13. CLINICAL RECORDS

13.1 Records Maintenance and Retention

(a) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(1) complete;

(2) accurately documented;

(3) readily accessible; and

(4) systematically organized.

(b) All of an individual's clinical records must be retained for the longer of the following time periods:

(1) eight years from the date of discharge or death; or

(2) for a minor, three years after a resident reaches 18 years of age.

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

(d) The facility must ensure that each clinical record contains a recent photograph of the resident, unless the resident objects.

13.2 Confidentiality

The facility must 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:

(a) transfer to another health care institution;

(b) law;

(c) third party payment contract; or

(d) the resident.

13.3 Contents

The clinical record must contain:

(a) sufficient information to identify the resident;

(b) a record of the resident’s assessments;

(c) the plan of care and services provided;

(d) the results of any preadmission screening conducted by the state; and

(e) progress notes.