SECTION 800 - RESIDENT RECORDS

801. Content (II)

A. All entries in the resident record shall be legible and complete, and shall be separately authenticated and dated promptly by the individual, identified by name and discipline, who is responsible for ordering, providing or evaluating the service or care furnished. Authentication may include written signatures or computerized or electronic entries. If an entry is signed on a date other than the date it was made, the date of the signature shall also be entered. Although use of initials in lieu of signatures is not encouraged, initials will be accepted provided such initials can be readily identified within the resident record.

B. Contents of the resident record may be stored in separate files, in separate areas within the facility, and the record shall include the following information:

1. Medical history and physical examination;

2. Consent form for treatment signed by the resident or his or her legal representative;

3. Care and services agreement;

4. Healthcare directives and special information, *e.g.*, advance directive information, do-not-resuscitate (DNR) orders, allergies;

5. Incidents involving the resident; (I)

6. Medical treatment;

7. Orders, including telephone and standing orders, for all medication, care, services, therapy, procedures, and diet from physicians or other legally authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted;

8. Individual Care Plan; (I)

9. Provisions for routine and emergency medical care, to include the name and telephone number of the resident’s physician;

10. Assessments and progress notes, *e.g.*, dietary, activity, therapy;

11. Record of administration of each dose of medication; (I)

12. Record of the use of restraints, if applicable, including time, type, reason and authority for applying; (I)

13. Treatment, procedure, wound care report (dictated or written into the record after treatment, procedure, or wound care) to include at least: (I)

a. Description of findings;

b. Techniques utilized to perform treatments and procedures;

c. Specimens removed, if applicable;

d. Name of provider;

14. Progress notes generated by physicians and healthcare professionals;

15. Notes of observation, including temperature, pulse, respiration, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition; (I)

16. Special procedures and preventive measures performed, *e.g.*, isolation for symptoms, diagnosis, and/or treatment of infectious conditions including but not limited to tuberculosis, influenza, pneumonia, therapies;

17. Reports of all laboratory, radiological, and diagnostic procedures along with tests performed and the results appropriately authenticated; (I)

18. Consultations by physicians or other healthcare professionals;

19. Photograph of resident, if the resident or his or her responsible party approves;

20. Date and hour of discharge or transfer, as applicable;

21. Discharge and/or transfer summary, including care and condition at discharge or transfer, date and time of discharge or transfer, instructions for self-care, instructions for obtaining post-treatment or procedure emergency care, and signature of physician authorizing discharge or transfer;

22. Date and circumstances of death, as applicable.

C. Except as required by law, records may contain written and interpretative findings and reports of diagnostic studies, tests, and procedures, *e.g.*, interpretations of imaging technology and video tapes without the medium itself.

D. Unauthorized alterations of information in the record are prohibited. Corrections to entry errors shall include the date the correction was made and the signature of the individual making the correction.

E. Records shall be maintained on all outpatients and shall be completed immediately after treatment is rendered. These records shall contain sufficient identification data, a description of what was done and/or prescribed for the outpatient and shall be signed by the attending physician. When an outpatient is admitted as a resident of the facility, all of the outpatient records shall be made a part of his or her permanent resident record.

802. Physician Orders (II)

A. Physician Orders. The resident's physician shall sign and date all treatment, care, and medication orders, including standing orders.

1. The use of a rubber stamp signature or electronic representation is acceptable under the following conditions:

a. The physician whose signature the rubber stamp or electronic representation denotes is the only one who has possession of the stamp or electronic representation and is the only one who uses it; and

b. The physician places in the administrative offices of the facility a signed statement to the effect that he or she is the only one who has the stamp or electronic representation and is the only one who will use it.

2. The use of rubber stamp signatures is not permissible on orders for "controlled substances."

3. Consultative reports and diagnostic procedures requested by a physician, *e.g.*, radiological, laboratory reports, shall be acknowledged by the physician signature. (I)

B. Verbal Orders. (I)

1. All orders for medication, treatment, care and diet shall be signed and dated by the individual receiving the orders.

2. Verbal orders received shall include the date of the order, description of the order, and identification of the physician or other legally authorized healthcare provider and the individual receiving the order.

3. Verbal orders in other specialized departments or services, as authorized in facility policy and procedures, may be received by those departments or services, *e.g.*, orders pertaining to physical therapy may be received by a physical therapist.

4. A committee (to include representation by physicians treating residents at the facility, a pharmacist, and the Director of Nursing) shall identify and list categories of diagnostic or therapeutic verbal orders (associated with any potential hazard to the resident) that shall be authenticated by the prescriber within a limited time period (within two (2) days after the order is given). A copy of this list shall be maintained at each staff work area.

a. Verbal orders designated by the committee as requiring authentication within a limited time period shall be authenticated and countersigned and dated by the prescriber or designee within a time period defined in facility policies and procedures, but in no case more than two (2) days after the order was given.

b. All other verbal orders shall be countersigned and dated by the prescriber or his or her designee within sixty (60) days.

c. Verbal orders for restraints shall be authenticated in the manner prescribed in Section 1012.B.

C. Standing Orders. (I)

1. Physician's standing orders, except for restraints, are permissible but shall take into consideration specific circumstances such as medication allergies, gender-specific orders, and the pertinent physical condition of the resident, when appropriate.

