;
839 emergency equipment; individual identification of clients and
840 transfer of records; communication with families; and responses
841 to family inquiries.
842 400.9983 Violations; penalties.—A violation of this part
843 or any rule adopted pursuant thereto shall be classified
844 according to the nature of the violation and the gravity of its
845 probable effect on facility clients. The agency shall indicate
846 the classification on the written notice of the violation as
847 follows:
848 (1) Class "I" violations are defined in s. 408.813. The
849 agency shall issue a citation regardless of correction and
850 impose an administrative fine of $5,000 for an isolated
851 violation, $7,500 for a patterned violation, or $10,000 for a
852 widespread violation. Violations may be identified, and a fine
853 must be levied, notwithstanding the correction of the deficiency
854 giving rise to the violation.
855 (2) Class "II" violations are defined in s. 408.813. The
856 agency shall impose an administrative fine of $1,000 for an
857 isolated violation, $2,500 for a patterned violation, or $5,000
858 for a widespread violation. A fine must be levied

859 notwithstanding the correction of the deficiency giving rise to
860 the violation.
861 (3) Class "III" violations are defined in s. 408.813. The
862 agency shall impose an administrative fine of $500 for an
863 isolated violation, $750 for a patterned violation, or $1,000
864 for a widespread violation. If a deficiency giving rise to a
865 class III violation is corrected within the time specified by
866 the agency, the fine may not be imposed.
867 (4) Class "IV" violations are defined in s. 408.813. The
868 agency shall impose for a cited class IV violation an
869 administrative fine of at least $100 but not exceeding $200 for
870 each violation. If a deficiency giving rise to a class IV
871 violation is corrected within the time specified by the agency,
872 the fine may not be imposed.
873 400.9984 Receivership proceedings.—The agency may apply s.
874 429.22 with regard to receivership proceedings for transitional
875 living facilities.
876 400.9985 Interagency communication.—The agency, the
877 department, the Agency for Persons with Disabilities, and the
878 Department of Children and Families shall develop electronic
879 systems to ensure that relevant information pertaining to the
880 regulation of transitional living facilities and clients is
881 timely and effectively communicated among agencies in order to
882 facilitate the protection of clients. Electronic sharing of
883 information shall include, at a minimum, a brain and spinal cord
884 injury registry and a client abuse registry.

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

885 Section 3. Section 400.805, Florida Statutes, is repealed.
886 Section 4. The title of part V of chapter 400, Florida
887 Statutes, consisting of sections 400.701 and 400.801, is
888 redesignated as "INTERMEDIATE CARE FACILITIES."
889 Section 5. Subsection (9) of section 381.745, Florida
890 Statutes, is amended to read:
891 381.745 Definitions; ss. 381.739-381.79.—As used in ss.
892 381.739-381.79, the term:
893 (9) "Transitional living facility" means a state-approved
894 facility, as defined and licensed under chapter 400 or chapter
895 429, or a facility approved by the brain and spinal cord injury
896 program in accordance with this chapter.
897 Section 6. Section 381.75, Florida Statutes, is amended to
898 read:
899 381.75 Duties and responsibilities of the department, of
900 transitional living facilities, and of residents.—Consistent
901 with the mandate of s. 381.7395, the department shall develop
902 and administer a multilevel treatment program for individuals
903 who sustain brain or spinal cord injuries and who are referred
904 to the brain and spinal cord injury program.
905 (1) Within 15 days after any report of an individual who
906 has sustained a brain or spinal cord injury, the department
907 shall notify the individual or the most immediate available
908 family members of their right to assistance from the state, the
909 services available, and the eligibility requirements.
910 (2) The department shall refer individuals who have brain

