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Aspen State Regulation Set: B 5.05 BAKER ACT ENFORCEMENT REGS

ST - BB000 - Initial Comments

Title Initial Comments

Type Memo Tag

Regulation Definition

Interpretive Guideline

These guidelines are meant solely to provide guidance to surveyors in the survey process.

The Florida Mental Health Act is found in Chapter 394, Part I in ss. 394.451-394.47892. These guidelines are meant solely to provide guidance to surveyors in the survey process.

Add the most current Baker Act Regulation Set to the survey if the Hospital or CSU is a designated Baker Act Receiving Facility. To generate a list, use AHCA's Florida Health Finder website <http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx> and filter by provider type and check the box at the bottom for "Baker Act Receiving Facility".

ST - BB001 - Designated Receiving Facility - Noncompliance

Title Designated Receiving Facility - Noncompliance

Type Rule

65E-5.351(1) FAC

Regulation Definition

Interpretive Guideline

Minimum Standards for Designated Receiving Facilities.
(1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.

In addition to possible loss of designation, chapter 395 requires compliance with the provisions of the Baker Act law and rule as a condition of licensure.

Add the most current Baker Act Regulation Set to the survey if the Hospital or CSU is a designated Baker Act Receiving Facility. To generate a list, use AHCA's Florida Health Finder website <http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx> and filter by provider type and check the box at the bottom for "Baker Act Receiving Facility".

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ST - BB002 - Designated Recvg Fac - Policies/ Procedures

Title Designated Recvg Fac - Policies/ Procedures

Type Rule

65E-5.351(2) FAC

Regulation Definition

Minimum Standards for Designated Receiving Facilities.
(2) Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in Chapter 65E-5, F.A.C.

Interpretive Guideline

Review the facility's policies and procedures manual(s) to determine if major issues are incorporated and that information correctly reflects statutory and regulatory requirements. See Policy and Procedure Worksheet.
-Interview the person responsible for the Baker Act program.

ST - BB003 - Designated Recvg Fac - Operating Hours

Title Designated Recvg Fac - Operating Hours

Type Rule

65E-5.351(3) FAC

Regulation Definition

Minimum Standards for Designated Receiving Facilities.
(3) Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per-day, 7-days-per-week.

Interpretive Guideline

Satellite sites belonging to a more comprehensive designated receiving facility, which are not fully operational at all times, are ineligible for inclusion in the designation.
-Observe all portions of the hospital which provide care and services to persons under the Baker Act.
-Review for 24/7 operation of the baker act program as a receiving facility.

ST - BB004 - Designated Recvg Fac - Monitoring Compliance

Title Designated Recvg Fac - Monitoring Compliance

Type Rule

65E-5.351(4-5) FAC

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Regulation Definition

Minimum Standards for Designated Receiving Facilities.
(4) Each receiving facility shall have a compliance program that monitors facility and professional compliance with Chapter 394, Part I, F.S., and this chapter. Every such program shall specifically monitor the adequacy of and the timeframes involved in the facility procedures utilized to expedite obtaining informed consent for treatment. This program may be integrated with other activities.
(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness

Interpretive Guideline

Review the facility's policy and procedure manual(s) to ensure that facility and professional compliance is monitored through its internal compliance program.
-Review compliance monitoring program for informed consent compliance.
-Interview person responsible for monitoring.
-Review a sample of patient medical records for compliance.
-Interview patients and families for informed consent provision.

FOR PUBLIC FACILITIES: Interview the administration about the centralized provision and coordination of acute care services for individuals with acute mental illness.

ST - BB005 - Delegation of Authority - Prior - In Writing

Title Delegation of Authority - Prior - In Writing

Type Rule

65E-5.110 FAC

Regulation Definition

Delegation of Authority.
In order to protect the health and safety of persons treated in or served by any receiving or treatment facility or any service provider, any delegation of an administrator's authority pursuant to Chapter 394, F.S., or these rules shall be documented in writing prior to exercising the delegated authority. Routine delegations of authority shall be incorporated in the facility's written policies.

Interpretive Guideline

Review facility policies and procedures to confirm if delegations of authority have been formalized and approved by the governing board.

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ST - BB006 - Min Stds Training - Abuse Reporting

Title Min Stds Training - Abuse Reporting

Type Rule

394.459(5)(g) FS

Regulation Definition

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.

(g) Facility staff shall be required, as a condition of employment, to become familiar with the requirements and procedures for the reporting of abuse.

Interpretive Guideline

Sample personnel files to ensure training in abuse reporting is documented. See also Rights 394.459(5)(e), F.S.

ST - BB007 - Background Screening

Title Background Screening

Type Rule

394.4572(1)(b)-(d) FS

Regulation Definition

Screening of mental health personnel.-

(b) Students in the health care professions who are interning in a mental health facility licensed under chapter 395, where the primary purpose of the facility is not the treatment of minors, are exempt from the fingerprinting and screening requirements if they are under direct supervision in the actual physical presence of a licensed health care professional.

(c) A volunteer who assists on an intermittent basis for less than 10 hours per month is exempt from the fingerprinting and screening requirements if a person who meets the screening requirement of paragraph (a) is always present and has the volunteer within his or her line of sight.

Interpretive Guideline

Surveyor should reference Z815 for employees.

- Sample personnel files to ensure that fingerprinting requirements are met for those individuals who have direct patient contact.

Interview the administrator and ask if the facility has students or volunteers. If so, this provision applies to them only.

IF THERE ARE CONCERNS WITH BACKGROUND SCREENING, THIS SHOULD BE CITED UNDER ZTAGS.

THIS PROVISION ADDS ADDITIONAL EXCEPTIONS TO BACKGROUND SCREENING REQUIREMENTS

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(d) Mental health personnel working in a facility licensed under chapter 395 who work on an intermittent basis for less than 15 hours per week of direct, face-to-face contact with patients, and who are not listed on the Department of Law Enforcement Career Offender Search or the Dru Sjodin National Sex Offender Public Website, are exempt from the fingerprinting and screening requirements, except that persons working in a mental health facility where the primary purpose of the facility is the mental health treatment of minors must be fingerprinted and meet screening requirements.

ST - BB008 - Removal of Certain Articles - Contraband

Title Removal of Certain Articles - Contraband

Type Rule

394.458(1)(a) FS

Regulation Definition

Introduction or removal of certain articles unlawful; penalty.

(a) Except as authorized by law or as specifically authorized by the person in charge of each hospital providing mental health services under this part, it is unlawful to introduce into or upon the grounds of such hospital, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:

1. Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;
2. Any controlled substance as defined in chapter 893; or
3. Any firearms or deadly weapon.

Interpretive Guideline

- Review facility policies and procedures that address contraband, weapons, intoxicating beverages or controlled substances and methods to deal with those situations when they may arise. Interview staff at admissions to determine if patients are searched for contraband prior to admission to a unit.
- Interview staff for knowledge of contraband items.

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ST - BB010 - Continuity of Care Management

Title Continuity of Care Management

Type Rule

65E-5.130 FAC

Regulation Definition

Continuity of Care Management System.

Persons receiving case management services.

(1) At the time of admission receiving facilities shall inquire of the person or significant others as to the existence of any advance directives and as to the identity of the person's case manager. If a case manager for the person is identified, the administrator or designee shall request the person's authorization to notify the person's case manager or the case management agency of the person's admission to the facility. If authorized, such notification shall be made within 12 hours to the published 24-hour telephone listing for the case manager or case management agency. This inquiry, notification, and the identity of the case manager or case management agency, if any, shall be documented on the face sheet or other prominent location in the person's clinical record.

(2) A department funded mental health case manager, when notified by a receiving facility that a client has been admitted, shall visit that person as soon as possible but no later than two working days after notification to assist with discharge and aftercare planning to the least restrictive, appropriate and available placement. If the person is located in a receiving facility outside of the case manager's district or region of residence, the department funded mental health case manager may substitute a telephone contact for a face-to-face visit which shall be documented in the case management record and in the person's clinical record at the receiving facility.

Interpretive Guideline

-If the clinical record reflects that the patient has a case manager, determine if the case manager's agency was notified of the patient's presence in the receiving facility within 12 hours.

-Review a sample of patient medical records for compliance.

-Interview patients, families, and case managers.

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ST - BB011 - Admission to State Treatment Fac - Documents

Title Admission to State Treatment Fac - Documents

Type Rule

65E-5.1302 FAC

Regulation Definition

Admissions to State Treatment Facilities.

(1) Receiving facilities must obtain approval from the state treatment facility prior to the transfer of a person. A state treatment facility shall be permitted to accept persons for transfer from a receiving facility if the administrator of the receiving facility has provided the following documentation, which documentation shall be retained in the person's clinical record:

(a) Recommended form CF-MH 7000, Jan. 98, "State Mental Health Facility Admission Form," with all required attachments, which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter;

(b) Recommended forms CF-MH 3040, Feb. 05, "Application for Voluntary Admission," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or CF-MH 3008, Feb. 05, "Order for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter; and

(c) Mandatory form CF-MH 3089, "Transfer Evaluation" as referenced in subsection 65E-5.1301(1), F.A.C.

(2) Use of recommended form CF-MH 7002, Feb. 05, "Physician to Physician Transfer," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for documentation when completed by the referring physician or in the absence of

Interpretive Guideline

-For patients who have been transferred from the receiving facility to a state mental hospital, review the closed record to ensure that the three required forms were provided in advance of the pre-admission staffing conducted by state hospital staff and that the recommended Physician-to-Physician Transfer form was prepared and delivered to the state hospital on the day of the patient's admission prior to or at the time of the patient's arrival.
-Interview staff who are involved with the transfer process.

The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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the referring physician the physician's designee within state law and approved facility protocols and practice guidelines, at the time of transfer. The form shall accompany the person to the state treatment facility and upon arrival shall be presented to admitting staff.

ST - BB012 - Discharge from Treatment Facility

Title Discharge from Treatment Facility

Type Rule

65E-5.1303(1-2) FAC

Regulation Definition

Discharge from Receiving and Treatment Facilities.

(1) Before discharging a person who has been admitted to a facility, the person shall be encouraged to actively participate in treatment and discharge planning activities and shall be notified in writing of his or her right to seek treatment from the professional or agency of the person's choice and the person shall be assisted in making appropriate discharge plans. The person shall be advised that, pursuant to Section 394.460, F.S., no professional is required to accept persons for psychiatric treatment.

(2) Discharge planning shall include and document consideration of the following:

- (a) The person's transportation resources;
- (b) The person's access to stable living arrangements;
- (c) How assistance in securing needed living arrangements or shelter will be provided to individuals who are at risk of re-admission within the next 3 weeks due to homelessness or transient status and prior to discharge shall request a commitment from a shelter provider that assistance will be rendered;
- (d) Assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed

Interpretive Guideline

-Review open records of patients nearing discharge and closed records to ensure that all required elements were addressed in the patient's discharge planning.

Interview patient as to level of participation in discharge planning.

-Discharges are to an appropriately licensed facility to meet the needs of the patient.

-If possible, observe a discharge which is in process

-Interview patients and families/representatives. See BA 088.

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psychotropic medications. Aftercare appointments for psychotropic medication and case management shall be requested to occur not later than 7 days after the expected date of discharge; if the discharge is delayed, the facility will notify the aftercare provider. The facility shall coordinate with the aftercare service provider and shall document the aftercare planning;

(e) To ensure a person's safety and provide continuity of essential psychotropic medications, such prescribed psychotropic medications, prescriptions, or multiple partial prescriptions for psychotropic medications, or a combination thereof, shall be provided to a person when discharged to cover the intervening days until the first scheduled psychotropic medication aftercare appointment, or for a period of up to 21 calendar days, whichever occurs first. Discharge planning shall address the availability of and access to prescribed psychotropic medications in the community;

(f) The person shall be provided education and written information about his or her illness and psychotropic medications including other prescribed and over-the-counter medications, the common side-effects of any medications prescribed and any adverse clinically significant drug-to-drug interactions common between that medication and other commonly available prescribed and over-the-counter medications;

(g) The person shall be provided contact and program information about and referral to any community-based peer support services in the community;

(h) The person shall be provided contact and program information about and referral to any needed community resources;

(i) Referral to substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments; and(j) The person shall be provided information about advance directives, including how to prepare and use the advance directives.

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ST - BB014 - Transfer Evaluation

Title Transfer Evaluation

Type Rule

65E-5.1301(1-3) FAC

Regulation Definition

Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities.

(1) A person in a receiving facility shall not be transferred to a state treatment facility without the completion of a transfer evaluation, in accordance with Section 394.461(2), F.S., using mandatory form CF-MH 3089, Feb. 05, "Transfer Evaluation," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. The process for conducting such transfer evaluations shall be developed by the community mental health center or clinic and be approved by the district or regional office of the department where the center or clinic is located and shall include:

- (a) Designation of the contracted mental health centers or clinics that are responsible for conducting the transfer evaluations, including the receiving facilities or persons for which each center or clinic is responsible;
- (b) Establishment of the time within which a mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be completed. This form shall be completed by the designated community mental health center and submitted to the court for all persons for whom involuntary placement in a state treatment facility is sought, and directly to the state treatment facility for all persons for whom voluntary admission is sought; and
- (c) Specification of the minimum training and education of the persons qualified to conduct the transfer evaluations and the

Interpretive Guideline

- Review facility policy for transfer evaluations to ensure process includes required components and is approved by DCF district/regional office.
- Review sample of transferred patients for Form CF-MH 3089.
- Sample employees completing Form CF-MH 3089 to ensure compliance with minimum training and education and evaluation.
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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training and educational qualifications of the evaluators' immediate supervisor. Unless otherwise established in writing by the district or region, the evaluator shall have at least a bachelor's degree and the immediate supervisor a master's degree in a clinical or human services area of study.

2) A community mental health center or clinic shall evaluate each person seeking voluntary admission to a state treatment facility and each person for whom involuntary placement in a state treatment facility is sought, to determine and document:

- (a) Whether the person meets the statutory criteria for admission to a state treatment facility; and
- (b) Whether there are appropriate more integrated and less restrictive mental health treatment resources available to meet the person's needs.

(3) Following an evaluation of the person, the executive director of the community mental health center or clinic shall recommend the admission to a state treatment facility or, if criteria for involuntary placement are not met, to alternative treatment programs and shall document that recommendation by completing and signing the form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C.

(a) The executive director's responsibility for completing and signing mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., may be delegated in writing to the chief clinical officer of the center or clinic.

(b) An original signature on the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., is required.

(c) A copy of the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be retained in the files of the community mental health center or clinic.

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(d) The completed and signed mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be forwarded to the court before the hearing at which a person's involuntary placement in a state treatment facility will be considered. The evaluator, or in the absence of the evaluator, another knowledgeable staff person employed by the community mental health center or clinic, shall be present at any hearing on involuntary placement in a state treatment facility to provide testimony as desired by the court.

ST - BB015 - Written Discharge Policies & Procedures

Title Written Discharge Policies & Procedures

Type Rule

65E-5.1303(4-6) FAC

Regulation Definition

Discharge from Receiving and Treatment Facilities.

(4) Receiving and treatment facilities shall have written discharge policies and procedures which shall contain:

(a) Agreements or protocols for transfer and transportation arrangements between facilities;

(b) Protocols for assuring that current medical and legal information, including medication administered on the day of discharge, is transferred before or with the person to another facility; and

(c) Policy and procedures which address continuity of services and access to necessary psychotropic medications.

(5) When a state mental health treatment facility has established an anticipated discharge date for discharge to the community which is more than seven days in advance of the person's actual discharge, at least 7 days notice must be given to the community agency which has been assigned case management responsibility for the implementation of the

Interpretive Guideline

Review Discharge Policies and Procedures to ensure they contain required components.

The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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person's discharge plan. When an impending discharge is known 7 days or less prior to the discharge, the staff of the state mental health treatment facility shall give verbal and written notice of the impending discharge to the community case management agency within 1 working day after the decision to discharge is made. Recommended form CF-MH 7001, Jan. 98, "State Mental Health Facility Discharge Form," which is incorporated by reference, may be used for this purpose, and may be obtained online at <https://www.flrules.org/Gateway/reference.asp?No=Ref-02361>

,
<http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms>.

(6) On the day of discharge from a state mental health treatment facility, the referring physician, or his or her designee, within the requirements of Section 394.4615, F.S., and the policies and procedures required by subsection (4) of this rule, shall immediately notify the community aftercare provider or entity responsible for dispensing or administering medications. Recommended form CF-MH 7002, Feb. 05, "Physician to Physician Transfer," as referenced in subsection 65E-5.1302(2), F.A.C., may be used for this purpose, and may be obtained online at <https://www.flrules.org/Gateway/reference.asp?No=Ref-02362>

,
<http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms>.

ST - BB016 - Pt Rights - Written Copy

Title Pt Rights - Written Copy

Type Rule

65E-5.140(1) FAC

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Regulation Definition

Rights of Persons.

(1) Every person admitted to a designated receiving or treatment facility or ordered to treatment at a service provider shall be provided with a written description of his or her rights at the time of admission. Recommended form CF-MH 3103, Feb. 05, "Rights of Persons in Mental Health Facilities and Programs," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. A copy of the rights statement, signed by the person evidencing receipt of the copy, shall be placed in the person's clinical record and shall also be provided to the person's guardian, guardian advocate, representative, and health care surrogate or proxy.

Interpretive Guideline

- Form entitled "Rights of Patients" (CF-MH 3103) is considered by the department to be sufficient.
- Interview staff and patients to verify that rights have been explained and a copy provided.
The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB017 - Pt Rights - Available on Request

Title Pt Rights - Available on Request

Type Rule

65E-5.140(2) FAC

Regulation Definition

Rights of Persons.

(2) To assure that persons have current information as to their rights, a copy of the Florida Mental Health Act (Chapter 394, Part I, F.S.) and Mental Health Act Regulations (Chapter 65E-5, F.A.C.) shall be available, and provided upon request, in every psychiatric unit of each receiving and treatment facility and by each service provider and, upon request shall be made available for review by any person, guardian, guardian advocate, representative, or health care surrogate or proxy. The administrator or designee of the facility or service provider shall make physicians, nurses, and all other direct service staff aware of the location of these documents so they

Interpretive Guideline

Observe unit and ask to see a copy of the Baker Act law (394, F.S.) and rules (65E-5, F.A.C.)

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are able to promptly access them upon request.

ST - BB018 - Pt Rights Posters

Title Pt Rights Posters

Type Rule

65E-5.140(3) FAC

Regulation Definition

Rights of Persons.

(3) Posters delineating rights of persons served in mental health facilities and by service providers, including those with telephone numbers for the Florida Abuse Hotline, Florida Local Advocacy Council, and the Advocacy Center for Persons with Disabilities, shall be legible, a minimum of 14 point font size, and shall be posted immediately next to telephones which are available for persons served by the facility or provider.

Interpretive Guideline

-Observe the unit to verify that phone numbers for the abuse Hotline, HORACE, and the Advocacy Center are posted near the telephones. While the font size may not be verified, it is necessary that the information be legible.

ST - BB019 - Pt Rights - Exercise of Rights

Title Pt Rights - Exercise of Rights

Type Rule

65E-5.140(4) FAC

Regulation Definition

Rights of Persons.

(4) Each person shall be afforded the opportunity to exercise his or her rights in a manner consistent with Section 394.459(1), F.S. The imposition of individual or unit restrictions and the development of unit policies and procedures shall address observance of protecting rights of persons served in developing criteria or processes to provide

Interpretive Guideline

-Interview patients to determine if any restrictions of rights or privileges, other than those provided for in the law and rule, have been placed on individuals or the entire unit.

-Review a sample of patient medical records for the imposition of individual or unit restrictions.

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for care and safety.

ST - BB020 - Pt Rights - Access to Outdoor

Title Pt Rights - Access to Outdoor

Type Rule

65E-5.150(1) FAC

Regulation Definition

Person's Right to Individual Dignity.

(1) Freedom of movement is a right of persons in mental health receiving and treatment facilities. Any restriction of this right requires a physician's order based upon risk factors. Each receiving and treatment facility shall have policies that describe freedom of movement and access to grounds. When a suitable area is immediately adjacent to the unit, the staff shall afford each person an opportunity to spend at least one half hour per day in an open, out of doors, fresh air activity area, unless there is a physician's order prohibiting this, with documentation in the person's clinical record of the clinical reasons that access to fresh air will not be accommodated.

Interpretive Guideline

-Interview patients to ensure that they have the opportunity to spend at least 30 minutes a day out-of-doors if desired, unless there is a physician's order prohibiting such activity or unless no secured area is available at the facility.
-Observe patients in outdoor activity as part of the survey process.

ST - BB021 - Pt Rights - Special Clothing Prohibited

Title Pt Rights - Special Clothing Prohibited

Type Rule

65E-5.150(2) FAC

Regulation Definition

Person's Right to Individual Dignity.

(2) Use of special clothing for identification purposes such as surgical scrubs or hospital gowns to identify persons who are in need of specific precautions or behavior modification

Interpretive Guideline

-Observe the patients on each unit to ensure they are wearing street clothing. If any patients are not wearing street clothing, interview the patients to determine the reason and review the clinical record to determine if orders for special clothing had been issued.

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restrictions is prohibited as a violation of individual dignity. Prison or jail attire shall not be permitted for persons admitted or retained in a receiving facility except while accompanied by a uniformed law enforcement officer, for purposes of security. Under non-psychiatric medical circumstances, use of special clothing may be ordered by the person's physician on an individual basis. Documentation of the circumstances shall be included in the person's clinical record.

ST - BB022 - Pt Rights - Treatment Denied/Delayed

Title Pt Rights - Treatment Denied/Delayed

Type Rule

394.459(2)(a) FS

Regulation Definition

Rights of patients.-
(2) RIGHT TO TREATMENT
(a) A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.

Interpretive Guideline

- Ensure compliance with federal and State health care emergency access provisions. Interview local law enforcement agency personnel to determine if persons are denied admission or if admission is delayed while insurance is verified.
- Observe care and services in the ED for the emergency provision of care.
- Interview patients, families/representatives, and case managers regarding how costs are collected, as appropriate.

ST - BB023 - Pt Rights - Treatment - Least Restrictive

Title Pt Rights - Treatment - Least Restrictive

Type Rule

394.459(2)(b) FS

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Regulation Definition

Rights of patients.-

(2)RIGHT TO TREATMENT

(b) It is further the policy of the state that the least restrictive appropriate available treatment be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient's condition.

Interpretive Guideline

-Observe care and treatments for least restrictive and in the best interest of the patient needs.

-Interview staff how least restrictive is assessed and reassessed and implemented for the best interest of the patient.

-Review facility policy and procedure for patient rights to ensure that patients receive the least restrictive appropriate available treatment.

ST - BB024 - Pt Rights-Participate in Activities

Title Pt Rights-Participate in Activities

Type Rule

394.459(2)(d) FS

Regulation Definition

Rights of patients.-

(2) RIGHT TO TREATMENT

(d) Every patient in a facility shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as determined by the facility.

Interpretive Guideline

-Observe care on the unit and activity participation.

-Review a sample of patient medical records.

ST - BB025 - Pt Rights - Physical Exam

Title Pt Rights - Physical Exam

Type Rule

394.459(2)(c) FS

Regulation Definition

Rights of patients.-

(2) RIGHT TO TREATMENT

Interpretive Guideline

-Review clinical records to find a physical examination performed within 24 hours of patient arrival. This may be documented on a form or dictated in narrative form.

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(c) Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

-Interview staff, patients, and families how this is conducted.

ST - BB026 - Pt Rights -Treatment Plan

Title Pt Rights -Treatment Plan

Type Rule

394.459(2)(e) FS

Regulation Definition

RIGHT TO TREATMENT

Not more than 5 days after admission to a facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation. The plan shall include a space for the patient's comments.

Interpretive Guideline

-Interview patients to determine that they have participated in the development of an individualized treatment plan within five days of admission.
-Review patient medical records to ensure the presence of the plan and that it is signed by the patient or guardian and that the form has space for the patient's comments.
-Interview staff to determine how the facility affords the patient or patient's guardian the opportunity to participate in treatment planning.

ST - BB027 - Pt Rights-Treatmt-Assessmt/Planning

Title Pt Rights-Treatmt-Assessmt/Planning

Type Rule

65E-5.160 FAC

Regulation Definition

Right to Treatment.

