4665.4100 RESIDENT'S HEALTH RECORD.

Subpart 1. **Maintaining a record.** Supervised living facilities shall maintain a resident's health record for each resident. It may be contained in a general resident record.

Subp. 2. **Required data.** Basic health information to be maintained in each resident's health record shall include:

A. identifying information: name, previous address, date of admission and discharge, person to contact in an emergency;

B. the physician responsible for his/her medical care as designated by the resident or guardian;

C. the name of the resident's dentist as designated by the resident, parent, or guardian; dates of dental examinations and treatments; special instructions for care and oral hygiene as recommended;

D. adverse reactions to drugs recorded and prominently posted as a precaution;

E. where professional therapy services are provided to the resident, regular notations regarding the resident's progress in such therapies;

F. dates and descriptions of all illnesses, accidents, treatments thereof, and immunizations, including examinations required in parts 4665.3300 to 4665.4000;

G. summary of hospitalizations, to include recommendations for follow-up and treatment; and

H. where the resident is being treated through a special diet, a copy of the diet, length of time to be used, prescription signed by the supervising physician, and the dates of review of the diet.

Subp. 3. **Nature of health record.** Upon request, a resident or parent or guardian shall be provided with a summary of the resident's health record within a reasonable period of time following discharge. All information contained in the resident's health records shall be considered privileged and confidential, and written consent of the resident or a parent shall be required for the release of information to persons not otherwise authorized to receive it. The resident shall have access to the health record upon request. All entries in the resident's health record shall be legible, dated, and authenticated by the signature and other identifying designation of the individual making the entry.

Subp. 4. **Retention of health record.** All resident health records shall be kept by the facility for at least three years following discharge or death. Employees of the department may review such records for accuracy and completeness.

Statutory Authority: *MS s 144.56*

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