SECTION 15. ADMINISTRATION. [NURSING FACILITIES]

...(10) Clinical records.

(a) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

1. Complete;

2. Accurately documented;

3. Readily accessible; and

4. Systematically organized.

(b) Retention of records. After resident's death or discharge the completed medical record shall be placed in an inactive file and retained for five (5) years or in case of a minor, three (3) years after the patient reaches the age of majority under state law, whichever is the longest.

(c) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

1. Transfer to another health care institution;

2. Law;

3. Third-party payment contract; or

4. The resident.

(e) The facility shall:

1. Permit each resident to inspect his or her records on request; and

2. Provide copies of the records to each resident no later than forty-eight (48) hours after a written request from a resident, at a photocopying cost not to exceed the amount customarily charged in the community.

(f) The clinical record shall contain:

1. Sufficient information to identify the resident;

2. A record of the resident's assessments;
3. The plan of care and services provided; and

4. The results of any preadmission screening conducted by the state; and

5. Progress notes.