State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

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January 14, 2011

Jocelyn Montgomery RN, PHN
Director of Clinical Affairs
California Association of Health Facilities
2201 K Street
Sacramento, CA 95816

Dear Ms. Montgomery,

I am responding to your email dated September 14, 2010. You asked three questions concerning Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). Specifically:

1. What regulations apply in regards to sending the medical record with a resident during an evacuation when there is no time for copying?

   Response: The following federal Centers for Medicare & Medicaid Services Resident Assessment Instrument (RAI) guidance, 42 Code of Federal Regulations (CFR) and Title 22 California Code of Regulations (CCR) Sections apply to SNFs, ICFs, and ICF Developmentally Disabled (ICF/DD) and Habilitative (ICF/DD-H) type facilities:

State Sources	**Facility Type**
• 72213	SNF
• 72519	SNF
• 72543(a) – (i)	SNF
• 72551(b)(10), (12)	SNF
• 72553(b)(10), (11), (13)	SNF
• 73543	ICF
• 73549(b)(9)	ICF
• 73551(b)	ICF
• 76557	ICF/DD
• 76563(b)(8)	ICF/DD
• 76928(b)(8), (10)	ICF/DD-H
• 76929(b)(10), (11)	ICF/DD-H

Federal Sources

- Centers for Medicare and Medicaid Services RAI 3.0 Manual Sections 2.3 and 2.4
- State Operations Manual (SOM), Appendix P, 42 CFR Section 483.75(m)(1), F-517
- SOM, Appendix J, 42 CFR Section 483.470(h), W438

2. Is there any requirement in terms of how quickly records need to be returned to the custody of the sending facility?

   Response: Neither State nor Federal regulations identify a specific time period within which a medical record must be returned to the sending facility. However, it is clear that the intent of the medical record is to provide a continuity of care for patients during any discharge, transfer, and/or evacuation (Title 22 CCR Section 72543(h)). Therefore, when the patient returns to the sending facility, it is logical that the medical record returns with the patient. In a case where the patient is discharged from the sending facility and admitted to the receiving facility, to the extent the emergency circumstances allow, the receiving facility copies appropriate portions of the record to ensure continuity of care, and promptly returns the original medical record to the sending facility.

3. Is it ever allowable for the receiving facility which is temporarily housing the evacuated resident to continue to use the original medical record, especially in situations where the residents are expected to be able to return to their home facility within a few days, or must the receiving facility always start a new chart?

   Response: It is recognized that a medical record, whether an evacuation package put together at the time of the evacuation or the original, complete record, is what the receiving facility needs to continue the care of the patient. However, the sending facility always retains ultimate ownership of the original medical record. This would be the case for both a temporarily transferred patient, or for a patient who has been discharged to the receiving facility.

   Additionally, Health and Safety Code (HSC) Section 1336.3 requires a facility to comply with HSC 1336.2(a)-(c). HSC Section 1336.2(a)(3) states, in part:

   > ". . . The health facility shall discuss the evaluation and medical assessment with the resident or the resident's representative *and make the evaluation and assessment part of the medical records for transfer."* [*Emphasis*].

   This provision contemplates that the sending facility will provide records to the receiving facility, whether that is a package of copied records, when there is time to do so, or the complete medical record when such preparation and copy time is not reasonable.

Each facility must agree upon the option of a receiving facility using the original medical record. Such language should be included in the facility's emergency transfer agreements. It is recommended that facilities give attention to the protection and maintenance of the record and the Personal Health Information contained therein (Title 22 CCR Sections 72551(b)(6), and 72553(b)(8)). The plans that these regulations describe provide the flexibility for each facility to determine the best method for the use and return of records, depending upon the individualized situation.

The attached recommendation is from the American Health Information Management Association, a leading authority in professional standards of recordkeeping practice. The attachment entitled "LTC Health Information Practice & Documentation Guidelines, Version 1.0, September 2001", is an example of the type of industry recommendation a facility could draw upon in creating a plan that is specific to their facility.

Additionally, when there has been a transfer of a resident(s) as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Medicare contractor for guidance. Further, if it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident and the receiving facility will admit the resident. For questions regarding situations occurring as a result of natural disasters, providers should contact the organizations mentioned. Patients' Health Records regulations for SNFs, ICFs, and ICF/DD-H facilities are found in the regulations cited above. These various sections require each facility to maintain a medical record for all patients admitted or accepted for care. As such, the receiving facility should start a new chart.

