

# History Tracking Report: 2010 to 2009 Requirements

## Accreditation Program: Long Term Care

### 2010 Chapter: Record of Care, Treatment, and Services

#### Standard RC.01.01.01

##### 2010 Standard Text:

The organization maintains complete and accurate clinical records.

**2010 Standard:** RC.01.01.01

**2010 EP:** 1

##### 2010 EP Text:

The organization defines the components of a complete clinical record. (See also RC.01.04.01, EP 1)

**2010 Standard:** RC.01.01.01

**2010 EP:** 4

##### 2010 EP Text:

The clinical record contains information unique to the resident, which is used for resident identification.

**2010 Standard:** RC.01.01.01

**2010 EP:** 5

##### 2010 EP Text:

The clinical record contains the information needed to support the resident's diagnosis and condition.

#### Standard IM.6.10

##### 2009 Standard Text:

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

**2009 Standard:** IM.6.10

**2009 EP:** 9

##### 2009 EP Text:

The {jc}organization{/2} defines a complete record and the timeframe within which the record is completed after discharge, not to exceed 30 days after discharge.

**Revision Code:** Split

**2009 Standard:** IM.6.10

**2009 EP:** 6

##### 2009 EP Text:

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

**Revision Code:** Split

**2009 Standard:** IM.6.10

**2009 EP:** 6

##### 2009 EP Text:

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

**Revision Code:** Split

<p><b>2010 Standard:</b> RC.01.01.01                      <b>2010 EP:</b> 6</p> <p><b>2010 EP Text:</b></p> <p>The clinical record contains the information needed to justify the resident’s care, treatment, and services.</p>	<p><b>2009 Standard:</b> IM.6.10                      <b>2009 EP:</b> 6</p> <p><b>2009 EP Text:</b>                                      <b>Revision Code:</b> Split</p> <p>The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.</p>
<p><b>2010 Standard:</b> RC.01.01.01                      <b>2010 EP:</b> 7</p> <p><b>2010 EP Text:</b></p> <p>The clinical record contains information that documents the course and result of the resident’s care, treatment, and services.</p>	<p><b>2009 Standard:</b> IM.6.10                      <b>2009 EP:</b> 6</p> <p><b>2009 EP Text:</b>                                      <b>Revision Code:</b> Split</p> <p>The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.</p>
<p><b>2010 Standard:</b> RC.01.01.01                      <b>2010 EP:</b> 8</p> <p><b>2010 EP Text:</b></p> <p>The clinical record contains information about the resident’s care, treatment, and services needed to provide continuity of care among providers.</p>	<p><b>2009 Standard:</b> IM.6.10                      <b>2009 EP:</b> 6</p> <p><b>2009 EP Text:</b>                                      <b>Revision Code:</b> Split</p> <p>The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.</p>
<p><b>2010 Standard:</b> RC.01.01.01                      <b>2010 EP:</b> 9</p> <p><b>2010 EP Text:</b></p> <p>The organization uses standardized formats to document the care, treatment, and services it provides to residents.</p>	<p><b>2009 Standard:</b> IM.6.10                      <b>2009 EP:</b> 3</p> <p><b>2009 EP Text:</b>                                      <b>Revision Code:</b> Retain</p> <p>Standardized formats are used for documenting all care, treatment, and services provided to {jc}patients{/6}.</p>
<p><b>2010 Standard:</b> RC.01.01.01                      <b>2010 EP:</b> 11</p> <p><b>2010 EP Text:</b></p> <p>All entries in the clinical record are dated.</p>	<p><b>2009 Standard:</b> IM.6.10                      <b>2009 EP:</b> 4</p> <p><b>2009 EP Text:</b>                                      <b>Revision Code:</b> Split</p> <p>{jc}Medical record{/8} entries* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**. *For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. **Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.</p>

**2010 Standard:** RC.01.01.01**2010 EP:** 12**2010 EP Text:**

The organization tracks the location of all components of the clinical record.

**2009 Standard:** IM.6.60**2009 EP:** 1**2009 EP Text:**

The {jc}organization{/2} has a process to track the location of all components of the {jc}medical record{/8}.

**Revision Code:** Retain**2010 Standard:** RC.01.01.01**2010 EP:** 13**2010 EP Text:**

If the clinical record is not maintained as a single entity, the organization has a system that allows staff to access information needed to provide care, treatment, and services to residents. (See also MM.01.01.01, EP 1)

**2009 Standard:** IM.6.60**2009 EP:** 2**2009 EP Text:**

The {jc}organization{/2} uses a system to assemble required information or make available a summary of information relative for {jc}patient{/1} care, treatment, and services provided.

**Revision Code:** Retain

**Standard RC.01.02.01**

**2010 Standard Text:**

Entries in the clinical record are authenticated.

