



7 Documentation Gaps That Put Group Homes at Risk During Investigations

A quick self-check for residential providers, DDD/IDD programs, and multi-home agencies.

Use this checklist to spot common documentation gaps before an incident, complaint, family concern, audit, or licensing review exposes them.

- 1** **No clear shift handoff**
Staff cannot quickly see what changed, what still needs follow-up, or what the next shift must know.

- 2** **Medication and treatment concerns are not tracked separately**
Refusals, changes, side effects, missed doses, and treatment updates are mixed into general notes instead of tracked where they can be found — and proven.

- 3** **Resident risk information is scattered**
Key risks such as feeding, behavior, diabetes, mobility, or supervision needs are not easy to locate before the shift begins.

- 4** **Incident notes lack context and follow-through**
The record may state what happened, but not what led up to it, what staff did, who was notified, or proof that follow-up actually occurred.

- 5** **Staff training, background checks, and role suitability are not easy to prove**
When licensing or investigators ask, files cannot quickly show who was trained on what, when checks were completed, or why staff fit the residents they support.

- 6** **Manager review and corrective action are not visible**
There is no consistent proof that supervisors reviewed notes, addressed concerns, or that corrective actions were completed — not just assigned.

- 7** **Open items do not have ownership, deadlines, or closure proof**
Tasks, concerns, and follow-up needs are documented loosely, with no responsible person, target date, or record showing the loop was closed.



Why this matters

When documentation is unclear, a home can look disorganized even when staff worked hard. Clear records help providers show what was known, what was done, who followed up — and prove the loop was closed.



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