SD

44_73_09_04 Record content

Each medical record shall show the condition of the resident from the time of admission until discharge and shall include the following:

(1)

Identification data;

(2)

Consent forms, except when unobtainable, or in an emergency;

(3)

History of the resident;

(4)

A current overall plan of care;

(5)

Report of the initial and periodic physical examinations, evaluations, and all plans of care with subsequent changes;

(6)

Diagnostic and therapeutic orders;

(7)

Progress notes from all disciplines, including practitioners, physical therapy, occupational therapy, and speech-language pathology;

(8)

Laboratory and radiology reports;

(9)

Description of treatments, diet, and services provided and medications administered;

(10)

All indications of an illness or an injury, including the date, the time, and the action taken regarding each;

(11)

A final diagnosis; and

(12)

A discharge summary, including all discharge instructions for home care.