RULE §19.1910 CLINICAL RECORDS

(a) The facility must maintain clinical records on each resident, in accordance with accepted professional health information management standards and practices, that are:

(i) complete;

(i) accurately documented;

(iii) readily accessible;

(iv) systematically organized; and

(v) protected from unauthorized release.

(b) Clinical records must be retained for: five years after medical services end; or for a minor, three years after a resident reaches legal age under Texas law.

(c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage method of the records, except when release is required by:

(i) transfer to another health care institution;

(ii) law or this chapter;

(iii) third party payment contract; or

(iv) the resident.

RULE §19.1911 CONTENTS OF THE CLINICAL RECORD

(a) A resident’s clinical record must meet all documentation requirements in the Texas Health and Human Services Commission rule at 1 TAC §371.214 (relating to Resource Utilization Group Classification System).

(b) The clinical record of each resident must contain:

(1) a face sheet that contains the attending physician’s current mailing address and telephone numbers;

(2) sufficient information to identify and care for the resident, to include at a minimum:
(i) full name of resident;
(ii) full home/mailing address;
(iii) social security number;
(iv) health insurance claim numbers, if applicable;
(v) date of birth; and
(vi) clinical record number, if applicable;

(3) a record of the resident's assessments;

(4) the comprehensive, interdisciplinary plan of care and services provided (see also §19.802 of this chapter (relating to Comprehensive Care Plans))...

(5) the results of any Preadmission Screening and Resident Review conducted by DADS;

(6) signed and dated clinical documentation from all health care practitioners involved in the resident's care, with each page identifying the name of the resident for whom the clinical care is intended;

(7) any directives or medical powers of attorney as described in §19.419 of this chapter (relating to Advance Directives);

(8) discharge information in accordance with §19.803 of this chapter (relating to Discharge Summary (Discharge Plan of Care)) and a physician discharge summary, to include, at least, dates of admission and discharge, admitting and discharge diagnoses, condition on discharge, and prognosis, if applicable;

(9) at admission or within 14 days after admission, documentation of an initial medical evaluation, including history, physical examination, diagnoses and an estimate of discharge potential and rehabilitation potential, and documentation of a previous annual medical examination;

(10) authentication of a hospital diagnosis, which may be in the form of a signed hospital discharge summary, a signed report from the resident's hospital or attending physician, or a transfer form signed by the physician;

(11) the physician's signed and dated orders, including medication, treatment, diet, restorative and special medical procedures, and routine care to maintain or improve the resident's functional abilities (required for the safety and well-being of the resident), which must not be changed either on a handwritten or computerized physician's order sheet after the orders have been signed by the physician unless space allows for additional orders below the physician's signature, including space for the physician to sign and date again;

(12) arrangements for the emergency care of the resident in accordance with §19.1204 of this chapter (relating to Availability of Physician for Emergency Care);
(13) observations made by nursing personnel according to the time frames specified in §19.1010 of this chapter (relating to Nursing Practices) and which facility staff must ensure show at least the following: items as specified on the MDS assessment; and current information, including:

(i) PRN medications and results;

(ii) treatments and any notable results;

(iii) physical complaints, changes in clinical signs and behavior, mental and behavioral status, and all incidents or accidents;

(iv) flow sheets which may include bathing, restraint observation and/or release documentation, elimination, fluid intake, vital signs, ambulation status, positioning, continency status and care, and weight;

(v) the resident's ability to participate in activities of daily living as defined in §19.1010(e)(1) of this chapter; and

(vi) dietary intake to include deviations from normal diet, rejection of substitutions, and physician's ordered snacks and/or supplemental feedings;

(vii) the date and hour all drugs and treatments are administered; and

(viii) documentation of special procedures performed for the safety and well-being of the resident.

RULE §19.1912 ADDITIONAL CLINICAL RECORD SERVICE REQUIREMENTS

(a) Index of admissions and discharges. The facility must maintain a permanent, master index of all residents admitted to and discharged from the facility. This index must contain at least the following information concerning each resident:

(i) name of resident (first, middle, and last);

(ii) date of birth;

(iii) date of admission;

(iv) date of discharge; and

(v) social security, Medicare, or Medicaid number.

(b) Facility closure. In the event of closure of a facility, change of ownership or change of administrative authority, the new management must maintain documented proof of the medical information required for the continuity of care of all residents. This documentation may be in the form of copies of the resident’s clinical record or the original clinical record. In a change of ownership, the two parties will agree and designate in writing who will be responsible for the retention and protection of the inactive and closed clinical records.

(c) Method of recording/correcting information. All resident care information must be recorded in ink or permanent print except for the medication/treatment diet section of the care plan.
Correction of errors will be in accordance with accepted health information management standards.

(1) Erasures are not allowed on any part of the clinical record, with the exception of the medication/treatment/diet section of the resident care plan.

