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ST - C1325 - Facial Coverings for Infection Control

Title Facial Coverings for Infection Control

Type Rule

59AER23-2

Regulation Definition

59AER23-2 Standards for the Appropriate Use of Facial Coverings for Infection Control.
(1) Health care practitioners and health care providers may choose to require a patient to wear a facial covering only when the patient is in a common area of the health care setting and is exhibiting signs or symptoms of or has a diagnosed infectious disease that can be spread through droplet or airborne transmission.
(2) Health care practitioners and health care providers may choose to require a visitor to wear a facial covering only when the visitor is:
(a) Exhibiting signs or symptoms of or has a diagnosed infectious disease that can be spread through droplet or airborne transmission,
(b) In sterile areas of the health care setting or an area where sterile procedures are being performed,
(c) In an in-patient or clinical room with a patient who is exhibiting signs or symptoms of or has a diagnosed infectious disease that can be spread through droplet or airborne transmission, or
(d) Visiting a patient whose treating health care practitioner has diagnosed the patient with or confirmed a condition affecting the immune system in a manner which is known to increase risk of transmission of an infection from employees without signs or symptoms of infection to a patient and whose treating practitioner has determined that the use of facial coverings is necessary for the patient ' s safety.

Interpretive Guideline

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(3) Opt-Out Requirements are as follows:
(a) Pursuant to 59AER23-2(1), health care practitioners and health care providers who choose to require a facial covering for any patient must include in the policy a provision for the opting-out of wearing a facial covering. Such policy must be in accordance with the Florida Patient Bill of Rights and Responsibilities, section 381.026, F.S.
(b) Pursuant to 59AER23-2(2), health care practitioners and health care providers who choose to require a facial covering for any visitor must include in the policy a provision for the opting-out of wearing a facial covering if an alternative method of infection control or infectious disease prevention is available.
(4) Health care practitioners and health care providers must allow an employee to opt out of facial covering requirements unless an employee is:
(a) Conducting sterile procedures,
(b) Working in a sterile area,
(c) Working with a patient whose treating health care practitioner has diagnosed the patient with or confirmed a condition affecting the immune system in a manner which is known to increase risk of transmission of an infection from employees without signs or symptoms of infection to a patient and whose treating practitioner has determined that the use of facial coverings is necessary for the patient ' s safety,
(d) With a patient on droplet or airborne isolation, or
(e) Engaging in non-clinical potentially hazardous activities that require facial coverings to prevent physical injury or harm in accordance with industry standards.
Rulemaking Authority 408.824 FS. Law Implemented 408.824 FS. History - New.

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ST - CZ000 - Initial Comments

Title Initial Comments

Type Memo Tag

Regulation Definition	Interpretive Guideline
	These guidelines are meant solely to provide guidance to surveyors in the survey process.

ST - CZ800 - Applicability; Definitions

Title Applicability; Definitions

Type Rule

408.802-803; 59A-35.030; 59A-35.090(1)

Regulation Definition	Interpretive Guideline
408.802 Applicability.-This part applies to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, and 765: (1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102. (2) Birth centers, as provided under chapter 383. (3) Abortion clinics, as provided under chapter 390. (4) Crisis stabilization units, as provided under parts I and IV of chapter 394. (5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394. (6) Residential treatment facilities, as provided under part IV of chapter 394.	

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(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.
(8) Hospitals, as provided under part I of chapter 395.
(9) Ambulatory surgical centers, as provided under part I of chapter 395.
(10) Nursing homes, as provided under part II of chapter 400.
(11) Assisted living facilities, as provided under part I of chapter 429.
(12) Home health agencies, as provided under part III of chapter 400.
(13) Nurse registries, as provided under part III of chapter 400.
(14) Companion services or homemaker services providers, as provided under part III of chapter 400.
(15) Adult day care centers, as provided under part III of chapter 429.
(16) Hospices, as provided under part IV of chapter 400.
(17) Adult family-care homes, as provided under part II of chapter 429.
(18) Homes for special services, as provided under part V of chapter 400.
(19) Transitional living facilities, as provided under part XI of chapter 400.
(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.
(21) Home medical equipment providers, as provided under part VII of chapter 400.
(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.
(23) Health care services pools, as provided under part IX of chapter 400.
(24) Health care clinics, as provided under part X of chapter 400.
(25) Organ, tissue, and eye procurement organizations, as

provided under part V of chapter 765.

408.803 Definitions.-As used in this part, the term:
(1) "Agency" means the Agency for Health Care Administration, which is the licensing agency under this part.
(2) "Applicant" means an individual, corporation, partnership, firm, association, or governmental entity that submits an application for a license to the agency.
(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, and 765.
(4) "Certification" means certification as a Medicare or Medicaid provider of the services that require licensure, or certification pursuant to the federal Clinical Laboratory Improvement Amendment (CLIA).
(5) "Change of ownership" means:
(a) An event in which the licensee sells or otherwise transfers its ownership to a different individual or entity as evidenced by a change in federal employer identification number or taxpayer identification number; or
(b) An event in which 51 percent or more of the ownership, shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange.
A change solely in the management company or board of directors is not a change of ownership.
(6) "Client" means any person receiving services from a provider listed in s. 408.802.
(7) "Controlling interest" means:
(a) The applicant or licensee;
(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or

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(c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.
The term does not include a voluntary board member.
(8) "License" means any permit, registration, certificate, or license issued by the agency.
(9) "Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency. The licensee is legally responsible for all aspects of the provider operation.
(10) "Low-risk provider" means a nonresidential provider, including a nurse registry, a home medical equipment provider, or a health care clinic.
(11) "Moratorium" means a prohibition on the acceptance of new clients.
(12) "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802.
(13) "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister of a patient or client.
(14) "Services that require licensure" means those services, including residential services, that require a valid license before those services may be provided in accordance with authorizing statutes and agency rules.
(15) "Voluntary board member" means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any

remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization.

