POLICY

The Executive Director shall coordinate with Health Services staff about how to establish resident health records in the Community, sustain appropriate confidentiality for resident records according to policy, and oversee staff training about the records. Each resident shall remain under the care of a physician while in the community. In addition, resident specific records shall include content as directed in this policy. Community staff shall always be truthful with any documentation.

OVERVIEW

Staff must receive appropriate job training about how policies related to misrepresentation, confidentiality and physician orders are implemented in the Community. Some documentation related to the health of residents does not become part of the limited health record package described here, but detailed instruction is available elsewhere about all the documents indicated below as required. Training material for medication techs specifies how to establish and maintain medication assistance/administration record (MAR) that is a significant part of the health record.

PROCEDURES

Resident Health Record Set-Up

The Nurse or Licensed Nurse Assistant in the Community is the staff member who usually manages resident health records and trains others about the established requirements, as follows:
1. The resident’s record will be maintained and updated as needed, to reflect current information.
2. All items marked “Do Not Purge” needs to be housed in plastic protectors.
3. Use a three-ring binder (at least 2” thick) for chart.
4. Create the following tabs for information that MUST be retained in each resident’s binder, according to direction below:

SECTION 1: Resident information Sheet/Face Sheet
- Face Sheet (in plastic protector sheet and reviewed/updated each quarter)
- POLST form/Advanced Directives (in plastic protector sheet)
- POA/Guardianship (in plastic protector sheet)
SECTION 2: Service Plan

- Pre Move-In RN Assessment (in plastic protector sheet and do not purge) to include all the elements required by the state for a comprehensive assessment along with other elements i.e. Self Medication evaluation, Smoking Evaluation, Pain, Psychotropic drug review, Cooking appliances etc.
- Service Plan (last quarter)
- Last 24 months of Service Plans in purged file easily accessible.

SECTION 3: History and Physical

- History and Physical (initial to be placed in plastic protector sheet and do not purge)
- History and Physical current year
- Office Visit Summary for 4 months
- Podiatrist notes for 1 year
- All other documentation from prescribers that are not orders for 3 months

SECTION 4: Orders

- Admit Orders (in plastic sheet protector and do not purge)
- Current 90 Day Physician Orders
- Physician orders that are dated after the review of the current 90 day order

SECTION 5: Progress Notes

- Move in note (plastic sheet protector and do not purge)
- Most current progress notes for the last 3 months

SECTION 6: Professional health Care Provider Notes

- Most current for 3 months

SECTION 7: Lab and Diagnostic Reports

- Most current for 6 months
- Vaccine records permanently, exception flu vaccines for 1 year

SECTION 8: Miscellaneous Records

- Durable Medical Equipment
- Any other relevant information

*MAR information will be stored electronically on QuickMAR*

5. In each resident health record, maintain information for each tab as stated below, noting what information is required in the record at all times “permanent”, and what can be removed when “outdated” (as indicated in bold).

a. Resident Information Sheet/Face Sheet: Complete a resident “face sheet” from QMAR or Real Page to include all information about contacts, such as family or guardian, preferred hospital, mortuary and physician(s), insurance information, or other. Insert directly behind
the tab in plastic sheet protector with other items located behind such as CPR, POLST, EMS, advance directive, power of attorney (for health care) and/or other. Update the resident face sheet quarterly and as needed.

b. **Service Plan/Assessment:** Move-in consultation (do not purge), assessment and service plan from before move-in (do not purge): then, after move-in, second current service plan (current service plan to be in the service plan binder) MMSE, depression scale, and other admission assessments **for the last Quarter.** Other assessments (social, dietary, pain, nutrition/hydration, cooking, pain, smoking self medication, psychotropic etc.) are all to be incorporated in the signed service plan.

c. **History and Physical:** Documentation of health examination by a physician, initial upon move in (Do not Purge), current; all subsequent documents related to physician examination for the **last 6 months.**

d. **Orders:** Initial orders (at move-in) (do not purge); **most recent** 90-day recaps and any orders since last 90-day recap. NOTE that all **prescriptions** must be taped on a sheet sized 8 1/2” x 11”. A resident’s health record always shall include physician orders signed by a legally authorized practitioner, as notification to staff for timely implementation.

e. **Progress Notes:** Documentation of heath and/or behavior related concerns, issues, falls, changes of condition, new medication, illness, etc. Progress Notes for the previous 90 days (3 months) should be kept in the resident chart unless electronically held in EMar. **Older Progress** Notes may be purged into resident history file.

f. **Professional HealthCare Providers:** Any notes received from outside providers, such as Home Health and Hospice. **for the last quarter** (90) days

g. **Laboratory/Special Reports:** Retain all lab documents **for the last 6 months** (and any other significant to resident’s current condition).

h. **Miscellaneous:** Information relevant to resident health care, as directed. Records for durable medical equipment would be ideal items to be found in this section.

6. Always keep in the binder the documents indicated above as “permanent,” but review each resident’s record at least quarterly and remove content that is “outdated” per description above to the residents purged file.

7. All discharged and clinical records will be maintained in an efficient, orderly and secure manner. The Community is responsible to store all information from a resident’s health record for **at least 5 years after** the resident leaves the Community.
8. Outdated/archived/purged records should be placed into a manila envelope and labeled “purged” with the date, including year and resident name. Continue to fill this envelope with outdated/archived records until full. Label the envelope with each date items were added. Once envelope has been put into use, place into file cabinet labeled with alphabet and year. If additional manila envelopes are required for same resident continue to date and label as above. Place a rubber band around all envelopes for that resident for that year.

9. Maintain outdated/archived records removed from a resident’s current health record onsite and available for review by authorized persons until at least six months after the resident leaves the Community.

10. After six months onsite storage, archived records can be stored at an off-site location but must be readily retrievable for review by authorized persons. The Executive Director should coordinate with the VP of Operations about any off-site storage arrangement.

11. Within 72 hours of a resident’s discharge, the Resident Health Record, financial record will be retrieved with the outdated/archived records will be assembled and filed in the discharge file for the appropriate year.

12. All discharged and clinical records will be maintained in an efficient and orderly manner and be secure from damage or theft, following State and Federal regulations.

13. Under no circumstances shall any document of the resident record be falsified and doing so will result in termination. The Vice President or President must be notified immediately of any suspected document tampering.

14. Original resident records must never leave the community unless being stored off site or accompanied to the physician office.

RETENTION GUIDELINES

5 Years after Discharge from Community