

State Regulations Pertaining to Clinical Records

Note: This document is arranged alphabetically by State. To move easily from State to State, click the "Bookmark" tab on the Acrobat navigation column to the left of the PDF document. This will open a Table of Contents for the document. The relevant federal regulations are at the end of the PDF.

ALABAMA

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420-5-10-.03 Administrative Management.

(32) Clinical records. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

- (a) Complete;
- (b) Accurately documented;
- (c) Readily accessible; and
- (d) Systematically organized.

(33) Clinical records must be retained for:

- (a) Five years from the date of discharge when there is no requirement in State law; or
- (b) For a minor, three years after a resident reaches legal age under State law.

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

(35) 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:

- (a) Transfer to another health care institution;
- (b) Law;
- (c) Third party payment contract; or
- (d) The resident.

(36) The clinical record must contain:

- (a) Sufficient information to identify the resident;
- (b) A record of the resident's assessments;
- (c) The Plan of Care and services provided;
- (d) The results of any pre-admission screening conducted by the State; and
- (e) Progress notes.

ALASKA

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7 AAC 12.770. Medical record service

(a) Each facility, with the exception of home health agencies, hospice agencies, intermediate care facilities for the mentally retarded, and birth centers, must have a medical record service that complies with the applicable provisions of this section. A frontier extended stay clinic must comply with (b), (d), (g), and (i) - (k) of this section in addition to the requirements of 7 AAC 12.483.

(b) A facility must keep records on all patients admitted or accepted for treatment. The medical records, including x-ray films, are the property of the facility and are maintained for the benefit of the patients, the medical staff, and the facility. Medical records are subject to the requirements of

AS 18.05.042 , 7 AAC 43.030, and 7 AAC 43.032. This section does not affect other statutory or regulatory requirements regarding access to, use of, disclosure of, confidentiality of, or retention of record contents, or regarding maintenance of health information in patients' records by health care providers. A facility must maintain originals or accurate reproductions of the contents of the originals of all records, including x-rays, consultation reports, and laboratory reports, in a form that is legible and readily available

(1) upon request, to the attending physician or other practitioner responsible for treatment, a member of the facility's medical staff, or a representative of the department; and

(2) upon the patient's written request, to another practitioner.

(c) Each in-patient medical record must include, as appropriate

(1) an identification sheet which includes the

(A) patient's name;

(B) medical record number;

(C) patient's address on admission;

(D) patient's date of birth;

(E) patient's sex;

(F) patient's marital status;

(G) patient's religious preference;

(H) date of admission;

(I) name, address, and telephone number of a contact person;

(J) name of the patient's attending physician;

(K) initial diagnostic impression;

(L) date of discharge and final diagnosis; and

(M) source of payment;

(2) a medical and psychiatric history and examination record;

(3) consultation reports, dental records, and reports of special studies;

(4) an order sheet which includes medication, treatment, and diet orders signed by a physician;

(5) progress notes for each service or treatment received;

(6) nurses' notes which must include

(A) an accurate record of care given;

(B) a record of pertinent observations and response to treatment including psychosocial and physical manifestations;

(C) an assessment at the time of admission;

(D) a discharge plan;

(E) the name, dosage, and time of administration of a medication or treatment, the route of administration and site of injection, if other than by oral administration, of a medication, the patient's response, and the signature of the person who administered the medication or treatment;

and

(F) a record of any restraint used, showing the duration of usage;

(7) court orders relevant to involuntary treatment;

(8) laboratory reports;

(9) x-ray reports;

(10) consent forms;

(d) A facility must maintain procedures to protect the information in medical records from loss, defacement, tampering, or access by unauthorized persons. A patient's written consent is required for release of information that is not authorized to be released without consent. A facility may not use or disclose protected health information except as required or permitted by 45 C.F.R. Part 160,

subpart C, and 45 C.F.R. Part 164, subpart E, revised as of October 1, 2005, and adopted by reference.

(e) A record must be completed within 30 days of discharge and authenticated or signed by the attending physician, dentist, or other practitioner responsible for treatment. The facility must establish policies and procedures to ensure timely completion of medical records. A record may be authenticated by a signature stamp or computer key instead of the treating practitioner's signature if the practitioner has given a signed statement to the hospital administration that the practitioner is the only person who

(1) has possession of the stamp or key; and

(2) may use the stamp or key.

(f) Medical records must be filed in accordance with a standard health information archival system to ensure the prompt location of a patient's medical record.

(g) The facility must ensure that a transfer summary, signed by the physician or other practitioner responsible for treatment, accompanies the patient, or is sent by electronic mail or facsimile transmission to the receiving facility or unit, if the patient is transferred to another facility or is transferred to a nursing or intermediate care service unit within the same facility. The transfer summary must include essential information relative to the patient's diagnosis, condition, medications, treatments, dietary requirement, known allergies, and treatment plan.

(h) Each facility subject to the provisions of this section, with the exception of an ambulatory surgical facility and a frontier extended stay clinic, must employ the services of a health information administrator who is registered by the American Health Information Management Association or a records technician who is accredited by the American Health Information Management Association to supervise the medical record service. If the administrator or technician is a consultant only, the administrator or technician must visit the facility not less than biannually to organize and evaluate the operation of the service and to provide written reports to the medical record service and the administration of the facility.

(i) The facility must safely preserve patient records for at least seven years after discharge of the patient, except that

(1) x-ray films or reproductions of films must be kept for at least five years after discharge of the patient; and

(2) the records of minors must be kept until the minor has reached the age of 21 years, or seven years after discharge, whichever is longer.

(j) If a facility ceases operation, the facility must inform the department within 48 hours before ceasing operations of the arrangements made for safe preservation of patient records as required in this section. The facility must have a policy for the preservation of patients' medical records in the event of the closure of the facility.

(k) If ownership of the facility changes, the previous licensee and the new licensee shall, before the change of ownership, provide the department with written documentation that

(1) the new licensee will have custody of the patient's records upon transfer of ownership, and that the records are available to both the new and former licensee and other authorized persons; or

(2) arrangements have been made for the safe preservation of patients' records, as required in this section, and the records are available to the new and former licensees and other authorized persons.

R9-10-904. Administration

...E. An administrator shall ensure that:

1. Nursing care institution policies and procedures are established, documented, and implemented that cover:

...p. Medical records including oral, telephone, and electronic records.

R9-10-913. Medical Records

A. An administrator shall ensure that:

1. A medical record is established and maintained for each resident;

2. An entry in a medical record is:

a. Documented only by a staff member authorized by nursing care institution policies and procedures;

b. Dated, legible, and authenticated; and

c. Not changed to make the initial entry illegible;

3. If a rubber-stamp signature or an electronic signature code is used to authenticate an order, the individual whose signature the stamp or electronic code represents is responsible for the use of the stamp or the electronic code;

4. A medical record is available to staff, physicians, and physicians' designees authorized by nursing care institution policies and procedures;

5. Information in a medical record is disclosed only with the written consent of a resident or the resident's representative or as permitted by law;

6. If a nursing care institution terminates operations:

a. A resident and the resident's medical records are transferred to another health care institution; and

b. The location of all other records and documents not transferred with residents is submitted in writing to the Department not less than 30 days before the nursing care institution services are terminated;

7. If the nursing care institution has a change of ownership, all nursing care institution records and documents, including financial, personnel, and medical records, are transferred to the new owner;

8. A medical record is:

a. Protected from loss, damage or unauthorized use;

b. Maintained in compliance with A.R.S. § 12-2297(D) for five years after the date of the resident's discharge unless the resident is less than 18 years of age, in which case the record is maintained for three years after the resident reaches 18 years of age or for three years after the date of the resident's transfer or discharge, whichever date occurs last; and

c. Provided to the Department within two hours of the Department's request;

B. If a nursing care institution keeps medical records electronically, an administrator shall ensure that:

1. Safeguards exist to prevent unauthorized access; and

2. The date and time of an entry in a medical record is recorded by the computer's internal clock.

C. An administrator shall require that medical records for a resident contains:

1. Resident information that includes:

a. The resident's name;

b. The resident's date of birth;

c. The resident's weight;

- d. The resident's social security number;
 - e. The resident's last known address;
 - f. The home address and telephone number of a designated resident representative; and
 - g. Any known allergies or sensitivities to a medication or a biological;
2. The admission date and physician admitting orders;
 3. The admitting diagnosis;
 4. The medical history and physical examination required in R9-10-908(5);
 5. A copy of the resident's living will, health care power of attorney, or other health care directive, if applicable;
 6. The name and telephone number of the resident's attending physician;
 7. Orders;
 8. Care plans;
 9. A record of medical services, nursing services, and medically-related social services provided to a resident;
 10. Documentation of any incident involving the resident;
 11. Notes by a physician, the physician's designee, nursing personnel, and any other individual providing nursing care institution services to the resident;
 12. Documentation of freedom from infectious pulmonary tuberculosis required in R9-10908; and
 13. Documentation of a medication or a biological administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The type of vaccine, if applicable;
 - d. The signature and professional designation of the individual administering or observing the self-administration of the medication or biological; and
 - e. Any adverse reaction a resident has to the medication or biological.

ARKANSAS

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333 ELECTRONIC RECORDS AND SIGNATURES

333.1 Facilities have the option of utilizing electronic records rather than, or in addition to, paper or "hardcopy" records. The facility must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown. Any electronic record or signature system shall, at a minimum:

- a. Require authentication and dating of all entries. "Authentication" means identification of the author of an entry by that author and no other, and that reflects the date of entry. An authenticated record shall be evidence that the entry to the record was what the author entered. To correct or enhance an entry, further authenticated entries may be made, by the original author, or by any other author, as long as the subsequent entries are authenticated as to who entered them, complete with date and time stamp of the entry, and that the original entries are not modified. "Entry" means any changes, deletions, or additions to a record, or the creation of a record. The electronic system utilized by the facility shall retain all entries for the life of the medical record and shall record the date and time of any entry, as well as identifying the individual who performed the entry. The electronic system must not allow any original signed entry or any stored data to be modified from its original content except for computer technicians correcting program malfunction or

abnormality. A complete audit trail of all events as well as all “before” and “after” data must be maintained.

b. Require data access controls using unique personal identifiers to ensure that unauthorized individuals cannot make entries to a record, or create or enter an electronic signature for a record. The facility shall maintain a master list of authorized users, past and present. Facilities shall terminate user access when the user leaves employment with the facility.

c. Include physical, technical, and administrative safeguards to ensure confidentiality of patient medical records, including procedures to limit access to only authorized users. The authorized user must certify in writing that the identifier will not be shared with or used by any other person and that they are aware of the requirements and penalties related to improper usage of their unique personal identifier.

d. Provide audit controls. The system must be capable of tracking and logging user activity within its electronic files. These audit logs shall include the date and time of access and the user ID under which access occurred. These logs shall be maintained a minimum of six years. The facility must certify in writing that it is monitoring the audit logs to identify questionable data access activities, investigate breaches, assess the security program, and are taking corrective actions when a breach in the security system becomes known.

e. Have a data recovery plan. Data must be backed up either locally or remotely. Backup media shall be stored at both on-site and off-site locations or alternatively at multiple offsite locations. The backup system must have the capability of timely restoring the data to the facility or to the central server in the event of a system failure. Barring a natural disaster of epic proportions (e.g., earthquake, tornado), timely means that the restoration of the backup occurs within a period of time that will permit no more than minimal disruption in the delivery of care and services to the residents. Pending restoration from backup, the facility shall maintain newly generated records in a paper format, and shall copy or transfer the contents of the paper records to the electronic system upon restoration of the system and backup. A full backup shall be performed at least weekly, with incremental or differential backups daily. Back up media shall be maintained both locally and at the off-site location or alternatively at multiple offsite locations until the next full weekly backup is successfully completed. Backups shall be tested periodically, but no less than monthly. Testing shall include restoration of the backup to a computer or system that shall not interfere with, or overwrite, current records. If utilizing a third party company for computer data storage and retrieval, the facility shall require that said third party company shall comply with these requirements.

f. Provide access to Department of Health and Human Services (DHHS), Office of Long Term Care (OLTC), and Centers for Medicaid or Medicare Services (CMS) personnel. Access may be by means of an identifier created for DHHS, OLTC, or CMS personnel, by a printout of the record, or both, as requested by DHHS, OLTC, or CMS personnel. Access must be in a “human readable” format, and shall be provided in a manner that permits DHHS, OLTC, or CMS personnel to view the records without facility personnel being present. Access shall include all entries and accompanying logs and shall list the date and time of any entry, as well as identifying the individual who performed the entry. Any computer system utilized, whether in-house or from a third-party vendor, must comply with this regulation.

333.2 Physicians’ Orders. When facility personnel take telephone orders from physicians or other individuals authorized by law or regulations to issue orders the facility documents the appropriate information, including but not limited to, the date and time of the order, and the identity of the physician or other authorized individual giving the order as well as the identity of the facility personnel taking the order. The facility shall ensure that the physician electronically countersigns

the physician's order upon the physician's next rounds at the facility or through Internet access from the physician's office.

333.3 For purposes of these regulations, in all instances in which the regulations requires, or appears to require, the facility to use written records or written signatures, the facility may use electronic records or electronic signatures in lieu of written records or written signatures when doing so conforms to the requirements of this section for the use of electronic records or electronic signatures.

600 RESIDENT RECORDS

601 RESIDENT RECORD MAINTENANCE

The facility will maintain an individual record on all residents admitted in accordance with accepted professional standards and practices. The resident record service must have sufficient staff, facilities, and equipment to provide records that are completely and accurately documented, readily accessible, and systematically organized.

602 CONTENTS OF RECORDS (TO FACILITATE RETRIEVING AND COMPILING INFORMATION)

The resident records will contain sufficient information to identify the resident, his/her diagnosis(es) and treatment, and to document the results accurately.

602.1 Admission and Discharge Record

- Record number
- Date and time of Admission
- Name
- Last known address
- Age
- Date of Birth
- Sex
- Marital status
- Name, address, and telephone numbers of attending physician and dentist.
- Name, address, and telephone number of next of kin.
- Date and time of discharge or death.
- Admitting and final diagnosis.

602.2 History and Physical Examination Prior to Admission

- Medical history
- Physical findings which includes a complete review of systems and diagnosis(es)
- Date and signature of physician

602.3 Physician Orders

- Date
- Orders for medication, treatment, care, diet, restraints, extend of activity, therapeutic home visits, discharge, or transfer.
- Telephone or verbal orders may be taken and written by licensed personnel and countersigned by the physician given the order within seven (7) days. Telephone or verbal orders for restraints must be signed by the physician giving the order within five (5) days.

602.4 Physician Progress Notes

- Written at the time of each visit.
- Dated.
- Signature of the physician.
- Written at least every sixty (60) days on skilled care patients and every one-hundred twenty (120) days on others.

602.5 Nursing Notes

- Each entry will be dated and signed by the person making such entry.
- PRN medications will be documented as to the time given, amount given, reason given, results, and signature of person giving the medication.
- Vital signs shall be taken and recorded on all patients as ordered by the attending physician, not less than weekly.
- Date and time of all treatments and dressings.
- Date and time of physician visits.
- Complete record of all restraints, including time of application and release, type of restraint, and reason for applying.
- Record all incidents and accidents, and follow-up involving the resident.
- The amount and type of bedtime nourishment taken by residents on calorie controlled diets.
- Condition on discharge or transfer.
- Disposition of personal belongings and medications upon discharge.
- Time of death and the name of person pronouncing the death of the resident and disposition of the body.
- Heights and weights of the residents will be obtained at the time of admission to the facility. Weights will then be recorded at least monthly.

602.6 Discharge Summaries Should Include:

- Signature of the physician
- Admitting and final diagnosis.
- Course of resident's treatment and condition while in the nursing home.
- Cause of death if applicable.
- Disposition of resident, i.e., transfer to hospital, nursing home, mortuary, or home.

603 INDEX

There will be an index of all residents admitted to the facility including:

- Name of resident.
- Record number.
- Former Address.
- Name of physician.
- Date of birth.
- Date of discharge.

604 RETENTION AND PRESERVATION OF RECORDS

604.1 Retention Requirements for Active Clinical Records

a. The maintenance schedule for records on resident charts are as follows:

1. Admission and Discharge Records Permanent
2. Miscellaneous Admission Records Permanent -Admission Nurse's Notes -Admission Height and Weight -Advance Directives -Informed Restraint Consent -Patient Rights -Authorization for Treatment
3. History and Physical Most recent
4. Rehabilitation Potential Evaluation Most recent
5. Physician's orders Six months
6. Physician's Progress Notes Six months
7. Resident Body Weight Six months
8. Transfer Forms 12 months or Most recent if older than 12 months
9. Laboratory and X-Ray Reports Six months or 12 months if ordered less often than monthly

10. Nurse's Notes/Nursing Flow Sheets Three months (ADL, Restraints, Clinitest: Results, Intake and Output, etc.)

11. Medication and Treatment Records Three months

12. Personal Effects Inventory Most recent

13. Hospital Discharge Summary Current 12 (Including History and Physical) months

14. TB Surveillance Record Permanent

15. Classification Status Current

16. Consultant Reports Initial and -Physicians Most recent -Occupational Therapist -Speech Therapist -Physical Therapist -Social Worker -Psychologist -Others

b. The maintenance schedule for active records in the nurse's station (other than those required to be maintained on the chart) are as follows:

Assessments and Re-assessments Most recent 12 months

Plan of Care 12 months Summary of Quarterly Progress Notes Change of Condition

Pharmacy Reviews Six months

PASSAR Level I Permanent

PASSAR Level II Most recent

c. Those portions of the active records not kept on the chart or at the nurse's station must be maintained in the facility and retrievable within 15 minutes upon request.

