

Effective Date: 04/01/92

Title: Section 415.22 - Clinical records

415.22 Clinical records. (a) The facility shall maintain clinical records for each resident in accordance with accepted professional standards and practice. The records shall be:

- (1) complete;
- (2) accurately documented;
- (3) readily accessible; and
- (4) systematically organized.

(b) Clinical records shall be retained for six years from the date of discharge or death or for residents who are minors, for three years after the resident reaches the age of majority (18).

(c) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility shall 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:

- (1) transfer to another health care institution;
- (2) law; or
- (3) the resident.

(e) The facility shall permit each resident to inspect his or her records and obtain copies of such records in accordance with the provisions of subparagraph (iv) of paragraph (1) of subdivision (c) of section 415.3 of this Part.

(f) The clinical record shall contain:

- (1) sufficient information to identify the resident;
- (2) a record of the resident's comprehensive assessments;
- (3) the plan of care and services provided;
- (4) the results of any preadmission screening conducted by the State;
- (5) progress notes by all practitioners and professional staff caring for the resident; and
- (6) reports of all diagnostic tests and results of treatments and procedures ordered for the resident.

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