RESIDENTIAL RECORD GUIDELINES

Prior to Admission:

With the referring agency screen resident to determine if needs can be met without interfering with the needs of current residents.

- Determine if services are within the contracted services and not in violation of the rules applicable to the license.
- Request any/all information pertaining to the resident's history both for medical/physical and mental status is submitted at the time of the intake.
- Evaluate if the new resident will alter the licensed evacuation classification time.
- Plan to adjust the evacuation instructions accordingly, to reflect that evacuation compliance will be met.
- Discuss the house rules and any/all restrictions.

Upon admission:

Complete a resident information face sheet.

- Referral information
- Release of information signed and dated with specific contact information and a time limit effective date e.g. license time period and/or annual to coincide with the Residential Service Plan.
- Admission criteria check list
- Informed consent for the services provided.
- The $ amount for room and board.
- The increase payment policy.
- The refund policy.
- Medication management and/or training on the self-medication option.
- The requirement to follow the agreed upon Residential Service Plan.
- The discharge policy.
- The grievance policy.
- Orientation to the facility and the safety practices to include evacuation routes.
- Discussion of the house rules with verifiable written documentation.
- Review of the residents rights with verifiable written documentation.
- Obtain dated signatures and provide copy to the resident and file the original

- Place written physician orders in file for prescribed medication, dietary supplement, or treatment therapy.
- Request copies of advance directive, letters of guardianship or conservatorship, if applicable.
- Start medication administration record.
- Explain and sign contract with private pay residents and/or representative, place in file.
- Advise the resident whether or not you are a Medicaid provider and document, sign and date money management agreements if this service is requested

After admission:

- Within 24 hours, provide resident orientation to basic fire safety: include showing resident how to respond to fire alarm and how to exit from the home in an emergency.
- Assess resident needs with input from the team: resident, case manager, family, doctor and/or other involved party.
- Develop written personal care plan within 14 days of admission; place in file.
- Document orientation and other discussions

All resident's records must include:

- Initial screening assessment
- General information: name, date of birth, date of admission, relative name and phone numbers, prior living arrangements, social security number, medical insurance numbers, doctor names, case manager name and the mortuary choice
- Medical history information
- Current physicians orders for medication, therapy, treatment, special diet
- Documentation of assignments or nursing delegations, if applicable
- Past six months medical charts
- Guardianship letters and advance care directives, if resident has these forms
- Residential Service Plans that meet the requirements of the Residential Treatment Facility rule
- Signed reports on all significant incidents
- Quarterly minimum unless county requires monthly narrative signed/dated progress reports relating to the personal care plan objectives and changes or significant incidents