State Regulations Pertaining to Physician Services

Note: This document is arranged alphabetically by State. To move easily from State to State, click the “Bookmark” tab on the Acrobat navigation column to the left of the PDF document. This will open a Table of Contents for the document. The relevant federal regulations are at the end of the PDF.

ALABAMA

420-5-10-03 Administrative Management.

(21) Medical director. The facility must designate a physician to serve as medical director.

(22) The medical director is responsible for:

(a) Implementation of resident care policies; and

(b) The coordination of medical care in the facility.

420-5-10-13 Physician Services.

(1) A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(2) Physician supervision. The facility must ensure that:

(a) The medical care of each resident is supervised by a physician; and

(b) Another physician supervises the medical care of residents when their attending physician is unavailable.

(3) Physician visits. The physician must:

(a) Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph (4)(a) of this section;

(b) Write, sign, and date progress notes at each visit; and

(c) Sign and date all orders.

(4) Frequency of physician visits.

(a) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
(b) A physician’s visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(c) Except as provided in paragraphs (4)(d) of this section, all required physician visits must be made by the physician personally.

(d) At the option of the physician, required visits, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (5)(a)1,2, and 3 of this section.

(5) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(a) Except as specified in paragraph (5)(b) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

1. Agrees to and has signed specific protocols established by the facility and the physician and is on file in the facility;

2. Is acting within the scope of practice as defined by State law; and

3. Is under the supervision of the physician.

(b) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility’s own policies.

Author: Patricia E. Ivie
History: Original rules filed: July 19, 1996; effective August 23, 1996.

ALASKA
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07 AAC 012.260. Medical Director. A medical director who is employed by or is a consultant to the nursing facility shall

(1) place a resident under the care of a physician;

(2) ensure that the use of an investigational drug is properly supervised by a member of the medical staff, that an informed consent form provided by the sponsoring company or agency is used, and that complete records on the drug, including protocol and side effects, are maintained; and
(3) supervise the infection control and employee health programs.

History - Eff. 11/19/83, Register 88; am 5/28/92, Register 122.
Authority:
AS 18.20.010
AS 18.20.060

07 AAC 012.265. Physician Services.

(a) Physicians shall review, recap, and sign orders for nursing facility residents at least once every 60 days.

(b) Physicians shall visit nursing facility residents and make a notation in each resident’s medical record of the resident’s status every 30 days for the first 90 days, and after that, every 60 days for skilled care residents, and every 90 days for intermediate care residents. If the condition of a resident warrants more frequent visits, a physician shall visit a resident as often as necessary.

History - Eff. 11/19/83, Register 88; am 5/28/92, Register 122.
Authority:
AS 18.20.010
AS 18.20.060

ARIZONA

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R9-10-910. Medical Services

A. A governing authority shall appoint a medical director.

B. A medical director shall ensure that:

1. A resident has an attending physician;

2. An attending physician is available 24 hours a day;

3. An attending physician designates a physician who is available when the attending physician is not available;

4. A physical examination is performed on a resident at least once every 12 months from the date of admission by an individual listed in R9-10-908(5);

5. As required in A.R.S. § 36-406, vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
a. The attending physician provides documentation that the vaccination is medically contraindicated;

b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical records that the resident or the resident's representative has been informed of the risks and benefits of each vaccination refused; or

c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention; and

6. A resident is assisted in obtaining, at the resident’s expense:

a. Vision services;

b. Hearing services;

c. Dental services;

d. Clinical laboratory services from a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;

e. Psychosocial services;

f. Physical therapy;

g. Speech therapy;

h. Occupational therapy;

i. Behavioral health services; and

j. Services for an individual who has a developmental disability as defined in A.R.S. Title 36, Chapter 5.1, Article 1.

C. If the attending physician designates a physician assistant or registered nurse practitioner to provide medical services to a resident, the attending physician is responsible for the medical services provided.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1).
302 GENERAL ADMINISTRATION

302.6 The name, address, and telephone number of attending physicians shall be available at each nurses' station.

312 PHYSICIAN'S SERVICES POLICIES

The facility shall have a written policy indicating that the health care of every patient is under the supervision of a physician, who based on a medical evaluation of the patient's immediate and long term needs, prescribes a planned regimen of total care.

500 PATIENT CARE SERVICES

501 PHYSICIAN SERVICES

502 ADMISSION ONLY ON RECOMMENDATION OF A PHYSICIAN

Patients shall be admitted to the facility only on recommendation of a physician. At the time of admission the physician must document level of care needed by the patient. A Certification Statement by the physician explaining the reason for nursing home placement should be obtained on the date of admission and a re-certification statement obtained every sixty (60) days.

503 CONTINUED SUPERVISION OF CARE

The health care of every patient shall be under the continuing supervision of a physician, who, based on a medical evaluation of the patient's immediate and long term needs, prescribes a planned regimen of total patient care. Patients in need of skilled care should be seen by a physician at least every sixty (60) days, and all others seen at least every one hundred twenty (120) days. A notation should be made at each visit and orders for treatment and medication renewed.

504 PHYSICAL EXAMINATION OF PATIENTS

The medical evaluation of the patient shall be based on a history and physical examination done within seventy-two (72) hours of admission unless such examination was performed within fifteen (15) days prior to admission. A history and physical completed during the patient's hospitalization may have been completed up to thirty (30) days prior to admission to the nursing home; however, the hospital discharge summary (upon completion) is to be forwarded to the nursing home.
505 PLANNED REGIMEN OF CARE

The planned regimen of total care for each patient shall be based on the attending physician’s order and shall cover medication, treatment, rehabilitative services (where appropriate), diets, precautions related to activities undertaken by the patient, and plans for continuing care and discharge.

506 ESTABLISHMENT RESTORATION POTENTIAL

The attending physician shall establish at the time of admission a restoration potential for the patient. This should be updated as needed but not less than on an annual basis.

507 EMERGENCY PHYSICIAN

The facility should make arrangements for emergency coverage by a physician if the attending physician or his attendant cannot be located. This should be done by a written agreement signed by the physician and the facility administrator.

517 TREATMENT AND MEDICATIONS

517.2 If it is necessary to take physician’s or dentist’s orders over the telephone or verbally, the order shall be immediately written on the physician’s order sheet in the medical record and signed by the nurse who took the order. Documentation shall include the name of the physician or dentist who gave the telephone or verbal order, the date, and the time of the order. The order shall be countersigned by the attending physician or dentist on his next regular visit or no more than seven (7) days from the time the telephone or verbal order was given. There shall be indication made by the nurse that the orders were transcribed (signature and time).

517.3 When computerized physician order sheets are utilized, the physician must sign each sheet at the bottom of the sheet, and date each sheet. If a physician’s signature is affixed to the sheet other than at the bottom, all orders appearing after the signature shall be invalid. When progress notes or recertification statements are written on the computerized order sheet, the name and date affixed by the physician at the bottom of the sheet will be sufficient. However, if progress notes or recertification statements appear elsewhere in the medical record, each sheet shall be signed and dated where they are written.

CALIFORNIA

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s 72301. Required Services.

...(g) The facility shall make arrangements for a physician or physicians to be available to furnish emergency medical care if the attending physician, or designee, is
unavailable. The telephone numbers of those physicians shall be posted in a conspicuous place in the facility.

72303. Physician Services - General Requirements.
(a) Physician services shall mean those services provided by physicians responsible for the care of individual patients in the facility. All persons admitted or accepted for care by the skilled nursing facility shall be under the care of a physician selected by the patient or patient's authorized representative.
(b) Physician services shall include but are not limited to:
(1) Patient evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission.
(2) An evaluation of the patient and review of orders for care and treatment on change of attending physicians.
(3) Patient diagnoses.
(4) Advice, treatment and determination of appropriate level of care needed for each patient.
(5) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others. Orders for restraints shall meet the requirements of Section 72319(b).
(6) Health record progress notes and other appropriate entries in the patient's health records.
(7) Provision for alternate physician coverage in the event the attending physician is not available.
(c) Nonphysician practitioners may be permitted to render those medical services which they are legally authorized to perform. Nonphysician practitioners means any of the following:
(1) Physicians' assistants working under the responsibility and supervision of a physician approved as a supervisor by the Board of Medical Quality Assurance and performing only those selected diagnostic and therapeutic tasks identified in Title 16, California Administrative Code, Chapter 13, Subchapter 3, Article 5.
(2) Registered nurses may perform patient care services utilizing "Standardized Procedures" which have been approved by the medical staff, or by the medical director if there is no organized medical staff, the registered nurse and the administrator as authorized in the Business and Professions Code, Chapter 5, Article 2, Section 2725.

s 72305. Physician Services - Medical Director.
(a) The facility shall have a medical director who shall be responsible for standards, coordination, surveillance and planning for improvement of medical care in the facility.
(b) The medical director shall:
(1) Act as a liaison between administration and attending physicians.

(2) Be responsible for reviewing and evaluating administrative and patient care policies and procedures.

(3) Act as a consultant to the director of nursing service in matters relating to patient care services.

(4) Be responsible for reviewing employees’ preemployment and annual health examination reports.

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

s72307. Physician Services - Supervision of Care.
(a) Each patient admitted to the skilled nursing facility shall be under the continuing supervision of a physician who evaluates the patient as needed and at least every 30 days unless there is an alternate schedule, and who documents the visits in the patient health record.
(b) Alternate schedules of visits shall be documented in the patient health record with a medical justification by the attending physician. The alternate schedule shall conform with facility policy.

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

s 72523. Patient Care Policies and Procedures.

... (c) Each facility shall establish and implement policies and procedures, including but not limited to:

(1) Physician services policies and procedures which include:

(A) Orientation of new physicians to the facility and changes in physician services and/or policies.

(B) Patient evaluation visits by the attending physician and documentation of alternate schedules for such visits.
Part 6 - Medical Care services.

6.1 PHYSICIAN CARE. Each facility resident shall be admitted to the facility by a physician and have the benefit of continuing health care under supervision of a physician. The facility shall have written policies developed by the medical advisor to coordinate and designate responsibility when more than one physician is treating a resident. [See Part 26 exceptions]

6.1.1 The facility shall take all necessary steps to assure that upon admission, the physician provides to the facility sufficient information to validate the admission and identify the resident and a medical plan of therapy to include diet, medications, treatments, special procedures, activities, specialized rehabilitative services, if applicable, and potential for discharge.

6.1.2 The facility shall take all necessary steps to assure that the admitting physician provides to the facility on admission the anticipated schedule of visits to meet resident needs, which shall be no less often than every 6 months. Acknowledgements of the visit schedule by the resident or authorized representative shall be documented in the health record.

6.1.3 The facility shall take all necessary steps to assure that telephone orders are received by a physician, licensed nurse or other appropriate disciplines as authorized by their professional licensure and are countersigned by the attending physician or dentist and entered in the record within 2 weeks.

6.1.4 The facility shall take all necessary steps to assure that the attending physician authenticates medical histories and physical examinations completed by other authorized personnel.

...6.1.6 The facility shall take all necessary steps to assure that the attending physician writes a progress note following each visit, and at least once per year provides a written evaluation of the resident’s current medical status compared to the previous year’s status.

6.1.7 The facility shall take all necessary steps to assure that all drugs and therapies ordered by the physician are supported by diagnoses indicating the use of those drugs and therapies.

Part 13. EMERGENCY SERVICES

13.1 EMERGENCY CARE POLICIES. The facility shall have and follow written policies for the care of residents in an emergency available for staff use, including: 1) arrangements for necessary medical care when a resident’s physician is unavailable (developed by persons described in Section 6.2)...

CONNECTICUT
(i) Medical staff.

(1) Each facility shall have an active organized medical staff. All members of such staff shall possess a full and unrestricted Connecticut license for the practice of medicine. The active organized medical active staff at a chronic and convalescent nursing home shall include no less than three (3) physicians.

(2) The medical director shall approve or deny applications for membership on the active organized medical staff after consultation with the existing active organized medical staff, if any, and subject to the ratification of the governing body. In reviewing an applicant's qualifications for membership, the medical director shall consider whether the applicant:

   (A) satisfies specific standards and criteria set in the medical by-laws of the facility; and

   (B) is available by phone twenty-four (24) hours per day; is available to respond promptly in an emergency; and is able to provide an alternate physician or coverage whenever necessary.

(3) All appointments shall be made in writing and shall delineate the physician's duties and responsibilities. The letter of appointment shall be signed by the medical director and the applicant.

(4) Requirements for active organized medical staff members.

   (A) Members shall meet at least once every ninety (90) days. Minutes shall be maintained for all such meetings. The regular business of the medical staff meetings shall include, but not be limited to, the hearing and consideration of reports and other communications from physicians, the director of nurses and other health professionals on:

      (i) patient care topics, including all deaths, accidents, complications, infections;

      (ii) medical quality of care evaluations; and

      (iii) interdisciplinary care issues, including nursing, physical therapy, therapeutic recreation, social work, pharmacy, podiatry, or dentistry.

   (B) Members shall attend at least fifty (50) percent of medical staff meetings per year. If two (2) or more members of the active medical staff are members of the same partnership or incorporated group practice, one (1) member of such an association may fulfill the attendance requirements for the other members of that association provided quorum requirements are met. In such case, the member in attendance shall be entitled to only one (1) vote.

   (C) The active organized medical staff shall adopt written by-laws governing the medical care of the facility's patients. Such by-laws shall be approved by the medical director and the governing body. The by-laws shall include, but not necessarily be limited to:
(i) acceptable standards of practice for the medical staff;

(ii) criteria for evaluating the quality of medical care provided in the facility;

(iii) criteria by which the medical director shall decide the admission or denial of admission of a patient based on the facility's ability to provide care;

(iv) standards for the medical director to grant or deny privileges and to discipline or suspend the privileges of members of the medical staff, including assurance of a due process of appeal in the event of such actions;

(v) quorum requirements for staff meetings, provided a quorum may not be less than fifty (50) percent of the physicians on the active medical staff;

(vi) specific definition of services, if any, which may be provided by nonphysician health professionals such as physician's assistants or nurse practitioners;

(vii) standards to assure that members of the medical staff request medical consultants where the diagnosis is obscure, or where there is doubt as to the serious nature of the illness or as to treatment. Such standards shall minimally mandate that the consultant be qualified to render an opinion in the field in which the opinion is sought, and that the consultation include examination of the patient and medical record;

(viii) standards to assure that, in the event of the medical director's absence, inability to act, or vacancy of the medical director's office, another physician on the facility's active organized medical staff is temporarily appointed to serve in that capacity; and

(ix) conditions for privileges for the medical staff other than the active organized medical staff.

(5) Each member of the facility's medical staff shall sign a statement attesting to the fact that such member has read and understood the facility's medical and facility policies and procedures, and applicable statutes and regulations, and that such member will abide by such requirements to the best of his/her ability.

(n) Medical and professional services.

...(5) Physician Visits.

(A) Each patient in a chronic and convalescent nursing home shall be examined by his/her personal physician at least once every thirty (30) days for the first ninety (90) days following admission. After ninety (90) days, alternative schedules for visits may be set if the physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at thirty (30) day intervals. At no time may the alternative schedule exceed sixty (60) days between visits.

(B) Each patient in a rest home with nursing supervision shall be examined by his/her personal physician at least once every sixty (60) days, unless the physician
decides this frequency is unnecessary and justifies the reason for an alternate schedule in the patient's medical record. At no time may the alternative schedule exceed one hundred and twenty (120) days between visits.

6.0 Services To Residents

6.1 General Services. Any nursing facility not providing skilled services shall implement each resident's physician's orders obtained on the day of admission and renewed or revised every 60 days thereafter.

6.2 Medical Services

6.2.1 All persons admitted to a nursing facility shall be under the care of a physician licensed to practice in Delaware.

6.2.2 All nursing facilities shall arrange for one or more licensed physicians to be called in an emergency. Names, telephone and fax numbers of these physicians shall be posted at all nurses' stations.

6.2.3 For a resident admitted or readmitted from the hospital with orders for nine or more medications (excluding over-the-counter medications), the attending physician or designee or medical director shall conduct a comprehensive medication review and reconciliation of past and present medications within 5 days.

6.2.4 All written or verbal physician orders shall be signed by the attending physician or prescriber within 10 days.

6.2.5 After the initial physician visit, an advanced practice nurse or physician's assistant, affiliated with the physician, may alternate with the physician, making every other required visit.

6.2.6 A progress note shall be written and signed by the physician or designee (an advanced practice nurse or physician's assistant) after examining the resident at each visit.
3207 PHYSICIAN SERVICES AND MEDICAL SUPERVISION OF RESIDENTS

3207.1 The Medical Director shall assume full responsibility for the overall supervision of the medical care provided in the facility. If the Medical Director is absent, he or she shall delegate the continuity and supervision of resident care to a qualified physician.

3207.2 The Medical Director shall:

(a) Coordinate medical care in the facility;

(b) Implement resident care policies;

(c) Develop written medical bylaws and medical policies;

(d) Serve as liaison with attending physicians to ensure the prompt issuance and implementation of orders;

(e) Review incidents and accidents that occur on the premises to identify hazards to health and safety;

(f) Ensure that medical components of resident care policies are followed;

(g) Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing procedures for emergency medical care; and

(h) Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substances registrations on file in the facility, along with initial and annual certifications of their freedom from communicable disease.

3207.3 Except as specified in subsection 3207.5 of this section, a physician may delegate tasks to a licensed physician assistant or licensed nurse practitioner who:

(a) Meets the applicable definition in section 3299 of this Chapter; and

(b) Is acting within the scope of practice as defined by District of Columbia law.