**2010 Standard:** RC.01.02.01

**2010 EP:** 1

**2010 EP Text:**

Only authorized individuals make entries in the clinical record.

**2010 Standard:** RC.01.02.01

**2010 EP:** 2

**2010 EP Text:**

The organization defines the types of entries in the clinical record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.

**2010 Standard:** RC.01.02.01

**2010 EP:** 3

**2010 EP Text:**

The author of each clinical record entry is identified in the clinical record.

**Standard IM.6.10**

**2009 Standard Text:**

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

**2009 Standard:** IM.6.10

**2009 EP:** 1

**2009 EP Text:**

Only authorized individuals make entries in the {jc}medical record{/8}.

**Revision Code:** Retain

**2009 Standard:** IM.6.10

**2009 EP:** 2

**2009 EP Text:**

The {jc}organization{/2} defines which entries made by non-independent practitioners require countersigning consistent with law or regulation.

**Revision Code:** Retain

**2009 Standard:** IM.6.10

**2009 EP:** 4

**2009 EP Text:**

{jc}Medical record{/8} entries\* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp\*\*. \*For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. \*\*Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

**Revision Code:** Split

**2010 Standard:** RC.01.02.01

**2010 EP:** 4

**2010 EP Text:**

Entries in the clinical record are authenticated by the author. Information introduced into the clinical record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

**2010 Standard:** RC.01.02.01

**2010 EP:** 4

**2010 EP Text:**

Entries in the clinical record are authenticated by the author. Information introduced into the clinical record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

**2010 Standard:** RC.01.02.01

**2010 EP:** 5

**2010 EP Text:**

The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.

**2009 Standard:** IM.6.10

**2009 EP:** 4

**2009 EP Text:**

**Revision Code:** Split

{jc}Medical record{/8} entries\* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp\*\*. \*For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. \*\*Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

**2009 Standard:** IM.6.10

**2009 EP:** 5

**2009 EP Text:**

**Revision Code:** Retain

The author authenticates either by written signature, electronic signature, or computer key or rubber stamp the following: The history and physical examination Medication orders Practitioner orders Discharge summary

**2009 Standard:** IM.6.10

**2009 EP:** 4

**2009 EP Text:**

**Revision Code:** Split

{jc}Medical record{/8} entries\* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp\*\*. \*For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. \*\*Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

**Standard RC.01.03.01**

**2010 Standard Text:**

Documentation in the clinical record is entered in a timely manner.

**2010 Standard:** RC.01.03.01

**2010 EP:** 1

**2010 EP Text:**

The organization has a written policy that requires timely entry of information into the clinical record. (See also PC.01.02.03, EP 1)

**2010 Standard:** RC.01.03.01

**2010 EP:** 2

**2010 EP Text:**

The organization defines the time frame for completion of the clinical record, which does not exceed 30 days after the resident's discharge.

**2010 Standard:** RC.01.03.01

**2010 EP:** 3

**2010 EP Text:**

The organization implements its policy requiring timely entry of information into the resident's clinical record. (See also PC.01.02.03, EP 2)

**Standard IM.6.10**

**2009 Standard Text:**

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}'s assessed, cared for, treated, or served.

**2009 Standard:** IM.6.10

**2009 EP:** 8

**2009 EP Text:**

**Revision Code:** Split

The {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.

**2009 Standard:** IM.6.10

**2009 EP:** 9

**2009 EP Text:**

**Revision Code:** Split

The {jc}organization{/2} defines a complete record and the timeframe within which the record is completed after discharge, not to exceed 30 days after discharge.

**2009 Standard:** IM.6.10

**2009 EP:** 8

**2009 EP Text:**

**Revision Code:** Split

The {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.

**Standard RC.01.04.01**

**2010 Standard Text:**

The organization audits its clinical records.

**2010 Standard:** RC.01.04.01

**2010 EP:** 1

**2010 EP Text:**

The organization conducts an ongoing review of clinical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also RC.01.01.01, EP 1)

**2010 Standard:** RC.01.04.01

**2010 EP:** 1

**2010 EP Text:**

The organization conducts an ongoing review of clinical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also RC.01.01.01, EP 1)

**Standard IM.6.10**

**2009 Standard Text:**

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

**2009 Standard:** IM.6.10

**2009 EP:** 12

**2009 EP Text:**

{jc}Medical record{/8}s are reviewed on an ongoing basis at the point of care.

**Revision Code:** Consolidate

**2009 Standard:** IM.6.10

**2009 EP:** 13

**2009 EP Text:**

The review of {jc}medical record{/8}s is based on {jc}organization{/2}-defined indicators that address the presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the record.

**Revision Code:** Consolidate

**Standard RC.01.05.01**

**2010 Standard Text:**

The organization retains its clinical records.

