RULES AND REGULATIONS OF THE MEDICAL STAFF

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.

July 2018

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ARTICLE I
MISSION STATEMENT

Levindale is a geriatric center and hospital dedicated to providing superior service for the aged, frail and ill in institutional, community and home settings. As an advocate for the elderly, Levindale accepts a leadership role in defining and developing, in collaboration with other agencies, a comprehensive continuum of nursing, medical and social services within the Jewish community of the Baltimore metropolitan area. Programs are operated within the values inherent in Judaism pursuant to Levindale's charter. As part of our Eden Alternative and Neighborhood Model programs, we are committed to creating an environment that promotes the celebration of life. L'Chaim (to Life).

ARTICLE II
PURPOSE AND SCOPE

The Medical Executive Committee ("MEC"), Division Chief, and/or the Medical Staff will adopt such Rules and Regulations as may be necessary for operations of the Medical Staff and to affect the purposes for which the Medical Staff is organized. These Rules and Regulations will apply to all Medical Staff members and Advanced Practice Providers ("APPs") as defined in the Medical Staff Bylaws (the "Bylaws").

ARTICLE III
DEFINITIONS

As used in these Rules and Regulations, the following terms shall have the meanings set forth below. If a term has not been defined below, it shall have the meaning set forth in the Bylaws.

(1) "Administrative Policies" means policies that are developed by administration, which refer to all departments organization-wide. These may be entity-specific policies or LifeBridge system-wide policies.

(2) "Attending Physician" or "Attending" means the physician who has assumed primary responsibility for the medical care of a specific Resident or Patient, or any physician who is providing coverage for the Attending Physician during the absence of the Attending. Active Medical Staff members may serve as Attending Physicians.

(3) "Specialty Hospital" means those areas of Levindale that provide specialty hospital care in accordance with federal and state laws and regulations.

(4) "Consultant physicians" or "Consultants" means those physicians, podiatrists, and dentists who are Consulting Staff members of the Medical Staff as defined in the Bylaws.

(5) "Designee" means an individual Attending Physician or licensed independent practitioner with privileges in the Specialty Hospital acting on behalf of the Attending Physician or licensed independent practitioner.

(6) "Health Care Agent" means the individual appointed by a competent Resident or Patient to make health care decisions for that Resident or Patient under the circumstances stated in the directive.

(7) "House Staff" shall refer to graduates of approved medical, osteopathic, dental, or podiatric schools that participate in graduate medical education training activities at Levindale.

(8) "Long-Term Care Unit(s)" means those units of Levindale in which long-term care is provided in accordance with federal and state laws and regulations, and shall include the subacute care unit and chronic ventilation unit.

(9) "Medical Director" means the individual appointed by the Levindale President and COO as head of the medical services and to whom the Medical Staff members are responsible.

(10) "Medical Staff Policy" means a policy that is developed by, and specifically relates to, the Medical Staff.

(11) "Patients" means those individuals admitted to the Specialty Hospital.

(12) "Personal Representative" means a person whom a Resident or Patient wishes to represent his/her interests in connection with his/her stay at Levindale.

(13) "Residents" means those individuals admitted to any of the Long-Term Care Units.

(14) "Subacute Unit" means that area of the Long-Term Care Units within Levindale in which skilled nursing care is provided to Residents.

(15) "Timed" means meeting the standard for medical record documentation (military time).

ARTICLE IV
RESIDENT/PATIENT RIGHTS

The Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) will be provided with a copy of the Resident/Patient rights, as well as a bill of responsibilities for Residents/Patients at Levindale. Medical staff members are expected to abide by the standards and guidelines set forth in these Bylaws. Rules & Regulations are provided at the time of appointment and/or during appeal.

All Residents/Patients admitted to Levindale have the right to choose an Attending Physician from those who have such privileges at Levindale. The Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) must be notified of any change in Attending Physician and how to reach the Attending Physician at all times. The Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) must also be informed about outcomes of care, including unanticipated outcomes.

Administrative and/or Medical Staff Policies, developed in cooperation with the Medical Staff and approved by the MEC, will address the following issues relating to Resident/Patient rights:

(1) Procedures for assigning Attending Physicians to Residents/Patients admitted to Levindale.

(2) Procedures for which informed consent is required.

