STANDARD OPERATING PROCEDURE

Resident Admission SOP

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

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

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** 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** 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** Collect the signed admission agreement, consent forms, insurance or payment information and emergency contact details, and confirm the responsible party's authority. **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** Review hospital discharge summaries, physician orders and recent medical history provided by the family or transferring facility.	Registered Nurse (RN)	☐
5.5	**Reconcile medications** Compare the medication list from the transferring facility or family against current physician orders and resolve any discrepancy before the first scheduled dose. **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** Assess the resident's physical condition, mobility, cognitive status, skin integrity and nutritional needs using the facility's standard assessment tool. **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** 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** 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** 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** 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** 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** 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

This is a template. Adapt it to your organization, equipment and local regulations before use.