**4658.0430 HEALTH INFORMATION MANAGEMENT SERVICE.**

Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.

Subp. 2. Quality of health information. A nursing home must develop and utilize a mechanism for auditing the quality of its health information management services.

Subp. 3. Person responsible for health information management. A nursing home must designate a person to be responsible for health information management.

**4658.0435 CONFIDENTIALITY OF CLINICAL RECORDS AND INFORMATION.**

Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.335 and 144.651, and federal regulations. A resident’s clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access.

Subp. 2. Electronic transmission of health care data. If a nursing home chooses to transmit or receive health care data by electronic means, the nursing home must develop and comply with policies and procedures to ensure the confidentiality, security, and verification of the transmission and receipt of information authorized to be transmitted by electronic means. A durable copy of the transmission must be placed in the resident’s clinical record.

**4658.0445 CLINICAL RECORD.**

Subpart 1. Unit record. A resident’s clinical record must be started at admission and incorporated into a central unit record system. The clinical record must contain sufficient information to identify the resident, contain a record of resident assessments, the comprehensive plan of care, progress notes on the implementation of the care plan, and a summary of the resident’s condition at the time of discharge.
Subp. 2. Form of entries and authentication. Data collected must be timely, accurate, and complete. All entries must be entered, authenticated, and dated by the person making the entry. If a nursing home uses an electronic paperless means of storing the clinical record, the nursing home must comply with part 4658.0475. All entries must be made as soon as possible after the observation or treatment in order to keep the clinical record current. In cases where authentication is done electronically or by rubber stamp, safeguards to prevent unauthorized use must be in place, and a rubber stamp may be used only if allowed by the licensing rules for that health care professional. Nursing assistants may document in the nursing notes if allowed by nursing home policy.

Subp. 3. Classification systems. All diagnoses and procedures must be accurately and comprehensively coded to ensure accurate resident medical profiles.

4658.0450 CLINICAL RECORD CONTENTS.
Subpart 1. In general. Each resident’s clinical record, including nursing notes, must include:

A. the condition of the resident at the time of admission;
B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;
C. the resident’s height and weight, according to part 4658.0520, subpart 2, item J;
D. the resident’s general condition, actions, and attitudes;
E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;
F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;
G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication;
H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810;
I. reports of laboratory examinations;
J. dates and times of all treatments and dressings;
K. dates and times of visits by all licensed health care practitioners;
L. visits to clinics or hospitals;
M. any orders or instructions relative to the comprehensive plan of care;
N. any change in the resident’s sleeping habits or appetite;
O. pertinent factors regarding changes in the resident’s general conditions; and

P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.

Subp. 2. Physician and professional services. The clinical record must contain the recording requirements of parts 4658.0710 to 4658.0725.

Subp. 3. Nursing services. The clinical record must contain the recording requirements of parts 4658.0515 to 4658.0530.

Subp. 4. Dietary and food services. The clinical record must contain the recording requirements of parts 4658.0600 and 4658.0625.

Subp. 5. Resident personal funds account. The clinical record must contain the recording requirements of part 4658.0255.

Subp. 6. Activities. The clinical record must contain the recording requirements of part 4658.0900.

Subp. 7. Social services. The clinical record must contain the recording requirements of parts 4658.1015 and 4658.1020.

4658.0455 TELEPHONE AND ELECTRONIC ORDERS.

A. Orders received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.335, 144.651, and 144.652.

B. Orders received by telephone or other electronic means, not including facsimile machine, must be immediately recorded or placed in the resident’s record by the person authorized by the nursing home and must be countersigned by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, whichever is sooner.

C. Orders received by facsimile machine must have been signed by the ordering health practitioner authorized to prescribe, and must be immediately recorded or a durable copy must be placed in the resident’s clinical record by the person authorized by the nursing home.

4658.0470 RETENTION, STORAGE, AND RETRIEVAL.

Subpart 1. Retention. A resident’s records must be preserved for a period of at least five years following discharge or death.

Subp. 2. Storage. Space must be provided for the safe and confidential storage of residents’ clinical records. Records of current residents must be stored on site.

Subp. 3. Retrieval. If records of discharged residents are stored off site, policies and procedures must be developed and implemented by clinical record personnel and the nursing home administration for the confidentiality, retention, and timely retrieval of records within one working day. The policies and procedures must specify who is authorized to retrieve a record. Off-site archived copies of clinical databases must be protected against fire, flood, and other emergencies.
The policies must address the location and retention of records if the nursing home discontinues operation.

**4658.0475 COMPUTERIZATION.**

If a nursing home is converting to an electronic paperless health information management system:

A. policies and procedures must be established and maintained that require password protection of the clinical database;

B. any outside contract for health information management services must include a provision that the company providing the services assumes responsibility for maintaining the confidentiality of all health information within its control;

C. audit trails must be developed for computer applications to determine the source and date of all entries and deletions;

D. backup systems must be implemented and maintained;

E. preventative maintenance must be implemented and maintained;

F. there must be a plan for preparing, securing, and retaining archived copies of computerized clinical databases;

G. procedures must be implemented for preparing and securing daily, weekly, and monthly archived copies of computerized clinical databases; and

H. there must be confidentiality and protection from unauthorized use of active and archived computerized clinical databases.

**4658.0715 MEDICAL INFORMATION FOR CLINICAL RECORD.**

A physician or physician designee must provide the following information for the clinical record:

A. the report of the admission history and physical examination;

B. the admitting diagnosis;

C. a description of the general medical condition, including disabilities and limitations;

D. a report of subsequent physical examinations;

E. instructions relative to the resident’s total program of care;

F. written orders for all medications with stop dates, treatments, rehabilitations, and any medically prescribed special diets;

G. progress notes;

H. any advanced directives; and
I. condition on discharge or transfer, or cause of death.