(3) The process for obtaining and documenting informed consent, including disclosure of the risks, benefits, and advantages of any procedure.

(4) Who may give informed consent for a procedure.

(5) The process for determining whether a Resident/Patient has an advance directive, as well as the procedure for documenting its content in the medical record and the mechanism for evaluating compliance with advanced directives. (Policy 180 Advanced Directive Care)

(6) The withholding of resuscitative services and the forgoing or withdrawing of life-sustaining treatment.

(7) The process for the procurement of organ or tissue donations for transplant, including the identification of potential donors, notification of families, notification of the organ procurement agency, and obtaining consent of the family.

ARTICLE V
ATTENDING PHYSICIAN REQUIREMENTS FOR NEW ADMISSIONS

Section 5.1 Information Upon Admission

All Nurse Practitioners may admit patients to the Specialty Hospital, but all such patients must have assigned an attending physician primarily responsible for their care. Physician Assistants may perform the admitting History and Physical in concert with the admitting Nurse Practitioner or physician.

Upon admission of a Resident/Patient, the Attending Physician, Nurse Practitioner, or Physician Assistant shall:

(1) Assess a Resident/Patient and perform a complete History and Physical, which must be signed, dated and timed.

(2) Seek, provide, and analyze needed information regarding a Resident's/Patient's current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance;

(3) Perform a review of and reconcile medications to avoid duplication and minimize drug interactions;

(4) (4) Provide appropriate information and documentation to support the appropriate level of care for the Resident/Patient at Levindale (i.e. Long-Term Care Units, Subacute Unit, Behavioral Health Unit, or Specialty Hospital) in accordance with the admission criteria for each level of care at Levindale;

(4) Notify the Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) of the Resident's/Patient's condition and plan of care on admission, and document such notification;

-(5) Review any available advance directives and identify code/directives of care status for each Resident/Patient. A determination of each Resident's/Patient's decision-making capacity must be made and documented on the appropriate form on the medical record. All appropriate forms and documents regarding resuscitation orders will be completed within seven days. Code status must be determined at the time of admission and re-assessed based on new information with changes in the Resident's/Patient's status. The Attending Physician must complete a MOLST Form for all Residents/Patients. (Care Policy 177) For those Residents/Patients deemed incapable of making medical decisions and who have not appointed a Health Care Agent, Levindale will, in accordance with state law and Levindale policies, attempt to identify an appropriate surrogate decision-maker or request that a legal guardian be appointed. Such-Health Care Agent, surrogate decision-maker, or legal guardian will be consulted regarding the Resident's/Patient's condition; when a second opinion is required by another Physician, this will be completed as soon as possible but must occur within 14 days.

(6) Be available to provide and verify orders upon admission for all Residents/Patients admitted to Levindale. Orders for care must include the following and be in keeping with Administrative Policies:

(a) Dietary orders;
(b) Activity level;
(c) Frequency of monitoring of vital signs and weight;
(d) Rehabilitation and/or therapeutic recreation services if indicated;
(e) PPD testing (if not known to be positive) for Residents only;
(f) Immunizations (influenza and pneumococcal pneumonia if not contraindicated);

(g) Appropriate lab tests, x-ray tests, and medications;
(h) Limitations and precautions on treatments and care such as code status;
(i) Condition on admission, prognosis, and rehabilitation ability if indicated, and or potential for discharge;
(j) Requests for specialty consultation; and
(k) For those Residents admitted to Long-Term Care Units, the appropriateness of self-medication must be addressed in keeping with administrative, nursing, and pharmacy policies.

(7) For those Residents who are admitted for the skilled nursing home, the Medicare certification form must be completed at the time of the initial assessment on or before the 14th day after admission, and on or before every additional 30 days of skilled care in keeping with Medicare rules and regulations. For a Patient admitted to the Chronic Hospital, the Medicare certification form, pre-admission, admission, and periodic recertification for hospital level of care will be completed in keeping with any state and federal regulations.

Section 5.2 Content of History and Physical Examination

The content of the admission history and physical examination will include the following:

(1) Resident's/Patient's chief complaint and/or reason for admission, and current medical status;

(2) Resident's/Patient's past medical history, social history, and family history;

(3) An evaluation of the Resident's/Patient's physical, mental, and functional status; and

(4) Formulation of the Resident's/Patient's treatment plan.

