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 - Admission Nurse's Notes - Admission Height and Weight - Advance Directives - Informed Restraint Consent - Patient Rights - Authorization for Treatment	Permanent
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 (ADL, Restraints, Clinitest: Results, Intake and Output, etc.)	Three months
11.	Medication and Treatment Records	Three months
12.	Personal Effects Inventory	Most recent
13.	Hospital Discharge Summary (Including History and Physical)	Current 12 months
14.	TB Surveillance Record	Permanent
15.	Classification Status	Current
16.	Consultant Reports - Physicians - Occupational Therapist - Speech Therapist - Physical Therapist - Social Worker - Psychologist - Others	Initial and Most recent

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:

1.	Assessments and Re-assessments	Most recent 12 months
2.	Plan of Care Summary of Quarterly Progress Notes Change of Condition	12 months
3.	Pharmacy Reviews	Six months
4.	PASSAR Level I	Permanent
5.	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.

608-699 RESERVED

700-800 RESERVED