**2010 Standard:** RC.01.05.01

**2010 EP:** 1

**2010 EP Text:**

The retention time of the clinical record is determined by its use and organization policy, in accordance with law and regulation.

Note: State law and regulation may address different retention time frames for clinical records for minors.

**2010 Standard:** RC.01.05.01

**2010 EP:** 6

**2010 EP Text:**

The residents' clinical records remain the organization's property and are transferred to the new owner, in the event of a change in the organization's ownership, unless otherwise indicated by law.

**2010 Standard:** RC.01.05.01

**2010 EP:** 8

**2010 EP Text:**

Original clinical records are not released unless the organization is responding to law and regulation.

**Standard IM.6.10**

**2009 Standard Text:**

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

**2009 Standard:** IM.6.10

**2009 EP:** 14

**2009 EP Text:**

**Revision Code:** Retain

The retention time of {jc}medical record{/8} information is determined by the {jc}organization{/2} based on law or regulation, and on its use for {jc}patient{/1} care, treatment, and services, legal, research, operational purposes, and educational activities.

**2009 Standard:** IM.6.10

**2009 EP:** 19

**2009 EP Text:**

**Revision Code:** Retain

In the event of a change in the organization's ownership, residents' clinical records remain the organization's property and are transferred to the new owner unless otherwise indicated by law.

**2009 Standard:** IM.6.10

**2009 EP:** 17

**2009 EP Text:**

**Revision Code:** Retain

Original {jc}medical record{/8}s are not released unless the {jc}organization{/2} is responding appropriately to laws or regulations, court orders, or subpoenas.

**Standard RC.02.01.01**

**2010 Standard Text:**

The clinical record contains information that reflects the resident's care, treatment, and services.

**2010 Standard:** RC.02.01.01

**2010 EP:** 1

**2010 EP Text:**

The clinical record contains the following demographic information:

- The resident's name, address, date of birth, and the name of any legally authorized representative
- The resident's sex
- The resident's language and communication needs

**2010 Standard:** RC.02.01.01

**2010 EP:** 2

**2010 EP Text:**

The clinical record contains the following clinical information:

- The reason(s) for admission for care, treatment, and services
- Any observations relevant to care, treatment, and services
- Any progress notes made by authorized individuals
- Any orders, including medications ordered or prescribed, and diagnostic and therapeutic orders
- Any allergies to medications
- Any medications administered, including the strength, dose, and rate
- Any medication administration devices used, including access site or route
- Any adverse drug reactions
- Any medications dispensed or prescribed on discharge
- Any assessment findings (See also PC.01.02.01, EP 1)
- Any consultation reports
- Any food allergies

**Standard IM.6.20**

**2009 Standard Text:**

Records contain {j}patient{/1}-specific information, as appropriate to the care, treatment, and services provided.

**2009 Standard:** IM.6.20

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

{j}Medical record{/8}s contain, as applicable, the following demographic information: Resident's name, address, date of birth, religion, marital status, social security number, gender, and the name of any legally authorized representative Resident's legal statusThe {j}patient{/1}'s language and communication needs.

**2009 Standard:** PC.2.120

**2009 EP:** 12

**2009 EP Text:**

**Revision Code:** Retain

At a minimum, the organization specifies the following time frames for assessments: The assessment findings are recorded in the medical record on admission within time frames noted in element of performance 11.

**2010 Standard:** RC.02.01.01**2010 EP:** 2**2010 EP Text:**

The clinical record contains the following clinical information:

- The reason(s) for admission for care, treatment, and services
- Any observations relevant to care, treatment, and services
- Any progress notes made by authorized individuals
- Any orders, including medications ordered or prescribed, and diagnostic and therapeutic orders
- Any allergies to medications
- Any medications administered, including the strength, dose, and rate
- Any medication administration devices used, including access site or route
- Any adverse drug reactions
- Any medications dispensed or prescribed on discharge
- Any assessment findings (See also PC.01.02.01, EP 1)
- Any consultation reports
- Any food allergies

**2009 Standard:** IM.6.20**2009 EP:** 1**2009 EP Text:****Revision Code:** Retain

{c}Medical record{/8}s contain, as applicable, the following clinical/case information: Care, treatment, and services provided to the resident before his or her arrival, if any Documentation and findings of assessments\*Initial medical assessment and conclusions or impressions drawn from medical history and physical examinationDiagnosis, diagnostic impression, or conditionsReason(s) for admission or care, treatment, and services Goals of the care and care plan Orders for care treatment and service as required by law or regulation Diagnostic and therapeutic ordersDiagnostic and therapeutic procedures, tests, and resultsProgress notes made by authorized individuals Reassessments and plan of care revisionsRelevant observations Consultation reportsAllergies to foods and medicinesMedications ordered or prescribedDosages of medications administered (including the strength, dose, or rate of administration), administration devices used, access site or route, known drug allergies, and adverse drug reactionsMedications dispensed or prescribed on dischargeRelevant diagnoses/conditions established during the course of care, treatment, and services\*See the "Provision of Care, Treatment, and Services " chapter in this manual.

