SECTION 17.0 MEDICAL RECORDS

17.1 A medical record shall be established and maintained for every person admitted to a facility in accordance with accepted professional standards and practices. The administrator shall have ultimate responsibility for the maintenance of medical records; such responsibility may be delegated in writing to a staff member.

17.2 Entries in the medical record relating to treatment, medication, diagnostic tests and other similar services rendered shall be made by the responsible persons at the time of administration. Only physicians shall enter or authenticate medical opinions or judgment.

a) All accidents, including falls, whether resulting in an injury or not, shall be immediately recorded in the resident's record.

b) Detailed descriptions of all pressure ulcers, or other skin lesions, shall be recorded in the resident's record.

17.3 Each medical record shall contain sufficient information to identify the resident and to justify diagnosis, treatment, care and documented results and shall include as deemed appropriate: a) identification data; b) pre-admission screening including mental status (or PASARR (Pre-Admission Screening and Annual Resident Review), where appropriate); c) medical history; d) plan of care and services provided; e) physical examination reports; f) admitting diagnosis; g) diagnostic and therapeutic orders; h) consent forms; i) physicians' progress notes and observations; j) nursing notes; k) medication and treatment records, including any immunizations; l) laboratory reports, X-ray reports, or other clinical findings; m) consultation reports; n) documentation of all care and services rendered (e.g., dental reports, physical and occupational therapy reports, social service summaries, podiatry reports, inhalation therapy reports, etc.); o) resident referral forms; p) diagnosis at time of discharge; and q) disposition and final summary notes.

17.4 At time of discharge, a discharge summary, summarizing the resident's stay, shall be completed promptly and signed by the attending physician.

17.5 Medical records of discharged residents shall be completed within a reasonable period of time (not to exceed sixty (60) days) with all clinical information pertaining to the resident's stay made part of the resident's medical record.

17.6 Confidentiality of medical records shall be governed by the provisions of reference 17 and the following:

a) Only authorized personnel shall have access to the records.

b) The facility shall release resident's medical information only with the written consent of the resident, parent, guardian or legal representative in accordance with reference 17.
17.7 Provisions shall be made for the safe storage of medical records to safeguard them against loss, destruction or unauthorized use.

17.8 All medical records, either original or accurately reproduced, shall be preserved for a minimum of five (5) years following discharge or death of the resident in accordance with reference 9.

a) Medical records of minors, however, shall be kept for at least five (5) years after such minor would have reached the age of eighteen (18) years.

17.9 The medical records of all residents shall be opened for inspection to duly authorized representatives of the licensing agency whose duty it is to enforce the regulations herein consistent with section 19.15 (a) herein.

a) Information contained in medical records gathered and collected for the purpose of enforcing these regulations is confidential in nature and shall not be publicly disclosed by any person obtaining such information by virtue of his office, unless by court order or as otherwise required by law.