3207.4 A physician's assistant shall be supervised by a physician.

3207.5 A physician may not delegate a task when regulations specify that the physician shall perform it personally, or when the delegation is prohibited under District law or by the facility’s own policies.

3207.6 The physician shall prescribe a planned regimen of medical care which includes the following:

(a) Medications and treatment;
(b) Rehabilitative services;

(c) Diet;

(d) Special procedures and contraindications for the health and safety of the resident;

(e) Resident therapeutic activities; and

(f) Plans for continuing care and discharge.

3207.7 A facility shall have available for each resident vaccines currently recommended by the U.S. Health Advisory Committee on Immunization Practices (ACIP) as appropriate for age, occupation, lifestyle, environmental situation, documented evidence of prior vaccine, if available, or immunity and current medical status.

3207.8 Each physician shall adhere to the written policies and regulations that govern the health services provided in the facility.

3207.9 The Medical Director shall make arrangements for the provision of medical care twenty-four (24) hours a day.

3207.10 Dated orders and dated progress notes in the resident’s medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident’s physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician.

3207.11 Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident’s medical record.

3207.12 A schedule with the names and telephone numbers of each physician and days he or she is on call shall be kept at each nursing station.

3207.13 There shall be available at each nursing station written procedures on emergency care, including care of residents, persons to be notified and reports to be prepared.

FLORIDA


(1) Each nursing home facility shall retain, pursuant to a written agreement, a physician licensed under Chapter 458 or 459, F.S., to serve as Medical Director. In
facilities with a licensed capacity of 60 beds or less, pursuant to written agreement, a physician licensed under Chapter 458 or 459 may serve as Medical Consultant in lieu of a Medical Director.

(2) Each resident or legal representative, shall be allowed to select his or her own private physician.

(3) Verbal orders, including telephone orders, shall be immediately recorded, dated, and signed by the person receiving the order. All verbal treatment orders shall be countersigned by the physician or other health care professional on the next visit to the facility.

(4) Physician orders may be transmitted by facsimile machine. It is not necessary for a physician to re-sign a facsimile order when he visits a facility.

(5) All physician orders shall be followed as prescribed, and if not followed, the reason shall be recorded on the resident’s medical record during that shift.

(6) Each resident shall be seen by a physician or another licensed health professional acting within their scope of practice at least once every thirty (30) days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter. A physician visit is considered timely if it occurs not later than ten (10) days after the date the visit was required. If a physician documents that a resident does not need to be seen on this schedule and there is no other requirement for physician’s services that must be met due to Title XVIII or XIX, the resident’s physician may document an alternate visitation schedule.

(7) If the physician chooses to designate another health care professional to fulfill the physician’s component of resident care, they may do so after the required visit. All responsibilities of a physician, except for the position of medical director, may be carried out by other health care professionals acting within their scope of practice.

(8) Each facility shall have a list of physicians designated to provide emergency services to residents when the resident’s attending physician, or designated alternate is not available.
Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23, 464.012 FS. History–New 4-1-82, Amended 4-1-84, Formerly 10D-29.107, Amended 10-5-92, 4-18-94, 1-10-95.

59A-4.1075 Medical Director.

(1) Each facility will have only one physician who is designated as Medical Director.

(2)(a) The Medical Director must be a physician licensed under Chapter 458 or 459, F.S. The nursing home administrator may require that the Medical Director be certified or credentialed through a recognized certifying or credentialing organization.

(b) A Medical Director who does not have hospital privileges shall be certified or credentialed through a recognized certifying or credentialing body, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Medical Directors Association, the Healthcare Facilities Accreditation Program of the American Osteopathic Association, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the Florida Medical Directors Association or a health maintenance organization licensed in Florida.

(c) A physician must have his/her principal office within 60 miles of all facilities for which he/she serves as Medical Director. Principal office is the office maintained by a physician pursuant to Section 458.351 or 459.026, F.S., and where the physician delivers the majority of medical services. The physician must specify the address of his/her principal office at the time of becoming Medical Director. The agency may approve a request to waive this requirement for rural facilities that exceed this distance requirement. A rural facility is a facility located in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other nursing home facility within the same county.

(d) The facility shall appoint a Medical Director who shall visit the facility at least once a month. The Medical Director shall review all new policies and procedures; review all new incident and new accident reports from the facility to identify clinical risk and safety hazards. The Medical Director shall review the most recent grievance logs for any complaints or concerns related to clinical issues. Each visit must be documented in writing by the Medical Director.

(3) A physician may be Medical Director of a maximum of ten (10) nursing homes at any one time. The Medical Director, in an emergency where the health of a resident is in jeopardy and the attending physician or covering physician cannot be located, may assume temporary responsibility of the care of the resident and provide the
(4) The Medical Director appointed by the facility shall meet at least quarterly with the quality assessment and assurance committee of the facility.

(5) The Medical Director appointed by the facility shall participate in the development of the comprehensive care plan for the resident when he/she is also the attending physician of the resident.

Specific Authority 400.141 FS. Law Implemented 400.141(2) FS. History–New 8-2-01.

GEORGIA

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290-5-8-.05 Professional Service.

(1) There shall be an organized professional staff, with one physician designated as chief of staff. The professional staff shall consist of at least one physician, one dentist and one registered nurse. Other professional personnel such as the dietitian, social worker, physical therapist, pharmacist, etc. may be included on the professional staff. This organization shall function under appropriate bylaws and shall meet at regularly scheduled intervals not less than semiannually. It shall be the responsibility of this staff to develop and review patient care policies and to advise administration on matters pertaining to patient care. The minutes of the meetings of this staff shall be available for inspection by the Department.

(2) Patients shall be admitted only on referral of a physician.

(3) Each patient shall be under the continuing care of a physician who sees the patient at least once every thirty (30) days following admission. The patient’s total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every thirty (30) days for the first ninety (90) days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit and he signs all his orders. Subsequent to the ninetieth day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient’s medical record that the patient’s condition does not necessitate visits at thirty-day intervals.

(4) A home shall admit only those patients for which it can provide needed care and only if the home has a permit covering that type of care. When a patient develops a condition
requiring care of a level or type not provided at that home, the administration shall arrange for transfer of the patient to another home, hospital or home health agency which has a permit or is certified to provide such care or shall make satisfactory arrangements for the needed care if the condition is to be of short duration.


290-5-8-10 Medical, Dental and Nursing Care.

(1) Each patient shall have a physician's written statement of his or her condition at time of admission or within forty-eight (48) hours thereafter and it shall be kept on file with the patient's medical record.

(2) Each patient shall have a physician's orders for treatment and/or care upon admission to the facility.

(3) Each home shall have an adequate arrangement for medical and dental emergencies.

(4) Reports of all evaluations and examinations shall be kept with the patient's medical records.

§11-94-12 Emergency care of patients. (a) There shall be written procedures for personnel to follow in an emergency including:

(1) Care of the patient;

(2) Notification of the attending physician and other persons responsible for the patient;

(3) Arrangements for transportation, hospitalization, or other appropriate services.


§11-94-28 Physician’s services.
(a) Admission and ongoing orders and plans of treatment shall be in writing, and carried out by the staff of the facility including arrangement for transfer to other facilities when indicated.

(b) All patients admitted to a facility shall be under the care of a physician selected by the patient.

(c) Physicians shall visit as necessary to assure adequate medical care. In intermediate care facilities, physician’s visits shall be made at least every sixty days unless the physician decides that this frequency is unnecessary and records the reasons for this decision; provided visits shall occur at least at one hundred-twenty day intervals. Physician’s visits in skilled nursing facilities shall be made every thirty days for the first ninety days. After ninety days, an alternate schedule of visits at sixty day intervals may be adopted where the attending physician justifies this in writing. This alternate schedule is not permitted when patients require specialized rehabilitative services.

(d) Physicians shall participate as appropriate in the interdisciplinary evaluation of patients and their plan of care.

(e) Physicians shall provide an annual health evaluation of each patient.

(g) Each patient shall have a physical examination by a physician within five days prior to admission or within one week after admission, and shall have had tuberculosis clearance as required by section 11-94-15(c)(10) and (11) within the previous year.

(h) The facility shall promptly notify the physician of any accident, injury, or change in the patient’s condition.

02. Physician Supervision. (7-1-93)

a. Each patient/resident shall be under the direct and continuing supervision of a physician of his own choice licensed by the Idaho Board of Medicine. (1-1-88)

b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/resident's medical record, with a physician's progress note. (1-1-88)

c. Each intermediate care patient shall be seen by the attending physician at least once every sixty (60) days unless justified otherwise in the patient's/resident's medical record by the attending physician. All physician visits shall be recorded in the patient's/resident's medical record with a physician's progress note. (1-1-88)

d. The physician shall provide the facility with medical information necessary to care for the patient/resident which includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information shall include diagnosis, medical findings, activity limitations, and rehabilitation potential. (1-1-88)

e. A physician's plan of care shall be provided to the facility upon admission of the patient/resident which reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the patient/resident. (1-1-88)

f. The physician's plan of care for the patient/resident shall be reviewed by the physician:

i. Every thirty (30) to sixty (60) days for skilled care patients/residents depending upon the visit schedule authorized. (1-1-88)

ii. At least every ninety (90) days for intermediate care patients/residents. (1-1-88)

iii. The plan of care shall be reordered with any changes included by the physician and signed and dated by the physician at the time of the review. (1-1-88)

03. Emergency Physician. Arrangements shall be made for a physician to be available for emergency calls at all times, and his name, address, and telephone number shall be readily available. (1-1-88)

04. Emergency Transfer. In the event that neither the patient's/resident's attending physician nor the emergency physician can be contacted, the patient/resident in an emergent situation may be transferred to the emergency department of a nearby hospital. (1-1-88)
Section 300.830 Consultation Services

...e) The facility shall arrange for an advisory physician or medical advisory committee as set forth in Section 300.1010.

Section 300.1010 Medical Care Policies

a) Advisory Physician or Medical Advisory Committee

1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician, he may be the advisory physician. (B)

2) Additional for Skilled Nursing Facilities. There shall be a medical advisory committee composed of two (2) or more physicians who shall be responsible for advising the administrator on the overall medical management of the residents and the staff in the facility. If the facility employs a house physician, the house physician may be one member of this committee.

b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents’ personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee. (B)

c) Every resident shall be under the care of a physician.

d) All residents, or their guardians, shall be permitted their choice of a physician.

e) All residents shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)

f) Physician treatment plans, orders and similar documentation shall have an original written signature of the physician. A stamp signature, with or without initials, is not sufficient.

g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:
1) An evaluation of the resident’s condition, including height and weight, diagnoses, plan of treatment, recommendations, treatment orders, personal care needs, and permission for participation in activity programs as appropriate.

2) Documentation of the presence or absence of tuberculosis infection by tuberculin skin test in accordance with Section 300.1025.

3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.)

4) Orders from the physician regarding weighting of the resident, and the frequency of such weighing, if ordered.

h) The facility shall notify the resident’s physician of any accident, injury, or significant change in a resident’s condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician’s plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B)

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

**Section 300.1030 Medical Emergencies**

a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:

1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).

2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).

3) Traumatic injuries (for example, fractures, burns, and lacerations).

4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).

5) Other medical emergencies (for example, convulsions and shock). (A, B)

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. (B)
c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. (B)

d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement.

(Source: Amended at 18 Ill. Reg. 15868, effective October 15, 1994)

Section 300.3220 Medical and Personal Care Program

...b) The Department shall not prescribe the course of medical treatment provided to an individual resident by the resident’s physician in a facility. (Section 2-104(a) of the Act)

...f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility’s Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

410 IAC 16.2-3.1-13 Administration and management

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 12-10-5.5; IC 16-28-5-1; IC 25-19-1

...(u) The facility must designate a physician to serve as medical director.

(v) The medical director shall be responsible for the following:

(1) Acting as a liaison between the administrator and the attending physicians to encourage physicians to write orders promptly and to make resident visits in a timely manner.

(2) Reviewing, evaluating, and implementing resident care policies and procedures and to guide the director of nursing services in matters related to resident care policies and services.
(3) Reviewing incidents and accidents that occur on the premises to identify hazards to health and safety.

(4) Reviewing employees' preemployment physicals and health reports and monitoring employees' health status.

(5) The coordination of medical care in the facility.

410 IAC 16.2-3.1-22 Physician services

Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1

Sec. 22. (a) A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(b) The facility must ensure the following:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

(3) Verbal/telephone orders shall contain the date and time, physician's order, signature of the licensed nurse accepting the order, and the name of the physician giving the order.

(c) The physician must do the following:

(1) Review the resident's total program of care as defined by the comprehensive assessment and care plan, including medications, and treatments, by signing and dating a recap of all current orders at each visit required by subsection (d).

(2) Write, or cause to be written, sign, and date progress notes at each visit. Dictated notes must be filed in the clinical record within seventy-two (72) hours of the visit and signed within seven (7) days of the time the transcription is completed, and notes shall become part of the permanent record within seventy-two (72) hours unless an emergency situation warrants immediate documentation.

(3) Sign and date all orders. Verbal orders shall be countersigned and dated on the clinical record at the physician's next visit. The use of facsimile to transmit physicians orders is permissible. All matters of privacy and confidentiality of records shall be maintained.

(d) Physician visits must conform to the following schedule:

(1) The resident must be seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission, and at least every sixty (60) days thereafter, unless more frequent visits are indicated.

(2) A physician's routine visit is considered timely if it occurs not later than ten (10) days after the date the visit was required.

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(3) Except as provided in subsection (f), all required physician visits must be made by the physician personally.

(4) 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, nurse practitioner, or clinical nurse specialist in accordance with subsection (f).

(e) The facility must provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of emergency.

(f) A physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

(1) is acting within the scope of practice as defined by state law; and

(2) is under the supervision of the physician.

(g) If the physician employs other licensed or certified personnel, the administrator of the facility shall ensure that the means of supervision and duties delegated are filed in writing with the facility. The scope and content of their practice shall be within that specified by appropriate statutes governing each profession.

(h) For purposes of IC 16-28-5-1, a breach of:

(1) subsection (e) is an offense;

(2) subsection (a), (b), or (f) is a deficiency; and

(3) subsection (c), (d), or (g) is a noncompliance.

(Indiana State Department of Health; 410 IAC 16.2-3.1-22; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1547, eff Apr 1, 1997; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA)
a. The resident is terminally ill, and

b. The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

c. The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

58.14(2) Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

58.14(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

58.14(4) Rescinded, effective 7/14/82.

58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident’s condition. (I, II, III)

58.14(6) A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

58.14(7) Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

58.14(8) Each resident shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured by the date of admission and is not to include preadmission physicals. (III) Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician.

Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status.
<table>
<thead>
<tr>
<th>Skilled Nursing Facilities</th>
<th>Initial Comprehensive Visit/Orders</th>
<th>Other Required Visits</th>
<th>Other Medically Necessary Visits and Orders</th>
<th>Certification/Recertification</th>
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<tr>
<td>Nurse practitioner and clinical nurse specialist employed by the facility</td>
<td>May not perform/May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
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<tr>
<td>Nurse practitioner and clinical nurse specialist not a facility employee</td>
<td>May not perform/May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td>May sign subject to state requirements</td>
</tr>
<tr>
<td>Physician assistant regardless of employer</td>
<td>May not perform/May not sign</td>
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</tbody>
</table>

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law*

*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

1 Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

2 Medically necessary visits may be performed prior to the initial comprehensive visit.
39-936. Statement on admission; qualified personnel; education and training of unlicensed personnel; examination and fees; state registry established; refresher course required; supplier of medication; limitations on involuntary transfer or discharge of resident; effect of reliance upon spiritual means or prayer for healing by resident.

...(e) All medical care and treatment shall be given under the direction of a physician authorized to practice under the laws of this state and shall be provided promptly as needed.


Each resident in a nursing facility shall be admitted and shall remain under the care of a physician.

(a) The facility shall ensure that both of the following conditions are met:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when the resident's attending physician is not available.

(b) The physician shall perform the following duties:

(1) At the time of the resident's admission to the facility, provide orders for the immediate care of the resident, current medical findings, and diagnosis. The physician shall provide a medical history within seven days after admission of the resident;

(2) review the resident's total program of care, including medications and treatments at each visit;

(3) write, sign and date progress notes at each visit; and

(4) sign all written orders at the time of the visit and all telephone orders within seven days of the date the order was given.

(c) A physician shall see the resident for all of the following:

(1) If it is necessary due to a change in the resident's condition determined by the physician or licensed nursing staff;

(2) if the resident or legal representative requests a physician visit; and
(3) at least annually.

(d) The physician may delegate resident visits to an advanced registered nurse practitioner or a physician assistant.

(e) At admission, the resident or the resident’s legal representative shall designate the hospital to which the resident is to be transferred in a medical emergency. If the resident’s attending physician does not have admitting privileges at the designated hospital, the facility shall assist the resident or the resident’s legal representative in making arrangements with another physician who has admitting privileges to assume the care of the resident during hospitalization. This information shall be available on the resident’s clinical record.

(f) Death of resident. The nursing facility shall obtain an order from a physician before allowing the removal of the body of a deceased resident.

(Authorized by and implementing K.S.A. 39-932; effective Nov. 1, 1993; amended Feb. 21, 1997; amended November 26, 2001.)

29-39-163. Administration

... (j) Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) the medical director shall be responsible for the following:

(A) Implementation of resident care policies reflecting accepted standards of practice;

(B) coordination of medical care in the facility; and

(C) provision of consultation to the facility staff on issues related to the medical care of residents.

