CSR 30-85.042 ADMINISTRATION AND RESIDENT CARE REQUIREMENTS FOR NEW AND EXISTING INTERMEDIATE CARE AND SKILLED NURSING FACILITIES

...(97) Facility staff shall include physician entries in the medical record with the following information: admission diagnosis, admission physical and findings of subsequent examinations; progress notes; orders for all medications and treatment; orders for extent of activity; orders for restraints including type and reason for restraint; orders for diet; and discharge diagnosis or cause of death.

...(99) Facilities shall ensure that the clinical record contains sufficient information to—

(A) Identify the resident;

(B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and

(C) Identify the discharge or transfer destination.

(100) Facilities shall ensure that the resident's clinical record must contain progress notes that include, but are not limited to:

(A) Response to care and treatment;

(B) Change(s) in physical, mental and psychosocial condition;

(C) Reasons for changes in treatment; and

(D) Reasons for transfer or discharge.

(101) The facility must safeguard clinical record information against loss, destruction or unauthorized use.

(102) The facility must keep all information confidential that is contained in the resident's records regardless of the form or storage method of the records, including video-, audio- or computer-stored information.

(103) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit and systematically organized.

(104) Facilities must retain clinical records for the period of time required by state law or five (5) years from the date of discharge when there is no requirement in state law.