

59A-36.007 Resident Care Standards.

An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.

(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:

(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.

(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.

(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.

(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.

(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.

(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

(2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community.

(a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests.

(b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility.

(c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate.

(d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time.

(3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must:

(a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services.

(b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation.

(c) The facility may not require residents to receive services from a particular health care provider.

(4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living.

(5) RESIDENT RIGHTS AND FACILITY PROCEDURES.

(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C.

(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.

(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.

(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package

provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:

1. Resident responsibilities;
2. Alcohol and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident abuse, neglect, and exploitation;
6. Administrative and housekeeping schedules and requirements;
7. Infection control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical restraints.

(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.

(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

(6) THIRD PARTY SERVICES.

(a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, contracting, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided.

(b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the particular resident's needs.

(c) The administrator or designee must ensure that:

1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility;
2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and
3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition.
4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3.

(d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection.

(7) ELOPEMENT STANDARDS.

(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to

Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.

1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.

2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.

(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:

1. An immediate search of the facility and premises,
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,
3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,
4. The continued care of all residents within the facility in the event of an elopement.

(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.

(8) PHYSICAL RESTRAINTS. Residents for whom a physician has prescribed a physical restraint must have a written care plan for the use of the physical restraint. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident.

(a) The care plan must specify:

1. The device prescribed for use;
2. The maximum amount of time the resident is to have the restraint applied each day; and,
3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of depression, or decline in mobility or function related to the use of the prescribed restraint.

(b) Facility staff must ensure that the device is applied appropriately and safely.

(c) The resident's physician must review the appropriateness of the continued use of the physical restraint annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical restraint and all requirements of this subsection apply.

(9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices.

(a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device.

(b) Documentation of each assistive device a resident uses must be included in the resident's record.

(c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment.

(d) All assistive devices must be clean, in good repair, and free of hazards.

(e) The facility must encourage and allow the resident to function with independence when using the assistive device.

(10) INFECTION CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of infectious diseases.

(a) The facility must implement a hand hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to infectious materials or bodily fluids. Hand hygiene may include the use of alcohol-based rubs, antiseptic handwash, or handwashing with soap and water.

(b) Standard precautions must be used when there is an anticipated exposure to transmissible infectious agents in blood, body fluids, secretions, excretions, nonintact skin, and mucuous membranes during the provision of personal services. Standard precautions include: hand hygiene, and dependent upon the exposure, use of gloves, gown, mask, eye protection, or a face shield.

(c) The facility must clean and disinfect reusable medical equipment and communal assistive devices that have been designed

for use by multiple residents before and after each use according to the manufacturer's recommendations.

(11) OTHER STANDARDS. Additional care standards for residents residing in a facility holding a limited mental health, extended congregate care or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.

(12) This rule is in effect for five years from its effective date.

Rulemaking Authority 429.41 FS. Law Implemented 429.255, 429.26, 429.28, 429.41 FS. History—New 9-17-84, Formerly 10A-5.182, Amended 10-20-86, 6-21-88, 8-15-90, 9-30-92, Formerly 10A-5.0182, Amended 10-30-95, 4-20-98, 11-2-98, 10-17-99, 7-30-06, 10-9-06, 4-15-10, 4-17-14, 5-10-18, Formerly 58A-5.0182, Amended 8-16-21.