(1) Patients shall have the opportunity to participate in the preparation of their own treatment and discharge plans at receiving and treatment facilities and by service providers. In instances when the person refuses or is unable to participate in such planning, such refusal or inability shall be documented in

Interpretive Guideline

-If patient is not participating, ensure patient refusal or inability to participate is documented in the clinical record.
-Review policies and procedures to ensure staff are directed to obtain advance directives, if any, from patients upon admission.
-Review patient medical records to ensure that significant results of diagnostic testing have been included in treatment planning, when appropriate.
-Review patient medical records to ensure the presence of treatment goals in the patient's treatment plan,

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the person's clinical record.

(2) Comprehensive service assessment and treatment planning, including discharge planning, shall begin the day of admission and shall also include the person's case manager if any, the person's friends, family, significant others, or guardian, as desired by the person. If the person has a court appointed guardian, the guardian shall be included in the service assessment and treatment planning. Obtaining legal consent for treatment, assessment and planning protocols shall also include the following:

- (a) How any advance directives will be obtained and their provisions addressed and how consent for treatment will be expeditiously obtained for any person unable to provide consent;
- (b) Completion of necessary diagnostic testing and the integration of the results and interpretations from those tests. The results and interpretation of the results shall be reviewed with the person;
- (c) The development of treatment goals specifying the factors and symptomology precipitating admission and addressing their resolution or mitigation;
- (d) The development of a goal within an individualized treatment plan, including the individual's strengths and weaknesses, that addresses each of the following: living arrangements, social supports, financial supports, and health, including mental health. Goals shall be inclusive of the person's choices and preferences and utilize available natural social supports such as family, friends, and peer support group meetings and social activities;
- (e) Objectives for implementing each goal shall list the actions needed to obtain the goal, and shall be stated in terms of outcomes that are observable, measurable, and time-limited;
- (f) Progress notes shall be dated and shall address each objective in relation to the goal, describing the corresponding progress, or lack of progress being made. Progress note entries

individualized to address the problems causing the admission.

Review patient medical records to ensure that each of the four required elements is incorporated into the individualized treatment plan and that the plan addresses the patient's preferences and support system.

- Review patient medical records to ensure each goal details actions needed to reach specified outcomes.
- Review patient medical records to ensure legibility so that staff and the patient can read the progress notes. Ensure the notes respond to the goals and objectives established in the individualized treatment plan.
- If the patient is to be retained beyond brief stabilization, periodic reviews of the patient's condition should be conducted and documented in order to modify the treatment plan, as needed.
- Review the clinical record to ensure that all parts of the patient's treatment are integrated toward a common outcome.
- Review the clinical record to ensure the physician summarizes the patient's plan at least monthly, except in long-term care (over 2 years) in which the update can occur every other month.
- Review the seclusion/restraint logbook and ensure that entries are also incorporated in each patient's clinical record. The clinical records should also detail any injuries mentioned by patients during interviews.
- Continued involuntary placement hearings generally take place after the original six-month order has expired.

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and the name and title of writer must be clearly legible;

(g) Periodic reviews shall be comprehensive, include the person, and shall be the basis for major adjustments to goals and objectives. Frequency of periodic reviews shall be determined considering the degree to which the care provided is acute care and the projected length of stay of the person;

(h) Progress note observations, participation by the person, rehabilitative and social services, and medication changes shall reflect an integrated approach to treatment;

(i) Facilities shall update the treatment plan, including the physician summary, at least every 30 days during the time a person is in a receiving or treatment facility except that persons retained for longer than 24 months shall have updates at least every 60 days;

(j) The clinical record shall comprehensively document the person's care and treatment, including injuries sustained and all uses of emergency treatment orders; and

(k) Persons who will have a continued involuntary outpatient placement hearing pursuant to Section 394.4655(7), F.S., or continued involuntary inpatient placement hearing pursuant to Section 394.467(7), F.S., shall be provided with comprehensive re-assessments, the results of which shall be available at the hearing.

(3) The physical examination required to be provided to each person who remains at a receiving or treatment facility for more than 12 hours must include:

(a) A determination of whether the person is medically stable; and

(b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out.

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ST - BB029 - Schedule of Daily Activities

Title Schedule of Daily Activities

Type Rule

65E-5.1601(2) FAC

Regulation Definition

General Management of the Treatment Environment.
(2) Each designated receiving and treatment facility shall develop a schedule of daily activities listing the times for specific events, which shall be posted in a common area and provided to all persons.

Interpretive Guideline

-Observe each patient unit of a receiving or treatment facility to observe the posted schedule of daily activities.
-Determine if the activity scheduled at the time of the tour is actually occurring.
-Interview patients to determine if the posted activities generally occur as scheduled.

ST - BB030 - Quality of Treatment-Interventions

Title Quality of Treatment-Interventions

Type Rule

65E-5.1601 (1, 3-4)FAC

Regulation Definition

General Management of the Treatment Environment.
(1) Management and personnel of the facility's treatment environment shall use positive incentives in assisting persons to acquire and maintain socially positive behaviors as determined by the person's age and developmental level.

(3) Interventions such as the loss of personal freedoms, loss of earned privileges or denial of activities otherwise available to other persons shall be minimized and utilized only after the documented failure of the unit's positive incentives for the individuals involved.

Interpretive Guideline

Observe for any evidence of a punitive approach to patient care. Review patient medical records for documentation of removal of a patient's privileges. Interview patients to determine if privileges have been removed, with or without documentation in the clinical record.

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(4) Facilities shall ensure that any verbal or written information provided to persons must be accessible in the language and terminology the person understands.

ST - BB031 - Behavioral Management Programs

Title Behavioral Management Programs

Type Rule

65E-5.1602 FAC

Regulation Definition

Individual Behavioral Management Programs.

When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the person shall be included, and the person's treatment plan shall reflect:

- (1) Documentation, signed by the physician that the person's medical condition does not exclude the proposed interventions;
- (2) Consent for the treatment to be provided;
- (3) A general description of the behaviors requiring the intervention, which may include previous emergency interventions;
- (4) Antecedents of that behavior;
- (5) The events immediately following the behavior;
- (6) Objective definition of the target behaviors, such as specific acts, level of aggression, encroachment on others' space, self-injurious behavior or excessive withdrawal;
- (7) Arrangements for the consistent collection and recording of data;
- (8) Analysis of data;
- (9) Based on data analysis, development of intervention strategies, if necessary;
- (10) Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;

Interpretive Guideline

Review patient medical record for any patient for whom privileges have been removed or specific behavioral interventions are implemented beyond those applied to all patients, to ensure the 12 essential elements are incorporated in the individual patient's behavior management plan.

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- (11) Continued data collection, if interventions are implemented; and
- (12) Periodic review and revision of the plan based upon data collected and analyzed.

ST - BB032 - Pt Rights to Consent

Title Pt Rights to Consent

Type Rule

394.459(3)(a) FS

Regulation Definition

Rights of patients.-

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT

(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate.

Interpretive Guideline

-Express and Informed consent means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. [394.455(9),F.S.]

-Incompetent to Consent to Treatment means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. [394.455(15), F.S.]

-Review clinical records to ensure that a signed consent for treatment has been signed by an individual authorized to provide consent before any treatment has been administered.

-Ensure from the progress notes and other documentation that the patient is not too confused or disoriented to provide informed consent, how that determination was made and who made it. Use of recommended form "Certification of Patient's Competence to Provide Express and Informed Consent" (CF-MH 3104) is considered by the department to be sufficient to document the competence of a person to give express and informed consent.

-Interview several patients authorizing their own treatment to determine their ability to provide informed consent and ensure it was documented.

-For patients who are incompetent to consent to treatment and have a guardian or guardian advocate, has that surrogate been asked to provide consent? If possible, telephone the guardian or guardian advocate to ensure that they were provided full disclosure of the proposed treatment prior to being asked to sign the authorization for treatment.

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-Keep in mind a patient's ability to consent may fluctuate.

ST - BB033 - Establish Consent - Treatment Facilities

Title Establish Consent - Treatment Facilities

Type Rule

65E-5.170(1)(b-c) FAC

Regulation Definition

Right to Express and Informed Consent.

(1) Establishment of Consent.

(b) Treatment Facilities. Upon entering a designated treatment facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to assess the person's ability to provide express and informed consent to admission and treatment, which shall be documented in the person's clinical record. The examination of a person alleged to be incapacitated or incompetent to consent to treatment, for this purpose, may be limited to documenting the letters of guardianship or order of the court. If a person has been adjudicated as incapacitated and a guardian appointed by the court or if a person has been found to be incompetent to consent to treatment and a guardian advocate has been appointed by the court, the limits of authority of the guardian or guardian advocate shall be determined prior to allowing the guardian or guardian advocate to authorize treatment for the person. A copy of any court order delineating a guardian's authority to consent to mental health or medical treatment shall be obtained by the facility and included in the person's clinical record prior to allowing the guardian to give express and informed consent to treatment for the person.

(c) If the admission is voluntary, the person's competence to provide express and informed consent for admission shall be documented by the admitting physician. Recommended form

Interpretive Guideline

-Review the patient medical record of any patients in the facility that have a court-appointed guardian.

-Ensure that the court order and/or letters of guardianship are in the record.

-Review the order/letters to determine what rights have been removed from the patient and delegated by the court to the guardian to ensure that the guardian has been given the authority to consent to mental health and/or medical treatment of the patient.

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CF-MH 3104, Feb. 05, "Certification of Person's Competence to Provide Express and Informed Consent," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. The completed form or other documentation shall be retained in the person's clinical record. Facility staff monitoring the person's condition shall document any observations which suggest that a person may no longer be competent to provide express and informed consent to his or her treatment. In such circumstances, staff shall notify the physician and document in the person's clinical record that the physician was notified of this apparent change in clinical condition

ST - BB034 - Pt Rights To Consent-Minors

Title Pt Rights To Consent-Minors

Type Rule

394.459(3)(a) FS

Regulation Definition

RIGHT TO EXPRESS AND INFORMED PATIENT
CONSENT

(3)(a)1.

... If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467.

Interpretive Guideline

-Express and informed consent must be provided by the patient's guardian.

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ST - BB035 - Establish Consent - Receiving Facilities

Title Establish Consent - Receiving Facilities

Type Rule

65E-5.170(1)(a) FAC

Regulation Definition

Right to Express and Informed Consent.

(1) Establishment of Consent.

(a) Receiving Facilities. As soon as possible, but in no event longer than 24 hours from entering a designated receiving facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to assess the person's ability to provide express and informed consent to admission and treatment. The examination of a minor for this purpose may be limited to the documentation of the minor's age. The examination of a person alleged to be incapacitated for this purpose may be limited to the documentation of letters of guardianship. Documentation of the assessment results shall be placed in the person's clinical record. The facility shall determine whether a person has been adjudicated as incapacitated and whether a guardian has been appointed by the court. If a guardian has been appointed by the court, the limits of the authority of the guardian shall be determined prior to allowing the guardian to authorize treatment. A copy of any court order delineating a guardian's authority to consent to mental health or medical treatment shall be obtained by the facility and included in the person's clinical record prior to allowing the guardian to give express and informed consent to treatment for the person.

Interpretive Guideline

-Ensure that the physician for a voluntary patient has documented the patient's competence to provide express and informed consent to the admission and to treatment within 24 hours of admission.

-Where the patient is a minor or an adult who is adjudicated as incapacitated by a court order, such documentation is sufficient to preclude the patient's ability to consent to his or her own treatment. In such situations, a guardian must decide whether or not to provide express and informed consent to recommended treatment.

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ST - BB036 - Pt Rights To Disclosure

Title Pt Rights To Disclosure

Type Rule

394.459(3)(a)2. FS

Regulation Definition

Rights of patients.-

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT

(a)2. Before giving express and informed consent, the following information shall be provided and explained in plain language to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient's guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and the guardian if the patient is a minor: the reason for admission or treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range for the medication, when applicable; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient.

Interpretive Guideline

- Examine the explanation in the patient medical record of the treatment to be given to determine if the information does in fact explain the risk/benefit of the treatment and alternatives.
- Review documentation of disclosure in patient medical record and interview selected patients to determine if full disclosure had been provided prior to being asked to sign consent to treatment form.
- Confirm that guardians or guardian advocates had been provided full disclosure prior to being asked to sign consent for treatment for persons adjudicated by a court to be incapacitated or incompetent to consent to treatment.

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ST - BB037 - Pt Rights To Consent - Consent Obtained

Title Pt Rights To Consent - Consent Obtained

Type Rule

394.459(3)(b) FS

Regulation Definition

Rights of patients.-

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT

(b) In the case of medical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, express and informed consent shall be obtained from the patient if the patient is legally competent, from the guardian of a minor patient, from the guardian of a patient who has been adjudicated incapacitated, or from the guardian advocate of the patient if the guardian advocate has been given express court authority to consent to medical procedures or electroconvulsive treatment as provided under s. 394.4598.

Interpretive Guideline

-Review policies and procedures of the facility to ensure that informed consent of the patient, guardian or guardian advocate is obtained only after full disclosure of all aspects of risk/benefit is given.

ST - BB038 - Pt Rights to Receive Services

Title Pt Rights to Receive Services

Type Rule

394.459(4)(a) FS

Regulation Definition

Rights of patients.-

(4) QUALITY OF TREATMENT

(a) Each patient shall receive services, including, for a patient placed under s. 394.4655, those services included in the court

Interpretive Guideline

-Interview staff/patients and observe the environment and staff-patient interaction to confirm that patients receive treatment where they are safe, treated appropriately, and protected from harm.

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order which are suited to his or her needs, and which shall be administered skillfully, safely, and humanely with full respect for the patient's dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his or her condition requires in order to live successfully in the community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all other programs of the department and other state agencies.

ST - BB039 - Quality Mental Health Treatment

Title Quality Mental Health Treatment

Type Rule

65E-5.180 FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

- (1) Each receiving and treatment facility and service provider shall, using nationally accepted accrediting standards for guidance, develop written policies and procedures for planned program activities designed to enhance the person's self image, as required by Section 394.459(2)(d), F.S. These policies and procedures shall include curriculum, specific content, and performance objectives and shall be delivered by staff with content expertise. Medical, rehabilitative, and social services shall be integrated and provided in the least restrictive manner consistent with the safety of the persons served.
- (2) Each facility and service provider, using nationally accepted accrediting standards for guidance, shall adopt written professional standards of quality, accuracy, completeness, and timeliness for all diagnostic reports, evaluations, assessments, examinations, and other procedures

Interpretive Guideline

- Program policies and procedures should be based on nationally accepted standards. Staff training shall be performed by persons who are competent by reason of training and/or experience in the subject matter.
- Review patient medical records to determine that reports are legible, understandable, signed and dated. Issues raised by these reports should be addressed in the individualized treatment and discharge plans for each patient.

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provided to persons under the authority of Chapter 394, Part I, F.S. Facilities shall monitor the implementation of those standards to assure the quality of all diagnostic products. Standards shall include and specify provisions addressing:

- (a) The minimum qualifications to assure competence and performance of staff who administer and interpret diagnostic procedures and tests;
- (b) The inclusion and updating of pertinent information from previous reports, including admission history and key demographic, social, economic, and medical factors;
- (c) The dating, accuracy and the completeness of reports;
- (d) The timely availability of all reports to users;
- (e) Reports shall be legible and understandable;
- (f) The documentation of facts supporting each conclusion or finding in a report;
- (g) Requirements for the direct correlation of identified problems with problem resolutions that consider the immediacy of the problem or time frames for resolution and which include recommendations for further diagnostic work-ups;
- (h) Requirement that the completed report be signed and dated by the administering staff; and
- (i) Consistency of information across various reports and integration of information and approaches across reports.

ST - BB040 - Pt Rights-Psychiatric Exams Include

Title Pt Rights-Psychiatric Exams Include

Type Rule

65E-5.180(3) FAC

Regulation Definition

Right to Quality Treatment.
The following standards shall be required in the provision of quality mental health treatment:

Interpretive Guideline

-Review clinical records for the presence of a psychiatric examination for all patients within 72 hours of admission on a voluntary or involuntary basis. The examination must include essential elements (a-g) required in the rule; issues of discharge or transfer diagnosis should be incorporated in the discharge or transfer summary completed upon the

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(3) Psychiatric Examination. Psychiatric examinations shall include: patient's departure from the facility.

- (a) Medical history, including psychiatric history, developmental abnormalities, physical or sexual abuse or trauma, and substance abuse;
- (b) Examination, evaluative or laboratory results, including mental status examination;
- (c) Working diagnosis, ruling out non-psychiatric causes of presenting symptoms of abnormal thought, mood or behaviors;
- (d) Course of psychiatric interventions including:
 - 1. Medication history, trials and results;
 - 2. Current medications and dosages;
 - 3. Other psychiatric interventions in response to identified problems;
- (e) Course of other non-psychiatric medical problems and interventions;
- (f) Identification of prominent risk factors including physical health, psychiatric and co-occurring substance abuse; and
- (g) Discharge or transfer diagnoses.

ST - BB041 - Pt Rights - Physical Transfer

Title Pt Rights - Physical Transfer

Type Rule

65E-5.180(4) FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

- (4) So that care will not be delayed upon arrival, procedures for the transfer of the physical custody of persons shall specify and require that documentation necessary for legal custody and medical status, including the person's medication administration record for that day, shall either precede or

Interpretive Guideline

- Review facility policies and procedures to ensure the specified documents are required to be transferred prior to or with the patient.
- Review closed clinical records to ensure that the facility is following the rule and its own policy in the transfer of records with a patient.

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accompany the person to his or her destination.

ST - BB042 - Mental Health Services

Title Mental Health Services

Type Rule

65E-5.180(5) FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

(5) Mental health services provided shall comply with the following standards:

- (a) In designated receiving facilities, the on-site provision of emergency psychiatric reception and treatment services shall be available 24-hours-a-day, seven-days-a-week, without regard to the person's financial situation.
- (b) Assessment standards shall include provision for determining the presence of a co-occurring mental illness and substance abuse, and clinically significant physical and sexual abuse or trauma.
- (c) A clinical safety assessment shall be accomplished at admission to determine the person's need for, and the facility's capability to provide, an environment and treatment setting that meets the person's need for a secure facility or close levels of staff observation.
- (d) The development and implementation of protocols or procedures for conducting and documenting the following shall be accomplished by each facility:
 - 1. Determination of a person's competency to consent to treatment within 24 hours after admission;
 - 2. Identification of a duly authorized decision-maker for the person upon any person being determined not to be competent to consent to treatment;

Interpretive Guideline

- Ensure that the facility is open and fully staffed to provide all essential functions 24-hours per day, 7-days per week. Each facility shall accept all persons brought to the facility by law enforcement officers for involuntary examination.
- Psychosocial evaluations shall address the patient's history of physical or sexual abuse or trauma, as well as substance abuse. Treatment and discharge planning should address these issues.
- The patient medical record should include documentation of the patient's need for a staff or facility-secure setting for the protection of the patient or others.
- Review the policies and procedures to ensure the inclusion of the four required elements related to express and informed consent and involvement of the patient and substitute decision-makers in the treatment planning process.
- Review policies and procedures to ensure special recognition is given in the application of seclusion or restraints to minors, elders, or persons with special medical problems.
- Review patient medical records to ensure that the reasons for any use of emergency interventions is specified in such a way that the patient or other authorized person may understand its necessity.
- Review patient medical records to ensure that any emergency use of psychotropic medications is based on an individual order by a physician and not standing orders.
- Review patient medical records of patients who have had a guardian advocate proposed/appointed by the court to ensure the required training has been provided to assist in treatment and discharge planning.

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3. Obtaining express and informed consent for treatment and medications before administration, except in an emergency; and

4. Required involvement of the person and guardian, guardian advocate, or health care surrogate or proxy, in treatment and discharge planning.

(e) Use of age sensitive interventions in the implementation of seclusion or in the use of physical force as well as the authorization and training of staff to implement restraints, including the safe positioning of persons in restraints. Policies, procedures and services shall incorporate specific provisions regarding the restraining of minors, elders, and persons who are frail or with medical problems such as potential problems with respiration.

(f) Plain language documentation in the person's clinical record of all uses of "as needed" or emergency applications of psychotropic medications, and all uses of physical force, restraints, seclusion, or "time-out" procedures upon persons, and the explicit reasons for their use.

(g) The prohibition of standing orders or similar protocols for the emergency use of psychotropic medication, restraint, or seclusion.

(h) Provision of required training for guardian advocates including activities and available resources designed to assist family members and guardian advocates in understanding applicable treatment issues and in identifying and contacting local self-help organizations.

ST - BB043 - Express & Informed Consent

Title Express & Informed Consent

Type Rule

65E-5.170(1)(d)-(7) FAC

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Regulation Definition

Right to Express and Informed Consent

(1) Establishment of Consent.

(d) In the event there is a change in the ability of a person on voluntary status to provide express and informed consent to treatment, the change shall be immediately documented in the person's clinical record. A person's refusal to consent to treatment is not, in itself, an indication of incompetence to consent to treatment.

1. If the person is assessed to be competent to consent to treatment and meets the criteria for involuntary inpatient placement, the facility administrator shall file with the court a petition for involuntary placement. Recommended form CF-MH 3032, Feb. 05, "Petition for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

2. If the person is assessed to be incompetent to consent to treatment, and meets the criteria for involuntary inpatient or involuntary outpatient placement, the facility administrator shall expeditiously file with the court both a petition for the adjudication of incompetence to consent to treatment and appointment of a guardian advocate, and a petition for involuntary inpatient or involuntary outpatient placement. Upon determination that a person is incompetent to consent to treatment the facility shall expeditiously pursue the appointment of a duly authorized substitute decision-maker that can make legally required decisions concerning treatment options or refusal of treatments for the person. Recommended forms CF-MH 3106, Feb. 05, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," which is incorporated by reference may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient

Interpretive Guideline

-Interview staff to determine if any voluntary status patients experienced a change in their ability to provide express and informed consent to treatment. If so, review the patient records to ensure this was documented.

-For involuntary patients, review patient records to ensure the petition was filed by the administrator.

-For patients incompetent to consent, review patient file to ensure this has been documented by a physician and the administrator filed the petition for adjudication of incompetence and petition for involuntary placement. This must be done prior to the approval of the transfer from voluntary to involuntary.

-For patients adjudicated incompetent to consent, review the patient file to ensure the facility pursued the appointment of a substitute decision maker (guardian advocate).

-Review patient records of voluntary patients to ensure they were offered and provided express and informed consent.

-Review patient records to ensure all documentation related to the appointment/discharge of a guardian is contained in the record.

-Review closely if the patient has fluctuated on their ability to consent

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFFormsInternet/Search/DCFFFormSearch.aspx>

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Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(e) Competence to provide express and informed consent shall be established and documented in the person's clinical record prior to the approval of a person's transfer from involuntary to voluntary status or prior to permitting a person to consent to his or her own treatment if that person had been previously determined to be incompetent to consent to treatment. Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., properly completed by a physician may be used for this purpose.

(f) Any guardian advocate appointed by a court to provide express and informed consent to treatment for the person shall be discharged and a notice of such guardian advocate discharge provided to the court upon the establishment and documentation that the person is competent to provide express and informed consent.

(g) If a person entering a designated receiving or treatment facility has been adjudicated incapacitated under Chapter 744, F.S., as described in Section 394.455(14), F.S., express and informed consent to treatment shall be sought from the person's guardian.

(h) If a person entering a designated receiving or treatment facility has been determined by the attending physician to be incompetent to consent to treatment as defined in Section 394.455(15), F.S., express and informed consent to treatment shall be expeditiously sought by the facility from the person's guardian advocate or health care surrogate or proxy.

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(i) A copy of the letter of guardianship, court order, or advance directive shall be reviewed by facility staff to ensure that the substitute decision-maker has the authority to provide consent to the recommended treatment on behalf of the person. If the facility relies upon the expression of express and informed consent for person's treatment from a substitute decision-maker, a copy of this documentation shall be placed in the person's clinical record and shall serve as documentation of the substitute decision-maker's authority to give such consent. With respect to a health care proxy, where no advance directive has been prepared by the person, facility staff shall document in the person's clinical record that the substituted decision-maker was selected in accordance with the list of persons and using the priority set out in Section 765.401, F.S. When a health care surrogate or proxy is used, the facility shall immediately file a petition for the appointment of a guardian advocate.

(2) Authorization for Treatment.

(a) Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment. If the person is incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician or a psychiatric nurse for the safety of the person or others. Chapter 394, Part I, F.S., and this rule chapter govern mental health treatment. Medical treatment for persons served in receiving and treatment facilities and by other service providers are governed by other statutes and rules.

