FLORIDA STATUTE 408
PART II
HEALTH CARE LICENSING:
GENERAL PROVISIONS

408.801 Short title; purpose.—

(1) This part may be cited as the "Health Care Licensing Procedures Act."

(2) The Legislature finds that there is unnecessary duplication and variation in the requirements for licensure by the agency. It is the intent of the Legislature to provide a streamlined and consistent set of basic licensing requirements for all such providers in order to minimize confusion, standardize terminology, and include issues that are otherwise not adequately addressed in the Florida Statutes pertaining to specific providers.

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.

(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.

[1](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.

[1](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

(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.

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

408.805 Fees required; adjustments.—Unless otherwise limited by authorizing statutes, license fees must be reasonably calculated by the agency to cover its costs in carrying out its responsibilities under this part, authorizing statutes, and applicable rules, including the cost of licensure, inspection, and regulation of providers.

(1) Licensure fees shall be adjusted to provide for biennial licensure under agency rules.

(2) The agency shall annually adjust licensure fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

(3) An inspection fee must be paid as required in authorizing statutes.

(4) Fees are nonrefundable.

(5) When a change is reported that requires issuance of a license, a fee may be assessed. The fee must be based on the actual cost of processing and issuing the license.

(6) A fee may be charged to a licensee requesting a duplicate license. The fee may not exceed the actual cost of duplication and postage.

(7) Total fees collected may not exceed the cost of administering this part, authorizing statutes, and applicable rules.

408.806 License application process.—

(1) An application for licensure must be made to the agency on forms furnished by the agency, submitted under oath or attestation, and accompanied by the appropriate fee in order to be accepted and considered timely. The application must contain information required by authorizing statutes and applicable rules and must include:

(a) The name, address, and social security number, or individual taxpayer identification number if a social security number cannot legally be obtained, of:

1. The applicant.

2. The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider.

3. The financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider; and

4. Each controlling interest if the applicant or controlling interest is an individual.

(b) The name, address, and federal employer identification number or taxpayer identification number of the applicant and each controlling interest if the applicant or controlling interest is not an individual.

(c) The name by which the provider is to be known.

(d) The total number of beds or capacity requested, as applicable.

(e) The name of the person or persons under whose management or supervision the provider will operate and the name of the administrator, if required.

(f) If the applicant offers continuing care agreements as defined in chapter 651, proof shall be furnished that the applicant has obtained a certificate of authority as required for operation under chapter 651.

(g) Other information, including satisfactory inspection results, that the agency finds necessary to determine the ability of the applicant to carry out its responsibilities under this part, authorizing statutes, and applicable rules.

(h) An attestation, under penalty of perjury, as required in s. 435.05(3), stating compliance with the provisions of this section and chapter 435.

(2)(a) The applicant for a renewal license must submit an application that must be received by the agency at least 60 days but no more than 120 days before the expiration of the current license. An application received more than 120 days before the expiration of the current license shall be returned to the applicant. If the renewal application and fee are received prior to the license expiration date, the license shall not be deemed to have expired if the license expiration date occurs during the agency's review of the renewal application.

(b) The applicant for initial licensure due to a change of ownership must submit an application that must be received by the agency at least 60 days prior to the date of change of ownership.

(c) For any other application or request, the applicant must submit an application or request that must be received by the agency at least 60 days but no more than 120 days before the requested effective date, unless otherwise specified in authorizing statutes or applicable rules. An application received more than 120 days before the requested effective date shall be returned to the applicant.

(d) The licensee's failure to timely file a renewal application and license application fee with the agency shall result in a $50 per day late fee charged to the licensee by the agency; however, the aggregate amount of the late fee may not exceed 50 percent of the licensure fee or $500, whichever is less. The agency shall provide a courtesy notice to the licensee by United States mail, electronically, or by any other manner at its address of record or mailing address, if provided, at least 90 days before the expiration of a license. This courtesy notice must inform the licensee of the expiration of the license. If the agency does not provide the courtesy notice or the licensee does not receive the courtesy notice, the licensee continues to be legally obligated to timely file the renewal application and license application fee with the agency and is not excused from the payment of a late fee. If an application is received after the required filing date and exhibits a hand-canceled postmark obtained from a United States post office dated on or before the required filing date, no fine will be levied.

