9.0 RECORDS AND REPORTS

9.1 There shall be a separate clinical record maintained on each resident as a chronological history of the resident’s stay in the nursing facility. Each resident’s record shall contain current and accurate information including the following:

9.1.1 Admission record which shall include the resident’s name, birth date, home address prior to entering the facility, identification numbers (including Social Security), date of admission, physician’s name, address and telephone number, admitting diagnoses, name, address and telephone number of resident’s representative, the facility’s medical record number, and advance directive(s) if applicable.

9.1.2 History and physical examination prepared by a physician within 14 days of the resident’s admission to the nursing facility. If the resident has been admitted to the facility from a hospital, the resident’s summary and history prepared at the hospital and the resident’s physical examination performed at the hospital, if performed within 14 days prior to admission to the facility, may be substituted. A record of subsequent annual medical evaluations performed by a physician must be contained in each resident’s file.

9.1.3 A record of post-admission diagnoses.

9.1.4 Physician’s orders which include a complete list of medications, dosages, frequency and route of administration, indication for usage, treatments, diets, restrictions on level of permitted activity if any, and use of restraints if applicable.

9.1.5 Physician’s progress notes.

9.1.6 Nursing notes, which shall be recorded by each person providing professional nursing services to the resident, indicating date, time, scope of service provided and signature of the provider of the service. Nursing notes shall include care issues, nursing observations, resident change of status and other significant events.

9.1.7 Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.

9.1.8 Inventory of resident's personal effects upon admission.

9.1.9 Results of laboratory tests, x-ray reports and results of other tests ordered by the physician.

9.1.10 Discharge record which includes date and time, discharge location, and condition of resident.

9.1.11 Special service notes, e.g., social services, activities, specialty consultations, physical therapy, dental, podiatry.
9.1.12 Interagency transfer form, if applicable.

9.1.13 Copies of power(s) of attorney and guardianship, if applicable.

9.1.14 Nutrition progress notes and record of resident weights.

9.1.15 CNA flow sheets.

9.2 Confidentiality of resident records shall be maintained in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) and 16 Delaware Code, §1121(6).

9.3 Records shall be retained for 6 years after discharge. For a minor, records shall be retained for three years after age of majority.

9.4 Electronic Record keeping

9.4.1 Where facilities maintain residents' records in electronic format by computer or other devices, electronic signatures shall be acceptable.

9.4.2 The facility shall have a written attestation policy.

9.4.3 The computer network and all devices used to maintain resident medical records shall have safeguards to prevent unauthorized access and alteration of records.

9.4.4 All data entry devices shall require user authentication to access the computer network.

9.4.5 The computer program shall control each person's extent of access to residents' records based on that individual's personal identifier.

9.4.6 The computer's internal clock shall record the date and time of each entry.

9.4.7 An entry, once recorded, shall not be deleted. Alterations or corrections shall supplement the original record.

9.4.8 All entries shall have the date and time of the entry and the individual's personal identifier logged in a file which is accessible to designated administrative staff only.

9.4.9 The computer system shall back up all data to ensure record retention.

9.4.10 The facility shall provide independent computer access to electronic records to satisfy the requirements of the survey and certification process.