Finally, it should be noted that Title 22 CCR Section 72551 refers to a "disaster tag" which is to be used during an evacuation. However, most fire departments are now using sequentially numbered tags that are not available to facilities. Therefore, in order to ensure the continuity of care of the patient after an evacuation, and to preserve the medical record from destruction during an emergency event, the Department will allow the practice of the medical record to follow the patient during such an evacuation, pursuant to direction found in Title 22 CCR Section 72543(i), which states;

> "The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department."

Such express and specific authorization may be granted through the use of a program flexibility (e.g., Title 22 CCR Sections 72213, 73227, 76227), which may be developed by the facility and approved by the Department in advance of the emergency event. If

approved in advance of the event, the facility can implement the program flexibility at the time of the event by notifying their District Office of their intent to implement the program flexibility as part of the activation of the facility's Emergency Response Plan. This contact must be followed by sending written justification and a copy of the pre-approved program flexibility to the District Office.

If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Pamela Dickfoss

Pamela Dickfoss
Acting, Deputy Director
Center for Health Care Quality

Attachments

22 CCR § 72213

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 3. Skilled Nursing Facilities
Article 2. License (Refs & Annos)

§ 72213. Program Flexibility.

(a) All skilled nursing facilities shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this Section, or a true copy thereof, shall be posted immediately adjacent to the facility's license.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1268, Health and Safety Code.

22 CCR § 72519

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 3. Skilled Nursing Facilities
Article 5. Administration
§ 72519. Patient Transfer.

(a) The licensee shall maintain written transfer agreements with other nearby health facilities to make the services of those facilities accessible and to facilitate the transfer of patients. Complete and accurate patient information, in sufficient detail to provide for continuity of care shall be transferred with the patient at time of transfer.

(b) When a patient is transferred to another facility, the following shall be entered in the patient health record:

(1) The date, time, condition of the patient and a written statement of the reason for the transfer.

(2) Informed written or telephone acknowledgement of the patient, patient's guardian or authorized representative except in an emergency or as provided in Section 72527(a)(5).

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72543

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 3. Skilled Nursing Facilities
Article 5. Administration
§ 72543. Patients' Health Records.

(a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending licensed healthcare practitioner acting within the scope of his or her professional licensure, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a facility ceases operation, the Department shall be informed within three business days by the licensee of the arrangements made for the safe preservation of the patients' health records.

(d) The Department shall be informed within three business days, in writing, whenever patient health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the patients' health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to a patient's stay shall be centralized in the patient's health record.

(h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department.

(i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

22 CCR § 72551
Cal. Admin. Code tit. 22, § 72551
Barclays Official California Code of Regulations Currentness
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 3. Skilled Nursing Facilities
Article 5. Administration (Refs & Annos)

§ 72551. External Disaster and Mass Casualty Program.

(a) A written external disaster and mass casualty program plan shall be adopted and followed. The plan shall be developed with the advice and assistance of county or regional and local planning offices and shall not conflict with county and community disaster plans. A copy of the plan shall be available on the premises for review by the Department.

(b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following:

(1) Sources of emergency utilities and supplies, including gas, water, food and essential medical supportive materials.

(2) Procedures for assigning personnel and recalling off-duty personnel.

(3) Unified medical command. A chart of lines of authority in the facility.

(4) Procedures for the conversion of all usable space into areas for patient observation and immediate care of emergency admissions.

(5) Prompt transfer of casualties when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care. Procedures for moving patients from damaged areas of the facility to undamaged areas.

(6) Arrangements for provision of transportation of patients including emergency housing where indicated. Procedures for emergency transfers of patients who can be

moved to other health facilities, including arrangements for safe and efficient transportation and transfer information.

(7) Procedures for emergency discharge of patients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow-up inquiry within 24 hours to ascertain that patients are receiving required care.

(8) Procedures for maintaining a record of patient relocation.

(9) An evacuation plan, including evacuation routes, emergency phone numbers of physicians, health facilities, the fire department and local emergency medical services agencies and arrangements for the safe transfer of patients after evacuation.