(e) The applicant must pay the late fee before a late application is considered complete and failure to pay the late fee is considered an omission from the application for licensure pursuant to paragraph (3)(b).

(3)(a) Upon receipt of an application for a license, the agency shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

(b) Requested information omitted from an application for licensure, license renewal, or change of ownership, other than an inspection, must be filed with the agency within 21 days after the agency's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

(c) Within 60 days after the receipt of a complete application, the agency shall approve or deny the application.

(4)(a) Licensees subject to the provisions of this part shall be issued biennial licenses unless conditions of the license category specify a shorter license period.

(b) Each license issued shall indicate the name of the licensee, the type of provider or service that the licensee is required or authorized to operate or offer, the date the license is effective, the expiration date of the license, the maximum capacity of the licensed premises, if applicable, and any other information required or deemed necessary by the agency.

(5) In accordance with authorizing statutes and applicable rules, proof of compliance with s. 408.810 must be submitted with an application for licensure.

(6) The agency may not issue an initial license to a health care provider subject to the certificate-of-need provisions in part I of this chapter if the licensee has not been issued a certificate of need or certificate-of-need exemption, when applicable. Failure to apply for the renewal of a license prior to the expiration date renders the license void.

(7)(a) An applicant must demonstrate compliance with the requirements in this part, authorizing statutes, and applicable rules during an inspection pursuant to s. 408.811, as required by authorizing statutes.

(b) An initial inspection is not required for companion services or homemaker services providers as provided under part III of chapter 400, for health care services pools as provided under part IX of chapter 400, or for low-risk providers as provided in s. 408.811(1)(c).

(c) If an inspection is required by the authorizing statute for a license application other than an initial application, the inspection must be unannounced. This paragraph does not apply to inspections required pursuant to ss. 383.324, 395.0161(4), and 429.67(6).

(d) If a provider is not available when an inspection is attempted, the application shall be denied.

(8) The agency may establish procedures for the electronic notification and submission of required information, including, but not limited to:

(a) Licensure applications.

(b) Required signatures.

(c) Payment of fees.

(d) Notarization or attestation of applications.

Requirements for electronic submission of any documents required by this part or authorizing statutes may be established by rule. As an alternative to sending documents as required by authorizing statutes, the agency may provide electronic access to information or documents.

(9) A licensee that holds a license for multiple providers licensed by the agency may request that all related license expiration dates be aligned. Upon such request, the agency may issue a license for an abbreviated licensure period with a prorated licensure fee.

408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.—

(1) An applicant for initial licensure, or initial licensure due to a change of ownership, as a home health agency, home medical equipment provider, or health care clinic shall:

(a) Demonstrate financial ability to operate, as required under s. 408.810(8) and this section. If the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses, and the applicant provides independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and will be available as needed, the applicant has demonstrated the financial ability to operate.

(b) Submit projected financial statements, including a balance sheet, income and expense statement, and a statement of cash flows for the first 2 years of operation which provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses.

(c) Submit a statement of the applicant's estimated startup costs and sources of funds through the break-even point in operations demonstrating that the applicant has the ability to fund all startup costs, working capital costs, and contingency financing requirements. The statement must show that the applicant has at a minimum 3 months of average projected expenses to cover startup costs, working capital costs, and contingency financing requirements. The minimum amount for contingency funding may not be less than 1 month of average projected expenses.

All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and may be in a compilation form. The financial statements must be signed by a certified public accountant.

(2) For initial, renewal, or change of ownership licenses for a home health agency, a home medical equipment provider, or a health care clinic, applicants and controlling interests who are nonimmigrant aliens, as described in 8 U.S.C. s. 1101, must file a surety bond of at least $500,000, payable to the agency, which guarantees that the home health agency, home medical equipment provider, or health care clinic will act in full conformity with all legal requirements for operation.

