

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1810 RESIDENT RECORD REQUIREMENTS**

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.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

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.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1830 Records Pertaining to Residents' Property

- a) The facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record.
- b) When purchases are made for a resident from the resident's personal monies, receipts shall be obtained and retained that verify the date, amount, and items purchased.
- c) A separate bookkeeping system shall be maintained by the facility which accounts for all transactions affecting each resident's account. Each individual resident, or the individual resident's representative, shall have access to the record of that individual resident's account.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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.

(Source: Amended at 26 Ill. Reg. 10523, effective July 1, 2002)

Section 300.1870 Retention of Facility Records

The facility shall retain the records referenced in this Section for a minimum of three years. It is suggested that the administrator check with legal counsel regarding the advisability of retaining records for a longer period of time, and the procedures to be followed in the event the facility ceases operation. The records for which this requirement applies are as follows:

- a) The annual financial statement described in Section 300.210 of this Part.
- b) The minutes of resident advisory council meetings required by Section 300.640(k) of this Part.
- c) The records of in-service training required by Section 300.650(b) (3) of this Part.

- d) Copies of reports of serious incidents or accidents involving residents required by Section 300.690 of this Part.
- e) Records of the emergency medication kit review by the pharmaceutical advisory committee required by Section 300.1610(i)(3) of this Part.
- f) The reports of findings and recommendations from consultants required in Section 300.1880(a) of this Part.
- g) Copies of the quarterly reports for all employees that are filed for Social Security and Unemployment Compensation as required by Section 300.1880(d) of this Part.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1880 Other Facility Record Requirements

- a) The facility shall maintain a file of reports of findings and recommendations from consultants. Each report shall be dated and indicate each specific date and time the consultant was in the facility.
- b) The facility shall complete the Illinois Department of Public Health Annual Long Term Care (LTC) Facility Survey.
- c) The facility shall maintain a permanent chronological resident registry showing date of admission, name of resident and date of discharge or death.
- d) The facility shall make available to the Department upon request copies of the quarterly reports for all employees that are filed for Social Security and Unemployment Compensation.
- e) Rules located in other Sections of this Part that pertain to the content and maintenance of facility records are as follows:
 - 1) The facility shall file an annual financial statement as described in Section 300.210 of this Part.
 - 2) Records and daily time schedules shall be kept on each employee as set forth in Section 300.650(a) and (b) of this Part.
 - 3) The facility shall maintain a controlled substances record as described in Section 300.1650(d) of this Part.

- 4) Menu and food purchase records shall be maintained as set forth in Section 300.2080(d) and (f) of this Part.
- 5) The facility shall maintain a file of all reports of serious incidents or accidents involving residents as required by Section 300.690 of this Part.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)