(b) A copy of information disclosed while attempting to obtain express and informed consent shall be given to the person and

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to any substitute decision-maker authorized to act on behalf of the person.

(c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, Feb. 05, "General Authorization for Treatment Except Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, Feb. 05, "Specific Authorization for Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, "General Authorization for Treatment Except Psychotropic Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission to permit routine medical care, psychiatric assessment, and other assessment and treatment except psychotropic medications. The more specific recommended form CF-MH 3042b, "Specific Authorization for Psychotropic Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, shall be completed prior to the administration of any psychotropic medications, except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person's clinical record.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for psychiatric treatment is sought from a person legally qualified to give it, except in

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instances where emergency treatment is ordered by a physician or a psychiatric nurse to preserve the immediate safety of the person or others.

(3) Receiving and treatment facilities shall request copies of any advance directives completed by persons admitted to the facilities, from the person or the person's family or representative.

(4) In addition to any other requirements, at least the following must be given to the person before express and informed consent will be valid:

(a) Identification of the proposed psychotropic medication, together with a plain language explanation of the proposed dosage range, the frequency and method of administration, the recognized short-term and long-term side effects, any contraindications which may exist, clinically significant interactive effects with other medications, and similar information on alternative medications which may have less severe or serious side effects.

(b) A plain language explanation of all other treatments or treatment alternatives recommended for the person.

(5) If a change in psychotropic medication is recommended which is not included in the previously signed CF-MH 3042b, "Specific Authorization for Psychotropic Medications" form, as referenced in paragraph 65E-5.170(2)(c), F.A.C., after an explanation and disclosure of the altered treatment plan is provided by the physician or a psychiatric nurse express and informed consent must be obtained from the person authorized to provide consent and be documented in the person's clinical record prior to the administration of the treatment or psychotropic medication.

(6) The facility or service provider staff shall explain to a guardian, guardian advocate, or health care surrogate or proxy, the duty of the substitute decision-maker to provide information to the facility or service provider on how the substitute decision-maker may be reached at any time during

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the person's hospitalization or treatment to provide express and informed consent for changes of treatment from that previously approved.

(7) Electroconvulsive treatment may be recommended to the person or the person's substitute decision-maker by the attending physician. Such recommendation must also be concurrently recommended by at least one other physician not directly involved with the person's care who has reviewed the person's clinical record. Such recommendation shall be documented in the person's clinical record and shall be signed by both physicians. Recommended form CF-MH 3057, Feb. 05, "Authorization for Electroconvulsive Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. If used, this form shall also be signed by the person, if competent, or by the guardian advocate, if previous court approval has been given, or by the guardian where the person has been found by the court to be incapacitated, or by the health care surrogate if the person had expressly delegated such authority to the surrogate in the advance directive.

Express and informed consent from the person or his or her substitute decision-maker, as required by Section 394.459(3), F.S., including an opportunity to ask questions and receive answers about the procedure, shall be noted on or attached to recommended form CF-MH 3057, "Authorization for Electroconvulsive Treatment," as referenced in subsection 65E-5.170(7), F.A.C., or its equivalent, as documentation of the required disclosures and of the consent. Each signed authorization form is permission for the person to receive a series of up to, but not more than, the stated number of electroconvulsive treatments identified on the form.

Additional electroconvulsive treatments require additional written authorization. The signed authorization form shall be retained in the person's clinical record and shall comply with the provisions of Section 458.325, F.S.

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ST - BB044 - Emergency Treatment Orders -Psychotropic Meds

Title Emergency Treatment Orders -Psychotropic Meds

Type Rule

65E-5.1703 FAC

Regulation Definition

Emergency Treatment Orders for the Administration of Psychotropic Medications.

(1) An emergency treatment order shall be consistent with the least restrictive treatment interventions, including the emergency administration of psychotropic medications or the emergency use of restraints or seclusion. Use of seclusion or restraint in an emergency situation is addressed in subparagraph 65E-5.180(7)(a)3., F.A.C., and is not addressed in this rule. This rule pertains only to the use of psychotropic medication in an emergency situation.

(a) The issuance of an emergency treatment order requires a physician's or a psychiatric nurse's practicing within the framework of an established protocol with a psychiatrist review of the person's condition for causal medical factors, such as insufficiency of psychotropic medication blood levels, as determined by drawing a blood sample; medication interactions with psychotropic or other medications; side effects or adverse reactions to medications; organic, disease or medication based metabolic imbalances or toxicity; or other biologically based or influenced symptoms.

(b) All emergency treatment orders may only be issued by a physician licensed under the authority of Chapter 458 or 459, F.S. or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist 394.463, Florida Statutes

(c) The physician must review, integrate and address such metabolic imbalances in the issuance of an emergency

Interpretive Guideline

- Review orders for patient, emergency orders for psychotropic medications expire after 24 hours.
- Review MAR to ensure medication was only administered during the 24 hours after the order.

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treatment order.

- (d) The use of an emergency treatment order must be consistent with the least restrictive treatment requirements, and, absent more appropriate interventions, an emergency treatment order is for immediate administration of rapid response psychotropic medications to a person to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person or others.
- (2) An emergency treatment order for psychotropic medication supersedes the person's right to refuse psychotropic medication if based upon the physician's assessment that the individual is not capable of exercising voluntary control over his or her own symptomatic behavior and that these uncontrolled symptoms and behavior are an imminent danger to the person or to others in the facility. When emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent adult, facility staff shall document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical.
- (3) The physician's or a psychiatric nurse's practicing within the framework of an established protocol with a psychiatrist initial order for emergency treatment may be by telephone but such a verbal order must be reduced to writing upon receipt and signed by a physician within 24 hours.
- (4) Each emergency treatment order shall only be valid and shall be authority for emergency treatment only for a period not to exceed 24 hours.
- (5) The need for each emergency treatment order must be documented in the person's clinical record in the progress notes and in the section used for physician's or a psychiatric nurse's practicing within the framework of an established protocol with a psychiatrist orders and must describe the

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specific behavior which constitutes a danger to the person or to others in the facility, and the nature and extent of the danger posed.

(6) Upon the initiation of an emergency treatment order the facility shall, within two court working days, petition the court for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent, unless the person voluntarily withdraws a revocation of consent or requires only a single emergency treatment order for emergency treatment.

(7) If a second emergency treatment order is issued for the same person within any 7 day period, the petition for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent shall be filed with the court within 1 court working day.

(8) While awaiting court action, treatment may be continued without the consent of the person, but only upon the daily written emergency treatment order of a physician or a psychiatric nurse's practicing within the framework of an established protocol with a psychiatrist who has determined that the person's behavior each day during the wait for court action continues to present an immediate danger to the safety of the person or others and who documents the nature and extent of the emergency each day of the specific danger posed. Such orders may not be written in advance of the demonstrated need for same.

(9) To assure the safety and rights of the person, and since emergency treatment orders by a physician or a psychiatric nurse's practicing within the framework of an established protocol with a psychiatrist absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature

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and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above.

ST - BB050 - Abuse Reporting, Training, etc.

Title Abuse Reporting, Training, etc.

Type Rule

65E-5.330 FAC

Regulation Definition

Training

(1) In order to ensure the protection of the health, safety, and welfare of persons treated in receiving and treatment facilities, required by Section 394.457(5)(b), F.S., the following is required:

- (a) Each designated receiving and treatment facility shall develop policies and procedures for abuse reporting and shall conduct training which shall be documented in each employee's personnel record or in a training log.
- (b) All staff who have contact with persons served shall receive training in verbal de-escalation techniques and the use of bodily control and physical management techniques based on a team approach. Less restrictive verbal de-escalation interventions shall be employed before physical interventions, whenever safety conditions permit.
- (c) All staff who have contact with persons served shall receive training in cardiopulmonary resuscitation within the first six months of employment if not already certified when employed and shall maintain current certification as long as duties require direct contact with persons served by the facility.
- (d) A personnel training plan that prescribes and assures that direct care staff, consistent with their assigned duties, shall receive and complete before providing direct care or

Interpretive Guideline

- Review facility policies and procedures to ensure staff are correctly instructed to immediately report suspected abuse, neglect, or exploitation of any child, elder, or disabled person, without internal review. Review personnel records (see Personnel Worksheet) to ensure documentation is present of staff training in these policies and procedures.
- Review personnel records to ensure each employee with patient contact has received training in a team approach to physical management techniques.
- Review personnel records to ensure each employee with patient contact has received training in CPR within the timeframes permitted.
- Review the facility's personnel training plan to ensure it contains the type and length of training events required in rule. Also review the personnel record of a sample of these staff to ensure the training events detailed in the plan were actually provided. In staff interviews, ask staff if they remember receiving the specified training events.

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assessment services, 14 hours of basic orientation training, documented in the employee's personnel record, in the following:

1. Rights of persons served by the facility and facility procedures required under Chapter 394, Part I, F.S., and Chapter 65E-5, F.A.C.;
2. Confidentiality laws including psychiatric, substance abuse, HIV and AIDS;
3. Facility incident reporting;
4. Restrictions on the use of seclusion and restraints, consistent with unit policies and procedures, and this chapter;
5. Abuse reporting required by Chapter 415, F.S.;
6. Assessment for past or current sexual, psychological, or physical abuse or trauma;
7. Cross-training for identification of, and working with, individuals recently engaging in substance abuse;
8. Clinical risk and competency assessment;
9. Universal or standard practices for infection control;
10. Crisis prevention, crisis intervention and crisis duration services;
11. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as referenced in subparagraph 65E-5.285(1)(a)2., F.A.C.; and
12. Honoring preferences contained in advance directives prepared by persons served by the facility.

ST - BB051 - Orientation, Cont. Training, Inservice

Title Orientation, Cont. Training, Inservice

Type Rule

65E-5.330(2) FAC

Regulation Definition

Training
(2) In addition to the training required in this rule, procedures

Interpretive Guideline

Review the training plan to ensure the continuing education is included and review personnel records to ensure the planned training was actually provided.

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must assure that mental health services staff shall annually receive 12 hours continuing training in the skills and knowledge employed in performing their respective responsibilities. Employees during their first year of employment shall undergo no less than the 14 hours of orientation, as described in paragraph (1)(c) above, and 12 hours of in-service training.

ST - BB052 - Training by Qualified Professionals

Title Training by Qualified Professionals

Type Rule

65E-5.330(3) FAC

Regulation Definition

Training
(3) Procedures shall require that individuals who deliver the staff training curriculum for mental health services shall be qualified by their experience and training in the content presented.

Interpretive Guideline

Review the facility's training plan to determine if the proposed trainer, if designated, is qualified to provide the training. If none is designated, review past training events to determine if the trainer for those events was qualified.

ST - BB053 - Training Plan - Mandatory Baker Act

Title Training Plan - Mandatory Baker Act

Type Rule

65E-5.330(4) FAC

Regulation Definition

Training
(4) A plan shall be developed and implemented providing for the mandatory training for employees, emergency room personnel and physicians and psychiatric nurse practicing within the framework of an established protocol with a

Interpretive Guideline

Review the facility's training plan to determine if a comprehensive training schedule has been prepared to address the needs of the specified personnel.

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psychiatrist in the Baker Act, relative to their positions and responsibilities, and any implementing local coordination agreements or protocols.

ST - BB061 - Pt Rights - Complaints

Title Pt Rights - Complaints

Type Rule

65E-5.180(6) FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

(6) Each facility shall develop a written policy and procedure for receiving, investigating, tracking, managing and responding to formal and informal complaints by a person receiving services or by an individual acting on his or her behalf.

(a) The complaint process shall be verbally explained during the orientation process and provided in writing in language and terminology that the person receiving services can understand. It will explain how individuals may address complaints informally through the facility staff and treatment team, and formally through the staff person assigned to handle formal complaints, as well as the administrator or designee of the facility. The person receiving services shall also be advised that he or she may contact the Local Advocacy Council, the Florida Abuse Registry, the Advocacy Center for Persons with Disabilities, or any other individual or agency at anytime during the complaint process to request assistance. The complaint process, including telephone numbers for the above named entities, shall be posted in plain view in common areas and next to telephones used by individuals receiving services. Any complaint may be verbal or written. Any staff

Interpretive Guideline

- Review the policy and procedure manual to ensure the presence of an approved procedure for handling patient complaints.
- Interview staff to determine if they understand their facility's procedure.
- Interview patients to determine how any complaints they made were addressed.
- Review clinical records to ensure the presence of any patient complaint, if any.

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person receiving an informal or formal complaint dealing with life-safety issues will take immediate action to resolve the matter.

(b) Informal complaints are initial complaints that are usually made verbally by a person receiving services or by an individual acting on his or her behalf. If resolution cannot be mutually agreed upon, a formal written complaint may be initiated.

(c) When the person receiving services, or a person acting upon that person's behalf, makes a formal complaint a staff person not named in the complaint shall assist the person in initiating the complaint. The complaint shall include the date and time of the complaint and detail the issue and the remedy sought. All formal complaints shall be forwarded to the staff person, or designee, who is assigned to track and monitor formal complaints. All formal complaints shall be tracked and monitored for compliance and shall contain the following information:

1. The date and time the formal complaint was originally received by staff;
2. The date and time the formal complaint was received by the staff assigned to track formal complaints;
3. The nature of the complaint;
4. The name of the person receiving services;
5. The name of the person making the complaint;
6. The name of the individual assigned to investigate the complaint;
7. The date the individual making the complaint was notified of the individual assigned to investigate the complaint;
8. The due date for the written response; and
9. At closure, the written disposition of the formal complaint.

(d) The investigation shall be completed within 7 days from the date of entry into the system for tracking complaints.

(e) A written response must be given or mailed to the person receiving services within 24 hours of disposition. The

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individual acting on behalf of the person receiving services shall be notified of the completion of the investigation but will not be given specific details of the disposition unless they have a legal right to the information or a signed release of information is in place.

(f) The disposition of a complaint may be appealed to the administrator of the facility. If appealed, the facility administrator or designee shall review the written complaint and the initial disposition. Within five working days, the facility administrator or designee will make a final decision concerning the outcome of the complaint and will provide a written response within 24 hours to the person receiving services. A copy of the written response shall also be given to the staff member assigned to track complaints.

ST - BB062 - Pt Rights-Behavior Mgt - De-Escalation

Title Pt Rights-Behavior Mgt - De-Escalation

Type Rule

65E-5.180(7) FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(a) General Standards.

1. Each facility will provide a therapeutic milieu that supports a culture of recovery and individual empowerment and responsibility. Each person will have a voice in determining his or her treatment options. Treatment will foster trusting relationships and partnerships for safety between staff and

Interpretive Guideline

-Review personnel records to ensure each staff member with direct patient care responsibilities has received training in verbal de-escalation and team oriented physical management techniques.

-Review personnel records to ensure that staff members who have patient contact receive training in alternatives to seclusion and restraint.

-Review patient medical records of persons for whom the unit logbook indicates restraints have been applied. The clinical record should document less restrictive interventions were attempted and failed before the use of restraints, unless physical injury was imminent.

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individuals. Facility practices will be particularly sensitive to persons with a history of trauma.

2. The health and safety of the person shall be the primary concern at all times.

3. Seclusion or restraint shall be employed only in emergency situations when necessary to prevent a person from seriously injuring self or others, and less restrictive techniques have been tried and failed, or if it has been clinically determined that the danger is of such immediacy that less restrictive techniques cannot be safely applied.

4. There is a high prevalence of past traumatic experience among persons who receive mental health services. The response to trauma can include intense fear and helplessness, a reduced ability to cope, and an increased risk to exacerbate or develop a range of mental health and other medical conditions. The experience of being placed in seclusion or being restrained is potentially traumatizing. Seclusion and restraint practices shall be guided by the following principles of trauma-informed care: assessment of traumatic histories and symptoms; recognition of culture and practices that are re-traumatizing; processing the impact of a seclusion or restraint with the person; and addressing staff training needs to improve knowledge and sensitivity.

5. When a person demonstrates a need for immediate medical attention in the course of an episode of seclusion or restraint, the seclusion or restraint shall be discontinued, and immediate medical attention shall be obtained.

6. Persons will not be restrained in a prone position. Prone containment will be used only when required by the immediate situation to prevent imminent serious harm to the person or others. To reduce the risk of positional asphyxiation, the person will be repositioned as quickly as possible.

7. Responders will pay close attention to respiratory function of the person during containment and restraint. All staff involved will observe the person's respiration, coloring, and

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other possible signs of distress and immediately respond if the person appears to be in distress. Responding to the person's distress may include repositioning the person, discontinuing the seclusion or restraint, or summoning medical attention, as necessary.

8. Objects that impair respiration shall not be placed over a person's face. In situations where precautions need to be taken to protect staff, staff may wear protective gear.

9. Unless necessary to prevent serious injury, a person's hands shall not be secured behind the back during containment or restraint.

10. The use of walking restraints is prohibited except for purposes of off-unit transportation and may only be used under direct observation of trained staff. In this instance, direct observation means that staff maintains continual visual contact of the person and is within close physical proximity to the person at all times.

11. The person shall be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others.

12. Seclusion or restraint use shall not be based on the person's seclusion or restraint use history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others.

13. Seclusion and restraint may not be used simultaneously for children less than 18 years of age.

14. A person who is restrained must not be located in areas, whenever possible, subject to view by persons other than involved staff or where exposed to potential injury by other persons. This does not apply to the use of walking restraints.

15. Each facility utilizing seclusion or restraint procedures shall establish and utilize a Seclusion and Restraint Oversight Committee.

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ST - BB063 - Pt Rights - Isolation

Title Pt Rights - Isolation

Type Rule

65E-5.180(7)(b-c) FAC

Regulation Definition

Right to Quality Treatment

(7) Seclusion and Restraint for Behavior Management

Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(b) Staff training.

Staff must be trained as part of orientation and subsequently on at least an annual basis. Staff responsible for the following actions will demonstrate relevant competency in the following areas before participating in a seclusion or restraint event or related assessment, or before monitoring or providing care during an event:

1. Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan,
2. Use of nonphysical intervention skills as well as bodily control and physical management techniques, based on a team approach, to ensure safety,
3. Observing for and responding to signs of physical and psychological distress during the seclusion or restraint event,
4. Safe application of restraint devices,
5. Monitoring the physical and psychological well-being of the person who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation,
6. Clinical identification of specific behavioral changes that

Interpretive Guideline

-Review personnel records to ensure each staff member with direct patient care responsibilities has received training in verbal de-escalation and team oriented physical management techniques.

-Review personnel records to ensure that staff members who have patient contact receive training in alternatives to seclusion and restraint.

-Review patient medical records of persons for whom the unit logbook indicates restraints have been applied. The clinical record should document less restrictive interventions were attempted and failed before the use of restraints, unless physical injury was imminent.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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indicate restraint or seclusion is no longer necessary,

7. The use of first aid techniques, and

8. Certification in the use of cardiopulmonary resuscitation, including required periodic recertification. The frequency of training for cardiopulmonary resuscitation will be in accordance with certification requirements, notwithstanding provision paragraph (7)(b).

(c) Prior to the Implementation of Seclusion or Restraint.

1. Prior intervention shall include individualized therapeutic actions such as those identified in a personal safety plan that address individual triggers leading to psychiatric crisis. Recommended form CF-MH 3124, Feb. 05, "Personal Safety Plan," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for the purpose of guiding individualized techniques. Prior interventions may also include verbal de-escalation and calming strategies. Non physical interventions shall be the first choice unless safety issues require the use of physical intervention.

2. A personal safety plan shall be completed or updated as soon as possible after admission and filed in the person's medical record.

a. This form shall be reviewed by the recovery team, and updated if necessary, after each incident of seclusion or restraint.

b. Specific intervention techniques from the personal safety plan that are offered or used prior to a seclusion or restraint event shall be documented in the person's medical record after each use of seclusion or restraint.

c. All staff shall be aware of and have ready access to each person's personal safety plan.

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ST - BB064 - Pt Rights - Isolation - Implementation

Title Pt Rights - Isolation - Implementation

Type Rule

65E-5.180(7)(d) FAC

Regulation Definition

Right to Quality Treatment

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(d) Implementation of Seclusion or Restraint.

1. A registered nurse or highest level staff member, as specified by written facility policy, who is immediately available and who is trained in seclusion and restraint procedures may initiate seclusion or restraint in an emergency when danger to oneself or others is imminent. An order for seclusion or restraint must be obtained from the physician, Advanced Registered Nurse Practitioner (ARNP), or Physician's Assistant (PA), if permitted by the facility to order seclusion and restraint and stated within their professional protocol. The treating physician must be consulted as soon as possible if the seclusion or restraint was not ordered by the person's treating physician.
2. An examination of the person will be conducted within one hour by the physician or may be delegated to an Advanced Registered Nurse Practitioner, Physician's Assistant, or Registered Nurse (RN), if authorized by the facility and trained in seclusion and restraint procedures as described in paragraph (7)(b). This examination shall include a face-to face assessment of the person's medical and behavioral condition, a

Interpretive Guideline

- Review patient medical records of persons for whom the unit logbook indicates restraints have been applied.
- Review order for seclusion or restraint to ensure compliance.
- Ensure the physical examination was conducted within 1 hour after to the seclusion and restraint being implemented.
- The clinical record should document less restrictive interventions were attempted and failed before the use of restraints, unless physical injury was imminent.

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review of the clinical record for any pre-existing medical diagnosis or physical condition which may contraindicate the use of seclusion or restraint, a review of the person's medication orders including an assessment of the need to modify such orders during the period of seclusion or restraint, and an assessment of the need or lack of need to elevate the person's head and torso during restraint. The comprehensive examination must determine that the risks associated with the use of seclusion or restraint are significantly less than not using seclusion or restraint and whether to continue or terminate the intervention. A licensed psychologist may conduct only the behavioral assessment portion of the comprehensive assessment if authorized by the facility and trained in seclusion and restraint procedures as described in paragraph (7)(b). Documentation of the comprehensive examination, including the time and date completed, shall be included in the person's medical record. If the face-to-face evaluation is conducted by a trained Registered Nurse, the attending physician who is responsible for the care of the person must be consulted as soon as possible after the evaluation is completed.

3. Each written order for seclusion or restraint is limited to four hours for adults, age 18 and over; two hours for children and adolescents age nine through 17; or one hour for children under age nine. A seclusion or restraint order may be renewed in accordance with these limits for up to a total of 24 hours, after consultation and review by a physician, ARNP, or PA in person, or by telephone with a Registered Nurse who has physically observed and evaluated the person. When the order has expired after 24 hours, a physician, ARNP, or PA must see and assess the person before seclusion or restraint can be re-ordered. The results of this assessment must be documented. Seclusion or restraint use exceeding 24 hours requires the notification of the Facility Administrator or designee.

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4. All orders must be signed within 24 hours of the initiation of seclusion or restraint.
5. The order shall include the specific behavior prompting the use of seclusion or restraint, the time limit for seclusion or restraint, and the behavior necessary for the person's release. Additionally, for restraint, the order shall contain the type of restraint ordered and the positioning of the person, including possibly elevating the person's head for respiratory and other medical safety considerations. Consideration shall be given to age, physical fragility, and physical disability when ordering restraint type.
6. An order for seclusion or restraint shall not be issued as a standing order or on an as-needed basis.
7. In order to protect the safety of each person served by a facility, each person shall be searched for contraband before or immediately after being placed into seclusion or restraints.
8. The person shall be clothed appropriately for temperature and at no time shall a person be placed in seclusion or restraint in a nude or semi-nude state.
9. Every secluded or restrained person shall be immediately informed of the behavior that resulted in the seclusion or restraint and the behavior and the criteria reflecting absence of imminent danger that are necessary for release.
10. For persons under the age of 18, the facility must notify the parent(s) or legal guardian(s) of the person who has been restrained or placed in seclusion as soon as possible, but no later than 24 hours, after the initiation of each seclusion or restraint event. This notification must be documented in the person's medical record, including the date and time of notification and the name of the staff person providing the notification.
11. For each use of seclusion or restraint, the following information shall be documented in the person's medical record: the emergency situation resulting in the seclusion or restraint event; alternatives or other less restrictive

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interventions attempted, as applicable, or the clinical determination that less restrictive techniques could not be safely applied; the name and title of the staff member initiating the seclusion or restraint; the date/time of initiation and release; the person's response to seclusion or restraint, including the rationale for continued use of the intervention; and that the person was informed of the behavior that resulted in the seclusion or restraint and the criteria necessary for release.