KENTUCKY

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Section 11. Physician Services [nursing facilities]. A physician shall personally approve a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

(1) Physician supervision. The facility shall ensure that:

(a) The medical care of each resident is supervised by a physician; and
(b) Another physician supervises the medical care of residents when their attending physician is unavailable.

(2) Physician visits. The physician shall:

(a) Review the resident’s total program of care, including medications and treatments, at each visit required by subsection (3) of this section;

(b) Write, sign and date progress notes at each visit; and

(c) Sign all orders.

(3) Frequency of physician visits. The resident shall be seen by a physician at least once every thirty (30) days for the first ninety (90) days after initial admission, and at least once every ninety (90) days thereafter.

(a) A physician visit is considered timely if it occurs not later than ten (10) days after the date the visit was required.

(b) Except as provided in paragraph (c) of this subsection, all required physician visits shall be made by the physician personally.

(c) 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 in accordance with subsection (5) of this section.

(4) Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of an emergency.

(5) Physician delegation of tasks.

(a) Except as specified in paragraph (b) of this subsection, a physician may delegate tasks to a physician assistant or nurse practitioner who is acting within the scope of practice as defined by state law, and is under the supervision of the physician.

(b) A physician shall not delegate a task when the regulations specify that the physician shall perform it personally, or when the delegation is prohibited under state law or by the facility’s own policies.

Section 15. Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

...(7) Medical director.

(a) The facility shall designate a physician to serve as medical director.

(b) The medical director shall be responsible for:
1. Implementation of resident care policies; and

2. The coordination of medical care in the facility.

§9801. Medical Director

A. The nursing home shall designate, pursuant to a written agreement, a physician currently holding an unrestricted license to practice medicine by the Louisiana State Board of Medical Examiners to serve as medical director.

B. The medical director shall serve as consultant regarding medical care policies and procedures.


HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:55 (January 1998).

§9803. Physician Supervision

A. A resident shall be admitted to the nursing home only with an order from a physician licensed to practice in Louisiana.

1. Each resident shall remain under the care of a physician licensed to practice in Louisiana and shall have freedom of choice in selecting his/her attending physician.

2. The nursing home shall be responsible for assisting in obtaining an attending physician, with the resident’s or sponsor’s approval, when the resident or sponsor is unable to find one.

B. Another physician supervises the medical care of residents when their attending physician is unavailable.

C. Any required physician task may also be satisfied when performed by an advanced-practice registered nurse or physician assistant who is not an employee of the nursing home, but who is working under the direction and supervision of a physician.

D. The nursing home shall provide or arrange for the provision of physician services 24 hours a day, in case of emergency.
E. The name and telephone numbers of the attending physicians and the physicians to be called in case of emergency, when the attending physician is not available, shall be posted at each nursing station. Upon request, the telephone numbers of the attending physician or his/her replacement in case of emergency shall be provided to the resident, guardian, or sponsor.


HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:55 (January 1998).

§9805. Physician Visits and Responsibilities

A. At the time each resident is admitted, the nursing home shall have attending physician’s orders for the resident’s immediate care. At a minimum, these orders shall consist of dietary, drugs (if necessary), and routine care to maintain or improve the resident’s functional abilities.

B. If the orders are from a physician other than the resident’s attending physician, they shall be communicated to the attending physician and verification entered into the resident’s clinical record by the nurse who took the orders.

C. A physical examination shall be performed by the attending physician within 72 hours after admission, unless such examination was performed within 30 days prior to admission, with the following exceptions:

1. if the physical examination was performed by another physician, the attending physician may attest to its accuracy by countersigning it and placing a copy in the resident’s record; or

2. if the resident is transferring from another nursing home with the same attending physician, a copy of the previous physical examination may be obtained from the transferring facility with the attending physician initialing its new date. The clinical history and physical examination, together with diagnoses shall be in the resident’s medical record.

D. Each resident shall be seen by his/her attending physician at intervals to meet the medical needs of the resident, but at least annually.

E. At each visit, the attending physician shall write, date and sign progress notes.

F. The physician’s treatment plan (physician’s orders) shall be reviewed by the attending physician at least once annually.

G. Physician telephone/verbal orders shall be received only by physicians, pharmacists, or licensed nurses. These orders shall be reduced to writing in the resident’s clinical record and signed and dated by the authorized individual receiving the order. Telephone/verbal orders shall be countersigned by the physician within seven days.

H. Use of signature stamps by physicians is allowed when the signature stamp is authorized by the individual whose signature the stamp represents. The administrative office of the
nursing home shall have on file a signed statement to the effect that the physician is the only one who has the stamp and uses it. There shall be no delegation of signature stamps to another individual.

I. At the option of the nursing home attending physician, any required physician task in a nursing home may also be satisfied when performed by an advanced-practice registered nurse when these tasks are within their realm of education and practice, or physician assistant when these tasks are so identified within their protocols, and who is not an employee of the nursing home, but who is working under the direction and supervision of an attending physician.


HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:55 (January 1998).

§9807. Standing Orders

A. Physician's standing orders are permissible but shall be individualized, taking into consideration such things as drug allergies, sex-specific orders, and the pertinent physical condition of the resident.

B. Over-the-counter drugs are to be utilized on a physician's standing orders. Controlled or prescription drugs except those commonly used in routine situations, should not be on standing orders and must be an individual order reduced to writing on the physician's order sheet as either a routine or pro re nata (prn) order. Each order shall include the following:

   1. name of the medication;
   2. strength of the medication;
   3. specific dose of the medication (not a dose range);
   4. route of administration;
   5. reason for administration;
   6. time interval between doses for administering the medication;
   7. maximum dosage or number of times to be administered in a specific time frame; and
   8. when to notify the attending physician if the medication is not effective.

C. Standing orders shall be signed and dated by the attending physician initially and at least annually thereafter.

D. A copy of the standing orders shall be maintained in the resident's active clinical record.
16.A. Physician Services

Each resident must be under the care of a physician.

16.A.1. A physician must personally approve, in writing, the recommendation that an individual be admitted to a nursing facility.

16.A.2. A physical examination, a copy of which must be in the resident's clinical record, must have been performed five (5) days prior to or within seven (7) days of admission.

16.A.3. The admitting physician must participate in the initial and ongoing medical evaluation and care planning of the resident.

16.A.4. The admitting physician must ensure that another physician supervises the medical care of residents, when the attending physician is unavailable.

16.A.5. The physician must visit the resident and review the resident's total program of care including medications and treatments as needed, at least once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter. A grace period of ten (10) days may be allowed for the resident whose condition during this period of time did not require medical attention.

16.A.6. Orders concerning medications and treatments shall be in writing, signed and dated by a physician and shall be in effect for the time specified by the physician, but in no case to exceed a period of sixty (60) days unless there is a written reorder. A grace period of ten (10) days may be allowed for the resident whose condition did not require a review and reorders during this period of time.

16.A.7. Orders for Schedule II controlled substances shall be in effect for no longer than one (1) week, unless there are specific written orders to the contrary. In no case shall the order be in effect for a period of more than thirty (30) days.

16.A.8. 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's assistant, nurse practitioner or clinical nurse specialist who meets the applicable definition, acts within the scope of State law, and is under the supervision of the physician.
16.A.9. At each visit, the physician, physician’s assistant, nurse practitioner or clinical nurse specialist must write, sign, and date progress notes.

16.A.10. Availability of Physician for Emergency Care

The facility must provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of an emergency.

16.A.11. Medical Director

a. There shall be a medical director who is responsible for the medical direction and coordination of medical care in the facility.

b. The duties, responsibilities and availability of the medical director, and the terms of agreement, shall be delineated in writing. The agreement shall be signed by the physician serving as medical director and by an authorized representative of the facility.

c. The medical director is responsible for the:

1. Overall coordination of medical care;

2. Liaison with attending physicians;

3. Participation in the Quality Assurance Committee and the Professional Policy Committee.

MARYLAND

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10.07.02.10 Physician Services.

A. Responsibility for the Resident’s Care. The attending physician shall:

(1) Assess a new admission in a timely manner, based on a facility-developed protocol, depending on:

(a) The individual’s medical stability;

(b) Recent and previous medical history;

(c) Presence of significant or previously unidentified medical conditions; or

(d) Problems that cannot be handled readily by phone;
(2) Seek, provide, and analyze needed information regarding a resident’s current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance;

(3) Provide appropriate information and documentation to support a facility-determined level of care for a new admission;

(4) Provide for the authorization of admission orders in a timely manner, based on a facility-developed protocol, to enable the nursing facility to provide safe, appropriate, and timely care; and

(5) For a resident who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the resident.

B. Support Resident Discharges and Transfers. The attending physician shall:

(1) Follow-up as needed with a physician or another health care practitioner at a receiving hospital within 24 hours of the transfer of an acutely ill or unstable resident;

(2) Provide whatever summary or documentation may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual; and

(3) Provide a pertinent medical discharge summary within 30 days of discharge or transfer of the resident.

C. Periodic, Pertinent On-site Visits to Residents. The attending physician or licensed or certified professional health care practitioner shall:

(1) Visit a resident as frequently as the resident’s condition requires, consistent with reasonable facility policies;

(2) Determine the progress of each resident’s condition at the time of a visit by evaluating the resident, talking with staff as needed, and reviewing relevant information, as needed;

(3) Review and respond to issues requiring a physician’s expertise, including:

(a) The resident’s current condition;

(b) The status of any acute episodes of illness since the last visit;

(c) Test results;

(d) Other actual or high-risk potential medical problems that may affect the individual’s functional, physical, or cognitive status; and

(e) Staff, resident, or family questions regarding the individual’s care and treatments; and

(4) At each visit, provide a legible progress note in a timely manner for placement on the chart, which includes relevant information about significant ongoing, active, or potential problems, including:
(a) Reasons for changing or maintaining current treatments or medications; and
(b) A plan to address relevant medical issues.

D. Timeliness of Visits and Progress Notes.

1. Within 30 days of admission, a physician shall visit a resident, assess the resident’s needs, and prescribe a regimen of medical care. After that, a physician, nurse practitioner, or physician assistant shall visit a resident every 30 days, except that a physician shall visit a resident at least every 120 days.

2. The timeliness of visits shall be based on a facility-developed protocol, depending on:
   (a) The resident’s medical stability;
   (b) Recent and previous medical history;
   (c) The presence of significant or previously unidentified medical conditions; or
   (d) Problems that cannot be handled readily by phone.

3. The physician or licensed or certified professional health care practitioner shall maintain progress notes and make appropriate revisions to the resident’s total program of care. The progress notes and revisions to the program of care shall cover, at a minimum, prognosis and changes in rehabilitation and other appropriate goals. The physician shall review and approve each program of care.

E. Alternate Schedule. If the physician determines that the resident’s condition requires less frequent visits than described in §D of this regulation, the physician may order an alternate schedule in the resident’s medical record. An alternate schedule may not be ordered for the resident’s first 90 days of stay. The alternate schedule may not exceed 60 days between visits. If there is no alternate schedule approved by the physician, visits may not exceed 30-day intervals.

F. Adequate Ongoing Coverage. The attending physician shall:

1. Designate an alternate physician or physicians who shall respond in an appropriate, timely manner if the attending physician is unavailable;

2. Update the facility about the attending physician’s current office address, phone, fax, and pager numbers to enable appropriate, timely communications, as well as the current office address, phone, fax, and pager numbers of designated alternate physicians;

3. Help ensure that alternate physicians provide adequate, timely support while covering and intervene with alternate physicians when informed of problems regarding coverage; and

4. Adequately inform alternate physicians about residents with active acute conditions or potential problems that may need medical follow-up during their on-call time.

G. Appropriate Care of Residents. The attending physician shall:
(1) Perform accurate, timely, and relevant medical assessments;

(2) Properly define and describe resident symptoms and problems, clarify and verify diagnoses, relate diagnoses to resident problems, and help establish a realistic prognosis and care goals;

(3) In consultation with the facility's staff:

(a) Determine appropriate services and programs for a resident, consistent with diagnoses, condition, prognosis, and resident wishes;

(b) Ensure that treatments are medically necessary and appropriate in accordance with nursing facility regulatory requirements; and

(c) Manage and document ethics issues consistent with relevant laws and regulations and with residents' wishes, including advising residents and families about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated;

(4) Respond in an appropriate time frame, based on a facility-developed protocol, to emergency and routine notification, to enable the facility to meet its clinical and regulatory obligations;

(5) Respond to notification of laboratory and other diagnostic test results in a timely manner, based on the resident's condition and clinical significance of the results;

(6) Analyze the significance of abnormal test results that may reflect important changes in the resident's status and explain the medical rationale for interventions or decisions not to intervene based on those results;

(7) Respond promptly to notification of, and assess and manage adequately, reported acute and other significant clinical condition changes in residents; and

(8) Ensure that individuals receiving palliative care have appropriate comfort and supportive care measures.

H. Appropriate, Timely Medical Orders. The attending physician shall:

(1) Provide timely medical orders based on an appropriate resident assessment, review of relevant pre-admission and post-admission information, and age-related and other pertinent risks of various medications and treatments;

(2) Provide sufficiently clear, legible written medication orders to avoid misinterpretation and potential medication errors, including:

(a) Medication strength and formulation, if alternate forms are available;

(b) Route of administration;

(c) Frequency and, if applicable, timing of administration; and
(d) Reason for which the medication is being given; and

(3) Institute safeguards to ensure the accuracy of verbal orders at the time the verbal orders are given and cosign the verbal orders in a timely fashion, but not later than the next visit to the resident.

I. Appropriate, Timely, and Pertinent Documentation. The attending physician shall:

(1) Provide documentation required to explain medical decisions, that promote effective care and allow a nursing facility to comply with relevant legal and regulatory requirements; and

(2) Complete death certificates in a timely fashion, including all information required of a physician.

### 10.07.02.11 Medical Director Qualifications.

A. Medical Director Qualifications. The nursing facility shall:

(1) Designate a medical director who has at least the following qualifications:

(a) A current license as a physician in this State;

(b) At least 2 years of experience or specialized training in the medical care of geriatric or chronically ill and impaired residents;

(c) Successful completion of a curriculum in physician management or administration from the American Medical Directors Association or another curriculum approved by the Department or its designee; and

(d) Privileges at a hospital in this State, participant in an HMO network, or credentialed by a credentialing organization approved by the Department;

(2) Have a written agreement with a medical director that specifies the medical director's duties and roles and the authority to adequately discharge those responsibilities; and

(3) Submit a copy of the medical director's credentials to the Department upon:

(a) The first license renewal of the facility after the effective date of this regulation; and

(b) A change in medical director.

B. The requirement specified in §A(1)(c) of this regulation becomes effective 3 years after the effective date of this regulation, but the medical director shall begin the educational process in physician management or administration within the first year from the date of employment as a medical director.
10.07.02.11-1 Medical Director Responsibilities.

A. General Responsibilities. The medical director is responsible for:

(1) Overall coordination, execution, and monitoring of physician services;

(2) Monitoring and evaluating the outcomes of the health care, including clinical and physician services provided to the facility’s residents; and

(3) Designating an alternate medical director with sufficient training and experience to perform the responsibilities of the medical director as described in the regulations of this chapter.

B. Practitioner Oversight. The medical director shall:

(1) Oversee all physicians and other licensed or certified professional health care practitioners who provide health care to the facility's residents;

(2) Ensure that there is a procedure for the review of the practitioners’ credentials and the granting of privileges for licensed or certified professional health care practitioners who treat residents of the nursing facility; and

(3) Recommend rules governing the performance of physicians and other licensed or certified professional health care practitioners who admit residents to the facility.

C. Defining the Scope of Medical Services.

(1) The medical director, in collaboration with the facility, shall recommend written policies and procedures that are approved by the licensee, delineating the scope of physician services and medical care.

(2) The facility shall make these policies and procedures available to a resident or resident’s representative upon admission and whenever a substantive change is made.

D. Ensuring Physician Accountability. The medical director, in collaboration with the facility, shall recommend policies and procedures that cover essential physician responsibilities to the residents and the facility, including:

(1) Accepting responsibility for the care of residents;

(2) Supporting resident discharges and transfers;

(3) Making periodic, pertinent resident visits in the facility;

(4) Providing adequate ongoing medical coverage;

(5) Providing appropriate resident care;

(6) Providing appropriate, timely medical orders;

(7) Providing appropriate, timely, and pertinent documentation;
(8) Advising residents and families about formulating advance directives; and

(9) Any other responsibilities as determined by the facility and the medical director.

E. Quality Assurance. The medical director shall actively participate in the facility's quality improvement process. Participation shall include:

(1) Regular attendance at, and reporting to, the facility's quality improvement committee meetings; and

(2) Routine participation in ongoing facility efforts to improve the overall quality of the clinical care, including facility efforts to evaluate and address the causes of various care-related problems and deficiencies cited by the Office of Health Care Quality.

F. Employee Health Oversight. The facility, in consultation with the medical director and other physicians, if necessary, shall establish and maintain surveillance of the health status of employees, including:

(1) Advising on the development and execution of an employee health program, which shall include provisions for determining that employees are free of communicable diseases according to current acceptable standards of practice; and

(2) Ensuring that the facility plans and implements required immunization programs.