59A-35.030 Definitions.
(1) "Address of record" means the location that is printed on the license and is the address at which the provider is licensed to operate. In the event a license displays multiple locations including branch offices, satellite offices, or off-site locations, the address of record is the main or principle office address.
(2) "Agency notification" or "Agency request" means the Agency sends notification by:
(a) Mail or personal delivery to the address of record for a licensee or applicant;
(b) Mail to an alternative mailing address if requested by the licensee or applicant, or
(c) Electronic mail if an electronic mail address has been provided.
(3) "Days" means calendar days.
(4) "Management company" means an entity retained by a licensee to administer or direct the operation of a provider. This does not include an entity that serves solely as a lender or lien holder.

59A-35.090 Background Screening.
(1) Definitions:
(a) "Arrest Report" means the detailed narrative written by the arresting law enforcement officer explaining the circumstances of the arrest.
(b) "Disposition" means the sentencing or other final settlement of a criminal case which shall include, regardless of adjudication, a plea of nolo contendere or guilty, or a conviction by a judge or jury.
(c) "Disqualifying Offense" means any criminal offense prohibited in Section 435.04 or 408.809(4), F.S.
(d) "Exemption from Disqualification" means an exemption

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granted by the Agency following a review of the Background Screening Application for Exemption, AHCA Form 3110-0019, January 2017, hereby incorporated by reference, and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09105, and an informal teleconference, during which the individual must present clear and convincing evidence to support a reasonable belief that he or she has been rehabilitated and does not present a danger to the health, safety, and welfare of the patient or individual as described in Section 435.07, F.S.
(e) "FBI" means the Federal Bureau of Investigation.
(f) "FDLE" means the Florida Department of Law Enforcement.
(g) "Level 2 Screening" means an assessment of the criminal history record obtained through a fingerprint search through the FDLE and FBI to determine whether screened individuals have any disqualifying offenses pursuant to Section 435.04 or 408.809(4), F.S. An analysis and review of court dispositions and arrest reports may be required to make a final determination.
(h) "Livescan Service Provider" means an entity that scans fingerprints electronically and submits them to FDLE.

ST - CZ802 - License or Application Denial; Revocation

Title License or Application Denial; Revocation

Type Rule

408.815(1-4) FS

Regulation Definition

408.815 License or application denial; revocation.-
(1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:

Interpretive Guideline

The program unit is responsible for issuing notification of enforcement action for licensure actions.

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(a) False representation of a material fact in the license application or omission of any material fact from the application.
(b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
(c) A violation of this part, authorizing statutes, or applicable rules.
(d) A demonstrated pattern of deficient performance.
(e) The applicant, licensee, or controlling interest has been or is currently excluded, suspended, or terminated from participation in the state Medicaid program, the Medicaid program of any other state, or the Medicare program.
(2) If a licensee lawfully continues to operate while a denial or revocation is pending in litigation, the licensee must continue to meet all other requirements of this part, authorizing statutes, and applicable rules and file subsequent renewal applications for licensure and pay all licensure fees. The provisions of ss. 120.60(1) and 408.806(3)(c) do not apply to renewal applications filed during the time period in which the litigation of the denial or revocation is pending until that litigation is final.
(3) An action under s. 408.814 or denial of the license of the transferor may be grounds for denial of a change of ownership application of the transferee.
(4) Unless an applicant is determined by the agency to satisfy the provisions of subsection (5) for the action in question, the agency shall deny an application for a license or license renewal based upon any of the following actions of an applicant, a controlling interest of the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred:
(a) A conviction or a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance

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fraud, unless the sentence and any subsequent period of probation for such convictions or plea ended more than 15 years before the date of the application; or
(b) Termination for cause from the Medicare program or a state Medicaid program, unless the applicant has been in good standing with the Medicare program or a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

ST - CZ803 - License Required; Display

Title License Required; Display

Type Rule

408.804 FS

Regulation Definition

408.804 License required; display.-
(1) It is unlawful to provide services that require licensure, or operate or maintain a provider that offers or provides services that require licensure, without first obtaining from the agency a license authorizing the provision of such services or the operation or maintenance of such provider.
(2) A license must be displayed in a conspicuous place readily visible to clients who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily. The license is valid only for the licensee, provider, and location for which the license is issued.
(3) Any person who knowingly alters, defaces, or falsifies a license certificate issued by the agency, or causes or procures any person to commit such an offense, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any licensee or provider who displays an altered, defaced, or falsified license certificate is

Interpretive Guideline

- Check to see that the license is for the facility and location where it is displayed. Contact the appropriate licensure unit if there are questions about the license.
- During tour determine if the license is displayed in a conspicuous location.
- If applicable, check to make sure the category of testing being done is reflected on the license, the ownership given on the face of the license is accurate, that the location of the facility is the address printed on the license, and that the license is properly displayed. Look at Z0827 Unlicensed Activity- 408.12, F.S. as unlicensed activity should be cited if there has been a change of ownership, or for clinical laboratories, testing outside of the specialty/subspecialties printed on the license are being performed.
- Regarding Nursing Homes, refer to 400.062(2) which states:
Separate licenses shall be required for facilities maintained in separate premises, even though operated under the same management. However, a separate license shall not be required for separate buildings on the same grounds.