(10) A tag containing all pertinent personal and medical information which shall accompany each patient who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining security in order to keep relatives, visitors and curious persons out of the facility during a disaster.

(12) Procedures for providing emergency care to incoming patients from other health facilities.

(13) Assignment of public relations liaison duties to a responsible individual employed by the facility to release information to the public during a disaster.

(c) The plan shall be reviewed at least annually and revised as necessary to ensure that the plan is current. All personnel shall be instructed in the requirements of the plan. There shall be evidence in the personnel files, or the orientation checklist, indicating that all new employees have been oriented to the plan and procedures at the beginning of their employment.

(d) The facility shall participate in all local and state disaster drills and test exercises when asked to do so by the local or state disaster or emergency medical services agencies.

(e) A disaster drill shall be held by the facility at six-month intervals. There shall be a written report of the facility's participation in each drill or test exercise. Staff from all shifts shall participate in drills or test exercises.

Note: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72553

Cal. Admin. Code tit. 22, § 72553
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 3. Skilled Nursing Facilities
Article 5. Administration

§ 72553. Fire and Internal Disasters.

(a) A written fire and internal disaster plan incorporating evacuation procedures shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the plan shall be available on the premises for review by the staff and the Department.

(b) The written plan shall include at least the following:

(1) Procedures for the assignment of personnel to specific tasks and responsibilities.

(2) Procedures for the use of alarm systems and signals.

(3) Procedures for fire containment.

(4) Priority for notification of staff including names and telephone numbers.

(5) Location of fire-fighting equipment.

(6) Procedures for evacuation and specification of evacuation routes.

(7) Procedures for moving patients from damaged areas of the facility to undamaged areas.

(8) Procedures for emergency transfer of patients who can be moved to other health facilities, including arrangements for safe and efficient transportation.

(9) Procedures for emergency discharge of patients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow-up inquiry within 24 hours to ascertain that patients are receiving their required care.

(10) A disaster tag containing all pertinent personal and medical information to accompany each patient who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining a record of patient relocation.

(12) Procedures for handling incoming or relocated patients.

(13) Other provisions as dictated by circumstances.

(c) Fire and internal disaster drills shall be held at least quarterly, under varied conditions for each individual shift of the facility personnel. The actual evacuation of patients to safe areas during a drill is optional.

(d) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

(4) Emergency telephone number of the local fire department.

(e) A dated, written report and evaluation of each drill and rehearsal shall be maintained and shall include signatures of all employees who participated.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 73227

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 4. Intermediate Care Facilities
Article 2. License (Refs & Annos)
§ 73227. Program Flexibility.

(a) All intermediate care facilities shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualification or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this section, or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 73221.

22 CCR § 73543

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 4. Intermediate Care Facilities
Article 4. Administration (Refs & Annos)
§ 73543. Patients' Health Records.

(a) Records shall be permanent, either typewritten or legibly written with pen and ink and shall be kept on all patients admitted or accepted for treatment. All health and social records of discharged patients shall be completed and filed within 30 days and such records shall be kept for a minimum of seven years, except for minors whose records shall be kept at least until one year after the minor has reached the age of 18 but in no case less than seven years. If a facility operates an X-ray unit, all exposed X-ray film shall be retained for seven years. All required records, either originals or faithful and accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon request of the attending licensed healthcare practitioner acting within the scope of his or her professional licensure, the facility or any authorized officer, agent or employee of either or any other person authorized by law to make such request.

(b) Information contained in the records shall be treated as confidential and disclosed only to authorized persons.

(c) If a facility ceases operation, the Department shall be informed immediately of the arrangements made for the safe preservation of the patients' records.

(d) The Department shall be informed in writing immediately whenever patients' health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the new applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation, stating:

(1) That the new licensee will have custody of the patients' records and these records will be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reasons for the unavailability of such patients' health records.

(f) Patients' health records shall be current and kept in detail consistent with acceptable professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department.

(g) Patients' health records shall be filed and stored so as to be protected against loss, destruction or unauthorized use.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment of subsection (a) and new Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

22 CCR § 73549

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 4. Intermediate Care Facilities
Article 4. Administration (Refs & Annos)
§ 73549. Disaster and Mass Casualty Program.

