HFS 132.45 RECORDS.

...(3) MEDICAL RECORDS — STAFF. Duties relating to medical records shall be completed in a timely manner.

(4) MEDICAL RECORDS — GENERAL.

(a) Availability of records. Medical records of current residents shall be stored in the facility and shall be easily accessible, at all times, to persons authorized to provide care and treatment. Medical records of both current and past residents shall be readily available to persons designated by statute or authorized by the resident to obtain the release of the medical records.

(b) Organization. The facility shall maintain a systematically organized records system appropriate to the nature and size of the facility for the collection and release of resident information.

(c) Unit record. A unit record shall be maintained for each resident and day care client.

(d) Indexes.

1. A master resident index shall be maintained.

2. A disease index shall be maintained which indexes medical records at least by final diagnosis.

(e) Maintenance. The facility shall safeguard medical records against loss, destruction, or unauthorized use, and shall provide adequate space and equipment to efficiently review, index, file, and promptly retrieve the medical records.

(f) Retention and destruction. 1. The medical record shall be completed and stored within 60 days following a resident's discharge or death.

2. An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 5 years following a resident's discharge or death. All other records required by this chapter shall be retained for a period of at least 2 years.

3. Medical records no longer required to be retained under subd. 2. may be destroyed, provided:

a. The confidentiality of the information is maintained; and

b. The facility permanently retains at least identification of the resident, final diagnosis, physician, and dates of admission and discharge. This may be achieved by way of the indexes required by par. (d).

4. A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes.
5. If the ownership of a facility changes, the medical records and indexes shall remain with the facility.

(g) Records documentation.

1. All entries in medical records shall be legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

2. A rubber stamp reproduction or electronic representation of a person's signature may be used instead of a handwritten signature, if:
   a. The stamp or electronic representation is used only by the person who makes the entry; and
   b. The facility possesses a statement signed by the person, certifying that only that person shall possess and use the stamp or electronic representation.

3. Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

(5) MEDICAL RECORDS — CONTENT. Except for persons admitted for short-term care, to whom s. HFS 132.70 (7) applies, each resident's medical record shall contain:

(a) Identification and summary sheet.

(b) Physician's documentation.

1. An admission medical evaluation by a physician or physician extender, including:
   a. A summary of prior treatment;
   b. Current medical findings;
   c. Diagnoses at the time of admission to the facility;
   d. The resident's rehabilitation potential;
   e. The results of the physical examination required by s. HFS 132.52 (3); and
   f. Level of care;

2. All physician's orders including, when applicable, orders concerning:
   a. Admission to the facility as required by s. HFS 132.52 (2) (a);
   b. Medications and treatments as specified by s. HFS 132.60 (5);
   c. Diets as required by s. HFS 132.63 (4);
   d. Rehabilitative services as required by s. HFS 132.64 (2);
   e. Limitations on activities;
   f. Restraint orders as required by s. HFS 132.60 (6); and
g. Discharge or transfer as required by s. HFS 132.53;
3. Physician progress notes following each visit as required by s. HFS 132.61 (2) (b) 6;
4. Annual physical examination, if required; and
5. Alternate visit schedule, and justification for such alternate visits as described in s. HFS 132.61 (2) (b).

(c) Nursing service documentation. 1. A history and assessment of the resident’s nursing needs as required by s. HFS 132.52;
2. Initial care plan as required by s. HFS 132.52 (4), and the care plan required by s. HFS 132.60 (8);
3. Nursing notes are required as follows:
   a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident’s condition, but at least weekly; and
   b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident’s condition, but at least every other week;
4. In addition to subds. 1., 2., and 3., nursing documentation describing:
   a. The general physical and mental condition of the resident, including any unusual symptoms or actions;
   b. All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care;
   c. The administration of all medications (see s. HFS 132.60 (5) (d)), the need for PRN medications and the resident’s response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;
   d. Food and fluid intake, when the monitoring of intake is necessary;
   e. Any unusual occurrences of appetite or refusal or reluctance to accept diets;
   f. Summary of restorative nursing measures which are provided;
   g. Summary of the use of physical and chemical restraints as required by s. HFS 132.60 (6) (g);
   h. Other non–routine nursing care given;
   i. The condition of a resident upon discharge; and
   j. The time of death, the physician called, and the person to whom the body was released.
(d) Social service records. Notes regarding pertinent social data and action taken.
(e) Activities records. Documentation of activities programming, a summary of attendance, and quarterly progress notes.
(f) Rehabilitative services. 1. An evaluation of the rehabilitative needs of the resident; and
2. Progress notes detailing treatment given, evaluation, and progress.

(h) Dental services. Records of all dental services.

(i) Diagnostic services. Records of all diagnostic tests performed during the resident’s stay in the facility.

(j) Plan of care. Plan of care required by s. HFS 132.60 (8).

(k) Authorization or consent. A photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident and any resident consent form required under this chapter, except that if the authorization or consent form exceeds one page in length an accurate summary may be substituted in the resident record and the complete authorization or consent form shall in this case be maintained as required under sub.(6) The summary shall include:

1. The name and address of the guardian or other person having authority to speak or act on behalf of the resident;
2. The date on which the authorization or consent takes effect and the date on which it expires;
3. The express legal nature of the authorization or consent and any limitations on it; and
4. Any other factors reasonably necessary to clarify the scope and extent of the authorization or consent.

(L) Discharge or transfer information. Documents, prepared upon a resident’s discharge or transfer from the facility, summarizing, when appropriate:

1. Current medical findings and condition;
2. Final diagnoses;
3. Rehabilitation potential;
4. A summary of the course of treatment;
5. Nursing and dietary information;
6. Ambulation status;
7. Administrative and social information; and
8. Needed continued care and instructions.

HFS 132.60 RESIDENT CARE
...(6) PHYSICAL AND CHEMICAL RESTRAINTS.
...(g) Records. Any use of restraints shall be noted, dated, and signed in the resident's clinical record on each tour of duty during which the restraints are in use.