911 or spinal cord injuries to other state agencies to ensure ~~assure~~
912 that rehabilitative services, if desired, are obtained by that
913 individual.
914 (3) The department, in consultation with emergency medical
915 service, shall develop standards for an emergency medical
916 evacuation system that will ensure that all individuals who
917 sustain traumatic brain or spinal cord injuries are transported
918 to a department-approved trauma center that meets the standards
919 and criteria established by the emergency medical service and
920 the acute-care standards of the brain and spinal cord injury
921 program.
922 (4) The department shall develop standards for designation
923 of rehabilitation centers to provide rehabilitation services for
924 individuals who have brain or spinal cord injuries.
925 (5) The department shall determine the appropriate number
926 of designated acute-care facilities, inpatient rehabilitation
927 centers, and outpatient rehabilitation centers~~,~~ needed based on
928 incidence, volume of admissions, and other appropriate criteria.
929 (6) The department shall develop standards for designation
930 of transitional living facilities to provide transitional living
931 services for individuals who participate in the brain and spinal
932 cord injury program ~~the opportunity to adjust to their~~
933 ~~disabilities and to develop physical and functional skills in a~~
934 ~~supported living environment~~.
935 ~~(a) The Agency for Health Care Administration, in~~
936 ~~consultation with the department, shall develop rules for the~~

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

937 ~~licensure of transitional living facilities for individuals who~~
938 ~~have brain or spinal cord injuries.~~
939 ~~(b) The goal of a transitional living program for~~
940 ~~individuals who have brain or spinal cord injuries is to assist~~
941 ~~each individual who has such a disability to achieve a higher~~
942 ~~level of independent functioning and to enable that person to~~
943 ~~reenter the community. The program shall be focused on preparing~~
944 ~~participants to return to community living.~~
945 ~~(c) A transitional living facility for an individual who~~
946 ~~has a brain or spinal cord injury shall provide to such~~
947 ~~individual, in a residential setting, a goal-oriented treatment~~
948 ~~program designed to improve the individual's physical,~~
949 ~~cognitive, communicative, behavioral, psychological, and social~~
950 ~~functioning, as well as to provide necessary support and~~
951 ~~supervision. A transitional living facility shall offer at least~~
952 ~~the following therapies: physical, occupational, speech,~~
953 ~~neuropsychology, independent living skills training, behavior~~
954 ~~analysis for programs serving brain-injured individuals, health~~
955 ~~education, and recreation.~~
956 ~~(d) All residents shall use the transitional living~~
957 ~~facility as a temporary measure and not as a permanent home or~~
958 ~~domicile. The transitional living facility shall develop an~~
959 ~~initial treatment plan for each resident within 3 days after the~~
960 ~~resident's admission. The transitional living facility shall~~
961 ~~develop a comprehensive plan of treatment and a discharge plan~~
962 ~~for each resident as soon as practical, but no later than 30~~

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

963 ~~days after the resident's admission. Each comprehensive~~
964 ~~treatment plan and discharge plan must be reviewed and updated~~
965 ~~as necessary, but no less often than quarterly. This subsection~~
966 ~~does not require the discharge of an individual who continues to~~
967 ~~require any of the specialized services described in paragraph~~
968 ~~(c) or who is making measurable progress in accordance with that~~
969 ~~individual's comprehensive treatment plan. The transitional~~
970 ~~living facility shall discharge any individual who has an~~
971 ~~appropriate discharge site and who has achieved the goals of his~~
972 ~~or her discharge plan or who is no longer making progress toward~~
973 ~~the goals established in the comprehensive treatment plan and~~
974 ~~the discharge plan. The discharge location must be the least~~
975 ~~restrictive environment in which an individual's health, well-~~
976 ~~being, and safety is preserved.~~
977 ~~(7) Recipients of services, under this section, from any~~
978 ~~of the facilities referred to in this section shall pay a fee~~
979 ~~based on ability to pay.~~
980 Section 7. Subsection (4) of section 381.78, Florida
981 Statutes, is amended to read:
982 381.78 Advisory council on brain and spinal cord
983 injuries.—
984 (4) The council shall~~:~~
985 ~~(a)~~ provide advice and expertise to the department in the
986 preparation, implementation, and periodic review of the brain
987 and spinal cord injury program.
988 ~~(b) Annually appoint a five-member committee composed of~~

