333 ELECTRONIC RECORDS AND SIGNATURES

333.1 Facilities have the option of utilizing electronic records rather than, or in addition to, paper or "hardcopy" records. The facility must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown. Any electronic record or signature system shall, at a minimum:

a. Require authentication and dating of all entries. "Authentication" means identification of the author of an entry by that author and no other, and that reflects the date of entry. An authenticated record shall be evidence that the entry to the record was what the author entered. To correct or enhance an entry, further authenticated entries may be made, by the original author, or by any other author, as long as the subsequent entries are authenticated as to who entered them, complete with date and time stamp of the entry, and that the original entries are not modified. "Entry" means any changes, deletions, or additions to a record, or the creation of a record. The electronic system utilized by the facility shall retain all entries for the life of the medical record and shall record the date and time of any entry, as well as identifying the individual who performed the entry. The electronic system must not allow any original signed entry or any stored data to be modified from its original content except for computer technicians correcting program malfunction or abnormality. A complete audit trail of all events as well as all “before” and “after” data must be maintained.

b. Require data access controls using unique personal identifiers to ensure that unauthorized individuals cannot make entries to a record, or create or enter an electronic signature for a record. The facility shall maintain a master list of authorized users, past and present. Facilities shall terminate user access when the user leaves employment with the facility.

c. Include physical, technical, and administrative safeguards to ensure confidentiality of patient medical records, including procedures to limit access to only authorized users. The authorized user must certify in writing that the identifier will not be shared with or used by any other person and that they are aware of the requirements and penalties related to improper usage of their unique personal identifier.

d. Provide audit controls. The system must be capable of tracking and logging user activity within its electronic files. These audit logs shall include the date and time of access and the user ID under which access occurred. These logs shall be maintained a minimum of six years. The facility must certify in writing that it is monitoring the audit logs to identify questionable data access activities, investigate breaches, assess the security program, and are taking corrective actions when a breach in the security system becomes known.

e. Have a data recovery plan. Data must be backed up either locally or remotely. Backup media shall be stored at both on-site and off-site locations or alternatively at multiple offsite locations. The
backup system must have the capability of timely restoring the data to the facility or to the central server in the event of a system failure. Barring a natural disaster of epic proportions (e.g., earthquake, tornado), timely means that the restoration of the backup occurs within a period of time that will permit no more than minimal disruption in the delivery of care and services to the residents. Pending restoration from backup, the facility shall maintain newly generated records in a paper format, and shall copy or transfer the contents of the paper records to the electronic system upon restoration of the system and backup. A full backup shall be performed at least weekly, with incremental or differential backups daily. Back up media shall be maintained both locally and at the off-site location or alternatively at multiple offsite locations until the next full weekly backup is successfully completed. Backups shall be tested periodically, but no less than monthly. Testing shall include restoration of the backup to a computer or system that shall not interfere with, or overwrite, current records. If utilizing a third party company for computer data storage and retrieval, the facility shall require that said third party company shall comply with these requirements.

f. Provide access to Department of Health and Human Services (DHHS), Office of Long Term Care (OLTC), and Centers for Medicaid or Medicare Services (CMS) personnel. Access may be by means of an identifier created for DHHS, OLTC, or CMS personnel, by a printout of the record, or both, as requested by DHHS, OLTC, or CMS personnel. Access must be in a “human readable” format, and shall be provided in a manner that permits DHHS, OLTC, or CMS personnel to view the records without facility personnel being present. Access shall include all entries and accompanying logs and shall list the date and time of any entry, as well as identifying the individual who performed the entry. Any computer system utilized, whether in-house or from a third-party vendor, must comply with this regulation.

333.2 Physicians' Orders. When facility personnel take telephone orders from physicians or other individuals authorized by law or regulations to issue orders the facility documents the appropriate information, including but not limited to, the date and time of the order, and the identity of the physician or other authorized individual giving the order as well as the identity of the facility personnel taking the order. The facility shall ensure that the physician electronically countersigns the physician's order upon the physician's next rounds at the facility or through Internet access from the physician's office.

333.3 For purposes of these regulations, in all instances in which the regulations requires, or appears to require, the facility to use written records or written signatures, the facility may use electronic records or electronic signatures in lieu of written records or written signatures when doing so conforms to the requirements of this section for the use of electronic records or electronic signatures.

600 RESIDENT RECORDS

601 RESIDENT RECORD MAINTENANCE

The facility will maintain an individual record on all residents admitted in accordance with accepted professional standards and practices. The resident record service must have sufficient staff, facilities, and equipment to provide records that are completely and accurately documented, readily accessible, and systematically organized.
602 CONTENTS OF RECORDS (TO FACILITATE RETRIEVING AND COMPILING INFORMATION)

The resident records will contain sufficient information to identify the resident, his/her diagnosis(es) and treatment, and to document the results accurately.

602.1 Admission and Discharge Record

- Record number
- Date and time of Admission
- Name
- Last known address
- Age
- Date of Birth
- Sex
- Marital status
- Name, address, and telephone numbers of attending physician and dentist.
- Name, address, and telephone number of next of kin.
- Date and time of discharge or death.
- Admitting and final diagnosis.