G. Other Related Duties. The medical director shall perform other essential duties related to clinical care and physician practices, including:

(1) Advising the administrator and the director of nursing on clinical issues, including the criteria for residents to be admitted, transferred, or discharged from the nursing facility;

(2) Working with the nursing facility to establish appropriate relationships with area hospitals and other pertinent institutions to improve care of the residents;

(3) Advising and consulting with the nursing facility staff regarding communicable diseases, infection control, and isolation procedures, and serving as a liaison with local health officials and public health agencies that have policies and programs that may affect the nursing facility's care and services to residents;

(4) Providing or arranging for temporary physician services as needed to ensure that each resident has continuous physician coverage;

(5) Participating as appropriate in facility committee projects and meetings concerning clinical care and quality improvement that require physician input; and

(6) Educating or overseeing the education of, and informing, all attending physicians about their roles, responsibilities, and applicable rules and regulations.

H. Medical Director Oversight Plan.
(1) Based upon physician and medical director responsibilities in nursing facilities, as described in this chapter, the medical director shall develop and implement a plan describing how the medical director will carry out the responsibilities for the:

(a) Overall monitoring, coordination, and execution of physician services and medical care to residents of the nursing facility; and

(b) Systematic review of the quality of health care, including medical and physician services, provided to the facility’s residents.

(2) Minimum Requirements of the Plan. The medical director oversight plan shall include, at least, a plan to ensure that physicians:

(a) Accept appropriate responsibility for residents under the physicians’ care in the nursing facility;

(b) Provide appropriate, timely medical care consistent with widely identified medical principles relevant to the facility's population; and

(c) Provide appropriate, timely, and pertinent medical documentation and orders.

(3) Documentation Regarding Medical Director Activities.

(a) The medical director shall keep documentation regarding the medical director's activities in relation to designated responsibilities.

(b) The documentation required in this subsection may include:

(i) Notes;

(ii) Minutes;

(iii) Copies of faxes, letters, and telephone communications with attending physicians, other facility staff and departments, the administration, the governing body, and others regarding concerns, inquiries, and interventions.

(c) The documentation required in this subsection shall show evidence of the medical director's interventions and follow-up of the effectiveness of those interventions.

I. Quality Assurance Committee Minutes. Committee minutes shall reflect monthly input from the medical director regarding physician issues and general facility clinical care issues.

10.07.02.11-2 Facility’s Responsibilities in Relation to the Facility’s Medical Director.

A. The nursing facility shall:

(1) Be responsible for working with the medical director to ensure adequate resident care and practitioner performance;
(2) Inform the physician of explicit requirements as a medical director and assist the medical director in gaining the necessary information and tools to properly execute those responsibilities; and

(3) Ensure that the medical director has the necessary support and authority to perform medical director duties effectively and to hold practitioners accountable.

B. When the attending physician and medical director document a resident's medical need for a particular treatment, assistive device, or equipment, that treatment, assistive device, or equipment shall be provided by the facility unless the facility documents in the quality assurance committee minutes the reason or reasons why the treatment, assistive device, or equipment should not be provided.

C. When the attending physician and medical director agree that a particular facility-developed protocol is required to ensure that quality medical care is delivered to the facility's residents, that protocol shall be implemented unless the facility documents in the facility's patient care committee minutes the reason or reasons why the protocol should not be implemented.

D. Evaluation of Medical Director's Performance.

(1) The facility shall have a mechanism for evaluating the medical director's performance and for providing the medical director with feedback about that performance.

(2) The criteria for evaluation shall be based on explicit medical director responsibilities and shall facilitate the medical director's improvement and performance of functions and duties.

10.07.02.14-1 Special Care Units — General.

...E. Physician Coordinator.

(1) If the facility's medical director does not have special training and experience in the discipline of the assigned special care unit, the facility shall hire a physician who is appropriately trained and experienced to provide:

(a) Overall medical supervision of the special care unit; and

(b) Coordination of all services for the assigned special care unit.

10.07.02.14-2 Special Care Units—Respiratory Care Unit.

...C. Physician Coordinator. If the facility's medical director does not have special training and experience in diagnosing, treating, and assessing respiratory problems, the facility shall hire a physician who has the special knowledge and experience to provide:

(1) Overall medical supervision of the respiratory care unit; and

(2) Coordination of all services for the respiratory care unit.
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 that 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.

MICHIGAN
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R 325.20403 Admission policies.

...(2) A patient shall only be admitted to a home on the recommendation and referral of a physician licensed to practice in Michigan.
(3) Before but not later than at the time of admission of a patient, an attending physician shall be designated to be responsible for the medical care and supervision of the patient.

R 325.20601 Medical direction of patients.

Rule 601.

(1) The care of a patient admitted to a home shall be under the continuing direction of a physician licensed to practice in Michigan.

(2) The administrator of the home shall be responsible for assuring or promptly arranging for this continuing medical care and direction by a licensed physician.

(3) The name and telephone numbers of the attending licensed physician and the licensed physician to be called in case of emergency when the attending physician is not available shall be posted at each nursing station. The telephone numbers of the attending physician or his or her replacement in case of emergency shall be provided to the patient, guardian, or designated representative on request.

History: 1981 AACS.

R 325.20602 Medical examination of patients.

Rule 602.

(1) Except in the case of a Friday admission, in which case a patient shall be examined by a licensed physician within 72 hours, a patient admitted to a home shall be examined by a licensed physician within 48 hours after admission, unless the patient has been examined by a licensed physician within 5 days before admission and a copy of that examination is available in the home at the time of the patient’s admission.

(2) A written record of the clinical history and physical examination, together with a diagnosis and treatment plan, shall appear in the patient’s clinical record.

(3) The examination shall include a chest x-ray, unless a chest x-ray has been taken within 90 days of admission and a report of the results of that x-ray examination is available in the home at the time of the patient’s admission for inclusion in the patient’s clinical record.

History: 1981 AACS.

R 325.20603 Medical visits to patients.

Rule 603.
(1) A patient in a home shall be seen and, to the extent appropriate, shall be examined by a licensed physician at least once every 60 days, unless justified otherwise and documented by the attending physician in the patient's clinical record. At a minimum, a patient in a home shall be seen and, to the extent appropriate, shall be examined by the attending physician at least once in each 6-month period, and a record of each physician visit to a patient shall be recorded with pertinent clinical observations in the patient's clinical record by the physician.

(2) Not later than at the time of admission of a patient, an attending physician shall be designated to be responsible for the medical care and supervision of the patient. This shall not preclude a patient from also receiving health services from another provider of choice, unless medically contraindicated.

History: 1981 AACS; 1983 AACS.

R 325.20604 Treatment of patients.

Rule 604.

(1) Treatment rendered to a patient shall be in accordance with the specific or standing written orders of the attending licensed physician. Standing orders shall be reproduced in the patient's clinical record and shall be signed by the attending physician within 48 hours.

(2) Telephone or other verbal orders from the physician shall be written on the patient's clinical record by the licensed nurse in charge and shall be signed by that licensed nurse. Telephone or other verbal orders recorded by the licensed nurse in charge shall be countersigned by the physician within 48 hours.

History: 1981 AACS.

R 325.20605 Physicians' assistants in homes.

Rule 605.

(1) A physician's assistant working under the supervision of a licensed approved physician, as set forth in parts 170 and 175 of the code, may carry out appropriate delegated functions in a home in accordance with written policies of the home formally adopted by the governing body, owner, or operator.

(2) The written policies governing the functions of the physician's assistant within the home shall be consistent with law and rules applicable to the home, the physician's assistant, and the supervising physician.

(3) The physician's assistant shall not substitute for the licensed physician insofar as the overall responsibility for a patient's care is concerned.
(4) The physician’s assistant shall not be or function as an employee of the home and shall be limited to providing care for the patients of the supervising physician.

(5) The attending physician supervising a physician’s assistant shall be required to visit the patient in a home at intervals prescribed in law and rule; shall check, renew, or amend physician orders at prescribed intervals; shall review and participate in the development of patient care plans following admission and at prescribed intervals; and shall review, approve, and countersign all physician assistant entries in the clinical record. Orders written in the clinical record by the physician’s assistant shall be countersigned by the attending supervising physician within 48 hours.

History: 1981 AACS; 1983 AACS.

R 325.20606 Applicability.

Rule 606. The provisions of R 325.20601 to R 325.20605 shall apply to all homes, except those subject to the provisions of section 21707(2)(b) of the code.

History: 1981 AACS.

R 325.21203 Medical audits.

Rule 1203.

(1) The home, through its medical director, if applicable, and the participation of 1 or more attending physicians, shall complete at least 1 medical audit annually...

MINNESOTA

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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 303 Current 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.

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

HIST: 20 SR 303

Current as of 01/19/05
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.

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

HIST: 20 SR 303

Current as of 01/19/05

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.

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

HIST: 20 SR 303

Current as of 01/19/05
121 PHYSICIAN SERVICES

121.01 General. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility.

121.02 Designated physician. Each resident shall have a designated physician or nurse practitioner who is responsible for their care. In the absence of the designated physician or nurse practitioner, another physician or nurse practitioner shall be designated to supervise the resident medical care.

121.03 Emergency physician. The facility shall arrange for the provision of physician or nurse practitioner services twenty-four (24) hours a day in case of an emergency.

121.04 Physician visit. The resident shall be seen by a physician or nurse practitioner every sixty (60) days.

19 CSR 30-85.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

...(12) A supervising physician shall be available to assist the facility in coordinating the overall program of medical care offered in the facility. II

...(42) Each facility resident shall be under the medical supervision of a Missouri-licensed physician who has been informed of the facility's emergency medical procedures and is kept informed of treatments or medications prescribed by any other professional lawfully authorized to prescribe medications. I/II

(43) Facilities shall ensure that at the time the resident is admitted, the facility obtains from a physician the resident's primary diagnosis along with current medical findings and the written orders for the immediate care of the resident. II/III

(44) The facility shall ensure that the resident's private physician, the physician's designee, the facility's supervising physician or an alternate physician shall examine the resident at least annually, and shall examine
(45) For each medical examination, the physician must review the resident’s care, including medications and treatments; write, sign and date progress notes; and sign and date all orders. The facility shall establish a policy requiring the physician to sign orders and to complete all other documentation required if the physician does not visit the resident routinely. II/III

**MONTANA**

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Montana regulations do not include specific content for Physician Services.

**NEBRASKA**

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12-006.03 Medical Director: The facility must designate a physician to serve as medical director. The medical director is responsible for:

1. Ensuring adequate medical practitioner availability and support;

2. Ensuring effective medical practitioner and facility compliance with requirements;

3. Evaluating and improving the quality of the care; and

4. Evaluating and improving the quality of the systems and processes that influence the care.

12-006.08 Medical Services: The facility must ensure that the medical care of each resident is supervised by a medical practitioner and that another medical practitioner supervises the medical care of the residents when their attending medical practitioner is unavailable.

12-006.08A Admission Criteria: The facility must ensure that each individual admitted to the facility has written approval of a recommendation for admittance to the facility by a medical practitioner. Each resident admitted to the facility must have a history and physical
examination completed by a medical practitioner within 30 days prior to or 14 days after admission. Each resident must remain under the care of a medical practitioner.

12-006B Medical Practitioner Responsibilities: The medical practitioner must:

1. Review the resident’s total program of care, including medications and treatments, at each visit required;
2. Write, sign and date progress notes at each visit;
3. Sign any order he/she gives.

NEVADA

Downloaded January 2011

NAC 449.74513 Medical director. (NRS 449.037)
1. A facility for skilled nursing shall employ a medical director who is licensed to practice medicine in this State.
2. The medical director shall:
   (a) Carry out the policies of the facility related to the medical care of its patients; and
   (b) Coordinate the medical care provided by the facility.
(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99).

NAC 449.74515 Physicians. (NRS 449.037)
1. A patient may be admitted to a facility for skilled nursing only upon the written approval of a physician. Upon a patient’s admission to the facility, the facility shall ensure that orders for the immediate care of the patient have been received from the patient’s attending physician.
2. Each patient admitted to a facility for skilled nursing must remain under the care of a physician.
3. A facility for skilled nursing shall ensure that:
   (a) The medical care of each patient in the facility is supervised by a physician; and
(b) A physician other than the attending physician of a patient supervises the care of that patient when the attending physician is not available.

4. A patient in a facility for skilled nursing must be visited by a physician at least once every 30 days for the first 90 days after his admission to the facility, and at least once every 60 days thereafter. For the purposes of this subsection, a visit from a physician shall be deemed to be timely if it occurs not later than 10 days after the date on which the visit is required. Except as otherwise provided in this section, each visit required by this subsection must be made by the physician.

5. At each visit to a patient required by subsection 4:

(a) The patient’s plan of care must be reviewed, including, without limitation, the medications and treatments prescribed for the patient;

(b) Progress notes of the visit must be prepared, signed and dated; and

(c) Any orders for the treatment of the patient must be signed and dated.

6. After the initial visit to a patient is made by a physician, every other visit to the patient may be made by a physician assistant, nurse practitioner or clinical nurse specialist on behalf of the physician if the physician assistant, nurse practitioner or clinical nurse specialist is acting:

(a) Within the authorized scope of his practice and under the supervision of the physician; and

(b) In accordance with state law and the policies of the facility for skilled nursing.

7. A facility for skilled nursing shall provide or arrange for the provision of physicians’ services 24 hours a day in the case of an emergency.

(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

NEW HAMPSHIRE

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He-P 803.14 Duties and Responsibilities of All Licensees.

...(i) Licensees shall:

...(5) Appoint a medical director who shall meet the requirements of He-P 803.17(a)...
He-P 803.15  Required Services

(f) At the time of a resident’s admission, the licensee shall obtain orders from a licensed practitioner for medications, prescriptions, and diet.

(g) The licensee shall have each resident obtain a health examination by a licensed practitioner within 30 days prior to or 48 hours after admission to the nursing home and every 90 days thereafter.

(h) The health examination referenced in (g) above shall include:

(1) Diagnoses, if any;

(2) Medical history;

(3) Medical findings, including the presence or absence of communicable disease;

(4) Vital signs;

(5) Prescribed and over-the-counter medications;

(6) Allergies; and

(7) Dietary needs.

NEW JERSEY

Downloaded January 2011

8:39-23.2 Mandatory medical services

(a) Each physician or advanced practice nurse order shall be properly entered into the resident’s medical record.

(b) Each resident’s attending physician or advanced practice nurse shall review the resident’s medical record on a scheduled basis to ensure that care plans and medical orders are properly followed.

(c) The facility shall maintain a list of consultant physicians who are available for referrals made by the attending physician and shall make arrangements for referrals to psychological services.

(d) A physician or advanced practice nurse shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30-day visits may be delegated by a physician to a New Jersey licensed physician assistant, in accordance with facility policies.
8:39-23.3 Defibrillator

(a) The facility shall maintain at least one defibrillator available to trained staff in a central location.

(b) The facility shall have a written protocol on the use of the defibrillator. The protocol shall address:

1. The testing and maintenance of the defibrillator according to the manufacturer’s operational guidelines; and

2. The training of staff in the use of the defibrillator.

(c) The facility shall arrange and pay for the training of a sufficient number of direct-care staff in cardio-pulmonary resuscitation and the proper use of the defibrillator to ensure that at least one direct-care staff member on every shift holds a current certification from the American Red Cross, American Heart Association or other training program recognized by the Department in cardio-pulmonary resuscitation and the use of the defibrillator.

(d) The facility shall notify the appropriate first aid, ambulance or rescue squad or other appropriate emergency medical services provider of the type of defibrillator acquired and its location.

SUBCHAPTER 24. ADVISORY MEDICAL SERVICES

8:39-24.1 Advisory medical staff qualifications

The medical director is board-certified in a primary care specialty, such as family medicine, gerontology, or general internal medicine.

8:39-24.2 Advisory resident medical services

(a) The facility arranges for physician or advanced practice nurse visits in the facility on a scheduled appointment basis in an office provided for that purpose.

(b) The facility has a staff or consultant psychiatrist with admitting privileges to the inpatient psychiatric unit at a hospital.

NEW MEXICO

Downloaded January 2011

7.9.2.37 PROCEDURES FOR ADMISSION OF RESIDENTS:
...B. "PHYSICIANS ORDERS": No person may be admitted as a resident except upon:

(1) Order of a physician.

(2) Receipt of information from a physician, before or on the day of admission, about the person's current medical condition and diagnosis, and receipt of a physician's initial plan of care and orders from a physician for immediate care of the resident; and

(3) Receipt of certification in writing from a physician that the person is free of active tuberculosis and clinically apparent communicable disease the person may be found to have.

7.9.2.44 TREATMENT AND ORDERS:

A. ORDERS:

(1) Restriction. Medications, treatments and rehabilitative therapies shall be administered as ordered by a physician or dentist subject to the resident's rights to refuse them. No medication, treatment or changes in medication or treatment may be administered to a resident without a physician's or dentist's written order which shall be filed in the resident's clinical record, except as provided in this section.

(2) Verbal orders: Verbal orders from physicians or dentists may be accepted by a nurse or pharmacist, or, in the case of verbal orders for rehabilitative therapy, by a therapist. Verbal orders shall be immediately written, signed and dated by the nurse, pharmacist or therapist on a not specifically limited as to time or number of doses when ordered shall be automatically stopped in accordance with the stop order policy required by Subsection A of 7.9.2.57 NMAC of these regulations.

(3) Notice to physicians or dentists: Each resident's attending physician or dentist shall be notified of stop order policies and contacted promptly for renewal of orders which are subject to automatic termination.

