

.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.