

Documentation in Resident Care Records – 711

The administrator must assure that the facility's policies and procedures for ongoing resident care records are implemented and meet the requirements described in Subsections 711.01 through 711.14 of these rules

01. Behavior Management Records. The facility must have behavior management records for residents when applicable. These records must document requirements in Section 225 and Subsection 320.02 of these rules. The records must also include the following:

- a. The date and time a specific behavior was observed;
- b. What interventions were used; and
- c. The effectiveness of the intervention.

02. Complaints. The facility must assure that the individual resident's record documents complaints and grievances, the date received, the investigation, outcome, and the response to the individual who made the complaint or grievance.

03. Involuntary Discharge. The facility's records must maintain documentation of:

- a. The facility's efforts to resolve the situation; and
- b. A copy of the signed and dated notice of discharge.

04. Refusal of Care Consequences. Documented evidence that if the resident refuses care or services, the resident has been informed of the consequences of the refusal and the notification of the resident's physician or authorized provider being notified.

05. Assessments. The resident's uniform assessment, including the admission assessment, and all assessments for the prior eighteen (18) months after the admission to the facility.

06. Negotiated Services Agreement. Signed and dated negotiated services agreements, including the admission Negotiated Service Agreement, and any modification and new agreements for the prior eighteen (18) months.

07. Care Plans. Signed and dated copies of all care plans prepared by outside service agencies, if appropriate, to include who is responsible for the integration of care and services.

08. Care Notes. Care notes that are signed and dated by the person providing the care and services must include:

- a. When the Negotiated Service Agreement is not followed, such as resident refusal, and the facility's response;

b. Delegated nursing tasks, such as treatments, wound care, and assistance with medications;

c. Unusual events such as incidents, reportable incidents, accidents, altercations and the facility's response;

d. Calls to the physician or authorized provider, reason for the call, and the outcome of the call;

e. Notification of the licensed professional nurse of a change in the resident's physical or mental condition; and

f. Notes of care and services provided by outside contract entities, such as nurses, home health, hospice, case managers, psychosocial rehabilitation specialists, or service coordinator.

09. Current List of Medications, Diet and Treatments. A current list of medications, diet, treatments prescribed for the resident which is signed and dated by a physician or authorized provider giving the order.

10. Six Month Review of Medications. Written documentation, signed and dated by the physician or authorized provider documenting their every six (6) month review, for possible dose reduction, of the resident's use of psychotropic or behavioral modifying medications.

11. Medications Not Taken. Documentation of any medication refused by the resident, not given to the resident or not taken by the resident with the reason for the omission.

12. PRN Medication. Documentation of all PRN medication with the reason for taking the medication.

13. Nursing Assessments. Nursing assessments, signed and dated, from the licensed professional nurse documenting the requirements in Section 305 of these rules.

14. Discharge Information. Date of discharge, location to where the resident was discharged, and disposition of the resident's belongings.