California Code Of Regulations
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Title 22@ Social Security
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Division 6@ Licensing of Community Care Facilities
|->
Chapter 2@ Social Rehabilitation Facilities
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Subchapter 1@ Basic Requirements
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Article 6@ Continuing Requirements
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Section 81069@ Client Medical Assessments

CA

81069 Client Medical Assessments

(a)

Prior to admitting a client into care or within 72 hours of admission, the licensee shall obtain and keep on file documentation of the client's medical assessment.

(1) Such assessment shall be performed by a licensed physician, or a designee, who is also a licensed professional, and the assessment shall not be more than one year old when obtained.

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(b)

The licensee of a social rehabilitation facility may accept medical assessments completed by a referring medical or mental health agency; however, the licensee must ensure all information required in Section 81069(f) is contained in the assessment. (1) If some of the information required in Section 81069(f) is not contained in the assessment, it shall be obtained by the licensee within 72 hours of admitting the client into care.

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into care.

(c)

If the licensee is unable to obtain a person's medical assessment prior to admission, the licensee shall ensure that the person is asked to self-report the following information prior to being admitted into care: (1) Any prescription and nonprescription medications currently being taken. (2) Any health-related conditions, including behavioral, that may require immediate attention or monitoring, or that may affect the health and safety of others in the facility. (A) If there is evidence that the person requires immediate health-related services, the licensee shall ensure that the person is referred to the appropriate licensed professional or facility and that a medical assessment is performed.

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(2)

Any health-related conditions, including behavioral, that may require immediate attention or monitoring, or that may affect the health and safety of others in the facility.

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(d)

The information a client provides pursuant to Sections 81069(c) through (c)(2)(A) shall be documented in the client's file. This documentation shall include the date

and time the client was asked to provide the information, and the name of the staff person interviewing the client. Any failure on the part of the client to provide the information shall also be documented and explained in the client's file.

(e)

For the purpose of developing an individual medication-management plan for a client, a licensed medical professional shall determine that a client is able to hold, manage, and safeguard his/her own medications, provided the following conditions are both met: (1) A licensed medical professional shall document any conditions that they recommend be part of the individual medication-management plan for the client pursuant to Sections 81075(o) and (p). (2) A licensed medical professional shall document that the client's medications do not need to be centrally stored pursuant to Section 81075(j).

(1)

A licensed medical professional shall document any conditions that they recommend be part of the individual medication-management plan for the client pursuant to Sections 81075(o) and (p).

(2)

A licensed medical professional shall document that the client's medications do not need to be centrally stored pursuant to Section 81075(j).

(f)

The medical assessment shall include the following: (1) The results of an examination for communicable tuberculosis and other contagious/ infectious diseases. (2) Identification of the client's special problems and needs, including any needs identified as a result of any medical information contained in the medical assessment. (3) A record of all prescribed and over-the counter medications being taken by the client. (4) A determination of the client's

ambulatory status, as defined in Section 81001(n)(2). (5) Identification of physical restrictions, including any medically necessary diet restrictions, to determine the client's capacity to participate in the licensee's program. (6) A physical examination of the person, indicating the physician's primary diagnosis and secondary diagnosis, if any. (7) Identification of other medical conditions, including those described in Section 81092, which are restricted, and in Section 81091, which would preclude care of the person by the licensee. (8) Documentation of prior medical services and history. (9) Current medical status including, but not limited to, height, weight, and blood pressure. (10) Identification of the client's needs as a result of any medical information contained in the report.

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A record of all prescribed and over-the counter medications being taken by the client.

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A determination of the client's ambulatory status, as defined in Section 81001(n)(2).

(5)

Identification of physical restrictions, including any medically necessary diet restrictions, to determine the client's capacity to participate in the licensee's program.

(6)

A physical examination of the person, indicating the physician's primary diagnosis and secondary diagnosis, if any.

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Identification of other medical conditions, including those described in Section 81092, which are restricted, and in Section 81091, which would preclude care of the person by the licensee.

(8)

Documentation of prior medical services and history.

(9)

Current medical status including, but not limited to, height, weight, and blood pressure.

(10)

Identification of the client's needs as a result of any medical information contained in the report.

(g)

The licensing agency shall have the authority to require the licensee to obtain a current written medical assessment, if such an assessment is necessary to verify the appropriateness of a client's placement.