310_675-7-10.1 Resident's clinical record

(a)

There shall be an organized, accurate, clinical and personal record, either typewritten or legibly written with pen and ink, for each resident admitted or accepted for treatment. The resident's clinical record shall document all nursing services provided.

(b)

The resident clinical record shall be retained for at least five years after the resident's discharge or death. A minor's record shall be retained for at least two years after the minor has reached the age of eighteen but, in no case, less than five years.

(c)

All required records, either original or microfilm copies, shall be maintained in such form as to be legible and readily available upon request of the attending physician, the facility, and any person authorized by law to make such a request.

(d)

Information contained in the resident record shall be confidential and disclosed only to the resident, persons authorized by the resident, and persons authorized by law.

(e)

Resident's records shall be filed and stored to protect against loss, destruction, or unauthorized use.

(f)

The Department shall be informed in writing immediately whenever any resident's records are defaced, or destroyed, before the end of the required retention period.

(g)

If a facility ceases operation, the Department shall be notified immediately of the arrangements for preserving the resident's record. The record shall be preserved for the required time and the information in the records shall be available to the health professionals or facilities assuming care of the resident so that continuity of care is available.

(h)

If the ownership of the facility changes, the new licensee shall have custody of the residents records and the records shall be available to the former licensee and other authorized persons.

(i)

A person employed by the owner shall be in charge of resident records and properly identifiable to others concerned.

(j)

The resident clinical record shall include: (1) An admission record sheet which shall include: (A) Identification of the resident (name, sex, age, date of birth, marital status). (B) Identification numbers as applicable: i. e., Medicare number, Medicaid number. (C) Date and time of admission. (D) Diagnosis and known allergies. (E) Name, address, and telephone number of responsible party, next of kin, pharmacist, and funeral home. (2) Physician's orders for medications, diet, treatment, and therapy. (3) Orders dated and signed by the physician giving the order. Verbal or telephone orders shall be signed by the physician within five working days, excluding weekends and holidays. (4) Initial orders given by the

physician at the time of admission shall be signed by the physician and placed in the clinical record within five working days of admission, excluding weekends and holidays. (5) The most recent medical history and physical examination signed and dated by the physician. (6) Nurse's notes, dated and signed at the time of entry. (7) Temperature, pulse, respirations, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition. (8) Progress notes generated by all health care professionals and allied health personnel. (9) An assessment and care plan based on the assessment. (10) An inventory of personal effects including clothing and property on admission, and as necessary. (11) Written acknowledgement by the resident or legal representative of receipt of the resident's rights upon admission and as needed. (12) Discharge summary signed by the attending physician that shall include the diagnosis or reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan, if appropriate, condition on discharge or transfer, or cause of death, date and time of discharge, and diagnosis on discharge. (13) A transfer or discharge form when a resident is transferred, or discharged, to the hospital, another facility or released from care. Transfer or discharge forms may be excluded when a resident is discharged to his/her home when the stay in the facility is for respite care only. The transfer form shall include, but not be limited to, the following information: (A) Identification of the resident and his attending physician. (B) Diagnosis, medications and medication administration schedule. (C) Name of transferring facility. (D) Name of receiving facility. (E) Date of transfer. (F) Family or legal representative. (G) Condition on transfer. (H) Reason for transfer. (I) Known allergies. (J) Pertinent medical history. (K) Any advance directive for medical care.

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sex, age, date of birth, marital status). (B) Identification numbers as applicable: i. e., Medicare number, Medicaid number. (C) Date and time of admission. (D) Diagnosis and known allergies. (E) Name, address, and telephone number of responsible party, next of kin, pharmacist, and funeral home.

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Identification of the resident (name, sex, age, date of birth, marital status).

(B)

Identification numbers as applicable: i. e., Medicare number, Medicaid number.

i.

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(C)

Date and time of admission.

(D)

Diagnosis and known allergies.

(E)

Name, address, and telephone number of responsible party, next of kin, pharmacist, and funeral home.

(2)

Physician's orders for medications, diet, treatment, and therapy.

(3)

Orders dated and signed by the physician giving the order. Verbal or telephone orders shall be signed by the physician within five working days, excluding weekends and holidays.

(4)

Initial orders given by the physician at the time of admission shall be signed by the physician and placed in the clinical record within five working days of admission,

excluding weekends and holidays.

(5)

The most recent medical history and physical examination signed and dated by the physician.

(6)

Nurse's notes, dated and signed at the time of entry.

(7)

Temperature, pulse, respirations, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition.

(8)

Progress notes generated by all health care professionals and allied health personnel.

(9)

An assessment and care plan based on the assessment.

(10)

An inventory of personal effects including clothing and property on admission, and as necessary.

(11)

Written acknowledgement by the resident or legal representative of receipt of the resident's rights upon admission and as needed.

(12)

Discharge summary signed by the attending physician that shall include the diagnosis or reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan, if appropriate, condition on discharge or transfer, or cause of death, date and time of discharge, and diagnosis on discharge.

(13)

A transfer or discharge form when a resident is transferred, or discharged, to the

hospital, another facility or released from care. Transfer or discharge forms may be excluded when a resident is discharged to his/her home when the stay in the facility is for respite care only. The transfer form shall include, but not be limited to, the following information: (A) Identification of the resident and his attending physician. (B) Diagnosis, medications and medication administration schedule. (C) Name of transferring facility. (D) Name of receiving facility. (E) Date of transfer. (F) Family or legal representative. (G) Condition on transfer. (H) Reason for transfer. (I) Known allergies. (J) Pertinent medical history. (K) Any advance directive for medical care.

(A)

Identification of the resident and his attending physician.

(B)

Diagnosis, medications and medication administration schedule.

(C)

Name of transferring facility.

(D)

Name of receiving facility.

(E)

Date of transfer.

(F)

Family or legal representative.

(G)

Condition on transfer.

(H)

Reason for transfer.

(I)

Known allergies.

(J)

Pertinent medical history.

(K)

Any advance directive for medical care.