(a) A written disaster and mass casualty program shall be adopted. The program shall be developed with the advice and assistance of qualified fire and safety experts and shall be in conformity with the California Emergency Plan of October 10, 1972, developed by the state office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974, developed by the office of Emergency Services, Department of Health. A copy of the Program shall be available on the premises for review by the Department.

(b) The program shall provide plans for local disasters occurring in the community and widespread disasters. The written program shall include at least the following:

(1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

(2) An efficient system of notifying and assigning personnel.

(3) Unified medical command.

(4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

(5) Prompt transfer of casualties when necessary and after preliminary medical or surgical services have been rendered to the facility most appropriate for administering definitive care.

(6) Arrangements for provision of transportation of patients including emergency housing where indicated.

(7) Arrangements for care of patients during transporting and while occupying emergency housing.

(8) Disposition and care of patients after evacuation of facility.

(9) A special disaster medical record, such as an appropriately designed tag that accompanies the casualty as he is moved.

(10) Procedures for the prompt discharge or transfer of inpatients at the time of the disaster who can be moved without jeopardy.

(11) Maintaining security in order to keep relatives and curious persons out of the triage area.

(12) Establishment of a public information center and assignment of public relations liaison duties to a responsible individual.

(c) The program shall be brought up-to-date at least annually and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere indicating that all new employees

have been oriented to the program and procedures at the beginning of their employment.

(d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills.

22 CCR § 73551

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 4. Intermediate Care Facilities
Article 4. Administration (Refs & Annos)
§ 73551. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) Program Coverage. The written program shall include at least the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire-fighting equipment.

(6) Specification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(8) List of persons and telephone numbers to call in the event of fire or disaster.

(c) Fire and internal disaster drills shall be held at least quarterly for each individual shift of intermediate care facility personnel and under varied conditions. The actual evacuation of patients to safe areas during a drill is optional.

(1) A dated written report and evaluation of each drill and rehearsal shall be maintained.

(d) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

(4) Emergency phone number of the local fire department.

22 CCR § 76227

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 8. Intermediate Care Facilities for the Developmentally Disabled
Article 2. License (Refs & Annos)
§ 76227. Program Flexibility.

(a) All facilities shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this Section, or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 76221.

Note: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 76928

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 8.5. Intermediate Care Facilities/Developmentally Disabled -Habilitative
Article 4. Administration
§ 76928. External Disaster and Mass Casualty Plan.

(a) A written external disaster and mass casualty plan shall be adopted. The plan shall be developed with the advice and assistance of county or regional local planning offices and shall not conflict with county and community disaster plans. A copy of the plan shall be available on the premises for review by the Department.

(b) The plan shall specify the procedures to be followed in event of community and widespread disasters. The written plan shall include at least the following:

(1) Sources of emergency utilities and supplies, including gas, electricity, water, food and essential medical and supportive materials.

(2) Procedures for assigning personnel and recalling off-duty personnel.

(3) A chart of lines of authority in the facility.

(4) Procedures for conversion of all usable space in client activity areas for immediate care of emergency admission.

(5) Procedures for moving clients from damaged areas of the facility to undamaged areas.

(6) Procedures for emergency transfers of clients who can be moved to other health facilities, including arrangements for safe and efficient transportation.

(7) Procedures for emergency discharge of clients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and 24-hour follow-up to ascertain that the clients are receiving their required care.

(8) Procedures for maintaining a record of client relocation.

(9) An evacuation plan, including evacuation routes, emergency phone numbers of physicians, health facilities, the fire department and local emergency medical services agencies.

(10) All pertinent personal and medical information shall accompany each client who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining security in order to keep relatives, visitors and curious persons out of the facility during a disaster, if necessary.

(c) The plan shall be brought up to date at least annually and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files indicating that all new employees have been oriented to the plan and procedures at the beginning of their employment.

(d) The facility shall conduct a disaster drill at least once a year. There shall be a written report of the drill.

Note: Authority cited: Sections 208.4 and 1267.7, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 76929

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 8.5. Intermediate Care Facilities/Developmentally Disabled -Habilitative
Article 4. Administration
§ 76929. Fire and Internal Disasters.