ST - BB065 - Restraints, Seclusion - Facility Guide

Title Restraints, Seclusion - Facility Guide

Type Rule

394.459(4)(b) FS

Regulation Definition

QUALITY OF TREATMENT

(b) Facilities shall develop and maintain, in a form accessible to and readily understandable by patients and consistent with rules adopted by the department, the following:

1. Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques.
2. Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures described in subparagraph 1. and for documenting and requiring review of any incidents resulting in injury to patients.
3. A system for investigating, tracking, managing, and responding to complaints by persons receiving services or individuals acting on their behalf.

Interpretive Guideline

- Review policies and procedures to ensure criteria for use of these interventions is in place as well as staff training, incident review, and complaint review. Such information must be made available to staff, guardian advocates and patients.
- Interview selected staff and patients to see if they are aware of such policies and procedures.
- Review restraint and seclusion log to determine frequency of use.
- Review patient medical records to determine what prompted use of the intervention, what alternatives were attempted, and whether adequate justification existed for their use.
- Were restraints and seclusion terminated as soon as the behavior which prompted their use is no longer a factor?

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ST - BB066 - Pt Rights-Restraint, Seclusion Limits

Title Pt Rights-Restraint, Seclusion Limits

Type Rule

394.459(4)(c) FS

Regulation Definition

Rights of patients.-

(4) QUALITY OF TREATMENT.-

(c) A facility may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Facilities shall ensure that all staff are made aware of these restrictions on the use of seclusion and restraint and shall make and maintain records which demonstrate that this information has been conveyed to individual staff members.

Interpretive Guideline

-Review policies and procedures to ensure use of restraint and seclusion is prohibited for reasons of punishment, inadequate staffing or staff convenience.

-Review personnel files to ensure each staff member has received training in these policies.

ST - BB067 - Restraints, Seclusion - Review Committee

Title Restraints, Seclusion - Review Committee

Type Rule

65E-5.180(7)(e) FAC

Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management

Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(e) During Seclusion or Restraint Use.

Interpretive Guideline

-Review records for patients who were in seclusion or restraints for the required assessment of vital signs within 15 minutes after initiation. For children under 12, ensure face to face observations are conducted by a nurse and continuous face-to-face observation is documented for the first hour then every 15 minutes.

-Review observation logs

-Observe, if possible, any patient who is in seclusion or restraint.

-Interview staff about monitoring and assessments for seclusion and restraint.

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1. When restraint is initiated, nursing staff shall see and assess the person as soon as possible but no later than 15 minutes after initiation and at least every hour thereafter. The assessment shall include checking the person's circulation and respiration, including necessary vital signs (pulse and respiratory rate at a minimum).
2. The person over age 12 who is secluded shall be observed by trained staff every 15 minutes. At least one observation an hour will be conducted by a nurse. Restrained persons must have continuous observation by trained staff. Secluded children age 12 and under must be monitored continuously by face-to-face observation or by direct observation through the seclusion window for the first hour and then at least every 15 minutes thereafter.
3. Monitoring the physical and psychological well-being of the person who is secluded or restrained shall include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; and any special requirements specified by facility policies. This monitoring shall be conducted by trained staff as required in paragraph (7)(b).
4. During each period of seclusion or restraint, the person must be offered reasonable opportunities to drink and toilet as requested. In addition, the person who is restrained must be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility shall have written policies and procedures specifying the frequency of providing drink, toileting, and check of bodily positioning to avoid traumatizing a person and retaining the person's maximum degree of dignity and comfort during the use of bodily control and physical management techniques.
5. Documentation of the observations and the staff person's name shall be recorded at the time the observation takes place.

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ST - BB068 - Pt Rights - Seclusion/Restraint-Release, Post

Title Pt Rights - Seclusion/Restraint-Release, Post

Type Rule

65E-5.180(7)(f) FAC

Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(f) Release from Seclusion or Restraint and Post-Release Activities.

1. Release from seclusion or restraint shall occur as soon as the person no longer appears to present an imminent danger to themselves or others. Upon release from seclusion or restraint, the person's physical condition shall be observed, evaluated, and documented by trained staff. Documentation shall also include: the name and title of the staff releasing the person; and the date and time of release.

2. After a seclusion or restraint event, a debriefing process shall take place to decrease the likelihood of a future seclusion or restraint event for the person and to provide support.

a. Each facility shall develop policies to address:

(I) A review of the incident with the person who was secluded or restrained. The person shall be given the opportunity to process the seclusion or restraint event as soon as possible but no longer than within 24 hours of release. This debriefing discussion shall take place between the person and either the recovery team or another preferred staff member. This review

Interpretive Guideline

-Review patient records and observation logs to ensure release occurred as soon as patient was no longer a danger to self or others.

-Review documentation of debriefing for each seclusion or restraint event.

-Review policies and procedures to ensure they address all required components.

-Review Committee notes/minutes to ensure reviews are conducted timely and patterns/trends are being monitored.

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shall seek to understand the incident within the framework of the person's life history and mental health issues. It should assess the impact of the event on the person and help the person identify and expand coping mechanisms to avoid the use of seclusion or restraint in the future. The discussion will include constructive coping techniques for the future. A summary of this review should be documented in the person's medical record.

(II) A review of the incident with all staff involved in the event and supervisors or administrators. This review shall be conducted as soon as possible after the event and shall address: the circumstances leading to the event, the nature of de-escalation efforts and alternatives to seclusion and restraint attempted, staff response to the incident, and ways to effectively support the person's constructive coping in the future and avoid the need for future seclusion or restraint. The outcomes of this review should be documented by the facility for purposes of continuous performance improvement and monitoring. The review findings will be forwarded to the Seclusion and Restraint Oversight Committee, and

(III) Support for other persons served and staff, as needed, to return the unit to a therapeutic milieu.

b. Within 2 working days after any use of seclusion or restraint, the recovery team shall meet and review the circumstances preceding its initiation and review the person's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion or restraint. The recovery team shall also assess the impact the event had on the person and provide any counseling, services, or treatment that may be necessary as a result. The recovery team shall analyze the person's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion or restraint, and

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upon the person's release from seclusion. The recovery team shall review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review shall be placed in the person's clinical record.

c. The Seclusion and Restraint Oversight Committee shall conduct timely reviews of each use of seclusion and restraints and monitor patterns of use, for the purpose of assuring least restrictive approaches are utilized to prevent or reduce the frequency and duration of use.

ST - BB069 - Pt Rights - Seclusion - Reporting

Title Pt Rights - Seclusion - Reporting

Type Rule

65E-5.180(7)(g) FAC

Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(g) Reporting.

1. All facilities, as defined in Section 394.455(10), F.S., are required to report each seclusion and restraint event to the Department of Children and Families. This reporting shall be done electronically using the Department's web-based application either directly via the data input screens or indirectly via the File Transfer Protocol batch process. The required reporting elements are: Provider tax identification number; Person's social security number and identification

Interpretive Guideline

-Review the seclusion and restraint log and compare a sample to the facility reporting system to ensure seclusion and restraints are being reported to DCF and CMS, in cases of death, if applicable.

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number; date and time the seclusion or restraint event was initiated; discipline of the person ordering the seclusion or restraint; discipline of the person implementing the seclusion or restraint; reason seclusion or restraint was initiated; type of restraint used; whether significant injuries were sustained by the person; and date and time seclusion or restraint was terminated. Facilities shall report seclusion and restraint events on a monthly basis. Events that result in death or significant injury either to a staff member or person shall be reported to the department's web based system in accordance with department operating procedures.

2. All facilities that are subject to the Conditions of Participation for Hospitals, 42 Code of Federal Regulations, part 482, under the Centers for Medicare and Medicaid Services (CMS), must report to CMS any death that occurs in the following circumstances:

- a. While a person is restrained or secluded;
- b. Within 24 hours after release from seclusion or restraint; or
- c. Within one week after seclusion or restraint, where it is reasonable to assume that use of the seclusion or restraint contributed directly or indirectly to the person's death.

Each death described in this section shall be reported to CMS by telephone no later than the close of business the next business day following knowledge of the persons' death. A report shall simultaneously be submitted to the Director of Mental Health/Designee in the Mental Health Program Office headquarters in Tallahassee, FL. The address is: 1317 Winewood Blvd., Tallahassee, FL, 32399-0700.

ST - BB071 - Pt Rights - RESTRAINTS

Title Pt Rights - RESTRAINTS

Type Rule

65E-5.180(7)(h) FAC

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Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(7) Seclusion and Restraint for Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(h) Nothing herein shall affect the ability of emergency medical technicians, paramedics or physicians or any person acting under the direct medical supervision of a physician to provide examination or treatment of incapacitated persons in accordance with Section 401.445, F.S.

Interpretive Guideline

ST - BB072 - Pt Rights-Restraints-Medical Devices

Title Pt Rights-Restraints-Medical Devices

Type Rule

65E-5.180(8) FAC

Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(8) Use of Protective Medical Devices with Frail or Mobility Impaired Persons.

(a) When ordering safety or protective devices such as posey vests, geri-chairs, mittens, and bed rails which also restrain, facility staff shall consider alternative means of providing such safety so that the person's need for regular exercise is accommodated to the greatest extent possible.

(b) Where frequent or prolonged use of safety or protective devices is required, the person's treatment plan shall address debilitating effects due to decreased exercise levels such as

Interpretive Guideline

-Review patient medical records for provision of alternative methods utilized other than the protective devices.

-Review the activity plan

-Observe patients in activities

-Review nursing assessments of patient skin, muscle tone, and bowel and bladder continence.

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circulation, skin, and muscle tone and the person's need for maintaining or restoring bowel and bladder continence.

(c) The treatment plan shall include scheduled activities to lessen deterioration due to the usage of such protective medical devices.

ST - BB073 - Pt Rights/Supervision

Title Pt Rights/Supervision

Type Rule

65E-5.180(9) FAC

Regulation Definition

Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

(9) Elevated Levels of Supervision. Receiving and treatment facilities shall ensure that where one-on-one supervision is ordered by a physician, it shall be continuous and shall not be interrupted as a result of shift changes or due to conflicting staff assignments. Such supervision shall be continuous until documented as no longer medically necessary by a physician.

Interpretive Guideline

- Review how one-on-one supervision is conducted
- Review schedule of assigned staff
- Observe patients who are on one-on-one supervision.

ST - BB074 - Pt Rights - Right to Communicate

Title Pt Rights - Right to Communicate

Type Rule

394.459(5)(a) & (e) FS

Regulation Definition

Rights of patients.-

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.-

Interpretive Guideline

- Review policies and procedures to ensure that all patients, regardless of age or stage of development, are assured of free and open communication by telephone, mail, and visitation, unless restricted for safety reasons.
- Review rules to ensure reasonableness as to patient right to communicate vs. hospital need to maintain order and

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(a) Each person receiving services in a facility providing mental health services under this part has the right to communicate freely and privately with persons outside the facility unless a qualified professional determines that such communication is likely to be harmful to the person or others in a manner directly related to the person's clinical well-being, the clinical well-being of other patients, or the general safety of staff. Each facility shall make available as soon as reasonably possible to persons receiving services a telephone that allows for free local calls and access to a long-distance service. A facility is not required to pay the costs of a patient's long-distance calls. The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially. The facility may establish reasonable rules for the use of this telephone, provided that the rules do not interfere with a patient's access to a telephone to report abuse pursuant to paragraph (f).

(e) Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner. Patients shall have the right to contact and to receive communication from their attorneys at any reasonable time.

provide scheduled treatment.

-Confirm availability of a private and toll-free telephone, particularly to report abuse.

-Interview patients and staff and review policies and procedures to determine that patients have the right to make and receive telephone calls.

- Ensure qualified professional documents finding that communication is limited for patient.

ST - BB075 - Pt Rights - Communication Restriction Notice

Title Pt Rights - Communication Restriction Notice

Type Rule

394.459(5)(d) FS

Regulation Definition

Rights of patients.-

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS

(d) If a patient's right to communicate with outside persons;

Interpretive Guideline

Interview patients to determine if their ability to communicate with others outside the facility has at any time been restricted. If a patient's communication was restricted, verify that:

-Full documentation of the extent and justified reasons for the restrictions are found in the patient medical record;

-That the patient and others required by statute have been notified in writing; and

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receive, send, or mail sealed, unopened correspondence; or receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative; a qualified professional must record the restriction and its underlying reasons in the patient's clinical file within 24 hours. The notice of the restriction must immediately served on the patient the patient's attorney, and the patient's guardian, guardian advocate, or representative. The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 3 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e).

-That reviews have been completed at least every three days.

ST - BB076 - Pt Rights - Communication Restrict-Recording

Title Pt Rights - Communication Restrict-Recording

Type Rule

65E-5.190(1) FAC

Regulation Definition

Right to Communication and Visits.

(1) If the treatment team imposes any restrictions on whom a person in a receiving or treatment facility may communicate, such restrictions and justification shall be recorded in the person's clinical record. Recommended form CF-MH 3049, Feb. 05, "Restriction of Communication or Visitors," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. Facility staff shall make competent adults aware that they have the ability to waive the confidentiality of their presence in a receiving or treatment facility and allowing all or specified individuals the person selects access to private and

Interpretive Guideline

-Review clinical records to determine if any restrictions reported by patients during interviews are adequately justified.
-Use of recommended form "Restriction of Communication or Visitors" (CF-MH 3049).
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFFormsInternet/Search/DCFFFormSearch.aspx>

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open communication with the person. Recommended form CF-MH 3048, Feb. 05, "Confidentiality Agreement," incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

ST - BB077 - Pt Rights - Communication - Correspondence

Title Pt Rights - Communication - Correspondence

Type Rule

394.459(5)(b) FS

Regulation Definition

Rights of patients.-

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS

(b) Each patient admitted to a facility under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless a qualified professional determines that such correspondence is likely to be harmful to the patient or others in a manner directly related to the patient's clinical well-being, the clinical well-being of other patients, or the general safety of staff. If there is reason to believe that such correspondence contains items or substances which may be harmful to the patient or others, the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

Interpretive Guideline

-Interview patients and staff and review policies and procedures to determine that people have the right to send and receive unopened mail unless restricted.

-Determine if stationery and stamps are provided to patients by the facility if needed.

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ST - BB078 - Pt Rights - Visitors

Title Pt Rights - Visitors

Type Rule

394.459(5)(c) FS

Regulation Definition

Rights of patients.-

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS

(c) Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless a qualified professional determines that such access would be detrimental to the patient in a manner directly related to the patient's clinical well being, the clinical well-being of other patients, or the general safety of staff.

Interpretive Guideline

-Review facility policies to ensure that family, guardians, guardian advocates, HRAC/APD members, and attorney have immediate access to a person unless it is considered detrimental to the person or unless the person chooses not to see the person. Telephone the HRAC to determine whether they have free access to any patient at any time. See B074 for facility rules governing visitors and visiting hours.

-Ensure qualified professional documents finding that access is limited for patient.

ST - BB080 - Pt Rights - Communication - Telephone

Title Pt Rights - Communication - Telephone

Type Rule

65E-5.190(2) FAC

Regulation Definition

Right to Communication and Visits.

(2) Immediate access to a telephone shall be provided to each person requesting to call his or her legal counsel, Florida Abuse Registry, Florida Local Advocacy Council, or the Advocacy Center for Persons with Disabilities.

Interpretive Guideline

-Tour the units to ensure the presence of toll-free telephones available adjacent to the site where rights/advocacy information is posted. Patients should be able to dial the phone, rather than relying on staff to do so. The phone should be located far enough away from the nurse's station to permit privacy of conversation. The cord may be shortened to prevent the phone's use as a weapon.

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ST - BB081 - Pt Rights/Reporting Abuse

Title Pt Rights/Reporting Abuse

Type Rule

394.459(5)(f) FS

Regulation Definition

Rights of patients.-

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS

(f) Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse. The facility staff shall orally and in writing inform each patient of the procedure for reporting abuse and shall make every reasonable effort to present the information in a language the patient understands. A written copy of that procedure, including the telephone number of the central abuse hotline and reporting forms, shall be posted in plain view.

Interpretive Guideline

-Interview patients to confirm that staff has advised them of procedures for reporting abuse.

-Observe the location of a telephone available for reporting abuse and the posting of the Abuse Registry's telephone number close to the phone.

-Tour the unit to view the posted abuse reporting procedure.

ST - BB082 - Pt Rights/Personal Effects

Title Pt Rights/Personal Effects

Type Rule

394.459(6) FS

Regulation Definition

Rights of patients.-

(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS -

A patient's right to the possession of his or her clothing and personal effects shall be respected. The facility may take

Interpretive Guideline

-Review policies and procedures to ensure compliance with statute.

-Interview patients and staff to determine that patients have the right to retain their clothing and personal effects. Sample patient charts to confirm presence of the required inventory, witnessed by two staff and by the patient, if possible.

-Upon discharge or transfer, does the clinical record reflect that personal effects were returned to the patient,

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temporary custody of such effects when required for medical and safety reasons. A patient's clothing and personal effects shall be inventoried upon their removal into temporary custody. Copies of this inventory shall be given to the patient and to the patient's guardian, guardian advocate, or representative and shall be recorded in the patient's clinical record. This inventory may be amended upon the request of the patient or the patient's guardian, guardian advocate, or representative. The inventory and any amendments to it must be witnessed by two members of the facility staff and by the patient, if able. All of a patient's clothing and personal effects held by the facility shall be returned to the patient immediately upon the discharge or transfer of the patient from the facility, unless such return would be detrimental to the patient. If personal effects are not returned to the patient, the reason must be documented in the clinical record along with the disposition of the clothing and personal effects, which may be given instead to the patient's guardian, guardian advocate, or representative. As soon as practicable after an emergency transfer of a patient, the patient's clothing and personal effects shall be transferred to the patient's new location, together with a copy of the inventory and any amendments, unless an alternate plan is approved by the patient, if able, and by the patient's guardian, guardian advocate, or representative.

representative, or guardian advocate?

ST - BB083 - Pt Rights/Personal Effects

Title Pt Rights/Personal Effects

Type Rule

65E-5.200 FAC

Regulation Definition

Right to Care and Custody of Personal Effects.
Each designated receiving and treatment facility shall develop policies and procedures governing what personal effects will

Interpretive Guideline

-Review policies and procedures to ensure the facility has developed sufficient procedures to meet the requirements. When personal effects are removed from a patient, the use of recommended form "Inventory of Personal Effects" (CF-MH 3043) is considered by the department to be sufficient. However, most facilities have modified the form to

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be removed from persons for reasons of personal or unit safety, how they will be safely retained by the facility, and how and when they will be returned to the person or other authorized individual. Policies and procedures shall specify how contraband and other personal effects determined to be detrimental to the person will be addressed when not returned to the person or other authorized individual. An inventory of personal effects shall be witnessed by two staff and by the person, if able, at the time of admission, at any time the inventory is amended, and at the time the personal effects are returned or transferred. Recommended form CF-MH 3043, Feb. 05, "Inventory of Personal Effects," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C. of this rule chapter may be used for this purpose.

be more inclusive of the items the patient was allowed to retain.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB084 - Pt Rights - Voting

Title Pt Rights - Voting

Type Rule

394.459(7) FS

Regulation Definition

Rights of patients.-
(7) VOTING IN PUBLIC ELECTIONS.-A patient who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections.

Interpretive Guideline

-Review facility policy and procedure. Interview patients and staff about the voter registration and voting by mail process.

ST - BB085 - Pt Rights - Voting

Title Pt Rights - Voting

Type Rule

65E-5.210 FAC

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Regulation Definition

Right to Vote in Public Elections.

The facility shall have voter registration forms and applications for absentee ballots readily available at the facility or in accordance with the procedures established by the supervisor of elections, and shall assure that each person who is eligible to vote and wishes to do so, may exercise his or her franchise. Each designated receiving and treatment facility shall develop policies and procedures governing how persons will be assisted in exercising their right to vote.

Interpretive Guideline

-Review policies to ensure the facility has procedures in place to assist patient in exercising their right to vote. It is unlikely that patients experiencing very short stays in a receiving facility will require access to voting. However, longer stay treatment facilities must actively extend this right to all patients whose competence has not been removed by a court.

ST - BB086 - Pt Rights - Habeas Corpus - Petition for Writ

Title Pt Rights - Habeas Corpus - Petition for Writ

Type Rule

394.459(8) FS

Regulation Definition

Rights of patients.-

(8) HABEAS CORPUS.-

(a) At any time, and without notice, a person held in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) At any time, and without notice, a person who is a patient in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may file a petition in the circuit court in the county where the patient is being held

Interpretive Guideline

-Sample clinical records for documentation that the patient had been given a notice of his/her right to file a petition. Use of recommended form "Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances" (CF-MH 3036) is considered by the department to be sufficient to document the required notice.
-If a petition had been filed, had it been provided to the clerk of the court within one working day?
-Interview staff to determine that they understand their responsibilities under the law.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any order needed to correct an abuse of the provisions of this part.

(c) The administrator of any receiving or treatment facility receiving a petition under this subsection shall file the petition with the clerk of the court on the next court working day.

(d) No fee shall be charged for the filing of a petition under this subsection.

ST - BB087 - Pt Rights - Habeas Corpus- Notice of Rights

Title Pt Rights - Habeas Corpus- Notice of Rights

Type Rule

65E-5.220 FAC

Regulation Definition

Right to Habeas Corpus.

(1) Upon admission to a receiving or treatment facility, each person shall be given notice of his or her right to petition for a writ of habeas corpus and for redress of grievances. Recommended form CF-MH 3036, Feb. 05, "Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. A copy of the notice shall be provided to the guardian, guardian advocate, representative, or the health care surrogate or proxy, and the person's clinical record shall contain documentation that the notice was provided. A petition form shall be promptly provided by staff to any person making a request for such a petition. Recommended form CF-MH 3090, Feb. 05, "Petition for Writ of Habeas Corpus or for Redress of Grievances,"

Interpretive Guideline

-Review clinical records to ensure that all patients admitted to a facility and other required persons have been notified of this right. Use of recommended form "Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances" (CF-MH 3036) is considered by the department to be sufficient to document the required notice.
-Use of recommended form "Petition for Writ of Habeas Corpus or for Redress of Grievances" (CF-MH 3090) is considered by the department to be sufficient.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFFormsInternet/Search/DCFFFormSearch.aspx>

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which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(2) Receiving and treatment facilities shall accept and forward to the appropriate court of competent jurisdiction a petition submitted by the person or others in any form in which it is presented.

ST - BB088 - Treatment and Discharge Planning

Title Treatment and Discharge Planning

Type Rule

394.459(11) FS

Regulation Definition

Rights of patients.-

(11) RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING.-The patient shall have the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of the patient's choice.

Interpretive Guideline

-Interview staff and patients to ensure that patients are informed of their right to participate in treatment, discharge planning, and selection of aftercare provider.

ST - BB089 - Pt Rights/Posting Notices

Title Pt Rights/Posting Notices

Type Rule

394.459(12) FS

Regulation Definition

Rights of patients.-

(12) POSTING OF NOTICE OF RIGHTS OF PATIENTS.-Each facility shall post a notice listing and

Interpretive Guideline

-Observe the unit and observe the following posters/notices:

--Patient Rights
--APD

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describing, in the language and terminology that the persons to whom the notice is addressed can understand, the rights provided in this section. This notice shall include a statement that provisions of the federal Americans with Disabilities Act apply and the name and telephone number of a person to contact for further information. This notice shall be posted in a place readily accessible to patients and in a format easily seen by patients. This notice shall include the telephone numbers of the Florida local advocacy council and Advocacy Center for Persons with Disabilities, Inc.

- Advocacy Center
- ADA Provisions
- Notices must be in simple language and located close to the telephone.

ST - BB090 - Right to Individual Dignity

Title Right to Individual Dignity

Type Rule

394.459(1) FS

Regulation Definition

RIGHT TO INDIVIDUAL DIGNITY.-It is the policy of this state that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, held, or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with persons who have a mental illness, except for the protection of the patient or others. Persons who have a mental illness but who are not charged with a criminal offense shall not be detained or incarcerated in the jails of this state. A person who is receiving treatment for mental illness shall not be deprived of any constitutional rights. However, if such a person is adjudicated incapacitated, his or her rights may be limited to the same extent the rights of any incapacitated person are limited by law.

Interpretive Guideline

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ST - BB091 - Maintenance of the Facility

Title Maintenance of the Facility

Type Rule

65E-5.1802 FAC

Regulation Definition

Maintenance of the Facility.

