

58A-5.024 Records.

The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.

(1) FACILITY RECORDS. Facility records shall include:

(a) The facility's license which shall be displayed in a conspicuous and public place within the facility.

(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:

1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a stage 2 pressure sore; and

2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is deceased, the date of death. Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.

(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).

(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.

(e) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.

(f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.;

(g) The facility's liability insurance policy required under Rule 58A-5.021, F.A.C.;

(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.

(i) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0182, F.A.C.

(j) If the facility advertises that it provides special care for persons with Alzheimer's disease or related disorders, a copy of all such facility advertisements as required by Section 429.177, F.S.

(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.

(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer's license or certificate to operate.

(m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.

(n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.

(o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.

(p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

(q) The facility's resident elopement response policies and procedures.

(r) The facility's documented resident elopement response drills.

(2) STAFF RECORDS.

(a) Personnel records for each staff member shall contain, at a minimum, a copy of the original employment application with references furnished and verification of freedom from communicable disease including tuberculosis. In addition, records shall contain the following, as applicable:

1. Documentation of compliance with all staff training required by Rule 58A-5.0191, F.A.C.;

2. Copies of all licenses or certifications for all staff providing services which require licensing or certification;
3. Documentation of compliance with level 1 background screening for all staff subject to screening requirements as required under Rule 58A-5.019, F.A.C.;

4. A copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C., for facilities with a licensed capacity of seventeen (17) or more residents; and

5. Documentation of facility direct care staff and administrator participation in resident elopement drills pursuant to paragraph 58A-5.0182(8)(c), F.A.C.

(b) The facility shall not be required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by a business entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 58A-5.019, F.A.C.

(c) The facility shall maintain the facility's written work schedules and staff time sheets as required under Rule 58A-5.019, F.A.C., for the last 6 months.

(3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:

(a) Resident demographic data as follows:

1. Name;

2. Sex;

3. Race;

4. Date of birth;

5. Place of birth, if known;

6. Social security number;

7. Medicaid and/or Medicare number, or name of other health insurance carrier;

8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and

9. Name, address, and phone number of health care provider, and case manager if applicable.

(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.

(c) Any health care provider's orders for medications, nursing services, therapeutic diets, do not resuscitate order, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.

(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.

(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.

(f) A weight record which is initiated on admission. Information may be taken from the resident's health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.

(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract.

(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.

(i) A copy of the resident's contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.

(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S.

(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.

(l) A copy of Alternate Care Certification for Optional State Supplementation (OSS) Form, CF-ES 1006, March 1998, if the resident is an OSS recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.

(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.

(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.

(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:

1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination described in Rule 58A-5.0181, F.A.C.;
4. The resident's contract described in Rule 58A-5.025, F.A.C.; and
5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.

(p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility.

(q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

(4) RECORD INSPECTION.

(a) All records required by this rule chapter shall be available for inspection at all times by staff of the agency, the department, the district long-term care ombudsman council, and the advocacy center for persons with disabilities.

(b) The resident's records shall be available to the resident, and the resident's legal representative, designee, surrogate, guardian, or attorney in fact, case manager, or the resident's estate, and such additional parties as authorized in writing.

(c) Pursuant to Section 429.35, F.S., agency reports which pertain to any agency survey, inspection, monitoring visit, or complaint investigation shall be available to the residents and the public.

1. Requestors shall be required to provide identification prior to review of records.

2. In facilities that are co-located with a licensed nursing home, the inspection of record for all common areas shall be the nursing home inspection report.

(d) The facility shall ensure the availability of records for inspection.

Specific Authority 429.41, 429.275 FS. Law Implemented 429.07, 429.075, 429.24, 429.27, 429.275, 429.28, 429.35, 429.41 FS. History—New 5-14-81, Amended 1-6-82, 5-19-83, 9-17-84, Formerly 10A-5.24, Amended 10-20-86, 6-21-88, 8-15-90, 9-30-92, Formerly 10A-5.024, Amended 10-30-95, 4-20-98, 11-2-98, 10-17-99, 7-30-06, 10-9-06.