§ 76927. Content of Unit Client Record.

(a) Each unit client record shall contain all information necessary to develop and evaluate the individual service plan; to document the client's progress and response to the plan; and, to protect the legal rights of the client, the staff and the facility.

(b) The unit client record contents shall be completed promptly at the conclusion of each required service or professional visit or as specified elsewhere in these regulations.

(1) Verbal orders shall be signed by the prescriber as specified in Section 76896(d)(2).

(2) Discharged unit client records shall be completed within thirty days.

(c) All entries in the unit client record shall be authenticated with the author's name, professional or job title, and the date and time of the entry.

(d) All entries and reports in the unit client record shall be permanent and capable of being photocopied. Entries shall be legibly handwritten, typewritten or electronically recorded.

(e) The unit client record shall contain:

(1) Admission record as required by Section 76926.

(2) Evidence of orientation to the facility as required by Section 76865(h).

(3) Client assessments as follows:

(A) Initial identification of current level of needs and functions as required by Section 76857(a)(11)(A).

(B) Medical, social and psychological evaluations as required by Section 76915(a)(2).

(C) Review and update of initial assessments as required by Section 76859(a)(1).

(D) Interdisciplinary team/staff assessment as required by Section 76859(a)(2).

(E) Nursing evaluation/assessment of health status as required by Section 76875(c).

(F) Assessment of bowel and bladder functions as required by Section 76865(n)(1).

(G) Recreational interests as required by Section 76859(c).

(H) Assessment of behavior, if applicable, as required by Section 76869(c)(2).

(I) Nutritional status, if food is refused, as required by Section 76882(b)(4).

(4) Physical examination as required by Section 76878(b)(2)(A) and (B).

(5) Dental examination as required by Section 76880(a).

(6) Integrated and coordinated individual service plan developed by the interdisciplinary team/staff with input from direct care staff. It shall contain elements as required by Section 76860(a)(1) through (4).

(7) Recreational activity plan as required by Section 76863(c).

(8) Health care plan as required by Section 76875(a)(2).

(9) Measures to prevent decubitus ulcers, contractures, and deformities as required by Section 76865(1).

(10) Bowel and bladder training plan, if applicable, as required by Section 76865(n)(2).

(11) Behavior management plan, if applicable, as required by Section 76869(c)(3)(4).

(12) Discharge plan, when anticipated, as required by Section 76860(a)(9).

(13) Review and update of the individual service plan as required by Sections 76857(a)(11)(C), 76875(a)(3), and 76858(b)(3).

(14) Progress notes as required by Sections 76860(a)(8), 76865(n)(3), 76869(c)(5)(A) through (D), 76867(d), 76874(e), and 76880(e).

(15) Notification of medication errors and adverse reactions to the practitioner who ordered the drug as required by Section 76876(h).

(16) Dental records as required by Sections 76880(e), and 76880(b)(2).

(17) Medication history as required by Section 76894(a)(4).

(18) All diagnostic and therapeutic prescriptions including diet and medications, as required by Sections 76874(e), 76864(b), and 76867(a).

(19) Medication and treatment administration records as required by Sections 76876(b), 76874(b)(3) and 76874(b)(4).

(20) Weight and height records as required by Sections 76865(i) and 76865(j).

(21) Vital signs and other flow sheet records, if ordered.

(22) Restraint records as required by Section 76868(a)(2) and (3).

(23) Developmental, medical and psychiatric diagnoses comprised of all admitting, concurrent and discharge conditions, including allergies.

(24) Discharge summary of treatment, including goals achieved and not achieved, and health care treatment prepared by the responsible practitioner(s).

(25) Consent(s) to treatment.

(26) 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 be 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.

Note: Authority cited: Sections 208.4 and 1267.7, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 76927, 22 CA ADC § 76927