11-16 Medical Records

(a)

Maintenance of Clinical Records. The facility shall maintain a separate and complete medical record for each resident admitted with all entries kept current, dated and signed. (i) The medical record shall include: (A) Identification and summary sheet(s) including resident's name, social security number, marital status, age, sex, home address, and religion; name, address, and telephone number of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnoses, final diagnoses, category of care, condition on discharge and disposition, source of payment, and any other information needed to meet State requirements. (B) Initial medical evaluation including medical history, physical examination and diagnosis. (C) Authentication of hospital diagnoses, in the form of a hospital discharge summary, or a written report from the physician who attended the resident in the hospital, or a transfer form used under a transfer agreement. (D) Physician's orders, including all medications, treatments, diet, rehabilitative and special medical procedures required for the safety and well-being of the resident. (E) Physician's progress notes describing significant changes in the resident's condition, dictated or written at the time of each visit. (F) Nurses' notes which shall include but not be limited to the following: (I) Concise and accurate record of nursing care administered. (II) Record of pertinent observation of the resident

including psycho-social as well as physical manifestations. (III) Name, dosage and time of administration of medications and treatments, route of administration except if by oral medication. (IV) Record of type of restraint and time of application and removal. The time of application and removal shall be necessary for all restraints prescribed by the physician for the support and protection of the resident. (G) Medication and treatment record including all medications, treatments and special procedures performed for the safety and well-being of the resident. (I) Laboratory and x-ray reports. (II) Consultation reports. (III) Dental reports. (IV) Social service notes. (V) Resident care referral reports. (VI) Activity reports.

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(C)

Authentication of hospital diagnoses, in the form of a hospital discharge summary, or a written report from the physician who attended the resident in the hospital, or a transfer form used under a transfer agreement.

(D)

Physician's orders, including all medications, treatments, diet, rehabilitative and special medical procedures required for the safety and well-being of the resident.

(E)

Physician's progress notes describing significant changes in the resident's condition, dictated or written at the time of each visit.

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(II)

Consultation reports.

(III)

Dental reports.

(IV)

Social service notes.

(V)

Resident care referral reports.

(VI)

Activity reports.

(b)

Retention of Records. (i) The facility shall have policies providing for the retention and safekeeping of residents' medical records by the governing body for the required period of time in the event that the facility discontinues operation. (ii) A copy of the resident's clinical record or an abstract thereof shall accompany the resident who is transferred to another facility.

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(c)

Staff Responsibility. An employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved if the facility does not have a full or part time medical record librarian. (i) The designated individual shall be trained by and receive regular consultation from a person skilled in record maintenance and preservation.

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