

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;

- (2) All physician's orders including:
 - (a) Admission to the facility;
 - (b) Medications and treatments;
 - (c) Diets;
 - (d) Rehabilitative services;
 - (e) Limitations on activities;
 - (f) Restraint orders;
 - (g) Discharge or transfer orders.
- (3) Physician progress notes following each visit.
- (4) Annual physical examination.
- (5) Alternate visit schedule, and justification for such alternate visits, not to exceed ninety (90) days.

C. NURSING SERVICE DOCUMENTATION:

- (1) An assessment of the resident's nursing needs.
- (2) Initial nursing care plan and any revisions.
- (3) Nursing notes are required as follows:
 - (a) For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and
 - (b) For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least monthly;
- (4) In addition to the nursing care plan, nursing documentation describing:
 - (a) The general physical and mental condition of the resident, including any unusual symptoms or actions;
 - (b) All incidents or accidents including time, place, injuries or potential complications from injury or accident, details of incident or accident, action taken, and follow-up care;
 - (c) The administration of all medications, the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;
 - (d) Food intake, when the monitoring of intake is necessary;
 - (e) Fluid Intake when monitoring of intake is necessary;
 - (f) Any unusual occurrences of appetite or refusal or reluctance to accept diets;
 - (g) Summary of restorative nursing measures which are provided;
 - (h) Summary of the use of physical and chemical restraints;
 - (i) Other non-routine nursing care given;
 - (j) The condition of a resident upon discharge; and
 - (k) The time of death, the physician called, and the person to whom the body was released.

D. SOCIAL SERVICES RECORDS:

- (1) A social history of the resident; and
- (2) Notes regarding pertinent social data and action taken.

E. ACTIVITIES RECORDS: Documentation of activities programming, a history and assessment, a summary of attendance, and quarterly progress notes.

F. REHABILITATIVE SERVICES:

- (1) An evaluation of the rehabilitative needs of the resident.
- (2) Plan of treatment.
- (3) Progress notes detailing treatment given, evaluation, and progress.

G. DIETARY ASSESSMENT: Record of the dietary assessment.

H. DENTAL SERVICES: Summary of all dental services resident has received.

I. DIAGNOSTIC SERVICES: Records of all diagnostic tests performed during the resident's stay in the facility.

J. PLAN OF CARE: Plan of care which includes integrated program activities, therapies and treatments designed to help each resident achieve specific goals as developed by an interdisciplinary team.

K. AUTHORIZATION OR CONSENT: A photocopy of any court order, power of attorney or living will authorizing another person to speak or act on behalf of the resident and any resident consent forms.

L. DISCHARGE OR TRANSFER INFORMATION: Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate:

- (1) Current medical finding and condition;
- (2) Final diagnosis;
- (3) Rehabilitation potential;
- (4) A summary of the course of treatment;
- (5) Nursing and dietary information;
- (6) Ambulation status;
- (7) Administrative and social information; and
- (8) Needed continued care and instructions.

[7-1-60, 5-2-89; 7.9.2.32 NMAC – Rn, 7 NMAC 9.2.32, 8-31-00]

7.9.2.33 OTHER RECORDS: The facility shall retain:

- A. DIETARY RECORDS:** All menus and therapeutic diets for one year.
- B. STAFFING RECORDS:** Records of staff work schedules and time worked for one year.
- C. SAFETY TESTS:** Records of tests of fire detection, alarm, and extinguishment equipment.
- D. RESIDENT CENSUS:** At least a daily census of all residents, indicating number of residents

requiring each level of care.

E. PROFESSIONAL CONSULTATIONS: Documentation of professional consultations by:

- (1) A dietician.
- (2) A registered nurse.
- (3) Others, as may be used by the facility.

F. IN-SERVICE AND ORIENTATION PROGRAMS: Subject matter, instructors and attendance records of all in-service and orientation programs.

G. TRANSFER AGREEMENTS: Transfer agreements.

H. FUNDS AND PROPERTY STATEMENT: The statement prepared upon a resident's discharge or transfer from the facility that accounts for all funds and receipted property held by the facility for the resident.

I. COURT ORDERS AND CONSENT FORMS: Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.

[7-1-60, 7-1-64, 5-2-89; 7.9.2.33 NMAC – Rn, 7 NMAC 9.2.33, 8-31-00]

7.9.2.34 LICENSE LIMITATIONS:

A. BED CAPACITY: No facility may house more residents than the maximum bed capacity for which it is licensed. Persons participating in a day care program are not residents for purposes of these regulations.

B. CARE LEVELS: No person who requires care greater than that which the facility is licensed to provide may be admitted to or retained in the facility, unless under waiver according to State guidelines.

C. OTHER CONDITIONS: The facility shall comply with all other conditions of the license.

[5-2-89; 7.9.2.34 NMAC – Rn, 7 NMAC 9.2.34, 8-31-00]

7.9.2.35 OTHER LIMITATIONS ON ADMISSION:

A. PERSONS REQUIRING UNAVAILABLE SERVICES: Persons who require services which the facility does not provide or make available shall not be admitted or retained.

B. COMMUNICABLE DISEASES:

(1) Restriction: No person suspected of having a disease in a communicable state shall be admitted or retained unless the facility has the means to manage the condition.

(2) Isolation techniques: Persons suspected of having a disease in a communicable state shall be managed according to Isolation Techniques for use in Hospitals, published by the U.S. Department of Health and