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subject to the penalties set forth in s. 408.815 and an administrative fine of $1,000 for each day of illegal display.

ST - CZ806 - Change of Address

Title Change of Address

Type Rule

59A-35.040 FAC

Regulation Definition

59A-35.040 License Required; Display.
(1) A license is valid only for the licensee, provider, and location for which the license is issued as it appears on the license.

(2) Any request to amend a license must be received by the Agency in advance of the requested effective date as detailed below. Requests to amend a license are not authorized until the license is issued.
(a) Requests to change the address of record must be received by the Agency 60 to 120 days in advance of the requested effective date for the following provider types:
1. Birth Centers, as provided under Chapter 383, F.S.,
2. Abortion Clinics, as provided under Chapter 390, F.S.,
3. Crisis Stabilization Units, as provided under Chapter 394, Parts I and IV, F.S.,
4. Short Term Residential Treatment Units, as provided under Chapter 394, Parts I and IV, F.S.,
5. Residential Treatment Facilities, as provided under Chapter 394, Part IV, F.S.,
6. Residential Treatment Centers for Children and Adolescents, as provided under Chapter 394, Part IV, F.S.,
7. Hospitals, as provided under Chapter 395, Part I, F.S.,
8. Ambulatory Surgical Centers, as provided under Chapter 395, Part I, F.S.,

Interpretive Guideline

- The licensure unit handles change of address, but surveyors may find that the provider has moved and therefore could cite this.

9. Nursing Homes, as provided under Chapter 400, Part II, F.S.,
10. Hospices, as provided under Chapter 400, Part IV, F.S.,
11. Homes for Special Services as provided under Chapter 400, Part V, F.S.,
12. Transitional Living Facilities, as provided under Chapter 400, Part XI, F.S.,
13. Prescribed Pediatric Extended Care Centers, as provided under Chapter 400, Part VI, F.S.,
14. Intermediate Care Facilities for the Developmentally Disabled, as provided under Chapter 400, Part VIII, F.S.,
15. Assisted Living Facilities, as provided under Chapter 429, Part I, F.S.,
16. Adult Family-Care Homes, as provided under Chapter 429, Part II, F.S.; and,
17. Adult Day Care Centers, as provided under Chapter 429, Part III, F.S.
(b) Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date for the following provider types:
1. Drug Free Workplace Laboratories as provided under Sections 112.0455 and 440.102, F.S.,
2. Home Health Agencies, as provided under Chapter 400, Part III, F.S.,
3. Nurse Registries, as provided under Chapter 400, Part III, F.S.,
4. Companion Services or Homemaker Services Providers, as provided under Chapter 400, Part III, F.S.,
5. Home Medical Equipment Providers, as provided under Chapter 400, Part VII, F.S.,
6. Health Care Services Pools, as provided under Chapter 400, Part IX, F.S.,
7. Health Care Clinics, as provided under Chapter 400, Part X, F.S., including certificate of exemption,
8. Organ and Tissue Procurement Agencies, as provided under

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Chapter 381, F.S.
(c) All other requests to amend a license including but not limited to services, licensed capacity, and other specifications which are required to be displayed on the license by authorizing statutes or applicable rules must be received by the Agency 60 to 120 days in advance of the requested effective date. This deadline does not apply to a request to amend hospital emergency services defined in Section 395.1041(2), F.S.

(3) Failure to submit a timely request shall result in a $500 fine.

(4) A licensee is not authorized to operate in a new location until a license is obtained which specifies the new location. Failure to amend a license prior to a change of the address of record constitutes unlicensed activity.

ST - CZ809 - Proof of Financial Ability to Operate

Title Proof of Financial Ability to Operate

Type Rule

59A-35.062(3)(e)&(7);408.803(7) &.810(8)

Regulation Definition

59A-35.062 Proof of Financial Ability to Operate.
(3) Definitions. The following definitions apply to this section for proof of financial ability to operate.
(e) "Financial instability" means the provider cannot meet its financial obligations. Evidence such as the issuance of bad checks, an accumulation of delinquent bills, or inability to meet current payroll needs shall constitute prima facie evidence that the ownership of the provider lacks the financial ability to operate. Evidence shall also include the Medicare or Medicaid program's indications or determination of financial

Interpretive Guideline

- This standard would be used by surveyors if evidence of financial instability is found and the licensee or any controlling interest in the licensee withholds information from the surveyor.
- The financial schedules and documentation of correction of the financial instability are submitted to the AHCA Home Care Unit <or other licensing unit> in the state office and reviewed by AHCA state office financial reviewers in the Financial Analysis Unit. Further administrative action may be taken by the state office.
- This standard applies to the following provider types:
· Nursing Home Facilities, as specified in Part II, Chapter 400, F.S.;
· Assisted Living Facilities, as specified in Part I, Chapter 429, F.S.;
· Home Health Agencies, as specified in Part III, Chapter 400, F.S.;
· Hospices, as specified in Part IV, Chapter 400, F.S.;

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instability or fraudulent handling of government funds by the provider.

408.803 Definitions.-As used in this part, the term:
(7) "Controlling interest" means:
(a) The applicant or licensee;
(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or
(c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.
The term does not include a voluntary board member.