Section 5.3 Time for Completion of Admission Assessment

Unless a Resident's/Patient's condition necessitates otherwise, the admission assessment shall be completed in accordance with the following time frames:

(1) For those Residents admitted to the long-term care units, a complete history and physical exam must be completed and documented in the medical record within 48 hours of admission. All admission exams must be signed, dated, and timed.

(2) For those Patients admitted to the Specialty Hospital, a complete history and physical exam must be completed and documented in the medical record no more than 7 days before or 24 hours after admission or registration. A copy of a history and physical exam which has been completed within seven days of admission may be accepted if completed by the Attending Physician. However, within 24 hours of admission, the Attending must still document a visit to the Patient in the medical record, and shall include any updates to the history and physical exam in the progress notes. All admission history and physicals must be signed, dated, and timed.

ARTICLE VI
REQUIREMENTS FOR ONGOING CARE

Section 6.1 Appropriate Care of Residents/Patients by the Attending Physician

The Attending Physician shall:

(1) Perform accurate, timely, legible, and relevant medical assessments; All entries must be signed, dated, and timed.

(2) Develop an overall treatment plan that properly defines and describes Resident/Patient symptoms and problems, clarifies and verifies diagnoses, relates diagnoses to Resident/Patient problems, and helps establish a realistic prognosis and care goals;

(3) In consultation with Levindale staff:

(a) Determine appropriate services and programs for a Resident/Patient, consistent with diagnoses, condition, prognosis, and Resident/Patient wishes;

(b) Ensure that treatments are medically necessary and appropriate in accordance with regulatory requirements; and

(c) Manage and document ethics issues consistent with relevant laws and regulations and with Resident's/Patient's wishes, including advising Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated;

(4) Respond in accordance with Levindale policy, to emergency and routine notification, to enable Levindale to meet its clinical and regulatory obligations;

(5) Response to notification of consultant recommendations and laboratory and other diagnostic test results is based on the Resident's/Patient's condition and clinical significance of the results. Such recommendations and/or results must be initialed and dated by the Attending upon review;

(6) Analyze the significance of abnormal test results that may reflect important changes in the Resident's/Patient's status and explain the medical rationale for interventions or decisions not to intervene based on those results;

(7) Review and sign rehabilitation therapy and recreational therapy treatment plans and periodic updates;

(8) Respond to notification of, and assess and manage adequately, acute and other significant clinical condition changes in Residents/Patients; and

(9) Ensure that individuals receiving palliative care have appropriate comfort and supportive care measures.

Section 6.2 Frequency of Follow-Up Visits by the Attending Physician

(1) For the first 90 days after admission to the Long-Term Care Unit, Residents must be visited by the Attending Physician every 30 days, or more frequently as required by the Resident's condition. After the initial 90 days, alternate visits may be made by a credentialed nurse practitioner or physician assistant. Residents with stable medical conditions may then be placed on an alternative care visit schedule, via the use of a written order, and should then be visited every 60 days. However, it is strongly recommended that Residents be seen on a monthly basis. If the Attending Physician does not visit within 10 days of the required visit time, the nursing staff will contact the Attending Physician. If the Attending Physician does not visit the Resident within 48 hours of this contact, the nursing staff will notify the Medical Director who will then attempt to contact the Attending Physician. The Resident, family, Health Care Agent (if applicable), and the Personal Representative (if applicable) will be notified of the need to select an alternate Attending Physician if the current Attending Physician remains non-compliant with the visit schedule.

(2) Residents admitted to the Subacute Unit and/or admitted as a skilled-care Resident must be visited at least weekly, or more frequently as required by the Resident's condition. Interim visits may be made by a credentialed nurse practitioner or physician assistant. However, the Attending Physician must visit the Resident at least every 30 days for the first 90 days. If there is a lapse of 10 days or more between visits, the nursing staff will contact the Attending Physician. If the Attending Physician does not visit the Resident within 48 hours of this contact, the nursing staff will notify the Medical Director who will then attempt to contact the Attending Physician. The Resident, family, Health Care Agent (if applicable), and the Personal Representative (if applicable) will be notified of the need to select an alternate Attending Physician if the current Attending Physician remains non-compliant with the visit schedule.

