

**CHILDREN'S RESIDENTIAL SERVICE
RESIDENT RECORDS REVIEW FORM**

FACILITY NAME: _____ DATE: _____

REVIEWED BY: _____ NUMBER OF RESIDENT'S: _____

OF CURRENT RESIDENT RECORDS REVIEWED: _____ # NUMBER OF FORMER RESIDENT RECORDS REVIEWED: _____

Standard	RESIDENT RECORDS	R1	R2	R3	R4	R5	R6	R7
§625	Children shall only be accepted by court order or a signed placement agreement							
§640.B	Facility shall accept and serve only those children whose needs are compatible with the services provided							
§660.A	A separate written or automated case record shall be maintained for each resident. A separate health record may be maintained on each resident							
§660.B	Each case record and health record shall be kept up to date and in a uniform manner							
§660.F	Each resident's written case and health records shall be stored separately subsequent to the resident's discharge							
§660.G	Written and automated records shall be stored in their entirety for a minimum of three years after discharge							
§660.H	Face sheet maintained permanently							
§680.A	Documentation of prior approval of the administrator of the Virginia Interstate compact shall be retained in the record of each resident admitted from outside the state of Virginia							
§680.B	Documentation that the provider has sent copies of all serious incident reports regarding any child placed through the Interstate Compact to the Administrator of the Virginia Interstate Compact, shall be kept in the record							
§680.C	No later than five days after a resident has been transferred to another facility operated by the same sponsor, the record shall contain documentation that the Administrator of the Virginia Interstate Compact was notified in writing of the transfer							
§710.A	Admission shall be based on evaluation of an application for admission							
§710.B.1	Application for admission addresses the educational needs of the resident							
§710.B.2	The mental health, emotional & psychological needs of the resident							

§710.B.3	The physical health needs, including immunization needs								
§710.B.4	The protection needs of the resident								
§710.B.5	The suitability of the resident's admission								
§710.B.5	The behavioral support needs of the resident								
§710.B.6	Information necessary to develop a service plan								
§710.C	Resident's record shall contain a completed application for admission at the time of admission or within 30 days following an emergency admission								
§720.A.1	The placement agreement authorizes the resident's placement								
§720.A.2	Addresses the acquisition of and consent for any needed medical treatment								
§720.A.3	The rights and responsibilities of each party								
§720.A.4	Addresses financial responsibility								
§720.A.5	Addresses the educational plan for the resident								
§720.B	Each resident's record shall contain, prior to a routine admission, a completed placement agreement signed by the facility representative, legal guardian and placing agency								
§720.C	The record of each person admitted based upon court order shall contain a copy of the court order								
§730.A	At the time of admission each resident's record shall contain a face sheet that contains (i) resident's full name, last known residence, birth date, birth place, gender, race, social security number or other unique identifier, religious preference, admission date and (ii) names, addresses and telephone numbers of legal guardians, placing agency, emergency contacts, and parents, if appropriate								
§730.B	Information shall be updated when changes occur								
§730.C	Face sheet for pregnant teens shall include expected delivery date and name of the hospital to provide delivery services								
§730.D	The face sheet of resident's transferred to facilities operated by the same sponsor shall include the address and dates of placement and transfer at each location								
§730.E.1	At the time of discharge the following information shall be added to the face sheet: Date of discharge								
§730.E.2	Reason for discharge								
§730.E.4	Names and addresses of persons the resident was discharged to								
§730.E.4	Forwarding address of resident, if known								
§740	Within three days following admission, individualized, measurable objectives and strategies for the first 30 days shall be developed. These shall be based on the reasons for the resident admission								
§750.A	An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter								
§750.B.1	ISP's shall describe in measurable terms the: strengths and needs of the resident								
§750.B.2	Resident's current level of functioning								

