481—65.20 (135C) Records.

65.20(1) *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. (II) The record shall include:

a. Name and previous address of resident; (III)

b. Birth date, sex, and marital status of resident; (III)

c. Church affiliation; (III)

d. Physician's name, telephone number, and address; (III)

e. Dentist's name, telephone number, and address; (III)

f. Name, address and telephone number of next of kin or legal representative; (III)

g. Name, address and telephone number of the person to be notified in case of emergency; (III)

h. Funeral director, telephone number, and address; (III)

i. Pharmacy name, telephone number, and address; (III)

j. Results of evaluation pursuant to rule 481—65.11(135C); (III)

k. Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)

l. Physician's orders for medication and treatments in writing, signed by the physician quarterly and diet orders renewed yearly; (III)

m. A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)

n. Any change in the resident's condition; (II, III)

o. A notation describing the resident's condition on admission, transfer, and discharge; (III)

p. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

q. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

r. Disposition of personal property; (III)

s. Copy of IPP pursuant to subrule 65.12(1); (III) and

t. Progress notes pursuant to subrules 65.12(4) and 65.12(5). (III)

65.20(2) *Confidentiality of resident records.* The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automatic data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the information being released, how the information is to be used, and the period of time for which the release is in effect. A third party, not requesting the release, shall witness the signing of the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record available to the resident. This determination

and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

65.20(3) *Incident records.* Each ICF/PMI shall maintain an incident record report and shall have available incident report forms. (II, III)

a. The report of every incident shall be in detail on a printed incident report form. (II, III)

b. The person in charge at the time of the incident shall oversee the preparation and sign the report. (III)

c. A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

65.20(4) *Retention of records.* Records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership. (III)

When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.