408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.
(8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to

· Adult Day Care Centers, as specified in Part III, Chapter 429, F.S.;
· Prescribed Pediatric Extended Care Centers, as specified in Part VI, Chapter 400, F.S.;
· Home Medical Equipment Providers, as specified in Part VII, Chapter 400, F.S.;
· Intermediate Care Facilities for the Developmentally Disabled, as specified in Part VIII, Chapter 400, F.S.;
· Health Care Clinics, as specified in Part X, Chapter 400, F.S.;
- The standard applies to Nurse Registries as specified in 59A-18.004(7) which states:
- An application for renewal of a license shall not be required to provide proof of financial ability to operate, unless the applicant has demonstrated financial instability at any time, pursuant to Section 408.810, F.S., in which case AHCA shall require the applicant for renewal to provide proof of financial ability to operate by submitting information as described in 59A-35.062(7)(b), F.A.C. and documentation of correction of the financial instability, to include evidence of the payment in full of any bad checks, delinquent bills or liens and all associated fees, costs, and changes related to the instability. If complete payment cannot be made, evidence must be submitted of partial payment along with a plan for payment of any liens or delinquent bills. If the lien is with a government agency or repayment is ordered by a federal, state, or district court, an accepted plan of repayment must be provided. If the licensed nurse registry has demonstrated financial instability as outlined above at any time the AHCA will request proof of financial ability to operate.
- None of the Hospital Unit Programs nor the Lab Unit Programs would have this requirement.
59A-35.062 is not applicable to Abortion Clinics.

provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of financial ability to operate if the provider has been licensed for at least 5 years, and:
(a) The ownership change is a result of a corporate reorganization under which the controlling interest is unchanged and the applicant submits organizational charts that represent the current and proposed structure of the reorganized corporation; or
(b) The ownership change is due solely to the death of a person holding a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership.

59A-35.062 Proof of Financial Ability to Operate.
(7) An applicant for renewal of a license shall not be required to provide proof of financial ability to operate, unless the licensee or applicant has demonstrated financial instability. If an applicant or licensee has shown signs of financial instability, as provided in Section 408.810(9), F.S., at any time, the Agency may require the applicant or licensee to provide proof of financial ability to operate by submission of:
(a) AHCA Form 3100-0009, July 2009, Proof of Financial Ability Form, that includes a balance sheet and income and expense statement for the next 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses; and,
(b) Documentation of correction of the financial instability, including but not limited to, evidence of the payment of any bad checks, delinquent bills or liens. If complete payment cannot be made, evidence must be submitted of partial payment along with a plan for payment of any liens or

delinquent bills. If the lien is with a government agency or repayment is ordered by a federal or state court, an accepted plan of repayment must be provided.

ST - CZ812 - Change of Ownership

Title Change of Ownership

Type Rule

408.803(5); 408.807 FS

Regulation Definition

408.803 Definitions. -- As used in this part, the term:
(5) "Change of ownership" means:
(a) An event in which the licensee sells or otherwise transfers its ownership to a different individual or entity as evidenced by a change in federal employer identification number or taxpayer identification number; or
(b) An event in which 51 percent or more of the ownership, shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange.
A change solely in the management company or board of directors is not a change of ownership.

408.807 Change of ownership.-Whenever a change of ownership occurs:
(1) The transferor shall notify the agency in writing at least 60 days before the anticipated date of the change of ownership.
(2) The transferee shall make application to the agency for a license within the timeframes required in s. 408.806.
(3) The transferor shall be responsible and liable for:
(a) The lawful operation of the provider and the welfare of the clients served until the date the transferee is licensed by the agency.

Interpretive Guideline

- This tag may be cited for unreported changes of ownership.

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(b) Any and all penalties imposed against the transferor for violations occurring before the date of change of ownership.
(4) Any restriction on licensure, including a conditional license existing at the time of a change of ownership, shall remain in effect until the agency determines that the grounds for the restriction are corrected.
(5) The transferee shall maintain records of the transferor as required in this part, authorizing statutes, and applicable rules, including:
(a) All client records.
(b) Inspection reports.
(c) All records required to be maintained pursuant to s. 409.913, if applicable.

ST - CZ813 - Results of Screening & Notification In File

Title Results of Screening & Notification In File

Type Rule

59A-35.090(3)(c), FAC

Regulation Definition

59A-35.090 Background Screening.
(3) Results of Screening and Notification.
(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.

Interpretive Guideline

ST - CZ814 - Background Screening Clearinghouse

Title Background Screening Clearinghouse

Type Rule

435.12(2)(b-d), FS

Aspen State Regulation Set: C 2.18 Core Licensure

Regulation Definition

435.12 Care Provider Background Screening Clearinghouse.-
(2)(b) Until such time as the fingerprints are enrolled in the national retained print arrest notification program at the Federal Bureau of Investigation:
1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.
2. Effective January 1, 2026, or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity.
(c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse.
1. Before January 1, 2024, initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made.
2. Effective January 1, 2024, initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.
(d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the person ' s full

Interpretive Guideline

Review employee files for verification that any break in service was less than 90 days or a new screening was completed.

Verify that the facility has an updated employee roster listed in the clearinghouse.

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first name, middle initial, and last name; social security number; date of birth; mailing address; sex; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.