§750.B.3	Goals, objectives and strategies established for the resident								
§750.B.4	Projected family involvement								
§750.B.5	Projected date for accomplishing each objective								
§750.B.6	Status of discharge planning and estimated length of stay								
§750.C	The initial ISP shall be reviewed within 60 days of the initial plan and each 90 day period thereafter and revised as necessary								
§750.E.1	There shall be a documented quarterly review of each resident's progress 60 days following the initial ISP and within each 90 day period thereafter. The report shall contain: The resident's progress toward meeting the plans objectives								
§750.E.2	Family involvement								
§750.E.3	Continuing needs								
§750.E.4	Resident's progress toward discharge								
§750.E.5	Status of discharge planning								
§750.F	Each plan and quarterly update shall include the date it was developed and the signature of the person who developed it								
§750.H.1	There shall be documentation showing the involvement of the following parties in developing and updating the ISP and quarterly progress reports: The resident								
§750.H.2	The resident's family, if appropriate, and legal guardian								
§750.H.3	The placing agency								
§750.H.4	Facility staff								
§750.I	The initial ISP and all quarterly progress reports shall be distributed to the resident, resident's family, legal guardian, placing agency and appropriate facility staff								
§760.A.1	Except when transfer is ordered by the court, the receiving facility shall document at the time of transfer: preparation through sharing information with the resident, resident's family and placing agency about the facility, staff, population served, activities and criteria for admission								
§760.A.2	Notification to the family, if appropriate, the resident, the placing agency and legal guardian								
§760.A.3	Receipt from the sending facility of a written summary of the resident's progress, justification for the transfer, and the resident's strengths and needs								
§760.A.4	Receipt of the resident's record								
§765.C	The record of each resident discharged upon receipt of a court order shall contain a copy of the court order								
§765.G.1	Unless discharge is ordered by the court, prior to the planned discharge date, each resident's record will contain: Documentation that the discharge was planned and discussed with the parent, legal guardian, placing agency and resident,								
§765.G.2	A written discharge plan								

§765.H.1	No later than 30 days after discharge a comprehensive discharge summary shall be placed in the resident's record and sent to the placing agency making the placement.								
§765.H.1.a	The summary shall include: Services provided to the resident								
§765.H.1.b	Resident's progress in meeting service plan objectives								
§765.H.1.c	Resident's continuing needs and recommendations for further services								
§765.H.1.d	Reasons for discharge and names of person discharged to								
§765.H.1.e	Dates of admission and discharge								
§765.H.1.f	Date the discharge summary was prepared and the signature of who prepared it								
§780.B	The provision of Case Management Services shall be documented in the resident's record								
§800.D	Health and dental complaints and injuries shall be recorded and shall include: the resident's name, complaint, and affected area and (ii) time of the complaint								
§810.B.1	The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: The Name, address and phone number of the physician to be notified								
§810.B.2	The Name, address and phone number of a relative or other person to be notified								
§810.B.3	Medical insurance company name and policy number								
§810.B.4.a	Information concerning: Use of medications								
§810.B.4.b	All allergies, including medication allergies								
§810.B.4.c	Substance abuse and use								
§810.B.4.d	Significant past and present medical problems								
§810.B.5	Written permission for emergency medical care, dental care and obtaining immunizations								
§840.A	Physical examination no earlier than 90 days prior to admission or 7 days following admission, except that if a child transfers from one licensed facility to another within the previous 12 months shall be acceptable. A physical examination shall be required, if none is available for each emergency admission, within 30 days								
§840.B	Within 7 days of placement each resident shall have had a screening assessment for TB as evidenced by completion of a screening form, containing at a minimum the current screening form published by the Department of Health. The screening assessment can be no older than 30 days								
§840.C	A screening assessment for TB shall be completed annually as evidenced by completion of a screening form, containing at a minimum the current screening form published by the Department of Health								
§840.D	Each resident's health record shall include documentation of (i) the initial physical examination (ii) an annual physical examination, by or under the direction of a licensed physician, including recommendations for follow-up care (iii) documentation of the provision of follow-up medical care recommended by the physician or as indicated by the needs of the resident								