The facility shall ensure the proper functioning and maintenance of the facility structure, finishes, fixtures, furnishings, and equipment. The facility shall ensure the ready availability of necessary medical equipment or devices for the populations served, including restraint equipment that is suitable to the safety and medical needs of the persons being served.

Interpretive Guideline

- Observe for physical plant issues, functional equipment, furnishings, etc, as well as availability of necessary medical equipment or devices.
- Interview staff.
- Review facility maintenance policies and procedures.

ST - BB094 - Sexual Misconduct Witness/Knowledge

Title Sexual Misconduct Witness/Knowledge

Type Rule

394.4593(5) FS

Regulation Definition

Sexual misconduct prohibited; reporting required; penalties.-
(5) An employee who witnesses sexual misconduct, or who otherwise knows or has reasonable cause to suspect that a person has engaged in sexual misconduct, shall immediately report the incident to the department's central abuse hotline and to the appropriate local law enforcement agency. Such employee shall also prepare, date, and sign an independent report that specifically describes the nature of the sexual misconduct, the location and time of the incident, and the

Interpretive Guideline

- Review facility policies and procedures related to sexual misconduct.

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persons involved. The employee shall deliver the report to the supervisor or program director, who is responsible for providing copies to the department's inspector general. The inspector general shall immediately conduct an appropriate administrative investigation, and, if there is probable cause to believe that sexual misconduct has occurred, the inspector general shall notify the state attorney in the circuit in which the incident occurred.

ST - BB095 - Human Rights Advocacy Comm

Title Human Rights Advocacy Comm

Type Rule

394.4595 FS

Regulation Definition

Florida statewide and local advocacy councils; access to patients and records.-
Any facility designated by the department as a receiving or treatment facility must allow access to any patient and the clinical and legal records of any patient admitted pursuant to the provisions of this act by members of the Florida statewide and local advocacy councils.

Interpretive Guideline

-Call the HRAC to determine if at any time, any member of the HRAC had a request to meet with a patient or to review a clinical record denied or delayed.

ST - BB096 - Pt's Representative - Voluntary Admissions

Title Pt's Representative - Voluntary Admissions

Type Rule

394.4597(1) FS

Regulation Definition

Persons to be notified; patient's representative.
VOLUNTARY PATIENTS.-At the time a patient is voluntarily

Interpretive Guideline

-For voluntary patients, there should be an emergency contact listed in the patient's clinical record. No notice shall be made without the consent of the patient.

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admitted to a receiving or treatment facility, the identity and contact information of a person to be notified in case of an emergency shall be entered in the patient's clinical record.

-Sample patient charts to confirm a representative has been designated for involuntary patients who have no guardian.

ST - BB097 - Pt's Representative - Involuntary Admissions

Title Pt's Representative - Involuntary Admissions

Type Rule

394.4597(2) FS

Regulation Definition

Persons to be notified; patient's representative.

(2) INVOLUNTARY PATIENTS.-

(a) At the time a patient is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed, the names, addresses, and telephone numbers of the patient's guardian or guardian advocate, or representative if the patient has no guardian, and the patient's attorney shall be entered in the patient's clinical record.

(b) If the patient has no guardian, the patient shall be asked to designate a representative. If the patient is unable or unwilling to designate a representative, the facility shall select a representative.

(c) The patient shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced.

(d) When the receiving or treatment facility selects a representative, first preference shall be given to a health care surrogate, if one has been previously selected by the patient. If the patient has not previously selected a health care surrogate, the selection, except for good cause documented in the patient's clinical record, shall be made from the following list in the order of listing:

Interpretive Guideline

-Confirm from patient clinical records that the representative selected by the facility (if the patient has not selected his/her own) is one of the seven permitted representatives and that the representative does not belong to one of the prohibited groups listed in paragraph (e).

-Ensure that the clinical chart documents the representative was notified by telephone or in person within 24 hours by the facility of the patient's admission.

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1. The patient's spouse.
 2. An adult child of the patient.
 3. A parent of the patient.
 4. The adult next of kin of the patient.
 5. An adult friend of the patient.
- (e) The following persons are prohibited from selection as a patient's representative:
1. A professional providing clinical services to the patient under this part.
 2. The licensed professional who initiated the involuntary examination of the patient, if the examination was initiated by professional certificate.
 3. An employee, an administrator, or a board member of the facility providing the examination of the patient.
 4. An employee, an administrator, or a board member of a treatment facility providing treatment for the patient.
 5. A person providing any substantial professional services to the patient, including clinical services.
 6. A creditor of the patient.
 7. A person subject to an injunction for protection against domestic violence under s. 741.30, whether the order of injunction is temporary or final, and for which the patient was the petitioner.
 8. A person subject to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence under s. 784.046, whether the order of injunction is temporary or final, and for which the patient was the petitioner.

ST - BB099 - Guardian Advocate - Petition for Appointment

Title Guardian Advocate - Petition for Appointment

Type Rule

394.4598(1-2) FS

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Regulation Definition

Guardian advocate.

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment

(2) The following persons are prohibited from appointment as a patient's guardian advocate:

(a) A professional providing clinical services to the patient under this part.

(b) The licensed professional who initiated the involuntary examination of the patient, if the examination was initiated by professional certificate.

(c) An employee, an administrator, or a board member of the facility providing the examination of the patient.

(d) An employee, an administrator, or a board member of a treatment facility providing treatment of the patient.

(e) A person providing any substantial professional services, excluding public and professional guardians, to the patient, including clinical services.

(f) A creditor of the patient.

(g) A person subject to an injunction for protection against domestic violence under s. 741.30, whether the order of injunction is temporary or final, and for which the patient was the petitioner.

(h) A person subject to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence under s. 784.046, whether the order of injunction is temporary or final, and for which the patient was the petitioner.

Interpretive Guideline

-Review policies and procedures to ensure consistency with statute.

-Sample patient charts to ensure that a guardian advocate is requested for all patients determined by staff to be incompetent to consent to treatment.

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ST - BB100 - Guardian Advocate- Provision of Pet'n Copies

Title Guardian Advocate- Provision of Pet'n Copies

Type Rule

65E-5.230(1) FAC

Regulation Definition

Guardian Advocate.

(1) A copy of the completed recommended form CF-MH 3106 "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., or its equivalent, shall be given to the person, the person's representative if any, and to the prospective guardian advocate with a copy retained in the person's clinical record.

Interpretive Guideline

-Review the clinical records of patients who are believed to be incompetent to consent to treatment to ensure that a petition has been completed and filed with the court. "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate" (CF-MH 3106) is considered by the department to be sufficient for this purpose.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB101 - Guardian Advocate- Duties, Responsibilities

Title Guardian Advocate- Duties, Responsibilities

Type Rule

394.4598(3) FS

Regulation Definition

Guardian advocate.

(3) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decision making. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian

Interpretive Guideline

-Does the chart reflect that the staff provided the prospective guardian advocate with the required information?
-Does the chart reflect that the guardian advocate met with the patient and his/her physician in person if possible or by telephone if not prior to consenting to treatment?
-Does the chart contain a court order authorizing the guardian advocate to: consent to mental health treatment?
-Consent to medical treatment? (as applicable) consent to ECT? (as applicable)

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advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

ST - BB102 - Guardian Advocate- Pre-Appointment Training

Title Guardian Advocate- Pre-Appointment Training

Type Rule

394.4598(4) FS; 65E-5.230(2) FAC

Regulation Definition

Guardian advocate.

(4) In lieu of the training required of guardians appointed pursuant to chapter 744, a guardian advocate must, at a minimum, participate in a 4-hour training course approved by the court before exercising his or her authority. At a minimum, this training course must include information about patient rights, psychotropic medications, the diagnosis of mental illness, the ethics of medical decisionmaking, and duties of guardian advocates.

65E-5.230(2), FAC

(2) The person's clinical record shall reflect that the guardian advocate has been appointed by the court and has completed the training required by Section 394.4598(4), F.S., and further training required pursuant to a court order, prior to being asked to provide express and informed consent to treatment.

Interpretive Guideline

-Review the clinical records of patients who have had a guardian advocate appointed by the court (usually at the same time as a hearing for involuntary placement). Look for a recommended form entitled "Certification of Guardian Advocate Training Completion (MH-CF 3120) or the form entitled "Completion of Guardian Advocate Training" taken from the Guardian Advocate Training & Resource Manual. The date of satisfactory training completion should be no later than the date the Guardian Advocate was asked to provide express and informed consent to treatment.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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Recommended form CF-MH 3120, Feb. 05, "Certification of Guardian Advocate Training Completion," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

ST - BB103 - Guardian Advocate-Auth to Consent to Treatmt

Title Guardian Advocate-Auth to Consent to Treatmt

Type Rule

394.4598(7) FS

Regulation Definition

Guardian advocate.

(7) If a guardian with the authority to consent to medical treatment has not already been appointed or if the patient has not already designated a health care surrogate, the court may authorize the guardian advocate to consent to medical treatment, as well as mental health treatment. Unless otherwise limited by the court, a guardian advocate with authority to consent to medical treatment shall have the same authority to make health care decisions and be subject to the same restrictions as a proxy appointed under part IV of chapter 765. Unless the guardian advocate has sought and received express court approval in proceeding separate from the proceeding to determine the competence of the patient to consent to medical treatment, the guardian advocate may not consent to:

- (a) Abortion.
 - (b) Sterilization.
 - (c) Electroconvulsive treatment.
 - (d) Psychosurgery.
 - (e) Experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56.
- The court must base its decision on evidence that the treatment

Interpretive Guideline

- Review the clinical records of any patient for whom a Guardian Advocate has consented to non-psychiatric medical treatment. Ensure that the signed court order delegates the authority to consent to medical as well as mental health treatment. If extraordinary treatment, such as ECT has been authorized by the Guardian Advocate, ensure that a separately signed court order authorizing the Guardian Advocate to consent to the procedure is in the clinical record.

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or procedure is essential to the care of the patient and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. The court shall follow the procedures set forth in subsection (1) of this section.

ST - BB104 - Guardian Advocate - Copy Petition to Consent

Title Guardian Advocate - Copy Petition to Consent

Type Rule

65E-5.230(5) FAC

Regulation Definition

Guardian Advocate.

(5) If a guardian advocate is required by Section 394.4598, F.S., or otherwise to petition the court for authority to consent to extraordinary treatment, a copy of the completed petition form shall be given to the person, a copy to the attorney representing the person, and a copy retained in the person's clinical record. Recommended form CF-MH 3108, Feb. 05, "Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. Any order issued by the court in response to such a petition shall be given to the person, attorney representing the person, guardian advocate, and to the facility administrator, with a copy retained in the patient's clinical record. Recommended form CF-MH 3109, Feb. 05, "Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order used by the court may be used for such documentation.

Interpretive Guideline

- Review the clinical records of any patient for whom the Guardian Advocate has filed a petition for authority to consent to extraordinary treatment.
- Ensure that copies of the petition have been provided, as required by rule. Use of recommended form "Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment" (CF-MH 3108) is considered by the department to be sufficient for such documentation. Any resultant court order should also be found in the clinical record prior to any consent for such extraordinary treatment. Use of recommended form "Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment" (CF-MH 3109), or other order used by the court is considered by the department to be sufficient for such documentation.
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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ST - BB105 - Guardian Advocate - Discharge

Title Guardian Advocate - Discharge

Type Rule

394.4598(8) FS

Regulation Definition

Guardian advocate.

(8) The guardian advocate shall be discharged when the patient is discharged from an order for involuntary outpatient placement or involuntary inpatient placement or when the patient is transferred from involuntary to voluntary status ...

Interpretive Guideline

In reviewing clinical records, ensure that any consent for treatment provided by a Guardian Advocate is based upon a court order issued since the patient's most recent admission. Also ensure that no Guardian Advocate has authorized any treatment for a patient after the patient has been permitted to transfer from involuntary to voluntary status. Use of recommended form "Notification to Court of Patient's Competence to Consent to Treatment and Discharge of Guardian Advocate" (CF-MH 3121) for documentation is considered by the department to be sufficient.

ST - BB106 - Guardian Advocate - Replacement

Title Guardian Advocate - Replacement

Type Rule

65E-5.230(3) FAC

Regulation Definition

(3) When a guardian advocate previously appointed by the court cannot or will not continue to serve in that capacity, and the person remains incompetent to consent to treatment, the facility administrator shall petition the court for a replacement guardian advocate. A copy of the completed petition shall be given to the person, the current guardian advocate, the prospective replacement guardian advocate, person's attorney, and representative, with a copy retained in the person's clinical record. Recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this

Interpretive Guideline

-At any time a Guardian Advocate has not been reasonably available to discuss treatment planning options, ensure that the facility administrator or his/her designee has made efforts to involve the Guardian Advocate. If these efforts have been unsuccessful, ensure that the administrator has petitioned the court for a successor Guardian Advocate, providing copies of the petition to all required parties. Use of recommended form, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate" (CF-MH 3106) is considered by the department to be sufficient for this documentation if parts I and III are completed.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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documentation if Parts I and III are completed.

ST - BB107 - Guardian Advocate - Discharge (Pt. Competenc)

Title Guardian Advocate - Discharge (Pt. Competenc)

Type Rule

65E-5.230(6) FAC

Regulation Definition

-At any time a person, who has previously been determined to be incompetent to consent to treatment and had a guardian advocate appointed by the court, has been found by the attending physician to have regained competency to consent to treatment, the facility shall notify the court that appointed the guardian advocate of the patient's competence and the discharge of the guardian advocate. Recommended form CF-MH 3121, Feb. 05, "Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

Interpretive Guideline

In reviewing clinical records, the surveyor should recognize any documentation by a physician that a patient continuing to reside at the facility may be currently competent to provide express and informed consent or to transfer from involuntary to voluntary status. In such cases, the Guardian Advocate should be discharged by the facility administrator and the court so informed. Use of recommended form "Notification to Court of Patient's Competence to Consent to Treatment and Discharge of Guardian Advocate" (CF-MH 3121) for documentation is considered by the department to be sufficient.

ST - BB108 - Health Care Surrogate or Proxy

Title Health Care Surrogate or Proxy

Type Rule

65E-5.2301(1)-(5) & (7) FAC

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Regulation Definition

Health Care Surrogate or Proxy.

(1) During the interim period between the time a person is determined to be incompetent to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S., and the time a guardian advocate is appointed by a court to provide express and informed consent to the person's treatment, a health care surrogate designated by the person, pursuant to Chapter 765, Part II, F.S., may provide such consent to treatment.

(2) In the absence of an advance directive or when the health care surrogate named in the advance directive is no longer able or willing to serve, a health care proxy, pursuant to Chapter 765, Part IV, F.S., may also provide interim consent to treatment.

(3) Upon the documented determination that a patient is incompetent to make health care decisions for himself or herself by one or more physicians, pursuant to Section 765.204, F.S., the facility shall notify the surrogate or proxy in writing that the conditions under which he or she can exercise his or her authority under the law have occurred.

Recommended form CF-MH 3122, Feb. 05, "Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(4) If the surrogate selected by the person is not available or is unable to serve or if no advance directive had been prepared by the person, a proxy may be designated as provided by law. Recommended form CF-MH 3123, Feb. 05, "Affidavit of Proxy," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(5) A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate shall be

Interpretive Guideline

-Due to the extended time between the patient's admission to a facility and the time at which a Guardian Advocate may be appointed by a court, it may be necessary for the patient to have treatment provided for which the patient is not competent to provide consent. In such cases, a health care surrogate designated through an advance directive or a health care proxy may be available to provide substituted judgment for the patient, i.e. that decision concerning treatment that the patient would have made had he or she been competent to do so.

-Use of recommended form "Certification of Patient's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy" (CF-MH 3122) is considered by the department to be sufficient for this purpose.

-No authorization for treatment from a health care surrogate or proxy should be accepted by a facility until a physician has documented the patient's incapacity and a petition has been filed with the court.

-Review patient records for those who were incompetent to consent to treatment to ensure the petition was filed within 2 working days.

-Review the facility policies and procedures on how direct care and assessment staff are trained in honoring patient treatment preferences. Review patient records for information provided about advance directives.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFFormsInternet/Search/DCFFFormSearch.aspx>

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filed with the court within 2 court working days of the determination of the patient's incompetence to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S. Recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose.

(7) Each designated receiving and treatment facility shall adopt policies and procedures specifying how its direct care and assessment staff will be trained on how to honor each person's treatment preferences as detailed in his or her advance directives. The person being served shall be provided information about advance directives and offered assistance in completing an advance directive, if willing and able to do so.

ST - BB109 - Health Care Surrogate or Proxy

Title Health Care Surrogate or Proxy

Type Rule

65E-5.2301(6) FAC

Regulation Definition

Health Care Surrogate or Proxy.

(6) The facility shall immediately provide to the health care surrogate or proxy the same information required by statute to be provided to the guardian advocate. In order to protect the safety of the person, the facility shall make available to the health care surrogate or proxy the training required of guardian advocates and ensure that the surrogate or proxy communicate with the person and person's physician prior to giving express and informed consent to treatment.

Interpretive Guideline

-Review clinical records of patients for whom consent to treatment has been provided by a health care surrogate or proxy to ensure that the record includes documentation that same requirements of Guardian Advocates has been extended to the surrogate/proxy.

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ST - BB110 - Notices - Voluntary Patients

Title Notices - Voluntary Patients

Type Rule

394.4599(1) FS

Regulation Definition

Notice.-

(1) VOLUNTARY ADMISSION.-Notice of an individual's voluntary admission shall be given only at the request of the individual, except that, in an emergency, notice shall be given as determined by the facility.

Interpretive Guideline

-Review policies and procedures to ensure that notice of a voluntary patient's admission is only given at the request of the patient, unless there is an emergency.

ST - BB111 - Notices - Involuntary Patients

Title Notices - Involuntary Patients

Type Rule

394.4599(2) FS

Regulation Definition

(2) INVOLUNTARY ADMISSION.-

(a) Whenever notice is required to be given under this part, such notice shall be given to the individual and the individual's guardian, guardian advocate, health care surrogate or proxy, attorney, and representative.

1. When notice is required to be given to an individual, it shall be given both orally and in writing, in the language and terminology that the individual can understand, and, if needed, the facility shall provide an interpreter for the individual.

2. Notice to an individual's guardian, guardian advocate, health care surrogate or proxy, attorney, and representative

Interpretive Guideline

a) Review policies and procedures to ensure that notice of an involuntary patient's whereabouts are given to specified persons by telephone or in person within 24 hours of arrival at the facility unless it is documented that the patient requested no notice be made.

Sample patient medical records to verify that notice was made and that all contact attempts were documented.

Notices to the patient should be given orally and in writing in the language and terminology that the person understands. If someone is hard of hearing or deaf, have interpreters been used?

b) Has the notice been either hand delivered to the patient, guardian, guardian advocate, representative, and attorney or sent by US mail and certified or registered mail with receipts contained in the chart?

d) A treatment facility is generally a state operated mental hospital rather than a community-based receiving facility.

e) Are notices of transfer and discharge provided as required?

f) Was notice provided prior to transfer?

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shall be given by mail with the date, time, and method of notice delivery documented in the clinical record. Hand delivery by a facility employee may be used as an alternative, with the date and time of delivery documented in the clinical record. If notice is given by a state attorney or an attorney for the department, a certificate of service is sufficient to document service.

(b) A receiving facility shall give prompt notice of the whereabouts of an individual who is being involuntarily held for examination to the individual's guardian, guardian advocate, health care surrogate or proxy, attorney or representative, or other emergency contact identified through electronic databases pursuant to s. 394.463(2)(a), by telephone or in person within 24 hours after the individual's arrival at the facility. Contact attempts shall be documented in the individual's clinical record and shall begin as soon as reasonably possible after the individual's arrival.

(c)1. A receiving facility shall give notice of the whereabouts of a minor who is being involuntarily held for examination pursuant to s. 394.463 to the minor's parent, guardian, caregiver, or guardian advocate, in person or by telephone or other form of electronic communication, immediately after the minor's arrival at the facility. The facility may delay notification for no more than 24 hours after the minor's arrival if the facility has submitted a report to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect and if the facility deems a delay in notification to be in the minor's best interest.

2. The receiving facility shall attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until the receiving facility receives confirmation from the parent, guardian, caregiver, or guardian advocate, verbally, by

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telephone or other form of electronic communication, or by recorded message, that notification has been received.

Attempts to notify the parent, guardian, caregiver, or guardian advocate must be repeated at least once every hour during the first 12 hours after the minor's arrival and once every 24 hours thereafter and must continue until such confirmation is received, unless the minor is released at the end of the 72-hour examination period, or until a petition for involuntary services is filed with the court pursuant to s. 394.463(2)(g). The receiving facility may seek assistance from a law enforcement agency to notify the minor's parent, guardian, caregiver, or guardian advocate if the facility has not received within the first 24 hours after the minor's arrival a confirmation by the parent, guardian, caregiver, or guardian advocate that notification has been received. The receiving facility must document notification attempts in the minor's clinical record.

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for:

a. Involuntary services pursuant to s. 394.4655 or s. 394.467 has been filed with the circuit or county court as applicable, and the address of such court

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or

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representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

(e) A treatment facility shall provide notice of an individual's involuntary admission on the next regular working day after the individual's arrival at the facility.

(f) When an individual is to be transferred from one facility to another, notice shall be given by the facility where the individual is located before the transfer.

ST - BB115 - Clinical Records, Confidential

Title Clinical Records, Confidential

Type Rule

394.4615(1-2) FS; 65E-5.250(1) FAC

Regulation Definition

394.4615(1)-(2), FS

Clinical records; confidentiality.

(1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent, by the patient or the patient's guardian or guardian advocate or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either

Interpretive Guideline

-A "Clinical Record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

-Review policies and procedures to ensure compliance with statute.

Examine patient charts to ensure they are marked "confidential." If the only issue found is failure to "mark" the confidential record, this is not deficient practice alone.

-Review charts to see if releases of information are present when they are requested. Confirm there is no release of information unless a competent patient has provided consent or consent has been given by a guardian or a guardian advocate unless information is needed under one of the specified exceptions.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

- Ensure release of records documentation is present for voluntary admissions.

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authorized or unauthorized disclosure to any person, organization, or agency.

(2) The clinical record shall be released when:

(a) The patient or the patient's guardian or legal custodian authorizes the release. The guardian or guardian advocate or legal custodian shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate or legal custodian may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care. A receiving facility must document that, within 24 hours of admission, individuals admitted on a voluntary basis have been provided with the option to authorize the release of information from their clinical record to the individual's health care surrogate or proxy, attorney, representative, or other known emergency contact.

(b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.

(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.

(d) The patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Families, and the Department of Corrections requests such records. These records shall be furnished without charge to the Department of Corrections.

65E-5.250, FAC Clinical Records; Confidentiality.

(1) Except as otherwise provided by law, verbal or written information about a person shall only be released when the competent person, or a duly authorized legal decision-maker such as guardian, guardian advocate, or health care surrogate

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or proxy provides consent to such release. When such information is released, a copy of a signed authorization form shall be retained in the person's clinical record. Recommended form CF-MH 3044, Feb. 05, "Authorization for Release of Information," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation. Consent or authorization forms may not be altered in any way after signature by the person or other authorized decision-maker nor may a person or other authorized decision-maker be allowed to sign a blank form.

ST - BB117 - Clinical Records - Release of Confid. Info

Title Clinical Records - Release of Confid. Info

Type Rule

394.4615(3-8) FS

Regulation Definition

Clinical records; confidentiality.

(3) Information from the clinical record may be released in the following circumstances:

- (a) When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.
- (b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the

Interpretive Guideline

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criteria for involuntary services or for preparing the proposed services plan pursuant to s. 394.4655 or s. 394.467, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider, under s. 394.4655 or s. 394.467 in accordance with state and federal law.

(4) Information from clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(5) Information from clinical records may be used by the Agency for Health Care Administration, the department, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities.

(6) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

(7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).

(8) Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

ST - BB118 - Clinical Records, Confidential

Title Clinical Records, Confidential

Type Rule

394.4615(9) FS

Regulation Definition

Clinical records; confidentiality.

(9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental

Interpretive Guideline

-This section of the law does not require information be provided to parent or next of kin, but does permit it to occur without patient consent if the professional releasing the permitted information believes it to be within his or her code of ethics.