(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.

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.

(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.

408.808 License categories.—

(1) STANDARD LICENSE.—A standard license may be issued to an applicant at the time of initial licensure, license renewal, or change of ownership. A standard license shall be issued when the applicant is in compliance with all statutory requirements and agency rules. Unless sooner revoked, a standard license expires 2 years after the date of issue.

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant making initial application for licensure or making application for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

(3) INACTIVE LICENSE.—An inactive license may be issued to a hospital or a health care provider subject to the certificate-of-need provisions in part I of this chapter when the provider is currently licensed, does not have a provisional license, and will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. Such designation may be made for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration by the licensee of the provider's progress toward reopening. However, if after 20 months in an inactive license status, a statutory rural hospital, as defined in s. 395.602, has demonstrated progress toward reopening, but may not be able to reopen prior to the inactive license expiration date, the inactive designation may be renewed again by the agency for up to 12 additional months. For purposes of such a second renewal, if construction or renovation is required, the licensee must have had plans approved by the agency and construction must have already commenced pursuant to s. 408.032(4); however, if construction or renovation is not required, the licensee must provide proof of having made an enforceable capital expenditure greater than 25 percent of the total costs associated with the hiring of staff and the purchase of equipment and supplies needed to operate the facility upon opening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted to the agency and must include a written justification for the inactive license with the beginning and ending dates of inactivity specified, a plan for the transfer of any clients to other providers, and the appropriate licensure fees. The agency may not accept a request that is submitted after initiating closure, after any suspension of service, or after notifying clients of closure or suspension of service, unless the action is a result of a disaster at the licensed premises. For the purposes of this section, the term "disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or manmade, which renders the provider inoperable at the premises. Upon agency approval, the provider shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive license period is the date the provider ceases operations. The end of the inactive license period shall become the license expiration date. All licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the approval of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part, authorizing statutes, and applicable rules.

(4) OTHER LICENSES.—Other types of license categories may be issued pursuant to authorizing statutes or applicable rules.

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

(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 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.

(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 photo optical 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.

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.

(1) An applicant for licensure must comply with the background screening requirements of s. 408.809.

(2) An applicant for licensure must provide a description and explanation of any exclusions, suspensions, or terminations of the applicant from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

(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 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.

(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)."

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.

(6) An applicant must provide the agency with proof of the applicant's legal right to occupy the property before a license may be issued. Proof may include, but need not be limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation.

(7) If proof of insurance is required by the authorizing statute, that insurance must be in compliance with chapter 624, chapter 626, chapter 627, or chapter 628 and with agency rules.

(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 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.

(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 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.

(10) The agency may not issue a license to a health care provider subject to the certificate-of-need provisions in part I of this chapter if the health care provider has not been issued a certificate of need or an exemption. Upon initial licensure of any such provider, the authorization contained in the certificate of need shall be considered fully implemented and merged into the license and shall have no force and effect upon termination of the license for any reason.

(11) The agency may adopt rules that govern the circumstances under which a controlling interest, an administrator, an employee, or a contractor, or a representative thereof, who is not a relative of the client may act as an agent of the client in authorizing consent for medical treatment, assignment of benefits, and release of information. Such rules may include requirements related to disclosure, bonding, restrictions, and client protections.

(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 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.

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.

(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.

(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.

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 license holder 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 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 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.

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

(1) Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in s. 55.03 for each day beyond the date set by the agency for payment of the fine.

(2) Violations of this part, authorizing statutes, or applicable rules shall be classified according to the nature of the violation and the gravity of its probable effect on clients. The scope of a violation may be cited as an isolated, patterned, or widespread deficiency. An isolated deficiency is a deficiency affecting one or a very limited number of clients or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency in which more than a very limited number of clients are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same client or clients have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the provider. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the provider or represent systemic failure that has affected or has the potential to affect a large portion of the provider's clients. This subsection does not affect the legislative determination of the amount of a fine imposed under authorizing statutes. Violations shall be classified on the written notice as follows:

(a) Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as provided in this section for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a provider or to required reports, forms, or documents that do not have the potential of negatively affecting clients. These violations are of a type that the agency determines do not threaten the health, safety, or security

of clients. The agency shall impose an administrative fine as provided in this section for a cited class IV violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

(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 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.

