

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;