CHAPTER 19

RECORDS

19.A. Clinical Records

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices.

19.A.1.All current clinical information pertaining to a resident's stay shall be available at the nurses station.

a.The resident's records must be kept in the facility at all times. The record may be in paper or electronic format.

b. All recording is done in the facility.

c. The records are immediately available to resident care personnel.

19.A.2.Pertinent, non-clinical information shall be kept current, including address and phone number of the resident's legal representative or interested family member.

19.B. Retention of Records

19.B.1. Active Clinical Records

The following current records shall be available and retained at the nurses station as indicated:

a. Identification sheet - retain permanently.

b. Physician Records

1. History and latest complete report of physical examination.

2. Progress notes - for at least past 12 months.

3. Order sheets - for at least past 12 months.

4. Consultations - for past 12 months.

c. Professional Services

1. All MDS forms for the past 15 months.

2. RAPS summary forms for the past 15 months.
3. Documentation of interventions, significant changes, observations, acute episodes, and progress notes for the past 12 months.

d. The Care Plan - for the past 12 months.

e. Results of any preadmission/annual screening - permanently.

f. Assessments by any additional professional discipline not included in the comprehensive assessment by the multidisciplinary team - for the past 24 months.

g. Medication and treatment sheets for past 6 months.

h. Diagnostic reports, lab, x-ray and diabetic records for past 12 months, unless frequent lab work, then 6 months.

i. Vital signs and weights for past six (6) months.

j. Personal care records - for past three (3) months.

k. List of valuables.

l. Transfer information.

19.B.2. Purging of the Active Clinical Record

Active clinical records may be purged after the period(s) of retention listed in 19.B.1. above. These purged records must be available at, or easily accessible to the nurses station.

19.C. Miscellaneous Records

19.C.1. Miscellaneous records shall be maintained and retained as follows:

a. Monthly activities schedule - retain for 12 months.

b. Staffing schedule - retain for 5 years for auditing purposes.

c. Menu plans - retain for 3 months.

d. Food purchase orders - retain for 5 years for auditing purposes.

e. Reports of fire drills - retain for 12 months.

f. Incident reports - in a separate file. Current file should include 12 months - retain for 5 years.

g. Quality Assurance Committee and utilization review reports - keep together for 12 months and retain for 5 years.

h. Minutes of Committee meetings, inservice, etc. keep together for 12 months and retain for 5 years.

i. Consultant reports - keep together for 12 months and retain for 5 years for auditing purposes.

j. Reports of surveys, inspections, water tests, permits - keep together for 12 months and retain for 3 years.

19.D. Inactive Clinical Records

19.D.1.Clinical records must be retained for:

a. The period of time required by State law or five years from the date of discharge, whichever is greater.

b. For a minor, three years after a resident reaches legal age under State law.

19.D.2.Before filing, each sheet should be checked to be sure that it is completed as appropriate.

19.D.3.Purged records shall be arranged in chronological order and filed in the inactive files.

19.D.4.For discharged/closed records, all material pertaining to the resident, including the clinical record, administrative record and care plan shall be filed together and according to accepted Medical Record standards.

19.E. Readmissions

19.E.1. When a facility readmits a resident within one month, the resident's clinical record must contain the following documentation:

a. New physician orders;

b. Updated physical exam;

c. A comprehensive assessment; and

d. A current note by all appropriate professionals.

19.E.2. For readmission after more than one month of discharge, a new record must be completed.

19.F. Transfers and Discharges

19.F.1. For transfers within a facility with distinct parts, the current record may be continued.

19.F.2. Before a facility transfers or discharges a resident from one facility to another facility, institution or agency, the facility must prepare a referral form. The referral form is forwarded at the time a resident is transferred. A copy is to be retained in the resident's record. To ensure the optimal continuity of care, the referral form shall contain an appropriate summary of information about the discharged resident.

19.G. Incident and Accident Records

19.G.1.A report on a separate form shall be made on any occurrence affecting the safety, health or well-being of a resident, staff or visitor which may result in an injury. Medication reactions and errors involving a resident shall also be recorded on the report.

19.G.2.Any resident who has sustained an injury or accident shall be examined by a physician, unless, after assessment by a Registered Professional Nurse, is determined not to require an examination by a physician. In either case, documentation of the incident or accident shall be recorded.

19.G.3.The extent of injury and treatment shall be recorded on the resident's record, with notification made by the facility and/or the physician, to the nearest relative, guardian or conservator of the resident.

19.G.4.The administrator or the director of nurses shall initial all incident and accident reports within twenty-four (24) hours of occurrence.

19.G.5.All incident and accident reports shall be kept on the premises of each facility and shall be reviewed at each meeting of the Quality Assurance Committee. The minutes of these meetings shall be available for review by Department personnel.

19.H. Individual Administrative Records

Records must be kept in the facility, but not necessarily in the nurse's station. Each resident shall have a separate folder which may include:

19.H.1.Resident rights acknowledgment;

19.H.2.Contract with resident;

19.H.3.Statement of who is responsible for personal needs monies;

19.H.4.Records of personal needs monies, including receipts, bank books, or statements and any relevant documentation. These may be filed in inactive files after twelve (12) months;

19.I. 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:

19.I.1. Transfer to another health care institution;

19.I.2. Law;

19.I.3. Third party payment contract;

19.I.4. The resident; or

19.I.5. The Department.

19.J. Access

The facility must:

19.J.1. Permit each resident and his/her authorized representative to inspect his or her records within twenty-four (24) hours of request. Such inspection shall occur at reasonable times and in the presence of a member of the facility's staff.

19.J.2. Provide copies of the records to each resident no later than two (2) business days after a written request from a resident, at a photocopying cost not to exceed the amount customarily charged in the community.

19.J.3. Records shall be made available for inspection and/or copying by representatives of the Department.

19.K. Storage of Records

19.K.1.The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

19.K.2.All records shall be completed prior to filing, and shall be filed in a manner to facilitate retrieval of the complete record when needed. Provision shall be made for adequate facilities and equipment, conveniently located, for the safe storage of all records and accessibility when needed.

19.K.3.In the event of change in ownership of any licensed facility, all resident records and registers shall remain the property of the facility.