420-5-10-.03 ADMINISTRATIVE MANAGEMENT.

(32) Clinical records. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(a) Complete;

(b) Accurately documented;

(c) Readily accessible; and

(d) Systematically organized.

(33) Clinical records must be retained for:

(a) Five years from the date of discharge when there is no requirement in State law; or

(b) For a minor, three years after a resident reaches legal age under State law.

(34) The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

(35) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

(a) Transfer to another health care institution;

(b) Law;

(c) Third party payment contract; or

(d) The resident.

(36) The clinical record must contain:

(a) Sufficient information to identify the resident;

(b) A record of the resident's assessments;

(c) The Plan of Care and services provided;

(d) The results of any pre-admission screening conducted by the State; and

(e) Progress notes.