



Trouves Health Care

TITLE:	RESIDENT RECORD	POLICY 4.01
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Authority: [WAC 388.78A.2390, Resident records](#)
[WAC 388.78A.2400, Protection of resident records](#)
[WAC 388.78A.2410, Content of resident records](#)
[WAC 388.78A.2420, Record retention](#)
[RCW 70.129.030, Notice of rights and services](#)

PURPOSE:

This policy outlines the procedures to maintain resident records for quality of care.

SCOPE:

The policy applies to all Trouves employees that use the resident record.

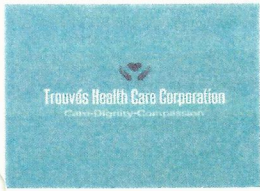
POLICY:

- A. Adequate records concerning the resident are maintained to provide care and services agreed upon with the resident and to respond appropriately in emergency situations.

- B. The records department maintains a current register of all residents, their roommates and identification of rooms in which they reside. In addition, a permanent record is kept of who resided in the facility for the past 5 years including:
 - 1. Move-in date;
 - 2. Full name;
 - 3. Date of birth;
 - 4. Date of moving out;
 - 5. Reason for moving out; and
 - 6. Location and address to which the resident was discharged.

The Trouves makes this register immediately available to:

- 1. Authorized department staff;
- 2. Representatives of the long-term care ombudsman's office; and
- 3. Representatives of the Washington state fire marshal when conducting fire safety inspections.



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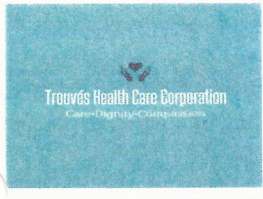
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- C. All resident records are secured in non-resident areas and information is filed in the resident record as outlined in the procedure below.

- D. Resident records are maintained in accordance with confidentiality of applicable state and federal statues and rules, including RCW 70.02 and 70.129. Trouves will:
 - 1. Allow authorized representatives of the department and other authorized regulatory agencies access to resident records;
 - 2. Provide any resident or other individual or organization access to resident records upon written consent of the resident or the resident's representative, unless state or federal law provide for broader access;
 - 3. Allow authorized agents, such as a management company, to use resident records solely for the purpose of providing care and services to residents and ensure that agents do not disclose such records except in a manner consistent with law; and
 - 4. Maintain ownership and control of resident records, except that resident records may be transferred to a subsequent person licensed by the department to operate the assisted living facility.

- E. Record retention includes management of all relevant information and documentation necessary for meeting a resident's current assessed needs.
 - 1. Outdated information that is no longer significant or relevant to the resident's current assessed services and care needs, is maintained in an inactive records stored securely in Trouves medical records office.
 - 2. All closed resident records are stored in the medical records office for six months after the date the resident leaves the facility and at Trouves Health Care corporate office for 5 years after the resident is discharged.
 - 3. All records, active, inactive, and closed, are available for review by the department and other authorized person.
 - 4. If for any reason Trouves ceases to operate as a licensed facility, records will continue to be retained in accordance with the time frame in D. 2.

- F. Resident records are available for resident or resident's representative's request to review within 24 business hours per RCW 70.129.030. Photocopies of records or portions of records will be available within 2 working days. Trouves charges \$.25 a page for photocopies of the record.



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PROCEDURE:

- A. Trouves' resident records include the following:
 - 1. Resident identifying information, including resident's:
 - a. Name;
 - b. Birth date;
 - c. Move-in date; and
 - d. Sleeping room identification.
 - 2. Current name, address, and telephone number of:
 - a. Resident's primary health care provider;
 - b. Resident's representative, if the resident has one;
 - c. Individual(s) to contact in case of emergency, illness or death; and
 - d. Family members or others, if any, the resident requests to be involved in the development or delivery of services for the resident.
 - 3. Resident's written acknowledgment of receipt of:
 - a. Required disclosure information prior to moving into the assisted living facility; and
 - b. Information required by long-term care resident rights per RCW [70.129.030](#).
 - 4. The resident's assessment and reassessment information.
 - 5. Clinical information such as admission weight, height, blood pressure, temperature, blood sugar and other laboratory tests required by the negotiated service agreement.
 - 6. The resident's negotiated service agreement consistent with WAC [388-78A-2140](#).
 - 7. Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.
 - 8. Medical and nursing services provided by Trouves for a resident, including:
 - a. A record of providing medication assistance and medication administration, which contains:
 - i. The medication name, dose, and route of administration;
 - ii. The time and date of any medication assistance or administration;
 - iii. The signature or initials of the person providing any medication assistance or administration; and
 - iv. Documentation of a resident choosing to not take his or her medications.
 - b. A record of any nursing treatments, including the signature or initials of the person providing them.



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9. Documentation consistent with WAC [388-78A-2120](#) Monitoring resident well-being.

10. Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.

11. Notices of and reasons for relocation as specified in RCW [70.129.110](#).

12. The individuals who were notified of a significant change in the resident's condition and the time and date of the notification.

13. When available, a copy of any legal documents in which:

- a. The resident has appointed another individual to make his or her health care, financial, or other decisions;
- b. The resident has created an advance directive or other legal document that establishes a surrogate decision maker in the future and/or provides directions to health care providers; and
- c. A court has established guardianship on behalf of the resident.

EXCEPTIONS:

No exceptions to this policy may be granted without the prior written approval of the Director.

SUPERCEDES:

None