

42 C.F.R. § 484.110

Condition of participation: Clinical records.

The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.

- (a) Standard: Contents of clinical record. The record must include:
- (1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;

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