**Section 340.1800 Resident Record Requirements**

a) Each facility shall designate an employee to be responsible for completing, maintaining and preserving the medical records.

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

c) 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.

d) 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 treatments 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 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 the particular piece of information.

e) 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 rehabilitation services, shall be included in the resident's progress record when the recommendations pertain to an individual resident.

3) 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 treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.

f) A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered. A medication administration record is not required for residents who have been approved to be fully responsible for their own medications in accordance with Section 340.1630(c).

g) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. This does not prohibit the use of universal progress notes.

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

(Source: Amended at 23 Ill. Reg. 7931, effective July 15, 1999)