4658.0700 MEDICAL DIRECTOR.

Subpart 1. Designation. A nursing home must designate a physician to serve as medical director.

Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for:

A. the development of resident care policies and procedures that are to be approved by the licensee;

B. implementation of resident care policies;

C. the development of standards of practice for medical care to provide guidance to attending physicians;

D. the medical direction and coordination of medical care in the nursing home, including serving as liaison with attending physicians, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services to meet the medical needs of residents;

E. surveillance of the health status of the nursing home’s employees as it relates to the performance of their assigned duties;

F. periodic advisement to the director of nursing services to ensure a quality level of delegated medical care provided to residents; and

G. participation, or designation of another physician for participation, on the quality assessment and assurance committee as required by part 4658.0070.

STAT AUTH: MS s 144A.04; 144A.08; 256B.431

HIST: 20 SR 303Current as of 01/19/05

4658.0705 MEDICAL CARE AND TREATMENT.

Subpart 1. Physician supervision. A nursing home must ensure that each resident has a physician designated to authorize and supervise the medical care and treatment of the resident during the resident’s stay in the nursing home, and must ensure that another physician is available to supervise the resident’s medical care when the attending physician is unavailable.
Subp. 2. Availability of physicians for emergency and advisory care.

A. A nursing home must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency, and to act in an advisory capacity.

B. The name and telephone number of the emergency physician must be readily available at all times.

C. A nursing home must develop and maintain policies and procedures regarding obtaining medical intervention when the resident’s attending physician or the emergency physician does not respond to a request for medical care or is not available in a timely manner.

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4658.0710 ADMISSION ORDERS AND PHYSICIAN EVALUATIONS.

Subpart 1. Physical examination. A resident must have a current admission medical history and complete physical examination performed and recorded by a physician, physician assistant, or nurse practitioner within five days before or within seven days after admission.

Subp. 2. Admission orders. A nursing home must have physician orders for a resident’s admission and immediate care at the time of admission.

Subp. 3. Frequency of physician evaluations.

A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required.

B. Except as provided in this item, all required physician visits must be made by the physician personally. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner according to parts 5600.2600 to 5600.2670, chapters 6330 and 6340, and Minnesota Statutes, sections 147.34 and 148.235.

Subp. 4. Physician visits. At each visit, a physician or physician’s designee must:

A. review the resident’s comprehensive plan of care, including medications and treatments, and progress notes;

B. write, sign, and date physician progress notes; and

C. sign and date all orders.
4658.0715 MEDICAL INFORMATION FOR CLINICAL RECORD.

A physician or physician designee must provide the following information for the clinical record:

A. the report of the admission history and physical examination;
B. the admitting diagnosis;
C. a description of the general medical condition, including disabilities and limitations;
D. a report of subsequent physical examinations;
E. instructions relative to the resident's total program of care;
F. written orders for all medications with stop dates, treatments, rehabilitations, and any medically prescribed special diets;
G. progress notes;
H. any advanced directives; and
I. condition on discharge or transfer, or cause of death.