ST - CZ815 - Background Screening; Prohibited Offenses

Title Background Screening; Prohibited Offenses

Type Rule

408.809(1)(3-8); 435.02(2); 435.06 FS

Regulation Definition

408.809 Background screening; prohibited offenses.-
(1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435:
(a) The licensee, if an individual.
(b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider.
(c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider.
(d) Any person who is a controlling interest.
(e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or contracting with a licensee or provider to work 20 hours a week or more who will have access to client funds,

Interpretive Guideline

- Employees and contractors who do not meet the background screening requirements cannot be retained in a direct care capacity, unless an exemption from disqualification has been approved by AHCA or the Department of Health (when a licensed or certified health care professional or certified nursing assistant).
- The employee or contractor with a disqualifying offense must have a copy of an exemption [granted by either DOH or AHCA] in their personnel file before the employee or contractor can be hired.
- An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with vulnerable persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
- Individuals may be provisionally employed in positions requiring background screening. They may be in training or orientation, but may NOT have access to residents/patients until the background screening process is completed.
- An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.
- If an individual is in the Clearinghouse and are working then they must be on that provider's employee roster within 10 days of their hire date. The same for once a person is no longer working for that provider. If they are in the Clearinghouse then their status in the employee roster must be updated within 10 days of a change.

Surveyor Probes:
- Level 2 includes FDLE and FBI screening.
- Staff who do not have access to client property, funds, or living areas or who do not have contact with clients are not required to be screened.

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personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

(3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a vulnerable adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical

- If an employee or contractor's responsibility requires him or her to have contact with clients, a Level 2 background screening is required.
- Does the licensee have evidence of contractor and employee screening?

systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(l) Section 817.505, relating to patient brokering.
(m) Section 817.568, relating to criminal use of personal identification information.
(n) Section 817.60, relating to obtaining a credit card through fraudulent means.
(o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(p) Section 831.01, relating to forgery.
(q) Section 831.02, relating to uttering forged instruments.
(r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
(s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
(t) Section 831.30, relating to fraud in obtaining medicinal drugs.
(u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
(v) Section 895.03, relating to racketeering and collection of unlawful debts.
(w) Section 896.101, relating to the Florida Money Laundering Act.
If, upon rescreening, a person who is currently employed or contracted with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a

current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

(5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.

(6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.

(7) The agency and the Department of Health may adopt rules

pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2).

(8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

435.06 Exclusion from employment.-
(1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity.
(2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any vulnerable person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any vulnerable person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07.

(b) If an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires background screening until the arrest is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with vulnerable persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or arrest for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was arrested, regardless of whether or not that person has filed for an exemption pursuant to this chapter.

435.02 Definitions.-For the purposes of this chapter, the term:

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(2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers.

ST - CZ816 - Background Screening-Compliance Attestation

Title Background Screening-Compliance Attestation

Type Rule

408.809(2) 435.05(2) 59A-35.090(2d-3b)

Regulation Definition

408.809 Background screening; prohibited offenses.-
(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks

Interpretive Guideline

- Is AHCA Recommended Form 3100-0008, September 2013, Affidavit of Compliance with Background Screening Requirements, in the employee's personnel file?
- Or, does the employee have a similar document attesting under penalty of perjury that they are in compliance with Chapter 435, F.S.
- Review staff records to verify attestation is on file.

required by level 2 screening may be borne by the licensee or the person fingerprinted. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required Documents and Fees.
(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, January 2017, herein incorporated by reference, available at

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http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if arrested for any disqualifying offense.
(e) An administrator or chief financial officer must be screened and qualified prior to appointment to the position.
(3) Results of Screening and Notification.
(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal.
(b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the arrest report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.

ST - CZ817 - Minimum Licensure Requirement - Inform AHCA

Title Minimum Licensure Requirement - Inform AHCA

Type Rule

408.810(3-4) FS; 59A-35.100 FAC

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Regulation Definition

408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(3) Unless otherwise specified in this part, authorizing statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of:
(a) Information contained in the most recent application for licensure.
(b) Required insurance or bonds.
(4) Whenever a licensee discontinues operation of a provider:
(a) The licensee must inform the agency not less than 30 days prior to the discontinuance of operation and inform clients of such discontinuance as required by authorizing statutes. Immediately upon discontinuance of operation by a provider, the licensee shall surrender the license to the agency and the license shall be canceled.
(b) The licensee shall remain responsible for retaining and appropriately distributing all records within the timeframes prescribed in authorizing statutes and applicable rules. In addition, the licensee or, in the event of death or dissolution of a licensee, the estate or agent of the licensee shall:
1. Make arrangements to forward records for each client to one of the following, based upon the client's choice: the client or the client's legal representative, the client's attending physician, or the health care provider where the client currently receives services; or
2. Cause a notice to be published in the newspaper of greatest general circulation in the county in which the provider was located that advises clients of the discontinuance of the

Interpretive Guideline

- Refer to s.408.820, F.S. regarding the Exemptions for this regulation.

- Regarding Nursing Homes, note that the closing of a nursing facility (408.810(4)(a)) must comply with 400.18(1), F.S. instead which states:
400.18 Closing of nursing facility.-
(1) In addition to the requirements of part II of chapter 408, the licensee also shall inform each resident or the next of kin, legal representative, or agency acting on behalf of the resident of the fact, and the proposed time, of discontinuance of operation and give at least 90 days' notice so that suitable arrangements may be made for the transfer and care of the resident. In the event any resident has no such person to represent him or her, the licensee shall be responsible for securing a suitable transfer of the resident before the discontinuance of operation. The agency shall be responsible for arranging for the transfer of those residents requiring transfer who are receiving assistance under the Medicaid program.

