59A-4.109 Resident Assessment and Care Plan.

(1) Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of:

(a) Physician’s orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.

(b) A preliminary nursing evaluation with physician’s orders for immediate care, completed on admission.

(c) A complete, comprehensive, accurate and reproducible assessment of each resident’s functional capacity which is standardized in the facility, and is completed within 14 days of the resident’s admission to the facility and every twelve months, thereafter. The assessment shall be:

1. Reviewed no less than once every 3 months,

2. Reviewed promptly after a significant change in the resident’s physical or mental condition,

3. Revised as appropriate to assure the continued accuracy of the assessment.

(2) The facility is responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.

(3) At the resident’s option, every effort shall be made to include the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the resident plan of care.

(4) All staff personnel who provide care, and at the resident’s option, private duty nurses or non employees of the facility, shall be knowledgeable of, and have access to, the resident’s plan of care.

(5) A summary of the resident’s plan of care and a copy of any advanced directives shall accompany each resident discharged or transferred to another health care facility, licensed under Chapter 400, Part II, F.S., or shall be forwarded to the receiving facility as soon as possible consistent with good medical practice.
Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23 FS. 
History–New 4-1-82, Amended 4-1-84, Formerly 10D-29.109, Amended 4-18-94, 1-10-95.

400.141 Administration and management of nursing home facilities.

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

...(p) Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.