604.2 Requirements for Retention and Preservation of Inactive/Closed Records

a. Resident records will be retained in the facility for a minimum of five years following discharge or death of the resident.

b. Resident records for minors will be kept for at least three years after they reach legal age of 18 years old.

c. The resident records will be kept on the premises at all times and will only be removed by subpoena.

d. In the case of change of ownership, the resident records will remain with the facility.

e. In case of closure, the records will be stored within the State of Arkansas for the retention period.

f. After the retention period is met, the records may be destroyed either by burning or shredding.

g. Records will be protected against loss, destruction or unauthorized use.

605 CONFIDENTIALITY

The information contained in the resident records is confidential and is not to be released without legal authorization or subpoena.

The records will be available to State Survey Agency personnel.

606 STAFFING

An individual will be designated as responsible for the resident record service. There will be written job descriptions for the resident record service personnel.

607 GENERAL INFORMATION

All entries in the resident records will be recorded in ink. There will be no alteration of information in the resident records. If an error is made, a single line will be drawn through the error, the word "error" written above and initialed.

801 PILOT PROJECT [HOMESTYLE FACILITIES]

Facilities participating in the project will be required to maintain detailed medical and social records of residents. The records will contain an initial assessment of the medical and social conditions and needs of residents at the time of admission which will form a baseline measure. The baseline will be compared by the Office of Long Term Care or its designees with subsequent records maintained by the facility to determine the level of functioning, social interaction, and medical

conditions of residents to determine whether HomeStyle facilities result in improvements in those areas, including but not limited to the type and dosage amounts and frequency of medications.

901 GENERAL ADMINISTRATION [ALZHEIMER'S SPECIAL CARE UNITS]

...d. Resident Record Maintenance

The ASCU shall develop and maintain a record-keeping system that includes a separate record for each resident and that documents each resident's health care, individual support plan, assessments, social information, and protection of each resident's rights.

e. Resident Records

The ASCU must follow the facility's policies and procedures and applicable state and federal laws and regulations governing:

- 1) The release of any resident information, including consent necessary from the client, parents or legal guardian;
- 2) Record retention;
- 3) Record maintenance; and,
- 4) Record content.

CALIFORNIA

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s 72471. Special Treatment Program Service Unit -Patient Health Records and Plans for Care.

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

s 72521. Administrative Policies and Procedures.

...(c) Each facility shall establish at least the following:

...(4) Written policies and procedures governing patient health records which shall be developed with the assistance of a person skilled in record maintenance and preservation.

(A) Policies and procedures governing access to, duplication of and dissemination of, information from the patient's health record.

(B) Policies and procedures shall be established to ensure the confidentiality of patient health information, in accordance with applicable laws and regulations.

s 72543. Patients' Health Records.

(a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a facility ceases operation, the Department shall be informed within three business days by the licensee of the arrangements made for the safe preservation of the patients' health records.

(d) The Department shall be informed within three business days, in writing, whenever patient health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the patients' health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to a patient's stay shall be centralized in the patient's health record.

(h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department.

(i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

s 72547. Content of Health Records.

(a) A facility shall maintain for each patient a health record which shall include:

(1) Admission record.

(2) Current report of physical examination, and evidence of tuberculosis screening.

(3) Current diagnoses.

- (4) Physician orders, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. Physician's orders shall be correctly recapitulated.
- (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include:
- (A) Records made by nurse assistants, after proper instruction, which shall include:
1. Care and treatment of the patient.
 2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.
 3. Notification to the licensed nurse of changes in the patient's condition.
- (B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed nurses on each patient and shall be specific to the patient's needs, the patient care plan and the patient's response to care and treatments.
- (C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.
- (D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.
- (E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for postural supports used for the support and protection of the patient.
- (F) Medications and treatments administered and recorded as prescribed.
- (G) Documentation of oxygen administration.
- (6) Temperature, pulse, respiration and blood pressure notations when indicated.
- (7) Laboratory reports of all tests prescribed and completed.
- (8) Reports of all X-rays prescribed and completed.
- (9) Progress notes written and dated by the activity leader at least quarterly.
- (10) Discharge planning notes when applicable.
- (11) Observation and information pertinent to the patient's diet recorded in the patient's health record by the dietitian, nurse or food service supervisor.
- (12) Records of each treatment given by the therapist, weekly progress notes and a record of reports to the physician after the first 2 weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.
- (13) Consent forms for prescribed treatment and medication not included in the admission consent for care.
- (14) Condition and diagnoses of the patient at time of discharge or final disposition.
- (15) A copy of the transfer form when the patient is transferred to another health facility.
- (16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.
- (17) The name, complete address and telephone number where the patient was transferred upon discharge from the facility.

Part 14. FACILITY RECORDS

14.1 HEALTH RECORDS. The facility shall maintain on its premises a health record for each resident. The record and the resident for which it is maintained shall be identified by a separate, unique number. The record shall contain sufficient information to identify the resident; provide and support resident diagnoses; include orders for medications, treatments, restorative services, diet, special procedures, and activities. It shall include a care plan and discharge plan and indicate in progress notes the resident's progress at appropriate intervals. The components of the record may be kept separately as long as they are readily retrievable.

14.1.1 Only physicians, dentists or persons operating under their supervision shall write or dictate medical histories and physical examinations in the medical record, and only dentists shall write dental histories.

14.1.2 Telephone orders shall be taken by licensed nurses or members of other appropriate disciplines as authorized by their professional licensure and as approved in facility policy. They shall be countersigned by the physician or dentist and entered into the record within two weeks.

14.1.3 All orders for diagnostic procedures, treatments, and medications shall be entered into the health record and authenticated and signed by the physician, except that orders for dental procedures shall be authenticated and signed by a dentist. All reports of x-ray, laboratory, EKG, and other diagnostic tests shall be authenticated by the person submitting them and incorporated into the health record within two weeks after receipt by the facility.

14.1.4 All entries in the health record shall be the original ink or typed copy of valid copies, kept current, dated, and signed or authenticated. The responsibility for completing the health record rests with the attending physician and the facility administrator. A physician may authenticate the health record by written signature, identifiable initials, computer key, or, under the following conditions, facsimile stamp:

(1) The physician whose signature the facsimile stamp represents is the only one who has possession of the stamp and is the only one who uses it; and

(2) The physician places in the medical record office a signed statement to the effect that the physician is the only one who has the stamp and the only one who will use it.

14.1.5 A completed health record shall be maintained on every resident from the time of admission through the time of discharge. All health records shall contain:

(1) Identification and summary sheet that includes:

(a) resident's name, health record number, social security number, marital status, age, race, home address, date of birth, place of birth, religion, occupation, name of informant and other available identifying sociological data (country of citizenship, father's name, mother's maiden name, military service, if any, and dates),

(b) name, address, and telephone number of referral source,

(c) name, address, and telephone number of attending physician and dentist,

(d) name of next of kin or other responsible person,

(e) date and time of admission and discharge,

(f) admitting diagnosis, final diagnosis(es), condition on discharge, and disposition, and

(g) attending physician's signature.

(2) Medical data that includes:

(a) medical history,

- (b) medical evaluation reports on admission and thereafter as needed and at least annually,
- (c) reports of any special examinations, including laboratory and x-ray reports,
- (d) reports of consultations by consulting physicians, if any,
- (e) reports from all consulting persons and agencies, if any,
- (f) reports of special treatments, such as physical or occupational therapy,
- (g) dental reports, if any,
- (h) treatment and progress notes written and signed by the attending physician at the time of each visit,
- (i) authentication of hospital diagnosis(es) in a hospital summary sheet or transfer form when applicable, and a summary of the course of treatment followed in the hospital if the resident is hospitalized,
- (j) physician orders for all medications, treatments, diet, and restorative and special procedures,
- (k) autopsy protocol, if any, and authorization for autopsy, and
- (3) plans and notes of the social service and activities service, including social history, social services assessment/plan, progress notes, activities assessment/plan and activities progress notes;
- (4) nutritional assessments and progress notes of the dietary service; and
- (5) reports or accidents or incidents experienced by the resident,
- (6) Nursing records, dated and signed by nursing personnel, which include the resident assessment required by Section 5.2, all medications and treatments administered, special procedures performed, notes of observations, and the time and circumstances of death.

14.2 FACILITIES. The facility shall provide a health record room or other health record accommodation and supplies and equipment adequate for health record functions. Health records shall be maintained and stored safely for confidentiality and protection from loss, damage, and unauthorized use.

14.3 PRESERVATION. All health records shall be completed promptly, not later than 30 days following resident discharge, filed, and retained for a period of time consistent with the applicable statute of limitations and the facility's written policies.

14.4 STAFFING. A Registered Record Administrator (RRA), Accredited Record Technician (ART), or other employee who is trained in medical records and who has consultation from a registered record administrator or accredited record technician shall be responsible for the custody, supervision, filing, and indexing of completed health records of all residents and for allied health records services.

CONNECTICUT

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19-13-D8t. Chronic and convalescent nursing homes and rest homes with nursing supervision

...(o) Medical records.

(1) Each facility shall maintain a complete medical record for each patient. All parts of the record pertinent to the daily care and treatment of the patient shall be maintained on the nursing unit in which the patient is located.

(2) The complete medical record shall include, but not necessarily be limited to:

(A) patient identification data, including name, date of admission, most recent address prior to admission, date of birth, sex, marital status, religion, referral source, Medicare/Medicaid number(s) or other insurance numbers, next of kin or guardian and address and telephone number;

- (B) name of patient's personal physician;
 - (C) signed and dated admission history and reports of physical examinations;
 - (D) signed and dated hospital discharge summary, if applicable;
 - (E) signed and dated transfer form, if applicable;
 - (F) complete medical diagnosis;
 - (G) all initial and subsequent orders by the physician;
 - (H) a patient assessment that shall include but not necessarily be limited to, health history, physical, mental and social status evaluation of problems and rehabilitation potential, completed within fourteen (14) days of admission by all disciplines involved in the care of the patient and promptly after a change in condition that is expected to have lasting impact upon the patient's physical, mental or social functioning, conducted no less than once a year, reviewed and revised no less than once every ninety (90) days in order to assure its continued accuracy;
 - (I) a patient care plan, based on the patient assessment, developed within seven (7) days of the completion of the assessment by all disciplines involved in the care of the patient and consistent with the objectives of the patient's personal physician, that shall contain the identification of patient problems and needs, treatments, approaches and measurable goals, and be reviewed at least once every ninety (90) days thereafter;
 - (J) a record of visits and progress notes by the physician;
 - (K) nurses notes to include current condition, changes in patient condition, treatments and responses to such treatments;
 - (L) a record of medications administered including the name and strength of drug, date, route and time of administration, dosage administered, and, with respect to PRN medications, reasons for administration and patient response/result observed;
 - (M) documentation of all care and ancillary services rendered;
 - (N) summaries of conferences and records of consultations;
 - (O) record of any treatment, medication or service refused by the patient including the visit of a physician, signed by the patient, whenever possible, including a statement by a licensed person that such patient was informed of the medical consequences of such refusal; and
 - (P) discharge plans, as required by Section 19a-535 of the Connecticut General Statutes and subsection (p) of this section.
- (3) All entries in the patient's medical record shall be typewritten or written in ink and legible. All entries shall be verified according to accepted professional standards.
- (4) Medical records shall be safeguarded against loss, destruction or unauthorized use.
- (5) All medical records, originals or copies, shall be preserved for at least ten (10) years following death or discharge of the patient.

DELAWARE

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9.0 Records and Reports

9.1 There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:

9.1.1 Admission record which shall include the resident's name, birth date, home address prior to entering the facility, identification numbers (including Social Security), date of admission, physician's name, address and telephone number, admitting diagnoses, name, address and

telephone number of resident's representative, the facility's medical record number, and advance directive(s) if applicable.

9.1.2 History and physical examination prepared by a physician within 14 days of the resident's admission to the nursing facility. If the resident has been admitted to the facility from a hospital, the resident's summary and history prepared at the hospital and the resident's physical examination performed at the hospital, if performed within 14 days prior to admission to the facility, may be substituted. A record of subsequent annual medical evaluations performed by a physician must be contained in each resident's file.

9.1.3 A record of post-admission diagnoses.

9.1.4 Physician's orders which include a complete list of medications, dosages, frequency and route of administration, indication for usage, treatments, diets, restrictions on level of permitted activity if any, and use of restraints if applicable.

9.1.5 Physician's progress notes.

9.1.6 Nursing notes, which shall be recorded by each person providing professional nursing services to the resident, indicating date, time, scope of service provided and signature of the provider of the service. Nursing notes shall include care issues, nursing observations, resident change of status and other significant events.

9.1.7 Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.

9.1.8 Inventory of resident's personal effects upon admission.

9.1.9 Results of laboratory tests, x-ray reports and results of other tests ordered by the physician.

9.1.10 Discharge record which includes date and time, discharge location, and condition of resident.

9.1.11 Special service notes, e.g., social services, activities, specialty consultations, physical therapy, dental, podiatry.

9.1.12 Interagency transfer form, if applicable.

9.1.13 Copies of power(s) of attorney and guardianship, if applicable.

9.1.14 Nutrition progress notes and record of resident weights.

9.1.15 CNA flow sheets.

9.2 Confidentiality of resident records shall be maintained in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) and 16 Delaware Code, §1121(6).

9.3 Records shall be retained for 6 years after discharge. For a minor, records shall be retained for three years after age of majority.

9.4 Electronic Record keeping

9.4.1 Where facilities maintain residents' records in electronic format by computer or other devices, electronic signatures shall be acceptable.

9.4.2 The facility shall have a written attestation policy.

9.4.3 The computer network and all devices used to maintain resident medical records shall have safeguards to prevent unauthorized access and alteration of records.

9.4.4 All data entry devices shall require user authentication to access the computer network.

9.4.5 The computer program shall control each person's extent of access to residents' records based on that individual's personal identifier.

9.4.6 The computer's internal clock shall record the date and time of each entry.

9.4.7 An entry, once recorded, shall not be deleted. Alterations or corrections shall supplement the original record.

9.4.8 All entries shall have the date and time of the entry and the individual's personal identifier logged in a file which is accessible to designated administrative staff only.

9.4.9 The computer system shall back up all data to ensure record retention.

9.4.10 The facility shall provide independent computer access to electronic records to satisfy the requirements of the survey and certification process

DISTRICT OF COLUMBIA

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3231. MEDICAL RECORDS

3231.1 The facility Administrator or designee shall be responsible for implementing and maintaining the medical records service.

3231.2 A designated employee of the facility shall be assigned the responsibility for ensuring that each medical record is maintained, completed and preserved.

3231.3 The training for the designated employee shall include the following areas:

- (a) Medical terminology;
- (b) Disease index coding systems;
- (c) Confidentiality;
- (d) Filing;
- (e) Storage; and
- (f) Analysis of records.

3231.4 The facility shall provide in-service training on medical records policies and procedures on reporting, recording, and legal aspects of documentation annually to each employee who writes in the medical records.

3231.5 The medical records shall be completed within thirty (30) days from the date of discharge.

3231.6 Each medical record shall be indexed according to the name of the resident and final diagnosis to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

3231.7 Basic information to be indexed by each diagnosis shall include at least the following:

- (a) Medical record number;
- (b) Age;
- (c) Sex;
- (d) Physician; and
- (e) Length of stay in days.

3231.8 Each facility shall maintain an area for processing medical records with adequate space, equipment, supplies, and lighting for staff.

3231.9 Each medical record shall serve as a basis for planning resident care and shall provide a means of communication between the physician and other employees involved in the resident's care.

3231.10 Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident.

3231.11 Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification.

3231.12 Each medical record shall include the following information:

- (a) The resident's name, age, sex, date of birth, race, marital status, home address, telephone number, and religion;
- (b) Full names, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;

- (c) Medicaid, Medicare and health insurance numbers;
- (d) Social security and other entitlement numbers;
- (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;
- (f) Date of discharge, and condition on discharge;
- (g) Hospital discharge summaries or a transfer form from the attending physician;
- (h) Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation potential;
- (i) Vaccine history, if available, and other pertinent information about immune status in relation to vaccine preventable disease;
- (j) Current status of resident's condition;
- (k) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition;
- (l) The resident's medical experiences upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;
- (m) Nurse's notes which shall be kept in accordance with the residents' medical assessment and the policies of the nursing service;
- (n) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;
- (o) The plan of care;
- (p) Consent forms and advance directives; and
- (q) A current inventory of the resident's personal clothing, belongings and valuables.

3231.13 The facility shall permit each resident to inspect his or her medical records on request.

FLORIDA

Downloaded January 2011

59A-4.118 Medical Records.

