# 449.150 Records of clients

**1.**

Each facility must maintain an organized system for clients' records.

**2.**

Clients' records must be available to members of the staff who have authority to review such records.

**3.**

Clients' records must be available to representatives of the Division.

**4.**

Clients' records must contain: (a) Identification information; (b) Past medical and social history; (c) Copies of initial and periodic examinations; (d) Evaluations and progress notes; and (e) A review and any revisions of each plan of treatment.

**(a)**

Identification information;

**(b)**

Past medical and social history;

**(c)**

Copies of initial and periodic examinations;

**(d)**

Evaluations and progress notes; and

**(e)**

A review and any revisions of each plan of treatment.

**5.**

There must be an overall plan of treatment stated in quantifiable terms which outlines goals to be accomplished through individually designed activities, therapies and treatments.

**6.**

The plan of treatment must state what service or person is responsible for treatment or services to the client.

**7.**

Entries must be made describing treatments and services rendered, medications administered, including those that are self-administered, and any symptoms or other indications of illness or injury, including the date, time and action taken regarding each incident.

**8.**

Records must be adequately safeguarded against destruction, loss or unauthorized use.

**9.**

Records must be retained for at least 5 years following a client's discharge.

**10.**

A discharge plan, as determined by a case management services assessment of the client, must be documented for each client discharged from the facility. The discharge plan must be formulated upon a client's admission to the facility.