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989 ~~one individual who has a brain injury or has a family member~~
990 ~~with a brain injury, one individual who has a spinal cord injury~~
991 ~~or has a family member with a spinal cord injury, and three~~
992 ~~members who shall be chosen from among these representative~~
993 ~~groups: physicians, other allied health professionals,~~
994 ~~administrators of brain and spinal cord injury programs, and~~
995 ~~representatives from support groups with expertise in areas~~
996 ~~related to the rehabilitation of individuals who have brain or~~
997 ~~spinal cord injuries, except that one and only one member of the~~
998 ~~committee shall be an administrator of a transitional living~~
999 ~~facility. Membership on the council is not a prerequisite for~~
1000 ~~membership on this committee.~~
1001 ~~1. The committee shall perform onsite visits to those~~
1002 ~~transitional living facilities identified by the Agency for~~
1003 ~~Health Care Administration as being in possible violation of the~~
1004 ~~statutes and rules regulating such facilities. The committee~~
1005 ~~members have the same rights of entry and inspection granted~~
1006 ~~under s. 400.805(4) to designated representatives of the agency.~~
1007 ~~2. Factual findings of the committee resulting from an~~
1008 ~~onsite investigation of a facility pursuant to subparagraph 1.~~
1009 ~~shall be adopted by the agency in developing its administrative~~
1010 ~~response regarding enforcement of statutes and rules regulating~~
1011 ~~the operation of the facility~~.
1012 ~~3. Onsite investigations by the committee shall be funded~~
1013 ~~by the Health Care Trust Fund.~~
1014 ~~4. Travel expenses for committee members shall be~~

1015 ~~reimbursed in accordance with s. 112.061.~~

1016 ~~5. Members of the committee shall recuse themselves from~~

1017 ~~participating in any investigation that would create a conflict~~

1018 ~~of interest under state law, and the council shall replace the~~

1019 ~~member, either temporarily or permanently.~~

1020 Section 8. Subsection (5) of section 400.93, Florida

1021 Statutes, is amended to read:

1022 400.93 Licensure required; exemptions; unlawful acts;

1023 penalties.—

1024 (5) The following are exempt from home medical equipment

1025 provider licensure, unless they have a separate company,

1026 corporation, or division that is in the business of providing

1027 home medical equipment and services for sale or rent to

1028 consumers at their regular or temporary place of residence

1029 pursuant to the provisions of this part:

1030 (a) Providers operated by the Department of Health or

1031 Federal Government.

1032 (b) Nursing homes licensed under part II.

1033 (c) Assisted living facilities licensed under chapter 429,

1034 when serving their residents.

1035 (d) Home health agencies licensed under part III.

1036 (e) Hospices licensed under part IV.

1037 (f) Intermediate care facilities <u>and</u>~~,~~ homes for special

1038 services~~, and transitional living facilities~~ licensed under part

1039 V.

1040 <u>(g) Transitional living facilities licensed under part XI.</u>

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1041 (h)~~(g)~~ Hospitals and ambulatory surgical centers licensed
1042 under chapter 395.
1043 (i)~~(h)~~ Manufacturers and wholesale distributors when not
1044 selling directly to consumers.
1045 (j)~~(i)~~ Licensed health care practitioners who use ~~utilize~~
1046 home medical equipment in the course of their practice~~,~~ but do
1047 not sell or rent home medical equipment to their patients.
1048 (k)~~(j)~~ Pharmacies licensed under chapter 465.
1049 Section 9. Subsection (21) of section 408.802, Florida
1050 Statutes, is amended to read:
1051 408.802 Applicability.—The provisions of this part apply
1052 to the provision of services that require licensure as defined
1053 in this part and to the following entities licensed, registered,
1054 or certified by the agency, as described in chapters 112, 383,
1055 390, 394, 395, 400, 429, 440, 483, and 765:
1056 (21) Transitional living facilities, as provided under
1057 part XI ~~V~~ of chapter 400.
1058 Section 10. Subsection (20) of section 408.820, Florida
1059 Statutes, is amended to read:
1060 408.820 Exemptions.—Except as prescribed in authorizing
1061 statutes, the following exemptions shall apply to specified
1062 requirements of this part:
1063 (20) Transitional living facilities, as provided under
1064 part XI ~~V~~ of chapter 400, are exempt from s. 408.810(10).
1065 Section 11. Effective July 1, 2015, a transitional living
1066 facility licensed before the effective date of this act pursuant

1067 to s. 400.805, Florida Statutes, must be licensed under part XI
1068 of chapter 400, Florida Statutes, as created by this act.
1069 Section 12. Except as otherwise expressly provided in this
1070 act, this act shall take effect July 1, 2014.

