writing by a physician as having been screened for tuberculosis Infection and provide a statement of medical evidence that he/she is currently free from communicable disease prior to beginning work.

C. DISEASE SURVEILLANCE AND CONTROL: Facilities shall develop and implement written policies for control of communicable diseases which ensure that employees and volunteers with systems or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician or physician extender.

D. VOLUNTEERS: Facilities may use volunteers provided that the volunteers receive the orientation, training, and supervision necessary to assure resident health, safety and welfare.

E. ABUSE OF RESIDENTS:

(1) Orientation for all employees: Except in an emergency, before performing any duties, each new employee, including temporary help, shall receive appropriate orientation to the facility and its policies, including, but not limited to, policies relating to fire prevention, accident prevention, and emergency procedures. All employees shall be oriented to resident's rights and to their position and duties by the time they have worked thirty (30) days.

(2) Training: Except for nurses, all employees who provide direct care to residents shall be trained through a program approved by the Department.

(3) Assignments: Employees shall be assigned only to resident care duties consistent with their training.

(4) Reporting: All employees will be instructed in the reporting requirements of the Adult Protective Services Act of abuse, neglect or exploitation of any resident.

F. CONTINUING EDUCATION:

(1) Nursing in-service: The facility shall require employees who provide direct care to residents to attend educational programs desired to develop and improve the skill and knowledge of the employees with respect to the needs of the facility's residents, including rehabilitative therapy, oral health care, wheelchair safety and transportation and special programming for developmentally disabled residents if the facility admits developmentally disabled person. These programs shall be conducted quarterly to enable staff to acquire the skills and techniques necessary to implement the individual program plans for each resident under their care.

(2) Dietary in-service: Educational programs shall be held quarterly for dietary staff, and shall include instruction in the proper handling of food, personal hygiene and grooming, and nutrition and modified diet patterns served by the facility.

(3) All other staff in-service: The facility shall provide in-service designed to improve the skills and knowledge of all other employees.

[7-1-60, 5-2-89; 7.9.2.27 NMAC – Rn & A, 7 NMAC 9.2.27, 8-31-00]

7.9.2.28 RECORDS – GENERAL: The administrator or administrator's designee shall provide the Department with any information required to document compliance with these regulations and shall provide reasonable means for examining records and gathering the information.

[7-1-60, 7-1-64; 7.9.2.28 NMAC – Rn, 7 NMAC 9.2.28, 8-31-00]

7.9.2.29 PERSONNEL RECORDS: A separate record of each employee shall be maintained, be kept current, and contain sufficient information to support assignment to the employee's current position and duties.

[7-1-60, 5-2-89; 7.9.2.29 NMAC – Rn, 7 NMAC 9.2.29, 8-31-00]

7.9.2.30 MEDICAL RECORDS – STAFF:

A. TIMELINESS: Duties relating to medical records shall be completed in a timely manner.

B. Each facility shall designate an employee of the facility as the person responsible for the medical record service, who:

(1) Is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American Medical Association; or

(2) Receives regular consultation but not less than four hours quarterly as appropriate from a person

who meets the requirements of Section 30.2.1. Such consultation shall not be substituted for the routine duties of staff maintaining records. The records consultant shall evaluate the records and records service, identify problem areas, and submit written recommendations for change to the administrator.

(3) Sufficient time will be allocated to the person who is designated responsible for medical record service to insure that accurate records are maintained.

[7-1-60, 5-2-89; 7.9.2.30 NMAC – Rn, 7 NMAC 9.2.30, 8-31-00]

7.9.2.31 MEDICAL RECORDS – GENERAL:

A. AVAILABILITY OF RECORDS: Medical records of current residents shall be stored in the facility and shall be easily accessible, at all times, to persons authorized by the resident to obtain the release of the medical records.

B. ORGANIZATION: The facility shall maintain a systematically organized records system appropriate to the nature and size of the facility for the collection and release of resident information.

C. UNIT RECORD: A unit record shall be maintained for each resident and day care client.

D. INDEXES: A master resident index shall be maintained.

E. MAINTENANCE: The facility shall safeguard medical records against loss, destruction, or unauthorized use, and shall provide adequate space and equipment to efficiently review,, index, file and promptly retrieve the medical records.

F. RETENTION AND DESTRUCTION:

(1) The medical record shall be completed and stored within sixty (60) days following a resident's discharge or death.

(2) An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least ten (10) years following a resident's discharge or death. All other records required by these regulations shall be retained for the period for which the facility is under review.

(3) Medical records no longer required to be retained under this section may be destroyed, provided:

(a) The confidentiality of the information is maintained; and

(b) The facility permanently retains at least identification of the resident, final diagnosis, physician, and dates of admission and discharge.

(4) A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes.

(5) If the ownership of a facility changes, the medical records and indexes shall remain with the facility.

G. RECORDS DOCUMENTATION:

(1) All entries in medical records shall be legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(2) Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

[7-1-60, 5-2-89; 7.9.2.31 NMAC – Rn, 7 NMAC 9.2.31, 8-31-00]

7.9.2.32 MEDICAL RECORDS – CONTENT: Except for persons admitted for short-term care, each resident's medical record shall contain:

A. IDENTIFICATION AND SUMMARY SHEET:

B. PHYSICIAN'S DOCUMENTATION:

(1) An admission medical evaluation by a physician, including:

(a) A summary of prior treatment;

(b) Current medical findings;

(c) Diagnosis at the time of admission to the facility;

(d) The resident's rehabilitation potential;

(e) The results of the required physical examination;

(f) Level of care;