7.9.2.48 MEDICAL DIRECTION IN SKILLED CARE FACILITIES:

A. MEDICAL DIRECTOR: Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

B. COORDINATION OF MEDICAL CARE: Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall be responsible for development of written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities
of attending physicians. If there is an organized medical staff, by-laws also shall be
developed by the medical director and approved by the licensee. Coordination of medical
care shall include liaison with attending physician to provide that physicians’ orders are
written promptly upon admission of a resident, that periodic evaluations of the adequacy
and appropriateness of health professional and supportive staff and services are conducted,
and that the medical needs of the residents are met.

C. RESPONSIBILITIES TO THE FACILITY: The medical director shall monitor the health
status of the facility's employees. Incidents and accidents that occur on the premises shall
be reviewed by the medical director to identify hazards to health and safety. [7-1-60, 5-2-
89; 7.9.2.48 NMAC - Rn, 7 NMAC 9.2.48, 8-31-00]

7.9.2.49 PHYSICIAN SERVICES IN ALL FACILITIES: The facility shall assure that the
following services are provided:

A. ATTENDING PHYSICIANS: Each resident shall be under the supervision of a physician of
the resident’s or guardian’s choice who evaluates and monitors the resident’s immediate
and long-term needs and prescribes measures necessary for the health, safety and welfare
of the resident. Each attending physician shall make arrangements for the medical care of
the physician’s residents in the physician's absence.

B. PHYSICIAN'S VISIT:

(1) Each resident who requires skilled nursing care shall be seen by a physician at least
every thirty (30) days and an intermediate care resident at least every sixty (60) days
unless the physician specifies and justifies in writing an alternate schedule of visits.

(2) The physician shall review the plan of care required at the time of each visit.

(3) The physician shall review the resident’s medications and other orders at least at the
time of each visit.

(4) The physician shall review the resident’s medications and orders at least at the time of
each visit.

C. AVAILABILITY OF PHYSICIANS FOR EMERGENCY PATIENT CARE: The facility shall have
written procedures, available at each nurse's station, for procuring a physician to furnish
necessary medical care in emergencies and for providing care pending arrival of a
physician. The names and telephone numbers of the physicians or medical service
personnel available for emergency care shall be posted at each nursing station.

[7-1-60, 5-2-89; 7.9.2.49 NMAC – Rn, 7 NMAC 9.2.49, 8-31-00]

NEW YORK
Section 415.15 - Medical services

415.15 Medical services. The nursing home shall develop and implement medical services to meet the needs of its residents.

(a) Medical director. The facility shall designate a full-time or part-time physician to serve as medical director. The medical director shall be responsible for:

(1) implementation of resident medical care policies;

(2) the coordination of physician services and medical care in the facility;

(3) coordinating the review, prior to granting or renewing professional privileges or association, of any physician, dentist or podiatrist as required by Public Health Law Section 2805-k. Hospital-based nursing homes may utilize the hospital's medical staff membership review system to facilitate this review. Such review shall be coordinated with the activities of the Quality Assessment and Assurance Committee established in section 415.27 of this Part and shall:

(i) provide for the maintenance and continuous collection of information concerning the facility's experience with negative health care outcomes and incidents injurious to residents, resident grievances, professional liability premiums, settlements, awards, costs incurred by the facility for resident injury prevention and safety improvement activities;

(ii) periodically reconsider the credentials, physical and mental capacity and competency in delivery of health care services of all physicians, dentists or podiatrists who are employed or associated with the facility;

(iii) gather information concerning individual physicians, dentists and podiatrists within the individual physician's, dentist's or podiatrist's personnel file maintained by the facility; and

(iv) prior to renewal of privileges of physicians, dentists, or podiatrists, solicit and consider information provided by the Resident Council about each such practitioner; and

(4) assuring that each resident's responsible physician attends to the resident's medical needs, participates in care planning, follows the schedule of visits maintained in accordance with subdivision (b) of this section, and complies with facility policies. When a physician fails to provide services which meet generally accepted standards of practice, the medical director shall take necessary corrective measures and refer the matter to the Office of Professional Medical Conduct of the Department as appropriate.

(b) Physician services. The facility shall ensure that a physician personally approves a recommendation that an individual be admitted to a nursing home. Each resident shall remain under the care of a physician and shall be provided care that meets prevailing standards of medical care and services.
(1) Physician supervision. The facility shall ensure that:
   (i) the medical care of each resident is supervised by a physician who assumes the principal
       obligation and responsibility to manage the resident’s medical condition and who agrees to
       visit the resident as often as necessary to address resident medical care needs; and
   (ii) another physician supervises the medical care of residents when the resident’s
       attending physician is unavailable.

(2) Physician visits and responsibilities. The facility shall ensure that the responsible
    physician:
   (i) participates as a member of the interdisciplinary care team in the development and
       review of the resident’s comprehensive care plan with the understanding that the minimum
       level of physician participation in interdisciplinary development and review of the care plan
       shall be a person-to-person conference with the registered professional nurse who has
       principal responsibility for development and implementation of the resident’s care plan;
   (ii) visits the resident whenever the resident’s medical condition warrants medical
       attention and establishes and maintains a schedule of visits appropriate to the resident’s
       medical condition. The frequency of visits shall be no less often than once every 30 days for
       the first 90 days after admission, and at least once every 60 days thereafter;
   (iii) reviews the resident’s total program of care, including medications and treatments, at
       each regularly scheduled visit;
   (iv) prepares, authenticates and dates progress notes at each visit;
   (v) authenticates and dates all orders;
   (vi) provides residents and designated representatives with his or her name, office address
       and telephone number and responds to calls from residents to discuss the resident’s
       medical care;
   (vii) participates in facility training programs to familiarize him or herself with State
       regulations and facility policies;
   (viii) is informed of the results of all Department of Health surveys related to medical
       service deficiencies and is involved in resolving such problems; and
   (ix) at the option of the physician and the facility, scheduled visits after the initial visit may
       alternate between personal visits by the responsible physician and visits by a registered
       physician’s assistant or certified nurse practitioner in accordance with paragraph (4) of this
       subdivision.

(3) Availability of physicians for emergency care. The facility shall provide or arrange for
    the provision of physician services 24 hours a day, in case of an emergency.

(4) Physician delegation of tasks. (i) Except as specified in subparagraph (ii) of this
    paragraph, a facility may permit a physician to delegate tasks to a registered physician’s
    assistant or certified nurse practitioner who:
    (a) meets the applicable requirements of Part 94 of this Title or is certified as a nurse
        practitioner, respectively;
    (b) is acting within the scope of practice as defined by State law; and
    (c) is under the supervision of the physician.
    (ii) The facility shall not permit a physician to delegate a task when the regulations specify
        that the physician must perform it personally or when the delegation is prohibited by the
        facility’s own policies.

Volume: C
(i) Admission Policies and Practices.

(1) The nursing home shall:

(i) admit a resident only on physician’s orders and in accordance with the resident assessment criteria and standards as promulgated and published by the department, and specified in sections 86-2.30(i) 400.12 of this Title...

NORTH CAROLINA

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10A NCAC 13D .2202 ADMISSIONS

(a) No patient shall be admitted except by a physician or other persons legally authorized to admit patients. Admission shall be in accordance with facility policies and procedures.

...(c) The facility shall acquire, prior to or at the time of admission, orders for the immediate care of the patient from the admitting physician or other person legally authorized to admit.

(d) Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnosis, and a summary of the hospital stay if the patient is being transferred from a hospital.

(e) If a patient is admitted from somewhere other than a hospital, the facility shall acquire a copy of the patient’s most recent medical history and physical, which shall have been updated within the preceding six months.


10A NCAC 13D .2206 MEDICAL DIRECTOR

(a) The facility shall designate a physician to serve as medical director.

(b) The medical director shall be responsible for implementation of patient care policies and coordination of medical care in the facility.

History Note: Authority G.S. 131E-104;

RRC objection due to lack of statutory authority Eff. July 13, 1995;

10A NCAC 13D .2501 AVAILABILITY OF PHYSICIAN’S SERVICES

(a) The facility shall ensure each patient’s care is supervised by a physician and that provisions are made for emergency physicians when attending physicians are unavailable. The names and telephone numbers of the designated physicians shall be posted at each nurse’s station.

(b) Patients shall be seen by a physician at least once every 30 days for the first 90 days and at least every 60 days thereafter. Following the initial visit, the physician may delegate this responsibility to a physician assistant or nurse practitioner every other visit. A physician’s visit is considered timely if the visit occurs not later than 10 days after the visit was required.

(c) Physicians shall review the patient’s medical plan of care, write or dictate and sign progress notes; and sign and date all current orders at each visit.

(d) Medical orders, given orally by the physician, nurse practitioner or physician assistant, shall be given only to a licensed nurse or other licensed professional who by law is allowed to accept physician’s orders, except orders for therapeutic diets which shall be given either to a dietitian or licensed nurse. The record of each telephone order shall include the name of physician giving the order, or other person legally authorized to prescribe, date and time of order, content of order and name of person receiving the order. The physician, or other person legally authorized to prescribe, who gives oral orders shall sign the orders within five days.


10A NCAC 13D .2502 PRIVATE PHYSICIAN

(a) Each patient or legal representative shall be allowed to select his or her private physician except in those facilities affiliated with medical teaching programs and having written policies requiring all patients to participate in the medical teaching program.

(b) The private physician shall fulfill given requirements as determined by applicable state and federal regulations, and the facility’s policies and procedures pertaining to physician services.

(c) The facility shall have the right, after informing the patient, to seek an alternative physician, when requirements are not being met and to ensure that the patient is provided with appropriate, adequate care and treatment.

History Note: Authority G.S. 131E-104; Eff. January 1, 1996.
10A NCAC 13D .2503 USE OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

(a) If a facility employs physician assistants or nurse practitioners it shall maintain the following information for each nurse practitioner and physician assistant:

(1) a statement of approval to practice as a nurse practitioner by the Board of Medical Examiners and Board of Nursing for each practitioner, or a statement of approval to practice as a physician assistant by the Board of Medical Examiners for each physician assistant;

(2) verification of current approval to practice; and

(3) a copy of instructions or written protocols signed by the nurse practitioner or physician assistant and the supervising physicians.

(b) The privileges of the nurse practitioner or physician assistant shall be clearly defined by the facility's policies and procedures and shall be limited to those privileges authorized in 21 NCAC 32M for the nurse practitioner or 21 NCAC 32O for the physician assistant.

History Note: Authority G.S. 131E-104; Eff. January 1, 1996.

10A NCAC 13D .2506 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS

Facilities with ventilator dependent care patients shall contract with a physician who has specialized training in pulmonary medicine. This physician shall be responsible for respiratory services and shall:

(1) establish, with the respiratory therapist and nursing staff, appropriate ventilator policies and procedures, including emergency procedures;

(2) assess each ventilator-dependent patient's status at least monthly with corresponding progress notes;

(3) be available on a emergency basis; and

(4) participate in individual patient care planning.

33-07-03.2-07. Governing body.

5. The governing body shall ensure the development and implementation of written resident care policies, procedures, and practices including:

a. Admission or retention policies which ensure:

... (2) Residents are admitted to the facility only by the order of a licensed health care practitioner.

(3) Resident information, including current medical findings, diagnosis, and orders from the licensed health care practitioner for immediate care of the resident are available to the facility prior to or at the time of admission.

(4) Other pertinent information including family history and past medical history is received from the licensed health care practitioner within forty-eight hours of admission.

(5) A physical examination of the resident is performed by the licensed health care practitioner within five days prior to admission or within forty-eight hours after admission, unless the licensed health care practitioner documents the current examination remains accurate.

(6) Each resident in the facility is under the supervision of a licensed health care practitioner.

(a) Licensed health care practitioners shall visit residents as often as medically indicated, but no less frequently than annually.

(b) Orders must be signed by the licensed health care practitioner at the time of each visit.

(c) Progress notes must be written or dictated at the time of each visit and signed within a timeframe as determined by the facility, not to exceed thirty days.

33-07-03.2-13. Medical services.

1. The facility shall have a licensed physician who is specified as the medical director or a medical staff organized under bylaws and rules approved by and responsible to the governing body. The medical director or medical staff shall be responsible for the quality of all medical care provided to residents and for the ethical and professional practices of its members.

2. The duties and responsibilities of the medical director or medical staff
must be delineated in a formal agreement with the governing body.

3. The medical director or medical staff shall be involved in the
development of written medical staff policies which are approved
by the governing body, which delineate the responsibilities of licensed
health care practitioners.

4. The medical director or a member of the medical staff shall participate
in the quality improvement and infection control program meetings.

History: Effective July 1, 1996.

General Authority: NDCC 23-01-03, 28-32-02

Law Implemented: NDCC 23-16-01, 28-32-02

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OHIO

3701-17-13 Medical supervision.

(A) Each nursing home operator shall arrange for the services of a physician to serve as the
home’s medical director, the medical director shall:

(1) In collaboration with the administrator, the nursing director, and other health
professionals, develop formal resident care policies for the nursing home that:

(a) Provide for the total medical and psycho-social needs of the resident, including
admissions, transfer, discharge planning, range of services available to the resident,
emergency procedures and frequency of physician visits in accordance with resident needs
and the applicable requirements of Chapter 3721. of the Revised Code and of rules 3701-17-
01 to 3701-17-26 of the Administrative Code.

(b) Promote resident rights as enumerated in section 3721.13 of the Revised Code.

(2) Make available medical care for residents not under the care of their own physicians and
to make available emergency medical care to all residents, provided their personal
physicians are not readily available.

(3) Meet periodically with nursing and other professional staff to discuss clinical and
administrative issues, including the need for additional staff, specific resident care problems
and professional staff needs for education or consultants to assist in meeting special needs
such as dentistry, podiatry, dermatology, and orthopedics, offer solutions to problems, and identify areas where policy should be developed. In carrying out this function, the medical director shall:

(a) Observe residents and facilities at least quarterly or more frequently as needed; and

(b) Review pharmacy reports, at least quarterly, including summaries of drug regimen reviews required by paragraph (H) of rule 3701-17-17 of the Administrative Code and the quality assurance activities required by paragraph (D) of rule 3701-17-06 of the Administrative Code, and take appropriate and timely action as needed to implement recommendations.

(4) Monitor the clinical practices of, and discuss identified problems with, attending physicians; act as a liaison between the attending physicians and other health professionals caring for residents and the residents' families; and intervene as needed on behalf of residents or the home’s administration.

(5) Maintain surveillance of the health of the nursing home's staff.

(6) Assist the administrator and professional staff in ensuring a safe and sanitary environment for residents and staff by reviewing incidents and accidents, identifying hazards to health and safety, and advising about possible correction or improvement of the environment.

(B) The nursing home shall not give any medication or treatment to any resident unless ordered by a physician or by other licensed health professionals, acting within their applicable scope of practice. If orders are given by telephone, they shall be recorded with the licensed health professional's name and the date, and the order and signed by the person who accepted the order. All orders, including facsimile, telephone, or verbal orders, shall be signed and dated by the physician or other licensed health professional working in collaboration with the physician who gave the order within fourteen days after the order was given.

(1) Telephone orders shall not be accepted by a person other than a licensed nurse on duty, another physician or a pharmacist, except that a licensed physical, occupational or respiratory therapist, audiologist, speech pathologist, dietitian, or other licensed health professional may receive, document and date medication and treatment orders concerning his or her specific discipline for residents under their care, to the extent permitted by applicable licensing laws.

(2) The nursing home may accept signed orders issued by a licensed health professional having prescriptive authority by facsimile transmission if the home has instituted procedural safeguards for authenticating and maintaining confidentiality of the facsimile order, and for handling it in an expedient and priority manner.

(3) An entry that is an electronic record as defined in section 3701.75 of the Revised Code may be authenticated by an electronic signature in accordance with section 3701.75 of the Revised Code.
(C) Each resident of a nursing home shall be under the supervision of a physician. Each resident of a nursing home shall be evaluated by a physician at least once every thirty days for the first ninety days after admission or three evaluations. After this period, each resident of a nursing home shall be evaluated by a physician at least every sixty days, except that if the attending physician documents in the medical record why it is appropriate, the resident may be evaluated no less frequently than once every one hundred twenty days.

(1) The evaluations required by this rule shall be made by the physician personally except after the initial thirty day evaluation, at the option of the physician, evaluations may alternate between personal evaluations by the physician and personal evaluations performed by a licensed health professional, acting within their applicable scope of practice, who is working in collaboration with the physician. In conducting the evaluation, the physician or licensed health professional shall solicit resident input to the extent of the resident's capabilities.

(2) The physician or licensed health professional shall write a progress note after each evaluation depicting the current condition of the resident based upon consideration of the physical, mental and emotional status of the resident.

(3) A physician or licensed health professional visit is considered timely if it occurs no later than ten calendar days after the date the visit was required.

R.C. 119.032 review dates: 05/19/2006 and 05/01/2011 CERTIFIED ELECTRONICALLY_________ Certification 05/19/2006___ Date Promulgated Under: 119.03 Statutory Authority: 3721.04 Rule Amplifies: 3721.02, 3721.03, 3721.05, 3721.07 Prior Effective Dates: 11/15/1976, 9/30/88, 5/20/91, 12/21/92, 10/20/2001

OKLAHOMA

Downloaded January 2011

310:675-7-2.1. Medical director

The facility shall designate a licensed physician to serve as medical director. The medical director is responsible for implementation of resident medical care policies and the coordination of medical care in the facility.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-7-9.1. Written administrative policies and procedures

(j) The facility has the following responsibilities concerning physicians:
(1) The health care services for each resident shall be under a physician's supervision.

(2) All physician orders shall be written in ink or indelible pencil and signed by the physician.

