

WAC 388-97-1720 Clinical records. (1) The nursing home must:

(a) Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

- (i) Complete;
- (ii) Accurately documented;
- (iii) Readily accessible; and
- (iv) Systematically organized.

(b) Safeguard clinical record information against alteration, loss, destruction, and unauthorized use; and

(c) Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

- (i) Transfer to another health care institution;
- (ii) Law;
- (iii) Third party payment contract; or
- (iv) The resident.

(2) The nursing home must ensure the clinical record of each resident includes at least the following:

(a) Resident identification and sociological data, including:

- (i) Name;
- (ii) Room number;
- (iii) Resident telephone number, if available; and
- (iv) Resident email address, if available.

(b) If a resident has a representative, the following representative information:

- (i) Name;
- (ii) Relationship to the resident;
- (iii) Phone number;
- (iv) Email address, if available; and
- (v) Mailing address, if available.

(c) The name and address of the individual or individuals the resident designates as significant;

(d) Medical information required under WAC 388-97-1260;

(e) Physician's orders;

(f) Assessments;

(g) Plans of care;

(h) Services provided;

(i) In the case of the medicaid-certified nursing facility, records related to preadmission screening and resident review;

(j) Progress notes;

(k) Medications administered;

(l) Consents, authorizations, releases;

(m) Allergic responses;

(n) Laboratory, X-ray, and other findings; and

(o) Other records as appropriate.

(3) The nursing home must:

(a) Designate an individual responsible for the record system who:

(i) Has appropriate training and experience in clinical record management; or

(ii) Receives consultation from a qualified clinical record practitioner, such as a registered health information administrator or registered health information technician.

(b) Make all records available to authorized representatives of the department for review and duplication as necessary; and

(c) Maintain the following:

(i) A master resident index having a reference for each resident including the health record number, if applicable; full name; date of birth; admission dates; and discharge dates; and

(ii) A chronological census register, including all admissions, discharge, deaths, and transfers, and noting the receiving facility. The nursing home must ensure the register includes discharges for social leave and transfers to other treatment facilities in excess of 24 hours.

(4) The nursing home must ensure the clinical record of each resident:

(a) Is documented and authenticated accurately, promptly, and legibly by individuals giving the order, making the observation, performing the examination, assessment, treatment, or providing the care and services. **"Authenticated"** means the authorization of a written entry in a record by signature, including the first initial and last name and title, or a unique identifier allowing identification of the responsible individual; and:

(i) Documents from other health care facilities that are clearly identified as being authenticated at that facility will be considered authenticated at the receiving facility; and

(ii) The original or a durable, legible, direct copy of each document will be accepted.

(b) Contains appropriate information for a deceased resident including:

(i) The time and date of death;

(ii) Apparent cause of death;

(iii) Notification of the physician and appropriate resident representative; and

(iv) The disposition of the body and personal effects.

(5) In cases where the nursing home maintains records by computer rather than hard copy, the nursing home must:

(a) Have in place safeguards to prevent unauthorized access; and

(b) Provide for reconstruction of information.

(6) The nursing home licensee must:

(a) Retain health records for the time period required in RCW 18.51.300:

(i) For a period of no less than eight years following the most recent discharge of the resident; except

(ii) That the records of minors must be retained for no less than three years following the attainment of age 18 years, or 10 years following their most recent discharge, whichever is longer.

(b) In the event of a change of ownership, provide for the orderly transfer of clinical records to the new licensee;

(c) In the event a nursing home ceases operation, make arrangements prior to cessation, as approved by the department, for preservation of the clinical records. The nursing home licensee must provide a plan for preservation of clinical records to the department's designated local home and community living administration office no later than seven days after the date of notice of nursing home closure as required by WAC 388-97-1640 (8) and (9) unless an alternate date has been approved by the department; and

(d) Provide a resident access to all records pertaining to the resident as required under WAC 388-97-0300(2).

[Statutory Authority: RCW 18.20.090, 18.51.070, 70.97.230, 70.128.040, chapters 70.129, 74.42, and 74.39 RCW. WSR 26-05-046, s 388-97-1720, filed 2/12/26, effective 3/15/26. Statutory Authority: Chapters 18.51

and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-1720,
filed 9/24/08, effective 11/1/08.]