...(5) Medical Records.

(a) The nursing home shall comply with the Tennessee Medical Records Act, T.C.A. §§ 68-11-301, et seq.

(b) The nursing home must maintain a medical record for each resident. Medical records must be accurate, promptly completed, properly filed and retained, and accessible. The facility must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(c) All medical records, in either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of residents under mental disability or minority, their complete facility records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the resident, whichever is longer. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the facility’s policies and procedures, and no record may be destroyed on an individual basis.

(d) When a nursing home closes with no plans of reopening, an authorized representative of the facility may request final storage or disposition of the facility’s medical records by the department. Upon transfer to the department, the facility relinquishes all control over final storage of the records and the files shall become property of the State of Tennessee.

(e) The nursing home must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure.

(f) The nursing home must have a procedure for ensuring the confidentiality of resident records. Information from or copies of records may be released only to authorized individuals, and the facility must ensure that unauthorized individuals cannot gain access to or alter resident records. Original medical records must be released by the facility only in accordance with federal and state laws, court orders or subpoenas.

(g) The medical record must contain information to justify admission, support the diagnosis, and describe the resident’s progress and response to medications and services.

(h) All entries must be legible, complete, dated and authenticated according to facility policy.

(i) All records must document the following:
1. Evidence of a physical examination, including a health history, performed no more than thirty (30) days prior to admission or within forty-eight (48) hours following admission;

2. Admitting diagnosis;

3. A dietary history as part of each resident’s admission record;

4. Results of all consultative evaluations of the resident and appropriate findings by clinical and other staff involved in the care of the resident;

5. Documentation of complications, facility acquired infections, and unfavorable reactions to drugs;

6. Properly executed informed consent forms for procedures and treatments specified by facility policy, or by federal or state law if applicable, as requiring written resident consent;

7. All practitioners’ orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the resident’s condition;

8. Discharge summary with disposition of case and plan for follow-up care; and,

9. Final diagnosis with completion of medical records within thirty (30) days following discharge.

(j) Electronic and computer-generated records and signature entries are acceptable.