S 72471. SPECIAL TREATMENT PROGRAM SERVICE UNIT-PATIENT HEALTH RECORDS AND PLANS FOR CARE.

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient’s care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

S 72521. ADMINISTRATIVE POLICIES AND PROCEDURES.

...(c) Each facility shall establish at least the following:

...(4) Written policies and procedures governing patient health records which shall be developed with the assistance of a person skilled in record maintenance and preservation.

(A) Policies and procedures governing access to, duplication of and dissemination of, information from the patient’s health record.

(B) Policies and procedures shall be established to ensure the confidentiality of patient health information, in accordance with applicable laws and regulations.

S 72543. PATIENTS’ HEALTH RECORDS.

(a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of
discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a facility ceases operation, the Department shall be informed within three business days by the licensee of the arrangements made for the safe preservation of the patients’ health records.

(d) The Department shall be informed within three business days, in writing, whenever patient health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the patients’ health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the patients’ health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Patients’ health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to a patient’s stay shall be centralized in the patient’s health record.

(h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department.

(i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
**S 72547. CONTENT OF HEALTH RECORDS.**

(a) A facility shall maintain for each patient a health record which shall include:

(1) Admission record.

(2) Current report of physical examination, and evidence of tuberculosis screening.

(3) Current diagnoses.

(4) Physician orders, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. Physician's orders shall be correctly recapitulated.

(5) Nurses' notes which shall be signed and dated. Nurses' notes shall include:

   (A) Records made by nurse assistants, after proper instruction, which shall include:
   
   1. Care and treatment of the patient.
   
   2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.
   
   3. Notification to the licensed nurse of changes in the patient's condition.

   (B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed nurses on each patient and shall be specific to the patient's needs, the patient care plan and the patient's response to care and treatments.

   (C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.

   (D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.

   (E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for postural supports used for the support and protection of the patient.

   (F) Medications and treatments administered and recorded as prescribed.

   (G) Documentation of oxygen administration.

(6) Temperature, pulse, respiration and blood pressure notations when indicated.

(7) Laboratory reports of all tests prescribed and completed.
(8) Reports of all X-rays prescribed and completed.

(9) Progress notes written and dated by the activity leader at least quarterly.

(10) Discharge planning notes when applicable.

(11) Observation and information pertinent to the patient’s diet recorded in the patient's health record by the dietitian, nurse or food service supervisor.

(12) Records of each treatment given by the therapist, weekly progress notes and a record of reports to the physician after the first 2 weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.

(13) Consent forms for prescribed treatment and medication not included in the admission consent for care.

(14) Condition and diagnoses of the patient at time of discharge or final disposition.

(15) A copy of the transfer form when the patient is transferred to another health facility.

(16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

(17) The name, complete address and telephone number where the patient was transferred upon discharge from the facility.