3231. MEDICAL RECORDS

3231.1 The facility Administrator or designee shall be responsible for implementing and maintaining the medical records service.

3231.2 A designated employee of the facility shall be assigned the responsibility for ensuring that each medical record is maintained, completed and preserved.

3231.3 The training for the designated employee shall include the following areas:

(a) Medical terminology;

(b) Disease index coding systems;

(c) Confidentiality;

(d) Filing;

(e) Storage; and

(f) Analysis of records.

3231.4 The facility shall provide in-service training on medical records policies and procedures on reporting, recording, and legal aspects of documentation annually to each employee who writes in the medical records.

3231.5 The medical records shall be completed within thirty (30) days from the date of discharge.

3231.6 Each medical record shall be indexed according to the name of the resident and final diagnosis to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

3231.7 Basic information to be indexed by each diagnosis shall include at least the following:

(a) Medical record number;

(b) Age;

(c) Sex;

(d) Physician; and

(e) Length of stay in days.

3231.8 Each facility shall maintain an area for processing medical records with adequate space, equipment, supplies, and lighting for staff.
3231.9 Each medical record shall serve as a basis for planning resident care and shall provide a means of communication between the physician and other employees involved in the resident's care.

3231.10 Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident.

3231.11 Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification.

3231.12 Each medical record shall include the following information:

(a) The resident's name, age, sex, date of birth, race, marital status, home address, telephone number, and religion;

(b) Full names, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;

(c) Medicaid, Medicare and health insurance numbers;

(d) Social security and other entitlement numbers;

(e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;

(f) Date of discharge, and condition on discharge;

(g) Hospital discharge summaries or a transfer form from the attending physician;

(h) Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation potential;

(i) Vaccine history, if available, and other pertinent information about immune status in relation to vaccine preventable disease;

(j) Current status of resident's condition;

(k) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition;

(l) The resident's medical experiences upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;

(m) Nurse's notes which shall be kept in accordance with the residents' medical assessment and the policies of the nursing service;

(n) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;

(o) The plan of care;
(p) Consent forms and advance directives; and

(q) A current inventory of the resident's personal clothing, belongings and valuables.

3231.13 The facility shall permit each resident to inspect his or her medical records on request.