(2) Correction of errors will be in accordance with accepted health information management standards.

(d) Required record retention. Periodic thinning of active clinical records is permitted; however, the following items must remain in the active clinical record:

(1) current history and physical;
(2) current physician's orders and progress notes;
(3) current resident assessment instrument (RAI) and subsequent quarterly reviews; in Medicaid-certified facilities, all RAI and Quarterly Reviews for the prior 15-month period;
(4) current care plan;
(5) most recent hospital discharge summary or transfer form;
(6) current nursing and therapy notes;
(7) current medication and treatment records;
(8) current lab and x-ray reports;
(9) the admission record; and
(10) the current permanency plan.

(e) Readmissions.

(1) If a resident is discharged for 30 days or less and readmitted to the same facility, upon readmission, to update the clinical record, staff must:

(A) obtain current, signed physician's orders;
(B) record a descriptive nurse note, giving a complete assessment of the resident's condition;
(C) include any changes in diagnoses, etc.;
(D) obtain signed copies of the hospital or transferring facility history and physical and discharge summary. A transfer summary containing this information is acceptable;
(E) complete a new RAI and update the comprehensive care plan if evaluation of the resident indicates a significant change, which appears to be permanent. If no such change has occurred, then update only the resident comprehensive care plan...

(2) A new clinical record must be initiated if the resident is a new admission or has been discharged for over 30 days.
(f) Signatures.

(1) The use of electronic data transmission of facsimiles (faxing) is acceptable for sending and receiving health care documents, including the transmission of physicians’ orders. Long term care facilities may utilize electronic transmission if they adhere to the following requirements:

(A) The facility must implement safeguards to assure that faxed documents are directed to the correct location to protect confidential health information.

(B) All faxed documents must be signed by the author before transmission.

(2) Stamped signatures are acceptable for all health care documents requiring a physician’s signature, if the

(3) The facility must maintain all letters of intent on file and make them available to representatives of the Texas Department of Human Services (DHS) upon request.

(4) Use of a master signature legend in lieu of the legend on each form for nursing staff signatures of medication, treatment, or flow sheet entries is acceptable under the following circumstances.

(A) Each nursing employee documenting on medication, treatment, or flow sheets signs his full name, title, and initials on the legend.

(B) The original master legend is kept in the clinical records office or director of nurses’ office.

(C) A current copy of the legend is filed at each nurses’ station.

(D) When a nursing employee leaves employment with the facility, his name is deleted from the list by lining through it and writing the current date by the name.

(E) The facility updates the master legend as needed for newly hired and terminated employees.

(F) The master signature legend must be retained permanently as a reference to entries made in clinical records.

(g) Destruction of Records. When resident records are destroyed after the retention period is complete, the facility must shred or incinerate the records in a manner which protects confidentiality. At the time of destruction, the facility must document the following for each record destroyed:

(A) resident name;

(B) medical record number, if used;

(C) social security number, Medicare/Medicaid number, or the date of birth; and

(D) date and signature of person carrying out disposal.

(h) Confidentiality. The facility must develop and implement policies and procedures to safeguard the confidentiality of medical record information from unauthorized access.
(1) Except as provided in paragraph (2) of this subsection, the facility must not allow access to a resident's clinical record unless a physician's order exists for supplies, equipment, or services provided by the entity seeking access to the record.

(2) The facility must allow access and/or release confidential medical information under court order or by written authorization of the resident or his or her legal representative (see §19.407 of this title (relating to Privacy and Confidentiality)).

**RULE §19.1913 CLINICAL RECORDS SERVICE SUPERVISOR**

The facility must designate in writing a clinical records supervisor who has the authority, responsibility, and accountability for the functions of the clinical records service. The clinical records supervisor must be:

(1) A registered health information administrator (RHIA) or registered health information technician (RHIT); or

(2) An individual with experience appropriate to the scope and complexity of services performed as determined by the Texas Department of Human Services, and who receives consultation at a minimum of every 180 days from an (RHIA) or (RHIT).

**RULE §19.1926 MEDICAID HOSPICE SERVICES**

(a) When a nursing facility (NF) contracts for hospice services for residents, the nursing facility must:

...(5) ensure that hospice documentation is a part of the current clinical record, which, at a minimum, must include the current and past:

(A) Texas Medicaid Hospice Recipient Election/Cancellation form;

(B) MDS assessment;

(C) Physician Certification of Terminal Illness form;

(D) Medicare Election Statement, if dually eligible;

(E) verification that the recipient does not have Medicare Part A;

(F) hospice interdisciplinary assessments;

(G) hospice plan of care; and

(H) current interdisciplinary notes, which include the following:

(i) nurses notes and summaries;

(ii) physician orders and progress notes; and

(iii) medication and treatment sheets during the hospice certification period.