(a) A written fire and internal disaster plan incorporating evacuation procedures, shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the plan shall be available on the premises for review by the Department.

(b) The written plan shall include at least the following:

(1) Procedures for the assignment of personnel to specific tasks and responsibilities.

(2) Procedures for the use of alarm systems and signals.

(3) Procedures for fire containment.

(4) Procedures for notification of the fire department, facility administrator, off-duty facility staff and the Department, including a list of such persons' names and telephone numbers.

(5) Location of fire-fighting equipment.

(6) Procedures for evacuation and specification of evacuation routes.

(7) Procedures for moving clients from damaged areas of the facility to undamaged areas.

(8) Procedures for emergency transfers of clients who can be moved to other health facilities, including arrangements for safe and efficient transportation.

(9) Procedures for emergency discharge of clients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and a 24-hour follow-up to ascertain that the clients are receiving their required care.

(10) A disaster tag containing all pertinent personal and medical information to accompany each client who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining a record of client relocation.

(c) Fire and internal disaster drills shall be held quarterly under varied conditions for each individual shift of facility personnel.

(d) Actual client evacuations shall be held at least three times a year, once on each shift.

(e) A dated written report and evaluation of each drill and rehearsal shall be maintained.

(f) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

(4) Telephone number of the local fire department.

Note: Authority cited: Sections 208.4 and 1267.7, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

W438
§483.470(h)(1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

Facility Practices §483.470(h)(1)

Emergency plans exist.

Emergency plans address those types of emergencies relevant to the facility, its geographic location and the needs of the individuals served.
Staff follow emergency procedures both during drills and in real emergencies.

Health and Safety Code

1336.2. (a) Before residents are transferred due to any change in the status of the license or operation of a facility, including a facility closure or voluntary or involuntary termination of a facility's Medi-Cal or Medicare certification, the facility shall take reasonable steps to transfer affected residents safely and minimize possible transfer trauma by, at a minimum, doing all of the following:

(1) Be responsible for ensuring that the resident's attending physician, if available, or a facility medical director, if available, completes the medical assessment of the resident's condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being given to the resident. The assessment shall not be considered complete unless it provides, in accordance with these assessments, recommendations for counseling, followup visits, and other recommended services, by designated health professionals, and for preventing or ameliorating potential adverse health consequences in the event of transfer.

(2) Be responsible for ensuring that the facility nursing staff and activity director complete an assessment of the social and physical functioning of the resident based on the relevant portions of the minimum data set, as described in Section 14110.15 of the Welfare and Institutions Code, before written notice of transfer is given to the resident. The assessment shall not be considered complete unless it provides recommendations for preventing or ameliorating potential adverse health consequences in the event of transfer. The assessment may be amended because of a change in the resident's health care needs. The assessment shall also include a recommendation for the type of facility that would best meet the resident's needs.

(3) Be responsible for evaluating the relocation needs of the resident including proximity to the resident's representative and determine the most appropriate and available type of future care and services for the resident before written notice of transfer is given to the resident or the resident's representative. The health facility shall discuss the evaluation and medical assessment with the resident or the resident's representative and make the evaluation and assessment part of the medical records for transfer.

If the resident or resident's representative chooses to make a transfer prior to completion of assessments, the facility shall inform the resident or the resident's representative, in writing, of the importance of obtaining the assessments and followup

consultation.

(4) At least 30 days in advance of the transfer, inform the resident or the resident's representative of alternative facilities that are available and adequate to meet resident and family needs.

(5) Arrange for appropriate future medical care and services, unless the resident or resident's representative has otherwise made these arrangements. This requirement does not obligate a facility to pay for future care and services.

(b) The facility shall provide an appropriate team of professional staff to perform the services required in subdivision (a).

(c) The facility shall also give written notice to affected residents or their representatives, advising them of the requirements in subdivision (a) at least 30 days in advance of transfer. If a facility is required to give written notice pursuant to Section 1336, then the notice shall advise the affected resident or resident's representative of the requirements in subdivision (a). If the transfer is made pursuant to subdivision (g), the notice shall include notification to the resident or resident's representative that the transfer plan is available to the resident or resident's representative free of charge upon request.