PCS for HB 1179

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1179 Licensure of Nurse Registries
SPONSOR(S): Health Innovation Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee		Poche	Shaw

SUMMARY ANALYSIS

In Florida, a nurse registry is an agency licensed to secure temporary employment for nurses, home health aides (HHAs), certified nursing assistants (CNAs), homemakers, and companions in a patient's home or with health care facilities or other entities. A person referred for contract by a nurse registry is compensated by fees as an independent contractor, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to licensed health care facilities or other entities. The person who is referred for contract then pays a fee to the nurse registry after the contract is signed with the patient, health care facility, or other entity.

Since a nurse registry operates as a referral service for health care workers working as independent contractors for a patient, health care facility, or other entity, a nurse registry is not required to meet the minimum wage and overtime requirements for employers established by the federal Fair Labor Standards Act (FLSA).

Currently, even if a nurse registry were found to be an employer of a person referred for contract, the registry remains exempt from the requirements of the FLSA relating to minimum wage and overtime payment under the exception for companionship services. However, a pending change to federal regulations, scheduled to take effect on January 1, 2015, will narrow the definition of "companionship services" to specifically exclude "the performance of medically related services." If a nurse registry is found to be an employer after the effective date of the new federal regulation, the registry must comply with the requirements of the FLSA relating to minimum wage and overtime payment, or violate federal law.

PCS for House Bill 1179 proposes several changes to statutes governing nurse registries to clarify the relationship between a nurse registry and the persons referred for contract by the registry. By confirming that each person referred for contract by a nurse registry is an independent contractor and that a nurse registry has no obligation to perform any tasks or oversight of a referred person's work so as to be misconstrued as an employee, a nurse registry may avoid liability for minimum wage and overtime payments as result of the change in federal rules governing companionship activities.

The PCS requires a nurse registry to notify the patient, the patient's family, or other person acting on behalf of the patient that the person referred for contract is an independent contractor and the nurse registry is not responsible to monitor, supervise, manage, or train the person referred for contract. However, the PCS also requires a nurse registry that has knowledge of a violation of law by a person referred to contract to advise the patient to terminate the contract and provide reasons for the suggested termination. The nurse registry must additionally cease referring the person for contract and notify the licensing board of any practice violations.

The PCS does not appear to have a fiscal impact on state or local governments.

The PCS provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Nurse Registries

In Florida, a nurse registry is an agency licensed to secure temporary employment for nurses, home health aides (HHAs), certified nursing assistants (CNAs), homemakers, and companions in a patient's home or with health care facilities or other entities.[1] A person referred for contract by a nurse registry is compensated by fees as an independent contractor, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to licensed health care facilities or other entities.[2] The person who is referred for contract then pays a fee to the nurse registry after the contract is signed with the patient, health care facility, or other entity. Nurse registries are governed by part II of chapter 408, F.S.,[3] associated rules in Chapter 59A-35, F.A.C., and the nurse registry rules in Chapter 59A-18, F.A.C.

A nurse registry must be licensed by the Agency for Health Care Administration (AHCA) in order to offer contracts in Florida.[4] In order to become licensed, a nurse registry must submit an application and a $2,000 licensure fee to the AHCA.[5] A nurse registry license automatically expires 2 years from the date it was issued and may be renewed biennially.[6]

A nurse registry has several responsibilities established by statute and rule, including, but not limited to:

- Confirming and annually reconfirming the licensure or certification of independent contractors;[7]
- Establishing a system for recording and following-up on complaints involving independent contractors referred for contract;[8]
- Preparing and maintaining a written comprehensive emergency management plan;[9] and
- Complying with the background screening requirements in s. 400.512, F.S., which require a level II background check for all employees and contractors.[10]

There are 519 licensed nurse registry locations in Florida.[11]

Nurse Registries and the Federal Fair Labor Standards Act (FLSA)