(1) The facility shall designate a full-time employee as being responsible and accountable for the facility's medical records. If this employee is not a qualified Medical Record Practitioner, then the facility shall have the services of a qualified Medical Record Practitioner on a consultant basis. A qualified Medical Record Practitioner is one who is eligible for a certification as a Registered Record Administrator or an Accredited Record Technician by the American Health Information Management Association or a graduate of a School of Medical Record Science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association.

(2) Each medical record shall contain sufficient information to clearly identify the resident, his diagnosis and treatment, and results. Medical records shall be complete, accurate, accessible and systematically organized.

(3) Medical records shall be retained for a period of five years from the date of discharge. In the case of a minor, the record shall be retained for 3 years after a resident reaches legal age under state law.

STATUTES:

400.141 Administration and management of nursing home facilities.

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

...(j) Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency.

...(t) Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

400.145 Records of care and treatment of resident; copies to be furnished.

(1) Unless expressly prohibited by a legally competent resident, any nursing home licensed pursuant to this part shall furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records which are in the possession of the facility. Such records shall include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records shall not be considered part of a deceased resident's estate and may be made available prior to the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765. A facility may charge a reasonable fee for the copying of resident records. Such fee shall not exceed \$1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages. The facility shall further allow any such spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help assure that the records are not damaged, destroyed, or altered.

(2) No person shall be allowed to obtain copies of residents' records pursuant to this section more often than once per month, except that physician's reports in the residents' records may be obtained as often as necessary to effectively monitor the residents' condition.

GEORGIA

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290-5-8-.11 Records.

(1) Each home shall maintain a complete medical record on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given. All active medical records shall be maintained at the nurses' station. The completed record shall normally contain the following:

- (a) Name, address, birth date, sex, marital status of the patient and religion; the name, address and telephone number of physician; the name, address and telephone number of the responsible party to contact in emergency;
 - (b) Date and time of admission;
 - (c) Date and time of discharge or death;
 - (d) Admitting diagnosis;
 - (e) Final diagnosis;
 - (f) Condition on discharge;
 - (g) History and physical examination;
 - (h) Treatment and medication orders;
 - (i) Physicians' progress notes (at least monthly);
 - (j) Nurses' notes;
 - (k) Special examination and reports.
- (2) Each home shall keep patient statistics, including admissions, discharges, deaths, patient days, and percent of occupancy. Statistical records shall be open for inspection and upon request, data shall be submitted to the Department.

HAWAII

Downloaded January 2011

§11-94-22 Medical record system.

- (a) There shall be available sufficient, appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, checking, indexing, filing, and prompt retrieval of records and record data.
- (b) If the employee who supervises medical records is not a registered records administrator, or accredited record technician, there shall be regularly scheduled visits by a consultant so qualified who shall provide reports to the administrator.
- (c) The following information shall be obtained and entered in the patient's record at the time of admission to the facility:
 - (1) Identifying information such as: name, date, and time of admission, date and place of birth, citizenship status, marital status, Social Security number or an admission number which can be used to identify the patient without use of name when the latter is desirable.
 - (2) Name and address of next of kin or legal guardian.
 - (3) Sex, height, weight, race, and identifying marks.
 - (4) Reason for admission or referral.
 - (5) Language spoken and understood.
 - (6) Information relevant to religious affiliation.
 - (7) Admission diagnosis, summary of prior medical care, recent physical examination, tuberculosis status, and physician's orders.
- (d) Records during stay shall also include:
 - (1) Appropriate authorizations and consents for medical procedures.
 - (2) Records of all periods of restraints with justification and authorization for each.
 - (3) Copies of initial and periodic examinations, evaluations, as well as progress notes at appropriate intervals.

- (4) Regular review or an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies and treatments and indicating which professional services or individual is responsible for providing the care or service.
- (5) Entries describing treatments, medications, tests, and all ancillary services rendered
- (e) When a patient is transferred to another facility or discharged, there shall be:
 - (1) Written evidence of the reason.
 - (2) Except in an emergency, documentation to indicate that the patient understood the reason for transfer, or that the guardian and family were notified.
 - (3) A complete summary including current status and care, final diagnosis, and prognosis.
- (f) There shall be a master alphabetical index of all patients admitted to the facility.
- (g) All entries in the patient's record shall be:
 - (1) Legible, typed or written in ink.
 - (2) Dated.
 - (3) Authenticated by signature and title of the individual making the entry.
- (4) All entries shall be written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical director.
- (h) All information contained in a patient's record, including any information contained in an automated data bank, shall be considered confidential.
- (i) The record shall be the property of the facility, whose responsibility shall be to secure the information against loss, destruction, defacement, tampering, or use by unauthorized persons.
- (j) There shall be written policies governing access to, duplication of, and dissemination of information from the record.
- (k) Written consent of the patient, if competent, or the guardian if patient is not competent, shall be required for the release of information to persons not otherwise authorized to receive it. Consent forms shall include:
 - (1) Use for which requested information is to be used.
 - (2) Sections or elements of information to be released and specific period of time during which the information is to be released.
 - (3) Consent of patient, or legal guardian, for release of any medical record information.
- (l) Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with this chapter.

IDAHO

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203.PATIENT/RESIDENT RECORDS

The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. (1-1-88)

01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person. (1-1-88)

02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: (1-1-88)

- a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. (1-1-88)
 - b. Medical history and physical examination, including both diagnosis and rehabilitative potential, signed by the attending physician. (1-1-88)
 - c. Transfer or referral report, where applicable. (1-1-88)
 - d. Special reports dated and signed by the person making the report, i.e., laboratory, X-ray, physical therapy, social services, consultation, and other special reports. (1-1-88)
 - e. Physician's order record containing the physician's authorization for required medications, tests, treatments, and diet. Each entry shall be dated and signed, or countersigned, by the physician. (1-1-88)
 - f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. (1-1-88)
 - g. Nurses' entries shall include the following information: (1-1-88)
 - i. Date, time and mode of admission; documentation of the patient's/resident's general physical and skin condition as well as mental attitude upon admission. (1-1-88)
 - ii. Medication administration record. (1-1-88)
 - iii. Date and times of all treatments and dressings. (1-1-88)
 - iv. Any change in the patient's/resident's physical or mental status. (1-1-88)
 - v. Any incident or accident occurring while the patient/resident is in the facility. (1-1-88)
 - vi. Date of each physician's visit. (1-1-88)
 - vii. Observations by licensed nursing personnel on labile, terminal, or acutely-ill patients/residents shall be recorded daily on each shift. (1-1-88)
 - viii. Observations by qualified nursing personnel on all other patients/residents shall be summarized and recorded at least monthly. (1-1-88)
 - h. Miscellaneous. Releases, consents, mortician's receipt. (1-1-88)
 - i. The signature of the charge nurse for each shift indicating the assumption of responsibility for all entries made by nonprofessional nursing personnel. (1-1-88)
03. Discharged Patients'/Residents' Records. (7-1-93)
- a. Following the discharge or death of a patient/resident, the records clerk shall place the chart in chronological order and review the entire record for completeness. (1-1-88)
 - b. If incomplete, the chart shall be returned to the proper person for prompt completion. No chart shall be permanently filed until all portions are complete. (1-1-88)
04. Retention. (7-1-93)
- a. There shall be adequate filing equipment and space to store closed charts and facilitate retrieval. (1-1-88)
 - b. Records shall be preserved in a safe location protected from fire, theft, and water damage for a period of time not less than seven (7) years. If the patient/resident is a minor, the record shall be preserved for a period of not less than seven (7) years following his eighteenth birthday. (1-1-88)
05. Confidentiality. The facility shall safeguard medical record information against loss, destruction, and unauthorized use. (1-1-88)

Section 300.1810 Resident Record Requirements

- a) Each facility shall have a medical record system that retrieves information regarding individual residents.
- b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.
- c) Record entries shall meet the following requirements:
 - 1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.
 - 2) All entries into the medical record shall be authenticated by the individual who made or authored the entry. "Authentication", for purposes of this Section, means identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
 - 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.
 - 4) Authentication shall include the initials of the signer's credentials. If the electronic signature system will not allow for the credential initials, the facility shall have a means of identifying the signer's credentials.
 - 5) Electronic Medical Records Policy. The facility shall have a written policy on electronic medical records. The policy shall address persons authorized to make entries, confidentiality, monitoring of record entries, and preservation of information.
 - A) Authorized Users. The facility shall develop a policy to assure that only authorized users make entries into medical records and that users identify the date and author of every entry in the medical records. The policy should allow written signatures, written initials supported by a signature log, or electronic signatures with assigned identifiers, as authentication by the author that the entry made is complete, accurate and final.
 - B) Confidentiality. The facility policy shall include adequate safeguards to ensure confidentiality of patient medical records, including procedures to limit access to authorized users. The authorized user must certify in writing that he or she is the only person with authorized user access to the identifier and that the identifier will not be shared or used by any other person. A surveyor or inspector in the performance of a State-required inspection may have access to electronic medical records, using the identifier and under the supervision of an authorized user from the facility. A surveyor or inspector may have access to the same electronic information normally found in written patient records. Additional summary reports, analyses, or cumulative statistics available through computerized records are the internal operational reports of the facility's Quality Assurance Committee.
 - C) Monitoring. The facility shall develop a policy to periodically monitor the use of identifiers and take corrective action as needed. The facility shall maintain a master list of authorized users past and present and maintain a computerized log of all entries. The logs shall include the date and time of access and the user ID under which access occurred.

D) Preservation. The facility shall develop a plan to ensure access to medical records over the entire record retention period for that particular piece of information.

6) A user may terminate authorization for use of electronic or computer-generated signature upon written notice to the individual responsible for medical records or other person designated by the facility's policy.

7) Each report generated by a user must be separately authenticated.

d) All physician's orders, plans of treatment, Medicare or Medicaid certification, recertification statements, and similar documents shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials, is not acceptable.

e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.

1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services shall be included in the resident's progress record when the recommendations pertain to an individual resident.

g) A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered.

h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

i) The facility may use universal progress notes in the medical records.

j) Each facility shall have a policy regarding the retirement and destruction of medical records. This policy shall specify the time frame for retiring a resident's medical record, and the method to be used for record destruction at the end of the record retention period. The facility's record retirement policy shall not conflict with the record retention requirements contained in Section 300.1840 of this Part.

k) Discharge information shall be completed within 48 hours after the resident leaves the facility. The resident care staff shall record the date, time, condition of the resident, to whom released, and the resident's planned destination (home, another facility, undertaker). This information may be entered onto the admission record form.

Section 300.1820 Content of Medical Records

a) No later than the time of admission, the facility shall enter the following information onto the identification sheet or admission sheet for each resident:

1) Name, sex, date of birth and Social Security Number, 2) Marital Status, and the name of spouse (if there is one), 3) Whether the resident has been previously admitted to the facility, 4) Date of current admission to the facility, 5) State or country of birth, 6) Home address, 7) Religious affiliation (if any), 8) Name, address and telephone number of any referral agency, state hospital, zone center or hospital from which the resident has been transferred (if applicable), 9) Name and telephone number of the resident's personal physician, 10) Name and telephone number of the resident's next of kin or responsible relative. 11) Race and origin, 12) Most recent occupation, 13)

Whether the resident or the resident's spouse is a veteran, 14) Father's name and mother's maiden name, 15) Name, address and telephone number of the resident's dentist, and 16) The diagnosis applicable at the time of admission.

b) At the time of admission, the facility shall obtain a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility (if available).

c) In addition to the information that is specified above, each resident's medical record shall contain the following:

1) Medical history and physical examination form that includes conditions for which medications have been prescribed, physician findings, all known diagnoses and restoration potential. This shall describe those known conditions that the medical and resident care staff should be apprised of regarding the resident. Examples of diagnoses and conditions that are to be included are allergies, epilepsy, diabetes and asthma.

2) A physician's order sheet that includes orders for all medications, treatments, therapy and rehabilitation services, diet, activities and special procedures or orders required for the safety and well-being of the resident.

3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. (B)

4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs.

A) Physicians and other consultants who provide direct care or treatment to residents shall make notations at the time of each visit with a resident.

B) Significant observations or developments regarding resident responses to activity programs, social services, dietary services and work programs shall be recorded as they are noted. If no significant observations or developments are noted for three months, an entry shall be made in the record of that fact.

C) Significant observations or developments regarding resident responses to nursing and personal care shall be recorded as they are noted. If no significant observations or developments are noted for a month, an entry shall be made in the record of that fact.

5) Any laboratory and x-ray reports ordered by the resident's physician.

6) Documentation of visits to the resident by a physician and to the physician's office by the resident. The physician shall record, or dictate and sign, the results of such visits, such as changes in medication, observations and recommendations made by the physician during the visits, in the record.

7) The results of the physical examination conducted pursuant to Section 300.1010(g) of this Part.

8) Upon admission from a hospital or state facility, a hospital summary sheet or transfer form that includes the hospital diagnosis and treatment, and a discharge summary. This transfer information, which may be included in the transfer agreement, shall be signed by the physician who attended the resident while in the hospital.

Section 300.1840 Retention and Transfer of Resident Records

a) Records of discharged residents shall be placed in an inactive file and retained as follows:

1) Records for any resident who is discharged prior to being 18 years old shall be retained at least until the resident reaches the age of

23.

2) Records of residents who are over 18 years old at the time of discharge shall be retained for a minimum of five years.

b) After the death of a resident, the resident's record shall be retained for a minimum of five years.

c) It is suggested that the administrator check with legal counsel regarding the advisability of retaining resident records for a longer period of time, and the procedures to be followed in the event the facility ceases operation.

d) When a resident is transferred to another facility, the transferring facility shall send with the resident a reason for transfer, summary of treatment and results, laboratory findings, and orders for the immediate care of the resident. This information may be presented in a transfer form or an abstract of the resident's medical record.

Section 300.1850 Other Resident Record Requirements

This Section contains references to rules located in other Subparts that pertain to the content and maintenance of medical records.

a) The resident's record shall include facts involved if the resident's discharge occurs despite medical advice to the contrary, as required by Section 300.620(f) of this Part.

b) The resident's record shall identify the reasons for any order and use of safety devices or restraints, as required by Sections 300.680(c) and 300.1040(d), respectively, of this Part.

c) The resident's record shall include information regarding the physician's notification and response regarding any serious accident or injury, or significant change in condition, as required by Section 300.1010(h) of this Part.

d) The resident's record shall contain the physician's permission, with contraindications noted, for participation in the activity program, as required by Section 300.1410(d) of this Part.

e) The records of residents participating in work programs shall document the appropriateness of the program for the resident and the resident's response to the program, as described in Section 300.1430(e) of this Part.

f) Telephone orders shall be transcribed into the resident's medical record or a telephone order form and signed by the nurse taking the order, as described in Section 300.1620(a)(2) of this Part.

g) Documentation of the review of medication order shall be entered in the resident's medical record as described in Section 300.1620(b) of this Part.

h) The resident's medical record shall include notations indicating any release of medications to the resident or person responsible for the resident's care, as described in Section 300.1620(e) of this Part.

i) Instances of inability to implement a physician's medication order shall be noted in the resident's medical record, as described in Section 300.1630(d) of this part.

j) Medication errors and drug reactions shall be noted in the resident's medical record as described in Section 300.1630(e) of this Part.

k) The resident's record shall include the physician's diet order and observations of the resident's response to the diet, as describe in Section 300.2040 of this Part.

l) The resident's record shall contain any physician determinations that limit the resident's access to the resident's personal property, as described in Section 300.3210(b) of this Part.

m) The facility shall comply with Section 300.3210(g) of this Part, which requires that any medical inadvisability regarding married residents residing in the same room be documented in the resident's record.

n) The facility shall permit each resident, resident's parent, guardian or representative to inspect and copy the resident's medical records as provided by Section 300.3220(g) of this Part.

o) Any resident transfer or discharge mandated by the physical safety of other residents shall be documented in the resident's medical record as required by Sections 300.3300(d) and (g) of this Part.

p) Summaries of discussions and explanations of any planned involuntary transfers or discharges shall be included in the medical record of the resident that is to be involuntarily transferred or discharged, as described in Section 300.3300(j) of this Part.

Section 300.1860 Staff Responsibility for Medical Records

a) Each skilled nursing facility shall have a health information management consultant.

1) Each skilled nursing facility that has a full-time or part-time health information management consultant shall designate that employee as the person responsible for ensuring that the facility's medical records are completed, maintained and preserved in accordance with this Subpart.

2) Each skilled nursing facility that does not have a full-time or part-time health information management consultant shall designate an employee to be responsible for completing, maintaining and preserving the facility's medical records. This individual shall be trained by, and receive regular consultation from, a health information management consultant in order to meet the requirements of this Subpart.

b) Each intermediate care facility that does not have a full-time or part-time health information management consultant shall designate an employee to be responsible for completing, maintaining and preserving the medical records in accordance with the requirements of this Subpart.

Section 300.3320 Confidentiality

a) The Department, the facility and all other public or private agencies shall respect the confidentiality of a resident's record and shall not divulge or disclose the contents of a record in a manner which identifies a resident, except upon a resident's death to a relative or guardian, or under judicial proceedings. This Section shall not be construed to limit the right of a resident or a resident's representative to inspect or copy the resident's records. (Section 2-206(a) of the Act)

b) Confidential medical, social, personal, or financial information identifying a resident shall not be available for public inspection in a manner which identifies a resident. (B) (Section 2-206(b) of the Act)

INDIANA

Downloaded January 2011

410 IAC 16.2-3.1-50 Clinical records

Sec. 50.

