04. Admission Policies.

a. The administrator shall not accept or keep patients/residents for whom the appropriate care level and services are not provided, or for which the facility is not licensed except in an emergency. (1-1-88)

b. All patients/residents must be admitted by a physician, and all care rendered under his direction. (1-1-88)

c. A history and physical examination shall be recorded within forty-eight (48) hours after admission to the facility, unless the patient/resident is accompanied by a record of a physical examination completed by a physician not more than five (5) days medical and/or psycho-social diagnosis, physician's plan of care, the patient’s/resident’s activity limitation and the rehabilitation potential, and shall be dated and signed by the physician. (1-1-88)

154. MEDICAL DIRECTION.

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

...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: (1-1-88)

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)
200. NURSING SERVICES

01. Director of Nursing Services. A registered nurse currently licensed by the state of Idaho and qualified by training and experience shall be designated Director of Nursing Services in each SNF and ICF and shall be responsible and accountable for: (1-1-88)

...e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; (1-1-88)

03. Patient/Resident Care. (7-1-93)

a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: (1-1-88)

i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; (1-1-88)

ii. Developed in coordination with other patient/resident care services provided to the patient/resident; (1-1-88)

iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; (1-1-88)

iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; (1-1-88)

v. Available for use by all personnel caring for the patient/resident. (1-1-88)

...c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. (1-1-88)