A nurse registry operates as a referral service for health care workers working as independent contractors for a patient, health care facility, or other entity. Because the patient, health care facility, or other entity has sole responsibility for hiring, firing, and paying the person referred for contract, a nurse registry is not required to meet the minimum wage and overtime requirements for employers established by the federal FLSA. However, a nurse registry may be considered an employer for the

[1] S. 400.462(6)(a), F.S.
[2] S. 400.462(21), F.S.
[3] S. 400.506(2), F.S. A nurse registry is also governed by the provisions in s. 400.506, F.S.
[4] S. 400.506(1), F.S.
[5] Rule 59A-18.004(1), F.A.C.
[6] Rule 59A-18.004(5), F.A.C.
[7] Rule 59A-18.005(3) and (4), F.A.C.
[8] Rule 59A-18.017(4), F.A.C.
[9] Rule 59A-18.018(1), F.A.C.
[10] S. 400.506(9), F.S.
[11] Agency for Health Care Administration, Florida HealthFinder, *Facility/Provider Locator-Nurse Registry*, available at www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last viewed on March 23, 2014).

purposes of the FLSA under certain circumstances.[12] Currently, if a nurse registry is found to be an employer of a person referred for contract, the registry remains exempt from the requirements of the FLSA relating to minimum wage and overtime payment under the exception companionship services.[13] The term "companionship services" means those services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed making, washing of clothes, and other similar services. They may also include the performance of general household work"[14]

A pending change to federal regulations, scheduled to take effect on January 1, 2015, will narrow the definition of "companionship services" to specifically exclude "the performance of medically related services."[15] If a nurse registry is found to be an employer after January 1, 2015, the registry must comply with the requirements of the FLSA relating to minimum wage and overtime payment, or violate federal law.

Effect of Proposed Changes

PCS for House Bill 1179 proposes several changes to statutes related to nurse registries to clarify the relationship between a nurse registry and the persons referred for contract by the registry. By confirming that each person referred for contract by a nurse registry is an independent contractor and that a nurse registry has no obligation to perform any tasks or oversight of a referred person's work so as to be misconstrued as an employee, a nurse registry may avoid liability for minimum wage and overtime payments as result of the change in federal rules governing companionship activities.

The PCS removes the requirement that a nurse registry ensure that a CNS or HHA is adequately trained to perform the tasks of a home health aide when either is referred for contract in a home setting. Instead, the PCS only requires a nurse registry to ensure that a CNA or HHA has presented credentials which demonstrate adequate training to perform HHA tasks in a home setting.

The PCS requires a nurse registry, when a person is referred for contract to a patient's home, to advise the patient, the patient's family, and any person acting on behalf of the patient at the time the contract for services is made that the person who has been referred is an independent contractor and that the nurse registry has no obligation to monitor, supervise, manage, or train any person referred for contract.

The PCS adds a provision to s. 400.506, F.S., which explicitly states that a person referred for contract by a nurse registry is an independent contractor and not an employee of the registry. It also states that a nurse registry is under no obligation to monitor, supervise, manager, or train any person referred for contract. Further, the PCS clarifies that a nurse registry has no duty to review or take action on any records it is required to maintain by statute, such as the referred person's application and name and address of the patient to whom a person was referred for contract and the fee collected by the registry.[16] However, if a nurse registry has knowledge of a violation of law by a person referred for contract by the registry, the PCS requires the registry to:

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[12] 78 Fed. Reg. 60453, 60483 (Oct. 1, 2013); "Determinations about the existence of an employment or joint employment relationship are made by examining all the facts in a particular case and assessing the 'economic realities' of the work relationship. See, e.g., *Goldberg v. Whitaker House Cooperative, Inc.*, 366 U.S. 28, 33 (1961). Factors to consider may include whether an employer has the power to direct, control, or supervise the worker(s) or the work performed; whether an employer has the power to hire or fire, modify the employment conditions or determine the pay rates or the methods of wage payment for the worker(s); the degree of permanency and duration of the relationship; where the work is performed and whether the tasks performed require special skills; whether the work performed is an integral part of the overall business operation; whether an employer undertakes responsibilities in relation to the worker(s) which are commonly performed by employers; whose equipment is used; and who performs payroll and similar functions. An economic realities test does not depend on 'isolated factors but rather upon the circumstances of the whole activity.' See *Rutherford Food Corp. v. McComb*, 331 U.S. 722, 730 (1947)."