(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. Any consultation must be provided by a medical records practitioner in accordance with accepted professional standards and practices. The records must be as follows:

(1) Complete.

(2) Accurately documented.

(3) Readily accessible.

(4) Systematically organized.

(b) Clinical records must be retained after discharge for:

(1) a minimum period of one (1) year in the facility and five (5) years total; or

(2) for a minor, until twenty-one (21) years of age.

(c) If a facility ceases operation, the director shall be informed within three (3) business days by the licensee of the arrangements made for the preservation of the residents' clinical records.

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

(e) 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 one (1) or more of the following:

(1) Transfer to another health care institution.

(2) Law.

(3) Third party payment contract.

(4) The resident or legal representative.

(f) The clinical record must contain the following:

(1) Sufficient information to identify the resident.

(2) A record of the resident's assessments.

(3) The care plan and services provided.

(4) The results of any preadmission screening conducted by the state.

(5) Progress notes.

(g) Each facility shall have a well-defined policy that ensures the staff has sufficient progress information to meet the residents' needs.

(h) A transfer form shall include:

(1) Identification data.

(2) Name of the transferring institution.

(3) Name of the receiving institution and date of transfer.

(4) Resident's personal property.

(5) Nurses' notes relating to the resident's:

(A) functional abilities and physical limitations;

(B) nursing care;

(C) medications;

(D) treatment;

(E) current diet; and

(F) condition on transfer.

(6) Diagnosis.

(7) Presence or absence of decubitus ulcer.

(8) Date of chest x-ray and skin test for tuberculosis.

(i) Current clinical records shall be completed promptly and those of discharged residents shall be completed within seventy

(70) days of the discharge date.

(j) If a death occurs, information concerning the resident's death shall include the following:

(1) Notification of the physician, family, responsible person, and legal representative.

(2) The disposition of the body, personal possessions, and medications.

(3) A complete and accurate notation of the resident's condition and most recent vital signs and symptoms preceding death.

IOWA

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481—58.15(135C) Records.

58.15(2) Resident clinical record. There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)
- d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)
- e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)
- f. Progress notes.
 - (1) Physician shall enter a progress note at the time of each visit; (III)
 - (2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)
- g. All laboratory, X-ray, and other diagnostic reports; (III)
- h. Nurse's record including:
 - (1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)
 - (2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)
 - (3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)
 - (4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)
- i. Medication record.
 - (1) An accurate record of all medications administered shall be maintained for each resident. (II, III)
 - (2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)
- j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- k. Transfer form.
 - (1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)
 - (2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)
 - (3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)
- l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, ophthalmologists, and others. (III)

58.15(3) Resident personal record. Personal records may be kept as a separate file by the facility.

- a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.
- b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)
- c. When the resident's records are closed, the information shall become a part of the final record. (III)
- d. Personal records shall include a duplicate copy of the contract(s). (III)

58.15(5) Retention of records.

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

KANSAS

Downloaded January 2011

28-39-163. Administration.

...(m) Clinical records.

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices. The records shall meet the following criteria:

- (A) Be complete;
- (B) be accurately documented; and
- (C) be systematically organized.

(2) Clinical records shall be retained according to the following schedule:

- (A) At least five years following the discharge or death of a resident; or
- (B) for a minor, five years after the resident reaches 18 years of age.

(3) Resident records shall be the property of the facility.

(4) The facility shall keep confidential all information in the resident's records, regardless of the form or storage method of the records, except when release is required by any of the following:

- (A) Transfer to another health care institution;
- (B) law;
- (C) third party payment contract;
- (D) the resident or legal representative; or
- (E) in the case of a deceased resident, the executor of the resident's estate, or the resident's spouse, adult child, parent, or adult brother or sister.

(5) The facility shall safeguard clinical record information against loss, destruction, fire, theft, and unauthorized use.

(6) The clinical record shall contain the following:

- (A) Sufficient information to identify the resident;
- (B) a record of the resident's assessments;
- (C) admission information;
- (D) the plan of care and services provided;

- (E) a discharge summary or report from the attending physician and a transfer form after a resident is hospitalized or transferred from another health care institution;
 - (F) physician's orders;
 - (G) medical history;
 - (H) reports of treatments and services provided by facility staff and consultants;
 - (I) records of drugs, biologicals, and treatments administered; and
 - (J) documentation of all incidents, symptoms, and other indications of illness or injury, including the date, the time of occurrence, the action taken, and the results of action.
- (7) The physician shall sign all documentation entered or directed to be entered in the clinical record by the physician.
- (8) Documentation by direct care staff shall meet the following criteria:
- (A) List drugs, biologicals, and treatments administered to each resident;
 - (B) be an accurate and functional representation of the actual experience of the resident in the facility;
 - (C) be written in chronological order and signed and dated by the staff person making the entry;
 - (D) include the resident's response to changes in condition with follow-up documentation describing the resident's response to the interventions provided;
 - (E) not include erasures or use of white-out. Each error shall be lined through and the word "error" added. The staff person making the correction shall sign and date the error. An entry shall not be recopied; and
 - (F) in the case of computerized resident records, include a system to ensure that when an error in documentation occurs, the original entry is maintained, and the person making the correction enters the date and that person's electronic signature in the record.
- (9) Clinical record staff.
- (A) The facility shall assign overall supervisory responsibility for maintaining the residents' clinical records to a specific staff person.
 - (B) The facility shall maintain clinical records in a manner consistent with current standards of practice.
 - (C) If the clinical record supervisor is not a qualified medical record practitioner, the facility shall provide consultation through a written agreement with a qualified medical record practitioner.

KENTUCKY

Downloaded January 2011

Section 15. Administration. [nursing facilities]

...(10) Clinical records.

- (a) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are:
 1. Complete;
 2. Accurately documented;
 3. Readily accessible; and
 4. Systematically organized.
- (b) Retention of records. After resident's death or discharge the completed medical record shall be placed in an inactive file and retained for five (5) years or in case of a minor, three (3) years after the patient reaches the age of majority under state law, whichever is the longest.

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

(d) The facility shall 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:

1. Transfer to another health care institution;
2. Law;
3. Third-party payment contract; or
4. The resident.

(e) The facility shall:

1. Permit each resident to inspect his or her records on request; and
2. Provide copies of the records to each resident no later than forty-eight (48) hours after a written request from a resident, at a photocopying cost not to exceed the amount customarily charged in the community.

(f) The clinical record shall contain:

1. Sufficient information to identify the resident;
2. A record of the resident's assessments;
3. The plan of care and services provided; and
4. The results of any preadmission screening conducted by the state; and
5. Progress notes.

LOUISIANA

Downloaded January 2011

Subchapter H. Resident Clinical Records

§9857. General Provisions

A. The nursing home shall maintain clinical records on each resident in accordance with accepted professional standards and practices. Each resident's clinical record shall be complete, accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

§9859. Maintenance of Records

A. The overall supervisory responsibility for the resident record service shall be assigned to a responsible employee of the facility.

B. All entries in the clinical record shall be either typewritten or legibly written in ink, dated, and signed.

C. If electronic signatures are used, the nursing home shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

D. If a facsimile communications system (FAX) is used, the nursing home shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the clinical record is retained.

E. A nursing home record may be kept in any written, photographic, microfilm, or other similar method or may be kept by any magnetic, electronic, optical, or similar form of data compilation which is approved for such use by the department.

F. No magnetic, electronic, optical, or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

G. A nursing home may, at its discretion, cause any nursing home record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of nursing home records.

H. Upon an oral or written request, the nursing home shall give the resident or his/her legal representative access to all records pertaining to himself/herself including current clinical records within 24 hours, excluding weekends and holidays. After receipt of his/her records for inspection, the nursing home shall provide, upon request and two working days notice, at a cost consistent with the provisions of R.S. 40:1299(A)(2)(b), photocopies of the records or any portions of them.

I. The nursing home shall ensure that all clinical records are completed within 90 days of discharge, transfer, or death. All information pertaining to a resident's stay is centralized in the clinical record.

§9861. Content

A. The clinical record contains sufficient information to identify the resident clearly, to justify the diagnosis and treatment, and to document the results accurately.

B. As a minimum, each clinical record shall contain:

1. sufficient information to identify the resident;
2. physician's orders;
3. progress notes by all practitioners and professional personnel providing services to the resident;
4. a record of the resident's assessments;
5. the plan of care;
6. entries describing treatments and services provided; and
7. reports of all diagnostic tests and procedures.

§9863. Confidentiality

A. The nursing home shall safeguard clinical record information against loss, destruction, or unauthorized use. The nursing home shall ensure the confidentiality of resident records, including information in a computerized record system, except when release is required by transfer to another health care institution, law, third party payment contract, or the resident. Information from or copies of records may be released only to authorized individuals, and the nursing home must ensure that unauthorized individuals cannot gain access to or alter resident records.

§9865. Retention

A. Clinical records shall be retained for a minimum of six years following a resident's discharge or death, unless the records are pertinent to a case in litigation, in which instance they shall be retained indefinitely or until the litigation is resolved.

B. A nursing home which is closing shall notify the department in writing at least 14 days prior to cessation of operation of their plan for the disposition of residents' clinical records for approval.

MAINE

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Maine regulations do not address medical records.

10.07.02.09 Resident Care Policies.

A. Written Policies. Comprehensive care facilities and extended care facilities shall develop written policies, consistent with these regulations, to govern the nursing care and related medical or other services they provide covering the following:

...(12) Clinical records...

10.07.02.20 Clinical Records.

A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices.

B. Contents of Record. Contents of record shall be:

- (1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;
- (2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;
- (3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;
- (4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);
- (5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);
- (6) Medical and social history of patient;
- (7) Report of physical examination;
- (8) Diagnostic and therapeutic orders;
- (9) Consultation reports;
- (10) Observations and progress notes;
- (11) Reports of medication administration, treatments, and clinical findings;
- (12) Discharge summary including final diagnosis and prognosis;
- (13) Discipline assessment; and
- (14) Interdisciplinary care plan.

C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions.

D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.

E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.

F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.

G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval.

MASSACHUSETTS

Downloaded January 2011

150.013: Clinical and Related Records

(A) All facilities shall provide conveniently located and suitably equipped areas for the recording and storage of records.

(B) All records shall be permanent, either typewritten or legibly written in ink (no record shall be written in pencil). No erasures or ink eradicator shall be used or pages removed.

(C) All records shall be complete, accurate, current, available on the premises of the facility for inspection and maintained in a form and manner approved by the Department. The following records shall be maintained:

(1) Daily census.

(2) Employee records on all employees.

(3) Patient care policies.

(4) Incident, fire, epidemic, emergency and other report forms.

(5) Schedules of names, telephone numbers, dates and alternates for all emergency or "on call" personnel.

(6) A Patient or Resident Roster approved by the Department.

(7) A Doctor's Order Book with a stiff cover and indexed, looseleaf pages. The Doctor's Order Book shall be current and accurate and shall include all medications, treatments, diets, restorative services and medical procedures ordered for patients or residents. Orders shall be dated, recorded and signed (telephone orders countersigned) by the attending physician or nurse practitioner or physician assistant. Facilities may keep Doctors' Order sheets in the patients' or residents' clinical record provided this procedure is so stated in the facility's written policies. The Doctors' Order sheets shall contain all data listed above.

(8) A bound Narcotic and Sedative Book with a stiff cover and numbered pages.

(9) A Pharmacy Record Book with stiff cover and numbered pages.

(10) A bound Day and Night Report Book with a stiff cover and numbered pages.

(11) Individual patient or resident clinical records in stiff-covered folders.

(12) Record forms to record medical, nursing, social and other service data.

(13) Identification and summary sheets on all patients or residents.

(14) Record forms for listing patients' or residents' clothing, personal effects and valuables.

(D) All facilities shall maintain a separate, complete, accurate and current clinical record in the facility for each patient or resident from the time of admission to the time of discharge. This record shall contain all medical, nursing and other related data. All entries shall be dated and signed. This record shall be kept in an individual folder at the nurses' or attendants' station. The clinical record shall include:

(1) Identification and Summary Sheet including: patient's or resident's name, bed and room number, social security number, age, sex, race, marital status (married, separated, widowed or divorced), religion, home address, and date and time of admission; names, addresses and telephone numbers of attending physician or physician-physician assistant team or physician-nurse practitioner team and alternates, of referring agency or institution, and of any other practitioner attending the patient or resident (dentist, podiatrist); name, address and telephone number of next

of kin or sponsor; admitting diagnosis, final diagnosis, and associated conditions on discharge; and placement.

(2) A Health Care Referral Form, Hospital Summary Discharge Sheets and other such information transferred from the agency or institution to the receiving facility (105 CMR 150.003(C)(1)).

(3) Admission Data recorded and signed by the admitting nurse or responsible person including: how admitted (ambulance, ambulation or other); referred by whom and accompanied by whom, date and time of admission; complete description of patient's or resident's condition upon admission, including vital signs on all admissions and weight (if ambulatory); and date and time attending physician or physician-physician assistant team or physician-nurse practitioner team notified of the admission.

(4) Initial Medical Evaluation and medical care plan including: medical history, physical examination, evaluation of mental and physical condition, diagnoses, orders and estimation of immediate and long-term health needs dated and signed by the attending physician (105 CMR 150.005(F)(1)) or signed by a nurse practitioner or physician assistant and countersigned by the supervising physician within ten days for Level I and Level II patients and within 30 days for Level III...patients (105 CMR 150.005(F)(4)).

(5) Physician's or Physician-Physician Assistant Team's or Physician-Nurse Practitioner Team's Progress Notes including: significant changes in the patient's or resident's condition, physical findings and recommendations recorded at each visit, and at the time of periodic reevaluation and revision of medical care plans (105 CMR 150.005(G)).

(6) Consultation Reports including: consultations by all medical, psychiatric, dental or other professional personnel who are involved in patient or resident care and services, recorded in each patient's or resident's clinical record. Such records shall include date, signature and explanation of the visit, findings, treatments and recommendations.

(7) Medication and Treatment Record including: date, time, dosage and method of administration of all medications; date and time of all treatments; special diets; restorative therapy services and special procedures for each patient or resident, dated and signed by the nurse or individual who administers the medication or treatment.

(8) A Record of all fires and all incidents involving patients or residents and personnel while on duty (105 CMR 150.002(D)(6)(c)).

(9) A Nursing Care Plan for each patient or resident (105.150.007(D)(2)).

(10) Nurses Notes containing accurate reports of all factors pertaining to the patient's or resident's needs or special problems and the overall nursing care provided.

(11) Initial Plans and written evidence of periodic review and revision of dietary, social service, restorative therapy services, activity, and other patient or resident care plans.

(12) Laboratory and X-ray Reports.

(13) A list of each patient's or resident's clothing, personal effects, valuables, funds or other property (105 CMR 150.002(E)(2), 150.002(E)(3)).

(14) Discharge or Transfer Data including: a dated, signed physician's order or physician assistant's order or nurse practitioner's order for discharge; the reason for discharge and a summary of medical information, including physical and mental condition at time of discharge; a complete and accurate health care referral form; date and time of discharge; address of home, agency or institution to which discharged; accompanied by whom; and notation as to arrangements for continued care or follow-up.

(15) Utilization Review Plan, Minutes, Reports and Special Studies.

(17) Certified facilities that admit residents with MR or DD/ORC shall maintain as part of the resident's record the DMR Rolland Integrated Service Plan (RISP) and the Specialized Service Provider Plan.

(E) All clinical records of residents or patients including those receiving outpatient restorative services shall be completed within two weeks of discharge and filed and retained for at least five years. Provisions shall be made for safe keeping for at least five years of all clinical records in the event the facility discontinues operation, and the Department shall be notified as to the location of the records and the person responsible for their maintenance.

(F) All information contained in clinical records shall be treated as confidential and shall be disclosed only to authorized persons.

(G) All facilities shall employ a medical records librarian or shall designate a trained employee of the facility to be responsible for ensuring that records are properly maintained, completed and preserved.

MICHIGAN

Downloaded January 2011

R 325.21102 Patient clinical records.

Rule 1102.

(1) A clinical record shall be provided for each patient in the home. The clinical record shall be current and entries shall be dated and signed.

(2) The clinical record shall include, at a minimum, all of the following:

(a) The identification and summary sheet, which shall include all of the following patient information:

(i) Name.

(ii) Social security number.

(iii) Veteran status and number.

(iv) Marital status.

(b) Name, address, and telephone number of next of kin, legal guardian, or designated representative.

(c) Name, address, and telephone number of person or agency responsible for patient's maintenance and care in the home.

(d) Date of admission.

(e) Clinical history and physical examination performed by the physician within 5 days before or on admission, including a report of chest x rays performed within 90 days of admission and a physician's treatment plan.

(f) Admission diagnosis and amendments thereto during the course of the patient's stay in the home.

(g) Consent forms as required and appropriate.

(h) Physician's orders for medications, diet, rehabilitative procedures, and other treatment or procedures to be provided to the patient.

(i) Physician's progress notes written at the time of each visit describing the patient's condition and other pertinent clinical observations.

(j) Nurse's notes and observations by other personnel providing care.

