

42 C.F.R. § 485.60

Condition of participation: Clinical records.

The facility must maintain clinical records on all patients in accordance with accepted professional standards and practice. The clinical records must be completely, promptly, and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

(a) Standard: Content. Each clinical record must contain sufficient information to identify the patient clearly and to justify the diagnosis and treatment. Entries in the clinical record must be made as frequently as is necessary to insure effective treatment and must be signed by personnel providing services. All entries made by assistant level personnel must be countersigned by the corresponding professional.

Documentation on each patient must be consolidated into one clinical record that must contain—

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