

### **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.

Authority Ga. L. 1964, pp. 507, 612, as amended by Ga. L. 1969, p. 715 et seq; and Ga. L. 1972, p. 1015 et seq. **Administrative History.** Original Rule was filed on October 26, 1976; effective November 15, 1976.