(k) Medication and treatment records.

(l) Laboratory and x-ray reports.

(m) Consultation reports.

(n) Time and date of discharge, final diagnosis and place to which patient was discharged, condition on discharge, and name of person, if any, accompanying patient.

(3) Copies of clinical history and physical examination report, discharge summary, transfer form, and other pertinent information arriving at the home with the patient upon transfer from another health facility shall be maintained in the facility.

(4) Clinical records of discharged patients shall be completed within 30 days following discharge.

(5) Clinical records shall be under the supervision of a full-time employee of the home.

(6) Clinical records are retained for a minimum of 6 years from the date of discharge or, in the case of a minor, 3 years after the individual comes of age under state law, whichever is longer.

(7) If a facility ceases to operate, the clinical records shall be transferred with the individual to another health care facility. It is the responsibility of the owner or corporate body to maintain clinical records of discharged patients for the length of retention as stated in subrule (6) of this rule.

(8) If the department believes that patient clinical records are not being properly maintained or completed, the department may order a home to secure from a registered record administrator or accredited record technician on-site consultation of up to 4 hours per quarter until the problem is corrected.

333.20175 Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.

Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient including a full and complete record of tests and examinations performed, observations made, treatments provided...

(3) Unless otherwise provided by law, the licensing and certification records required by this article are public records.

(4) Departmental officers and employees shall respect the confidentiality of patient clinical records and shall not divulge or disclose the contents of records in a manner that identifies an individual except pursuant to court order.

MINNESOTA

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4658.0430 HEALTH INFORMATION MANAGEMENT SERVICE.

Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.

Subp. 2. Quality of health information. A nursing home must develop and utilize a mechanism for auditing the quality of its health information management services.

Subp. 3. Person responsible for health information management. A nursing home must designate a person to be responsible for health information management.

4658.0435 CONFIDENTIALITY OF CLINICAL RECORDS AND INFORMATION.

Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.335 and 144.651, and federal regulations. A resident's clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access.

Subp. 2. Electronic transmission of health care data. If a nursing home chooses to transmit or receive health care data by electronic means, the nursing home must develop and comply with policies and procedures to ensure the confidentiality, security, and verification of the transmission and receipt of information authorized to be transmitted by electronic means. A durable copy of the transmission must be placed in the resident's clinical record.

4658.0445 CLINICAL RECORD.

Subpart 1. Unit record. A resident's clinical record must be started at admission and incorporated into a central unit record system. The clinical record must contain sufficient information to identify the resident, contain a record of resident assessments, the comprehensive plan of care, progress notes on the implementation of the care plan, and a summary of the resident's condition at the time of discharge.

Subp. 2. Form of entries and authentication. Data collected must be timely, accurate, and complete. All entries must be entered, authenticated, and dated by the person making the entry. If a nursing home uses an electronic paperless means of storing the clinical record, the nursing home must comply with part 4658.0475. All entries must be made as soon as possible after the observation or treatment in order to keep the clinical record current. In cases where authentication is done electronically or by rubber stamp, safeguards to prevent unauthorized use must be in place, and a rubber stamp may be used only if allowed by the licensing rules for that health care professional. Nursing assistants may document in the nursing notes if allowed by nursing home policy.

Subp. 3. Classification systems. All diagnoses and procedures must be accurately and comprehensively coded to ensure accurate resident medical profiles.

4658.0450 CLINICAL RECORD CONTENTS.

Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:

- A. the condition of the resident at the time of admission;
- B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;
- C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;
- D. the resident's general condition, actions, and attitudes;
- E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;
- F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;
- G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication;
- H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810;
- I. reports of laboratory examinations;

- J. dates and times of all treatments and dressings;
- K. dates and times of visits by all licensed health care practitioners;
- L. visits to clinics or hospitals;
- M. any orders or instructions relative to the comprehensive plan of care;
- N. any change in the resident's sleeping habits or appetite;
- O. pertinent factors regarding changes in the resident's general conditions; and
- P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.

Subp. 2. Physician and professional services. The clinical record must contain the recording requirements of parts 4658.0710 to 4658.0725.

Subp. 3. Nursing services. The clinical record must contain the recording requirements of parts 4658.0515 to 4658.0530.

Subp. 4. Dietary and food services. The clinical record must contain the recording requirements of parts 4658.0600 and 4658.0625.

Subp. 5. Resident personal funds account. The clinical record must contain the recording requirements of part 4658.0255.

Subp. 6. Activities. The clinical record must contain the recording requirements of part 4658.0900.

Subp. 7. Social services. The clinical record must contain the recording requirements of parts 4658.1015 and 4658.1020.

4658.0455 TELEPHONE AND ELECTRONIC ORDERS.

A. Orders received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.335, 144.651, and 144.652.

B. Orders received by telephone or other electronic means, not including facsimile machine, must be immediately recorded or placed in the resident's record by the person authorized by the nursing home and must be countersigned by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, whichever is sooner.

C. Orders received by facsimile machine must have been signed by the ordering health practitioner authorized to prescribe, and must be immediately recorded or a durable copy must be placed in the resident's clinical record by the person authorized by the nursing home.

4658.0470 RETENTION, STORAGE, AND RETRIEVAL.

Subpart 1. Retention. A resident's records must be preserved for a period of at least five years following discharge or death.

Subp. 2. Storage. Space must be provided for the safe and confidential storage of residents' clinical records. Records of current residents must be stored on site.

Subp. 3. Retrieval. If records of discharged residents are stored off site, policies and procedures must be developed and implemented by clinical record personnel and the nursing home administration for the confidentiality, retention, and timely retrieval of records within one working day. The policies and procedures must specify who is authorized to retrieve a record. Off-site archived copies of clinical databases must be protected against fire, flood, and other emergencies. The policies must address the location and retention of records if the nursing home discontinues operation.

4658.0475 COMPUTERIZATION.

If a nursing home is converting to an electronic paperless health information management system:

- A. policies and procedures must be established and maintained that require password protection of the clinical database;

- B. any outside contract for health information management services must include a provision that the company providing the services assumes responsibility for maintaining the confidentiality of all health information within its control;
- C. audit trails must be developed for computer applications to determine the source and date of all entries and deletions;
- D. backup systems must be implemented and maintained;
- E. preventative maintenance must be implemented and maintained;
- F. there must be a plan for preparing, securing, and retaining archived copies of computerized clinical databases;
- G. procedures must be implemented for preparing and securing daily, weekly, and monthly archived copies of computerized clinical databases; and
- H. there must be confidentiality and protection from unauthorized use of active and archived computerized clinical databases.

4658.0715 MEDICAL INFORMATION FOR CLINICAL RECORD.

A physician or physician designee must provide the following information for the clinical record:

- A. the report of the admission history and physical examination;
- B. the admitting diagnosis;
- C. a description of the general medical condition, including disabilities and limitations;
- D. a report of subsequent physical examinations;
- E. instructions relative to the resident's total program of care;
- F. written orders for all medications with stop dates, treatments, rehabilitations, and any medically prescribed special diets;
- G. progress notes;
- H. any advanced directives; and
- I. condition on discharge or transfer, or cause of death.

MISSISSIPPI

Downloaded January 2011

122 REHABILITATIVE SERVICES

122.01 Rehabilitative services....Each resident's medical record shall contain written evidence that services are provided in accordance with the written orders of an attending physician or nurse practitioner.

124 MEDICAL RECORDS SERVICES

1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.
2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed.
3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use.
4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse

practitioner orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis.

5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.

6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.

7. Medical records of discharged residents shall be completed within sixty (60) days following discharge.

8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years.

9. A resident index, including the resident's full name and birth date, shall be maintained.

MISSOURI

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CSR 30-85.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

...(97) Facility staff shall include physician entries in the medical record with the following information: admission diagnosis, admission physical and findings of subsequent examinations; progress notes; orders for all medications and treatment; orders for extent of activity; orders for restraints including type and reason for restraint; orders for diet; and discharge diagnosis or cause of death.

...(99) Facilities shall ensure that the clinical record contains sufficient information to—

(A) Identify the resident;

(B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and

(C) Identify the discharge or transfer destination.

(100) Facilities shall ensure that the resident's clinical record must contain progress notes that include, but are not limited to:

(A) Response to care and treatment;

(B) Change(s) in physical, mental and psychosocial condition;

(C) Reasons for changes in treatment; and

(D) Reasons for transfer or discharge.

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

(102) The facility must keep all information confidential that is contained in the resident's records regardless of the form or storage method of the records, including video-, audio- or computer-stored information.

(103) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit and systematically organized.

(104) Facilities must retain clinical records for the period of time required by state law or five (5) years from the date of discharge when there is no requirement in state law.

MONTANA

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37.106.314 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: MEDICAL RECORDS

- (1) A health care facility shall initiate and maintain by storing in a safe manner and in a safe location a medical record for each patient and resident.
- (2) A health care facility, excluding a hospital, shall retain a patient's or resident's medical records for no less than five years following the date of the patient's or resident's discharge or death.
- (3) A medical record may be microfilmed or preserved via any other electronic medium that yields a true copy of the record if the health care facility has the equipment to reproduce records on the premises.
- (4) A signature of a physician may not be stamped on a medical record unless there is a statement in the facility administrator's or manager's file signed by the physician stating that the physician is responsible for the content of any document signed with his rubber stamp.

NEBRASKA

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12-006.04G Medical Records Staffing:

The facility must assign overall supervisory responsibility for the medical record service to a full-time employee of the facility, and must maintain sufficient supporting personnel competent to carry out the functions of the medical record services.

12-006.16A Clinical Records: The facility must maintain clinical records on each resident in accordance with accepted professional standards and practice. Clinical records must contain at a minimum:

1. Sufficient information to identify the resident;
2. A record of the resident's assessments, including those assessments performed by services under agreement with the facility;
3. The plan of care and services including medication administration, provided by facility staff and services provided under agreement with the facility;
4. Interdisciplinary progress notes to include effect of care provided, residents' response to treatment, change in condition, and changes in treatment;
5. Medical practitioner orders which are signed and dated;
6. Allergies;
7. Person to contact in an emergency situation;
8. Name of attending medical practitioner; and
9. Advanced directives if available.

12-006.16B The clinical record must be:

1. Complete;
2. Accurately documented;
3. Readily accessible;
4. Systematically organized; and
5. Legible.

12-006.16C Clinical Record Safeguards: The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

12-006.16C1 If the facility maintains a resident's record by computer, electronic signatures are acceptable. If attestation is done on computer records, safeguards to prevent unauthorized access, and to provide for reconstruction of information must be in place.

12-006.16C2 The facility must protect the confidentiality of all information contained in the resident's records, regardless of the form or storage method of the records, except when release is authorized by:

1. Transfer agreement to another health care facility or health care service;
2. Law;
3. Third party payment contract; or
4. The resident or designee.

12-006.16C3 Records are subject to inspection by authorized representatives of the Department.

12-006.16D Record Retention and Preservation: Resident clinical records must be maintained and preserved for a period of at least five years or, in case of a minor, five years after the resident becomes of age under Nebraska law. In cases in which a facility ceases operation, all records of each resident must be transferred to the health care facility to which the resident moves. All other resident records of a facility ceasing operation must be disposed of by shredding, burning, or other similar protective measures in order to preserve the resident's rights of confidentiality. Records or documentation of the actual fact of resident medical record destruction must be permanently maintained.

NEVADA

Downloaded January 2011

Medical Records

NAC 449.74441 Maintenance. (NRS 449.037)

1. A facility for skilled nursing shall maintain medical records for each patient in the facility in accordance with accepted professional principles.

2. A medical record must be:

- (a) Complete;
- (b) Accurate;
- (c) Organized; and
- (d) Readily accessible to those persons who are authorized to review the records.

3. A medical record must include:

- (a) Sufficient information to identify the patient;
- (b) A record of the assessments of the patient conducted pursuant to NAC 449.74433 and 449.74435;
- (c) The patient's plan of care and the services provided to the patient;
- (d) The results of any assessment of the patient conducted by a state agency before his admission to the facility; and
- (e) Periodic progress notes prepared by appropriate members of the staff.

4. A facility for skilled nursing shall maintain the medical records of a patient:

- (a) For at least 5 years after the discharge of the patient, unless state law requires otherwise; and
- (b) For at least 3 years after the patient reaches 18 years of age if the patient is a minor.

5. A facility for skilled nursing shall ensure that:

- (a) Information contained in a medical record is not lost, destroyed or used in an unauthorized manner.

(b) No person willfully and knowingly falsifies or causes another person to falsify information contained in a medical record.

6. Information contained in a medical record is confidential and must not be released without the written consent of the patient except:

(a) As required by law;

(b) Under a contract involving a third-party payor; or

(c) As required upon the transfer of the patient to another medical facility. (Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

NEW HAMPSHIRE

Downloaded January 2011

He-P 803.14 Duties and Responsibilities of All Licensees.

...(r) Any licensee that maintains electronic records shall develop written policies and procedures designed to protect the privacy of residents and employees that, at a minimum, include:

(1) Procedures for backing up files to prevent loss of data;

(2) Safeguards for maintaining the confidentiality of information pertaining to residents and personnel; and

(3) Systems to prevent tampering with information pertaining to residents and personnel.

He-P 803.19 Resident Records.

(a) The licensee shall maintain a legible, current and accurate record for each resident based on services provided at the nursing home.

(b) At a minimum, resident records shall contain the following:

(1) A copy of the resident's admission agreement and all documents required by He-P 803.15(c);

(2) Identification data, including:

a. Vital information including the resident's name, date of birth, and marital status;

b. Resident's religious preference, if known;

c. Resident's veteran status if known; and

d. Name, address and telephone number of an emergency contact person;

(3) The name and telephone number of the resident's licensed practitioner(s);

(4) Resident's health insurance information;

(5) Copies of any executed legal orders and directives, such as guardianship orders issued under RSA 464-A, a durable power of attorney for healthcare, or a living will;

(6) A record of the health examination(s) in accordance with He-P 803.15(h);

(7) Written, dated and signed orders for the following:

a. All medications, treatments and special diets; and

b. Laboratory services and consultations;

(8) Results of any laboratory tests, or consultations;

(9) All assessments and care plans, and documentation that the resident and the guardian or agent, if any, has participated in the development of the care plan;

(10) Documentation of informed consent;

(11) All admission and progress notes;

(12) Documentation of any alteration in the resident's daily functioning such as:

a. Signs and symptoms of illness; and

b. Any action that was taken including practitioner notification;

(13) Documentation of any medical or specialized care;

- (14) Documentation of unusual incidents;
 - (15) The consent for release of information signed by the resident, guardian or agent, if any;
 - (16) Discharge planning and referrals as applicable;
 - (17) Transfer or discharge documentation, including notification to the resident, guardian or agent, if any, of transfer or discharge;
 - (18) Room change documentation, including notification to the resident, guardian or agent, if any, and if applicable;
 - (19) The medication record as required by He-P 803.16(y) and (ac); and
 - (20) Documentation of a resident's refusal of any care or services.
- (c) Resident records and resident information shall be kept confidential and only provided in accordance with law.
- (d) The licensee shall develop and implement a written policy and procedure document that specifies the method by which release of information from a resident's record shall occur.
- (e) Resident records shall be available to health care workers and any other person authorized by law or rule to review such records
- (f) When not being used by authorized personnel, resident records shall be safeguarded against loss or unauthorized use or access.
- (g) Records shall be retained for 4 years after discharge, except for records of Medicaid residents, which shall be retained for 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6-year period, whichever is longer.
- (h) The licensee shall arrange for storage of, and access to, resident records as required by (g) above in the event the nursing home ceases operation.

NEW JERSEY

Downloaded January 2011

SUBCHAPTER 33. MANDATORY QUALITY ASSESSMENT AND/OR QUALITY IMPROVEMENT

8:39-33.2 Mandatory quality assessment and/or quality improvement policies and procedures

(a) The quality assessment and/or quality improvement program shall identify problems in the care and services provided to the residents and shall include the audit of medical records.

SUBCHAPTER 35. MANDATORY MEDICAL RECORDS

8:39-35.1 Mandatory organization for medical records

At least 14 days before a facility plans to cease operations, it shall notify the New Jersey State Department of Health and Senior Services in writing of the location and method of retrieval of medical records.

8:39-35.2 Mandatory policies and procedures for medical records

(a) Each active medical record shall be kept at the nurses' station for the resident's unit.

(b) The facility shall maintain for staff use a current list of standard professional abbreviations commonly used in the facility's medical records.

(c) Medical records shall be organized with a uniform format across all records.