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provider operation. The notice must inform clients that they may obtain copies of their records and specify the name, address, and telephone number of the person from whom the copies of records may be obtained. The notice must appear at least once a week for 4 consecutive weeks.

59A-35.100 Minimum Licensure Requirements.
Provider location. A licensee must maintain proper authority for operation of the provider at the address of record. If such authority is denied, revoked or otherwise terminated by the local zoning or code enforcement authority, the Agency may deny or revoke an application or license, or impose sanctions.

ST - CZ818 - Minimum Licensure Requirement - Client Notice

Title Minimum Licensure Requirement - Client Notice

Type Rule

408.810(5) FS

Regulation Definition

408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:
1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you receive, please call toll-free (phone number)."

Interpretive Guideline

During observation, interview and record review determine if client, immediate family or representative have been informed of the right to report.

- Refer to s.408.820, F.S. regarding the Exemptions for this regulation.

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2. Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free (phone number)."
3. Medicaid fraud. An agency-written description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report suspected Medicaid fraud, please call toll-free (phone number)."
The agency shall publish a minimum of a 90-day advance notice of a change in the toll-free telephone numbers.
(b) Each licensee shall establish appropriate policies and procedures for providing such notice to clients.

ST - CZ819 - Minimum Licensure Req - Financial Viability

Title Minimum Licensure Req - Financial Viability

Type Rule

408.810(9) FS

Regulation Definition

408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(9) A controlling interest may not withhold from the agency any evidence of financial instability, including, but not limited to, checks returned due to insufficient funds, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services, or adverse court action concerning the financial viability of the provider or any

Interpretive Guideline

- Refer to s.408.820, F.S. regarding the Exemptions for this regulation.

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other provider licensed under this part that is under the control of the controlling interest. A controlling interest shall notify the agency within 10 days after a court action to initiate bankruptcy, foreclosure, or eviction proceedings concerning the provider in which the controlling interest is a petitioner or defendant. Any person who violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense.

ST - CZ820 - Minimum LIcensure Req - Ownership Interest

Title Minimum LIcensure Req - Ownership Interest

Type Rule

408.810(12-13) FS

Regulation Definition

408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(12) The licensee shall ensure that no person holds any ownership interest, either directly or indirectly, regardless of ownership structure, who:
(a) Has a disqualifying offense pursuant to s. 408.809; or
(b) Holds or has held any ownership interest, either directly or indirectly, regardless of ownership structure, in a provider that had a license revoked or an application denied pursuant to s. 408.815.
(13) If the licensee is a publicly traded corporation or is wholly owned, directly or indirectly, by a publicly traded corporation, subsection (12) does not apply to those persons whose sole relationship with the corporation is as a

Interpretive Guideline

If concerns arise related to owner/controlling interest having a disqualifying offense, revoked license, or denied license application, check BGS for screening results.

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shareholder of publicly traded shares. As used in this subsection, a "publicly traded corporation" is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

ST - CZ821 - Reporting Requirements; Electronic Submission

Title Reporting Requirements; Electronic Submission

Type Rule

59A-35.110(1-2) FAC

Regulation Definition

59A-35.110 Reporting Requirements; Electronic Submission.
(1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including:
(a) Insurance coverage renewal;
(b) Bond renewal;
(c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider;
(d) Annual sanitation inspections;
(e) Fire inspections.
(2) Electronic submission of information.
(a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at
https://apps.ahca.myflorida.com/SingleSignOnPortal:
1. Nursing homes:
Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing

Interpretive Guideline

During entrance conference, determine if there has been a "CHOW".

- Regarding 59A-35.110(1)(f), this does not apply to Home Care Unit programs since there is a different process through the Department of Health in chapter 400 Part III & IV, F.S.
- Regarding 59A-35.110(2), this only applies to nursing homes and assisted living facilities.

59A-35.110 FAC does not apply to Abortion Clinics

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Home Adverse Incident, AHCA Form 3110-0010 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.

2. Assisted living facilities:

Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.

3. Hospitals:

Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.

4. Ambulatory Surgical Centers:

Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the

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incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.
5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, May 2018, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.
6. For the purposes of this rule, the following applies for submitting adverse incident reports:
a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S.
b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident.
c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident.
d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later.
e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to

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exceed $500.
(b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission.
(c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored.

ST - CZ824 - Right of Inspection; Inspection Reports

Title Right of Inspection; Inspection Reports

Type Rule

408.811 FS; 59A-35.120 FAC

Regulation Definition

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.-
(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.
(a) All inspections shall be unannounced, except as specified in s. 408.806.

Interpretive Guideline

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(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.
(c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance.
(d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure inspections based upon:
1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures.
2. Outcome measures that demonstrate quality performance.
3. Successful participation in a recognized, quality program.
4. Accreditation status.
5. Other measures reflective of quality and safety.
6. The length of time between inspections.
The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance.
(2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification.
(3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an offsite review.

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(4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency.
(5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required.
(6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership.
(b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection.

59A-35.120 Inspections.
(1) When regulatory violations are identified by the Agency:
(a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency notice to the provider, unless an alternative timeframe is required or approved by the Agency.
(b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time.

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(2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency.
(3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide:
(a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation.
(b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection.