**2010 Standard:** RC.02.01.01**2010 EP:** 4**2010 EP Text:**

As needed to provide care, treatment, and services, the clinical record contains the following additional information:

- Any advance directives (See also RI.01.05.01, EP 11)
- Orders, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn
- Any informed consent, when required by organization policy (See also RI.01.03.01, EP 13)
- Any records of communication with the resident, such as telephone calls or e-mail
- Any resident-generated information (for example, choices, habits, routine)
- Referrals or communication made to external or internal care providers and community agencies
- Any physician's summary and final diagnosis when the resident is admitted either from a hospital or from another health care organization
- The discharge plan or the reason for lack of an ongoing plan when discharge potential does not exist

**2009 Standard:** IM.6.20**2009 EP:** 3**2009 EP Text:****Revision Code:** Retain

{c}Medical record{/8}s contain, as applicable, the following information: Evidence of known advance directives Evidence of informed consent when required by organization policy Orders, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn Discharge plan, or the reason for lack of an ongoing plan when discharge potential does not exist Referrals or communications made to external or internal care providers and community agencies Physician's summary and the resident's final diagnosis when the resident is admitted from either a hospital or another health care organization

**Standard RC.02.01.05**

**2010 Standard Text:**

The clinical record contains documentation of the use of restraint.

**2010 Standard:** RC.02.01.05

**2010 EP:** 2

**2010 EP Text:**

The use of restraint, including the trial of alternatives to restraint, is documented in the clinical record. (See also PC.03.02.09, EP 5; PC.03.02.13, EP 1)

**2010 Standard:** RC.02.01.05

**2010 EP:** 2

**2010 EP Text:**

The use of restraint, including the trial of alternatives to restraint, is documented in the clinical record. (See also PC.03.02.09, EP 5; PC.03.02.13, EP 1)

**Standard PC.11.90**

**2009 Standard Text:**

When alternatives to restraint are ineffective, restraint is safely and appropriately used.

**2009 Standard:** PC.11.90

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Consolidate

When alternatives to restraint are ineffective and restraint is used, the organization uses a process that addresses the following elements in accordance with law and regulation: The use of restraint is based on the resident's assessed needs, including precipitating factors, and is documented.

**2009 Standard:** PC.11.90

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Split

When alternatives to restraint are ineffective and restraint is used, the organization uses a process that addresses the following elements in accordance with law and regulation: The trial of alternatives before the use of restraint is documented.

**Standard RC.02.01.09**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to the activities program at least quarterly.

**2010 Standard:** RC.02.01.09

**2010 EP:** 1

**2010 EP Text:**

The activity providers document the provision of activities to the resident based on the interdisciplinary care plan at least quarterly in the clinical record.

**2010 Standard:** RC.02.01.09

**2010 EP:** 2

**2010 EP Text:**

The activity providers document the resident's response to the activities program based on the interdisciplinary care plan at least quarterly in the clinical record.

**2010 Standard:** RC.02.01.09

**2010 EP:** 3

**2010 EP Text:**

The activity providers document in the clinical record any report given to the primary nurse of changes in the resident's response to the activity program.

**Standard IM.6.70**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to the activities program at least quarterly.

**2009 Standard:** IM.6.70

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and response to the activities program based on the interdisciplinary care plan are documented at least quarterly in the clinical record.

**2009 Standard:** IM.6.70

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and response to the activities program based on the interdisciplinary care plan are documented at least quarterly in the clinical record.

**2009 Standard:** IM.6.70

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

The activity providers document in the clinical record and report to the charge nurse changes in the resident's response to the activity program .

**Standard RC.02.01.11**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to nutrition care services at least quarterly.

**2010 Standard:** RC.02.01.11

**2010 EP:** 1

**2010 EP Text:**

The provision of nutrition care services is documented at least quarterly in the clinical record.