(3) Patients admitted to the Specialty Hospital must be visited at least three times per week, or more frequently as required by the Patient's condition. Visits may be made by a credentialed nurse practitioner or physician assistant. However, the Attending Physician must visit the Patient at least weekly. If the Attending Physician has not visited the Patient for ten or more days, the nursing staff will contact the Attending Physician. If the Attending Physician does not visit the Patient within 48 hours of this contact, the nursing staff will notify the Medical Director who will then attempt to contact the Attending Physician. The Resident, family, Health Care Agent (if applicable), and the Personal Representative (if applicable) will be notified of the need to select an alternate Attending Physician if the current Attending Physician remains non-compliant with the visit schedule.

(4) Any Patients in the Specialty Hospital who do not meet the Specialty Hospital level of care may be seen less frequently based on their clinical condition, but no less frequently than monthly.

Section 6.3 Advanced Practice Professional Visits

Physician Assistants and/or Nurse Practitioners who have privileges at Levindale may care for Residents/Patients at Levindale in accordance with state and federal regulations and within the scope of their privileges. Resident/Patient visits may be made by a physician assistant or nurse practitioner as noted in Section 6.2

Section 6.4 Progress Notes

Progress notes will be written at the time of each Resident/Patient visit in accordance with state, federal, and Levindale policies. Such notes must be legible, signed, dated, timed, and should include documentation regarding the following:

(1) Status of the Resident's/Patient's current medical condition at the time of each visit;

(2) Medication changes and reason for changes. Other issues that should be addressed periodically include;

(a) Reason and ongoing need for vascular access devices; change formatting for this section)

(b) Presence and need for psychotropic drugs used, and/or taper;

(c) Changes in mental or functional status

(d) Significant fluctuations in weight;

(e) Any incidents/adverse events (e.g., falls, injuries);

(f) Problems with skin care;

(g) Findings/recommendations by consultants;

(h) Procedures performed;

(i) Lab work and diagnostic test results, including how any abnormal results are addressed;

(j) Review of progress with rehabilitation treatment plan;

(k) Resident/Patient, family, Health Care Agent (if applicable), and Personal Representative (if applicable) education; and

(l) Review of the Resident's/Patient's interdisciplinary care plan.

Section 6.5 Care Planning

Attending Physicians or their Designees are encouraged to participate in the interdisciplinary care planning for Residents/Patients at Levindale. The Attending Physician or her or his Designee should be informed of when such care planning will occur. If the Attending Physician or her or his Designee does not attend, recommendations of the care planning team should be communicated to the Attending Physician by a representative of the interdisciplinary team.

ARTICLE VII
REQUIREMENTS FOR TRANSFER OR DISCHARGE

Section 7.1 Resident/Patient Discharges or Transfers to Another Facility/Transfers within Levindale

The Attending Physician must periodically document the progression of the Resident/Patient toward discharge goals for Residents/Patients admitted to the Specialty Hospital and nursing home. For those Residents in Long-Term Care Units, discharge potential should be noted at admission and periodically thereafter if there is a change in status. The nursing staff will notify the Attending of a potential discharge as soon as possible. A physician order is required for discharge from Levindale. The Attending Physician must write the order along with the orders needed to support the plan. The goal is to ensure all Patients will have medications, treatments, equipment, and needed post discharge follow-up in a written discharge plan. If the Attending Physician is unable to visit Levindale to issue orders in person, telephone orders may be obtained.

A physician order is also required for transfer of a Resident/Patient within Levindale between the Hospital and nursing home. A new admission assessment is required each time a Resident/Patient is transferred between the Hospital and nursing home. If the Attending Physician must be changed, the Resident/Patient, family, Health Care Agent (if applicable), and the Personal Representative (if applicable) shall be notified. The Attending must write an order indicating the change in physician and ensure handoff to the accepting Attending.

For Residents/Patients discharged to the community, the discharge form will be completed by the Levindale nursing staff and other ancillary staff. The Attending Physician should indicate at the time of discharge any test results, consults, or other information that should be forwarded to the Resident's/Patient's community physician's office. Discharge summaries will be faxed to community providers as indicated in the discharge summary by the medical records department.

For any Resident/Patient who transfers to another facility or to another level of care within Levindale, or is discharged to the community, and such transfer or discharge necessitates a transfer of care to another healthcare

practitioner, the Attending will continue to provide all necessary services until another physician has assumed responsibility for the care of the Resident/Patient.

