12-006.04G Medical Records Staffing:

The facility must assign overall supervisory responsibility for the medical record service to a full-time employee of the facility, and must maintain sufficient supporting personnel competent to carry out the functions of the medical record services.

12-006.16A Clinical Records: The facility must maintain clinical records on each resident in accordance with accepted professional standards and practice. Clinical records must contain at a minimum:

1. Sufficient information to identify the resident;
2. A record of the resident's assessments, including those assessments performed by services under agreement with the facility;
3. The plan of care and services including medication administration, provided by facility staff and services provided under agreement with the facility;
4. Interdisciplinary progress notes to include effect of care provided, residents' response to treatment, change in condition, and changes in treatment;
5. Medical practitioner orders which are signed and dated;
6. Allergies;
7. Person to contact in an emergency situation;
8. Name of attending medical practitioner; and
9. Advanced directives if available.

12-006.16B The clinical record must be:

1. Complete;
2. Accurately documented;
3. Readily accessible;
4. Systematically organized; and
5. Legible.
12-006.16C  Clinical Record Safeguards: The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

12-006.16C1 If the facility maintains a resident’s record by computer, electronic signatures are acceptable. If attestation is done on computer records, safeguards to prevent unauthorized access, and to provide for reconstruction of information must be in place.

12-006.16C2 The facility must protect the confidentiality of all information contained in the resident’s records, regardless of the form or storage method of the records, except when release is authorized by:

1. Transfer agreement to another health care facility or health care service;
2. Law;
3. Third party payment contract; or
4. The resident or designee.

12-006.16C3 Records are subject to inspection by authorized representatives of the Department.

12-006.16D  Record Retention and Preservation: Resident clinical records must be maintained and preserved for a period of at least five years or, in case of a minor, five years after the resident becomes of age under Nebraska law. In cases in which a facility ceases operation, all records of each resident must be transferred to the health care facility to which the resident moves. All other resident records of a facility ceasing operation must be disposed of by shredding, burning, or other similar protective measures in order to preserve the resident’s rights of confidentiality. Records or documentation of the actual fact of resident medical record destruction must be permanently maintained.