ST - CZ827 - Unlicensed Activity

Title Unlicensed Activity

Type Rule

408.812 FS; 408.8065(3) FS

Regulation Definition

408.812 Unlicensed activity.-
(1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license.
(2) The operation or maintenance of an unlicensed provider or

Interpretive Guideline

- This tag can be cited in conjunction with Z0803 License Required; Display,- 408.804 F.S.
- License required when the provider is offering services not authorized and printed on the face of the license, when the licensed owner is not operating and it is being operated by another entity that is not licensed to operate.
- It may also be cited if the Agency has notified the provider to cease unlicensed activity and the provider continues to operate.

- This tag is not cited when Homemaker Companion Services is providing Home Health Agency services working out

the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients, and constitutes abuse and neglect, as defined in s. 415.102. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation, the person or entity is subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses, impose actions under s. 408.814, and regardless of correction, impose a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained or the unlicensed activity ceases.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the

of the scope of the Homemaker Companion Services license.

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provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.
(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.-
(3) In addition to the requirements of s. 408.812, any person who offers services that require licensure under part VII or part X of chapter 400, or who offers skilled services that require licensure under part III of chapter 400, without obtaining a valid license; any person who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application, and any person who violates or conspires to violate this section, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

ST - CZ828 - Administrative Fines; Violations

Title Administrative Fines; Violations

Type Rule

408.813(3) FS

Regulation Definition

408.813 Administrative fines; violations.-As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.

(3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the

Interpretive Guideline

- Review the license, including the capacity.
- What services is the facility licensed to provide?
- Is the facility under a moratorium?
- Is the facility providing services for 24 hours or more to a census that exceeds their capacity?
- Observe the number of residents, sleeping arrangements and medications.
- Review records, including the admission/discharge log, medication records and resident records.
- Review staff qualifications, including licensure.

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amount of the fine may not exceed $500 for each violation. Unclassified violations include:
(a) Violating any term or condition of a license.
(b) Violating any provision of this part, authorizing statutes, or applicable rules.
(c) Exceeding licensed capacity.
(d) Providing services beyond the scope of the license.
(e) Violating a moratorium imposed pursuant to s. 408.814.
(f) Violating the parental consent requirements of s. 1014.06

- Interview residents, staff, family members, case managers and any third party providers, including health care providers and home health to determine what services are provided and by whom.

The Central Office program unit is responsible for preparation of requests for sanctions for licensure actions.

ST - CZ829 - Moratorium; Emergency Suspension

Title Moratorium; Emergency Suspension

Type Rule

408.814 FS

Regulation Definition

408.814 Moratorium; emergency suspension.-
(1) The agency may impose an immediate moratorium or emergency suspension as defined in s. 120.60 on any provider if the agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client.
(2) A provider or licensee, the license of which is denied or revoked, may be subject to immediate imposition of a moratorium or emergency suspension to run concurrently with licensure denial, revocation, or injunction.
(3) A moratorium or emergency suspension remains in effect after a change of ownership, unless the agency has determined that the conditions that created the moratorium, emergency suspension, or denial of licensure have been corrected.
(4) When a moratorium or emergency suspension is placed on a provider or licensee, notice of the action shall be posted and visible to the public at the location of the provider until the action is lifted.

Interpretive Guideline

Determine through observations if the facility has posted the moratorium visible to the public.

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ST - CZ830 - Emergency Management Planning

Title Emergency Management Planning

Type Rule

408.821 FS

Regulation Definition

408.821 Emergency management planning; emergency operations; inactive license.-
(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:
(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.
(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.
(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.
(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which

Interpretive Guideline

approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(4) . . . Licensees providing residential or inpatient services

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must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

ST - CZ841 - In-person Visitation

Title In-person Visitation

Type Rule

408.823(1-2) FS

Regulation Definition

(1) This section applies to developmental disabilities centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part IV of chapter 400, intermediate care facilities for the developmentally disabled licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429.

(2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include infection control and education policies for visitors; screening, personal protective equipment, and other infection control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any vaccination or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor.
(b) A resident, client, or patient may designate a visitor who is

Interpretive Guideline

This tag will only apply to the following facilities.
-Hospitals
-Nursing Homes
-Hospices (inpatient/residential)
-Intermediate Care Facilities
-Assisted Living Facilities

When conducting initial, CHOW, visitation complaint, or the first relicensure after implementation review the policies and check the facility website (if there is one) for the required posting.

The facility is not required to have a website but if they do, the visitation policy should be posted.

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a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care.

(c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:

1. End-of-life situations.
2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently died.
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. Pediatric patients.

(d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures.

(e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must

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make the visitation policies and procedures available to the agency for review at any time, upon request.
(f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites.

ST - CZ870 - Parental Consent for Health Services

Title Parental Consent for Health Services

Type Rule

1014.06, FS

Regulation Definition

(1) Except as otherwise provided by law, a health care practitioner, as defined in s. 456.001, or an individual employed by such health care practitioner may not provide or solicit or arrange to provide health care services or prescribe medicinal drugs to a minor child without first obtaining written parental consent.
(2) Except as otherwise provided by law or a court order, a provider, as defined in s. 408.803, may not allow a medical procedure to be performed on a minor child in its facility without first obtaining written parental consent.
(3) This section does not apply to an abortion, which is governed by chapter 390.
(4) This section does not apply to services provided by a clinical laboratory, unless the services are delivered through a direct encounter with the minor at the clinical laboratory facility. For purposes of this subsection, the term "clinical laboratory" has the same meaning as provided in s. 483.803.
(5) A health care practitioner or other person who violates this section is subject to disciplinary action pursuant to s. 408.813 or s. 456.072, as applicable, and commits a misdemeanor of the first degree, punishable as provided in s. 274 775.082 or s.

