§ 76561. Content of Records.

(a) A record shall be maintained for each client which shall include the following:

(1) Individual program plan.

(2) Report(s) of the preadmission evaluation(s).

(3) Reports of previous histories and evaluations.

(4) The statement of the client's developmental potential and service needs that can be used as a basis for programming and placement potential as required in Section 76313(a)(2).

(5) Drug and treatment orders.

(6) Diet orders.

(7) The comprehensive evaluation and individual program plan designed by an interdisciplinary team as required in Section 76313.

(8) Reports of accidents, seizures, illnesses and immunizations.

(9) Records of all periods of restraint with justification and authorization for each.

(10) Progress notes written by members of the interdisciplinary team at least monthly. In addition, progress notes will be written by members of the other disciplines who are requested to assess the client.

(11) Medications and treatments prescribed and recorded as given.

(12) Annual physical examination.

(13) Temperature, pulse and respiration where indicated.

(14) Reports of all laboratory tests and X-rays ordered.

(15) Discharge summary to include condition, diagnosis and final disposition.

(16) At the time of permanent release or transfer, a summary of findings, progress and plans shall be recorded.

(17) Physician orders, including drug, treatment and diet orders signed on each visit. Physicians' orders recapitulated as appropriate.

(18) Consent forms for prescribed treatment and medication.

(19) An inventory of all client's valuables made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the client or the client's

authorized representative with one copy retained by each. The inventory list shall include but not limited to the following:

(A) Items of jewelry.

(B) Items of furniture.

(C) Radios, televisions and other appliances.

(D) Prosthetic devices.

(E) Other valuable items so identified by the client, client's parents or authorized representative.

(20) Name, dosage and time of administration of drugs, the route of administration if other than oral and site of injection.

(21) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.

(22) Nursing progress notes for specific medical episodes.

(23) Program staff documentations shall include:

(A) A list of the client's problems or needs, as identified from the individual assessment.

(B) The program objectives for resolving problems or meeting needs of the client. These objectives shall be measurable, observable, within time frames and subject to frequent review and updating.

(C) A written plan for meeting the program objectives which shall include, but not be limited to the following:

1. Resources to be used.

2. Frequency of plan review and updating.

3. Persons responsible for carrying out the plan.

4. Evaluation criteria.

(D) A summary of the progress of the client shall be written at least monthly evaluating the program objectives, the success or failure of the plan and any other pertinent information.

(E) Temperature, intake of food and liquid, restraint observation, behavior counts and other similar items shall be recorded in a timely manner using a flow chart or other method which meets the approval of the Department.

(F) Height and weight shall be recorded as required in Section 76323(i) and (j).

(24) The client's admission record.

(b) Daily narrative notes are not required.

Note: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 76561, 22 CA ADC § 76561