(d) In the event of a temporary suspension of a facility's license pursuant to Section 1296, the 30-day notice requirement in subdivision (c) shall not apply, but the facility shall provide the relocation services required in subdivision (a) unless the department provides the services pursuant to subdivision (f).

(e) The department may make available assistance for the placement of hard-to-place residents based on the department's determination of the benefit and necessity of that assistance. A hard-to-place resident is a resident whose level of care, physical malady, or behavioral management needs are substantially beyond the norm.

(f) The department may provide, or arrange for the provision of, necessary relocation services at a facility, including medical assessments, counseling, and placement of patients, if the department determines that these services are needed promptly to prevent adverse health consequences to patients, and the facility refuses, or does not have adequate staffing, to provide the services. In these cases, the facility or the licensee shall reimburse the department for the cost of providing the relocation services. The department's participation shall not relieve the facility of any responsibility under this section. If the department does not provide or arrange for the provision of the necessary relocation services, and the facility refuses to provide the relocation services required in subdivision (a), then the department shall request that the Attorney General's office or the local district attorney's office seek injunctive relief and damages in the same manner as provided for in Chapter 5

(commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code.

(g) If 10 or more residents are likely to be transferred due to any voluntary or involuntary change in the status of the license or operation of a facility, including a facility closure or voluntary or involuntary termination of a facility's Medi-Cal or Medicare certification, the facility shall submit a proposed relocation plan for the affected residents to the department for approval at least 15 days prior to the written transfer notification given to any resident or resident's representative. The plan shall provide for implementation of the relocation services in subdivision (a) and shall describe the availability of beds in the area for residents to be transferred, the proposed discharge process, and the staffing available to assist in the transfers. The plan shall become effective upon the date the department grants its approval. The department shall base its approval of a relocation plan on the standards specified in this section. The department shall promptly either approve or reject the plan within 10 working days of receipt from the facility. If the department rejects the plan, the facility may resubmit amended relocation plans, each of which the department shall promptly either approve or reject within 10 working days of receipt from the facility. Until one plan has been approved by the department, and until the facility complies with the requirements in subdivision (a), the facility may not issue a notice of transfer. The facility shall submit the relocation plan to the local long-term care ombudsman at the same time the plan is submitted to the department.

(h) The resident shall have the right to remain in the facility for up to 60 days after the approved written notice of the facility's intent to transfer the resident if an appropriate placement based on the relocation assessment and relocation recommendations has not been made. The facility shall be required to maintain an appropriate level of staffing in order to ensure the well-being of all the residents as they continue to reside in the facility. The department shall monitor the facility's staging of transfers, and, if it determines that the facility's staging of placements is causing a detrimental impact on those residents being transferred, then the department shall limit the number of residents being transferred per day until the department determines that it would be safe to increase the numbers.

1336.3. (a) In the event of an emergency, such as earthquake, fire, or flood which threatens the safety or welfare of patients in a facility, the facility shall do all of the following:

(1) Notify, as soon as possible, family members, patients' guardians, the state department, and the ombudsperson for that facility of the emergency and the steps that the facility plans to take for the patient's welfare.

(2) Provide the services set forth in subdivision (a) of Section 1336.2 if further relocation of the patient is necessary.

(3) Undertake prompt medical assessment of, and provide counseling as needed to, patients whose further relocation is not necessary but who have suffered or may suffer adverse health consequences due to the emergency or sudden transfer.

(b) Each facility shall adopt a written emergency preparedness plan and shall make that plan available to the state department upon request. The plan shall comply with the requirements in this section and the state department's Contingency Plan for Licensed Facilities. The facility, as part of its emergency preparedness planning, shall seek to enter into reciprocal or other agreements with nearby facilities and hospitals to provide temporary care for patients in the event of an emergency. The facility shall report to the state department the name of any facility or hospital which fails or refuses to enter into such agreements and the stated reason for that failure or refusal.

Section 1336.2 shall not apply in the event of transfers made pursuant to an emergency preparedness plan. In any event, however, the facility shall provide the notice and services described in subdivisions (a) to (c), inclusive.

CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Medicare assessments in nursing homes and the mandated Medicare assessments in swing bed hospitals.