(3) No medication or treatment shall be administered except on a physician's order.

(4) The facility shall have a written policy that provides for physician services to be available twenty-four hours per day.

(5) A list of physicians shall be posted at the nursing station for use if the resident's attending physician is not available.

(6) The facility shall arrange for one, or more, physicians to be available in an emergency and to advise the facility. The physician called at the time of any emergency shall be noted in the records. If unable to contact a physician, the resident shall be transferred to a hospital emergency room.

310:675-9-7.1. Physician services

Each resident shall be under the care of a licensed physician, who shall be responsible for the resident's overall medical care. The physician's duties shall include but not be limited to:

(1) Completing an admission history and physical that includes chief complaints, course of present illness, past medical history, and examination findings by body systems and diagnosis within two weeks of admission unless a physical was conducted within the previous sixty days.

(2) Prescribing diet, treatments and medications.

(3) Noting the resident's specific advance directives, if known.

(4) Continuing supervision, as required by the resident's care including, but not limited to:

(A) Writing progress notes at each visit.

(B) Visiting as needed.

(C) Participating in developing, and reviewing, the resident's care plan.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-13-4. Medical director
(a) The facility shall designate an Oklahoma licensed medical doctor or osteopathic physician to serve as its medical director.

(b) The medical director shall coordinate the medical services within the facility.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

OREGON

411-086-0040 Admission of Residents

(1) Admission Conditions:

...(b) No person shall be admitted to the facility except on the order of a physician;

(c) Admission medical information shall include a statement concerning the diagnosis and general condition of the resident, a medical history and physical, or a medical summary. Other pertinent medical information, orders for medication, diet, and treatments shall also be provided.

411-086-0200 Physician Services

(Effective 11/1/92)

(1) MEDICAL DIRECTOR. Each nursing facility shall have a physician medical director designated in writing. The medical director shall:

(a) Serve on the Quality Assessment and Assurance Committee; and

(b) Assist the facility to assure that adequate medical care is provided on a timely basis in accordance with facility policy (OAR 411-085-0210).

(c) Serve as attending physician for those residents who are not able to obtain services of another physician or ensure another physician is available to serve as attending physician.

(2) ATTENDING PHYSICIAN. Each resident shall be under the care of a physician who is responsible for the resident’s medical care.

(a) Physician Assistant. The physician may delegate tasks to a physician assistant pursuant to ORS Chapter 677 and rules adopted by the Board of Medical Examiners. The physician assistant must be under the direction and supervision of the resident’s physician.
(b) Nurse Practitioner. The physician may delegate tasks to a nurse practitioner pursuant to ORS Chapter 678 and the rules adopted by the Oregon State Board of Nursing.

(c) Clinical Nurse Specialist in Gerontological Nursing. The physician may delegate responsibilities identified in subsection (4)(a) of this rule to a registered nurse who is certified by the American Nurses Association’s Credentialing Center as a "Clinical Specialist in Gerontological Nursing." The specific tasks which may be delegated to the clinical nurse specialist are governed by the scope of practice as specified by the Oregon State Board of Nursing.

(d) Delegation.

(A) Except as provided in Section (4) of this rule, a physician may delegate tasks to a physician assistant, nurse practitioner or clinical nurse specialist who is acting within the scope of practice as defined by Oregon law and who is under the supervision of a physician. EXCEPT: A physician may not delegate a task in a Medicare-certified facility when federal regulations specify the physician must perform it personally.

(B) The physician assistant, nurse practitioner or clinical nurse specialist substituting for physician visits as described in Subsection (4)(a) of this rule may not be an employee of the nursing facility.

(3) MEDICATIONS AND TREATMENTS.

(a) Authorization. Physician’s orders shall either be initially written and signed by the physician, nurse practitioner (NP) or physician assistant (PA), or given verbally or by telephone. If given verbally or by telephone, the orders shall be accepted only by a licensed nurse and must be written and mailed to the physician, NP or PA within 72 hours to be signed and returned to the facility for filing in the resident’s chart.

(b) Promptly Carried Out. All physician orders shall be promptly carried out unless inconsistent with the resident’s expressed wishes.

(c) Orders Required. Medications and treatments shall be administered only on the order of a physician or a designee pursuant to ORS Chapters 677, 678, and 679 and the rules thereunder adopted.

(d) Standing Orders. Therapies and drugs not requiring prescription under ORS 689 may be ordered from standing orders of the attending physician, NP or PA. Therapies and drugs so ordered shall be reviewed and signed at least annually by the attending physician. Use of standing orders shall be authorized by licensed personnel and transcribed to the physician order form.

(4) PHYSICIAN VISITS.

(a) Frequency. Physician visits shall be according to resident’s needs. The physician shall comply with Medicare/Medicaid requirements when applicable. Physician visits shall conform to the following schedule:
(A) Medicare Facilities. For residents in Medicare certified facilities, each resident must be seen by the physician at least every 30 days for the first 90 days after admission, then every 60 days thereafter. If authorized by the physician, every other visit after the first visit may be conducted by a physician’s assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner.

(B) Medicaid Only Facilities. For residents in Medicaid certified facilities which are not certified for Medicare, each resident must be seen by the physician at least every 30 days for the first 90 days after admission, then every 60 days thereafter. If authorized by the physician, visits after the first visit may be conducted by a physician’s assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner; however, the physician must visit the resident at least annually.

(C) Licensed Only Facilities. For residents in all facilities which are not certified for either Medicaid or Medicare, each resident shall be visited by the physician every 30 days for the first 90 days, then every 180 days thereafter. If authorized by the physician, visits after the first visit may be conducted by a physician's assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner; however, the physician must visit the resident at least annually.

(D) Timely Visit. A visit required pursuant to Paragraph (4)(a)(A), (B), or (C) of this rule will be considered "timely" if it occurs not later than ten days after the date the visit was required.

(b) Assessments, Observation. The facility shall ensure a physician's assessment and determination of type of care needed is performed for each resident. The results and observations shall be recorded in the physician's progress notes at time of admission and at least annually thereafter.

(c) Policies. The facility shall establish policies to assure physician services are provided in all cases when the attending physician or his/her alternate physician cannot or does not respond to the resident's needs.

(d) Failure to Visit. If the physician or physician designee fails to visit the resident according to resident's need, fails to respond to requests for assistance in resident's care, or fails to return verbal or telephone orders reduced to writing and forwarded to the physician by the facility, then the facility administrator shall ensure:

(A) Reasonable and repeated attempts are made and documented in the clinical record to get the physician or physician designee to visit resident or return signed orders;

(B) The medical director is notified and the Quality Assessment and Assurance Committee reviews the situation;

(C) The County Medical Society, State Medical Society, and the Board of Medical Examiners are notified in writing of the problem;
(D) The Division is notified in writing of the physician’s failure to visit resident(s) or complete his/her progress notes or signed orders; and

(E) The resident and the resident’s significant other(s) are notified.

(e) Emergency Backup. Each facility shall provide for one or more physicians to be called in the event of a medical emergency. The names and telephone numbers of such physicians shall be posted at each nurses’ station.

(5) DOCUMENTATION. All physician orders, physician visits, and responses thereto shall be promptly documented in the resident’s clinical record.


Stats. Implemented: ORS 441.055 & 441.615

§211.2. Physician services.

(a) The attending physician shall be responsible for the medical evaluation of the resident and shall prescribe a planned regimen of total resident care.

(b) The facility shall have available, prior to or at the time of admission, resident information which includes current medical findings, diagnoses and orders from a physician for immediate care of the resident. The resident’s initial medical assessment shall be conducted no later than 14 days after admission and include a summary of the prior treatment as well as the resident’s rehabilitation potential.

(c) A facility shall have a medical director who is licensed as a physician in this Commonwealth and who is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to the residents. The medical director may serve on a full- or part-time basis depending on the needs of the residents and the facility and may be designated for single or multiple facilities. There shall be a written agreement between the physician and the facility.

(d) The medical director’s responsibilities shall include at least the following:

(1) Review of incidents and accidents that occur on the premises and addressing the health and safety hazards of the facility. The administrator shall be given appropriate information
from the medical director to help insure a safe and sanitary environment for residents and personnel.

(2) Development of written policies which are approved by the governing body that delineate the responsibilities of attending physicians.

Authority: The provisions of this § 211.2 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).


§ 211.3. Oral and telephone orders.

(a) A physician’s oral and telephone orders shall be given to a registered nurse, physician or other individual authorized by appropriate statutes and the State Boards in the Bureau of Professional and Occupational Affairs and shall immediately be recorded on the resident’s clinical record by the person receiving the order. The entry shall be signed and dated by the person receiving the order. Written orders may be by fax.

(b) A physician’s oral and telephone orders for care and treatments, shall be dated and countersigned with the original signature of the physician within 7 days of receipt of the order. If the physician is not the attending physician, he shall be authorized and the facility so informed by the attending physician and shall be knowledgeable about the resident’s condition.

(c) A physician’s telephone and oral orders for medications shall be dated and countersigned by the prescribing practitioner within 48 hours. Oral orders for Schedule II drugs are permitted only in a bona fide emergency.

(d) Oral orders for medication or treatment shall be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the responsible practitioner. An initial written order as well as a countersignature may be received by a fax which includes the practitioner’s signature.

(e) The facility shall establish policies identifying the types of situations for which oral orders may be accepted and the appropriate protocols for the taking and transcribing of oral orders in these situations, which shall include:

(1) Identification of all treatments or medications which may not be prescribed or dispensed by way of an oral order, but which instead require written orders.

(2) A requirement that all oral orders be stated clearly, repeated by the issuing practitioner, and be read back in their entirety by personnel authorized to take the oral order.
Identification of all personnel authorized to take and transcribe oral orders.

The policy on fax transmissions.

Authority

The provisions of this § 211.3 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source


§ 211.7. Physician assistants and certified registered nurse practitioners.

(a) Physician assistants and certified registered nurse practitioners may be utilized in facilities, in accordance with their training and experience and the requirements in statutes and regulations governing their respective practice.

(b) If the facility utilizes the services of physician assistants or certified registered nurse practitioners, the following apply:

1. There shall be written policies indicating the manner in which the physician assistants and certified registered nurse practitioners shall be used and the responsibilities of the supervising physician.

2. There shall be a list posted at each nursing station of the names of the supervising physician and the persons, and titles, whom they supervise.

3. A copy of the supervising physician’s registration from the State Board of Medicine or State Board of Osteopathic Medicine and the physician assistant’s or certified registered nurse practitioner’s certificate shall be available in the facility.

4. A notice plainly visible to residents shall be posted in prominent places in the institution explaining the meaning of the terms “physician assistant” and “certified registered nurse practitioner.”

(c) Physician assistants’ and certified registered nurse practitioners’ documentation on the resident’s record shall be countersigned by the supervising physician within 7 days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, medications and any other notation made by the physician assistant or certified registered nurse practitioner.
(d) Physicians shall countersign and date their verbal orders to physician assistants or certified registered nurse practitioners within 7 days.

(e) This section may not be construed to relieve the individual physician, group of physicians, physician assistant or certified registered nurse practitioner of responsibility imposed by statute or regulation.

Authority

The provisions of this § 211.7 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source


RHODE ISLAND

Downloaded January 2011

Section 13.0 Medical Director and Attending Physicians

13.1 The governing body or other legal authority shall designate a physician to serve as medical director. The medical director shall be a physician licensed to practice in Rhode Island in accordance with the provisions of reference 27 herein. Upon appointment, the name of the medical director shall be submitted to the Department. Each time a new medical director is appointed, the name of said physician shall be reported promptly to the Department. The medical director's Rhode Island medical license number, medical office address, telephone number, emergency telephone number, hospital affiliation and other credentialing information shall be maintained on file at the facility and updated as needed.

Duties and Responsibilities of the Medical Director

13.2 Responsibilities of the medical director shall include, but not be limited to:

a) coordination of medical care in the facility, b) ensuring completion of employee health screening and immunization requirements contained in sections 14.11 and 14.12 herein. c) the implementation of facility policies and procedures related to the medical care...
delivered in the facility; d) physician and advanced practice practitioner credentialing; e) practitioner performance reviews; f) employee health including infection control measures; g) evaluation of health care delivery, including oversight of medical records and participation in quality improvement; h) provision of staff education on medical issues; i) participation in state survey process, including the resolution of deficiencies, as needed.

13.3 The medical director, charged with the aforementioned duties and responsibilities for the delivery of medical care in the nursing facility, shall be immune from civil or criminal prosecution for reporting to the Board of Medical Licensure and Discipline the unprofessional conduct, incompetence or negligence of a nursing facility physician or limited registrant; provided, that the report, testimony, or other communication was made in good faith and while acting within the scope of authority conferred by this section.

13.4 The administrator shall notify the medical director immediately when any enforcement order as described in section 9.0 herein is issued by the Department or when the administrator is notified of any Medicare/Medicaid certification enforcement action. The administrator shall provide copies of all statements of deficiencies and related plans of correction to the medical director in a timely fashion.

13.5 The medical director shall attend the quarterly quality assurance/improvement meetings, as required in section 10.7 (d) herein. The administrator, or his/her designee, shall provide the medical director with adequate notice of the quarterly quality assurance/improvement meeting.

13.6 Each nursing facility shall maintain an active file of all physicians attending residents for any reason(s), including their phone numbers and addresses, an emergency phone number, their current medical license numbers, and the physician's preferred admitting hospital. This file of physicians shall be revised and updated, as needed, but no less than annually.

13.7 The governing body or other legal authority shall make available to each physician attending residents in the facility all of the policies governing resident care management and services.

Section 21.0 Resident Care Policies

21.5 Resident care policies shall be available for review by all residents, physicians, community agencies, relatives and personnel and shall include provisions for at least the following:

...d) the frequency of physician visits shall be at a minimum of 90 days

Section 23.0 Physician Service
23.1 All residents shall remain or be under the care of a physician of his or her choice, subject to the physician’s concurrence.

23.1.1 All physician assistant services shall be in accordance with the provisions of Chapter 5-54 of the General Laws.

23.1.2 All nurse practitioner services shall be in accordance with the provisions of Chapter 5-34 of the General Laws.

23.2 No less than the following resident care information shall be made available to facilities by the referring source prior to or upon admission and provided only in accordance with the requirements of reference 17: 44

a) current medical findings;

b) summary of pre-admission treatment and care; and

c) diagnosis and medical orders by the physician for immediate resident care.

23.3 Each facility shall establish and comply with policies governing medical care supervision. Such policies shall include no less than the following:

a) that every resident be under the continued medical supervision of a physician of his or her choice;

b) that a prescribed medical care plan be established for each resident by the attending physician. Accordingly, recommendations or orders from consultants shall be approved by the attending physician prior to implementation of the order.

c) that the medical care plan be based on a physical examination done within 48 hours of admission unless such was performed within 5 days prior to admission;

d) that each resident be seen by an attending physician and the medical care plan be renewed or revised in accordance with the needs of the resident at least every 90 days;

e) that arrangements be made for physician coverage in the absence of the attending physician; and, and progress notes be written and signed by the physician at the time of each visit.

f) any physician's verbal order for drugs, and biologicals shall be given in accordance with the provisions of section 25.8 (b) herein.

23.4 Written policies and procedures pertaining to emergency medical care including a listing of physician coverage, shall be established and maintained at each nursing station. The facility must provide or arrange for physician's services 24 hours a day in case of an emergency.
23.5 Standing orders shall not be permitted. All orders shall be recorded in the resident’s medical record and shall be properly signed. However, a physician’s order for an individual resident may refer to treatments described in a written protocol adopted by the facility. An exception to the requirements of this section shall be made for the administration of influenza and pneumococcal immunizations as provided in section 22.5 herein.

SOUTH CAROLINA

Downloaded January 2011

605. Medical Staff (I)

The facility shall have a medical director who is a physician who shall be responsible for implementation of policies and procedures that pertain to the care and treatment of the residents and the coordination of medical care in the facility.

802. Physician Orders (II)

A. Physician Orders. The resident’s physician shall sign and date all treatment, care, and medication orders, including standing orders.

1. The use of a rubber stamp signature or electronic representation is acceptable under the following conditions:

   a. The physician whose signature the rubber stamp or electronic representation denotes is the only one who has possession of the stamp or electronic representation and is the only one who uses it; and

   b. The physician places in the administrative offices of the facility a signed statement to the effect that he or she is the only one who has the stamp or electronic representation and is the only one who will use it.

1. The use of rubber stamp signatures is not permissible on orders for “controlled substances.”

2. Consultative reports and diagnostic procedures requested by a physician, e.g., radiological, laboratory reports, shall be acknowledged by the physician signature. (I)

B. Verbal Orders. (I)

1. All orders for medication, treatment, care and diet shall be signed and dated by the individual receiving the orders.
2. Verbal orders received shall include the date of the order, description of the order, and identification of the physician or other legally authorized healthcare provider and the individual receiving the order.

3. Verbal orders in other specialized departments or services, as authorized in facility policy and procedures, may be received by those departments or services, e.g., orders pertaining to physical therapy may be received by a physical therapist.

4. A committee (to include representation by physicians treating residents at the facility, a pharmacist, and the Director of Nursing) shall identify and list categories of diagnostic or therapeutic verbal orders (associated with any potential hazard to the resident) that shall be authenticated by the prescriber within a limited time period (within two (2) days after the order is given). A copy of this list shall be maintained at each staff work area.

   a. Verbal orders designated by the committee as requiring authentication within a limited time period shall be authenticated and countersigned and dated by the prescriber or designee within a time period defined in facility policies and procedures, but in no case more than two (2) days after the order was given.

   b. All other verbal orders shall be countersigned and dated by the prescriber or his or her designee within sixty (60) days.

   c. Verbal orders for restraints shall be authenticated in the manner prescribed in Section 1012.B.

