19-13-D8T. CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION

...(o) Medical records.

(1) Each facility shall maintain a complete medical record for each patient. All parts of the record pertinent to the daily care and treatment of the patient shall be maintained on the nursing unit in which the patient is located.

(2) The complete medical record shall include, but not necessarily be limited to:

(A) patient identification data, including name, date of admission, most recent address prior to admission, date of birth, sex, marital status, religion, referral source, Medicare/Medicaid number(s) or other insurance numbers, next of kin or guardian and address and telephone number;

(B) name of patient's personal physician;

(C) signed and dated admission history and reports of physical examinations;

(D) signed and dated hospital discharge summary, if applicable;

(E) signed and dated transfer form, if applicable;

(F) complete medical diagnosis;

(G) all initial and subsequent orders by the physician;

(H) a patient assessment that shall include but not necessarily be limited to, health history, physical, mental and social status evaluation of problems and rehabilitation potential, completed within fourteen (14) days of admission by all disciplines involved in the care of the patient and promptly after a change in condition that is expected to have lasting impact upon the patient's physical, mental or social functioning, conducted no less than once a year, reviewed and revised no less than once every ninety (90) days in order to assure its continued accuracy;

(I) a patient care plan, based on the patient assessment, developed within seven (7) days of the completion of the assessment by all disciplines involved in the care of the patient and consistent with the objectives of the patient's personal physician, that shall contain the identification of patient problems and needs, treatments, approaches and measurable goals, and be reviewed at least once every ninety (90) days thereafter;

(J) a record of visits and progress notes by the physician;

(K) nurses notes to include current condition, changes in patient condition, treatments and responses to such treatments;
(L) a record of medications administered including the name and strength of drug, date, route and time of administration, dosage administered, and, with respect to PRN medications, reasons for administration and patient response/result observed;

(M) documentation of all care and ancillary services rendered;

(N) summaries of conferences and records of consultations;

(O) record of any treatment, medication or service refused by the patient including the visit of a physician, signed by the patient, whenever possible, including a statement by a licensed person that such patient was informed of the medical consequences of such refusal; and

(P) discharge plans, as required by Section 19a-535 of the Connecticut General Statutes and subsection (p) of this section.

(3) All entries in the patient’s medical record shall be typewritten or written in ink and legible. All entries shall be verified according to accepted professional standards.

(4) Medical records shall be safeguarded against loss, destruction or unauthorized use.

(5) All medical records, originals or copies, shall be preserved for at least ten (10) years following death or discharge of the patient.