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.

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:

(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 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.

(5) For any application subject to denial under subsection (4), the agency may consider mitigating circumstances as applicable, including, but not limited to:

(a) Completion or lawful release from confinement, supervision, or sanction, including the terms of probation, and full restitution.

(b) Execution of a compliance plan with the agency.

(c) Compliance with an integrity agreement or compliance plan with another government agency.

(d) Determination by any state Medicaid program or the Medicare program that the controlling interest or entity in which the controlling interest was an owner or officer is currently allowed to participate in the state Medicaid program or the Medicare program, directly as a provider or indirectly as an owner or officer of a provider entity.

(e) Continuation of licensure by the controlling interest or entity in which the controlling interest was an owner or officer, directly as a licensee or indirectly as an owner or officer of a licensed entity in the state where the action occurred.

(f) Overall impact upon the public health, safety, or welfare; or

(g) Determination that a license denial is not commensurate with the prior action taken by the Medicare or state Medicaid program.

After considering the circumstances set forth in this subsection, the agency shall grant the license, with or without conditions, grant a provisional license for a period of no more than the licensure cycle, with or without conditions, or deny the license.

(6) In order to ensure the health, safety, and welfare of clients when a license has been denied, revoked, or is set to terminate, the agency may extend the license expiration date for up to 30 days for the sole purpose of allowing the safe and orderly discharge of clients. The agency may impose conditions on the extension, including, but not limited to, prohibiting or limiting admissions, expedited discharge planning, required status reports, and mandatory monitoring by the agency or third parties. When imposing these conditions, the agency shall consider the nature and number of clients, the availability and location of acceptable alternative placements, and the ability of the licensee to continue providing care to the clients. The agency may terminate the extension or modify the conditions at any time. This authority is in addition to any other authority granted to the agency under chapter 120, this part, and authorizing statutes but creates no right or entitlement to an extension of a license expiration date.

408.816 Injunctions.—

(1) In addition to the other powers provided by this part, authorizing statutes, and applicable rules, the agency may institute injunction proceedings in a court of competent jurisdiction to:

(a) Restrain or prevent the establishment or operation of a provider that does not have a license or is in violation of any provision of this part, authorizing statutes, or applicable rules. The agency may also institute injunction proceedings in a court of competent jurisdiction when a violation of this part, authorizing statutes, or applicable rules constitutes an emergency affecting the immediate health and safety of a client.

(b) Enforce the provisions of this part, authorizing statutes, or any minimum standard, rule, or order issued or entered into pursuant thereto when the attempt by the agency to correct a violation through administrative sanctions has failed or when the violation materially affects the health, safety, or welfare of clients or involves any operation of an unlicensed provider.

(c) Terminate the operation of a provider when a violation of any provision of this part, authorizing statutes, or any standard or rule adopted pursuant thereto exists that materially affects the health, safety, or welfare of a client.

Such injunctive relief may be temporary or permanent.

(2) If action is necessary to protect clients of providers from immediate, life-threatening situations, the court may allow a temporary injunction without bond upon proper proofs being made. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should be issued, the court, pending the determination on final hearing, shall enjoin the operation of the provider.

408.817 Administrative proceedings.—Administrative proceedings challenging agency licensure enforcement action shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

408.818 Health Care Trust Fund.—Unless otherwise prescribed by authorizing statutes, all fees and fines collected under this part, authorizing statutes, and applicable rules shall be deposited into the Health Care Trust Fund, created in s. 408.16, and used to pay the costs of the agency in administering the provider program paying the fees or fines.

408.819 Rules.—The agency is authorized to adopt rules as necessary to administer this part. Any licensed provider that is in operation at the time of adoption of any applicable rule under this part or authorizing statutes shall be given a reasonable time under the particular circumstances, not to exceed 6 months after the date of such adoption, within which to comply with such rule, unless otherwise specified by rule.