§840.E.1.a	Each physical examination report shall include: Information necessary to determine the health and immunization needs of the resident, including immunizations administered at the time of the exam								
§840.E.1.b	Vision exam								
§840.E.1.c	Hearing exam								
§840.E.1.d	General physical condition, including documentation of apparent freedom from communicable disease, including TB								
§840.E.1.e	Allergies, chronic conditions, handicaps								
§840.E.1.f	Nutritional requirements, including special diets								
§840.E.1.g	Restrictions on physical activities, if any								
§840.E.1.h	Recommendations for further treatment, immunizations or other examinations indicated								
§840.E.2	Date of the physical examination								
§840.E.3	Signature of a licensed physician, the physician's designee or an official from the health department								
§840.G	Each resident's health record shall include written documentation of (i) an annual examination by a licensed dentist and (ii) documentation of follow-up dental care recommended by the dentist or indicated by the needs of the resident.								
§840.H	Each resident's health record shall include notations of health and dental complaints and injuries and shall summarize symptoms and treatment given								
§840.I	Each resident's health record shall include or document the facilities efforts to obtain, treatment summaries of ongoing psychiatric or other mental health treatment and reports, if applicable								
§850.E	Medication prescribed by a person authorized by law shall be administered as prescribed								
§850.F.1	A medication administration record shall be maintained of all medicines received by each resident and shall include: The date the medication was prescribed								
§850.F.2	Drug name								
§850.F.3	Schedule for administration								
§850.F.4	Strength								
§850.F.5	Route								
§850.F.6	Identity of the individual who administered the medication								
§850.F.7	Dates the medication was discontinued or changed								
§850.H	Medication refusals shall be documented including actions taken by staff								
§900.A.1	Within 30 days of admission the provider shall develop and implement a written behavior support plan that allows the resident to self-manage their behaviors. Each individualized plan shall include: Identification of positive and problem behaviors								
§900.A.2	Identification of triggers for behaviors								
§900.A.3	Identification for successful intervention strategies for problem behavior								
§900.A.4	Techniques for managing anger and anxiety								

§900.A.5	Identification of interventions that may escalate inappropriate behavior								
§900.B.1	Individualized behavior support plans shall be developed in consultation with: The resident								
§900.B.2	Legal guardian								
§900.B.3	Resident's parents, if applicable								
§900.B.4	Program director								
§900.B.5	Placing agency staff								
§900.B.6	Other applicable individuals								
§910.D	Time Out: Staff shall check on the resident in time out at least every fifteen minutes, or more depending upon the resident's disability, condition and behavior								
§910.E	Use of timeout and staff checks on residents shall be documented								
§940.E	All physical restraints shall be reviewed and evaluated to plan for continued staff development for performance improvement								
§940.I.1	Each application of physical restraint shall be fully documented in the resident's record including: Date								
§940.L.2	Time								
§940.L.3	Staff involved								
§940.L.4	Justification for the restraint								
§940.L.5	Less restrictive measures that were unsuccessfully tried prior to using physical restraint								
§940.L.6	Duration								
§940.L.7	Description of method or methods used								
§940.L.8	Signature of person completing the report and date								
§940.L.9	Reviewers signature and date								
§970.A	Each resident of compulsory school attendance shall be enrolled in an appropriate educational program within school business days								
§970.D	When a child with a disability has been placed in a residential facility the facility shall contact the division superintendent of the resident's home locality. Documentation of this contact shall be kept in the resident's record								
§990.D	All overnight out of state or out of country recreational trips require written permission from each resident's legal guardian. Documentation of the written permission shall be kept in the resident's record								
§1000.A	Opportunities shall be provided for residents to participate in activities and utilize resources in the community								
§1010.A	Provision shall be made for each resident to have an adequate supply of clean, comfortable, and well-fitting clothes and shoes for indoor and outdoor wear								
§1010.C	Residents shall have the opportunity to participate in the selection of their clothing								

