Public Health Code
Medical Services Long Term Care Facilities

Section 19-13-D8t(n)

(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.

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

(2) Transferred Patients. When the responsibility for the care of a patient is being transferred from one health care institution to another, the patient must be accompanied by a medical information transfer document, which shall include the following information:

(A) name, age, marital status, and address of patient, institution transferring the patient, professional responsible for care at that institution, person to contact in case of emergency, insurance or other third party payment information;
(B) chief complaints, problems, or diagnoses;

(C) other information, including physical or mental limitations, allergies, behavioral and management problems;
(D) any special diet requirements;
(E) any current medications or treatments, and
(F) prognosis and rehabilitation potential.

(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;
(ii) dental examination and evaluation;
(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 Papanicolau smear, except the Papanicolau 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.

(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.

(1) No medication or treatments shall be given without the order of a physician or a health care practitioner with the statutory authority to prescribe medications or treatments. If orders are given verbally or by telephone, they shall be recorded by an on duty licensed nurse or on duty health care practitioner with the statutory authority to accept verbal or telephone orders with the physician's name, and shall be signed by the physician on the next visit.

(2) 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.

(3) Professional services provided to each patient by the facility shall include, but not necessarily be limited to, the following:

(A) monthly:

(i) blood pressure, and

(ii) weight check;

(B) yearly:

(i) hematocrit, hemoglobin and red blood cell indices determination;

(ii) urinalysis, including determination of qualitative protein glucose and microscopic examination of urine sediment;

**(iii) immunization against influenza in accordance with the recommendations of the Advisory Committee on Immunization Practices, established by the United States Secretary of Health and Human Services;**

(iv) blood urea nitrogen or creatinine;

(v) dental examination and evaluation;

(vi) rectal examination, including a determination for occult blood in stool, on patients forty (40) years or over; and

(vii) breast examination on all women;

(C) every two (2) years, visual acuity, grossly tested, for near and distant vision for sighted patients;

(D) every five (5) years:

(i) screening audiometry for patients without a hearing aid; and

(ii) tonometry for sighed patients forty (40) years or over; and

(E) every ten (10) years, tetanus-diphtheria toxoid immunization following completion of initial series.

**(F) Immunization against pneumococcal disease in accordance with the recommendations of the National Advisory Committee on Immunization Practices, established by the Secretary of Health and Human Services.**