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, are exempt from s. 408.810(5)-(10).

(2) Birth centers, as provided under chapter 383, are exempt from s. 408.810(7)-(10).

(3) Abortion clinics, as provided under chapter 390, are exempt from s. 408.810(7)-(10).

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394, are exempt from s. 408.810(8)-(10).

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394, are exempt from s. 408.810(8)-(10).

(6) Residential treatment facilities, as provided under part IV of chapter 394, are exempt from s. 408.810

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394, are exempt from s. 408.810(8)-(10).

(8) Hospitals, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(9).

(9) Ambulatory surgical centers, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(10).

(10) Nursing homes, as provided under part II of chapter 400, are exempt from ss. 408.810(7) and 408.813(2).

(11) Assisted living facilities, as provided under part I of chapter 429, are exempt from s. 408.810(10).

(12) Home health agencies, as provided under part III of chapter 400, are exempt from s. 408.810(10).

(13) Nurse registries, as provided under part III of chapter 400, are exempt from s. 408.810(6) and (10).

(14) Companion services or homemaker services providers, as provided under part III of chapter 400, are exempt from s. 408.810(6)-(10).

(15) Adult Day care centers, as provided under part III of chapter 429, are exempt from s. 408.810(10).

(16) Adult family-care homes, as provided under part II of chapter 429, are exempt from s. 408.810(7)-(10).

(17) Homes for special services, as provided under part V of chapter 400, are exempt from s. 408.810(7)-(10).

(18) Transitional living facilities, as provided under part XI of chapter 400, are exempt from s. 408.810(10).

(19) Prescribed pediatric extended care centers, as provided under part VI of chapter 400, are exempt from s. 408.810(10).

(20) Home medical equipment providers, as provided under part VII of chapter 400, are exempt from s. 408.810(10).

(21) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400, are exempt from s. 408.810(7).

(22) Health care services pools, as provided under part IX of chapter 400, are exempt from s. 408.810(6)-(10).

(23) Health care clinics, as provided under part X of chapter 400, are exempt from s. 408.810(6), (7), and (10).

(24) Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765, are exempt from s. 408.810(5)-(10).

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 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) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400, an assisted living facility licensed under part I of chapter 429, or a home health agency or companion services or homemaker services provider licensed under part III of chapter 400 shall furnish all of the following information to the agency in a survey on the direct care workforce:

(a) The number of registered nurses and the number of direct care workers by category employed by the licensee.

(b) The turnover and vacancy rates of registered nurses and direct care workers and the contributing factors to these rates.

(c) The average employee wage for registered nurses and each category of direct care worker.

(d) Employment benefits for registered nurses and direct care workers and the average cost of such benefits to the employer and the employee.

(e) Type and availability of training for registered nurses and direct care workers.

(3) An administrator or designee shall include the information required in subsection (2) on a survey form developed by the agency by rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey before the agency issues the license renewal.

(5) The agency shall continually analyze the results of the surveys and publish the results on its website. The agency shall update the information published on its website monthly.

408.823 In-person visitation.—

(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 May 6, 2022, 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 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 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 homepages of their websites.

(3) The agency shall dedicate a stand-alone page on its website to explain the visitation requirements of this section and provide a link to the agency's web page to report complaints.

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(1) In addition to any other remedies provided by law, the agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:

(a) If the applicant, licensee, or a licensee subject to this part which shares a common controlling interest with the applicant has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency

or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency; or

(b) For failure to comply with any repayment plan.

(2) In reviewing any application requesting a change of ownership or change of the licensee, registrant, or certificate holder, the transferor shall, prior to agency approval of the change, repay or make arrangements to repay any amounts owed to the agency. Should the transferor fail to repay or make arrangements to repay the amounts owed to the agency, the issuance of a license, registration, or certificate to the transferee shall be delayed until repayment or until arrangements for repayment are made.

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, and 765 or rules adopted pursuant to those chapters.

408.832 Conflicts.—In case of conflict between this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, and 765, this part shall prevail.