

F841

(Rev. ~~Rev. 225~~; Issued: ~~08-08-24~~; Effective: ~~08-08-24~~; Implementation: ~~08-08-24~~)

§483.70(g) Medical director.

§483.70(g)(1) The facility must designate a physician to serve as medical director.

§483.70(g)(2) The medical director is responsible for—

- (i) Implementation of resident care policies; and**
- (ii) The coordination of medical care in the facility.**

DEFINITIONS

“Medical director” *refers to* a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

“Physician/practitioner” (physician assistant, nurse practitioner, clinical nurse specialist) *refers to* the individual who has responsibility for the medical care of a resident.

“Current professional standards of practice” refers to approaches to care, procedures, techniques, treatments, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

“Resident care policies” refers to the facility’s overall goals, directives, and governing statements that direct the delivery of care and services to residents consistent with current professional standards of practice.

GUIDANCE

If the medical director does not hold a valid license to practice in the State where the nursing home is located refer to F839 - §483.70(e) Staff qualifications. The facility must designate a physician to serve as medical director (unless waived per §488.56(b) by CMS).

The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility. This may be included in the medical director’s job description or through a separate facility policy. Facilities and medical directors have flexibility on how all the duties will be performed. However, the facility must ensure *that* all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. For example, some, but not all duties may be conducted remotely using various technologies (e.g., phone, email, fax, telehealth, etc., that is compliant with all confidentiality and privacy requirements).

It is important that the medical director’s responsibilities require that he/she be knowledgeable about current professional standards of practice in caring for long term

care residents, and about how to coordinate and oversee other practitioners.

If the medical director is also an attending physician, there should be a process to ensure there are no concerns with the individual's performance as a physician (i.e., otherwise, the medical director is monitoring his/her own performance). If there are concerns regarding his/her performance, the facility's administration should have a process for how to address these situations.

While medical directors who work for multi-facility organizations, such as corporate or regional offices, may be involved in policy development, the facility's individual policies must be based on the facility's unique environment and its resident's needs, and not based on a broad, multi-facility structure.

Although the medical director is not required to sign policies, the facility must be able to show that the development, review, and approval of resident care policies included his/her input.

Medical director responsibilities must include:

- *Implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care.*
- Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. (Refer to F868).
- *Addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities.*
- *Active involvement in the process of conducting the facility assessment (Refer to F838).*

NOTE: Having a designee does not change or absolve the Medical Director's responsibility to fulfill his or her role as a member of the QAA committee, or his or her responsibility for overall medical care in the facility.

In addition, the medical director responsibilities should include, but are not limited to:

- *Administrative decisions including recommending, developing and approving facility policies related to residents care. Resident care includes the resident's physical, mental and psychosocial well-being;*
- Ensuring the appropriateness and quality of medical care and medically related care;
- Assisting in the development of educational programs for facility staff and other professionals;
- Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents. Refer to Infection Control requirements at §483.80;
- Cooperating with facility staff to establish policies for assuring that the rights of individuals (residents, staff members, and community members) are respected;
- Supporting and promoting person-directed care such as the formation of advance directives, end-of-life care, and provisions that enhance resident decision making, including choice regarding medical care options;
- Identifying performance expectations and facilitating feedback to physicians and

- other health care practitioners regarding their performance and practices;
- Discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care, *for example, physicians assigning new psychiatric diagnoses and/or prescribing psychotropic medications without following professional standards of practice; and*
- Assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners (e.g., nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law.
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INVESTIGATIVE PROCEDURES

If a deficiency has been identified regarding a resident's care, also determine if the medical director had knowledge or should have had knowledge of a problem with care, or physician services, or lack of resident care policies and practices that meet current professional standards of practice and failed:

- To get involved or to intercede with other physicians or practitioners to facilitate and/or coordinate medical care; and/or
- To provide guidance for resident care policies.

Interview the medical director about his/her:

- Involvement in assisting facility staff with resident care policies, medical care, and physician issues;
- Understanding of his/her roles, responsibilities and functions and the extent to which he/she receives support from facility management for these roles and functions;
- Process for providing feedback to physicians and other health care practitioners regarding their performance and practices, including discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current professional standards of care;
- Input into the facility's scope of services including the capacity to care for residents with complex or special care needs, such as dialysis, hospice or end-of-life care, respiratory support with ventilators, intravenous medications/fluids, dementia and/or related conditions, or problematic behaviors or complex mood disorders;
- His/her participation or involvement in conducting the Facility Assessment and the Quality Assessment and Assurance (QAA) Committee.

Interview facility leadership (e.g., Administrator, Director of Nursing, and others as appropriate) about how they interact with the medical director related to the coordination of medical care, the facility's clinical practices and concerns or issues with other physicians or practitioners.

Also, refer to §483.30 Physician Services for more information.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F841, the surveyor's investigation will generally show that the facility failed to do any *one* of the following:

- Designate a physician to serve as medical director; **or**
- Ensure the medical director fulfilled his/her responsibility for the implementation of resident care policies or the coordination of medical care in the facility.

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health and safety, includes, but is not limited to:

- The facility's medical director was aware of and did not intervene when a health care practitioner continued over several months to provide inappropriate medical care for infection prevention to a resident that was inconsistent with current professional standards of care. As a result this resident's health continued to decline, and was hospitalized with a severe infection.

An example of Level 3, actual harm that is not immediate jeopardy, includes, but is not limited to:

- The Director of Nursing repeatedly requested the medical director's assistance in coordinating medical care with attending physicians for residents receiving psychotropic medications. In particular there were several physicians who had a known history of failing to provide justification for continued use of these medications and not attempting a gradual dose reduction for the residents under his/her care. As a result of the medical director's failure to intervene, several residents continued to receive these medications without medical/clinical justification. Based on record review and interviews with residents, their representative's and staff, there was no supporting evidence to indicate that an Immediate Jeopardy situation existed. However, due to the continuation of the use of these psychotropic medications, the residents withdrew from activities and from eating in the dining room. This caused decreased appetite and substantial weight loss for several residents. Actual harm, both physical and psychosocial was indicated. Unnecessary Medications, was also cited for not ensuring the residents were receiving the lowest dose possible.

An example of Level 2, no actual harm, with a potential for more than minimal harm, that is not immediate jeopardy, includes, but is not limited to:

- The administrator had made multiple requests for the medical director to meet with physicians to ensure that they were familiar with the facility's resident care policies. At the time of the survey the medical director was interviewed and stated that she had not yet had an opportunity to introduce herself to or meet with physicians. Although no actual harm occurred, due *to* the medical director's failure to ensure implementation of resident care policies, the potential for more than minimal harm existed.
- *The medical director, who is responsible for overseeing the medical care in the facility, was made aware of residents newly diagnosed with schizophrenia by their physician and/or other practitioner and their medical records did not contain documentation to support the new diagnoses. The medical director did not review the medical records for these residents nor did he/she discuss the new diagnoses with the residents' physician and/or diagnosing practitioner. This practice resulted in residents being potentially misdiagnosed with schizophrenia and receiving antipsychotic medications. None of the residents experienced harm, but they were at risk for harm by receiving treatment, including antipsychotic medications, when they may not have been clinically indicated. Note: If this*

occurred on three or more residents, at minimum, this would be cited at a scope of pattern (e.g., "E").

Level 1 - Severity 1 does not apply for this regulatory requirement