59A-4.118 MEDICAL RECORDS.

(1) The facility shall designate a full-time employee as being responsible and accountable for the facility's medical records. If this employee is not a qualified Medical Record Practitioner, then the facility shall have the services of a qualified Medical Record Practitioner on a consultant basis. A qualified Medical Record Practitioner is one who is eligible for a certification as a Registered Record Administrator or an Accredited Record Technician by the American Health Information Management Association or a graduate of a School of Medical Record Science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association.

(2) Each medical record shall contain sufficient information to clearly identify the resident, his diagnosis and treatment, and results. Medical records shall be complete, accurate, accessible and systematically organized.

(3) Medical records shall be retained for a period of five years from the date of discharge. In the case of a minor, the record shall be retained for 3 years after a resident reaches legal age under state law.

STATUTES:

400.141 Administration and management of nursing home facilities.

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

...(j) Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency.

...(t) Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

400.145 Records of care and treatment of resident; copies to be furnished.
(1) Unless expressly prohibited by a legally competent resident, any nursing home licensed pursuant to this part shall furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records which are in the possession of the facility. Such records shall include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records shall not be considered part of a deceased resident's estate and may be made available prior to the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765. A facility may charge a reasonable fee for the copying of resident records. Such fee shall not exceed $1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages. The facility shall further allow any such spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help assure that the records are not damaged, destroyed, or altered.

(2) No person shall be allowed to obtain copies of residents' records pursuant to this section more often than once per month, except that physician's reports in the residents' records may be obtained as often as necessary to effectively monitor the residents' condition.