**2010 Standard:** RC.02.01.11

**2010 EP:** 2

**2010 EP Text:**

The resident's response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

**2010 Standard:** RC.02.01.11

**2010 EP:** 3

**2010 EP Text:**

Clinical record documentation includes the following information regarding nutrition care services:

- The resident's understanding of prescribed diets
- The resident's food consumption and nutrient status
- The resident's fluid consumption and hydration status
- Significant weight changes, in accordance with law or regulation
- The resident's ability to eat with or without adaptive devices
- Current status and changes in the resident's physical or behavioral status that affect nutrition (for example, the ability to function with or without natural teeth or dentures)
- Summary of the resident's nutritional status, including the extent to which nutritional goals included in the interdisciplinary care plan are affected or achieved

**Standard IM.6.80**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to nutrition care services at least quarterly.

**2009 Standard:** IM.6.80

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

**2009 Standard:** IM.6.80

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

**2009 Standard:** IM.6.80

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

Documentation includes the current status and changes in the resident's nutritional status, including the following information: The resident's acceptance of prescribed diets The resident's food and fluid consumption Significant weight loss or gain consistent with law or regulation Hydration status The resident's ability to eat independently The resident's ability to use adaptive devices for eating Current status and changes in the resident's physical or behavioral condition, including symptoms Summary of the resident's condition, which includes the extent to which nutritional goals included in the interdisciplinary care plan are achieved

**Standard RC.02.01.13**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to nursing care.

**2010 Standard:** RC.02.01.13

**2010 EP:** 1

**2010 EP Text:**

The provision of nursing care that is based on the interdisciplinary care plan is documented in the clinical record.

**2010 Standard:** RC.02.01.13

**2010 EP:** 2

**2010 EP Text:**

The resident's response to the nursing care that is based on the interdisciplinary care plan is documented in the clinical record.

**2010 Standard:** RC.02.01.13

**2010 EP:** 3

**2010 EP Text:**

Clinical record documentation includes the following information regarding nursing care:

- Medications and treatment given and untoward reactions
  - Nursing care provided
  - Current status and changes in the resident's physical or behavioral condition, including symptoms
  - Summary by licensed nursing staff of the resident's condition, which includes the extent to which nursing goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrants
- Note: In determining the frequency of preparing a summary of the residents condition, consideration should be given to residents with complex needs or short lengths of stay.

**Standard IM.6.90**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to nursing care.

**2009 Standard:** IM.6.90

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of nursing care that is based on the interdisciplinary care plan and the resident's response to this care are documented in the clinical record.

**2009 Standard:** IM.6.90

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of nursing care that is based on the interdisciplinary care plan and the resident's response to this care are documented in the clinical record.

**2009 Standard:** IM.6.90

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

Documentation includes the following: Medications and treatment given and untoward reactions Nursing care provided Current status and changes in the resident's physical or behavioral condition, including symptoms Summary by licensed nursing staff of the resident's condition, which includes the extent to which nursing goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrants Note: In determining the frequency of preparing a summary of the residents condition, consideration should be given to residents with complex needs or short lengths of stay.

**Standard RC.02.01.15**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to medical treatment and care, and changes in the resident's condition.

**2010 Standard:** RC.02.01.15

**2010 EP:** 1

**2010 EP Text:**

The provision of medical treatment and care is documented in the clinical record.

**2010 Standard:** RC.02.01.15

**2010 EP:** 2

**2010 EP Text:**

The resident's response to medical treatment and care is documented in the clinical record.

**2010 Standard:** RC.02.01.15

**2010 EP:** 3

**2010 EP Text:**

Documentation in the resident's clinical record includes, before or on admission, the following:

- Admitting diagnosis
- Current medical findings
- Diet prescribed
- The resident's functional status

**2010 Standard:** RC.02.01.15

**2010 EP:** 4

**2010 EP Text:**

Documentation in the resident's clinical record includes medical observations and recommendations made after the initial medical assessment, as well as progress notes that are reported at the time of observation and that describe significant changes, as defined by the organization, in the resident's condition.

**2010 Standard:** RC.02.01.15

**2010 EP:** 5

**2010 EP Text:**

Documentation in the resident's clinical record includes progress notes recorded by the physician at each visit.

**Standard IM.6.100**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to medical treatment and care.

**2009 Standard:** IM.6.100

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of medical treatment and care and the resident's response to medical treatment and care are documented in the clinical record.

**2009 Standard:** IM.6.100

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of medical treatment and care and the resident's response to medical treatment and care are documented in the clinical record.

**2009 Standard:** IM.6.100

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

Documentation in the resident's clinical record includes, before or on admission, the submission of the following: Admitting diagnosis Current medical findings Diet prescribed The resident's functional status

**2009 Standard:** IM.6.100

**2009 EP:** 3

**2009 EP Text:**

**Revision Code:** Retain

Documentation in the resident's clinical record includes medical observations and recommendations made after the initial medical assessment, as well as progress notes that are reported at the time of observation and that describe significant changes in the resident's condition.

**2009 Standard:** IM.6.100

**2009 EP:** 4

**2009 EP Text:**

**Revision Code:** Retain

Documentation in the resident's clinical record includes progress notes recorded by the physician at each visit.