For any Resident/Patient who transfers to another acute care facility, the Attending Physician will provide necessary information and/or documentation that may be needed at the time of transfer to ensure care continuity at the receiving facility. The Attending will provide follow-up as needed with a physician or another healthcare practitioner within 24 hours of the transfer of an acutely ill or unstable Resident/Patient.

Section 7.2 Discharge Against Medical Advice

If a Resident/Patient requests discharge against medical advice the Attending Physician or her or his Designee must be contacted to determine if the Resident/Patient has the capacity to make this decision. If the Attending Physician believes the Resident/Patient lacks capacity to make the decision, and the Resident/Patient continues to request discharge, a formal assessment of the Resident's/Patient's capacity will be initiated. Questions may be referred to the Medical Director and/or administration. Medical staff will follow organizational policies for discharge against medical advice. They should use their best judgment in arranging for post-discharge care for the Resident/Patient. (Care 154 AMA Policy)

Section 7.3 Discharge Summaries

The Attending Physician or her or his Designee must complete discharge summaries.

STAT discharge summaries must be completed for those transfers to facilities, which require a discharge summary before admission, and for transfers between the Hospital and nursing home within Levindale.

All other discharge summaries must be finalized within thirty (30) days of discharge or the medical record will be considered delinquent and delinquent medical record penalties will be implemented.

The contents of the discharge summary shall include the following:

(1) Patient name;

(2) Admit date;

(3) Time;

(4) Discharge or expiration date;

(5) History; chief complaint, and/or reason for admission;

(6) Pertinent physical examination findings;

(7) Course in institution including pertinent clinical events;

(8) Pertinent lab data, results of diagnostic tests, procedures performed such as transfusions or invasive procedures, and consultations, including name of consultant;

(9) Final diagnosis;

(10) Discharge medications/allergies;

(11) Discharge plan, including medical follow-up, referrals for post-discharge care such as home care, and equipment ordered;

(12) Condition on discharge;

(13) Name(s) of the individual dictating the discharge summary and the Attending Physician.

ARTICLE VIII
ORDERS, PHARMACY PROTOCOLS, LAB MONITORING, PHARMACY REVIEW, MEDICATION RECONCILIATION

Section 8.1 Orders

(1) All orders must be legible, and should be signed, dated, and timed.

(2) Orders for medication must include drug, dose, timing/frequency, route of administration, duration of therapy, and medical diagnosis, symptom, or condition.

(2) Physician and/or APP shall verify the accuracy of both verbal and phone orders at the time the orders are given and cosign the orders as soon as possible but no more than 30 days after the order is given. An administrative and/or pharmacy policy, approved by the MEC, shall specifically address who may give verbal/telephone orders, to whom verbal/telephone orders may be given, and the time frames for required signatures. Telephone orders for restraints must be signed within 24-hours. (CARE-162 Verbal and Telephone Orders)

(3) APPs may have state or federal regulatory limitations on orders they may write and these limitations will be followed.

(4) Medical staff policies may be developed with and approved by the MEC to limit order writing to specific categories or specialties.

(6) PRN orders not used within 60 days will be automatically stopped.

(7) House Staff under the supervision of an Attending Physician may write orders. Students not yet licensed may not write orders

(8) Admission orders issued by APPs should be countersigned by the Attending at the time of the next visit.

Section 8.2 Pharmacy Protocols, Lab Monitoring, and Pharmacy Review

(1) Pharmacy protocols are established and approved by the MEC for pharmacist management of dosage adjustment and for monitoring of medications.

(2) In accordance with policies approved by the MEC, medication substitutions may be made by the pharmacy. The Attending Physician will sign medication substitution forms per pharmacy policy.

(3) In accordance with federal and state laws and regulations, Levindale pharmacists will review medication profiles on a regular basis and identify concerns for Attending Physicians. These concerns must be addressed by the Attending or her or his Designee at the time of their next regular visit if not sooner. Any concerns relating to prescribing that are identified by the pharmacy will be trended and referred to the Medical Director to review with the prescribing practitioner.

(4) Administrative policies, approved by the MEC, shall address the use of generic equivalents, Automatic stop orders, reporting of adverse drug reactions, use of medications brought to Levindale by Residents/Patients, and self-medication by Residents/Patients.

