150.005: PHYSICIAN SERVICES

(A) Facilities that provide Level I, II or III care shall establish written policies and procedures governing the delivery of physician and other medically related services.

(B) Facilities that provide Level I, II or III care shall provide medical supervision through a written agreement with (a) an organized medical staff of a hospital, (b) an organized medical staff within the facility, (c) a local medical society, or (d) two or more advisory physicians (at least one of whom does not have a proprietary interest in the facility).

(1) Supervisory and advisory functions shall include: advice on the development of medical and patient care policies concerning patient admissions and discharge, medical records, responsibilities of attending physicians or physician-physician assistant team or physician-nurse practitioner team, supportive and preventive services, emergency medical care, and the review of the facility’s overall program of patient care.

(2) Staff or advisory physicians shall spend at least four hours per month in the facility devoted to supervisory and advisory functions.

(C) Every patient or resident shall have an attending physician who is responsible for his continuing medical care and periodic reevaluation.

(1) Each patient or resident or (if he is not competent) his next of kin or sponsor shall on admission designate a physician, physician-physician assistant team or physician-nurse practitioner team to serve as his attending physician. If the patient or resident does not have a physician, an attending physician or physician-physician assistant team or physician-nurse practitioner team shall be designated by the facility with the approval of the patient or resident or his next of kin or sponsor.

(2) The addresses and telephone numbers of attending physicians, physician-physician assistant teams or physician-nurse practitioner teams at which they can be routinely reached for emergencies, and the addresses and telephone numbers of alternate physicians or physician-physician assistant teams or physician-nurse practitioner teams, providing coverage for an attending physician, physician-physician assistant team or physician-nurse practitioner team in his/their absence shall be recorded in the patient’s or resident’s record and be readily available to personnel on duty in case of emergencies.

(D) All facilities shall have written agreements for emergency physician-physician assistant team or physician-nurse practitioner team services when the patient’s or residents own physician or physician-physician assistant team or physician-nurse practitioner team or alternate is not immediately available.
(1) A schedule listing the names and telephone numbers of “emergency” physicians or physician-physician assistant teams or physician-nurse practitioner teams and the specific days each is on call shall be posted at each nurses’ or attendants’ station.

(2) If medical orders for the immediate care of a patient or resident are not available at the time of admission, the emergency or advisory physician shall be contacted to provide temporary orders until the attending physician assumes responsibility.

(3) Facilities shall establish and follow procedures that cover immediate care of the patient, persons to be notified and reports to be prepared in case of emergencies.

(4) The date, time and circumstances surrounding each call to an “emergency” physician and his findings, treatment, and recommendations shall be recorded in the patient's or resident's clinical record. The facility shall notify the attending physician and record such notification in the clinical record.

(E) All medical, psychiatric and other consultations shall be recorded in the patient's or resident's clinical record and dated and signed by the consulting physician or practitioner.

(F) Every patient or resident shall have a complete admission physical exam and medical evaluation. Based on this information, the attending physician or physician-physician assistant team or physician-nurse practitioner team shall develop a medical care plan that shall include such information as the following:

(1) Primary diagnosis

Other diagnoses or associated conditions

Pertinent findings of physical exam (including vital signs and weight, if ambulatory).

Weight shall be included for non-ambulatory patients in a SNCFC.

Significant past history

Significant special conditions, disabilities or limitations

Prognosis

Assessment of physical capability (ambulation, feeding assistance bowel and bladder control)

Assessment of mental capacity

Treatment plan including:

Medications

Special treatments or procedures

Restorative services

Dietary needs
Order of ambulation and activities

Special requirements necessary for the individual’s health or safety

Preventive or maintenance measures

Short and long term goals

Estimated length of stay.

(2) The medical care plan shall be completed and recorded in the patient’s or resident’s clinical record as follows:

(a) Level I or II, within five days prior to admission, up to 48 hours following admission. (b) Level III or IV, within 14 days prior to admission, up to 72 hours following admission.

(3) If the medical care plan is completed within the specified time limits prior to admission by the physician who will continue as the attending physician, a repeat examination and evaluation following admission to the facility is not required.

(4) If a nurse practitioner or physician assistant performs the complete physical exam and medical evaluation, the supervising physician shall review and countersign the evaluation within ten days for Level I and Level II patients and within 30 days for Level III and Level IV patients; the supervising physician shall also complete an onsite physical examination and medical evaluation within this time period. If the supervising physician has been the physician of record during the patient’s hospital stay and a work-up has been performed within five days prior to admission, then the initial physical examination by the supervising physician shall not be necessary.

(G) Each patient or resident shall be re-examined and re-evaluated, and his medical care plan reviewed and revised, if indicated, by the attending physician, physician-physician assistant team or physician-nurse practitioner team to assure appropriate medical services and patient placement. Reviews shall be recorded in the clinical record at least as often as follows:

(1) Level II, every 30 days. If after 90 days following admission in the opinion of the attending physician or physician-physician assistant team or physician-nurse practitioner team it is deemed unnecessary to see the patient with such frequency, an alternate schedule of visits by the physician or physician-physician assistant team or physician-nurse practitioner team may be adopted providing the justification is documented in the patient’s medical record. At no time may the alternate schedule exceed 60 days.

(2) Level III, every 60 days. If after 90 days following admission in the opinion of the attending physician or physician-physician assistant team or physician-nurse practitioner team it is deemed unnecessary to see the patient with such frequency, an alternate schedule of visits by the physician or physician-physician assistant team or physician-nurse practitioner team may be adopted providing the justification is documented in the patient’s medical record. At no time may the alternate schedule exceed 90 days.

(3) Level IV, every six months, except for Community Support Residents every three months, unless the physician documents that fewer visits are necessary.
(4) If the re-examinations and re-evaluations and reviews of the medical care plan are conducted by a nurse practitioner or physician assistant, the supervising physician shall perform an onsite review and evaluation of each patient in conjunction with the nurse practitioner or physician assistant at least every six months for Level I and Level II patients and at least every 12 months for Level III patients and Level IV patients.

(5) At the time of the supervising physician’s on-site visit, the physician shall write a progress note confirming that he/she has personally evaluated the patient, has reviewed the medical care plans developed by the nurse practitioner or physician assistant and has participated in any necessary revisions.

150.002: ADMINISTRATION

(1) No later than November 30, 2005, the administrator of a nursing facility shall acquire an automated external defibrillator and develop policies and procedures for the rendering of automated external defibrillation in the facility.

(2) For the purposes of 105 CMR 150.000, the facility shall contract with or employ a physician who shall be the automated external defibrillation medical director for the facility.

(a) The medical director shall oversee and coordinate the automated external defibrillation activities of the facility including:

1. maintenance and testing of equipment in accordance with manufacture’s guidelines;

2. certification and training of facility personnel;

3. periodic performance review of the facility automated external defibrillation activity.

(b) The medical director shall integrate the facility automated external defibrillation activity with the local Emergency Medical response system.