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775.083.

ST - CZ871 - Attempted Inspection

Title Attempted Inspection

Type Rule

408.806(7)(d) FS

Regulation Definition	Interpretive Guideline
(d) If a provider is not available when an inspection is attempted, the application shall be denied.	If the provider is not open during the hours listed on the current application, the field office should recommend denial of the application to the Licensure Unit. Contact the Unit if you are unsure of the hours of operation.

ST - CZ872 - Right of Medical Conscience

Title Right of Medical Conscience

Type Rule

381.00321 (2)(a – b) and (6)

Regulation Definition	Interpretive Guideline
381.00321 (2) RIGHT OF MEDICAL CONSCIENCE.- (a) A health care provider or health care payor has the right to opt out of participation in or payment for any health care service on the basis of a conscience-based objection. A health care provider must, at the time of the conscience-based objection or as soon as practicable thereafter, provide written notice of his or her conscience-based objection to the health care provider's supervisor or employer, if applicable, and document his or her conscience-based objection to a particular health care service in the patient's medical file. Additionally, if a patient, or potential patient, when attempting to schedule an appointment with the provider indicates to the provider that he or she is seeking a specific health care service for which the	

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provider has a conscience-based objection, the provider must notify the patient that he or she does not provide such service before scheduling the appointment. A health care provider who is a student must provide written notice of his or her conscience based objection to the educational institution at the time the conscience-based objection is made or as soon as practicable thereafter.
(b) The exercise of the right of medical conscience is limited to conscience-based objections to a specific health care service. This section may not be construed to waive or modify any duty a health care provider or health care payor may have to provide or pay for other health care services that do not violate their right of medical conscience, to waive or modify any duty to provide any informed consent required by law, or to allow a health care provider or payor to opt out of providing health care services to any patient or potential patient because of that patient's or potential patient's race, color, religion, sex, or national origin. Additionally, a health care payor may not decline to pay for a health care service it is contractually obligated to cover during the plan year.

(6) This section may not be construed to override any requirement to provide emergency medical treatment in accordance with state law or the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. s. 1395dd

ST - CZ873 - Vaccination

Title Vaccination

Type Rule

381.00316(3)&(5)

Regulation Definition

(3)(a) A business entity may not require any person to provide any documentation certifying vaccination with any vaccine

Interpretive Guideline

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defined under subsection (2) or postinfection recovery from COVID-19, or require a COVID-19 test, to gain access to, entry upon, or service from the business operations in this state or as a condition of contracting, hiring, promotion, or continued employment with the business entity.
(b) A business entity may not discharge or refuse to hire a person; deprive or attempt to deprive a person of employment opportunities; adversely affect a person's status as an employee or as an applicant for employment; or otherwise discriminate against a person based on knowledge or belief of the person's status relating to vaccination with any vaccine defined under subsection (2) or COVID-19 postinfection recovery, or a person's failure to take a COVID-19 test.
(c) For matters relating to vaccines other than those defined under subsection (2), a business entity shall provide for exemptions and reasonable accommodations for religious and medical reasons in accordance with federal law.
(d) A licensed facility as defined in s. 395.002 may not discriminate in providing health care to a patient based solely on that patient's vaccination status with a COVID-19 vaccine.
(5)(a) A business entity or governmental entity may not require a person to wear a face mask, a face shield, or any other facial covering that covers the mouth and nose. A business entity or governmental entity may not deny any person access to, entry upon, service from, or admission to such entity or otherwise discriminate against a person based on such person's refusal to wear a face mask, a face shield, or any other facial covering that covers the mouth and nose.
(b) Paragraph (a) does not apply to:
1. A health care provider or health care practitioner as those terms are defined in s. 408.824, provided that such health care provider or health care practitioner is in compliance with that section.
2. A business entity or governmental entity when a face mask, a face shield, or any other facial covering that covers the

mouth and nose is required safety equipment consistent with occupational or laboratory safety requirements, in accordance with standards adopted by the Department of Health. The Department of Health shall adopt emergency rules to develop such standards. Emergency rules adopted under this subparagraph are exempt from s. 120.54(4)(c) and shall remain in effect until replaced by rules adopted under the nonemergency rulemaking procedures of the Administrative Procedure Act

ST - CZ874 - Facial Coverings

Title Facial Coverings

Type Rule

408.824(3-4)

Regulation Definition

Facial covering requirements for health care practitioners and health care providers.-
(3) By August 1, 2023, each health care practitioner who owns or operates an office and each health care provider shall establish facial covering policies and procedures for their respective health care settings, if such health care practitioner or health care provider requires any individual to wear a facial covering for any reason. Such policies and procedures must comply with the standards developed under subsection (2) and must be accessible from the home page of such health care practitioner's or health care provider's website or conspicuously displayed in the lobby of its health care service setting or settings.
(4) Effective August 1, 2023:
(a) Health care practitioners and health care providers may not require any person to wear a facial covering for any reason unless the requirement is in accordance with the standards developed under subsection (2) and the policies and

Interpretive Guideline

procedures established under subsection (3).
(b) A health care practitioner or a health care provider in violation of paragraph (a) or subsection (3) is subject to disciplinary action by the agency or a board as defined in s.456.001, or the department if there is no board, as applicable.