Section 8.3 Medication Reconciliation.

Medications shall be reconciled upon admission to Levindale, upon in-house transfers within Levindale, and upon discharge from Levindale. The process includes reconciling medication from home lists, discharge summaries, referring facility medication lists and Medical Administration Records, and the Patient and family. Policies, procedures, and forms for medication reconciliation will be developed, updated periodically, and approved by the MEC. Compliance with the process will be tracked by the facility Quality Assurance/Performance Improvement (QAPI) process for Long Term Care.

ARTICLE IX
MEDICAL RECORDS

(1) Medical records must be maintained and completed in keeping with Levindale policies. An administrative policy shall address the requirements pertaining to completion of medical records and will establish penalties for failure to complete a medical record within the prescribed time frame. This policy will be reviewed and approved by the MEC as it pertains to Medical Staff members.

(2) Lab reports must be initialed, timed, and dated before they are placed in the medical record. Lab reports or diagnostic test results returned to the chart following discharge will be flagged for signature post-discharge, and must be signed and dated.

(3) The use of abbreviations must conform to the accepted standards outlined in medical record department policies and procedures. Unacceptable abbreviations are set forth in the table below:

DO NOT USE	POTENTIAL PROBLEM	PREFERRED TERM
U	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit
IU (International Unit)	Mistaken as IV (intravenous) or the number 10 (ten)	Write "international unit"
Q.D., QD, qd (daily) QOD, Q.O.D. (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "0" mistaken for "I"	Write "every day" or "every other day"
Trailing Zero (X.0 mg) Lack of leading zero (.Xmg)	Decimal point is missed	Never write a zero by itself and after a decimal point (x mg), and always use a zero before a decimal point (0.xmg)
MS $MS0_4$ $MgSO^4$	Confused for one another. Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"

ARTICLE X
CHANGE IN RESIDENT/PATIENT CONDITION

The nursing staff is required to notify the Attending Physician or her or his Designee of any change in a Resident's/Patient's condition.

If the Attending Physician does not respond within 15 minutes to an urgent or emergent call, nursing staff should again attempt to contact him/her. If no response is received after another 15 minutes, the Medical Director or Designee will be contacted. Persistent problems with contacting an Attending Physician will be referred to the Medical Director.

There will be Administrative Policies, approved by the MEC, for triggering the rapid response team or a code. (CARE-171 Rapid Response Team)

ARTICLE XI
RESIDENT/PATIENT DEATH

Administrative policies, approved by the MEC, will address Resident/Patient deaths at Levindale. Such policies will address completion of death certificates, notification of the medical examiner, criteria for determining deaths, in which autopsies should be performed, the mechanism for documenting information for performing autopsies, notification of the involved practitioner(s) that an autopsy is going to be performed, and communication with families of the deceased. Autopsies for Levindale Patients are performed at Sinai Hospital of Baltimore unless the family has made arrangements for an autopsy to be performed elsewhere. Death certificates must be completed within 24 hours by the Attending Physician or her or his Designee. Nurse Practitioners and Physician Assistants may pronounce death and record the death certificate. All deaths must be documented in the Medical Record by the pronouncing practitioner.

Upon notification by the facility that organ donation any be appropriate, physicians will comply with the requirements of the Transplant Resource Center and the Medical Eye Bank of Maryland as per the Levindale Administrative policy "Resident/Patient Organ Donation", which is reviewed periodically by the MEC. (CARE-179 Organ Donation)

ARTICLE XII
MEDICAL STAFF COVERAGE FOR RESIDENTS/PATIENTS

Medical staff members shall be responsible for providing coverage for Residents/Patients 24 hours a day, seven days a week. All Attending Physicians shall designate a Physician member of the Medical Staff as an alternate physician who shall respond in an appropriate, timely manner if the Attending is unavailable for any reason. The Attending Physician must provide Levindale with his/her current office address, phone, fax, pager numbers, and E-mail address to ensure appropriate, timely communication, as well as the name(s), current office address, phone, fax, and pager numbers of designated alternate physician(s).

Attending Physicians must adequately inform alternate covering physicians about Residents/Patients with active acute conditions or potential problems that may need medical follow-up during their on-call time.

