**Policy**

## The following is used as a guide for the type of documents that are filed in the folders in the “Resident Documents” section of the patient’s electronic medical record.

## Accounts Receivable

# Bed hold

# All notices of non-coverage (ABNs)

# KePro determinations to appeals

# Medicaid cards

# Level of care (9401 for Medicaid)

# PASARR (7000)

# **Admission Agreements and Addendums**

1. Admission agreement/contract
2. Application for residency
3. Personal account authorizations, mail authorizations, etc.

**Advance Directives**

1. Power of Attorney for healthcare, financial, dual
2. Living Will
3. Ohio DNR

**Assessments**

1. 20 Minute Safety Checks
2. Elopement risk
3. Toileting and TIAN plans, programs and assessments
4. MMSE
5. Personal inventory

**Audits**

1. Five-day admission audits
2. Other audits

**Case Manager Documents**

1. Insurance Updates
2. Optum Notes

**Consults/Referrals**

1. All outside consults (specialists, etc.)
2. All ancillary visits (eye, ear, podiatry, dental, etc.)
3. Dialysis paperwork
4. Psych notes and consults
5. Referral reports and documents
6. Wound care consultants

**Dietary**

1. Fluid Restrictions
2. Liability Waivers

**Discharge Documents**

1. Mortician Receipt
2. Other discharge papers
3. Transfer/Discharge Form

**Financial Disclosure**

1. Financial disclosure documents

**Flowsheets**

1. eMAR Offline Report
2. MAR and TAR
3. Narcotic sheets
4. Aide Flowsheets

**History and Physical**

1. For doctors that don’t use Matrix for their H&P and either use another system or still hand write it

**Hospice**

1. All hospice documentation: Election of Benefits (signed by the resident/family), Notes, Care Plan, etc.

**Hospital Paperwork**

1. All records sent from the hospital after an inpatient stay, outpatient procedure, emergency room visit
2. Nurse to nurse report

**Insurance Cards/Verification**

1. Copies of Medicare, social security and insurance cards
2. Eligibility check
3. MSP form
4. Insurance questionnaire
5. Insurance authorizations/insurance certifications
6. Sexual Offender Check

**Lab**

1. Laboratory results
2. Immunizations records

**Medicare Certifications and Recertifications**

1. SNF certifications
2. Therapy certifications

**Medications (Not to be used after 3/28/19)**

**Orders**

1. Prescriptions
2. Orders for outpatient therapy, procedures, etc.
3. Handwritten doctor’s, NP and PA orders
4. Orders for DME, prosthetics, etc.

**Other** (**Not to be used after 4/4/13**)

1. Other forms with no category prior to 4/4/2013
2. Anything in “Resident Forms” prior to 4/4/2013

**Pharmacy Reviews**

1. Pharmacy consult reviews and reports
2. Pharmacy recommendations: formulary changes, drug interaction information
3. Pharmacy non-covered reports

**Plan of Care (Not to be used after 3/28/19)**

**Progress Notes (Previously called Resident Notes)**

1. Physician notes
2. Agency nurse notes – AL only
3. Downtime progress notes

**Qualified Income Trust (different from Resident Trust Documents folder)**

1. All documents related to the resident’s trust fund (used to be personal use accounts)

**Radiology**

1. X-ray, CT, MRI, Doppler, ultrasound, PET scan, etc.

**Record Requests**

1. Record requests

**Rehab/Restorative Documents (previously “Rehab”, contains all Rehab documents attached prior**

**to 4/4/13)**

1. Handwritten therapy documentation
2. Handwritten restorative documentation
3. Therapy logs

**Resident Trust Documents**

1. All resident bank trust fund documents (does not include qualified income trust documents)

**Therapy Documentation**

1. OT Daily Notes
2. OT Weekly Notes
3. OT Evaluation
4. OT Discharge Evaluation
5. PT Daily Notes
6. PT Weekly Notes
7. PT Evaluation
8. PT Discharge Evaluation
9. SLP Daily Notes
10. SLP Weekly Notes
11. SLP Evaluation
12. SLP Discharge Evaluation
13. Import/Other (therapy logs)