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health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

-Interview staff to ensure their understanding of this provision.

ST - BB120 - Clinical Records, Confidential-Right to Waive

Title Clinical Records, Confidential-Right to Waive

Type Rule

65E-5.250(2) FAC

Regulation Definition

Clinical Records; Confidentiality.
(2) Facility staff shall inform each person that he or she has the right to waive, in writing, the confidentiality of his or her presence in a receiving or treatment facility and to communicate with all or a group of individuals as specified by the person. Recommended form CF-MH 3048, Feb. 05, "Confidentiality Agreement," as referenced in subsection 65E-5.190(1), F.A.C., may be used for this purpose.

Interpretive Guideline

-If patient rights materials signed by the patient at admission do not include the required notice, review policies to ensure the facility has procedures in place to inform patients at some early time in their hospitalization. Interview patients to ensure they know their right to have open access initiated by others outside the facility. Limiting contact to only those who know an access code is prohibited without the consent of the patient. However, if the patient does not want anyone to know their whereabouts, the facility must take steps to ensure this is honored.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB121 - Clinical Records, Confidential - Pt. Access

Title Clinical Records, Confidential - Pt. Access

Type Rule

394.4615(10) FS

Regulation Definition

Clinical records; confidentiality.
(10) Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to

Interpretive Guideline

Interview patients to determine if they know they have the right to access their own clinical records. If any patients indicate they have requested, but been denied, access to their records, review the clinical record to determine if the required procedures had been followed and required documentation is present.
If access to the clinical record had been restricted, verify that there is written notice by the physician in the clinical

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inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

record with the reasons for the restriction. The reason for the restriction should be given to the person, the person's guardian, guardian advocate, representative and attorney. Patient charts should be sampled to ensure that any restriction to accessing one's own record is documented by the physician with justification of why this is not in patient's best interest and that the restriction is reviewed and renewed at least every 7 days. Staff should be interviewed to determine if they know how to respond to patient requests for accessing their record.

ST - BB122 - Clinical Records, Confidential-Restrict Acces

Title Clinical Records, Confidential-Restrict Acces

Type Rule

65E-5.250(4) FAC

Regulation Definition

Clinical Records; Confidentiality.

(4) When a person's access to his or her clinical record or any part of his or her record is restricted by written order of the attending physician, such restriction shall be documented in the person's clinical record. If the request is denied or such access is restricted, a written response shall be provided to the person. Recommended form CF-MH 3110, Feb. 05, "Restriction of Person's Access to Own Record," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for such documentation.

Interpretive Guideline

-Review clinical records of patients who state that requested access to the record had been denied. Use of recommended form "Restriction of Patient Access to Own Record" (CF-MH 3110) is considered by the department to be sufficient for such documentation.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB123 - Clinical Records, Confidential - Pol & Proced

Title Clinical Records, Confidential - Pol & Proced

Type Rule

65E-5.250(5) FAC

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Regulation Definition

Clinical Records; Confidentiality.

(5) Each receiving facility shall develop detailed policies and procedures governing release of records to each person requesting release, including criteria for determining what type of information may be harmful to the person, establishing a reasonable time for responding to requests for access, and identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record.

Interpretive Guideline

-Policies and procedures should specify in detail how reasonable access to a patient's own record will be assured. This should include what records will be released, to whom, when, where, and how.

ST - BB124 - Clinical Records, Confidential - Alteration

Title Clinical Records, Confidential - Alteration

Type Rule

394.4615(11) FS

Regulation Definition

Clinical records; confidentiality.

(11) Any person who fraudulently alters, defaces, or falsifies the clinical record of any person receiving mental health services in a facility subject to this part, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Interpretive Guideline

Review of patient charts should include observation of methods of correcting mistakes in charting to ensure that medical records are not altered or defaced in any way. Use of "white-out" or eradication of errors is unacceptable; a simple line drawn through the error, with the date/time and person's initials and credentials who made the entry is acceptable.

ST - BB125 - Transportation To A Receiving Facility

Title Transportation To A Receiving Facility

Type Rule

394.462(1)(k) FS

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Regulation Definition

(1) TRANSPORTATION TO A RECEIVING FACILITY
(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

Interpretive Guideline

-Interview law enforcement officials to determine if the facility has, at any time, declined to accept a patient brought for involuntary examination.
-Review patient records to determine whether the facility promptly arranged for examination and treatment of persons arrested for felonies meeting criteria for involuntary treatment, regardless of where the patient is being held.

ST - BB126 - Transportation To A Receiving Facility

Title Transportation To A Receiving Facility

Type Rule

394.4625(1)(g) FS

Regulation Definition

(1) TRANSPORTATION TO A RECEIVING FACILITY.
(g) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

Interpretive Guideline

-Interview law enforcement and county designated emergency medical transport/private transport company to see if the facility has refused to accept patients.

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ST - BB127 - Transportation To A Receiving Facility

Title Transportation To A Receiving Facility

Type Rule

394.4625(1)(I) FS

Regulation Definition

TRANSPORTATION TO A RECEIVING FACILITY.

(I) The appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or the nearest receiving facility if neither apply, must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the appropriate services

Interpretive Guideline

-Interview law enforcement and county designated emergency medical transport/private transport company to see if the facility has provided basic screening or triage to patients delivered to the facility.

ST - BB128 - Transportation to A Receiving Facility

Title Transportation to A Receiving Facility

Type Rule

394.4625(1)(h) FS

Regulation Definition

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or to

Interpretive Guideline

-Interview law enforcement officials to determine if the facility has, at any time, declined to accept a patient brought for involuntary examination.
-Review patient records to determine whether the facility promptly arranged for examination and treatment of persons arrested for felonies meeting criteria for involuntary treatment, regardless of where the patient is being held.

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the nearest receiving facility if neither apply. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held or by telehealth.

ST - BB130 - Voluntary Admissions - Auth To Recv Patients

Title Voluntary Admissions - Auth To Recv Patients

Type Rule

394.4625(1)(a) FS

Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS.-

(a) A facility may receive for observation, diagnosis, or treatment any adult who applies by express and informed consent for admission or any minor whose parent or legal guardian applies for admission. Such person may be admitted to the facility if found to show evidence of mental illness and to be suitable for treatment, and:

1. If the person is an adult, is found, to be competent to provide express and informed consent; or
2. If the person is a minor, the parent or legal guardian provides express and informed consent and the facility performs, a clinical review to verify the voluntariness of the minor's assent.

Interpretive Guideline

- Review policies and procedures to ensure compliance with statute especially regarding limitation of voluntary status to persons who are competent to provide express and informed consent for admission and treatment.
- Any admission of a person under the age of 18 requires an application for admission by the minor's guardian (usually the biological parent). In the absence of an application by the minor's guardian, a judicial hearing is required. The minor's concurrence with the voluntary admission is also required; in the absence of such, the admission must be handled under the involuntary examination provisions.
- Assure voluntary admissions of minors contain a clinical review to verify a minor's assent.

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ST - BB131 - Voluntary Admission - Application Forms

Title Voluntary Admission - Application Forms

Type Rule

65E-5.270(1) FAC

Regulation Definition

Voluntary Admission.

Recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., may be used to document an application of a competent adult for admission to a receiving facility.

Recommended form CF-MH 3097, Feb. 05, "Application for Voluntary Admission - Minors," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document a guardian's application for admission of a minor to a receiving facility. Recommended form CF-MH 3098, Feb. 05, "Application for Voluntary Admission - State Treatment Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document an application of a competent adult for admission to a state treatment facility.

Any application for voluntary admission shall be based on the person's express and informed consent.

Interpretive Guideline

-Use of the following recommended forms, properly completed, is considered by the department to be sufficient to document an application for voluntary admission:

--"Application for Voluntary Admission" (CF-MH 3040) for a competent adult to a receiving facility;

--"Application for Voluntary Admission - Minors" (CF-MH 3097) for a guardian's application for admission of a minor to a receiving facility; or

--"Application for Voluntary Admission - State Treatment Facility" (CF-MH 3098) for a competent adult for admission to a state treatment facility.

-Review records to ensure that one of the above forms are in the clinical records of each patient considered at any time to be on voluntary status.

-Interview patients to ensure that they were not coerced into voluntary status and that they appear able to make well-reason, willful and knowing decisions.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB132 - Voluntary Admits - Assess Ability to Consent

Title Voluntary Admits - Assess Ability to Consent

Type Rule

394.4625(1)(b) FS

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Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS -

(b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:

1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center or adult family-care home, when such person has been diagnosed as suffering from dementia.
2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s.400.0255 (12).
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

Interpretive Guideline

-Review facility records to ensure that the specified types of people have been admitted voluntarily only after their ability to provide express and informed consent has been assessed by an authorized service or professional while the patient is still at his or her licensed residence.

-The notice of emergency discharge or transfer must have been given to the resident's legal guardian or representative by telephone or in person, prior to the transfer, if possible. The resident is still entitled to a hearing on the transfer or discharge.

-The statute doesn't specify that this group of persons must be from a facility licensed under Ch. 400, F.S. However, since the entire paragraph relates to licensed facilities, one can presume this was the legislature's intent. Further, the Baker Act prohibits a health care surrogate or proxy from consenting to the provision of mental health treatment for a voluntary patient; requiring that the patient be discharged or transferred to involuntary status.

ST - BB133 - Voluntary Admission - Document Assessment

Title Voluntary Admission - Document Assessment

Type Rule

65E-5.270(3) FAC

Regulation Definition

Voluntary Admission.

(3) Documenting the assessment of each person pursuant to Section 394.4615(1)(b), F.S., shall be done prior to moving the person from his or her residence to a receiving facility for voluntary admission. Recommended form CF-MH 3099, Feb.

Interpretive Guideline

-Review the clinical records of persons who have been admitted to the receiving facility from a licensed facility. Ensure that the assessment was conducted by an authorized organization prior to the patient's removal from the facility. Use of recommended form "Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons Pursuant to s. 394.4625(1), F.S." (CF-MH 3099) is considered by the department to be sufficient.

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05, "Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons from Facilities Licensed under Chapter 400, F.S.," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter and used for this purpose.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB134 - Voluntary Admission-Adjudicated Incapacitated

Title Voluntary Admission-Adjudicated Incapacitated

Type Rule

394.4625(1)(c) FAC

Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS -

(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

Interpretive Guideline

-Ensure that the assessor used by the sending facility was an authorized professional and one without any conflict of interest and that the service designated by DCF was unable to respond within the two-hour time frame.

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ST - BB135 - Volunt Admit - Incapacitated Persons

Title Volunt Admit - Incapacitated Persons

Type Rule

394.4625(1)(d) FS

Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS -

(d) A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.

Interpretive Guideline

Review policies and procedures and patient charts to confirm that persons who have been adjudicated incapacitated by the court are only admitted on an involuntary basis. Patients, if admitted on voluntary status, who have a health care surrogate or proxy currently making health care decisions for them cannot have such surrogates or proxies give consent to their mental health treatment and must be admitted on an involuntary status.

ST - BB136 - Volunt Admit - Incapacitated Persons

Title Volunt Admit - Incapacitated Persons

Type Rule

394.4625(1)(e) FS

Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS -

(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to

Interpretive Guideline

-Verify through review of clinical records that no voluntary patients have an authorization for treatment provided by a health care surrogate or proxy. If the chart reflects that a surrogate or proxy had been consenting to the patient's medical treatment immediately prior to the patient's admission on a voluntary basis to psychiatric care, but the patient is currently considered competent to consent to his or her own treatment, determine the circumstances under which the patient's competency to consent had been restored.

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involuntary status.

ST - BB137 - Doc. of Competence to Consent

Title Doc. of Competence to Consent

Type Rule

394.4625(1)(f) FS

Regulation Definition

Voluntary admissions.-

(1) AUTHORITY TO RECEIVE PATIENTS -

(f) Within 24 hours after admission of a voluntary patient, the treating physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

Interpretive Guideline

-Review patient charts to ensure that the admitting physician has documented in the record, within 24 hours after admission, that the person is able to provide express and informed consent.

ST - BB138 - Doc of Competence - Form

Title Doc of Competence - Form

Type Rule

65E-5.270(1)(a) FAC

Regulation Definition

Voluntary Admission.

(1) (a) Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., may be used to document the competence of a person to give

Interpretive Guideline

-Review clinical records to verify that a physician has certified a voluntary patient's competence to consent within 24 hours of the patient's admission or prior to permitting an involuntary patient to convert to voluntary status.
-Use of recommended form "Certification of Patient's Competence to Provide Express and Informed Consent" (CF-MH 3104) is considered by the department to be sufficient to document the competence of a person to give express and informed consent to be a voluntary patient.

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express and informed consent to be on voluntary status. The original of the completed form shall be retained in the person's clinical record.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB139 - Notice of Right to Discharge

Title Notice of Right to Discharge

Type Rule

394.4625(3) FS

Regulation Definition

Voluntary admissions.-
(3) NOTICE OF RIGHT TO DISCHARGE -
At the time of admission and at least every 6 months thereafter, a voluntary patient shall be notified in writing of his or her right to apply for a discharge.

Interpretive Guideline

-Review clinical records to ensure that voluntary patients are notified at the time of their admission and at least every 6 months thereafter of their right to apply for a discharge.

ST - BB140 - Volunt Admit - Right to Request Discharge

Title Volunt Admit - Right to Request Discharge

Type Rule

65E-5.270(2) FAC

Regulation Definition

Voluntary Admission.
(2) Persons on voluntary status shall be advised of their right to request discharge. Recommended forms CF-MH 3051a, Feb. 05, "Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or CF-MH 3051b, Feb. 05, "Notice of Right of Person on Voluntary Status to Request Discharge from a Treatment Facility," which

Interpretive Guideline

-Review clinical records to verify that the patient has been notified of his or her right to request discharge.
-Use of recommended forms "Notice of Voluntary Patient's Right to Request Discharge from a Receiving Facility" (CF-MH 3051a) or "Notice of Voluntary Patient's Right to Request Discharge from a Treatment Facility" (CF-MH 3051b) is considered by the department to be sufficient to document the giving of such advice.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter and used to document the giving of such advice. A copy of the notice or its equivalent shall be given to the person and to the person's parent if a minor, with the original of each completed application and notice retained in the person's clinical record.

ST - BB141 - Discharge of Voluntary Patient

Title Discharge of Voluntary Patient

Type Rule

394.4625(2)(a)-(b) FS

Regulation Definition

Voluntary admissions.-

(2) DISCHARGE OF VOLUNTARY PATIENTS -

(a) A facility shall discharge a voluntary patient:

1. Who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility.
2. Who revokes consent to admission or requests discharge. A voluntary patient or a relative, friend, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. The patient must be discharged within 24 hours of the request, unless the request is rescinded or the patient is transferred to involuntary status pursuant to this section. The 24-hour time period may be extended by a treatment facility when necessary for adequate discharge planning, but shall not exceed 3 days exclusive of weekends and holidays. If the patient, or another on the patient's behalf, makes an oral request for discharge to a staff member, such request shall be immediately entered in the patient's clinical record. If the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the

Interpretive Guideline

-Review policies and procedures to ensure consistency with statute.

-Sample clinical records of discharged patients to ensure that patients are discharged within 24 hours when they are determined to be sufficiently improved or when they have revoked consent to admission/treatment or requested discharge, unless the request is rescinded or the person is transferred to involuntary status.

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patient.

(b) A voluntary patient who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status pursuant to this section or unless the refusal or revocation is freely and voluntarily rescinded by the patient.

ST - BB142 - Transfer To Voluntary Status

Title Transfer To Voluntary Status

Type Rule

394.4625(4) FS

Regulation Definition

Voluntary admissions.-

(4) TRANSFER TO VOLUNTARY STATUS.-An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599, and if the patient is a minor, the minor's assent to voluntary care must be verified as provided in paragraph (1)(a).

Interpretive Guideline

- The process begins immediately but the actual transfer from involuntary to voluntary status requires that a physician or clinical psychologist first examine the patient to certify competence to provide express and informed consent.
- Review patient clinical records and interview patients to see if there are methods in place to accomplish patient transfer to voluntary status, when requested and only when patient is competent to provide well-reasoned, willing, and knowing decisions about his or her medical and mental health treatment.
- Documentation of notice should be in the clinical record.
- Assure voluntary admissions of minors contain a clinical review to verify a minor's assent.

ST - BB143 - Transfer to Voluntary Status

Title Transfer to Voluntary Status

Type Rule

65E-5.270(1)(b) FAC

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Regulation Definition

Voluntary Admission.

(1) (b) Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., may be used to document a person applying for transfer from involuntary to voluntary status is competent to provide express and informed consent. The original of the completed form shall be filed in the person's clinical record. A change in legal status must be followed by notice sent to individuals pursuant to Section 394.4599, F.S.

Interpretive Guideline

-If a patient is transferred from involuntary to voluntary status, use of recommended form "Certification of Patient's Competence to Provide Express and Informed Consent" (CF-MH 3104) is considered by the department to be sufficient to document a person applying for transfer is competent to provide express and informed consent.
-Documentation of notice should be in the clinical record.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB144 - Transfer to Involuntary Status

Title Transfer to Involuntary Status

Type Rule

394.4625(5) FS

Regulation Definition

Voluntary admissions.-

(5) TRANSFER TO INVOLUNTARY STATUS.-When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency

Interpretive Guideline

-Review policies and procedures to ensure consistency with statute.
-Determine how and when the treating professional is notified when a person on voluntary status requests discharge.
-Interview staff and review clinical records to assure that a person who refuses or revokes consent to treatment is discharged within 24 hours unless transferred to involuntary status.
-If transferred to involuntary status, confirm that the petition was filed with the court within 2 working days.

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treatment rendered in the least restrictive manner, upon the order of a physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

ST - BB145 - Volunt Admit - Refusal of Treatment

Title Volunt Admit - Refusal of Treatment

Type Rule

65E-5.270(4) FAC

Regulation Definition

Voluntary Admission.

(4) If a competent adult or the guardian of a minor refuses to consent to mental health treatment, the person shall not be eligible for admission on a voluntary status. A person on voluntary status who refuses to consent to or revokes consent to treatment shall be discharged from a designated receiving or treatment facility within 24 hours after such refusal or revocation, unless the person is transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person. When a person refuses or revokes consent to treatment, facility staff shall document this immediately in the person's clinical record. Recommended form CF-MH 3105, Feb. 05, "Refusal or Revocation of Consent to Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. Should a competent person withdraw his or her refusal or revocation of consent to treatment, the person shall be asked to complete Part II of recommended form CF-MH 3105, "Refusal or Revocation of Consent to Treatment," as referenced in subsection 65E-5.270(4), F.A.C., or similar documentation, and the original shall be retained in the person's clinical record.

Interpretive Guideline

- Review clinical records of patients admitted on a voluntary basis to ensure that a valid consent to treatment has been signed by a competent adult patient or the guardian of a minor.
- Review progress notes to determine if the patient had ever refused consent to treatment. If so, recommended form "Refusal or Revocation of Consent to Treatment" (CF-MH 3105) should have been completed. The facility should have discharged the patient within 24 hours unless the patient withdrew the refusal to consent, in which case, the patient shall be asked to complete Part II of recommended form "Refusal or Revocation of Consent to Treatment" (CF-MH 3105).
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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ST - BB146 - Voluntary Admit - Request for Discharge

Title Voluntary Admit - Request for Discharge

Type Rule

65E-5.270(5) FAC

Regulation Definition

Voluntary Admission.

(5) An oral or written request for discharge made by any person following admission to the facility shall be immediately documented in the person's clinical record. Recommended forms CF-MH 3051a, "Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility," as referenced in subsection 65E-5.270(2), F.A.C., or CF-MH 3051b, "Notice of Right of Person on Voluntary Status to Request Discharge from a Treatment Facility," as referenced in subsection 65E-5.270(2), F.A.C., may be used for this purpose. This form may also be completed by a relative, adult friend, or attorney of the person.

Interpretive Guideline

-Interview voluntary patients to determine if they know they have the right to request discharge and if, at any time, had requested discharge from the facility. If so, review their clinical record to ensure that request was documented. Use of recommended forms "Notice of Voluntary Patient's Right to Request Discharge from a Receiving Facility" (CF-MH 3051a) or, "Notice of Voluntary Patient's Right to Request Discharge from a Treatment Facility" (CF-MH 3051b) is considered by the department to be sufficient.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB147 - Voluntary Admission

Title Voluntary Admission

Type Rule

65E-5.270(6) FAC

Regulation Definition

Voluntary Admission.

(6) When a person on voluntary status refuses treatment or requests discharge and the facility administrator makes the determination that the person will not be discharged within 24 hours from a designated receiving or treatment facility, a

Interpretive Guideline

-In each case where a voluntary patient is transferred to involuntary status following refusal of treatment or request for discharge, ensure that a petition for involuntary placement has been initiated. Use of recommended form "Petition for Involuntary Placement" (CF-MH 3032) is considered to be sufficient.

The petition must be initiated and filed with the court within the allowable timeframes.

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petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement", as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. The first expert opinion by a psychiatrist shall be obtained on the petition form within 24 hours of the request for discharge or refusal of treatment to justify the continued detention of the person and the petition shall be filed with the court within 2 court working days after the request for discharge or refusal to consent to treatment was made.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB148 - Voluntary Admission

Title Voluntary Admission

Type Rule

65E-5.270(7) FAC

Regulation Definition

Voluntary Admission.

(7) If a person is delivered to a receiving facility for voluntary examination from any program or residential placement licensed under the provisions of Chapter 400, F.S., without first arranging an independent evaluation of the resident's competence to provide express and informed consent to admission and treatment, as required in Sections 394.4625(1)(b) and (c), F.S., the receiving facility shall notify the Agency for Health Care Administration by using recommended form CF-MH 3119, Feb. 05, "Notification of Non-Compliance with Required Certificate," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter

Interpretive Guideline

-Interview the administrator to determine if any patients were delivered from a residential placement prior to independent evaluation of competence to provide express and informed consent. If so, review the clinical records to ensure the notice of non-compliance was sent to AHCA.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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ST - BB150 - Involuntary Exam - Criteria

Title Involuntary Exam - Criteria

Type Rule

394.463(1) FS

Regulation Definition

Involuntary examination.

- (1) CRITERIA -A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:
- (a) 1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. The person is unable to determine for himself or herself whether examination is necessary; and
- (b) 1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able and responsible family members or friends or the provision of other services; or
2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Interpretive Guideline

-Review clinical records to ensure patients who meet criteria and refuse voluntary examination had been provided proper explanation of what a voluntary examination is, which should be documented in the clinical record. Verify patient meets criteria through documentation in clinical record.

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ST - BB151 - Involuntary Exam - Initiation

Title Involuntary Exam - Initiation

Type Rule

394.463(2)(a) FS

Regulation Definition

(2) INVOLUNTARY EXAMINATION.-

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer may take a person who appears

Interpretive Guideline

Review patient charts to verify that a copy of an ex parte order, a law enforcement report, or a certificate of a mental health professional is present and completed by an authorized person.

1. The ex parte order for involuntary examination, with attached document giving the findings, shall accompany the patient to the receiving facility and be retained in the patient's clinical record.
2. Mandatory form "Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a) shall accompany the patient to the nearest receiving facility for retention in the patient's clinical record.
3. Mandatory form "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b) shall expire seven days after the certificate is signed, unless the patient has been taken into custody and delivered to a receiving facility. The certificate is valid throughout the state. The completed certificate shall accompany the patient to a receiving facility and be retained in the person's clinical record.

Copies of court orders, reports and certificates required to be submitted to the Agency for Health Care Administration, should be sent to the Baker Act Reporting Center at the Florida Mental Health Institute, which collects these on the Agency's behalf. Review clinical records to ensure that the initiating documents are sent to the BA Reporting Center on the next working day.

Actions by law enforcement, such as transport method, is not surveyable.

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to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination.

The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody and include all emergency contact information required under

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subparagraph 2. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

ST - BB152 - Involuntary Exam - Min Stds

Title Involuntary Exam - Min Stds

Type Rule

65E-5.2801(2-4) FAC

Regulation Definition

Involuntary Examination.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

(3) If not released, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in

Interpretive Guideline

- Sample patients for involuntary examinations not meeting criteria for involuntary inpatient/outpatient placement for documentation in clinical record to verify voluntary a placement was offered.
- Review for Application of Voluntary Admission and Certification of Person's Competence to Provide Express and Informed Consent.
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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paragraph 65E-5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission - Minors," as referenced in subsection 65E-5.270(1), F.A.C., may be used if the person wishes to apply for voluntary admission.

