

COLORADO

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.

14.5 LONG-TERM CARE FACILITY RECORDS. The facility shall maintain current the following records:

- 1) daily census including current resident problems and room numbers,
- 2) admission and discharge analysis records,
- 3) master resident file,
- 4) resident number index, and
- 5) disease index and
- 6) file of all accident and incident reports, including without limitation, those required by Part 3 of Chapter II.