2. Over-the-counter medications may be utilized on a physician's standing orders. Controlled or legend medications shall be an individual order reduced to writing on the physician's order sheet as either a routine or *pro re nata* (prn) order and shall not be utilized on a physician's standing order unless the medications have been identified by the facility as those commonly used in routine situations. Each standing order shall include on the order sheet the following, as appropriate:

a. Name of the medication;

b. Strength of the medication;

c. Specific dose (or dose range) of the medication;

d. Mode of administration;

e. Reason for administration;

f. Time interval between doses for administering the medication; and

g. Maximum dosage or number of times to be administered in a specific time period.

3. Standing orders shall be signed and dated by the prescribing physician initially and reviewed at least annually thereafter.

D. Standing orders regarding restraints are prohibited.

803. Individual Care Plan (ICP) (II)

A. The facility shall develop an ICP with participation by, and as evidenced by the signatures of the resident or responsible party, or documentation that the facility attempted to obtain the signatures, and an interdisciplinary team of qualified individuals, within fourteen (14) days of admission. The ICP shall be reviewed and/or revised as changes in resident needs occur, but not less than quarterly by the interdisciplinary team.

B. The ICP shall describe:

1. The needs of the resident, including the services that are to be furnished, *i.e.*, what assistance, how much, who will provide the assistance, how often, and when;

2. Advance directives and healthcare power-of-attorney, as applicable;

3. Recreational and social activities that are suitable, desirable, and important to the resident;

4. Dietary needs and preferences of resident as approved by a physician;

5. Discharge planning, to include assessing continuing care needs and developing a plan designed to assure the resident's needs will be met after discharge or transfer.

804. Record Maintenance

A. Organization.

1. The administrator shall designate a staff member the responsibility for the maintenance of resident and outpatient records.

2. Resident and outpatient records shall be properly indexed and filed for ready access by staff members.

B. Accommodations.

1. The licensee shall provide space, supplies, and equipment adequate for the maintenance, protection and storage of resident and outpatient records.

2. The facility shall maintain records pertaining to resident personal funds accounts, as applicable, financial matters, statements of resident rights and responsibilities, and resident possessions (provided that the facility has been notified by the resident or responsible party that items have been added or removed).

3. The licensee shall determine the medium in which information is stored. The information shall be readily retrievable and accessible by staff, as needed.

4. Records of residents and outpatients shall be maintained for at least six (6) years following discharge or death. Facilities that microfilm (or use other processes that accurately reproduce or form a durable medium) inactive records before six (6) years have expired shall process the entire record. Records may be destroyed after six (6) years provided that:

a. Records of minors must be retained until after the expiration of the period of election following achievement of majority as prescribed by statute; and

b. The facility retains an index, register, or summary cards providing such basic information as dates of admission and discharge, and name of responsible physician for all records so destroyed.

5. Records of residents and outpatients are the property of the facility and shall not be removed without court order. As an exception, when a resident moves from one licensed facility to another within the same provider network (same licensee), the

original record may follow the resident; the sending facility shall maintain documentation of the resident's transfer and discharge date and identification information. In the event of change of licensee, all resident records or copies of resident records shall be transferred to the new licensee.

6. When a resident is transferred from one facility to another, a transfer summary, to include copies of relevant documents, shall accompany the resident to the receiving facility at the time of transfer or be forwarded immediately after the transfer. Documentation of the information forwarded shall be maintained in the resident record.

7. Upon discharge or death of a resident, the record shall be completed and filed in an inactive file within a time period as determined by the facility, but no later than thirty (30) days after discharge or death.

8. Facilities shall comply with R.61-19 with regard to vital statistics.

C. Access.

1. The resident and outpatient record is confidential. Records containing protected or confidential health information shall be made available only to individuals granted access to that information, in accordance with State, Federal, and local laws.

2. A facility may charge a fee for the search and duplication of a resident record in accordance with S.C. Code Ann. Section 44-7-325 (1976, as amended).

D. Copies of the criminal record check results of direct care staff shall be provided to the Department upon request within a reasonable amount of time after receiving the request. A copy of the criminal record check results shall be retained at the facility.

E. Regulation-required documents other than resident records, *e.g.*, fire drills, medication destruction records, activity schedules, firefighting equipment inspections, monthly pharmacist reviews, controlled medication count sheets, emergency generator logs, shall be maintained for a minimum of twelve (12) months or until the next inspection by the Department's Division of Health Licensing, whichever is longer. Records of menus as served shall be maintained for at least thirty (30) days and available for inspection.

805. Electronic Resident Records

A. Electronic records are subject to all of the standards of this regulation.

B. A facility that maintains electronic records shall:

1. Retain the hard copy originals of any materials that cannot be electronically stored;

2. Employ an off-site backup storage system as protection in the event that the on-site system is damaged or destroyed;

3. Use an imaging mechanism that is able to copy documents with signatures;

4. Assure that records, once put in electronic form, are unalterable.

C. Electronic signatures may be used any place in the resident or outpatient record that requires a signature, provided signature identification can be verified and an electronic signature may be legally used. Electronic authorization shall be limited to a unique identifier (confidential code) used only by the individual making the entry to preclude the improper or unauthorized use of any electronic signature.