61-17.800.801 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, for example, advance directive information, do-not-resuscitate (DNR) orders, allergies; 5. Accidents and/or 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, for example, 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, for example, 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.

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, for example, advance directive information, do-not-resuscitate (DNR) orders, allergies;

5.

Accidents and/or 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, for example, 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;

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, for example, 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, for example, 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.