[13] 29 CFR §552.109(a)

[14] 29 CFR §552.6

[15] 78 Fed. Reg. at 60557.

[16] S. 400.506(10), F.S.

- Advise the patient to terminate the referred person's contract;
- Provide the reason for advising for termination of the contract;
- Cease referring the person for contract to any other patient, health care facility, or other entity; and
- Notify the appropriate licensing board of any practice violations.

The PCS provides an effective date of July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; penalties.
Section 2: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The PCS clarifies that each person referred for contract by a nurse registry is an independent contractor and that a nurse registry is not responsible for certain actions or activities that may be associated with an employer-employee relationship, such as training and management of a referred person. As a result, a nurse registry may be able to avoid complying with minimum wage requirements and overtime payments required under the new federal DOL rule that removes the exemption from these requirements under the FLSA for companionship services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The PCS does not require rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to nurse registries; amending s.
3 400.506, F.S.; providing that a nurse registry must
4 ensure that a certified nursing assistant referred for
5 contract and a home health aide referred for contract
6 provide certain credentials to the nurse registry;
7 providing that a nurse registry must advise the
8 patient, or person representing the patient, that a
9 person referred for contract by the nurse registry is
10 an independent contractor and that the nurse registry
11 has no obligation to monitor, supervise, manage, or
12 train a person referred for contract; providing that a
13 person referred for contract by a nurse registry is an
14 independent contractor and not an employee of the
15 nurse registry; providing obligations of a nurse
16 registry when the nurse registry has knowledge of a
17 violation of law by a person referred for contract;
18 providing that a nurse registry has no obligation to
19 review or take action upon records that are required
20 to be maintained by the nurse registry under this
21 section; providing an exception; providing an
22 effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25
26 Section 1. Paragraph (a) of subsection (6) of section

27 400.506, Florida Statutes, is amended to read:
28 400.506 Licensure of nurse registries; requirements;
29 penalties.—
30 (6)(a) A nurse registry may refer for contract in private
31 residences registered nurses and licensed practical nurses
32 registered and licensed under part I of chapter 464, certified
33 nursing assistants certified under part II of chapter 464, home
34 health aides who present documented proof of successful
35 completion of the training required by rule of the agency, and
36 companions or homemakers for the purposes of providing those
37 services authorized under s. 400.509(1). A licensed nurse
38 registry shall ensure that each certified nursing assistant
39 referred for contract by the nurse registry and each home health
40 aide referred for contract by the nurse registry has presented
41 credentials which demonstrate adequate training ~~is adequately~~
42 ~~trained~~ to perform the tasks of a home health aide in the home
43 setting. Each person referred by a nurse registry must provide
44 current documentation that he or she is free from communicable
45 diseases.
46 (d) When a person is referred for contract to a patient's
47 home by a nurse registry, the nurse registry shall advise the
48 patient, the patient's family, or any other person acting on
49 behalf of the patient at the time the contract for services is
50 made that the person referred for contract is an independent
51 contractor and that the nurse registry has no obligation to
52 monitor, supervise, manage, or train a person referred for

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

53 contract.
54 (19) A person referred for contract by a nurse registry is
55 an independent contractor and not an employee of the nurse
56 registry. A nurse registry is not required to monitor,
57 supervise, manage, or train persons referred for contract by the
58 nurse registry. If a nurse registry has knowledge of a
59 violation of law by a person referred for contract, the nurse
60 registry shall advise the patient to terminate the referred
61 person's contract, providing the reason for the suggested
62 termination; cease referring the person; and notify the
63 licensing board of any practice violations.
64 (20) A nurse registry has no obligation to review or take
65 action upon records that are required to be maintained by the
66 nurse registry under this section except as required in
67 subsection (19).
68 Section 2. This act shall take effect July 1, 2014.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing PCB: Health Innovation
2 Subcommittee
3 Representative Steube offered the following:
4
5 **Amendment**
6 Remove line 63 and insert:
7 licensing board of any practice violations. This section does
8 not affect or negate any other obligations imposed on a nurse
9 registry under chapter 408.
10