481—71.20(135G) Records.

71.20(1) *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. The record shall include:

a. Name and previous address of resident;

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

c. Provisional or admitting diagnosis;

d. A biopsychosocial history sufficient to provide data on the resident's relevant past history, present situation, social support system, community resource contacts, and other information relevant to appropriate treatment and discharge planning;

e. The name, telephone number and address of the licensed mental health professional completing the biopsychosocial history;

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

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

h. Pharmacy name, telephone number, and address;

i. Written orders for treatment and medications, signed by a physician, physician associate or advanced registered nurse practitioner;

j. Any change in the resident's condition;

k. Notations describing the resident's condition on admission, transfer, and discharge;

l. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer;

m. Individualized treatment and discharge or transfer plan pursuant to rule 481—71.14(135G);

n. Progress notes, including any use of seclusion or restraint pursuant to rule 481—71.16(135G), recorded by the physician, physician associate, advanced registered nurse practitioner or mental health professional and, when appropriate, others significantly involved in active treatment modalities. Progress notes must contain a concise assessment of the resident's progress and recommendations for revising the treatment plan as indicated by the resident's condition;

o. The discharge summary, including a recapitulation of the resident's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the resident's condition on discharge.

71.20(2) *Confidentiality of resident records.* The facility shall have policies and procedures providing that each resident shall be assured confidential treatment of all information, including information contained in electronic records.

a. The facility shall limit access to any resident records to staff and consultants providing professional services 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. This restriction shall not preclude access by representatives of state or federal regulatory agencies.

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, physician associate, advanced registered nurse practitioner or mental health professional determines the disclosure of the record or a section thereof is contraindicated, in which case the designated information will be redacted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record.

71.20(3) *Incident records.*

a. Each subacute care facility shall maintain an incident record report and shall have available incident report forms.

b. A report of every unusual occurrence shall be detailed on the printed incident report form.

c. The person in charge at the time of the unusual occurrence shall oversee the preparation of and sign the incident report.

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

71.20(4) *Retention of records.*

a. 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.

b. 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 or advanced registered nurse practitioner.

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