(d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available:

1. Legible identifying data, such as resident's name, date of birth, sex, address, and next of kin, and person to notify in an emergency;

2. The name, address, and telephone number of the resident's physician, an alternate physician or advanced practice nurse, and dentist;
 3. Complete transfer information from the sending facility, including results of diagnostic, laboratory, and other medical and surgical procedures, and a copy of the resident's advance directive, if available, or notice that the resident has informed the sending facility of the existence of an advance directive;
 4. A history and results of a physical examination, including weight, performed by the physician or advanced practice nurse on admission, in accordance with N.J.A.C. 8:39-11.2(c) and results of the most recent examination by the physician, or advanced practice nurse, or New Jersey licensed physician assistant;
 5. An assessment and plan of care made by each discipline involved in the resident's care;
 6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided;
 7. All physician's or advanced practice nurse's orders for the last three months;
 8. Telephone orders, each of which shall be countersigned by a physician or advanced practice nurse within seven days, except for orders for non-prescription drugs or treatments, which shall be signed at the physician's or advanced practice nurse's next visit to the resident;
 9. Records of all medications and other treatments that have been provided during the last three months;
 10. Consultation reports for the last six months;
 11. Records of all laboratory, radiologic, and other diagnostic tests for the last six months;
 12. Records of all admissions, discharges, and transfers to and from the facility that occurred in the last three months;
 13. Signed consent and release forms;
 14. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the resident concerning this;
 15. A discharge plan for those residents identified by the facility as likely candidates for discharge into the community or a less intensive care setting; and
 16. A discharge note written on the day of discharge for residents discharged to the community, a less intensive care setting, another nursing home or hospital, which includes at least the diagnosis, prognosis, and psychosocial and physical condition of the resident.
- (e) The medical record shall be completed within 30 days of discharge.
- (f) If part of a care plan is not implemented, the record shall explain why.
- (g) All entries in the resident's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.
1. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.
 2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.
 3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:
 - i. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall sign the original order, history and/or examination at an off-site location;
 - ii. The original shall be FAXed to the long-term care facility for inclusion into the medical record;

iii. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall submit the original for inclusion into the medical record within 72 hours; and

iv. The FAXed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process that produces a permanent copy, the plain-paper report may be included as a part of the medical record, as an alternate to replacement of the copy by the original report.

(h) If a resident or the resident's legally authorized representative requests, orally or in writing, a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, resident's attorney, or third party insurer where permitted by law.) A copy of the medical record from an individual admission shall be provided to the resident or the resident's legally authorized representative within two working days of request.

1. The facility shall establish a policy assuring access to copies of medical records for residents who do not have the ability to pay; and

2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The resident or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(i) Access to the medical record shall be limited only to the extent necessary to protect the resident. A verbal explanation for any denial of access shall be given to the resident or legal guardian by the physician or advanced practice nurse and there shall be documentation of this in the medical record. In the event that direct access to a copy by the resident is medically contraindicated (as documented by a physician or advanced practice nurse in the resident's medical record), the medical record shall be made available to a legally authorized representative of the resident or the resident's physician or advanced practice nurse.

(j) The resident shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(k) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the resident, or until the resident reaches the age of 23 years, whichever is the longer period of time. A summary sheet of each medical record shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years.

SUBCHAPTER 36. ADVISORY MEDICAL RECORDS

8:39-36.1 Advisory policies and procedures for medical records

(a) The name by which the resident wishes to be called is entered on the cover or first page of the medical record.

(b) There is a comprehensive discharge summary with statistical and narrative information from each service completed for each resident.

(c) The full medical records for all discharged or deceased residents are completed within 15 days.

(d) Telephone orders are countersigned by a physician or advanced practice nurse within 48 hours except for orders for non-prescription drugs or treatments, which are countersigned within seven days.

8:39-36.2 Advisory staff education and training for medical records

The facility requires that staff use only standard professional abbreviations in medical records and maintains a current list of such abbreviations.

8:39-36.3 Advisory staff qualifications for medical records

(a) The facility utilizes the services of a medical record practitioner or consultant who is:

1. Certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or
2. A graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611).

NEW MEXICO

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7.9.2.30 MEDICAL RECORDS - STAFF:

- A. **TIMELINESS:** Duties relating to medical records shall be completed in a timely manner.
- B. Each facility shall designate an employee of the facility as the person responsible for the medical record service, who:
- (1) Is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American Medical Association; or
 - (2) Receives regular consultation but not less than four hours quarterly as appropriate from a person who meets the requirements of Section 30.2.1. Such consultation shall not be substituted for the routine duties of staff maintaining records. The records consultant shall evaluate the records and records service, identify problem areas, and submit written recommendations for change to the administrator.
 - (3) Sufficient time will be allocated to the person who is designated responsible for medical record service to insure that accurate records are maintained.

7.9.2.31 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 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:** A master resident index shall be maintained.
- 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 sixty (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 ten (10) years following a resident's discharge or death. All other records required by these regulations shall be retained for the period for which the facility is under review.
 - (3) Medical records no longer required to be retained under this section 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.
- (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) 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.

7.9.2.32 MEDICAL RECORDS - CONTENT: Except for persons admitted for short-term care, each resident's medical record shall contain:

A. IDENTIFICATION AND SUMMARY SHEET:

B. PHYSICIAN'S DOCUMENTATION:

- (1) An admission medical evaluation by a physician, including:
 - (a) A summary of prior treatment;
 - (b) Current medical findings;
 - (c) Diagnosis at the time of admission to the facility;
 - (d) The resident's rehabilitation potential;
 - (e) The results of the required physical examination;
 - (f) Level of care;
- (2) All physician's orders including:
 - (a) Admission to the facility;
 - (b) Medications and treatments;
 - (c) Diets;
 - (d) Rehabilitative services;
 - (e) Limitations on activities;
 - (f) Restraint orders;
 - (g) Discharge or transfer orders.
- (3) Physician progress notes following each visit.
- (4) Annual physical examination.
- (5) Alternate visit schedule, and justification for such alternate visits, not to exceed ninety (90) days.

C. NURSING SERVICE DOCUMENTATION:

- (1) An assessment of the resident's nursing needs.
- (2) Initial nursing care plan and any revisions.
- (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 monthly;
- (4) In addition to the nursing care plan, 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, injuries or potential complications from injury or accident, details of incident or accident, action taken, and follow-up care;
- (c) The administration of all medications, 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 intake, when the monitoring of intake is necessary;
- (e) Fluid Intake when monitoring of intake is necessary;
- (f) Any unusual occurrences of appetite or refusal or reluctance to accept diets;
- (g) Summary of restorative nursing measures which are provided;
- (h) Summary of the use of physical and chemical restraints;
- (i) Other non-routine nursing care given;
- (j) The condition of a resident upon discharge; and
- (k) The time of death, the physician called, and the person to whom the body was released.

D. SOCIAL SERVICES RECORDS:

- (1) A social history of the resident; and
- (2) Notes regarding pertinent social data and action taken.

E. ACTIVITIES RECORDS: Documentation of activities programming, a history and assessment, a summary of attendance, and quarterly progress notes.

F. REHABILITATIVE SERVICES:

- (1) An evaluation of the rehabilitative needs of the resident.
- (2) Plan of treatment.
- (3) Progress notes detailing treatment given, evaluation, and progress.

G. DIETARY ASSESSMENT: Record of the dietary assessment.

H. DENTAL SERVICES: Summary of all dental services resident has received.

I. DIAGNOSTIC SERVICES: Records of all diagnostic tests performed during the resident's stay in the facility.

J. PLAN OF CARE: Plan of care which includes integrated program activities, therapies and treatments designed to help each resident achieve specific goals as developed by an interdisciplinary team.

K. AUTHORIZATION OR CONSENT: A photocopy of any court order, power of attorney or living will authorizing another person to speak or act on behalf of the resident and any resident consent forms.

L. DISCHARGE OR TRANSFER INFORMATION: Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate:

- (1) Current medical finding and condition;
- (2) Final diagnosis;
- (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.

7.9.2.45 PHYSICAL AND CHEMICAL RESTRAINTS:

G. RECORDS: Any use of restraints shall be noted, dated, and documented in the resident's clinical record on each tour of duty during which the restraints are in use.]

NEW YORK

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Section 415.22 - Clinical records

415.22 Clinical records. (a) The facility shall maintain clinical records for each resident in accordance with accepted professional standards and practice. The records shall be:

- (1) complete;
 - (2) accurately documented;
 - (3) readily accessible; and
 - (4) systematically organized.
- (b) Clinical records shall be retained for six years from the date of discharge or death or for residents who are minors, for three years after the resident reaches the age of majority (18).
- (c) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use;
- (d) The facility shall 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:
- (1) transfer to another health care institution;
 - (2) law; or
 - (3) the resident.
- (e) The facility shall permit each resident to inspect his or her records and obtain copies of such records in accordance with the provisions of subparagraph (iv) of paragraph (1) of subdivision (c) of section 415.3 of this Part.
- (f) The clinical record shall contain:
- (1) sufficient information to identify the resident;
 - (2) a record of the resident's comprehensive assessments;
 - (3) the plan of care and services provided;
 - (4) the results of any preadmission screening conducted by the State;
 - (5) progress notes by all practitioners and professional staff caring for the resident; and
 - (6) reports of all diagnostic tests and results of treatments and procedures ordered for the resident.

Section 415.27 - Quality assessment & assurance

...(c) Committee functions. The quality assessment and assurance committee shall:

...(3) define methods for identification and selection of clinical and administrative problems to be reviewed. The process shall include but not be limited to:

...(ii) regularly scheduled reviews of clinical records, resident complaints and suggestions, reported incidents and other documents pertinent to problem identification...

NORTH CAROLINA

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SECTION .2400 - MEDICAL RECORDS

10A NCAC 13D .2401 MAINTENANCE OF MEDICAL RECORDS

(a) The facility shall establish a medical records service. It shall be directed, staffed and equipped to ensure:

- (1) records are processed, indexed and filed accurately;

(2) records are stored in such a manner as to provide protection from loss, damage or unauthorized use;

(3) records contain sufficient information to identify the patient plus a record of all assessments; plan of care; pre-admission screening, if applicable; records of implementation of plan of care; progress notes; and record of discharge, including a discharge summary signed by the physician; and

(4) records are readily accessible by authorized personnel.

(b) The facility shall ensure that a master patient index is maintained, listing patients alphabetically by name, dates of admission, dates of discharge and case number.

(c) The administrator shall designate an employee who works full-time to be the medical records manager. The manager shall advise, administer, supervise and perform work involved in the development, analysis, maintenance and use of medical records and reports. If that employee is not qualified by training or experience in medical record science, he or she shall receive consultation from a registered records administrator or an accredited medical record technician to ensure compliance with rules contained in this Subchapter. The facility shall provide orientation, on-the-job training and in-service programs for all medical records personnel.

10A NCAC 13D .2402 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records shall ensure that medical records, whether original, computer media or microfilm, be kept on file for a minimum of five years following the discharge of an adult patient.

(b) The manager of medical records shall ensure that if the patient is a minor when discharged from the nursing facility, records shall be kept on file until his or her 19th birthday and, then, for five years.

(c) If a facility discontinues operation, the licensee shall make known to the Division of Health Service Regulation where its records are stored. Records are to be stored in a business offering retrieval services for at least 11 years after the closure date.

(d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall take precautions to ensure the confidentiality and safekeeping of the records. The original of the microfilmed medical records shall not be destroyed until the manager of medical records has had an opportunity to review the processed film for content.

(e) Nothing in this Subchapter shall be construed to prohibit the use of automation of medical records, provided that all of the provisions in this Rule are met and the medical record is readily available for use in patient care.

(f) All medical records are confidential. Only authorized personnel shall have access to the records. Signed authorization forms concerning approval or disapproval of release of medical information outside the facility shall be a part of each patient's medical record. Representatives of the Department shall be notified at the time of inspection of the name and record number of any patient who has denied medical record access to the Department.

(g) Medical records are the property of the facility, and they shall not be removed from the facility except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

33-07-03.2-17. Resident record services.

The governing body of the facility shall establish and implement policies and procedures to ensure the facility has a resident record service with administrative responsibility for resident records.

1. A resident record must be maintained and kept confidential for each resident admitted to the facility. The resident record shall be complete, accurately and legibly documented, and readily accessible.

a. The resident or the resident's legal representative have the right to view and authorize release of their medical information.

b. The facility shall develop policies which address access to resident records.

c. Resident records may be removed from the facility only upon subpoena, court order, or pursuant to facility policies when a copy of the original record is maintained at the facility.

2. All records of discharged residents must be preserved for a period of ten years from date of discharge. Records of deceased residents must be preserved to seven years.

a. In the case of minors, records must be retained for the period of minority and ten years from the date of live discharge. Records of deceased residents who are minors must be preserved for the period of minority and seven years.

b. It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified timeframes until such time the governing body determines the records no longer have a research, legal, or medical value.

3. If the facility does not employ an accredited record technician or registered record administrator, an employee of the facility must be assigned the responsibility for ensuring that records are maintained, completed, and preserved. The designated employee shall receive consultation at least annually from an accredited record technician or registered record administrator.

4. Each resident record must include:

a. The name of the resident, personal licensed health care practitioner, dentist, and designated representative or other responsible person, admitting diagnosis, final diagnosis, condition on discharge, and disposition.

b. Initial medical evaluation including medical history, physical examination, and diagnosis.

c. A report from the licensed health care practitioner who attended the resident in the hospital or other health care setting, and a transfer form used under a transfer agreement.

d. Licensed health care practitioner's orders, including all medication, treatments, diet, restorative plan, activities, and special medical procedures.

e. Licensed health care practitioner's progress notes describing significant changes in the resident's condition, written at the time of each visit.

f. Current comprehensive resident assessment and plan of care.

g. Quarterly reviews of resident assessments and nurse's notes containing observations made by nursing personnel for the past year.

h. Medication and treatment records including all medications, treatments, and special procedures performed.

i. Laboratory and x-ray reports.

j. Consultation reports.

k. Dental reports.

l. Social service notes.

m. Activity service notes.

n. Resident care referral reports.

5. All entries into the resident record must be authenticated by the individual who made the written entry, as defined by facility policy and applicable state laws and regulations, and must at a minimum include the following:

a. All entries the licensed health care practitioner personally makes in writing must be signed and dated by the licensed health care practitioner.

b. Telephone and verbal orders may be used provided they are given only to qualified licensed personnel and reduced to writing and signed or initialed by a licensed health care practitioner responsible for the care of the patient.

c. Signature stamps may be used consistent with facility policies as long as the signature stamp is used only by the licensed health care practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate the practitioner is the sole user of the signature stamp.

d. Electronic signatures may be used if the facility's medical staff and governing body adopt a policy permitting authentication by electronic signature. The policy must include:

(1) The staff within the facility authorized to authenticate entries in resident records using an electronic signature.

(2) The safeguards to ensure confidentiality, including:

(a) Each user must be assigned a unique identifier generated through a confidential access code.

(b) The facility shall certify in writing each identifier is kept strictly confidential. This certification must include a commitment to terminate the user's use of that particular identifier if it is found the identifier has been misused. Misused means the user has allowed another individual to use the user's personally assigned identifier, or the identifier has otherwise been inappropriately used.

(c) The user must certify in writing the user is the only individual with user access to the identifier and the only individual authorized to use the signature code.

(d) The facility shall monitor the use of the identifiers periodically and take corrective action as needed. The process by which the facility will conduct the monitoring must be described in policy.

(3) A process to verify the accuracy of the content of the authenticated entries, including:

(a) A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

(b) An opportunity for the user to verify the accuracy of the document and to ensure the signature has been properly recorded.

(c) As part of the quality improvement activities, the facility shall periodically sample records generated by the system to verify accuracy and integrity of the system.

(4) A user may terminate authorization for use of an electronic signature upon written notice to the staff member in charge of resident records.

(5) Each report generated by the user must be separately authenticated.

(6) A list of confidential access codes must be maintained under adequate safeguards by facility administration.

3701-17-19 Records and reports.

(A) Nursing homes shall keep the following records and such other records as the director may require:

(1) An individual medical record shall be maintained for each resident. Such record shall be started immediately upon admission of a resident to the home and shall contain the following:

(a) Admission record. Name, residence, age, sex, race/ethnicity, religion, date of admission, name and address of nearest relative or guardian, admission diagnoses from referral record and name of attending physician.

(b) Referral record. All records, reports, and orders which accompany the resident as required by rule 3701-17-10 of the Administrative Code.

(c) Nursing/care notes. A note of the condition of the resident on admission and subsequent notes as indicated to describe changes in condition, unusual events or accidents. Other individuals rendering services to the resident may enter notes regarding the services they render.

(d) Medication administration record. A doctor's order sheet upon which orders are recorded and signed by the physician, including telephone orders as required by rule 3701-17-13 of the Administrative Code; a nurse's treatment sheet upon which all treatments or medications are recorded as given, showing what was done or given, the date and hour, and signed by the nurse giving the treatment or medication; or other documentation authenticating who gave the medication or treatment.

(e) Resident progress notes. A sheet or sheets upon which the doctor, dentist, advanced practice nurse and other licensed health professionals may enter notes concerning changes in diagnosis or condition of the resident. Resident refusal of treatment and services shall also be documented in the progress notes.

(f) Resident assessment record. All assessments and information required by rule **3701-17-10 of the Administrative Code**.

(g) Care plan. The plan of care required by rule 3701-17-14 of the Administrative Code.

(2) The nursing home shall maintain all records required by state and federal laws and regulations, as to the purchase, delivery, dispensing, administering, and disposition of all controlled substances including unused portions.

(3) The nursing home shall submit an annual report to the department of health on a form prescribed by the director for calendar year 1999.

(4) The nursing home shall maintain a record of all residents admitted to or discharged from the nursing home, and of any additional information necessary to complete the report required in paragraph (A)(3) of this rule.

