

144G.43 RESIDENT RECORD REQUIREMENTS.

Subdivision 1. **Resident record.** (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.

(c) The facility may not disclose to any other person any personal, financial, or medical information about the resident, except:

(1) as may be required by law;

(2) to employees or contractors of the facility, another facility, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the resident, but only the information that is necessary for the provision of services;

(3) to persons authorized in writing by the resident, including third-party payers; and

(4) to representatives of the commissioner authorized to survey or investigate facilities under this chapter or federal laws.

Subd. 2. **Access to records.** The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.

Subd. 3. **Contents of resident record.** Contents of a resident record include the following for each resident:

(1) identifying information, including the resident's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;

(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) the resident's advance directives, if any;

(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;

(7) the facility's current and previous assessments and service plans;

(8) all records of communications pertinent to the resident's services;

(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;

- (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
- (11) documentation that services have been provided as identified in the service plan;
- (12) documentation that the resident has received and reviewed the assisted living bill of rights;
- (13) documentation of complaints received and any resolution;
- (14) a discharge summary, including service termination notice and related documentation, when applicable; and
- (15) other documentation required under this chapter and relevant to the resident's services or status.

Subd. 4. Transfer of resident records. With the resident's knowledge and consent, if a resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider:

- (1) the resident's full name, date of birth, and insurance information;
- (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any;
- (3) the resident's current documented diagnoses that are relevant to the services being provided;
- (4) the resident's known allergies that are relevant to the services being provided;
- (5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided;
- (6) all medication administration records that are relevant to the services being provided;
- (7) the most recent resident assessment, if relevant to the services being provided; and
- (8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney.

Subd. 5. Record retention. Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate.

History: 2019 c 60 art 1 s 21,47