2.3 Responsibilities of Nursing Homes for Completing Assessments

The clinical requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, or payment category. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

An RAI (MDS + CAA process + utilization guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice Residents**: When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between, and participation of both, the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

- **Short-term or respite residents**: An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required, however, a discharge assessment is required:
  - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-") (See chapter 3 for more information).
  - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet those needs upon admission.
  - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g. pediatric or residents with a psychiatric diagnosis)**: Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed Facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level care in order to be reimbursed under the SNF PPS. In addition, effective October 1, 2010, CMS will begin to collect MDS data for quality monitoring purposes of swing bed facilities. Therefore, swing bed providers must also complete the entry record, discharge assessments, and death in facility record. Requirements for the Medicare-required PPS assessments, entry record, discharge assessments and death in facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.

The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - The OBRA assessments are a condition of participation and therefore should be performed prior to certification *as if the beds were already certified.*
  - Then, assuming a survey is completed where the SNF has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey.

- NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.
- For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. If a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment - the facility simply continues the OBRA schedule using the actual admission date as Day 1.
- Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare PPS assessments.

- **Adding Certified Beds:**
  - If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - Medicare and Medicaid residents should not be placed in a bed until the facility has been notified that the bed has been certified.
- **Change In Ownership**: There are two types of change in ownership transactions:
  - The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - **Example**: if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare PPS assessment was combined with the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.
  - There are also situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - The beds are no longer certified.
    - There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures, debts, provider number, etc.
    - Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.
- **Resident Transfers:**
  - When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.
  - When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within

14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-day Medicare-required PPS assessment.

- The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.
- The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper (i.e., the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff).
- When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Medicare contractor for guidance.
- When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their State agency and their Regional Office, State agency, and Medicare contractor for guidance.

2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types and regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data does not restart with each readmission to the facility:
  - In some states, when a resident is discharged return anticipated, the state requires the medical record be closed. In these instances, when the resident returns to the facility, the facility must open a new record. The facility should copy the previous RAI and transfer that copy to the new record. Unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it in the new record.
  - Facilities may develop their own specific policies regarding how to handle these return situations, including linking the prior electronic MDS to the new admission record, but the15-month requirement for maintenance of the RAI data must be adhered to.

— In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record to familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.

- After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) must be maintained in the active clinical record until the resident is discharged return not anticipated.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident.
- Nursing homes that are not capable of maintaining MDSs electronically must adhere to the current requirement that either (not both) a hand written or a computer-generated copy be maintained in the clinical record – either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.
- All state licensure and state practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard.

- In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

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4.8.3 Disaster Plans

HIM STANDARD:
- A disaster plan for recovering health records damaged by fire, flood, or other destructive events is in place.
- The disaster plan includes provisions for recovering healthcare records on different types of storage media.
- The disaster plan includes provisions for a backup system to provide the healthcare organization's staff necessary access to health records during emergency situations.

Every long term care facility should have a disaster plan in place to deal with unexpected events and outline how health information/medical records will be protected from damage. A well thought out disaster plan will minimize disruption, ensure stability, and provide for orderly recovery when faced with an unforeseen event.

A plan should be in place to deal with water damage (flood, sewage back-up, sprinkler damage, etc), fire, power failures (electronic medical records and clinical information systems), resident evacuation, and other natural disasters common to your area such as a hurricane or tornado.

AHIMA has the following practice brief on disaster planning which details the steps to take in preparing for potential adverse events.

Research

- Perform a literature search on disasters and disaster planning relative to medical records or health information. Search the archives of your favorite health information listservs or Web sites. Check the Internet to see if other health organizations have posted disaster plans on their Web sites. Collect sample health information disaster plans from peers.
- Talk to colleagues who have experienced the types of disasters your facility could expect.
- Contact several fire/water/storm damage restoration companies to determine the services available in your area and obtain any instructional information they can provide. Services may include document, electronic media, and equipment restoration as well as storage.

These companies can often be located in the yellow pages under "fire/water damage restoration" or in the *Disaster Recovery Yellow Pages.*[7]

- Determine to what extent the facility's insurance covers the costs associated with moving health information, operating elsewhere, recovering damaged information, or lost revenue secondary to the inability to restore information. In addition, determine whether your insurer offers consultation and advice on disaster planning. Many insurers provide this at little or no cost to their clients.

