§ 211.5. CLINICAL RECORDS.

(a) Clinical records shall be available to, but not be limited to, representatives of the Department of Aging Ombudsman Program.

(b) Information contained in the resident’s record shall be privileged and confidential. Written consent of the resident, or of a designated responsible agent acting on the resident’s behalf, is required for release of information. Written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties.

(c) Records shall be retained for a minimum of 7 years following a resident’s discharge or death.

(d) Records of discharged residents shall be completed within 30 days of discharge. Clinical information pertaining to a resident’s stay shall be centralized in the resident’s record.

(e) When a facility closes, resident clinical records may be transferred with the resident if the resident is transferred to another health care facility. Otherwise, the owners of the facility shall make provisions for the safekeeping and confidentiality of clinical records and shall notify the Department of how the records may be obtained.

(f) At a minimum, the resident’s clinical record shall include physicians’ orders, observation and progress notes, nurses’ notes, medical and nursing history and physical examination reports; identification information, admission data, documented evidence of assessment of a resident’s needs, establishment of an appropriate treatment plan and plans of care and services provided; hospital diagnoses authentication—discharge summary, report from attending physician or transfer form—diagnostic and therapeutic orders, reports of treatments, clinical findings, medication records and discharge summary including final diagnosis and prognosis or cause of death. The information contained in the record shall be sufficient to justify the diagnosis and treatment, identify the resident and show accurately documented information.

(g) Symptoms and other indications of illness or injury, including the date, time and action taken shall be recorded.

(h) Each professional discipline shall enter the appropriate historical and progress notes in a timely fashion in accordance with the individual needs of a resident.

(i) The facility shall assign overall supervisory responsibility for the clinical record service to a medical records practitioner. Consultative services may be utilized, however, the facility shall employ sufficient personnel competent to carry out the functions of the medical record service.

NOTES OF DECISIONS

Alteration of medical records during the course of a licensure survey in order to produce the appearance of compliance with regulations constitutes fraud and deceit justifying the Department