(B) A record shall be kept showing the name and hours of duty of all persons who work in the home. The nursing home shall maintain each employee's current home address in its personnel file.

(C) All records and reports required under rules 3701-17-01 to 3701-17-26 of the Administrative Code shall be prepared, maintained, filed, and transmitted when required, and shall be made available for inspection at all times when requested by the director or his authorized representative. The records may be maintained in electronic format, microfilm, or other method that assures a true and accurate copy of the records are available.

(1) The nursing home shall maintain the records and reports required by paragraph (A)(1) of this rule in the following manner:

- (a) The home shall safeguard the records and reports against loss, destruction, or unauthorized use and store them in a manner that protects and ensures confidentiality.
- (b) The home shall maintain the records and reports for seven years following the date of the resident's discharge, except if the resident is a minor, the records shall be maintained for three years past the age of majority but not less than seven years.
- (c) Upon closure of the home, the operator shall provide and arrange for the retention of records and reports in a secured manner for not less than seven years.
- (2) The nursing home shall maintain all other records and reports required by rules 3701-17-01 to 3701-17-26 of the Administrative Code for seven years.
- (3) Upon the request of the resident, or legal representative, the nursing home shall provide:
 - (a) Access to medical and financial records and reports pertaining to the resident within twenty-four hours, excluding holidays and weekends; and
 - (b) Photocopies of any records and reports, or portions thereof, at a cost not to exceed the community standard for photocopying, unless otherwise specified by law, upon two working days advanced notice.
- (D) All records and reports required by Chapter 3701-13 of the Administrative Code shall be maintained and made available in accordance with that chapter.

OKLAHOMA

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310:675-7-10.1. Resident's clinical record

- (a) There shall be an organized, accurate, clinical and personal record, either typewritten or legibly written with pen and ink, for each resident admitted or accepted for treatment. The resident's clinical record shall document all nursing services provided.
- (b) The resident clinical record shall be retained for at least five years after the resident's discharge or death. A minor's record shall be retained for at least two years after the minor has reached the age of eighteen but, in no case, less than five years.
- (c) All required records, either original or microfilm copies, shall be maintained in such form as to be legible and readily available upon request of the attending physician, the facility, and any person authorized by law to make such a request.
- (d) Information contained in the resident record shall be confidential and disclosed only to the resident, persons authorized by the resident, and persons authorized by law.
- (e) Resident's records shall be filed and stored to protect against loss, destruction, or unauthorized use.
- (f) The Department shall be informed in writing immediately whenever any resident's records are defaced, or destroyed, before the end of the required retention period.
- (g) If a facility ceases operation, the Department shall be notified immediately of the arrangements for preserving the resident's record. The record shall be preserved for the required time and the information in the records shall be available to the health professionals or facilities assuming care of the resident so that continuity of care is available.
- (h) If the ownership of the facility changes, the new licensee shall have custody of the residents records and the records shall be available to the former licensee and other authorized persons.
- (i) A person employed by the owner shall be in charge of resident records and properly identifiable to others concerned.
- (j) The resident clinical record shall include:

- (1) An admission record sheet which shall include:
 - (A) Identification of the resident (name, sex, age, date of birth, marital status).
 - (B) Identification numbers as applicable: i. e., Medicare number, Medicaid number.
 - (C) Date and time of admission.
 - (D) Diagnosis and known allergies.
 - (E) Name, address, and telephone number of responsible party, next of kin, pharmacist, and funeral home.
- (2) Physician's orders for medications, diet, treatment, and therapy.
- (3) Orders dated and signed by the physician giving the order. Verbal or telephone orders shall be signed by the physician within five working days, excluding weekends and holidays.
- (4) Initial orders given by the physician at the time of admission shall be signed by the physician and placed in the clinical record within five working days of admission, excluding weekends and holidays.
- (5) The most recent medical history and physical examination signed and dated by the physician.
- (6) Nurse's notes, dated and signed at the time of entry.
- (7) Temperature, pulse, respirations, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition.
- (8) Progress notes generated by all health care professionals and allied health personnel.
- (9) An assessment and care plan based on the assessment.
- (10) An inventory of personal effects including clothing and property on admission, and as necessary.
- (11) Written acknowledgement by the resident or legal representative of receipt of the resident's rights upon admission and as needed.
- (12) Discharge summary signed by the attending physician that shall include the diagnosis or reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan, if appropriate, condition on discharge or transfer, or cause of death, date and time of discharge, and diagnosis on discharge.
- (13) A transfer or discharge form when a resident is transferred, or discharged, to the hospital, another facility or released from care. Transfer or discharge forms may be excluded when a resident is discharged to his/her home when the stay in the facility is for respite care only. The transfer form shall include, but not be limited to, the following information:
 - (A) Identification of the resident and his attending physician.
 - (B) Diagnosis, medications and medication administration schedule.
 - (C) Name of transferring facility.
 - (D) Name of receiving facility.
 - (E) Date of transfer.
 - (F) Family or legal representative.
 - (G) Condition on transfer.
 - (H) Reason for transfer.
 - (I) Known allergies.
 - (J) Pertinent medical history.
 - (K) Any advance directive for medical care.

Clinical Records

(1) Clinical Records Department. The facility shall ensure the preparation, completeness, accuracy, preservation, and filing of a clinical record for each resident in accordance with facility policy (OAR 411-085-0210). This rule does not apply to nonmedical records.

(2) Director. The facility shall designate in writing a staff person to function as clinical records coordinator who shall ensure compliance with this rule. Services of a qualified medical record consultant (RRA or ART) shall be provided as needed.

(3) Staffing, Equipment. There shall be personnel, space, and equipment to provide efficient, systematic processing of clinical records including but not limited to reviewing, indexing, filing, and prompt retrieval.

(4) Filing. A system of identification and filing to ensure the rapid location of resident clinical records shall be maintained. A resident master index containing at least the full name of each resident, date of birth, clinical record number as applicable, date of admission, date of discharge, legal representative and physician of record shall be maintained.

(5) Content of Clinical Record. A clinical record shall be maintained for each resident. Each record shall contain supporting data, written in sequence of events to justify the diagnosis and warrant the treatment and results. All entries shall be kept current, accurate, dated and signed. All clinical records shall be either typewritten or recorded legibly in ink and shall include but not be limited to the following information:

(a) Admitting diagnosis and identification data including the resident's name, previous address, date and time of admission, sex, date of birth, marital status, religious preference and social security number; name, address, and telephone number of nearest relative or personal agent; place admitted from; attending physician; alternate physician (clinic or service); dentist; legal representative and RN care manager;

(b) A medical history and physical exam or medical summary as to the resident's condition which is signed by a physician. If a resident is re-admitted within 30 days for the same condition, the previous history and physical or medical summary, with an interval note signed by a physician, will suffice. If an ongoing clinical record is maintained in a comprehensive care facility, it may be used if accompanied by a physical exam report completed within the previous 30 days;

(c) Clinical reports, current, dated, and signed. Such reports include, but are not limited to, laboratory, x-ray, and results of tests/exams including those for communicable diseases;

(d) Physician's orders, current, dated and signed;

(e) Physician's progress notes dated and signed;

(f) Timely, written, dated, pertinent, complete and signed clinical observations. Clinical observations shall include changes in condition, results of treatments and medications, and unusual events. Clinical observations shall include outcome of the resident care plan and shall be summarized by nursing staff at least quarterly unless the resident's condition dictates otherwise;

(g) Record of medication administration including name of drug, dosage, frequency, mode of administration, date, time and signature of the person administering medication. Documentation shall also include, when applicable, site of injection, reaction, reason for withholding any medication, and reason for administering any "prn" (as needed) medication;

(h) Record of treatments administered which shall be dated, timed and signed by those performing treatments;

- (i) Miscellaneous items such as releases, consent forms, mortician's receipts, valuables list and medical correspondence as applicable;
 - (j) Discharge summary prepared in accordance with OAR 411-086-0160 and signed by the attending physician. The summary shall include admitting diagnosis/reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan if appropriate, condition on discharge or cause of death; and
 - (k) The "Directive to Physicians" ("Living Will"), the Power of Attorney for Health Care and similar legal documents regarding resident care directives, if any, shall be filed in the resident's clinical record in a manner which makes them prominent and conspicuous.
- (6) Record Retention. All clinical records shall be kept for a period of five years after the date of last discharge of the resident. A clinical record for each resident for whom care has been provided in the previous six months shall be immediately available for review by Division representatives upon request.
- (7) Resident Transfer. When a resident is transferred to another facility, the following information shall accompany the resident:
- (a) The name of the facility from which transferred;
 - (b) The names of attending physicians prior to transfer;
 - (c) The name of physician to assume care;
 - (d) The date and time of discharge;
 - (e) Most recent history and physical;
 - (f) Current diagnosis, orders from a physician for immediate care of the resident, nursing, and other information germane to the resident's condition;
 - (g) A copy of the discharge summary. If the discharge summary is not available at time of transfer, it shall be transmitted as soon as available, but no later than seven days after transfer; and
 - (h) A copy of the current Directive and Power of Attorney for Health Care, if any.
- (8) Ownership of Records. Clinical records are the property of the licensee. The clinical record, either in original or microfilm form, shall not be removed from the control of the facility except where necessary for a judicial or administrative proceeding. Authorized representatives of the Division shall be permitted to review and obtain copies of clinical records as necessary to determine compliance with OAR 411:
- (a) If a facility changes ownership all clinical records in original or microfilm form shall remain in the facility and ownership shall be transferred to the new licensee;
 - (b) In the event of dissolution of a facility, the administrator shall ensure that clinical records are transferred to another health care facility or to the resident's primary care physician, and shall notify the Division as to the location of each clinical record. The party to whom the records are transferred must have agreed to serve as custodian of the records.

PENNSYLVANIA

Downloaded January 2011

§ 211.5. Clinical records.

- (a) Clinical records shall be available to, but not be limited to, representatives of the Department of Aging Ombudsman Program.
- (b) Information contained in the resident's record shall be privileged and confidential. Written consent of the resident, or of a designated responsible agent acting on the resident's behalf, is

required for release of information. Written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties.

(c) Records shall be retained for a minimum of 7 years following a resident's discharge or death.

(d) Records of discharged residents shall be completed within 30 days of discharge. Clinical information pertaining to a resident's stay shall be centralized in the resident's record.

(e) When a facility closes, resident clinical records may be transferred with the resident if the resident is transferred to another health care facility. Otherwise, the owners of the facility shall make provisions for the safekeeping and confidentiality of clinical records and shall notify the Department of how the records may be obtained.

(f) At a minimum, the resident's clinical record shall include physicians' orders, observation and progress notes, nurses' notes, medical and nursing history and physical examination reports; identification information, admission data, documented evidence of assessment of a resident's needs, establishment of an appropriate treatment plan and plans of care and services provided; hospital diagnoses authentication—discharge summary, report from attending physician or transfer form—diagnostic and therapeutic orders, reports of treatments, clinical findings, medication records and discharge summary including final diagnosis and prognosis or cause of death. The information contained in the record shall be sufficient to justify the diagnosis and treatment, identify the resident and show accurately documented information.

(g) Symptoms and other indications of illness or injury, including the date, time and action taken shall be recorded.

(h) Each professional discipline shall enter the appropriate historical and progress notes in a timely fashion in accordance with the individual needs of a resident.

(i) The facility shall assign overall supervisory responsibility for the clinical record service to a medical records practitioner. Consultative services may be utilized, however, the facility shall employ sufficient personnel competent to carry out the functions of the medical record service.

Notes of Decisions

Alteration of medical records during the course of a licensure survey in order to produce the appearance of compliance with regulations constitutes fraud and deceit justifying the Department of Health to refuse to renew a nursing home license. *Colonial Gardens Nursing Home, Inc. v. Department of Health*, 382 A.2d 1273 (Pa. Cmwlth. 1978).

RHODE ISLAND

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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.

SOUTH CAROLINA

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SECTION 500 - POLICIES AND PROCEDURES

501. General

...D. If the facility permits any portion of a resident's record to be generated by electronic or optical means, there shall be policies and procedures to prohibit the use or authentication by unauthorized users.

SECTION 800 - RESIDENT RECORDS

801. Content

A. All entries in the resident record shall be legible and complete, and shall be separately authenticated and dated promptly by the individual, identified by name and discipline, who is responsible for ordering, providing or evaluating the service or care furnished. Authentication may include written signatures or computerized or electronic entries. If an entry is signed on a date other than the date it was made, the date of the signature shall also be entered. Although use of initials in lieu of signatures is not encouraged, initials will be accepted provided such initials can be readily identified within the resident record.

B. Contents of the resident record may be stored in separate files, in separate areas within the facility, and the record shall include the following information:

1. Medical history and physical examination;
2. Consent form for treatment signed by the resident or his or her legal representative;
3. Care and services agreement;
4. Healthcare directives and special information, e.g., advance directive information, do-not-resuscitate (DNR) orders, allergies;
5. Incidents involving the resident;
6. Medical treatment;
7. Orders, including telephone and standing orders, for all medication, care, services, therapy, procedures, and diet from physicians or other legally authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted;
8. Individual Care Plan;
9. Provisions for routine and emergency medical care, to include the name and telephone number of the resident's physician;
10. Assessments and progress notes, e.g., dietary, activity, therapy;
11. Record of administration of each dose of medication;
12. Record of the use of restraints, if applicable, including time, type, reason and authority for applying;
13. Treatment, procedure, wound care report (dictated or written into the record after treatment, procedure, or wound care) to include at least:
 - a. Description of findings;
 - b. Techniques utilized to perform treatments and procedures;
 - c. Specimens removed, if applicable;
 - d. Name of provider;
14. Progress notes generated by physicians and healthcare professionals;
15. Notes of observation, including temperature, pulse, respiration, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition;
16. Special procedures and preventive measures performed, e.g., isolation for symptoms, diagnosis, and/or treatment of infectious conditions including but not limited to tuberculosis, influenza, pneumonia, therapies;
17. Reports of all laboratory, radiological, and diagnostic procedures along with tests performed and the results appropriately authenticated;
18. Consultations by physicians or other healthcare professionals;
19. Photograph of resident, if the resident or his or her responsible party approves;
20. Date and hour of discharge or transfer, as applicable;
21. Discharge and/or transfer summary, including care and condition at discharge or transfer, date and time of discharge or transfer, instructions for self-care, instructions for obtaining post-

treatment or procedure emergency care, and signature of physician authorizing discharge or transfer;

22. Date and circumstances of death, as applicable.

C. Except as required by law, records may contain written and interpretative findings and reports of diagnostic studies, tests, and procedures, e.g., interpretations of imaging technology and video tapes without the medium itself.

D. Unauthorized alterations of information in the record are prohibited. Corrections to entry errors shall include the date the correction was made and the signature of the individual making the correction.

E. Records shall be maintained on all outpatients and shall be completed immediately after treatment is rendered. These records shall contain sufficient identification data, a description of what was done and/or prescribed for the outpatient and shall be signed by the attending physician. When an outpatient is admitted as a resident of the facility, all of the outpatient records shall be made a part of his or her permanent resident record.

804. Record Maintenance

A. Organization.

1. The administrator shall designate a staff member the responsibility for the maintenance of resident and outpatient records.

2. Resident and outpatient records shall be properly indexed and filed for ready access by staff members.

B. Accommodations.

1. The licensee shall provide space, supplies, and equipment adequate for the maintenance, protection and storage of resident and outpatient records.

2. The facility shall maintain records pertaining to resident personal funds accounts, as applicable, financial matters, statements of resident rights and responsibilities, and resident possessions (provided that the facility has been notified by the resident or responsible party that items have been added or removed).

3. The licensee shall determine the medium in which information is stored. The information shall be readily retrievable and accessible by staff, as needed.

4. Records of residents and outpatients shall be maintained for at least six (6) years following discharge or death. Facilities that microfilm (or use other processes that accurately reproduce or form a durable medium) inactive records before six (6) years have expired shall process the entire record. Records may be destroyed after six (6) years provided that:

a. Records of minors must be retained until after the expiration of the period of election following achievement of majority as prescribed by statute; and

b. The facility retains an index, register, or summary cards providing such basic information as dates of admission and discharge, and name of responsible physician for all records so destroyed.

5. Records of residents and outpatients are the property of the facility and shall not be removed without court order. As an exception, when a resident moves from one licensed facility to another within the same provider network (same licensee), the original record may follow the resident; the sending facility shall maintain documentation of the resident's transfer and discharge date and identification information. In the event of change of licensee, all resident records or copies of resident records shall be transferred to the new licensee.

6. When a resident is transferred from one facility to another, a transfer summary, to include copies of relevant documents, shall accompany the resident to the receiving facility at the time of transfer or be forwarded immediately after the transfer. Documentation of the information forwarded shall be maintained in the resident record.

7. Upon discharge or death of a resident, the record shall be completed and filed in an inactive file within a time period as determined by the facility, but no later than thirty (30) days after discharge or death.

8. Facilities shall comply with R.61-19 with regard to vital statistics.

C. Access.

1. The resident and outpatient record is confidential. Records containing protected or confidential health information shall be made available only to individuals granted access to that information, in accordance with State, Federal, and local laws.

2. A facility may charge a fee for the search and duplication of a resident record in accordance with S.C. Code Ann. Section 44-7-325 (1976, as amended).

