19-13-D8t. Chronic and convalescent nursing homes and rest homes with nursing supervision

...(d) General Conditions.

(1) Patient admission.

(A) Patients shall be admitted to the facility only after a physician certifies the following:

(i) That a patient admitted to a chronic and convalescent nursing home has uncontrolled and/or unstable and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision or has chronic conditions requiring substantial assistance with personal care, on a daily basis...

...(n) Medical and professional services.

(1) A comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours of admission; however, if the physician who attended the patient in an acute or chronic care hospital is the same physician who will attend the individual in the facility, a copy of a hospital discharge summary completed within five (5) working days of admission and accompanying the patient may serve in lieu of this requirement. A patient assessment shall be completed within fourteen (14) days of admission and a patient care plan shall be developed within seven (7) days of completion of the assessment.

(A) The comprehensive history shall include, but not necessarily be limited to:

(i) chief complaints;

(ii) history of present illness;

(iii) review of systems;

(iv) past history pertinent to the total plan of care for the patient;

(v) family medical history pertinent to the total plan of care for the patient; and

(vi) personal and social history.

(B) The comprehensive examination shall include, but not necessarily be limited to:

(i) blood pressure;

(ii) pulse;

(iii) weight;
(iv) rectal examination with a test for occult blood in stool, unless done within one (1) year of admission;

(v) functional assessment; and

(vi) cognitive assessment, which for the purposes of these regulations shall mean an assessment of a patient’s mental and emotional status to include the patient’s ability to problem solve, decide, remember, and be aware of and respond to safety hazards.

(C) The patient assessment and patient care plan shall be developed in accordance with subparagraphs (H) and (I) of subsection (o) (2) of this section.

(3) The attending physician shall record a summary of findings, problems and diagnoses based on the data available within seven (7) days after the patient’s admission, and shall describe the overall treatment plan, including dietary orders and rehabilitation potential and, if indicated, any further laboratory, radiologic or other testing, consultations, medications and other treatment, and limitations on activities.

(4) The following tests and procedures shall be performed and results recorded in the patient’s medical record within thirty (30) days after the patient’s admission:

(A) unless performed within one (1) year prior to admission:
  (i) hematocrit, hemoglobin and red blood cell indices determination;
  (ii) urinalysis, including protein and glucose qualitative determination and microscopic examination;
  (iii) tuberculosis screening by skin test or chest X-ray;
  (iv) blood sugar determination; and
  (v) blood urea nitrogen or creatinine;

(B) unless performed within two (2) years prior to admission:
  (i) visual acuity, grossly tested, for near and distant vision; and
  (ii) for women, breast and pelvis examinations, including Papanicolaou smear, except the Papanicolaou smear may be omitted if the patient is over sixty (60) years of age and has had documented repeated satisfactory smear results without important atypia performed during the patient’s sixth decade of life, or who has had a total hysterectomy;

(C) unless performed within five (5) years prior to admission:
  (i) tonometry on all sighted patients forty (40) years or older; and
  (ii) screening and audiometry on patients who do not have a hearing aid; and

(D) unless performed within ten (10) years prior to admission:
  (i) tetanus-diphtheria toxoid immunization for patients who have completed the initial series, or the initiation of the initial series for those who have not completed the initial series; and
  (ii) screening for syphilis by a serological method.
...(7) Annually, each patient shall receive a comprehensive medical examination, at which
time the attending physician shall update the diagnosis and revise the individual's overall
treatment plan in accordance with such diagnosis. The comprehensive medical exam shall
minimally include those services required in subdivision (1) (B) of this subsection.

...(9) The requirements in this subsection for tests, procedures and immunizations need
not be repeated if previously done within the time period prescribed in this subsection and
documentation of such is recorded in the patient's medical record. Tests and procedures
shall be provided to the patient given the patient's consent provided no medical reason or
contraindication exists, or the attending physician determines that the test or procedure is
not medically necessary. Immunizations against influenza and pneumococcal disease shall be
provided in accordance with the recommendations of the Advisory Committee on
Immunization Practices, established by the United States Secretary of Health and Human
Services unless medically contraindicated or the patient objects on religious grounds.
Documentation of tests, procedures and immunizations provided or reasons for not
providing said tests, procedures and immunization shall be so noted by the attending
physician in the patient’s medical record.