**2010 Standard:** RC.02.01.15                      **2010 EP:** 6  
**2010 EP Text:**  
 Upon the resident’s discharge, documentation in the resident’s clinical record includes the complete transfer form and the discharge summary.

**2009 Standard:** IM.6.100                      **2009 EP:** 5  
**2009 EP Text:**                                      **Revision Code:** Retain  
 Upon the resident’s discharge, documentation in the resident’s clinical record includes the completion of the transfer form when appropriate, the discharge summary, and the resident’s clinical record.

**2010 Standard:** RC.02.01.15                      **2010 EP:** 7  
**2010 EP Text:**  
 If the resident dies in the organization, the course of events leading up to the resident’s death is documented.

**2009 Standard:** IM.6.100                      **2009 EP:** 6  
**2009 EP Text:**                                      **Revision Code:** Retain  
 If the resident expires in the organization, the course of events leading up to the resident’s death is documented.

**2010 Standard:** RC.02.01.15                      **2010 EP:** 8  
**2010 EP Text:**  
 Documentation in the resident’s clinical record includes evidence that the attending physician has reviewed the consulting physician’s orders for consistency with the interdisciplinary plan of care.

**2009 Standard:** IM.6.100                      **2009 EP:** 7  
**2009 EP Text:**                                      **Revision Code:** Retain  
 Documentation in the resident’s clinical record includes evidence that the attending physician has reviewed the consulting physician’s orders for consistency with the overall care plan.

**2010 Standard:** RC.02.01.15                      **2010 EP:** 9  
**2010 EP Text:**  
 Clinical record documentation includes significant changes, as determined by the organization, in the resident’s condition, care, treatment, and services.

**2009 Standard:** IM.6.140                      **2009 EP:** 1  
**2009 EP Text:**                                      **Revision Code:** Retain  
 Clinical record documentation includes significant changes in the resident’s condition, care, and treatment.

**Standard RC.02.01.17**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to rehabilitation services.

**2010 Standard:** RC.02.01.17

**2010 EP:** 1

**2010 EP Text:**

Documentation in the clinical record describes the provision of rehabilitation services that are based on the interdisciplinary care plan and includes the following:

- Reason for admission or referral to rehabilitation services
- Rehabilitation treatments, modalities, or procedures provided
- The resident's involvement in rehabilitation services

**2010 Standard:** RC.02.01.17

**2010 EP:** 1

**2010 EP Text:**

Documentation in the clinical record describes the provision of rehabilitation services that are based on the interdisciplinary care plan and includes the following:

- Reason for admission or referral to rehabilitation services
- Rehabilitation treatments, modalities, or procedures provided
- The resident's involvement in rehabilitation services

**2010 Standard:** RC.02.01.17

**2010 EP:** 2

**2010 EP Text:**

Documentation in the clinical record describes the resident's response to rehabilitation services, including the progress toward treatment goals as described in the interdisciplinary care plan.

**2010 Standard:** RC.02.01.17

**2010 EP:** 2

**2010 EP Text:**

Documentation in the clinical record describes the resident's response to rehabilitation services, including the progress toward treatment goals as described in the interdisciplinary care plan.

**Standard IM.6.110**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to rehabilitation services.

**2009 Standard:** IM.6.110

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of rehabilitation services that are provided based on the interdisciplinary care plan and the resident's response to these services are documented in the clinical record.

**2009 Standard:** IM.6.110

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Split

Documentation describes the following: The resident's and family's perception of and involvement in rehabilitation services Reason for the referral to rehabilitation services or admission for medically complex services Rehabilitation treatments, modalities, or procedures provided The resident's response to treatment The resident's involvement in rehabilitation services The resident's progress toward treatment goals

**2009 Standard:** IM.6.110

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of rehabilitation services that are provided based on the interdisciplinary care plan and the resident's response to these services are documented in the clinical record.

**2009 Standard:** IM.6.110

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Split

Documentation describes the following: The resident's and family's perception of and involvement in rehabilitation services Reason for the referral to rehabilitation services or admission for medically complex services Rehabilitation treatments, modalities, or procedures provided The resident's response to treatment The resident's involvement in rehabilitation services The resident's progress toward treatment goals

**2010 Standard:** RC.02.01.17

**2010 EP:** 3

**2010 EP Text:**

Documentation in the clinical record includes a summary of rehabilitation achievement and estimates of further rehabilitation potential at time frames defined by the organization in accordance with law and regulation, or more often if the resident's condition warrants.

**2009 Standard:** IM.6.110

**2009 EP:** 3

**2009 EP Text:**

Assessment of rehabilitation achievement and estimates of further rehabilitation potential are entered at least weekly.

**Revision Code:** Retain

**2010 Standard:** RC.02.01.17

**2010 EP:** 4

**2010 EP Text:**

Documentation in the clinical record includes a rehabilitation discharge plan.

