MEDICAL RECORDS

NAC 449.74441 Maintenance. (NRS 449.037)

1. A facility for skilled nursing shall maintain medical records for each patient in the facility in accordance with accepted professional principles.

2. A medical record must be:
   (a) Complete;
   (b) Accurate;
   (c) Organized; and
   (d) Readily accessible to those persons who are authorized to review the records.

3. A medical record must include:
   (a) Sufficient information to identify the patient;
   (b) A record of the assessments of the patient conducted pursuant to NAC 449.74433 and 449.74435;
   (c) The patient's plan of care and the services provided to the patient;
   (d) The results of any assessment of the patient conducted by a state agency before his admission to the facility; and
   (e) Periodic progress notes prepared by appropriate members of the staff.

4. A facility for skilled nursing shall maintain the medical records of a patient:
   (a) For at least 5 years after the discharge of the patient, unless state law requires otherwise; and
   (b) For at least 3 years after the patient reaches 18 years of age if the patient is a minor.

5. A facility for skilled nursing shall ensure that:
   (a) Information contained in a medical record is not lost, destroyed or used in an unauthorized manner.
   (b) No person willfully and knowingly falsifies or causes another person to falsify information contained in a medical record.

6. Information contained in a medical record is confidential and must not be released without the written consent of the patient except:
(a) As required by law;

(b) Under a contract involving a third-party payor; or

(c) As required upon the transfer of the patient to another medical facility. (Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)