STANDARD OPERATING PROCEDURE

# Resident Admission SOP

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| **Document no.** | SOP-SNR-001 |
| **Revision** | 1.0 |
| **Owner** | Director of Nursing |
| **Effective date** | September 15, 2026 |
| **Review cycle** | Every 12 months |

## 1. Purpose

To admit each new resident smoothly and safely, gather accurate baseline information, and put an initial care plan in place before the first shift change.

## 2. Scope

Applies to planned admissions of new residents into assisted living or skilled nursing care. Emergency or hospital transfer readmissions are covered by a separate procedure.

### Definitions

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| **Baseline assessment** | The initial evaluation of a resident's physical, cognitive and functional status completed at admission. |
| **Care plan** | A written plan describing a resident's needs and the specific tasks staff will perform to meet them, reviewed and updated regularly. |
| **Responsible party** | The family member or legal representative authorized to make decisions on behalf of the resident when needed. |

## 3. Responsibilities

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| **Admissions Coordinator** | Collects intake paperwork, verifies insurance or payment source and coordinates the move-in day schedule. |
| **Registered Nurse (RN)** | Completes the baseline assessment, reconciles medications and builds the initial care plan. |
| **Certified Nursing Assistant (CNA)** | Assists the resident with settling into their room and reports observations from the first shift. |
| **Family Member / Responsible Party** | Provides history, belongings and signs required admission documents. |

### RACI matrix

| Activity | Admissions Coordinator | Registered Nurse (RN) | Certified Nursing Assistant (CNA) | Family Member / Responsible Party |
|---|---|---|---|---|
| Collect intake paperwork and verify payment source | R/A | I | - | R |
| Complete the baseline assessment | I | R/A | C | C |

| Activity | Admissions Coordinator | Registered Nurse (RN) | Certified Nursing Assistant (CNA) | Family Member / Responsible Party |
|---|---|---|---|---|
| Build the initial care plan | I | R/A | I | I |
| Settle the resident into their room | I | I | R/A | C |

R = Responsible, A = Accountable, C = Consulted, I = Informed

## 4. Materials and PPE

### Materials, tools and systems

- Admission agreement and consent forms
- Baseline assessment tool in the EHR or paper chart
- Medication reconciliation form
- Room readiness checklist
- Emergency contact and responsible party form

### Personal protective equipment

- Disposable gloves for the physical assessment

## 5. Procedure

| Step | Task | Owner | Done |
|---|---|---|---|
| 5.1 | **Confirm the room is ready**<br>Confirm the assigned room is clean, equipped with any needed mobility or safety equipment, and labeled with the resident's name before arrival. | Admissions Coordinator | ☐ |
| 5.2 | **Greet the resident and family**<br>Greet the resident and family warmly on arrival, introduce the care team members present, and orient them to the immediate area. | Admissions Coordinator | ☐ |
| 5.3 | **Collect and verify admission paperwork**<br>Collect the signed admission agreement, consent forms, insurance or payment information and emergency contact details, and confirm the responsible party's authority.<br>**Checkpoint:** All required consent and financial forms are signed and verified before the baseline assessment begins. | Admissions Coordinator | ☐ |
| 5.4 | **Review medical history and recent records**<br>Review hospital discharge summaries, physician orders and recent medical history provided by the family or transferring facility. | Registered Nurse (RN) | ☐ |
| 5.5 | **Reconcile medications**<br>Compare the medication list from the transferring facility or family against current physician orders and resolve any discrepancy before the first scheduled dose.<br>**Warning:** Do not administer a medication until any discrepancy between the transfer record and the physician's order is resolved. | Registered Nurse (RN) | ☐ |
| 5.6 | **Complete the baseline assessment**<br>Assess the resident's physical condition, mobility, cognitive status, skin integrity and nutritional needs using the facility's standard assessment tool.<br>**Checkpoint:** The baseline assessment, including a skin check, is completed and documented on the day of admission. | Registered Nurse (RN) | ☐ |

| Step | Task | Owner | Done |
|---|---|---|---|
| 5.7 | **Identify immediate risks**<br>Identify fall risk, elopement risk, allergies and any urgent care needs from the assessment, and communicate them to the care team right away. | Registered Nurse (RN) | ☐ |
| 5.8 | **Build the initial care plan**<br>Create the initial care plan covering mobility assistance, dietary needs, medication schedule and any immediate risk interventions identified in the assessment. | Registered Nurse (RN) | ☐ |
| 5.9 | **Communicate the care plan to the shift team**<br>Brief the certified nursing assistants and incoming shift on the new resident's care plan and any immediate precautions before the end of the admission day. | Registered Nurse (RN) | ☐ |
| 5.10 | **Help the resident settle in**<br>Help the resident unpack, set up personal items and orient them to the call system, bathroom and dining schedule. | Certified Nursing Assistant (CNA) | ☐ |
| 5.11 | **Observe and report the first shift**<br>Observe the resident through the first shift for adjustment, appetite, sleep and any signs of distress, and report findings to the nurse. | Certified Nursing Assistant (CNA) | ☐ |
| 5.12 | **Follow up with the family**<br>Contact the responsible party within the first day or two to confirm the resident is settling in and address any questions about the care plan. | Admissions Coordinator | ☐ |

## 6. Quality checks

- Baseline assessment is completed and documented on the day of admission.
- Medication reconciliation is completed before the first scheduled dose.
- The care plan is communicated to the shift team before shift change.
- Consent and financial forms are signed and on file before admission is considered complete.

## 7. Records

- Signed admission agreement and consent forms
- Baseline assessment documentation
- Medication reconciliation form
- Initial care plan

## 8. KPIs

- Percentage of admissions with same-day baseline assessment completed
- Medication reconciliation completion rate before first dose
- Time from admission to initial care plan communicated to staff
- Family follow-up completion rate within 48 hours

## 9. Common mistakes

- Administering a scheduled medication before reconciling it against the physician's order.
- Skipping the skin check during the baseline assessment.
- Not briefing the incoming shift on a new resident's care plan and risks.
- Leaving consent forms unsigned until after the resident has already moved in.

## 10. Revision history

| Revision | Date | Description | Reviewed by |
|---|---|---|---|
| 1.0 | September 15, 2026 | Initial release | Alexa Uskova |

## Approval

| Prepared by | Approved by | Date |
|---|---|---|
| | | |

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