D. Copies of the criminal record check results of direct care staff shall be provided to the Department upon request within a reasonable amount of time after receiving the request. A copy of the criminal record check results shall be retained at the facility.

E. Regulation-required documents other than resident records, e.g., fire drills, medication destruction records, activity schedules, firefighting equipment inspections, monthly pharmacist reviews, controlled medication count sheets, emergency generator logs, shall be maintained for a minimum of twelve (12) months or until the next inspection by the Department's Division of Health Licensing, whichever is longer. Records of menus as served shall be maintained for at least thirty (30) days and available for inspection.

805. Electronic Resident Records

A. Electronic records are subject to all of the standards of this regulation.

B. A facility that maintains electronic records shall:

1. Retain the hard copy originals of any materials that cannot be electronically stored;
2. Employ an off-site backup storage system as protection in the event that the on-site system is damaged or destroyed;
3. Use an imaging mechanism that is able to copy documents with signatures;
4. Assure that records, once put in electronic form, are unalterable.

C. Electronic signatures may be used any place in the resident or outpatient record that requires a signature, provided signature identification can be verified and an electronic signature may be legally used. Electronic authorization shall be limited to a unique identifier (confidential code) used only by the individual making the entry to preclude the improper or unauthorized use of any electronic signature.

SOUTH DAKOTA

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44:04:09:01. Record services for hospitals and nursing facilities. All hospitals and nursing facilities must comply with §§ 44:04:09:02 to 44:04:09:05, inclusive.

44:04:09:02. Medical record department. There must be an organized medical record system. A medical record must be maintained for each level of care for each patient or resident admitted to the facility.

44:04:09:03. Medical record department staff. The medical record functions must be performed by persons trained and equipped to facilitate the accurate processing, checking, indexing, filing, and retrieval of all medical records. The individual responsible for the medical records service must have knowledge and training in the field of medical records.

44:04:09:04. Written policies and confidentiality of records. There must be written policies and procedures to govern the administration and activities of the medical record service. They must include policies and procedures pertaining to the confidentiality and safeguarding of medical records, the record content, continuity of a patient's or resident's medical records during subsequent admissions, requirements for completion of the record, and the entries to be made by various authorized personnel.

44:04:09:05. Record content. Each medical record must show the condition of the patient or resident from the time of admission until discharge and must include the following:

- (1) Identification data;
- (2) Consent forms, except when unobtainable;
- (3) History of the patient or resident;
- (4) A current overall plan of care;
- (5) Report of the initial and periodic physical examinations, evaluations, and all plans of care with subsequent changes;
- (6) Diagnostic and therapeutic orders;
- (7) Progress notes from all disciplines, including practitioners, physical therapy, occupational therapy, and speech pathology;
- (8) Laboratory and radiology reports;
- (9) Description of treatments, diet, and services provided and medications administered;
- (10) All indications of an illness or an injury, including the date, the time, and the action taken regarding each;
- (11) A final diagnosis; and
- (12) A discharge summary, including all discharge instructions for home care.

44:04:09:07. Authentication. A health care facility must ensure entries to the medical or care record are signed or electronically authenticated. If the facility permits any portion of the medical or care record to be generated by electronic or optical means, policies and procedures must exist to prohibit the use of authentication by unauthorized users.

44:04:09:08. Retention of medical or care records. A health care facility must retain medical or care records for a minimum of ten years from the actual visit date of service or resident care. The retention of the record for ten years is not affected by additional and future visit dates. Records of minors must be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date of service or resident care. Initial, annual, and significant-change resident assessment records, as required in §§

44:04:06:15 and 44:04:06:16, must be retained for ten years from the actual visit date of resident care. The retention of the record for ten years is not affected by additional and future visit dates.

44:04:09:09. Storage of medical or care records. A health care facility must provide for filing, safe storage, and easy accessibility of medical or care records. The medical or care records must be preserved as original records or in other readily retrievable and reproducible form. Medical or care records must be protected against access by unauthorized individuals. All medical or care records must be retained by the health care facility upon change of ownership.

44:04:09:10. Destruction of medical or care records. After the minimum retention period of ten years from the actual visit date of care outlined in § 44:04:09:08, the medical or care record may be destroyed at the discretion of the health care facility. Before the destruction of the medical or care record, the health care facility must prepare and retain a patient or resident index or abstract. The patient or resident index or abstract must include:

- (1) Name;
- (2) Medical record number;

- (3) Date of birth;
- (4) Summary of visit dates;
- (5) Attending or admitting physician; and
- (6) Diagnosis or diagnosis code. The health care facility must destroy the medical or care record in a way that maintains confidentiality.

44:04:09:11. Disposition of medical or care records on closure of facility or transfer of ownership. If a health care facility ceases operation, the facility must provide for safe storage and prompt retrieval of medical or care records and the patient or resident indexes specified in §

44:04:09:10. The health care facility may arrange storage of medical or care records with another health care facility of the same licensure classification, transfer medical or care records to another health care provider at the request of the patient or resident, relinquish medical records to the patient or resident or the patient's or resident's parent or legal guardian, or arrange storage of remaining medical records with a third party vendor who undertakes such a storage activity. At least 30 days before closure, the health care facility must notify the department in writing indicating the provisions for the safe preservation of medical or care records and their location and publish in a local newspaper the location and disposition arrangements of the medical or care records. If ownership of the health care facility is transferred, the new owner shall maintain the medical or care records as if there was not a change in ownership.

TENNESSEE

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1200-08-06-.06 BASIC SERVICES.

...(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.

TEXAS

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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;
- (ii) 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 RAIs 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.

UTAH

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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.

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13. CLINICAL RECORDS

13.1 Records Maintenance and Retention

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

- (1) complete;
- (2) accurately documented;
- (3) readily accessible; and
- (4) systematically organized.

(b) All of an individual's clinical records must be retained for the longer of the following time periods:

- (1) eight years from the date of discharge or death; or
- (2) for a minor, three years after a resident reaches 18 years of age.

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

(d) The facility must ensure that each clinical record contains a recent photograph of the resident, unless the resident objects.

13.2 Confidentiality

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:

- (a) transfer to another health care institution;
- (b) law;
- (c) third party payment contract; or
- (d) the resident.

13.3 Contents The clinical record must contain:

- (a) sufficient information to identify the resident;
- (b) a record of the resident's assessments;
- (c) the plan of care and services provided;
- (d) the results of any preadmission screening conducted by the state; and
- (e) progress notes.

12 VAC 5-371-360. Clinical records. (revised 1/11/2006)

A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices. Written policies and procedures shall be established specifying content and completion of clinical records.

B. Clinical records shall be confidential. Only authorized personnel shall have access as specified in §8.01-413 and § 32.1-127.1:03 of the Code of Virginia.

C. Records shall be safeguarded against destruction, fire, loss or unauthorized use.

D. Overall supervisory responsibility for assuring that clinical records are maintained, completed and preserved shall be assigned to an employee of the nursing facility. The individual shall have work experience or training which is consistent with the nature and complexity of the record system and be capable of effectively carrying out the functions of the job.

E. An accurate and complete clinical record shall be maintained for each resident and shall include, but not be limited to:

1. Resident identification;
2. Designation of attending physician;
3. Admitting information, including resident medical history, physical examination and diagnosis;
4. Physician orders, including all medications, treatments, diets, restorative and special medical procedures required;
5. Progress notes written at the time of each visit;
6. Documented evidence of assessment of resident's needs, establishment of an appropriate treatment plan, and interdisciplinary plan of care;
7. Nurse's notes written in chronological order and signed by the individual making the entry;
8. All symptoms and other indications of illness or injury, including date, time, and action taken on each shift;
9. Medication and treatment record, including all medications, treatments and special procedures performed;
10. Copies of radiology, laboratory and other consultant reports; and
11. Discharge summary.

F. Verbal orders shall be immediately documented in the clinical record by the individual authorized to accept the orders, and shall be countersigned.

G. Clinical records of discharged residents shall be completed within 30 days of discharge.

H. Clinical records shall be kept for a minimum of five years after discharge or death, unless otherwise specified by state or federal law.

I. Permanent information kept on each resident shall include:

1. Name;
2. Social security number;
3. Date of birth;
4. Date of admission and discharge; and
5. Name and address of guardian, if any.

J. Clinical records shall be available to residents and legal representatives, if they wish to see them.

K. When a nursing facility closes, the owners shall make provisions for the safekeeping and confidentiality of all clinical records.

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388-97-1720 Clinical records.

(1) The nursing home must:

(a) Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

- (i) Complete;
- (ii) Accurately documented;
- (iii) Readily accessible; and
- (iv) Systematically organized.

(b) Safeguard clinical record information against alteration, loss, destruction, and unauthorized use; and

(c) 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;
- (iii) Third party payment contract; or
- (iv) The resident.

(2) The nursing home must ensure the clinical record of each resident includes at least the following:

- (a) Resident identification and sociological data, including the name and address of the individual or individuals the resident designates as significant;
- (b) Medical information required under WAC 388-97-1260;
- (c) Physician's orders;
- (d) Assessments;
- (e) Plans of care;
- (f) Services provided;
- (g) In the case of the medicaid-certified nursing facility, records related to preadmission screening and resident review;
- (h) Progress notes;
- (i) Medications administered;
- (j) Consents, authorizations, releases;
- (k) Allergic responses;
- (l) Laboratory, X ray, and other findings; and
- (m) Other records as appropriate.

(3) The nursing home must:

(a) Designate an individual responsible for the record system who:

- (i) Has appropriate training and experience in clinical record management; or
- (ii) Receives consultation from a qualified clinical record practitioner, such as a registered health information administrator or registered health information technician.

(b) Make all records available to authorized representatives of the department for review and duplication as necessary; and

(c) Maintain the following:

(i) A master resident index having a reference for each resident including the health record number, if applicable; full name; date of birth; admission dates; and discharge dates; and

(ii) A chronological census register, including all admissions, discharge, deaths and transfers, and noting the receiving facility. The nursing home must ensure the register includes discharges for social leave and transfers to other treatment facilities in excess of twenty-four hours.

(4) The nursing home must ensure the clinical record of each resident:

(a) Is documented and authenticated accurately, promptly and legibly by individuals giving the order, making the observation, performing the examination, assessment, treatment or providing the care and services.

(i) "Authenticated" means the authorization of a written entry in a record by signature, including the first initial and last name and title, or a unique identifier allowing identification of the responsible individual; and:

(ii) Documents from other health care facilities that are clearly identified as being authenticated at that facility will be considered authenticated at the receiving facility; and

(iii) The original or a durable, legible, direct copy of each document will be accepted.

(b) Contains appropriate information for a deceased resident including:

(i) The time and date of death;

(ii) Apparent cause of death;

(iii) Notification of the physician and appropriate resident representative; and

(iv) The disposition of the body and personal effects.

(5) In cases where the nursing home maintains records by computer rather than hard copy, the nursing home must:

(a) Have in place safeguards to prevent unauthorized access; and

(b) Provide for reconstruction of information.

(6) The nursing home licensee must:

(a) Retain health records for the time period required in RCW 18.51.300:

(i) For a period of no less than eight years following the most recent discharge of the resident; except

(ii) That the records of minors must be retained for no less than three years following the attainment of age eighteen years, or ten years following their most recent discharge, whichever is longer.

(b) In the event of a change of ownership, provide for the orderly transfer of clinical records to the new licensee;

(c) In the event a nursing home ceases operation, make arrangements prior to cessation, as approved by the department, for preservation of the clinical records. The nursing home licensee must provide a plan for preservation of clinical records to the department's designated local aging and adult administration (AASA) office no later than seven days after the date of notice of nursing home closure as required by WAC [388-97-162](#) (8) and (9) unless an alternate date has been approved by the department.

(d) Provide a resident access to all records pertaining to the resident as required under WAC 388-97-0300(2).

74.42.420 Resident record system.

The facility shall maintain an organized record system containing a record for each resident. The record shall contain:

(1) Identification information;

(2) Admission information, including the resident's medical and social history;

- (3) A comprehensive plan of care and subsequent changes to the comprehensive plan of care;
- (4) Copies of initial and subsequent periodic examinations, assessments, evaluations, and progress notes made by the facility and the department;
- (5) Descriptions of all treatments, services, and medications provided for the resident since the resident's admission;
- (6) Information about all illnesses and injuries including information about the date, time, and action taken; and
- (7) A discharge summary.

Resident records shall be available to the staff members directly involved with the resident and to appropriate representatives of the department. The facility shall protect resident records against destruction, loss, and unauthorized use. The facility shall keep a resident's record after the resident is discharged as provided in RCW 18.51.300.

WEST VIRGINIA

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§64-13-7. Comprehensive Care Plans.

...7.4. Plans for Care and Medical Records.

7.4.a. Plans for care.

...7.4.a.4. A nursing home shall have written policies and procedures to ensure that through the resident care conferences or other means of coordination, the resident care plan shall be reviewed and revised as needed, but at least quarterly. The review shall be noted in the medical record.

7.4.b. Discharge.

...7.4.b.4. A nursing home shall complete medical records promptly within a time period specified in the nursing homes policies and procedures manual, not to exceed thirty (30) days after the resident is discharged.

§64-13-13. Clinical Records.

13.1. Records Maintenance and Retention.

13.1.a. A nursing home shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

13.1.a.1. Complete;

13.1.a.2. Accurately documented;

13.1.a.3. Readily accessible; and

13.1.a.4. Systematically organized.

13.1.b. All of a resident's clinical records shall be retained for the longer of the following time periods:

13.1.b.1. Five (5) years from the date of discharge or death; or

13.1.b.2. For a minor, three (3) years after a resident reaches eighteen (18) years of age.

13.1.c. A nursing home shall safeguard clinical record information against loss, destruction, or unauthorized use.

13.1.d. A nursing home shall ensure that each clinical record contains a photograph of the resident, unless the resident objects.

13.2. Confidentiality. A nursing home shall keep all information contained in the resident's clinical record confidential, except when release is required by:

13.2.a. Transfer to another health care institution;

13.2.b. Law;

- 13.2.c. Third party payment contract; or
- 13.2.d. The resident.
- 13.3. Contents. The clinical record shall contain:
 - 13.3.a. Sufficient information to identify the resident;
 - 13.3.b. All the resident's assessments;
 - 13.3.c. The resident's plan of care and services provided;
 - 13.3.d. The results of any pre-admission screening conducted by the State;
 - 13.3.e. Progress notes; and
 - 13.3.f. Physician orders.

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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)
- (i). 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.

Section 16. Medical Records.

(a) Maintenance of Clinical Records. The facility shall maintain a separate and complete medical record for each resident admitted with all entries kept current, dated and signed.

(i) The medical record shall include:

(A) Identification and summary sheet(s) including resident's name, social security number, marital status, age, sex, home address, and religion; name, address, and telephone number of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnoses, final diagnoses, category of care, condition on discharge and disposition, source of payment, and any other information needed to meet State requirements.

(B) Initial medical evaluation including medical history, physical examination and diagnosis.

(C) Authentication of hospital diagnoses, in the form of a hospital discharge summary, or a written report from the physician who attended the resident in the hospital, or a transfer form used under a transfer agreement.

(D) Physician's orders, including all medications, treatments, diet, rehabilitative and special medical procedures required for the safety and well-being of the resident.

(E) Physician's progress notes describing significant changes in the resident's condition, dictated or written at the time of each visit.

(F) Nurses' notes which shall include but not be limited to the following:

(I) Concise and accurate record of nursing care administered.

(II) Record of pertinent observation of the resident including psycho-social as well as physical manifestations.

(III) Name, dosage and time of administration of medications and treatments, route of administration except if by oral medication.

(IV) Record of type of restraint and time of application and removal. The time of application and removal shall be necessary for all restraints prescribed by the physician for the support and protection of the resident.

(G) Medication and treatment record including all medications, treatments and special procedures performed for the safety and well-being of the resident.

(I) Laboratory and x-ray reports.

(II) Consultation reports.

(III) Dental reports.

(IV) Social service notes.

(V) Resident care referral reports.

(VI) Activity reports.

(b) Retention of Records.

(i) The facility shall have policies providing for the retention and safekeeping of residents' medical records by the governing body for the required period of time in the event that the facility discontinues operation.

(ii) A copy of the resident's clinical record or an abstract thereof shall accompany the resident who is transferred to another facility.

(c) Staff Responsibility. An employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved if the facility does not have a full or part time medical record librarian.

(i) The designated individual shall be trained by and receive regular consultation from a person skilled in record maintenance and preservation.

FEDERAL REGULATIONS

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§ 483.75 Administration.

(1) Clinical records.

(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—

- (i) Complete;
- (ii) Accurately documented;
- (iii) Readily accessible; and
- (iv) Systematically organized.

(2) Clinical records must be retained for—

- (i) The period of time required by State law; or
- (ii) Five years from the date of discharge when there is no requirement in State law; or
- (iii) For a minor, three years after a resident reaches legal age under State law.

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

(4) 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;
- (iii) Third party payment contract; or
- (iv) The resident.

(5) The clinical record must contain—

- (i) Sufficient information to identify the resident;
- (ii) A record of the resident's assessments;
- (iii) The plan of care and services provided;
- (iv) The results of any preadmission screening conducted by the State; and
- (v) Progress notes.