

5122-30-23

Facility records.

(A) Each facility shall maintain resident and staff records, including at a minimum:

(1) A roster of the names and ages of all residents, and date of admission. The roster shall be considered part of the client records, and individual residents shall be listed as to their residency status and maintained on the roster for three years post discharge.

(2) For each resident, the facility shall maintain:

(a) A written referral from the referring entity or individual, if applicable, that specifies:

(i) Name, address and telephone number of the referring entity;

(ii) For individuals receiving mental health services, the name, address, and telephone number of the person or entity responsible for the continued provision of mental health services.

(b) Immediately accessible written emergency information, which includes the name and birth date of the resident, current medical information, medications, and the name, address, and phone number of the person(s) to be notified in the event of an emergency.

(c) Class one and class two facilities shall have records of a medical assessment conducted by a qualified healthcare practitioner within twelve months prior to the date of admission. The assessment for a resident of a class two facility shall include, but not be limited to, identifying whether the resident is capable of self-administering medication, and, if assistance is needed, the type of assistance required. No resident shall be admitted to a class two facility unless the resident is capable of self-administering medication with or without assistance;

(d) A copy of the signed resident agreement, in accordance with rule 5122-30-24 of the Administrative Code.

(e) List of current medications, including name, dosage and schedule for the resident to take medications.

(f) List of all current medical diagnoses and allergies, if applicable.

(g) In a class one facility that administers medication, a record of all medications administered.

(h) In a class one or class two facility, a record of all medications self-administered by residents with assistance, to include the date, time and medication self-administered by the resident.

- (i) List of other entities providing services, including, but not limited to physical or behavioral health care, social services, educational services, etc., and phone number and contact person.
 - (j) Personal care services plan for residents of class one and class two facilities, or notation that the resident is not in need of personal care services.
 - (k) Notation of provision of personal care services, including the resident's progress or functional status, in accordance with the following schedule:
 - (i) For residents of a class one facility, at least monthly.
 - (ii) For residents of a class two facility, at least weekly.
 - (3) For each resident with a mental illness or severe mental disability, a copy of the written notification to the board serving the county in which the facility is located of the resident's placement in the facility within seven days of the resident's admission, including date of notification.
 - (4) For each staff, the facility shall maintain:
 - (a) Test results indicating no active tuberculosis.
 - (b) Records of training received.
 - (c) All records and reports verifying compliance with rule 5122-30-20 of the Administrative Code.
 - (d) All records and reports verifying compliance with rule 5122-30-31 of the Administrative Code.
- (B) The facility shall also maintain:
 - (1) Fire and other disaster policies and procedures, including evacuation, emergency contact, etc.
 - (2) Copies of all major unusual incident reports, submitted in accordance with rule 5122-30-16 of the Administrative Code.
 - (3) Records of fire drills.
 - (4) Appropriate financial records which utilize standard basic bookkeeping techniques to document facility income and expenditure. Financial records may be kept off-site at a central business office, but shall be made available at

the facility on request of the Department.

(5) Current fire alarm system testing reports, as applicable.

(6) Current sprinkler system testing reports, as applicable.

(7) Copies of the current department license, and plan(s) of correction, if any.

(8) Copies of required licenses, permits and inspections, including fire, certificate of occupancy when required, and any other permits or inspections when required by this chapter of the Administrative Code, or other federal, state or local law.

(C) Each resident's record shall be stored in a locked area accessible only to staff, to protect and ensure individual resident confidentiality, except that emergency information shall be immediately accessible. An operator or staff shall not disclose or knowingly allow the disclosure of any information regarding a resident, to persons not directly involved in the resident's care and treatment without authorization from the resident or a signed release of information if required, unless authorized by section 5122.31 of the Revised Code or as otherwise permitted by law.

(D) Each staff record shall be stored in a locked area accessible only by individuals permitted by facility policy or state or federal law. Records of staff employed by a class one facility may be maintained at the facility or at another location with other personnel records.

(E) The facility shall maintain a record for each current resident and staff, and for three years post discharge or employee termination. All other facility records shall be maintained for the current and most recent past full licensure cycle.

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CERTIFIED ELECTRONICALLY

Certification

04/05/2017

Date

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