481—70.25(231D) Participant documents.

70.25(1) Documentation for each participant shall be maintained by the program and shall include:

a. A participation record including the participant's name, birth date, and home address; identification numbers; date of beginning participation; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;

b. Application forms;

c. The initial evaluations and updates;

d. A nutritional assessment as necessary;

e. The initial individual service plan and updates;

f. Signed authorizations for permission to release medical information, photographs, or other media information as necessary;

g. A signed authorization for the participant to receive emergency medical care as necessary;

h. A signed managed risk policy and signed managed risk consensus agreements, if any;

i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;

j. Medication lists, which shall be maintained in conformance with 481—paragraph 67.5(2)*"d"*;

k. Advance health care directives as applicable;

l. A complete copy of the participant's contractual agreement, including any updates;

m. A written acknowledgment that the participant or the participant's legal representative, if applicable, has been fully informed of the participant's rights;

n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;

o. Incident reports involving the participant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the participant's medical record);

p. A copy of waivers of admission or retention criteria, if any;

q. When the participant is unable to advocate on the participant's own behalf or the participant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs); and

r. Authorizations for the release of information, if any.

70.25(2) The program records relating to a participant shall be retained for a minimum of three years after the discharge or death of the participant.

70.25(3) All records shall be protected from loss, damage and unauthorized use.

[**ARC 8177B**, IAB 9/23/09, effective 1/1/10; **ARC 4976C**, IAB 3/11/20, effective 4/15/20]