§1020.A	The provider shall provide opportunities appropriate to the ages and developmental levels of residents for learning the value and use of money								
§1020.D	A resident's funds, including allowances or earnings, shall be used for the resident's benefit								
§1030.A	Assignment of chores, that are paid or unpaid work assignments shall be in accordance with the age, health, ability and service plan of the resident								
§1070.A	Any serious incident, accident or injury to the resident, any overnight absence from the facility without permission, any runaway and any other unexplained absence from the facility shall be reported within 24 hours to (i) placing agency (ii) parent or legal guardian (iii) noted in the resident's record								
§1070.B.1	The provider shall document the following: the date and time the incident occurred								
§1070.B.2	A brief description of the incident								
§1070.B.3	The action taken as a result of the incident								
§1070.B.4	The name of the person who completed the report								
§1070.B.5	The name of the person who made the report to the placing agency and to the parents and/or legal guardian								
§1070.B.6	The name of the person to whom the report was made								
§1070.C	The provider shall notify the regulatory authority within 24 hours of any serious injury or death of a resident, and all other situations required by regulatory authority. Such reports shall include:								
§1070.C.1	The provider shall document the following: the date and time the incident occurred								
§1070.C.2	A brief description of the incident								
§1070.C.3	The action taken as a result of the incident								
§1070.C.4	The name of the person who completed the report								
§1070.C.5	The name of the person who made the report to the placing agency and to the parents and/or legal guardian								
§1070.C.6	The name of the person to whom the report was made								
§1080.B	Any case of suspected child abuse or neglect shall be reported to the local CPS unit								
§1080.D.1	When a case of suspected child abuse or neglect is reported to CPS, the resident's record shall include: The date and time the suspected abuse or neglect occurred								
§1080.D.2	A description of the suspected abuse or neglect								
§1080.D.3	Action taken as a result of the suspected abuse or neglect								
§1080.D.4	The name of the person to whom the report was made at the local CPS								
INDEPENDENT LIVING PROGRAMS									
§1120.B	Within 14 days of placement the provider must complete an assessment, including strengths and needs, of the resident's life skills using an independent living assessment tool approved by the regulatory authority. The assessment must cover the following areas:								
§1120.B.1	Money management and consumer awareness								

§1120.B.2	Food management								
§1120.B.3	Personal appearance								
§1120.B.4	Social skills								
§1120.B.5	Health/sexuality								
§1120.B.6	Housekeeping								
§1120.B.7	Transportation								
§1120.B.8	Educational planning/career planning								
§1120.B.9	Job seeking skills								
§1120.B.10	Job maintenance skills								
§1120.B.11	Emergency and safety skills								
§1120.B.12	Knowledge of community resources								
§1120.B.13	Interpersonal skills/social relationships								
§1120.B.14	Legal skills								
§1120.B.15	Leisure activities								
§1120.B.16	Housing								
§1120.C	The resident's ISP shall include in addition to the requirements found in 22 VAC 42-11-630, goals, objectives and strategies addressing each of the following areas, as applicable								
§1120.C.1	Money management and consumer awareness								
§1120.C.2	Food management								
§1120.C.3	Personal appearance								
§1120.C.4	Social skills								
§1120.C.5	Health/sexuality								
§1120.C.6	Housekeeping								
§1120.C.7	Transportation								
§1120.C.8	Educational planning/career planning								
§1120.C.9	Job seeking skills								
§1120.C.10	Job maintenance skills								
§1120.C.11	Emergency and safety skills								
§1120.C.12	Knowledge of community resources								
§1120.C.13	Interpersonal skills/social relationships								
§1120.B.14	Legal skills								
§1120.B.15	Leisure activities								
§1120.B.16	Housing								