**Section 390.1610 Resident Record Requirements**

a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

c) Record entries shall meet the following requirements:

1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.

2) All entries into the medical record shall be authenticated by the individual who made or authored the entry. "Authentication", for purposes of this Section, means identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.

3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatment including, but not limited to, radiologic or laboratory reports and other similar reports.

4) Authentication shall include the initials of the signer's credentials. If the electronic signature system will not allow for the credential initials, the facility shall have a means of identifying the signer's credentials.

5) Electronic Medical Records Policy. The facility shall have a written policy on electronic medical records. The policy shall address persons authorized to make entries, confidentiality, monitoring of record entries, and preservation of information.

A) Authorized Users. The facility shall develop a policy to assure that only authorized users make entries into medical records and that users identify the date and author of every entry in the medical records. The policy should allow written signatures, written initials supported by a signature log, or electronic signatures with assigned identifiers, as authentication by the author that the entry made is complete, accurate and final.

B) Confidentiality. The facility policy shall include adequate safeguards to ensure confidentiality of patient medical records, including procedures to limit access to authorized users. The authorized user must certify in writing that he or she is the only person with authorized user access to the identifier and that the identifier will not be shared or used by any other person. A surveyor or inspector in the performance of a State-required inspection may have access to electronic medical records, using the identifier and under the supervision of an authorized user from the facility. A surveyor or inspector may have access to the same electronic information normally found in written patient records. Additional summary reports, analyses, or cumulative statistics available through computerized records are the internal operational reports of the facility's Quality Assurance Committee.

C) Monitoring. The facility shall develop a policy to periodically monitor the use of identifiers and take corrective action as needed. The facility shall maintain a master list of authorized users past and present and maintain a computerized log of all entries. The logs shall include the date and time of access and the user ID under which access occurred.

D) Preservation. The facility shall develop a plan to ensure access to medical records over the entire record retention period for that particular piece of information.

d) All physician's orders, plans of treatment, Medicare or Medicaid certification, recertification statements, and similar documents shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials, is not acceptable.

e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatment and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.

1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or habilitation services, shall be included in the resident's progress record when the recommendations pertain to an individual resident.

g) A medication administration record shall be maintained that contains the date and time each medication is given, name of drug, dosage, and by whom administered.

h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

i) The records maintained for each resident shall be adequate for:

1) Planning and continuously evaluating each resident's habilitation program,

2) Furnishing evidence of each resident's progress and response to the habilitation program, and

3) Protecting each resident's legal rights.

j) The facility may use universal progress notes in the medical records.

k) Each facility shall have a policy regarding the retirement and destruction of medical records. This policy shall specify the time frame for retiring a resident's medical record, and the method to be used for record destruction at the end of the record retention period. The facility's record retirement policy shall not conflict with the record retention requirements contained in Section 390.1650 of this Part.

l) Discharge information shall be completed within 48 hours after the resident leaves the facility.

1) Within 48 hours after the resident leaves the facility the resident care staff shall record the date, time, condition of the resident, to whom released, and the resident's planned destination (home, another facility, undertaker). This information may be entered onto the admission record form.

2) The discharge information shall also include reasons for discharge, diagnosis, individual habilitation plan, physical, pertinent medical and social histories, orders and staff recommendations for immediate care to ensure the optimal continuity of care for the resident.

m) At the time of discharge, the facility shall provide those responsible for the resident's post-discharge care with a discharge summary. A copy of this discharge summary shall be retained as a part of the resident record.

n) When a resident is temporarily transferred to another location, the facility shall provide the temporary caretaker with medical and other information necessary and useful in the care and treatment of the resident.

o) At least six months prior to a resident's 18th birthday, the facility shall complete a report regarding the resident's guardianship status and any actions needed to establish guardianship.

p) Each resident record is the property of the facility. The facility shall be responsible for securing resident record information against loss, defacement, tampering or use by unauthorized persons.

(Source: Amended at 23 Ill. Reg. 8021, effective July 15, 1999)