602.2 History and Physical Examination Prior to Admission

- Medical history
- Physical findings which includes a complete review of systems and diagnosis(es)
- Date and signature of physician

602.3 Physician Orders

- Date
- Orders for medication, treatment, care, diet, restraints, extend of activity, therapeutic home visits, discharge, or transfer.
- Telephone or verbal orders may be taken and written by licensed personnel and countersigned by the physician given the order within seven (7) days. Telephone or verbal orders for restraints must be signed by the physician giving the order within five (5) days.

602.4 Physician Progress Notes

- Written at the time of each visit.
Dated.
Signature of the physician.

Written at least every sixty (60) days on skilled care patients and every one-hundred twenty (120) days on others.

602.5 Nursing Notes
Each entry will be dated and signed by the person making such entry.
PRN medications will be documented as to the time given, amount given, reason given, results, and signature of person giving the medication.
Vital signs shall be taken and recorded on all patients as ordered by the attending physician, not less than weekly.
Date and time of all treatments and dressings.
Date and time of physician visits.
Complete record of all restraints, including time of application and release, type of restraint, and reason for applying.
Record all incidents and accidents, and follow-up involving the resident.
The amount and type of bedtime nourishment taken by residents on calorie controlled diets.
Condition on discharge or transfer.
Disposition of personal belongings and medications upon discharge.
Time of death and the name of person pronouncing the death of the resident and disposition of the body.
Heights and weights of the residents will be obtained at the time of admission to the facility. Weights will then be recorded at least monthly.

602.6 Discharge Summaries Should Include:
Signature of the physician
Admitting and final diagnosis.
Course of resident’s treatment and condition while in the nursing home.
Cause of death if applicable.
Disposition of resident, i.e., transfer to hospital, nursing home, mortuary, or home.

603 INDEX
There will be an index of all residents admitted to the facility including:

- Name of resident.
- Record number.
- Former Address.
- Name of physician.
- Date of birth.
- Date of discharge.

604 RETENTION AND PRESERVATION OF RECORDS
604.1 Retention Requirements for Active Clinical Records
a. The maintenance schedule for records on resident charts are as follows:

1. Admission and Discharge Records Permanent
3. History and Physical Most recent
4. Rehabilitation Potential Evaluation Most recent
5. Physician’s orders Six months
6. Physician’s Progress Notes Six months
7. Resident Body Weight Six months
8. Transfer Forms 12 months or Most recent if older than 12 months
9. Laboratory and X-Ray Reports Six months or 12 months if ordered less often than monthly
10. Nurse’s Notes/Nursing Flow Sheets Three months (ADL, Restraints, Clinitest: Results, Intake and Output, etc.)
11. Medication and Treatment Records Three months
12. Personal Effects Inventory Most recent
13. Hospital Discharge Summary Current 12 (Including History and Physical) months
14. TB Surveillance Record Permanent

15. Classification Status Current

16. Consultant Reports Initial and -Physicians Most recent -Occupational Therapist -Speech Therapist -Physical Therapist -Social Worker -Psychologist -Others

b. The maintenance schedule for active records in the nurse’s station (other than those required to be maintained on the chart) are as follows:

Assessments and Re-assessments Most recent 12 months

Plan of Care 12 months Summary of Quarterly Progress Notes Change of Condition

Pharmacy Reviews Six months

PASSAR Level I Permanent

PASSAR Level II Most recent

c. Those portions of the active records not kept on the chart or at the nurse’s station must be maintained in the facility and retrievable within 15 minutes upon request.

604.2 Requirements for Retention and Preservation of Inactive/Closed Records

a. Resident records will be retained in the facility for a minimum of five years following discharge or death of the resident.

b. Resident records for minors will be kept for at least three years after they reach legal age of 18 years old.

c. The resident records will be kept on the premises at all times and will only be removed by subpoena.

d. In the case of change of ownership, the resident records will remain with the facility.

e. In case of closure, the records will be stored within the State of Arkansas for the retention period.

f. After the retention period is met, the records may be destroyed either by burning or shredding.

g. Records will be protected against loss, destruction or unauthorized use.

605 CONFIDENTIALITY

The information contained in the resident records is confidential and is not to be released without legal authorization or subpoena.

The records will be available to State Survey Agency personnel.

606 STAFFING

An individual will be designated as responsible for the resident record service. There will be written job descriptions for the resident record service personnel.
607 GENERAL INFORMATION
All entries in the resident records will be recorded in ink. There will be no alteration of information in the resident records. If an error is made, a single line will be drawn through the error, the word “error” written above and initialed.

801 PILOT PROJECT [HOMESTYLE FACILITIES]
Facilities participating in the project will be required to maintain detailed medical and social records of residents. The records will contain an initial assessment of the medical and social conditions and needs of residents at the time of admission which will form a baseline measure. The baseline will be compared by the Office of Long Term Care or its designees with subsequent records maintained by the facility to determine the level of functioning, social interaction, and medical conditions of residents to determine whether HomeStyle facilities result in improvements in those areas, including but not limited to the type and dosage amounts and frequency of medications.
...d. Resident Record Maintenance

The ASCU shall develop and maintain a record-keeping system that includes a separate record for each resident and that documents each resident’s health care, individual support plan, assessments, social information, and protection of each resident’s rights.

e. Resident Records

The ASCU must follow the facility’s policies and procedures and applicable state and federal laws and regulations governing:

1) The release of any resident information, including consent necessary from the client, parents or legal guardian;
2) Record retention;
3) Record maintenance; and,
4) Record content.