Ohio Administrative Code

Rule 3701-17-19 Records and reports.

Effective: July 17, 2025

(A) Nursing homes will keep the following records and such other records as follows:

(1) An individual medical record will be maintained and routinely updated for each resident. Such record will be started immediately upon admission of a resident to the home and contain the following:

(a) Identification record: Name, residence, age, gender, race/ethnicity, religion, date of admission, name and address of nearest relative or legal guardian, admission diagnoses from referral record and name of the resident's physician and, if applicable, other licensed health professional acting within the applicable scope of practice. If applicable, the contact information of the nearest relative or legal guardian is obligated to be reviewed and updated every six months to ensure appropriate notification in the event of an emergency, quarantine, or closure.

(b) Referral record. All records, reports, and orders which accompany the resident in accordance with rule 3701-17-10 of the Administrative Code.

(c) Nursing notes and care notes. A note of the condition of the resident on admission and subsequent notes as indicated to describe changes in condition, unusual events or accidents. Other individuals rendering services to the resident may enter notes regarding the services they render.

(d) Medication administration record. A doctor's order sheet upon which orders are recorded and signed by the physician or other licensed health professional acting within the applicable scope of practice, including telephone orders in accordance with rule 3701-17-13 of the Administrative Code; a nurse's treatment sheet upon which all treatments or medications are recorded as given, showing what was done or given, the date and hour, and signed by the nurse giving the treatment or medication; or other documentation authenticating who gave the medication or treatment.

(e) Resident progress notes. A sheet or sheets upon which the doctor, dentist, advanced practice

nurse and other licensed health professionals may enter notes concerning changes in diagnosis or condition of the residentincluding a resident's refusal of treatment and services.

(f) Resident assessment record. All assessments and information in accordance with rule 3701-17-10 of the Administrative Code.

(g) Care plan. The plan of care set forth in rule 3701-17-14 of the Administrative Code.

(h) Photograph. A photograph is necessary for residents who have been identified as being a elopement risk. The photograph of the resident will be updated annually.

(2) The nursing home will maintain all records obligated by state and federal laws and regulations, as to the purchase, delivery, dispensing, administering, and disposition of all controlled substances including unused portions.

(3) The nursing home will maintain a record of all residents admitted to or discharged from the nursing home.

(B) A record will be kept showing the name and hours of duty of all persons who work in the home.

(C) All records and reports maintained in accordance withrules 3701-17-01 to 3701-17-26 of the Administrative Code will be prepared, maintained, filed, and transmitted as necessary, and be made available for inspection at all times when requested by the director or the director's authorized representative. The records may be maintained in electronic format, microfilm, or other method that assures a true and accurate copy of the records are available.

(1) The nursing home will maintain the records and reports set forth in paragraph (A)(1) of this rule in the following manner:

(a) Safeguard the records and reports against loss, destruction, or unauthorized use and store them in a manner that protects and ensures confidentiality.

(b) Maintain the records and reports for seven years following the date of the resident's discharge,

except if the resident is a minor, the records will be maintained for three years past the age of majority but not less than seven years.

(c) Upon closure of the home, the operator will provide and arrange for the retention of records and reports in a secured manner for not less than seven yearsand notify the director of the location where the records will be stored.

(2) The nursing home will maintain all other records and reports as set forth in rules 3701-17-01 to 3701-17-26 of the Administrative Code for seven years.

(3) Upon the request of the resident or former resident, or the resident's or former resident's legal representative, the nursing home will provide:

(a) Access to medical and financial records and reports pertaining to the resident within twenty-four hours, excluding holidays and weekends; and

(b) Photocopies of any records and reports, or portions thereof, at a cost not to exceed the community standard for photocopying, unless otherwise specified by law, upon two working days advanced notice.

(D) All records and reports mandated by Chapter 3701-13 of the Administrative Code will be maintained and made available in accordance with that chapter.

(E) Upon the change of operator of a nursing home, the records kept pursuant to this rule will be transferred to the new operator of the home.