**2009 Standard:** IM.6.110

**2009 EP:** 4

**2009 EP Text:**

Documentation includes a progress report and reassessment, including the following: Summary of the resident's condition, which includes the extent to which rehabilitation goals included in the interdisciplinary care plan are achieved, every two weeks for the first quarter, every month for the second quarter, and quarterly thereafter or more frequently when a resident's condition changes Estimates of the resident's further rehabilitation potential Discharge plan

**Revision Code:** Retain

**Standard RC.02.01.19**

**2010 Standard Text:**

Clinical record documentation includes the provision of and response to social services.

**2010 Standard:** RC.02.01.19

**2010 EP:** 1

**2010 EP Text:**

Documentation in the clinical record describes the provision of social services, including the following:

- Summary of the resident's problems and condition
- Specified goals related to social services, including discharge planning
- Services provided
- Referrals to outside agencies, resources, or individuals

**2010 Standard:** RC.02.01.19

**2010 EP:** 1

**2010 EP Text:**

Documentation in the clinical record describes the provision of social services, including the following:

- Summary of the resident's problems and condition
- Specified goals related to social services, including discharge planning
- Services provided
- Referrals to outside agencies, resources, or individuals

**Standard IM.6.120**

**2009 Standard Text:**

Clinical record documentation includes the provision of and response to social service interventions.

**2009 Standard:** IM.6.120

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and the resident's response to social service interventions are documented in the clinical record.

**2009 Standard:** IM.6.120

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Split

Documentation of social service interventions includes the following: Specified goals related to social services, including discharge planning, that are an integral part of the interdisciplinary care plan Services provided and their outcomes Summary of the resident's problems, services provided, goals, and condition, which includes the extent to which social services goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrants Referrals to outside agencies, resources, or individuals, as well as follow-up actions or recommendations of outside agencies, resources, or individuals Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

**2010 Standard:** RC.02.01.19

**2010 EP:** 2

**2010 EP Text:**

Documentation in the clinical record describes the response to social services, including the following:

- Outcomes of services provided
- The extent to which social services goals are achieved, as described in the interdisciplinary care plan. This documentation occurs at least quarterly or more often if the resident's condition warrants.
- Follow-up actions or recommendations of outside agencies, resources, or individuals

Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

**2010 Standard:** RC.02.01.19

**2010 EP:** 2

**2010 EP Text:**

Documentation in the clinical record describes the response to social services, including the following:

- Outcomes of services provided
- The extent to which social services goals are achieved, as described in the interdisciplinary care plan. This documentation occurs at least quarterly or more often if the resident's condition warrants.
- Follow-up actions or recommendations of outside agencies, resources, or individuals

Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

**2009 Standard:** IM.6.120

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

The provision of and the resident's response to social service interventions are documented in the clinical record.

**2009 Standard:** IM.6.120

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Split

Documentation of social service interventions includes the following: Specified goals related to social services, including discharge planning, that are an integral part of the interdisciplinary care plan. Services provided and their outcomes. Summary of the resident's problems, services provided, goals, and condition, which includes the extent to which social services goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrants. Referrals to outside agencies, resources, or individuals, as well as follow-up actions or recommendations of outside agencies, resources, or individuals. Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

**Standard RC.02.01.21**

**2010 Standard Text:**

Clinical record documentation includes resident education.

**2010 Standard:** RC.02.01.21

**2010 EP:** 1

**2010 EP Text:**

The provision of resident education is documented in the clinical record.

**2010 Standard:** RC.02.01.21

**2010 EP:** 2

**2010 EP Text:**

The resident's response to education is documented in the clinical record.

**Standard IM.6.130**

**2009 Standard Text:**

Clinical record documentation includes the provision of education and its effectiveness.

**2009 Standard:** IM.6.130

**2009 EP:** 1

**2009 EP Text:**

The provision of and the resident's response to education are documented in the clinical record.

**Revision Code:** Split

**2009 Standard:** IM.6.130

**2009 EP:** 1

**2009 EP Text:**

The provision of and the resident's response to education are documented in the clinical record.

**Revision Code:** Split

**Standard RC.02.01.25****2010 Standard Text:**

Treatment provided to the resident by external resources is documented in the clinical record.

**2010 Standard:** RC.02.01.25

**2010 EP:** 1

**2010 EP Text:**

The clinical record includes information from external resources who provide treatment to the resident.

**Standard IM.6.150****2009 Standard Text:**

Treatment provided to the resident by off-site sources is documented in the clinical record.

**2009 Standard:** IM.6.150

**2009 EP:** 1

**2009 EP Text:**

Clinical record documentation includes treatment provided to the resident by off-site sources.

