

449.725 Records

1.

A facility must maintain an organized system for keeping residents' records. A resident's records must be available to professionals and other members of the staff who are directly involved with the resident. The records must be available to representatives of the Division.

2.

The record for each resident must include the following: (a) Information, relating to the resident's identification. (b) Admission data, including past medical and social history. (c) Copies of initial and periodic examinations, evaluations and progress notes. (d) Assessments and goals of each plan of care and modifications to the plan. (e) Discharge summaries. (f) An overall plan of care describing the goals to be accomplished through individually designed activities, therapies and treatments. (g) The plan of care must indicate which professional service or person is responsible for the care or service. (h) Entries describing treatments and services rendered. (i) Medications administered. (j) All symptoms and other indications of illness or injury, including the date, time and action taken regarding each such incident.

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(b)

Admission data, including past medical and social history.

(c)

Copies of initial and periodic examinations, evaluations and progress notes.

(d)

Assessments and goals of each plan of care and modifications to the plan.

(e)

Discharge summaries.

(f)

An overall plan of care describing the goals to be accomplished through individually designed activities, therapies and treatments.

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The plan of care must indicate which professional service or person is responsible for the care or service.

(h)

Entries describing treatments and services rendered.

(i)

Medications administered.

(j)

All symptoms and other indications of illness or injury, including the date, time and action taken regarding each such incident.

3.

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

4.

Records must be retained for a minimum of 3 years following the discharge of a resident.