ARTICLE XIII
ROLE OF CONSULTING STAFF

To the extent possible, on-site consultation should be requested to avoid any unnecessary transfers of Residents/Patients off-site.

Consulting members of the Medical Staff are privileged at Levindale in accordance with the Medical Staff Bylaws. Consultants will record findings, diagnosis, and recommendations in the Resident's/Patient's medical record, and will sign and print their name, time, and date the consultation notes. Consultants may write orders at time of consultation in accordance with the Medical Staff Bylaws. Recommendations made by a consultant should be reviewed by the Attending Physician or her or his Designee. Whenever a consultant has not been authorized to write orders, the Attending Physician will review the recommendations of the consultant and initiate orders in accordance with the Resident's/Patient's plan of care.

In general, consults should be completed within two working days unless the initial request identifies a different timeframe. More urgent consults should be called directly by the requesting attending or their Designee. All consult requests should be written as an order with details as to the specific physician and/or discipline being

consulted, time frame requested, whether the consultant is to consult only and provide opinion, or if they are to consult and treat, which gives the consultant authority to write orders. When a consult is completed, the consultant should either contact the attending directly or make sure the consult will be made available to the attending in a timely fashion. The consultant should indicate in the progress notes that the consult has been completed and the consult should be left with the staff on the unit for the physician to review.

Consultations are mandatory for Patients with the following conditions:

(1) Patients on a ventilator – pulmonary consult

(2) Acute rehabilitation Patients – physical medicine consult

(3) Behavioral health unit Patients – psychiatry consult

(4) Patients on Cardiac Monitor - cardiology consult

ARTICLE XIV
HOUSE STAFF

Section 14.1 Supervision

The Affiliation Agreement between Sinai Hospital of Baltimore, Inc. and Levindale Hebrew Geriatric Center and Hospital shall address the roles and responsibilities of House Staff at Levindale. These policies will address supervision requirements of all House Staff by members of the Medical Staff. Each Medical Staff member is responsible for documenting his/her supervision in the medical record.

When the supervising Medical Staff member is not available, he/she must make arrangements for another Medical Staff member to assume responsibility for the supervision of the House Staff caring for his/her Residents/Patients.

Section 14.2 Medical Record Entries

The following medical record entries by House Staff must be countersigned by the supervising Medical Staff member:

(1) Admission notes;

(2) History and physicals;

(3) Procedure notes;

(4) Consultations; and

(5) Discharge summaries.

Section 14.3 Role and Responsibilities

Each training program under which House Staff provide Resident/Patient care will develop policies and protocols to define the duties, responsibilities, and authority of House Staff members in each clinical area, based on the knowledge and skill of the House Staff.

Members of the House Staff involved in the care of Residents/Patients may write orders and perform medical procedures under the supervision of a member of the Medical Staff.

As appropriate, an explanation of the role of House Staff in providing Resident/Patient care will be provided to Residents/Patients, family, Health Care Agents (if applicable), and Personal Representatives (if applicable).

ARTICLE XV
MEDICAL STUDENTS/ALLIED HEALTH PRACTITIONER STUDENTS

A Medical Staff Policy, approved by the MEC, shall address the role of medical students and allied health practitioner students in the care of Residents/Patients. Students are not to write in the medical chart.

ARTICLE XVI
PROTOCOLS AND GUIDELINES

Protocols and guidelines to improve the process of care and clinical outcomes may be developed by the Medical Director, clinical departments, and/or the Medical Staff and must be approved by the MEC. Initiation of a protocol requires a physician order. Approved protocols and guidelines shall be reviewed and updated at least every two years.

ARTICLE XVII
RESTRAINTS

An Administrative Policy, developed in cooperation with the Medical Staff and approved by the MEC, shall address the use of restraints. This policy will be based on federal and state regulations as well as The Joint Commission standards, and will focus on reducing safety risks of Residents/Patients by weighing the need for restraints against maintaining the rights and dignity of Residents/Patients.

Restraints will be ordered for Patients in the Specialty Hospital only when assessment indicates that the Patient's safety or the safety of others is at risk, and when alternative and less restrictive interventions have proven unsuccessful. Orders for restraints must include, at a minimum, the date, time, type of restraint, medical diagnosis, and duration of restraint.