**Revision Code:** Retain

**Standard RC.02.01.27**

**2010 Standard Text:**

Effects of medications on residents, and associated pharmacist evaluation and physician consultation, are documented in the clinical record.

**2010 Standard:** RC.02.01.27

**2010 EP:** 1

**2010 EP Text:**

Clinical records include documentation of the resident’s response to medications. (See also MM.07.01.01, EPs 1 and 2)

**2010 Standard:** RC.02.01.27

**2010 EP:** 2

**2010 EP Text:**

Clinical records include documentation of the clinical or consultant pharmacists’ findings, conclusions, and recommendations (for example, additional laboratory monitoring) resulting from monitoring of the medication regimen.

**Standard IM.6.160**

**2009 Standard Text:**

Effects of medications on residents, and associated pharmacist evaluation and physician consultation, are documented.

**2009 Standard:** IM.6.160

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

Clinical records include documentation of the following: Resident’s response to medications Pharmacist’s evaluation and consultation with the physician The need for additional laboratory monitoring  
Note: Documentation can be included in the resident’s clinical record or in another location such as the pharmacist’s report.

**2009 Standard:** IM.6.160

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

Clinical records include documentation of the following: Resident’s response to medications Pharmacist’s evaluation and consultation with the physician The need for additional laboratory monitoring  
Note: Documentation can be included in the resident’s clinical record or in another location such as the pharmacist’s report.

**Standard RC.02.03.07**

**2010 Standard Text:**

Qualified staff receive and record verbal orders.

**2010 Standard:** RC.02.03.07

**2010 EP:** 1

**2010 EP Text:**

The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.

**2010 Standard:** RC.02.03.07

**2010 EP:** 2

**2010 EP Text:**

Only authorized staff receive and record verbal orders.

**2010 Standard:** RC.02.03.07

**2010 EP:** 3

**2010 EP Text:**

Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.

**2010 Standard:** RC.02.03.07

**2010 EP:** 4

**2010 EP Text:**

Verbal orders are authenticated within the time frame specified by law and regulation.

**Standard IM.6.50**

**2009 Standard Text:**

Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.

**2009 Standard:** IM.6.50

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

Qualified personnel are identified, as defined by {jc}organization{/2} policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone orders.

**2009 Standard:** IM.6.50

**2009 EP:** 1

**2009 EP Text:**

**Revision Code:** Split

Qualified personnel are identified, as defined by {jc}organization{/2} policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone orders.

**2009 Standard:** IM.6.50

**2009 EP:** 2

**2009 EP Text:**

**Revision Code:** Retain

Verbal or telephone orders are dated and identifies the names of the individuals who gave, received, and implemented the order.

**2009 Standard:** IM.6.50

**2009 EP:** 3

**2009 EP Text:**

**Revision Code:** Retain

When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.

**Standard RC.02.04.01**

**2010 Standard Text:**

The organization documents the resident’s discharge information.

**2010 Standard:** RC.02.04.01

**2010 EP:** 1

**2010 EP Text:**

The organization documents in the clinical record the discharge information it provides to the resident and to the receiving organization.

**2010 Standard:** RC.02.04.01

**2010 EP:** 2

**2010 EP Text:**

The resident’s discharge information includes the following:

- The reason for transfer, discharge, or referral
- Treatment provided, diet, medication orders, and orders for the resident’s immediate care
- Referrals provided to the resident, the referring licensed independent practitioner’s name, and the name of the licensed independent practitioner who has agreed to be responsible for the resident’s medical care and treatment, if this person is someone other than the referring licensed independent practitioner
- Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
- Information about the resident’s behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the resident’s care
- Any advance directives
- Instructions given to the resident before discharge

**Standard IM.6.170**

**2009 Standard Text:**

Discharge information provided to the resident or to the family, as appropriate and permissible, and/or to the receiving organization is documented.

**2009 Standard:** IM.6.170

**2009 EP:** 1

**2009 EP Text:**

Clinical record documentation includes discharge information provided to the resident and/or to the receiving organization.

**Revision Code:** Retain

**2009 Standard:** IM.6.170

**2009 EP:** 2

**2009 EP Text:**

Discharge information includes the following: Medical findings, diagnosis(es), and treatment orders  
 Summary of the care, treatment, and services provided and progress toward achieving goals  
 Diet orders and medication orders  
 Behavioral status, ambulation status, nutrition status, and rehabilitation potential  
 The resident’s physical and psychosocial status  
 Nursing information useful in resident care  
 Advance directives  
 Referrals provided to the resident  
 The reason for transfer, discharge, or referral  
 Physician’s orders for the resident’s immediate care  
 Instructions given to the resident before discharge  
 The referring physician’s name  
 The physician who has agreed to be responsible for the resident’s medical care and treatment, if other than the referring physician

**Revision Code:** Retain