RCW 74.42.420 Resident record system. The facility shall maintain an organized record system containing a record for each resident. The record shall contain:

(1) Identification information, including the information listed in RCW 18.51.095(1);

(2) Admission information, including the resident's medical and social history;

(3) A comprehensive plan of care and subsequent changes to the comprehensive plan of care;

(4) Copies of initial and subsequent periodic examinations, assessments, evaluations, and progress notes made by the facility and the department;

(5) Descriptions of all treatments, services, and medications provided for the resident since the resident's admission;

(6) Information about all illnesses and injuries including information about the date, time, and action taken; and

(7) A discharge summary.

Resident records shall be available to the staff members directly involved with the resident and to appropriate representatives of the department. The facility shall protect resident records against destruction, loss, and unauthorized use. The facility shall keep a resident's record after the resident is discharged as provided in RCW 18.51.300. [2021 c 159 § 10; 1979 ex.s. c 211 § 42.]

Findings—2021 c 159: See note following RCW 18.20.520.