ARTICLE XVIII
TRANSFUSIONS

At the time of ordering transfusions or blood products, consent for the transfusion must be obtained from the Resident/Patient or the Health Care Agent or Personal Representative. The physician, nurse practitioner, or physician assistant ordering the transfusions must document the reason for the transfusion, including medical diagnosis, utilizing the transfusion order form approved by MEC.

ARTICLE XIX
INVASIVE PROCEDURES

Section 19.1 Requirements

Medical staff may only perform procedures –

(1) that they are credentialed and privileged to perform;

(2) for which informed consent is obtained by the Medical Staff member performing the procedure

or her or his Designee; and

(3) for which documentation is completed in the medical record in a written procedure note.

Section 19.2 Pre-Procedure Checklist/Site Marking/Time Out

An administrative policy developed in cooperation with the Medical Staff and approved by the MEC will address pre-procedure checklist, site marking, and time out. This policy will be in keeping with Federal, State, and The Joint Commission requirements.

ARTICLE XX
ISOLATION AND INFECTION

An administrative policy, approved by the MEC, shall address the use of infection control guidelines as recommended by the Centers for Disease Control and Prevention, the reporting and surveillance of infections in the Chronic Hospital and the Long-Term Care Units by the Medical Staff, and the procedures for isolation of infectious Patients.

All members of the Medical Staff are required to receive annual flu vaccinations in accordance with LifeBridge policy. Exceptions to this requirement will be in accordance with LifeBridge policy.

ARTICLE XXI
RESIDENT/PATIENT AND VISITOR SAFETY

Administrative policies approved by the MEC address safety issues regarding Residents/Patients and visitors. Such policies shall address, at a minimum, sentinel events, fire safety, biohazard safety, cardiac and respiratory arrest, and Resident/Patient falls or injuries. Medical Staff members shall report Resident/Patient and/or visitor safety concerns to Administration. Compliance with handwashing and other infection control policies is expected of all Medical Staff members. Safety issues are tracked and trended through the facility Safety Committee and reported through the organizational QA/PI process.

ARTICLE XXII
DISCLOSURE OF UNEXPECTED EVENTS

Medical Staff members shall report unanticipated outcomes or adverse events to Administration. Disclosure to the Patient and/or family of unexpected adverse events shall be completed in keeping with organizational policies.

ARTICLE XXIII
RESEARCH

Administrative policies, approved by the MEC, shall address the conduct of research within Levindale. These policies will address the process for the approval of research protocols, the use of investigational drugs and devices, the need to obtain informed consent from research subjects, and scientific misconduct and other ethical issues related to research.

ARTICLE XXIV
UTILIZATION REVIEW

A Utilization Plan, developed in collaboration with the Medical Staff and approved by the MEC, shall address appropriate utilization of care for Residents/Patients. The utilization review plan will be reviewed and approved by the MEC and the governing body on an annual basis.

ARTICLE XXV
INTEGRITY/CONFLICT OF INTEREST

There is a LifeBridge Health policy identifying circumstances under which LifeBridge and all of its subsidiaries shall require all employees, Medical staff, members of the Board, and the executive staff to disclose any activities that could result in a possible conflict of interest between the person's duties to LifeBridge Health or its subsidiary and outside interests of the person or his or her family member.

ARTICLE XXVI
CULTURE CHANGE/PATIENT-CENTERED CARE

Patient-centered care shifts the facility and staff from a medical institution to a person centered, homelike environment of care. Key players in this transformation are the Patients, Residents, families and staff. Resident's unmet needs and desires are ascertained, their families involved and staff's willingness to adapt and learn. This philosophy of care is embraced throughout Levindale and applies to all Medical Staff members.

ARTICLE XXVII
OTHER MEDICAL STAFF POLICIES

The Medical Director of Levindale may develop other policies and procedures, to be approved by the MEC, pertinent to the care of Residents/Patients. These policies and procedures will be outlined in the medical staff policy manual or the Levindale administrative manual, both of which are available in the Medical Staff Office and available on the LifeBridge Health online policy portal

ARTICLE XXVIII
ADOPTION, AMENDMENT, AND REVIEW

These Rules and Regulations shall be adopted, and may be amended, as set forth in the Medical Staff Bylaws and will be reviewed annually.

Revised: 2/18/2016
Revised: 6/20/2018
Revised: 7/23/2018