Adult Foster Home Resident Records Checklist

This is a guide, to view all current requirements see OAR for Adult Foster Homes rules sets 411-49, 50, 51, and 52 link to State of Oregon: APD-AFH - APD-AFH Laws, Rules and Policies

Prior to admission

- ☐ Conduct and document a screening using the Department's current Adult Foster Home Screening and Assessment and General Information form (SDS0902) to determine if a prospective resident's care needs exceed the license classification of the home. The screening must::
  - ☐ Evaluate the ability of prospective residents to evacuate the home within three minutes along with all occupants of the home.
  - ☐ Determine if licensee and caregivers can meet the needs of the prospective residents in addition to other residents.
  - ☐ Include medication diagnoses, medications, personal care needs, nursing care needs, nutritional needs, activities, lifestyle preferences, and other information, as needed, to assure the prospective resident's care needs shall be met.
- ☐ Provide a signed copy of completed screening to prospective residents and/or their representatives whether they move in or not.
- ☐ Offer private-pay residents the opportunity to have a long-term care assessment. (APD0913)
- ☐ Review:
  - ☐ House Policies;
  - ☐ Residents' Bill of Rights (APD0305A);
  - ☐ Nondiscrimination Policy; and
  - ☐ Residency Agreements: Medicaid OR Private Pay
- ☐ Obtain:
  - ☐ Physician or nurse practitioner orders for any medication, special diet, treatment and/or therapy.
  - ☐ Nursing instruction and delegations OR make arrangements for a qualified relative OR a medical professional (e.g., home health nurse) to perform the nursing tasks until AFH caregivers are trained or delegated as appropriate0

At time of admission

- ☐ Obtain signed copy:
  - ☐ House Policies;
  - ☐ Resident's Bill of Rights;
  - ☐ Nondiscrimination Policy for Resident Signature; and
  - ☐ Residency Agreements: Medicaid OR Private Pay
  - ☐ Licensee or Administrator documented they provided resident or resident's representative with the information developed by the Long-Term Care Ombudsman describing availability and services Omdurman provides.
  - ☐ Offered Resident the Option to Formulate an Advance Directive and Obtain Signature on Verification Form
- ☐ Obtain:
  - ☐ Copies of Guardianship, Conservatorship, Advance Directive for Health Care, Health Care Power of Attorney and Physician's Order for Life Sustaining Treatment (POLST).

After admission

- ☐ **Within 24 hours of arrival**, give resident(s) an orientation on basic fire safety and emergency procedures (APD0342A), including:
  - ☐ How to respond to smoke alarms;
  - ☐ How to participate in an evacuation drill; and
  - ☐ Location of the emergency exits from the home.
- ☐ Assess residents' needs with input from resident, family, case manager, doctor and other involved person. Develop a **care plan within 14 days of admission**. (se0340) or create your own but must contain same information)

All resident records must include

- ☐ Initial Department's Adult Foster Home Screening and Assessment and General Information form and any re-admission Screen and Assessments if the resident was in an inpatient status at another facility (hospital, skilled rehab., etc.)
- ☐ General information: Date of admission, date of birth and prior living arrangement of the resident; names, addresses and phone numbers of relatives, significant persons, case manager and medical providers; and medical insurance number if applicable.
- ☐ For private-pay residents: Retain a signed notice of right to receive a long-term care assessment **and** signed Private Pay Residency Agreement.
- ☐ For Medicaid residents: Retain signed Medicaid Residency Agreement.
- ☐ If the licensee manages or handles a resident's money, keep a detailed record on an expenditure form (APD0713).
- ☐ Medical and legal information:
  - ☐ Medical history;
  - ☐ **Current** physician or nurse practitioner orders for medications, special diet, treatment and therapy;
  - ☐ Written parameter to clarify "as needed" or "P.R.N." orders for medications and treatments;
  - ☐ Nursing instructions, delegations and assessments;
  - ☐ If restraints are deemed necessary.
    - ☐ A written assessment signed by medical professional, which includes:
      - ☐ Documentation of all other alternatives and less restrictive measures tried;
      - ☐ Identification of alternative, less restrictive measures that must be used in
      - ☐ place of the restraint whenever possible;
      - ☐ Written procedural guidance for the correct use of the restraint;
      - ☐ The frequency and procedures for nighttime use, if applicable; and
      - ☐ Dangers and precautions related to the use of the restraint.
    - ☐ Written order from the resident's physician, nurse practitioner or Christian Science practitioner, that includes specific parameters including: type, circumstances, duration of use and procedures for nighttime use; and
    - ☐ Written consent by the resident or resident's legal representative to use the specific type of physical restraint.
  - ☐ Medication administration records (MAR); (APD0812a)
  - ☐ Complete and current care plan, **updated and signed every 6 months or sooner with changes in care needs**;
  - ☐ **Current** copies of Guardianship, Conservatorship, Advance Directive for Health Care, Health Care Power of Attorney and Physician's Order for Life Sustaining Treatment (POLST) documents, as applicable;
  - ☐ Signed **current** copies of the house policies and Residents' Bill of Rights;
  - ☐ Written reports of all incidents related to the health or safety of resident; and
  - ☐ **Weekly narrations** of resident's progress with each entry signed and dated by the person writing them.
  - ☐ Any approved variances for residents.

- Record Rention. Records, inluding any financial records for residents, must be kept for a period of three years from the date the resident left the home.
- Completed medication administration records retained in the resident records for at least the last six months or from the date of admission, whichever is less. (Older records may be stored separately).