RESIDENT CARE POLICY

A. Individual Resident Service Plan

A resident assessment and an individual service plan for providing care, which is based on the assessment, must be completed. The assessment must be completed by the appropriate staff and documented on a form developed by the facility. When a facility is unable to obtain information required for the comprehensive assessment, the facility should document its attempts to obtain the information.

B. Facility shall obtain copy of most recent medical records and/or profile from residents medical and mental health doctor documenting diagnosis and medications.

C. Emergency Care Policy

This policy should be used to instruct staff on the handling of resident emergencies.

D. Resident Notes

1. Observation Notes - This document can be used to document unusual changes in resident's physical, mental and emotional condition.

2. Incident Report - In the event of an accident or injury requiring emergency medical, dental or nursing care, or in the event of apparent death, the personal care facility will describe and document the injury, accident, or illness on a separate report. The report must contain a statement of final disposition and be maintained on file.

3. Reports of Abuse

Any facility staff who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation must report the abuse, neglect, or exploitation. Reports of abuse, neglect, or exploitation are to be made to _____ and must follow the facility's internal policies regarding abuse, neglect, or exploitation.

A. Medication

1. All medication will be locked in a central location. We will make reasonable accommodations for clients that are self administering their medications.

2. Medication Profile Record- Supervision of a resident's medication includes listing on an individual resident's medication profile record the medication name, strength, dosage, amount received, directions for use, route of administration, prescription number, pharmacy name, and the date each medication was issued by the pharmacy.

3. Medication Self-Administration Counseling Form - Residents who self-administer their own medications shall be counseled at least once a month by facility staff to ascertain if the residents continue to be capable of self-administering their medication. A written record of counseling shall be kept by the facility.

4. Medication Disposal - Medication no longer being used by the resident due to: being discontinued by order of physician; resident deceased; or medications passed the expiration date, must be disposed of by a registered pharmacist licensed in the state of Texas.

4. Medication Not Taken - When the facility supervises or administers the medications a written record shall be kept when the resident does not receive or take his/her medications/treatments as prescribed. The documentation shall include the date and time the dose should have been taken and the name and strength of medication missed. This documentation can be on the Observation Notes, on a Medication Refusal Form or on a Monthly Medication Sheet. All of these forms are included in the Optional Section.

5. Controlled Drugs – If facilities store controlled drugs, facility policies and procedures must address the prevention of the diversion of the controlled drugs. [

6. Monthly Medication Sheet - Used to document daily supervision of medication.

7. PRN Medication - This form can be used to document PRN medication.

8. Release of Medications Log and Release of Liability - This form can be when a resident leaves the home for a period of time and the medication is sent with the family.

Release for Medical Information

HIPAA requires healthcare organizations to comply with specific rules regarding privacy regulations in regards to residents' health information. The Release for Medical Information provides for residents and/or their responsible party to allow the facility to release information in regards to residents and release for emergency medical care.

MEDICATION SELF-ADMINISTRATION COUNSELING

Resident's Name:

DATE	TIME	COUNSELING REMARKS

NOTE: Sign after each entry.