420-5-10-09 RESIDENT ASSESSMENT.

(1) Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

(2) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.

(3) Comprehensive assessments. The facility must make a comprehensive assessment of a resident’s needs which:

(a) For Medicare/Medicaid certified facilities only, is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and

(b) Describes the resident’s capability to perform daily life functions and significant impairments in a functional capacity.

(4) The comprehensive assessment must include at least the following information:

(a) Medically defined conditions and prior medical history;

(b) Medical status measurement;

(c) Physical and mental functional status;

(d) Sensory and physical impairments;

(e) Nutritional status and requirements;

(f) Special treatments or procedures;

(g) Mental and psychosocial status;

(h) Discharge potential;

(i) Dental condition;

(j) Activities potential;

(k) Rehabilitation potential;

(l) Cognitive status; and

(m) Drug therapy.

(5) Frequency. Assessments must be conducted:
(a) No later than 14 days after the date of admission;

(b) Promptly after a significant change in the resident's physical or mental condition; and

(c) In no case less often than once every 12 months.

(6) Review of assessments. The nursing facility must examine each resident no less than once every three months, (quarterly) and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(7) The results of the assessment are used to develop, review, and revise the resident’s comprehensive plan of care.

(8) Coordination.

(a) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(9) Certification. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(a) Penalty for Falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties, as specified by the Enforcement Regulations for SNFs and NFs as published in the Federal Register on November 10, 1994, and become effective on July 1, 1995.

(b) Use of independent assessors. If the State determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph 9(a) of this section, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(10) Comprehensive care plans. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The plan of care must deal with the relationship of items or services ordered to be provided (or withheld) to the facility’s responsibility for fulfilling other requirements in these regulations.

(11) A comprehensive care plan must be:

(a) Developed within 7 days after the completion of the comprehensive assessment;

(b) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident's legal representative; and
(c) Periodically reviewed and revised by a team of qualified persons after each assessment.

(12) The services provided or arranged by the facility must:

(a) Meet professional standards of quality; and

(b) Be provided by qualified persons in accordance with each resident’s written plan of care.

(13) Discharge summary. When the facility anticipates discharge, a resident must have a discharge summary that includes:

(a) A recapitulation of the resident's stay;

(b) A final summary of the resident's status to include items in paragraph (4)(a) through (m) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(c) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(14) Pre-admission screening for mentally ill individuals and individuals with mental retardation. A nursing facility must not admit any new resident with:

(a) Mental illness as defined in paragraph (c)(1) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; and

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

2. If the individual requires such level of services, whether the individual requires specialized services for mental illness; or

(b) Mental retardation, as defined in paragraph (c)(2) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission; and

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

2. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(c) Definition. For purposes of this section:

1. An individual is considered to have "mental illness" if the individual has a serious mental illness as defined at 483.102(b)(1), of Title 42 Code of Federal Regulations revised 10/1/93.
2. An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in 483.102(b)(3) of Title 42 Code of Federal Regulations revised 10/1/93, or is a person with a related condition as described in 435.1009 of Title 42 Code of Federal Regulations revised 10/1/93.