Drafting the Plan

- List the various types of disasters that might directly impair the operation of the facility, such as fire, explosion, tornado, hurricane, flood, earthquake, severe storm, bioterrorism, or extended power failure.
- List your department's core processes. For example, at a large hospital, the core processes might be maintenance of a correct master patient index (MPI), assembly, deficiency analysis, coding, abstracting, release of information, transcribing dictation, chart tracking, locating and provision, and generating birth certificates.
- Correlate the disaster plan/recommendations to the facility disaster plan mandated under Life/Safety codes.
- Make sure facility insurance policy addresses record restoration in case of damage.

For each plausible disaster and core process, generate a contingency plan. The document might include:

- facility name
- department name
- contingency plan originator
- date
- the major function being addressed, such as chart tracking and location and provision
- the disaster being considered, such as a hurricane
- assumptions about the disaster, such as how will the disaster affect utilities; staffing and the ability of staff to report to work; security of health information and the facility itself; hardware and software; equipment and supplies; other departments; and residents presenting to the facility for treatment
- description of the existing process used for the major function being addressed
- an if/then scenario stating what will happen if a specific function cannot be performed
- interdependencies, such as which processes depend on the provision of certain information or services
- solutions and alternatives, including steps that can be taken to minimize damage or disruption before the disaster, ensure stability, or provide for orderly recovery
- the limitations and benefits of each solution or alternative
- activities that will need to be performed before the disaster in order to make this alternative possible, such as equipment acquisition, implementation of back-up systems, and development of disaster-related forms, materials, procedures, and staff training
- the names of the individuals responsible for performing these activities

- a list of individuals and departments with phone numbers to be contacted or notified relative to the disaster and implementation of this particular contingency plan

Implementing the Plan

- Perform the preparatory activities listed in each of the contingency plans.
- Share the preliminary plans with the facility's safety officer and risk manager.
- Develop written agreements with potential disaster recovery vendors or alternative service providers and locations as needed.
- Provide staff with the training and tools necessary to implement the plan.
- Test the plan.
- Reevaluate and revise the plan and corresponding procedures based on the input of staff, the safety officer, and the risk manager, and on simulated disaster trials.
- Include disaster training as part of staff orientation.
- Measure staff competency by asking staff to describe or demonstrate their roles and responsibilities during specific disasters. Include competencies in staff performance standards.
- Conduct drills at least semiannually.
- Review and update the plan at least annually.
- Repeat training and test competencies at least annually.

Restoring Damaged Records

In the event records are damaged in an actual disaster, contact a fire/water/storm damage restoration company. If services are contracted, the contract must provide that the business partner will:

- specify the method of recovery
- not use or further disclose the information other than as permitted or required by the contract
- use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract
- report to the contracting organization any inappropriate use or disclosure of the information of which it becomes aware
- ensure that any subcontractors or agents with access to the information agree to the same restrictions and conditions
- indemnify the healthcare facility from loss due to unauthorized disclosure
- upon termination of the contract, return or destroy all health information received from the contracting organization and retain no copies
- specify the time that will elapse between acquisition and return of information and equipment
- authorize the contracting entity to terminate the contract if the business partner violates any material term of the contract

To the extent records cannot be reconstructed by the damage restoration company, reconstruct the information by:

- reprinting documents from any undamaged databases, such as admission, transcription, laboratory, and radiology databases or data backup services
- retranscribing documents from the dictation system
- obtaining copies from recipients of previously distributed copies, such as physicians' offices, other healthcare facilities, or the business office

If unable to reconstruct part or all of a resident's health information, document the date, the information lost, and the event precipitating the loss in the resident's record. When appropriate, document what and how information was reconstructed. Authenticate the entry as per facility policy. When information is disclosed that would have normally included the missing portion, include a copy of the entry documenting the loss of that information.

Create and retain a record of the disaster event and a list of resident records affected, with recovery efforts, successes, and failures. This will allow for easy retrieval of general information regarding the past event should any legal or accreditation issues arise.

Post Disaster

Following the disaster, meet with staff and allow them the opportunity to:

- evaluate departmental performance and identify opportunities for improvement
- begin the grieving and healing process that may follow emotionally charged disasters

Disaster Plan Practice Brief prepared by: Gwen Hughes, RHIA Professional Practice Division