C. Standing Orders. (I)

1. Physician’s standing orders, except for restraints, are permissible but shall take into consideration specific circumstances such as medication allergies, gender-specific orders, and the pertinent physical condition of the resident, when appropriate.

2. Over-the-counter medications may be utilized on a physician’s standing orders. Controlled or legend medications shall be an individual order reduced to writing on the physician’s order sheet as either a routine or pro re nata (prn) order and shall not be utilized on a physician’s standing order unless the medications have been identified by the facility as those commonly used in routine situations. Each standing order shall include on the order sheet the following, as appropriate:

   a. Name of the medication;

   b. Strength of the medication;

   c. Specific dose (or dose range) of the medication;

   d. Mode of administration;

   e. Reason for administration;

   f. Time interval between doses for administering the medication; and
g. Maximum dosage or number of times to be administered in a specific time period.

3. Standing orders shall be signed and dated by the prescribing physician initially and reviewed at least annually thereafter.

D. Standing orders regarding restraints are prohibited.

901. General

...C. Residents and/or outpatients shall be admitted to the facility only on physician orders and all care rendered under his or her direction. In the institutional nursing home setting, individuals living on that campus, but outside the nursing home may be admitted by the administrator, provided that the admission is authorized by physician order within two (2) business days of admission. (I)

D. A medical history and physical examination shall be completed in the manner prescribed in Section 1201. (II)

1004. Physician Services (II)

A. Each resident or responsible party shall designate a physician licensed to practice in South Carolina for the supervision of the care and treatment of the resident.

1. Residents shall be seen by the attending physician at least once every sixty (60) days, unless more frequent visits are indicated. As an exception, another legally authorized healthcare provider who is authorized by the attending physician in writing, may make the sixty (60) day visits and the resident or the resident's responsible party shall be notified in writing of the person who will be making the visits in lieu of the attending physician.

2. A facility shall not restrict a resident's or responsible party's choice in attending physician coverage, provided that the physician agrees to, and demonstrates that he or she will provide care in accordance with facility policies and procedures.

B. Residents who have an attending physician licensed in a state other than South Carolina shall have thirty (30) days from admission to establish an attending physician licensed in South Carolina. (I)

C. Each resident shall be informed of the name, specialty, and a way of contacting the physician responsible for his or her care.

D. At least one (1) physician shall be available on call at all times.
44:04:04:07. Admissions of patients or residents...

...A nursing facility may admit and retain patients or residents only on the orders of a physician.


CHAPTER 44:04:05

PHYSICIAN SERVICES

44:04:05:01.01. Admissions to nursing facilities. Each resident admitted to a nursing facility may be admitted only on the order of a physician. Prior to or upon admission of a resident, the attending physician must provide the staff of the facility with documented information regarding current medical findings and with written orders for the immediate care of the individual. This information must include a medical evaluation, diagnosis, and rehabilitation potential. The information on the resident must be based on a physical examination done within 48 hours after admission unless the examination was performed within the five days prior to admission. The resident's health care shall continue under the supervision of a physician. If a resident transfers from one nursing facility to another while retaining the same physician, the requirement for the physical examination shall be waived; however, the schedule for physician visits shall continue.

The resident must be seen by the attending physician at least once every 30 days for the first 90 days following admission. Subsequent to the 90th day following admission, the physician shall visit the resident whenever necessary; but the time between visits may not exceed 60 days. A physician extender may conduct every other visit with the resident’s permission.

The resident's total care program including medications and treatments must be reviewed during the physician's visits.


General Authority: SDCL 34-12-13.
Law Implemented: SDCL 34-12-13.

44:04:05:02. Medical orders in hospitals and nursing facilities. All medical orders must be in writing and signed by the physician or the physician extender. Telephone orders may be taken only when there is an urgent need to initiate or change a medical order. The physician or physician extender shall sign or initial the orders for nursing facility residents on the next visit to the facility. The physician or physician extender shall sign or initial the orders for all hospital patients as soon as possible. Each patient's or resident's physician is responsible for documenting written orders and progress notes on each patient's or resident's clinical record.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995; 27 SDR 59, effective December 17, 2000; 30 SDR 84, effective December 4, 2003.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:05:03. Emergency physician coverage for hospitals and nursing facilities. A patient’s or resident’s physician shall arrange for the care of the patient or resident by an alternate physician during the physician's unavailability. A hospital must have one or more physicians on duty or call at all times and available to the hospital on-site or by telephone within 20 minutes to give necessary orders or medical care to patients in case of emergency.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995; 27 SDR 59, effective December 17, 2000.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:05:06. Physician extenders. If the services of a physician extender are utilized, the facility must develop written policies regarding the extender's role in the care of the patient or resident.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.
44:04:05:07. Medical director required. A critical access hospital and a nursing facility must appoint a physician licensed in South Dakota to serve as a medical director. The medical director shall assure physician services are provided only by qualified caregivers.

General Authority: SDCL 34-12-13.
Law Implemented: SDCL 34-12-13.

1200-08-06-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.
(1) Every person admitted for care or treatment shall be under the supervision of a physician who holds a license in good standing to practice in Tennessee. The name of the resident's attending physician shall be recorded in the resident's medical record.

1200-08-06-.06 BASIC SERVICES.
...(2) Physician Services.
(a) Policies and procedures concerning services provided by the nursing home shall be available for the admitting physicians.
(b) Residents shall be aided in receiving dental care as deemed necessary.
(c) Each nursing home shall retain by written agreement a physician to serve as a Medical Director.
(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:

1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care;

2. Ensure the delivery of emergency and medical care when the resident's attending physician or his/her designated alternate is unavailable;
3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;

4. Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements;

5. Review and take appropriate action on reports from the Director of Nursing regarding significant clinical developments;

6. Monitor the health status of nursing home personnel to ensure that no health conditions exist which would adversely affect residents; and,

7. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control.

**TEXAS**

Downloaded January 2011

**Sec. 242.151. PHYSICIAN SERVICES.**

(a) An institution shall have at least one medical director who is licensed as a physician in this state.

(b) The attending physician is responsible for a resident’s assessment and comprehensive plan of care and shall review, revise, and sign orders relating to any medication or treatment in the plan of care. The responsibilities imposed on the attending physician by this subsection may be performed by an advanced practice nurse or a physician assistant pursuant to protocols jointly developed with the attending physician.

(c) Each resident has the right to choose a personal attending physician.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.

**Sec. 242.156. REQUIRED MEDICAL EXAMINATION.**

(a) Except as required by federal law, the department shall require that each resident be given at least one medical examination each year.

(b) The department shall specify the details of the examination.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.
Sec. 242.159. AUTOMATED EXTERNAL DEFIBRILLATORS.

(a) An institution shall have available for use at the institution an automated external defibrillator, as defined by Section 779.001, and shall comply with the training, use, and notification requirements of Chapter 779.

(b) An institution that does not have funds available for purposes of Subsection (a) may solicit gifts, grants, or donations to purchase or maintain an automated external defibrillator for use at the institution.

(c) The use of an automated external defibrillator must be consistent with a resident’s advance directive executed or issued under Subchapter C, Chapter 166.

(d) Notwithstanding Section 74.151(b), Civil Practice and Remedies Code, Section 74.151(a), Civil Practice and Remedies Code, applies to administration of emergency care using an automated external defibrillator by an employee or volunteer at an institution.

(e) An institution shall employ at least one person who is trained in the proper use of an automated external defibrillator.

(e-1) An institution is not required to comply with Subsections (a) and (e) until September 1, 2012. This subsection expires January 1, 2013.

Added by Acts 2009, 81st Leg., R.S., Ch. 257, Sec. 1, eff. September 1, 2009.

RULE §19.1201 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that:

(1) the medical care and other health care of each resident is supervised by an attending physician. Any consultations must be ordered by the attending physician;

(2) another physician supervises the medical care and other health care of residents when their attending physician is unavailable; and

(3) if children are admitted to the facility:

(A) appropriate pediatric consultative services are utilized, in accordance with the comprehensive assessment and plan of care; and

(B) a pediatrician or other physician with training or expertise in the clinical care of children with complex medical needs participates in all aspects of the medical care.

Source Note: The provisions of this §19.1201 adopted to be effective May 1, 1995, 20 TexReg 2393.
RULE §19.1202  Physician Visits

The physician must:

(1) review and/or revise and sign orders relating to the resident’s total program of care, including medications and treatments, according to the visit schedule required by §19.1203(2) of this title (relating to Frequency of Physician Visits);

(2) write, sign, and date progress notes at each visit;

(3) sign and date all orders;

(4) write, sign, and date a physician’s discharge summary within 20 workdays of being notified by the facility of the discharge, except as specified in §19.1912(e) of this title (relating to Additional Clinical Record Service Requirements), if the resident has been temporarily discharged for 30 days or less, and readmitted to the same facility; and

(5) provide documentation in the clinical record as specified in §19.1911 and §19.1912 of this title (relating to Contents of the Clinical Record and Additional Clinical Record Service Requirements).

Source Note: The provisions of this §19.1202 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.1203  Frequency of Physician Visits

Physician visits must conform to the following schedule:

(1) Licensed-only facility. Each resident must have a medical examination at least annually by his physician and as necessary to meet the needs of the resident. Physician orders must be reviewed and revised as necessary at least once every 60 days, unless the resident’s physician specifies, in writing in the resident’s clinical record, a different schedule for each review and revision.

(2) Medicaid-certified facilities and Medicare skilled nursing facilities.

(A) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(B) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(C) Except as provided in paragraph (3) of this section and §19.1205(c) of this title (relating to Physician Delegation of Tasks), all required visits must be made by the physician personally.

(3) Medicare skilled nursing facilities. At the option of the physician, required visits in Medicare skilled nursing facilities after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical
nurse specialist in accordance with §19.1205 of this title (relating to Physician Delegation of Tasks).

Source Note: The provisions of this §19.1203 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective October 15, 1998, 23 TexReg 10496.

RULE §19.1204 Availability of Physician for Emergency Care

The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

Source Note: The provisions of this §19.1204 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.1205 Physician Delegation of Tasks

(a) In a Medicare skilled nursing facility (SNF), except as specified in subsection (b) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

(1) meets the applicable definition in 42 Code of Federal Regulations §491.2 (see §19.101 of this title (relating to Definitions)) or in the case of a clinical nurse specialist, is licensed as such by the state;

(2) is acting within the scope of practice as defined by state law; and

(3) is under the supervision of the physician.

(b) In a Medicare SNF, a physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies.

(c) In a Medicaid nursing facility, any required physician task may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. Services must be provided in the context of applicable state laws, rules, and regulations governing the practice of nurse practitioners, clinical nurse specialists, and physician assistants.

Source Note: The provisions of this §19.1205 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.1206 Physician Signatures

Signature stamps and faxed signed documents are acceptable if used as described in §19.1912(f)(2) of this title (relating to Additional Clinical Record Service Requirements).
RULE §19.1207 Prescription of Psychoactive Medication

(a) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) Medication-related emergency--A situation in which it is immediately necessary to administer medication to a resident to prevent:

(A) imminent probable death or substantial bodily harm (emotional or physical) to the resident; or

(B) imminent physical or emotional harm to another because of threats, attempts, or other acts the resident overtly or continually makes or commits.

(2) Psychoactive medication--A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness. The term includes the following categories when used as described by this subdivision:

(A) anti-psychotics or neuroleptics;

(B) antidepressants;

(C) agents for control of mania or depression;

(D) anti-anxiety agents;

(E) sedatives, hypnotics, or other sleep-promoting drugs; and

(F) psychomotor stimulants.

(b) A person may not administer a psychoactive medication to a resident who does not consent to the prescription unless:

(1) the resident is having a medication-related emergency; or

(2) the person authorized by law to consent on behalf of the resident has consented to the prescription.

(c) Consent to the prescription of psychoactive medication given by a resident, or by a person authorized by law to consent on behalf of the resident, is valid only if:

(1) the consent is given voluntarily and without coercive or undue influence;

(2) the person who prescribes the medication, or that person's designee, provides the resident and, if applicable, the person authorized by law to consent on behalf of the
resident, with the following information in a single document identified as being for the purpose of consent to treatment with psychoactive medication:

(A) the specific condition to be treated;

(B) the beneficial effects on that condition expected from the medication;

(C) the probable clinically significant side effects and risks associated with the medication, as reported in widely available pharmacy databases or the manufacturer's package insert; and

(D) the proposed course of the medication;

(3) the resident and, if appropriate, the person authorized by law to consent on behalf of the resident, are informed in writing that consent may be revoked; and

(4) the consent is evidenced in the resident’s clinical record by a signed form prescribed by the facility, or by a statement of the person who prescribes the medication or that person’s designee, that documents consent was given by the appropriate person and the circumstances under which the consent was obtained.

(A) Consent is valid until:

(i) consent is withdrawn; or

(ii) the practitioner has discontinued the medication.

(B) For purposes of this rule, a medication will be considered to be discontinued if therapy has been suspended for more than 70 days. If the suspended therapy is resumed within the 70-day period, an oral explanation of side effects should be documented in the clinical record.

(d) The Health and Safety Code, Chapter 313, Consent to Medical Treatment, provides guidance on treatment decisions when a resident is comatose, incapacitated, or otherwise mentally or physically incapable of communication. An ethics committee also may prove helpful in such situations.

(e) A resident’s refusal to consent to receive psychoactive medication must be documented in the resident’s clinical record.

(f) If a person prescribes psychoactive medication to a resident without the resident’s consent because the resident is having a medication-related emergency:

(1) the person must document the necessity of the order in the resident’s clinical record in specific medical or behavioral terms; and

(2) treatment of the resident with the psychoactive medication must be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the resident’s personal liberty.
(g) A physician, or a person designated by the physician, is not liable for civil damages or an administrative penalty and is not subject to disciplinary action for a breach of confidentiality of medical information for a disclosure of the information provided under subsection (c)(2) made by the resident, or the person authorized by law to consent on behalf of the resident, that occurs while the information is in the possession or control of the resident or the person authorized by law to consent on behalf of the resident.

Source Note: The provisions of this §19.1207 adopted to be effective July 1, 2002, 27 TexReg 4362

RULE §19.1208 Physicians' Reporting Communicable Diseases

The physician must report all reportable communicable diseases immediately according to the requirements specified in §19.1601(2)(D) of this title (relating to Infection Control).

Source Note: The provisions of this §19.1208 adopted to be effective May 1, 1995, 20 TexReg 2393.

RULE §19.1210 Certification and Recertification Requirements in Medicaid-Certified Facilities

(a) A recipient's physician must certify and recertify the recipient's need for nursing facility care in accordance with this section.

(b) A recipient's physician must certify the recipient's need for nursing facility care no later than 20 days after the recipient's admission to the facility.

(c) A recipient's physician must recertify the recipient's need for nursing facility care every 180 days that the recipient remains in the nursing facility after the first certification.

(d) A nursing facility must:

(1) ensure that each certification and recertification statement states: "I hereby certify that this resident requires/continues to require nursing facility care for 180 days"; and

(2) keep the physician's certification and recertification statements in the recipient's clinical record.

Source Note: The provisions of this §19.1210 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective July 1, 1996, 21 TexReg 4408; amended to be effective September 1, 2008, 33 TexReg 7264.

RULE §19.1907 Medical Director

(a) The nursing facility must designate a physician to serve as medical director.
(b) The medical director is responsible for:

implementation of resident care policies (see §19.1922 of this title (relating to Resident Care Policies)); and the coordination of medical care in the facility.

Source Note: The provisions of this §19.1907 adopted to be effective May 1, 1995, 20 TexReg 2393.

UTAH

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R432-150-9. Medical Director.

(1) The administrator must retain by formal agreement a licensed physician to serve as medical director or advisory physician according to resident and facility needs.

(2) The medical director or advisory physician shall:

(a) be responsible for the development of resident care policies and procedures including the delineation of responsibilities of attending physicians;

(b) review current resident care policies and procedures with the administrator;

(c) serve as a liaison between resident physicians and the administrator;

(d) review incident and accident reports at the request of the administrator to identify health hazards to residents and employees and;

(e) act as consultant to the director of nursing or the health services supervisor in matters relating to resident care policies.


(1) A physician must personally approve in writing a recommendation that an individual be admitted to a nursing care facility.

(a) Each resident must remain under the care of a physician licensed in Utah to deliver the scope of services required by the resident.

(b) Nurse practitioners or physician assistants, working under the direction of a licensed physician may initiate admission to a nursing care facility pending personal review by the physician.

(2) The facility must provide supervision to ensure that the medical care of each resident is supervised by a physician. When a resident’s attending physician is unavailable, another qualified physician must supervise the medical care of the resident.
(3) The physician must:

(a) review the resident's total program of care, including medications and treatments, at each visit;
(b) write, sign, and date progress notes at each visit;
(c) indicate, in writing, direction and supervision of health care provided to residents by nurse practitioners or physician assistants; and
(d) sign all orders.

(4) Physician visits must conform to the following:

(a) The physician shall notify the facility of the name of the nurse practitioner or physician assistant who is providing care to the resident at the facility.
(b) Each resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter.
(c) Physician visits must be completed within ten days of the date the visit is required.
(d) Except as required by R432-150-16(4)(f), all required physician visits must be made by the physician.
(e) 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.

