**Section 370.1210 General**

a) An active record shall be kept for each resident. This record shall be kept current, dated, signed, complete, legible, and available at all times to the appropriate personnel of the facility and to the representatives of the Department and the Illinois Department of Mental Health and Developmental Disabilities. Each resident shall be evaluated by the facility's staff and an individual habilitation plan developed within fifteen (15) days of admission to the facility. Such evaluation shall include a written entry in the resident's permanent record regarding present work or training assignment outside the facility, social and vocational training program goals within the facility and probable length of stay needed in the facility to accomplish independent living goals.

b) Each resident's record shall be written in ink or typed, and each entry shall be dated and signed. The record shall include the following:

1) Identification sheet(s) and/or admission form(s) including resident's name, social security number, marital status, birthdate, age, birthplace, sex, home address, and religion; name, address and telephone number of referral agency, personal physician; next of kin or other responsible person.

2)

A) A statement that the resident is free of communicable diseases, including active tuberculosis. It shall be signed and dated by the physician. This shall be completed within one (1) month prior to, or within seventy-two (72) hours after admission.

B) Any additional information pertaining to the resident's medical and personal history that may be helpful in the management of the resident shall be included.

3) Results of an examination by a psychologist determining mental and functional level completed within the last year. If a current psychological evaluation is unavailable, the staff psychologist shall make such an evaluation within fifteen (15) days of the resident's admission.

4) Progress record towards goals documented a minimum of at least once monthly.

5) A full written report on any serious incident or accident involving a resident while on the premises. This report shall include the date and time of each incident or accident and the action taken concerning it. These incidents and accidents shall include medication errors and drug reactions and all situations requiring the emergency services of a physician, a hospital, the police, the fire department, the coroner, etc. The Department shall be notified by a phone call to the Regional Office of all such incidents or accidents. Such notification shall be made within twenty-four (24) hours of their occurrence. A written copy of this report shall be sent to the Department within seven (7) days of such incident or accident.

6) Consultants shall make written reports of their findings and recommendations at the time of each visit. These shall be included in the resident's progress record if concerned with an individual resident.

7) Discharge information shall be recorded within seventy-two (72) hours after the resident leaves the facility. This shall indicate the date, time, condition of the resident, to whom released and where going (home, another facility, etc.). This information may be part of the admission record form.