(4) If not released and the person wishes to transfer from involuntary to voluntary status, recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., documenting the person is competent to provide express and informed consent, may be used for this purpose.

ST - BB153 - Involuntary Exam - Forms Distribution

Title Involuntary Exam - Forms Distribution

Type Rule

65E-5.280(5) FAC

Regulation Definition

Involuntary Examination.

(5) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, designated receiving facilities shall forward copies of each recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order provided by the court, mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., accompanied

Interpretive Guideline

-These forms include:

- Recommended form "Ex Parte Order for Involuntary Examination" (CF-MH 3001) or other order provided by the court,
- Mandatory form "Report of Law Enforcement Officer Initiating Involuntary Examination" (CF MH 3052a),
- Mandatory form "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b),
- Regardless of which of the above three methods was used to initiate the involuntary examination, the form must be accompanied by the mandatory form "Cover Sheet to Agency for Health Care Administration" (CF-MH 3118).
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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by mandatory form CF-MH 3118, June 2016, "Cover Sheet to Department of Children and Families," <http://www.flrules.org/Gateway/reference.asp?No=Ref-07006>, which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

ST - BB154 - Involuntary Exam-Initiation-Report Prepared

Title Involuntary Exam-Initiation-Report Prepared

Type Rule

394.463(2)(b) FS

Regulation Definition

2) INVOLUNTARY EXAMINATION.-
(b) A person may not be removed from any program or residential placement licensed under chapter 400 or chapter 429 and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate, or a law enforcement officer's report is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's report shall notify the department of such admission by certified mail or by e-mail, if available, by the next working day. The provisions of this paragraph do not apply when transportation is provided by the patient's family or guardian.

Interpretive Guideline

-Ensure that the facility notifies DCF by certified mail on the next working day if a facility or service licensed under s.400 F.S. sends a person on involuntary status to a receiving facility without an order/report/certificate.
-If it is determined that an ALF or LTC resident has been admitted without going through the Baker Act process, consider a complaint referral on that ALF or LTC facility.

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ST - BB155 - Involuntary Exam- Notify AHCA

Title Involuntary Exam- Notify AHCA

Type Rule

65E-5.280(6) FAC

Regulation Definition

Involuntary Examination.

(6) If a person is delivered to a receiving facility for an involuntary examination from any program or residential placement licensed under the provisions of Chapter 400, F.S., without an ex parte order, the mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination" as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination" as referenced in subsection 65E-5.260(1), F.A.C., the receiving facility shall notify the Agency for Health Care Administration by the method and timeframe required by Section 394.463(2)(b), F.S. The receiving facility may use recommended form CF-MH 3119, Feb. 05, "Notification of Non-Compliance with Required Certificate," as referenced in subsection 65E-5.270(7), F.A.C., for this purpose.

Interpretive Guideline

-Review the clinical record for each patient referred to the facility from a chapter 400 licensed facility. The record should include one of the following three forms, completed prior to the patient's removal from the chapter 400 facility:

--Recommended form "Ex Parte Order for Involuntary Examination" (CF-MH 3001) or other order provided by the court,

--Mandatory form "Report of Law Enforcement Officer Initiating Involuntary Examination" (CF-MH 3052a), or

--Mandatory form "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b)

-The receiving facility's use of recommended form "Notification of Non-Compliance with Required Certificate" (CF-MH 3119) sent to the BA Reporting Center is considered by the department to be sufficient for AHCA notification.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

****PLEASE NOTE STATUTE CHANGE THAT NOTICE GOES TO DCF.**

ST - BB156 - Involuntary Exam- Clinical Record

Title Involuntary Exam- Clinical Record

Type Rule

65E-5.280(7) FAC

Regulation Definition

Involuntary Examination.

Interpretive Guideline

-Review the clinical records of patients presented to a receiving facility for involuntary examination. Each patient's

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(7) Documentation that each completed form was submitted in a timely way shall be retained in the person's clinical record.

chart, regardless of the length of time retained at the facility, should include documentation that AHCA, through the BA Reporting Center, was properly notified in a timely way.

ST - BB157 - Involuntary Exam

Title Involuntary Exam

Type Rule

394.463(2)(f) FS

Regulation Definition

Involuntary examination.-

(2)(f) A patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Such examination shall include, but not be limited to, consideration of the patient's treatment history at the facility and any information regarding the patient's condition and behavior provided by knowledgeable individuals. Evidence that criteria under subparagraph (1)(b)1. are met may include, but need not be limited to, repeated admittance for involuntary examination despite implementation of appropriate discharge plans. For purposes of this paragraph, the term "repeated admittance" means three or more admissions into the facility within the immediately preceding 12 months. An individual's basic needs being served while admitted to the facility may not be considered evidence that criteria under subparagraph (1)(b)1. are met. Emergency treatment may be provided upon the order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist if the physician or psychiatric nurse determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist

Interpretive Guideline

-Review patient charts to ensure that patients are examined by a physician or a clinical psychologist without unnecessary delay and that they are not released from the facility without the documented approval of an appropriate health care provider.
-Once the involuntary examination has been initiated, the patient's agreement to be voluntary does not eliminate the requirement for the examination to be performed by the appropriate health care provider.

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or a clinical psychologist or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

ST - BB158 - Involuntary Examination - Examination Defined

Title Involuntary Examination - Examination Defined

Type Rule

65E-5.100(6) FAC

Regulation Definition

Definitions.

As used in this chapter the following words and phrases have the following definitions:

(6) Examination means the integration of the physical examination required under Section 394.459(2), F.S., with other diagnostic activities to determine if the person is medically stable and to rule out abnormalities of thought, mood, or behavior that mimic psychiatric symptoms but are due to non-psychiatric medical causes such as disease, infection, injury, toxicity, or metabolic disturbances. Examination includes the identification of person-specific risk factors for treatment such as elevated blood pressure, organ dysfunction, substance abuse, or trauma.

Interpretive Guideline

While a clinical psychologist can perform part of the legally required examination, the process of ruling out non-psychiatric medical causes of the symptoms requires medical expertise.

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ST - BB159 - Involuntary Exam

Title Involuntary Exam

Type Rule

65E-5.2801(1) FAC

Regulation Definition

Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination:

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

(a) A thorough review of any observations of the person's recent behavior;

(b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility", as referenced in subsection 65E-5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination", as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely

Interpretive Guideline

-Review medical records for a complete medical exam for involuntary patients; which is a face-to face examination.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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manner to determine if the person meets criteria for release.

ST - BB160 - Involuntary Exam - Clinical Record

Title Involuntary Exam - Clinical Record

Type Rule

65E-5.2801(5) FAC

Regulation Definition

Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person's clinical record.

Interpretive Guideline

-Review the clinical record of patients presented to the facility for involuntary examination to ensure that the required documentation is present.

ST - BB161 - Involuntary Exam

Title Involuntary Exam

Type Rule

65E-5.2801(6) FAC

Regulation Definition

Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(6) If the patient is not released or does not become voluntary as a result of giving express and informed consent to admission and treatment in the first part of the involuntary examination, the person shall be examined by a psychiatrist to determine if the criteria for involuntary inpatient or involuntary outpatient placement are met.

Interpretive Guideline

-Review clinical records to verify that patients who are admitted on involuntary status are examined by a psychiatrist, if not earlier released or transferred to voluntary status following certification by a physician.

-If not released, use of recommended, "Application for Voluntary Admission" form (CF-MH 3040) or recommended form "Application for Voluntary Admission - Minors" (CF-MH 3097) will be considered by the department to be sufficient if the patient wishes to apply for voluntary admission.

-If not released and the patient wishes to transfer from involuntary to voluntary status, use of recommended form "Certification of Patient's Competence to Provide Express and Informed Consent" (CF-MH 3104) documenting the patient is competent to provide express and informed consent, will be considered by the department to be sufficient.

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ST - BB163 - Involuntary Exam

Title Involuntary Exam

Type Rule

65E-5.2801(7) FAC

Regulation Definition

Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

(7) After the initial mandatory involuntary examination, the person's clinical record shall include:

- (a) An intake interview;
- (b) The mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(1), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.; and
- (c) The psychiatric evaluation, including the mental status examination or the psychological status report.

Interpretive Guideline

-Review clinical records to verify the required forms are included.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB164 - Involuntary Exam - Actions Req Within 72 Hrs

Title Involuntary Exam - Actions Req Within 72 Hrs

Type Rule

394.463(2)(g) FS

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Regulation Definition

(2) INVOLUNTARY EXAMINATION

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary services shall be filed in the circuit court or with the county court, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. The petition shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition. If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:
 - a. Intends to file a petition for involuntary services, such patient may be held at the facility through the next working day thereafter and the petition must be filed no later than such date. If the facility fails to file the petition by the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).
 - b. Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until

Interpretive Guideline

- Review clinical records to determine that patients determined not to meet the criteria for involuntary placement are released from the facility on a timely basis; no more than 72 hours from arrival at a receiving facility, but see provisions regarding weekend discharge at subparagraph (4).
- Review policies and procedures and patient charts to determine that the receiving facility ensures that no patient is detained in excess of 72 hours unless a competent patient has given informed consent to voluntary admission and signed recommended form entitled "Application for Voluntary Admission" (CF-MH 3040) or the administrator has filed a Petition for Involuntary Placement (CF-MH 3032).
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>
- Assure minor evaluated within 12 hours of arrival.

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the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

ST - BB165 - Notice of Release

Title Notice of Release

Type Rule

394.463(3) FS

Regulation Definition

Involuntary examination.-
(3) NOTICE OF RELEASE -
Notice of the release shall be given to the patient's guardian or representative, to any person who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

Interpretive Guideline

-Review policies and procedures to ensure compliance with statute.
Sample clinical records to confirm presence of recommended form "Notice of Release or Discharge" (CF-MH 3038) is used to inform patients, guardians and representatives, guardian advocates, persons who executed a certificate admitting the patient to the receiving facility and to the court which ordered the patient's examined.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

ST - BB166 - Involuntary Exam/E.M.S.

Title Involuntary Exam/E.M.S.

Type Rule

65E-5.280(4)(c) FAC

Regulation Definition

Involuntary Examination.
(4)(c) The 72-hour involuntary examination period set out in Section 394.463(2)(f), F.S., shall not be exceeded. In order to document the 72-hour period has not been exceeded, recommended form CF-MH 3102, Feb. 05, "Request for Involuntary Examination After Stabilization of Emergency Medical Condition," which is incorporated by reference and

Interpretive Guideline

-In order to document the 72-hour period has not been exceeded, use of recommended form "Request for Involuntary Examination After Emergency Medical Services" (CF-MH 3102) is considered by the department to be sufficient. The form may be sent by fax, or otherwise, to promptly communicate its contents to the receiving facility to which the patient will be sent, at which appropriate medical treatment is available.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. The form may be sent by fax, or otherwise, to promptly communicate its contents to a designated receiving facility at which appropriate medical treatment is available.

ST - BB169 - Disposition-Initial Mand. Involuntary Exam

Title Disposition-Initial Mand. Involuntary Exam

Type Rule

65E-5.2801(8) FAC

Regulation Definition

Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(8) Disposition Upon Initial Mandatory Involuntary Examination.

(a) The release of a person from a receiving facility requires the documented approval of a psychiatrist, clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician after the completion of an initial mandatory involuntary examination. Recommended form CF-MH 3111, Feb. 05, "Approval for Release of Person on Involuntary Status from a Receiving Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. A copy of the form used shall be retained in the person's clinical record.

(b) In order to document a person's transfer from involuntary to voluntary status, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in

Interpretive Guideline

-Review clinical records for discharged patients who completed an initial involuntary examination to ensure release from involuntary status was approved by the appropriate medical professional. If transferred to voluntary status, review CF-MH 3040; CF-MH 3104. For patients meeting criteria for involuntary inpatient/outpatient services, ensure placement was initiated within 72 hours of arrival by filing CF-MH 3032 (signed by administrator and filed in court) with copies retained in the clinical record.

-Ensure notice (CF-MH 3038) was provided to all those required.

If the patient converts to voluntary after the involuntary commitment has been done, verify the patient's ability to provide express and informed consent.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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paragraph 65E-5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission - Minors," as referenced in subsection 65E-5.270(1), F.A.C., completed prior to transfer, may be used.

(c) A person for whom an involuntary examination has been initiated shall not be permitted to consent to voluntary admission until after examination by a physician to confirm his or her ability to provide express and informed consent to treatment. Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., may be used for documentation.

(d) If the facility administrator, based on facts and expert opinions, believes the person meets the criteria for involuntary inpatient or involuntary outpatient placement or is incompetent to consent to treatment, the facility shall initiate involuntary placement within 72 hours of the person's arrival by filing a petition for involuntary placement. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement" as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. Such petition shall be signed by the facility administrator or designee within the 72-hour examination period. The petition shall be filed with the court within the 72-hour examination period or, if the 72 hours ends on a weekend or legal holiday, no later than the next court working day thereafter. A copy of the completed petition shall be retained in the person's clinical record and a copy given to the person and his or her duly authorized legal decision-maker or representatives.

(e) When a person on involuntary status is released, notice

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shall be given to the person's guardian or representative, to any individual who executed a certificate for involuntary examination, and to any court which ordered the person's examination with a copy retained in the person's clinical record. Recommended form CF-MH 3038, Feb. 05, "Notice of Release or Discharge," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

ST - BB170 - Involuntary Placement

Title Involuntary Placement

Type Rule

394.467(3) FS

Regulation Definition

Involuntary inpatient placement.-
(3) ADMISSION TO A TREATMENT FACILITY.-A patient may be retained by a facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience or another psychiatrist, experience, or another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol, who personally examined the patient. If a psychiatrist, a clinical psychologist with at least 3 years is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist of clinical experience, or a

Interpretive Guideline

-Review the patient's clinical record to make sure the petition was filed promptly in the court in the county where the person is located.
Sample clinical records to ensure that the recommended form "Petition for Involuntary Placement" (CF-MH 3032) was completed by both experts and by the administrator within the 72-hour period.
-Document that the "Petition for Involuntary Placement" was filed with the court within the permitted 72 hours period, or if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFFormsInternet/Search/DCFFFormSearch.aspx>

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psychiatric nurse practicing within the framework of an established protocol with a psychiatrist is not available to provide a second opinion, the petitioner must certify as such and the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a clinical psychologist, or by a psychiatric nurse.

Any opinion authorized in this subsection may be conducted through a face-to-face examination or in person examination, or by electronic means. Recommendations for involuntary services must be entered on a petition for involuntary services which shall be made a part of the patient's clinical record. The filing of the petition authorizes the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

Involuntary services.-

ST - BB171 - Petition/Involuntary Placement

Title Petition/Involuntary Placement

Type Rule

394.467(4) FS

Regulation Definition

Involuntary services.-

(4) PETITION FOR INVOLUNTARY INPATIENT PLACEMENT -

A petition for involuntary services may be filed by: The administrator of a receiving or a service provider who is treating the person being petitioned petition for involuntary inpatient placement or inpatient placement followed by outpatient services, must be filed in the court in the county where the patient is located. When the petition has been filed, the clerk of the court shall provide copies of the petition and

Interpretive Guideline

Review patient charts to ensure petitions are filed promptly in the court of the county where the person is located.

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the recommended services plan, if applicable, to the department, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for the filing of a petition under this subsection.

ST - BB172 - Involuntary Placement

Title Involuntary Placement

Type Rule

65E-5.290(1-6 & 9) FAC

Regulation Definition

Involuntary Inpatient Placement.

- (1) If a person is retained involuntarily after an involuntary examination is conducted, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement", as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., or other forms adopted by the court may be used for this purpose. A copy of the completed petition shall be retained in the person's clinical record.
- (2) Each criterion alleged must be substantiated by evidence.
- (3) Use of recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other form used by the court, when properly completed, will satisfy the requirements of Section 394.4599, F.S. A copy of that completed form, or its equivalent, shall be retained in the

Interpretive Guideline

- (1) Use of recommended form "Petition for Involuntary Placement" (CF-MH 3032) is considered by the department to be sufficient.
- (2) Use of recommended form "Notice of Petition for Involuntary Placement" (CF-MH 3021) when properly completed, is considered by the department to satisfy the requirements of s. 394.4599, F.S.
- (3) Use of recommended form "Notice to Court Request for Continuance of Involuntary Placement Hearing" (CF-MH 3113) is considered by the department to be sufficient.
- (4) Use of recommended form "Application for Appointment of Independent Expert Examiner" (CF-MH 3022) is considered by the department to be sufficient to request the expert examiner.
- (5) Use of recommended form "Notification to Court of Withdrawal of Petition on Involuntary Placement" (CF-MH 3033) is considered by the department to be sufficient.
- (6) Use of recommended form "Order for Involuntary Placement" (CF-MH 3008) or other order used by the court, is considered by the department to be sufficient for this purpose.

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person's clinical record. Whenever potential involuntary inpatient placement in a state treatment facility is proposed, a copy of the completed notice form shall also be provided to the designated community mental health center or clinic for purposes of conducting a transfer evaluation.

(4) Recommended form CF-MH 3113, Feb. 05, "Notice to Court - Request for Continuance of Involuntary Placement Hearing," as referenced in paragraph 65E-5.285(2)(b), F.A.C., may be used by the counsel representing a person in requesting a continuance. A completed copy of the form used shall be provided to the facility administrator for retention in the person's clinical record.

(5) Recommended form CF-MH 3022, Feb. 05, "Application for Appointment of Independent Expert Examiner," as referenced in paragraph 65E-5.285(2)(c), F.A.C., may be used to request the expert examiner.

(6) Recommended form CF-MH 3033, Feb. 05, "Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Outpatient Placement," as referenced in paragraph 65E-5.285(2)(d), F.A.C., may be used if the facility administrator seeks to withdraw the petition for involuntary placement prior to the hearing. The facility shall retain a copy in the person's clinical record. When a facility withdraws a petition for involuntary inpatient placement, it shall notify the court, state attorney, attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately. In all cases involving potential involuntary inpatient placement in a state treatment facility, a copy of the notification form shall also be provided to the designated community mental health center or clinic responsible for conducting a transfer evaluation.

(9) If the court concludes that the person meets the criteria for involuntary inpatient placement pursuant to Section 394.467,

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F.S., it shall prepare an order. Recommended form CF-MH 3008, "Order for Involuntary Inpatient Placement," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., or other order used by the court, may be used for this purpose. This signed order shall be given to the person, guardian, guardian advocate or representative, counsel for the person, state attorney, and administrator of the receiving or treatment facility, with a copy of the order retained in the person's clinical record.

ST - BB173 - Procedure/Involuntary Placement

Title Procedure/Involuntary Placement

Type Rule

394.467(7)(b) FS

Regulation Definition

Involuntary inpatient placement.-
(7)(PROCEDURE FOR CONTINUED INVOLUNTARY INPATIENT PLACEMENT
(b) If the patient continues to meet the criteria for involuntary inpatient services and is being treated at a receiving facility, the administrator must, before the expiration of the period the receiving facility is authorized to retain the patient, file in the court that issued the initial order for involuntary inpatient placement, a petition requesting authorization for continued involuntary services. The administrator may petition for inpatient or outpatient services. The petition must be accompanied by a statement from the patient's physician, psychiatrist, psychiatric nurse, or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment developed in consultation with the patient or the patient's guardian advocate, if applicable. If the petition is for

Interpretive Guideline

"Petitions for Continued Involuntary Placement" are rarely filed by receiving facility administrators, since the patient would have had to exceed the maximum period of the court order, usually six months. However, petitions filed with the state Division of Administrative Hearings should be filed at least 25 days prior to the person's expiration of the order for involuntary placement or for a person involuntarily placed while as a minor who is about to reach the age of 18.
-Review clinical records to see if hearings for continued involuntary placement are conducted for people who remain at the facility.
-Check clinical records of patients who are involuntarily placed to see the petitions are present requesting continued authorization for involuntary placement and that the petitions are accompanied by the person's physician, psychiatrist, psychiatric nurse, or clinical psychologist or physician noting what the person's treatment and continued response to treatment has been documented.

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involuntary outpatient services, it must comply with the requirements of subparagraph (4)(d)3. When the petition has been filed, the clerk of the court shall provide copies of the petition and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender. Notice of the hearing must be provided as set forth in s.394.4599. If a patient's attendance at the hearing is voluntarily waived, the judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, before waiving the presence of the patient from all or a portion of the hearing. Alternatively, if at the hearing the judge finds that attendance at the hearing is not consistent with the best interests of the patient, the judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The testimony in the hearing must be under oath, and the proceedings must be recorded.

ST - BB174 - Involuntary Placement - Continued Placemt

Title Involuntary Placement - Continued Placemt

Type Rule

65E-5.300(1) FAC

Regulation Definition

Continued Involuntary Inpatient Placement at Treatment Facilities.

(1) In order to request continued involuntary inpatient placement, the treatment facility administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the person, file a request for continued placement. Recommended form CF-MH 3035, Feb. 05, "Petition Requesting Authorization for Continued Involuntary Inpatient Placement," which is incorporated by reference and

Interpretive Guideline

-Use of recommended form "Petition Requesting Authorization for Continued Involuntary Placement" (CF-MH 3035) is considered by the department to be sufficient as documentation of the request.
-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of that request. The petition shall be filed with the Division of Administrative Hearings within 20 days prior to the expiration date of a person's authorized period of placement or, in the case of a minor, the date when the minor will reach the age of majority. The petition shall contain the signed statement of the person's physician or clinical psychologist justifying the request and shall be accompanied by the following additional documentation:

- (a) Evidence justifying the request by the physician or clinical psychologist for involuntary inpatient placement, including how the person meets each of the statutorily required criteria;
- (b) A brief summary of the person's treatment during the time he or she was placed; and
- (c) An individualized treatment plan.

ST - BB175 - Procedure/Involuntary Placement

Title Procedure/Involuntary Placement

Type Rule

394.467(7)(e) FS

Regulation Definition

Involuntary inpatient placement.-

(7) PROCEDURE FOR CONTINUED INVOLUNTARY INPATIENT PLACEMENT

(7)(e) If continued involuntary inpatient placement is necessary for a patient admitted while serving a criminal sentence, but his or her sentence is about to expire, or for a minor involuntarily placed, but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement.

Interpretive Guideline

-Review clinical records of such patients to ensure that petitions were filed with the Division of Administrative Hearings in a timely manner.

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ST - BB176 - Discharge/Involuntary Patients

Title Discharge/Involuntary Patients

Type Rule

394.469(1) FS

Regulation Definition

Discharge of involuntary patients.-

(1) POWER TO DISCHARGE -

At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:

(a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer.

(b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or

(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

Interpretive Guideline

-Review policies and procedures to ensure compliance with the statute.

-Review closed patient charts to ensure the patients were discharged appropriately.

c) a "community facility" is defined in the Baker Act as any community service provider contracting with the department to furnish substance abuse or mental health services under part IV of this chapter.

ST - BB177 - Discharge/Involuntary Patients

Title Discharge/Involuntary Patients

Type Rule

65E-5.320 FAC

Regulation Definition

Discharge of Persons on Involuntary Status.

A receiving or treatment facility administrator shall provide prompt written notice of the discharge of a person on involuntary status to the person, guardian, guardian advocate,

Interpretive Guideline

-Use of recommended form "Notice of Release or Discharge" (CF-MH 3038) is considered by the department to be sufficient to document such notice.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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representative, initiating professional, and circuit court, with a copy retained in the person's clinical record. Recommended form CF-MH 3038, "Notice of Release or Discharge," as referenced in paragraph 65E-5.280(7)(c), F.A.C., may be used as documentation of such notice. If the discharge occurs while a court hearing for involuntary placement or continued involuntary placement is pending, all parties including the state attorney and attorney representing the person, shall be given telephonic notice of the discharge by the facility administrator or his or her designee.

ST - BB178 - Transfer/Patient Among Facilities

Title Transfer/Patient Among Facilities

Type Rule

394.4685 FS

Regulation Definition

Transfer of patients among facilities.-

(1) TRANSFER BETWEEN PUBLIC FACILITIES.-

(a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility. A patient who has been admitted to a public treatment facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment or mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. The department shall respond to the request for transfer within 2 working days after receipt of

Interpretive Guideline

- Review policies and procedures to ensure compliance with statutes permitting transfer of patients between receiving and treatment facilities.
 - Sample closed clinical records of patients who have been transferred to confirm prior approval of the patient's transfer by the facility that received the person.
 - Are time lines met? Verify that the transfer to the facility occurred as planned.
- Emergency access to care is also governed by chapter 395, F.S.