(5) The facility must provide or arrange for the provision of physician services 24 hours a day in case of an emergency.

R432-200-7. Administration and Organization. [small health care facilities]

...(5) Medical Director.

The administrator of each facility shall retain, by formal agreement, a licensed physician to serve as medical director or advisory physician on a consulting basis according to the residents' and facility's needs.

(6) Medical Director Responsibilities.

The medical director or advisory physician shall have responsibility for at least the following:

(a) Review or develop written resident-care policies and procedures including the delineation of responsibilities of attending physicians;
(b) Review resident-care policies and procedures annually with the administrator;
(c) Serve as liaison between the resident's physician and the administrator;
(d) Serve as a member of the quality assurance committee (see R432-200-10);
(e) Review incident and accident reports at the request of the administrator to identify health hazards to residents and employees;
(f) Act as consultant to the health services supervisor in matters relating to resident-care policies.

R432-200-13. Admission and Discharge. [small health care facilities]

...(b) Residents shall be admitted by, and remain under the care of, a physician or individual licensed to prescribe care for the resident.

(c) There shall be a written order (a documented telephone order is acceptable) for admission and care at the time of admission

R432-200-14. Physician Services. [small health care facilities]

(1) General Requirements.
(a) Each resident in need of nursing services, habilitative, or rehabilitative care shall be under the care of a licensed physician.
(b) Each resident shall be permitted to choose his physician.
(c) Upon admission, each resident shall have orders for treatment and care.

(2) Physician Responsibilities.
(a) Each resident shall have a medical history and pertinent physical examination at least annually.
(b) Each intermediate care resident shall be seen at least once during the first 60 days of residency.
(c) The attending physician or medical practitioner shall see the resident whenever necessary but at least every 60 days, unless the attending physician or practitioner documents in the resident's record why the resident does not need to be seen this frequently.
(d) The physician or practitioner shall establish and follow a schedule alternating visits.
(e) Each visit and evaluation shall be documented in the resident's record.

(3) Policies and Procedures. There shall be policies and procedures that provide for:
(a) Access to physician services in case of medical emergency or when the attending physician is not available;

(b) Names and telephone numbers of on-call physicians in the health services supervisor's office;

(c) Reevaluation of the resident and review of care and treatment orders when there is a change of attending physician which shall be completed within 15 days of such change.

(4) Non-Physician Practitioners. The following practitioners may render medical services according to state law:

(a) Nurse practitioners licensed to practice in the state of Utah;

(b) Physicians' assistants working under the supervision of a licensed physician and performing only those selected diagnostic and therapeutic tasks identified in Rules and Regulations and Standards for Utilization of Physician Assistants.

(5) Physician Orders and Notes.

(a) The following items shall be part of the treatment record and shall be signed and dated by a physician:

(i) Admission orders;

(ii) Medication, treatment, therapy, laboratory, and diet orders;

(iii) History and physical examinations;

(iv) Physician's progress notes;

(v) The discharge summary;

(vi) All discharge orders;

(b) All telephone orders shall be recorded immediately and include:

(i) date and time of order;

(ii) the receiver's signature and title; and

(iii) the order shall be countersigned and dated within 15 days by the physician who prescribed the order.

(c) The attending physician shall complete the resident's medical record within 60 days of the resident's discharge, transfer, or death.

(6) Notification of Physician.

(a) The attending physician shall be notified promptly upon:

(i) Admission of the resident;
(ii) A sudden and/or marked adverse change in the resident's signs, symptoms, or behavior;

(iii) Any significant weight change in a 30-day period unless the resident's physician stipulates another parameter in writing;

(iv) Any adverse response or reaction by a resident to a medication or treatment;

(v) Any error in medication administration or treatment;

(vi) The discovery of a decubitus ulcer, the beginning of treatment, and if treatment is not effective. Notification shall be documented.

(b) The physician shall be notified if the facility is unable to obtain or administer drugs, equipment, supplies, or services promptly as prescribed. If the attending physician or his designee is not readily available, emergency medical care shall be provided. The telephone numbers of the emergency care physician shall be posted at the control station.

(c) All attempts to notify physicians shall be noted in the resident's record including the time and method of communication and the name of the person acknowledging contact, if any.

7.15 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(a) Physician supervision. The facility must ensure that:

(1) the medical care of each resident is supervised by a physician; and

(2) another physician supervises the medical care of residents when their attending physician is unavailable.

(b) Physician visits. The physician must:

(1) review the resident’s total program of care, including medications and treatments, and examine the resident personally at each visit required by subsection 7.15(c).

(2) write, sign and date progress notes at each visit; and

(3) sign and date all orders.
(c) Frequency of physician visits. The resident must be seen by a physician:

(1) within 48 hours prior to admission or within 48 hours following admission; and

(2) at least every 6 months thereafter and as the resident’s condition warrants. The facility must assure that physician visits occur as clinically indicated for the resident.

(d) Except as provided in subsection 7.15(e), all required physician visits must be made by the physician personally.

(e) After the initial visit, at the option of the physician, required six-month visits, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with subsection 7.15(g) below.

(f) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day in case of emergency.

(g) Physician delegation of tasks. Except as specified in subsection 7.15(h), a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

(1) is licensed as such by the State;

(2) is acting within the scope of practice as defined by State law; and

(3) is under the supervision of the physician.

(h) A physician may not delegate a task when these rules specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility’s own policies.

11.3 Medical Director

(a) The facility must designate a physician to serve as medical director.

(b) The medical director is responsible for:

(1) implementation of resident care policies; and

(2) the coordination of medical care in the facility.
A. Each nursing facility shall have a written agreement with one or more physicians licensed by the Virginia Board of Medicine to serve as medical director.

B. The duties of the medical director shall include, but are not limited to:

1. Advising the administrator and the director of nursing on medical issues, including the criteria for residents to be admitted, transferred or discharged from the nursing facility;

2. Advising on the development and execution of policies and procedures that have a direct effect upon the quality of medical and nursing care delivered to residents;

3. Acting as liaison and consulting with the administrator and the attending physician on matters regarding medical and nursing care policies and procedures of the nursing facility;

4. Advising and providing consultation to the nursing facility staff regarding communicable diseases, infection control and isolation procedures, and serving as liaison with local health officials;

5. Providing temporary physician services when the admitting physician is not the attending physician, in order to assure that the resident has temporary medical orders;

6. Providing physician services in case of emergency in the event that the resident’s attending physician cannot be reached; and

7. Advising on the development and execution of an employee health program, which shall include provisions for determining that employees are free of communicable diseases according to current acceptable standards of practice.

12VAC5-371-240. Physician services.

A. Each resident shall be under the care of a physician licensed by the Virginia Board of Medicine. Nurse practitioners and physician assistants licensed to practice in Virginia may provide care in accordance with their practice agreements.

B. Prior to, or at the time of admission, each resident, his designated representative, or the entity responsible for his care shall designate an attending physician.

C. A complete medical plan of care must be provided at the time of admission, or within 48 hours after admission. The plan shall include:

1. Primary diagnosis;

2. Identification of resident problems;

3. Medical history and physical exam;

4. Orders for medications;

5. Treatments;
6. Restorative services;
7. Activity levels;
8. Diet;
9. Special procedures recommended for health and safety of the resident; and
10. Advance directives, if known.

D. The admission medical plan of care shall be prescribed and signed by the attending physician. Subsequent medical plans of care for the same resident may be prescribed and signed by a nurse practitioner or physician assistant according to their practice agreements.

E. The physician, nurse practitioner or physician assistant shall review the resident's medical plan of care at each visit and write a progress note.

F. Each resident shall be seen by his attending physician and the resident's total program of care shall be reviewed and appropriately revised as necessary.

G. All verbal orders shall be immediately recorded and signed by the individual receiving them, and shall be countersigned by the prescribing person.

WASHINGTON

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388-97-1260 Physician services.

(1) The nursing home must ensure that the resident is seen by the physician whenever necessary.

(2) Except as specified in RCW 74.42.200, a physician must personally approve in writing a recommendation that an individual be admitted to a nursing home.

(3) The nursing home must ensure that:

(a) Except as specified in RCW 74.42.200, the medical care of each resident is supervised by a physician;

(b) Another physician supervises the medical care of residents when their attending physician is unavailable; and

(c) Physician services are provided twenty-four hours per day, in case of emergency.

(4) The physician must:
(a) Write, sign and date progress notes at each visit;

(b) Sign and date all orders; and

(c) In medicare and medicare/medicaid certified facilities, review the resident’s total program of care, including medications and treatments, at each federally required visit.

(5) Except as specified in subsections (6), (7), and (9) of this section, a physician may delegate tasks to a physician's assistant or advanced registered nurse practitioner who is:

(a) Licensed by the state;

(b) Acting within the scope of practice as defined by state law; and

(c) Under the supervision of the physician.

(6) The physician may not delegate a task when the delegation is prohibited under state law or by the facility's own policies.

(7) If the resident’s primary payor source is medicare, the physician may:

(a) Alternate federally required physician visits between personal visits by:

(i) The physician; and

(ii) An advanced registered nurse practitioner or physician's assistant; and

(b) Not delegate responsibility for the initial required physician visit. This initial visit must occur within the first thirty days of admission to the facility.

(8) If the resident's payor source is medicaid, the physician may delegate any federally required physician task, including tasks which the regulations specify must be performed personally by the physician, to a physician's assistant or advanced registered nurse practitioner who is not an employee of the facility but who is working in collaboration with a physician.

(9) If the resident's payor source is not medicare or medicaid:

(a) In the medicare only certified facility or in the medicare certified area of a medicare/medicaid facility, the physician may alternate federally required physician visits between personal visits by the physician and an advanced registered nurse practitioner or physician’s assistant. The physician may not delegate responsibility for the initial required physician visit.

(b) In the medicaid only certified facility or in the medicaid certified area of a medicare/medicaid facility, the physician may delegate any federally required physician task, including tasks which the regulations specify must be performed personally by the physician, to a physician's assistant or advanced registered nurse practitioner who is not an employee of the facility but who is working in collaboration with a physician.
(10) The following table describes the physician visit requirements related to medicare or medicaid certified area and payor type.

(11) The attending physician, or the physician-designated advanced registered nurse practitioner or physician’s assistant must:

(a) Participate in the interdisciplinary plan of care process as described in WAC 388-97-1020;

(b) Provide to the resident, or where applicable the resident’s surrogate decision maker, information so that the resident can make an informed consent to care or refusal of care (see WAC 388-97-0260); and

(c) Order resident self-medication when appropriate.

(12) The nursing home must obtain from the physician the following medical information before or at the time of the resident’s admission:

(a) A summary or summaries of the resident’s current health status, including history and physical findings reflecting a review of systems;

(b) Orders, as necessary for medications, treatments, diagnostic studies, specialized rehabilitative services, diet, and any restrictions related to physical mobility; and

(c) Plans for continuing care and discharge.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1260, filed 9/24/08, effective 11/1/08.]

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74.42.200 Supervision of health care by physician — When required.

The health care of each resident shall be under the continuing supervision of a physician: PROVIDED, That a resident of a facility licensed pursuant to chapter 18.51 RCW but not certified by the federal government under Title XVIII or Title XIX of the Social Security Act as now or hereafter amended shall not be required to receive the continuing supervision of a health care practitioner licensed pursuant to chapter 18.22, 18.25, 18.32, 18.57, 18.71, and 18.83 RCW, nor shall the state of Washington require such continuing supervision as a condition of licensing. The physician shall see the resident whenever necessary, and as required and/or consistent with state and federal regulations.

[1980 c 184 § 8; 1979 ex.s. c 211 § 20.]

WEST VIRGINIA

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A physician shall personally approve in writing a recommendation that a person be admitted to a nursing home. Each resident shall remain under the care of a physician.

8.16.a. Physician supervision. A nursing home shall ensure that:

8.16.a.1. The medical care of each resident is supervised by a physician; and

8.16.a.2. Another physician supervises the medical care of residents when their attending physician is unavailable.

8.16.b. Physician visits. The physician shall:

8.16.b.1. Review the resident’s total program of care, including medications and treatments, and examine the resident personally at each visit required by Subdivision 8.16.c. of this subsection;

8.16.b.2. Write, sign, and date progress notes at each visit; and

8.16.b.3. Sign and date all orders.

8.16.c. Frequency of physician visits. The resident shall be seen by a physician:

8.16.c.1. Within five (5) days prior to admission or within seventy-two (72) hours following admission; and
8.16.c.2. At least every thirty (30) days for the first ninety (90) days after admission, and as the resident’s condition warrants. A nursing home shall assure that physician visits occur as clinically indicated for the resident.

8.16.c.3. After the ninety (90) day requirement has expired, the physician shall visit every sixty (60) days and as the resident’s condition warrants.

8.16.d. Except as provided in Subdivision 8.16.e. of this Subsection, all required physician visits shall be made by the physician personally.

8.16.e. After the initial visit, at the option of the physician, the required visit every sixty (60) days may be alternated between personal visits by the physician and visits by a physician’s assistant, nurse practitioner or clinical nurse specialist in accordance with subdivision 8.16.g. of this Subsection.

8.16.f. Availability of physicians for emergency care. A nursing home shall provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of an emergency.

8.16.g. Physician delegation of tasks. Except as specified in paragraph 8.16.c.2 of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

8.16.g.1. Is licensed by the State;

8.16.g.2. Is acting within the scope of practice as defined by W. Va. Code ’30-3-1 et seq.; and

8.16.g.3. Is under the supervision of the physician.

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HFS 132.52 Procedures for admission.

(2) PHYSICIAN’S ORDERS. No person may be admitted as a resident except upon:

(a) Order of a physician;

(b) Receipt of information from a physician, before or on the day of admission, about the person’s current medical condition and diagnosis, and receipt of a physician’s initial plan of care and orders from a physician for immediate care of the resident; and

HFS 132.61 Medical services.

(1) MEDICAL DIRECTION IN SKILLED CARE FACILITIES.
(a) Medical director. Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

(b) Coordination of medical care. Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall develop written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities of attending physicians. If there is an organized medical staff, by-laws also shall be developed by the medical director and approved by the licensee. Coordination of medical care shall include liaison with attending physicians to provide that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

(c) Responsibilities to the facility. The medical director shall monitor the health status of the facility's employees. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety.

(2) PHYSICIAN SERVICES IN ALL FACILITIES. The facility shall assure that the following services are provided:

(a) Attending physicians. Each resident shall be under the supervision of a physician of the resident's or guardian's choice who evaluates and monitors the resident's immediate and long-term needs and prescribes measures necessary for the health, safety, and welfare of the resident. Each attending physician shall make arrangements for the medical care of a physician's residents in the physician's absence.

Note: For medical examinations and assessments required for admission, see s. HFS 132.52.

(b) Physicians' visits. 1. Each resident who requires skilled nursing care shall be seen by a physician at least every 30 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

2. Each resident who does not require skilled nursing care shall be seen by a physician at least every 90 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

3. In no case may a physician's alternate schedule specify fewer than one visit annually.

4. The physician shall review the plan of care required under s. HFS 132.52 (2) (b) at the time of each visit.

5. The physician shall review the resident's medications and other orders at least at the time of each visit. Note: For review by a registered nurse, see s. HFS 132.60 (5) (a) 4.

6. The physician shall write, date and sign a note on the resident's progress at the time of each visit.
7. Physician visits are not required for respite care residents except as provided under s. HFS 132.70 (5).

(c) Availability of physicians for emergency patient care. The facility shall have written procedures, available at each nurse's station, for procuring a physician to furnish necessary medical care in emergencies and for providing care pending arrival of a physician. The names and telephone numbers of the physicians or medical service personnel available for emergency calls shall be posted at each nursing station.

Note: For reporting requirements, see s. HFS 132.45 (5) (c) 4; for requirements to notify others, see s. HFS 132.60 (3) (a).

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (2) (b), Register, January, 1987, No. 373, eff. 2−1−87; correction in (2) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1996, No. 492.

WYOMING

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Section 5. Organization and Administration.

(c) Resident Care Policies. The Nursing Care Facility shall have written policies to govern nursing care and related medical or other services provided.

... (v) The medical director or director of nursing shall be designated in writing to be responsible for the execution of resident care policies.

(A) If the director of nursing is delegated the responsibility for day-to-day execution of resident care policies, the medical director shall serve as the advisory physician from whom the director of nursing receives medical guidance.

Section 8. Physician Services.

(a) There shall be available to the facility, prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for the immediate care of the resident.

(i) If the resident information is not immediately available, the facility shall be responsible for contacting a physician to obtain temporary medical orders.

(b) Emergency Care of Residents. The facility shall arrange for necessary medical care in case of emergency.
(i) There shall be established procedures to be followed in an emergency, which cover immediate care of the resident, persons to be notified, and reports to be prepared.

(ii) A list of physicians to be called in case the resident’s physician or his designated substitute cannot be found shall be posted at every nursing station. Such roster shall include telephone numbers of the physicians.

FEDERAL REGULATIONS

§ 483.40 Physician services.

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(a) Physician supervision. The facility must ensure that—

(1) The medical care of each resident is supervised by a physician; and

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

(b) Physician visits. The physician must—

(1) Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

(c) Frequency of physician visits. (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.
(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(e) Physician delegation of tasks in SNFs. (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;

(ii) Is acting within the scope of practice as defined by State law; and

(iii) Is under the supervision of the physician.

(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.


§ 483.75 Administration.

(i) Medical director.

(1) The facility must designate a physician to serve as medical director.

(2) The medical director is responsible for—

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.