R432-150-25. MEDICAL RECORDS.

(1) The facility must implement a medical records system to ensure complete and accurate retrieval and compilation of information.

(2) The administrator must designate an employee to be responsible and accountable for the processing of medical records.

(a) The medical records department must be under the direction of a registered record administrator, RRA, or an accredited record technician, ART.

(b) If an RRA or ART is not employed at least part time, the facility must consult with an RRA or ART according to the needs of the facility, but not less than semi-annually.

(3) The resident medical record and its contents must be retained, stored and safeguarded from loss, defacement, tampering, and damage from fires and floods.

(a) Medical records must be protected against access by unauthorized individuals.

(b) Medical records must be retained for at least seven years. Medical records of minors must be kept until the age of eighteen plus four years, but in no case less than seven years.

(4) The facility must maintain an individual medical record for each resident. The medical record must contain written documentation of the following:

(a) records made by staff regarding daily care of the resident;

(b) informative progress notes by staff to record changes in the resident's condition and response to care and treatment in accordance with the care plan;

(c) a pre-admission screening;

(d) an admission record with demographic information and resident identification data;

(e) a history and physical examination up-to-date at the time of the resident's admission;

(f) written and signed informed consent;

(g) orders by clinical staff members;

(h) a record of assessments, including the comprehensive resident assessment, care plan, and services provided;

(i) nursing notes;

(j) monthly nursing summaries;
(k) quarterly resident assessments;
(l) a record of medications and treatments administered;
(m) laboratory and radiology reports;
(n) a discharge summary for the resident to include a note of condition, instructions given, and referral as appropriate;
(o) a service agreement if respite services are provided;
(p) physician treatment orders; and
(q) information pertaining to incidents, accidents and injuries.
(r) If a resident has an advanced directive, the resident’s record must contain a copy of the advanced directive.

(5) All entries into the medical record must be authenticated including date, name or identifier initials, and title of the person making the entries

(6) Resident respite records must be maintained within the facility.

R432-200-28. MEDICAL RECORDS.[ SMALL HEALTH CARE FACILITIES]

(1) Organization

(a) Medical records shall be complete, accurately documented, and systematically organized to facilitate retrieval and compilation.

(b) There shall be written policies and procedures to accomplish these purposes.

(c) The medical record service shall be under the direction of a registered record administrator (RRA) or an accredited record technician (ART).

(d) If an RRA or an ART is not employed at least part-time, the facility shall consult at least annually with an RRA or ART according to the needs of the facility.

(e) A designated individual in the facility shall be responsible for day-to-day record keeping.

(2) Retention and Storage.

(a) Provision shall be made for the filing, safe storage, and easy accessibility of medical records.

(i) The record and its contents shall be safeguarded from loss, defacement, tampering, fires, and floods.

(ii) Records shall be protected against access by unauthorized individuals.

(b) Medical records shall be retained for at least seven years after the last date of resident care. Records of minors shall be retained until the minor reaches age 18 or the age of majority plus an additional two years. In no case shall the record be retained less than seven years.
(c) All resident records shall be retained within the facility upon change of ownership.

(d) When a facility ceases operation, provision shall be made for appropriate safe storage and prompt retrieval of all medical records.

(3) Release of Information.

(a) There shall be written procedures for the use and removal of medical records and the release of information.

(b) Medical records shall be confidential.

(i) Information may be disclosed only to authorized persons in accordance with federal, state, and local laws.

(ii) Requests for other information which may identify the resident (including photographs) shall require the written consent of the resident or guardian if the resident is judged incompetent.

(c) Authorized representatives of the Department may review records to determine compliance with licensure rules and standards.

(4) Physician or Licensed Practitioner Documentation

Rubber-stamp signatures may be used in lieu of the written signature of the physician or licensed practitioner if the facility retains the signator's signed statement acknowledging ultimate responsibility for the use of the stamp and specifying the conditions for its use.

(5) Medical Record.

(a) Records shall be permanent (typewritten or hand written legibly in ink) and capable of being photocopied.

(b) Records shall be kept for all residents admitted or accepted for treatment and care.

(c) Records shall be kept current and shall conform to good medical and professional practice based on the service provided to each resident.

(d) All records of discharged residents shall be completed and filed within 60 days of discharge.

(e) All entries shall be authenticated including date, name or identified initials, and title of persons making entries.

(6) Contents of the Medical Record

A facility shall maintain an individual medical record for each resident which shall include:

(a) Admission record (face sheet) including the resident’s name; social security number; age at admission; birth date; date of admission; name, address, telephone number of spouse, guardian, authorized representative, person or agency responsible for the resident; and name, address, and telephone number of the attending physician;

(b) Admission and subsequent diagnoses and any allergies;
(c) Reports of physical examinations signed and dated by the physician;

(d) Signed and dated physician orders for drugs, treatments, and diet;

(e) Signed and dated progress notes including but not limited to:

(i) Records made by staff regarding the daily care of the resident;

(ii) Informative progress notes by appropriate staff recording changes in the resident's condition. Progress notes shall describe the resident's needs and response to care and treatment, and shall be in accord with the plan of care;

(iii) Documentation of administration of all "PRN" medications and the reason for withholding scheduled medications;

(iv) Documentation of use of restraints in accordance with facility policy including type of restraint, reason for use, time of application, and removal;

(v) Documentation of oxygen administration;

(vi) Temperature, pulse, respiration, blood pressure, height, and weight notations, when required;

(vii) Laboratory reports of all tests prescribed and completed;

(viii) Reports of all x-rays prescribed and completed;

(ix) Records of the course of all therapeutic treatments;

(x) Discharge summary including a brief narrative of conditions and diagnoses of the resident and final disposition;

(xi) A copy of the transfer form when the resident is transferred to another health care facility;

(xii) Resident-care plan.