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the request by the facility administrator.

(b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.

(2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.-

(a) A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.

(b) A public receiving facility initiating a patient transfer to a licensed hospital for acute care mental health services not accessible through the public receiving facility shall notify the hospital of such transfer and send the hospital all records relating to the emergency psychiatric or medical condition.

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.-

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so

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transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES.-A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

ST - BB179 - Transfer/Patient Among Facilities

Title Transfer/Patient Among Facilities

Type Rule

65E-5.310 FAC

Regulation Definition

Transfer of Persons Among Facilities.

(1) Recommended form CF-MH 3046, Feb. 05, "Application for and Notice of Transfer to Another Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used to request the transfer of a person to another receiving or treatment facility. This application, or its equivalent, shall be completed and filed with the facility administrator or designee. A copy of the completed application shall be retained in the person's clinical record.

(2) The administrator of the facility or designee at which the person resides shall, without delay, submit an application for transfer to the administrator of the facility to which a person has requested transfer. Upon acceptance of the person by the facility to which the transfer is sought, the administrator of the

Interpretive Guideline

- Use of recommended form "Application for and Notice of Transfer to Another Facility" (CF-MH 3046) is considered by the department to be sufficient.
- Use of recommended form "Application for and Notice of Transfer to Another Facility" (CF-MH 3046) is considered by the department to be sufficient for this documentation.
- Use of recommended form "Application for and Notice of Transfer to Another Facility" (CF-MH 3046) will be considered by the department to be sufficient for this purpose.
- Review policies and procedures to ensure that a copy of the patient's clinical record and other relevant documents are transferred with the patient to another facility.
- Review policies and procedures to ensure that patient safety and care during transport is addressed.
- The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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transferring facility or his or her designee shall mail the statutorily required notices to the person, the person's attorney, guardian, guardian advocate or representative, retaining a copy in the person's clinical record. Recommended form CF-MH 3046, "Application for and Notice of Transfer to Another Facility," as referenced in subsection 65E-5.310(1), F.A.C., may be used for this documentation.

(3) If the proposed transfer of a person originates with the administrator of the facility or his or her designee or with the treating physician a notice of transfer is required. The notice shall be completed by the administrator or designee of the transferring facility, after acceptance of the person by the facility to which he or she will be transferred, with copies provided prior to the transfer to those required by law, with a copy retained in the person's clinical record Recommended form CF-MH 3046, "Application for and Notice of Transfer to Another Facility," as referenced in subsection 65E-5.310(1), F.A.C., may be used for this purpose.

(4) All relevant documents including a copy of the person's clinical record, shall be transferred prior to or concurrent with the person to the new facility.

(5) Each facility shall develop and implement policies and procedures for transfer that provide for safety and care during transportation.

ST - BB180 - Involuntary Placement - Documentation

Title Involuntary Placement - Documentation

Type Rule

394.467(6)(e) FS

Regulation Definition

Involuntary inpatient placement.-
(6) HEARING ON INVOLUNTARY INPATIENT
PLACEMENT.-

Interpretive Guideline

If the patient is an involuntary inpatient, review the patient medical record for the required documentation.

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(e) The administrator of the petitioning facility shall provide a copy of the court order and adequate documentation of a patient's mental illness to the administrator of a treatment facility if the patient is ordered for involuntary inpatient placement, whether by civil or criminal court. The documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychiatric nurse, a clinical psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied by adequate orders and documentation.

ST - BB181 - Petition Filed by Receiving/Treating Facility

Title Petition Filed by Receiving/Treating Facility

Type Rule

65E-5.285(1)(b-c) FAC

Regulation Definition

Involuntary Outpatient Placement.

(1) Petition for Involuntary Outpatient Placement.

(b) Petition Filed by Receiving Facility Administrator.

1. If a person is retained involuntarily in a receiving facility, a petition for involuntary outpatient placement must be filed with the circuit court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. Recommended form CF-MH 3130, Feb. 05, "Petition for Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. A copy of the completed petition shall be retained in the person's

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clinical record.

2. A petition filed by a receiving facility administrator shall be filed in the county where the facility is located.

3. The administrator of the receiving facility or a designated department representative shall identify the service provider that will have the responsibility of developing a treatment plan and primary responsibility for service provision under an order for involuntary outpatient placement, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment.

Recommended form CF-MH 3140, Sept. 06, "Designation of Service Provider for Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

4. A treatment plan, complying with the requirements of Section 394.4655, F.S., and this rule, shall be attached to the petition, along with a certification from the service provider that:

- a. The proposed services are available in the person's local community;
- b. There is space available in the program or service for the person;
- c. Funding is available for the program or service;
- d. The service provider agrees to provide those services; and
- e. Proposed services have been deemed to be clinically appropriate by a physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse, as defined in Section 394.455, F.S., who consults with, is employed by, or has a contract with the service provider.

5. Recommended form CF-MH 3145, Sept. 06, "Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement", which is incorporated by reference and may be obtained

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pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for the development of a treatment plan.

6. If the service provider developing a treatment plan, pursuant to involuntary outpatient placement determines the person is in need of services that cannot be proposed due to non-availability of services, funding, a willing provider, or other reason, it shall submit a completed recommended form CF-MH 3150, Feb. 05, "Notice to Department of Children and Families of Non-Filing of Petition for Involuntary Outpatient Placement or Diminished Treatment Plan Due to Non-Availability of Services or Funding," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

7. A copy of the petition for involuntary outpatient placement and the proposed treatment plan shall be provided within 1 working day after filing by the clerk of the court to the respondent, department, guardian or representative, state attorney, and counsel for the respondent. A notice of filing of the petition shall be provided by the clerk of court using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form adopted by the court.

(c) Petition Filed by Treatment Facility Administrator.

1. A petition for involuntary outpatient placement filed by a treatment facility administrator shall be filed prior to the expiration of the involuntary inpatient placement order in the county where the person will be living after discharge from the treatment facility.

2. A copy of form CF-MH 7001, Jan. 98, "State Mental Health Facility Discharge Form," as referenced in subsection 65E-5.1305(1), F.A.C., shall be attached to the petition.

3. The service provider designated by the department that will have primary responsibility for service provision shall provide

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a certification to the court, attached to the petition, that the services recommended in the discharge plan are available in the local community and that the provider agrees to provide those services.

4. The petition shall have attached an individualized treatment or service plan that addresses the needs identified in the discharge plan developed by the treatment facility as represented by form CF-MH 3145, "Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.285(1)(b)5., F.A.C. The plan must have been deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in Section 394.455, F.S.

5. A copy of the petition for involuntary outpatient placement and the proposed treatment plan shall be provided within 1 working day after filing by the clerk of the court to the respondent, department, guardian or representative, state attorney, and counsel for the respondent. A notice of filing of the petition shall be provided by the clerk of court using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other equivalent form adopted by the court.

ST - BB185 - Minors; Admission & Placement

Title Minors; Admission & Placement

Type Rule

394.4785(2) FS

Regulation Definition

Children and adolescents; admission and placement in mental facilities

Interpretive Guideline

Review policies and procedures to confirm compliance with statute.
Review clinical records and also observe where people are sharing common areas to ensure that minors under 14

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(2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending physician or a designee or on-call physician or psychiatric nurse each day and documented in the case record.

years of age are not sharing common areas with adults.

Review clinical records of patients age 14 or older who are sharing a room or ward with an adult to ensure that the placement is documented initially and on a daily basis by the physician as medically necessary.

ST - BB190 - Access/Emergency Svcs. & Care

Title Access/Emergency Svcs. & Care

Type Rule

395.1041(6) FS

Regulation Definition

Access to emergency services and care.-

(6) RIGHTS OF PERSONS BEING TREATED -

A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s.394.463 shall adhere to rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

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ST - BB191 - Emergency Medical Conditions

Title Emergency Medical Conditions

Type Rule

394.463(2)(h) FS

Regulation Definition

(2) INVOLUNTARY EXAMINATION.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.467 the patient may be offered voluntary outpatient or inpatient services, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary services or must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been met.

Interpretive Guideline

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ST - BB193 - Emergency Medical Conditions

Title Emergency Medical Conditions

Type Rule

394.463(2)(i) FS

Regulation Definition

(2) INVOLUNTARY EXAMINATION.-

(i) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a facility and released; or
2. The patient must be transferred to a designated facility in which appropriate medical treatment is available. However, the facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist

Interpretive Guideline

ST - BB194 - Emergency Medical Conditions

Title Emergency Medical Conditions

Type Rule

65E-5.280(4)(a) FAC

Regulation Definition

Involuntary Examination.

(4) Emergency Medical Conditions -

(a) Recommended form CF-MH 3101, Feb. 05, "Hospital Determination that Person Does Not Meet Involuntary Placement Criteria," which is incorporated by reference and

Interpretive Guideline

-Use of recommended form "Emergency Medical Services' Determination that Person Does Not Meet Involuntary Placement Criteria" (CF-MH 3101) is considered by the department to be sufficient.

-The Department of Children and Family Services Forms are also available at <https://eds.myflfamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx>

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may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used to document the results of the examination prescribed in Section 394.463(2)(g), F.S.

ST - BB195 - Emergency Medical Conditions-Policy

Title Emergency Medical Conditions-Policy

Type Rule

65E-5.280(4)(b) FAC

Regulation Definition

Involuntary Examination.
(4) Emergency Medical Conditions - (b) Receiving facilities shall develop policies and procedures that expedite the transfer of persons referred from non-designated hospitals after examination or treatment of an emergency medical condition, within the 12 hours permitted by Section 394.463(2)(h), F.S.

Interpretive Guideline

-Review the policy and procedures for expedited transfer to non-designated hospital after examination

ST - BB196 - UNLAWFUL ACTIVITIES

Title UNLAWFUL ACTIVITIES

Type Rule

394.463(5) FS

Regulation Definition

(5) UNLAWFUL ACTIVITIES RELATING TO EXAMINATION AND TREATMENT; PENALTIES.-
(a) A person may not knowingly and willfully:
1. Furnish false information for the purpose of obtaining emergency or other involuntary admission of another;
2. Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary

Interpretive Guideline

This tag is to only be cited with the person falsifying information is an employee or contactor acting on behalf of the facility.

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procedure of another person under false pretenses; or
3. Cause, or conspire with or assist another to cause, without lawful justification, the denial to any person of any right accorded pursuant to this chapter.

(b) A person who violates this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding \$5,000.

ST - BB197 - Discharge procedures

Title Discharge procedures

Type Rule

394.468(2) FS

Regulation Definition

(2) Discharge planning and procedures for any patient's release from a receiving facility or treatment facility must include and document the patient's needs, and actions to address such needs, for at a minimum:

- (a) Follow-up behavioral health appointments;
- (b) Information on how to obtain prescribed medications; and
- (c) Information pertaining to:
 - 1. Available living arrangements;
 - 2. Transportation; and
- (d) Referral to:
 - 1. Care coordination services. The patient must be referred for care coordination services if the patient meets the criteria as a member of a priority population as determined by the department under s. 394.9082(3)(c) and is in need of such services.
 - 2. Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist.
- (3) During the discharge transition process and while the patient is present unless determined inappropriate by a physician or psychiatric nurse practicing within the framework

Interpretive Guideline

Refer to tags B141, B012, B177, B176.

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of an established protocol with a psychiatrist a receiving facility shall coordinate, face-to-face or through electronic means, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service. The transition process must, at a minimum, include all of the following criteria:

- (a) Implementation of policies and procedures outlining strategies for how the receiving facility will comprehensively address the needs of patients who demonstrate a high use of receiving facility services to avoid or reduce future use of crisis stabilization services. For any such patient, policies and procedures must include, at a minimum, a review of the effectiveness of previous discharge plans created by the facility for the patient, and the new discharge plan must address problems experienced with implementation of previous discharge plans.
- (b) Developing and including in discharge paperwork a personalized crisis prevention plan that identifies stressors, early warning signs or symptoms, and strategies to deal with crisis.
- (c) Requiring a staff member to seek to engage a family member, legal guardian, legal representative, or natural support in discharge planning and meet face to face or through electronic means to review the discharge instructions, including prescribed medications, follow-up appointments, and any other recommended services or follow-up resources, and document the outcome of such meeting.
- (d) When the recommended level of care at discharge is not immediately available to the patient, the receiving facility must, at a minimum, initiate a referral to an appropriate provider to meet the needs of the patient to continue care until the recommended level of care is available.

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ST - BB198 - Peer Specialist - Background Screening

Title Peer Specialist - Background Screening

Type Rule

397.417(4) FS

Regulation Definition

Interpretive Guideline

(4) BACKGROUND SCREENING.-

(a) A peer specialist, or an individual who is working toward certification and providing recovery support services as provided in subsection (3), must have completed or have been lawfully released from confinement, supervision, or any nonmonetary condition imposed by the court for any felony and must undergo a background screening as a condition of initial and continued employment. The applicant must submit a full set of fingerprints to the department or to a vendor, an entity, or an agency that enters into an agreement with the Department of Law Enforcement as provided in s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints 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 national processing. The department shall screen the results to determine if a peer specialist meets certification requirements. The applicant is responsible for all fees charged in connection with state and federal fingerprint processing and retention. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein. Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph shall be retained as provided in s. 435.12 and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's

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national retained fingerprint arrest notification program, as provided in s. 943.05(4). Any arrest record identified must be reported to the department.

ST - BB300 - Definitions

Title Definitions

Type Memo Tag

394.455 FS; 65E-5.100(1-5, 7-16) FAC

Regulation Definition

Interpretive Guideline

394.455 Definitions.-As used in this part, the term:

- (1) "Access center" means a facility that has medical, mental health, and substance abuse professionals to provide emergency screening and evaluation for mental health or substance abuse disorders and may provide transportation to an appropriate facility if an individual is in need of more intensive services.
- (2) "Addictions receiving facility" is a secure, acute care facility that, at a minimum, provides emergency screening, evaluation, detoxification, and stabilization services; is operated 24 hours per day, 7 days per week; and is designated by the department to serve individuals found to have substance abuse impairment who qualify for services under this part.
- (3) "Administrator" means the chief administrative officer of a receiving or treatment facility or his or her designee.
- (4) "Adult" means an individual who is 18 years of age or older or who has had the disability of nonage removed under chapter 743.
- (5) "Clinical psychologist" means a person licensed to practice psychology under chapter 490 , or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.
- (6) "Clinical record" means all parts of the record required to

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be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by facility staff which pertains to the patient ' s hospitalization or treatment.

(7) "Clinical social worker" means a person licensed as a clinical social worker under s. 491.005 or s. 491.006.

(8) "Community facility" means a community service provider that contracts with the department to furnish substance abuse or mental health services under part IV of this chapter.

(9) "Community mental health center or clinic" means a publicly funded, not-for-profit center that contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

(10) "Coordinated specialty care program" means an evidence-based program for individuals who are experiencing the early indications of serious mental illness, especially symptoms of a first psychotic episode, and which includes, but is not limited to, intensive case management, individual or group therapy, supported employment, family education and supports, and the provision of appropriate psychotropic medication as needed.

(11) "Court," unless otherwise specified, means the circuit court

(12) "Department" means the Department of Children and Families.

(13) "Designated receiving facility" means a facility approved by the department which may be a public or private hospital, crisis stabilization unit, or addictions receiving facility; which provides, at a minimum, emergency screening, evaluation, and short-term stabilization for mental health or substance abuse disorders; and which may have an agreement with a corresponding facility for transportation and services.

(14) "Detoxification facility" means a facility licensed to provide detoxification services under chapter 397.

(15) "Electronic means" means a form of telecommunication

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which requires all parties to maintain visual as well as audio communication when being used to conduct an examination by a qualified professional.

(16) "Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(17) "Facility" means any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have or who have been diagnosed as having a mental illness or substance abuse impairment. The term does not include a program or an entity licensed under chapter 400 or chapter 429.

(18) "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward ' s person if the ward is a minor or has been adjudicated incapacitated.

(19) "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment pursuant to this part.

(20) "Hospital" means a hospital licensed under chapter 395 and part II of chapter 408.

(21) "Incapacitated" means that a person has been adjudicated incapacitated pursuant to part V of chapter 744 and a guardian of the person has been appointed.

(22) "Incompetent to consent to treatment" means a state in which a person ' s judgment is so affected by a mental illness or a substance abuse impairment that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment.

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(23) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 to determine whether a person qualifies for involuntary services.

(24) "Involuntary services" means court-ordered outpatient services or inpatient placement for mental health treatment pursuant to s. 394.4655 or s. 394.467.

(25) "Law enforcement officer" has the same meaning as provided in s. 943.10.

(26) "Marriage and family therapist" means a person licensed to practice marriage and family therapy under s. 491.005 or s. 491.006.

(27) "Mental health counselor" means a person licensed to practice mental health counseling under s. 491.005 or s. 491.006.

(28) "Mental health overlay program" means a mobile service that provides an independent examination for voluntary admission and a range of supplemental onsite services to persons with a mental illness in a residential setting such as a nursing home, an assisted living facility, or an adult family-care home or a nonresidential setting such as an adult day care center. Independent examinations provided through a mental health overlay program must only be provided under contract with the department or be attached to a public receiving facility that is also a community mental health center.

(29) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by dementia, traumatic brain injury, antisocial behavior, or substance abuse.

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(30) "Minor" means an individual who is 17 years of age or younger and who has not had the disability of nonage removed pursuant to s. 743.01 or s. 743.015.

(31) "Mobile crisis response service" or "mobile response team" means a nonresidential behavioral health crisis service available 24 hours per day, 7 days per week which provides immediate intensive assessments and interventions, including screening for admission into a mental health receiving facility, an addictions receiving facility, or a detoxification facility, for the purpose of identifying appropriate treatment services.

(32) "Patient" means any person, with or without a co-occurring substance abuse disorder, who is held or accepted for mental health treatment.

(33) "Physician" means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental illness or a physician employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense.

(34) "Physician assistant" means a person licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental disorders.

(35) "Private facility" means a hospital or facility operated by a for-profit or not-for-profit corporation or association which provides mental health or substance abuse services and is not a public facility.

(36) "Psychiatric nurse" means an advanced practice registered nurse licensed under s. 464.012 who has a master's or doctoral degree in psychiatric nursing and holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 1 year of post-master's clinical experience under the supervision of a physician.

(37) "Psychiatrist" means a medical practitioner licensed under chapter 458 or chapter 459 for at least 3 years, inclusive of psychiatric residency.

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(38) "Public facility" means a facility that has contracted with the department to provide mental health services to all persons, regardless of ability to pay, and is receiving state funds for such purpose.

(39) "Qualified professional" means a physician or a physician assistant licensed under chapter 458 or chapter 459; a psychiatrist licensed under chapter 458 or chapter 459; a psychologist as defined in s. 490.003(7); or a psychiatric nurse as defined in this section.

(40) "Receiving facility" means a public or private facility or hospital designated by the department to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. The term does not include a county jail.

(41) "Representative" means a person selected to receive notice of proceedings during the time a patient is held in or admitted to a receiving or treatment facility.

(42) "Restraint" means:

(a) A physical restraint, including any manual method or physical or mechanical device, material, or equipment attached or adjacent to an individual ' s body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one ' s body. "Physical restraint" includes the physical holding of a person during a procedure to forcibly administer psychotropic medication. "Physical restraint" does not include physical devices such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests or for purposes of orthopedic, surgical, or other similar medical treatment when used to provide support for the achievement of functional body position or proper balance or when used to protect a person from falling out of bed.

(b) A drug or medication used to control a person ' s behavior

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or to restrict his or her freedom of movement which is not part of the standard treatment regimen of a person with a diagnosed mental illness.

(43) "Seclusion" means the physical segregation or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this part, the term does not mean isolation due to a person's medical condition or symptoms.

(44) "Secretary" means the Secretary of Children and Families.

(45) "Service provider" means a receiving facility, a facility licensed under chapter 397, a treatment facility, an entity under contract with the department to provide mental health or substance abuse services, a community mental health center or clinic, a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced practice registered nurse, a psychiatric nurse, or a qualified professional as defined in s. 39.01.

(46) "Substance abuse impairment" means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner that a person has lost the power of self-control and has inflicted or is likely to inflict physical harm on himself, herself, or another.

(47) "Telehealth" has the same meaning as provided in s.456.47.

(48) "Transfer evaluation" means the process by which a person who is being considered for placement in a state treatment facility is evaluated for appropriateness of admission to such facility.

(49) "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the

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department for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the department when rendering such services to a person pursuant to the provisions of this part. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the United States Department of Veterans Affairs.

(50) "Triage center" means a facility that has medical, mental health, and substance abuse professionals present or on call to provide emergency screening and evaluation for mental health or substance abuse disorders for individuals transported to the center by a law enforcement officer.

65E-5.100 Definitions.

As used in this chapter the following words and phrases have the following definitions:

- (1) Advance directive means a witnessed written document described in Section 765.101, F.S.
- (2) Assessment means the systematic collection and integrated review of individual-specific data. It is the process by which individual-specific information such as examinations and evaluations are gathered, analyzed, monitored and documented to develop the person ' s individualized plan of treatment and to monitor recovery. Assessment specifically includes efforts to identify the person ' s key medical and psychological needs, competency to consent to treatment, patterns of a co-occurring mental illness and substance abuse, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, and physical or sexual abuse or trauma.
- (3) Certified recovery specialist means an individual credentialed by the Florida Certification Board as a Certified

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Recovery Peer Specialist, Certified Recovery Peer Specialist - Adult, Certified Recovery Peer Specialist - Family, Certified Recovery Peer Specialist - Veteran, or Certified Recovery Support Specialist.

(4) Discharge plan means the plan developed with and by the person which sets forth how the person will meet his or her needs, including living arrangements, transportation, aftercare, physical health, and securing needed psychotropic medications for the post-discharge period of up to 21 days.

(5) Emergency treatment order (ETO) means a written emergency order for psychotropic medications, as described in Rule 65E-5.1703, F.A.C.; or a written emergency order for seclusion or restraint, as described in subsection (7), of Rule 65E-5.180, F.A.C.

(7) Health care proxy means a competent adult who has not been expressly designated by an advance directive to make health care decisions for a particular incapacitated individual, but is authorized pursuant to Section 765.401, F.S., to make health care decisions for such individual.

(8) Health care surrogate means any competent adult expressly designated by a principal ' s advance directive to make health care decisions on behalf of the principal upon the principal ' s incapacity.

(9) Person means an individual of any age, unless statutorily restricted, with a mental illness served in or by a mental health facility or service provider.

(10) Personal Safety Plan is a form used to document information regarding calming strategies that the person identifies as being helpful in avoiding a crisis. The plan also lists triggers that are identified that may signal or lead to agitation or distress.

(11) Pro re nata (PRN) means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the

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circumstances set out in the order. A PRN order shall not be used as an emergency treatment order.

(12) Protective medical devices mean a specific category of medical restraint that includes devices, or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care, such as geri-chairs, posey vests, mittens, belted wheelchairs, sheeting, and bed rails. The requirements for the use and documentation of use of these devices are for specific medical purposes rather than for behavioral control.

(13) Recovery Plan may also be referred to as a "service plan" or "treatment plan." A recovery plan is a written plan developed by the person and his or her recovery team to facilitate achievement of the person's recovery goals. This plan is based on assessment data, identifying the person ' s clinical, rehabilitative and activity service needs, the strategy for meeting those needs, documented treatment goals and objectives, and documented progress in meeting specified goals and objectives.

(14) Recovery Team may also be referred to as "service team" or "treatment team." A recovery team is an assigned group of individuals with specific responsibilities identified on the recovery plan who support and facilitate a person ' s recovery process. Team members may include the person, psychiatrist, guardian/guardian advocate, community case manager, family member, peer specialist and others as determined by the person ' s needs and preferences.

(15) Seclusion and Restraint Oversight Committee is a group of staff members or volunteers that monitors the use of seclusion and restraint in a facility in order to assist in safely reducing the use of these practices. Members are selected by the administrator and include, but are not limited to, the administrator or designee, medical director or a physician designated by the medical director, quality assurance staff, and a certified recovery specialist, if available. If no certified

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recovery specialist is employed by the facility, a volunteer certified recovery specialist may be selected by the administrator.

(16) Standing order means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person.