He-P 803.19 Resident Records.

(a) The licensee shall maintain a legible, current and accurate record for each resident based on services provided at the nursing home.

(b) At a minimum, resident records shall contain the following:

(1) A copy of the resident's admission agreement and all documents required by He-P 803.15(c);

(2) Identification data, including:

a. Vital information including the resident's name, date of birth, and marital status;

b. Resident's religious preference, if known;

c. Resident's veteran status if known; and

d. Name, address and telephone number of an emergency contact person;

(3) The name and telephone number of the resident's licensed practitioner(s);

(4) Resident's health insurance information;

(5) Copies of any executed legal orders and directives, such as guardianship orders issued under RSA 464-A, a durable power of attorney for healthcare, or a living will;

(6) A record of the health examination(s) in accordance with He-P 803.15(h);

(7) Written, dated and signed orders for the following:

a. All medications, treatments and special diets; and

b. Laboratory services and consultations;

(8) Results of any laboratory tests, or consultations;

(9) All assessments and care plans, and documentation that the resident and the guardian or agent, if any, has participated in the development of the care plan;

(10) Documentation of informed consent;

(11) All admission and progress notes;

(12) Documentation of any alteration in the resident's daily functioning such as:

a. Signs and symptoms of illness; and

b. Any action that was taken including practitioner notification;

(13) Documentation of any medical or specialized care;

(14) Documentation of unusual incidents;

(15) The consent for release of information signed by the resident, guardian or agent, if any;

(16) Discharge planning and referrals as applicable;

(17) Transfer or discharge documentation, including notification to the resident, guardian or agent, if any, of transfer or discharge;

(18) Room change documentation, including notification to the resident, guardian or agent, if any, and if applicable;

(19) The medication record as required by He-P 803.16(y) and (ac); and

(20) Documentation of a resident's refusal of any care or services.

(c) Resident records and resident information shall be kept confidential and only provided in accordance with law.

(d) The licensee shall develop and implement a written policy and procedure document that specifies the method by which release of information from a resident's record shall occur.

(e) Resident records shall be available to health care workers and any other person authorized by law or rule to review such records

(f) When not being used by authorized personnel, resident records shall be safeguarded against loss or unauthorized use or access.

(g) Records shall be retained for 4 years after discharge, except for records of Medicaid residents, which shall be retained for 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6-year period, whichever is longer.

(h) The licensee shall arrange for storage of, and access to, resident records as required by (g) above in the event the nursing home ceases operation.

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