**WAC 388-107-0560 Resident records—Clinical records.** (1) The enhanced services facility 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; or

(iii) The resident.

(2) The enhanced services facility must ensure the clinical record of each resident includes a minimum of the following:

(a) Resident identification and sociological data, including the name and address of the individual or individuals the resident designates as significant;

(b) Medical information;

(c) Physician's orders;

(d) Assessments;

(e) Person-centered service plans;

(f) Services provided;

(g) Progress notes;

(h) Medications administered;

(i) Consents, authorizations, releases;

(j) Allergic responses;

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

(l) Other records as appropriate.

(3) The enhanced services facility must maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.96A RCW.

[Statutory Authority: RCW 70.97.230 and HCBS Final Rule 42 C.F.R. WSR 16-14-078, § 388-107-0560, filed 7/1/16, effective 8/1/16. Statutory Authority: Chapter 70.97 RCW. WSR 14-19-071, § 388-107-0560, filed 9/12/14, effective 10/13/14.]