(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient’s needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient’s condition.

(2) Implementing of each patient’s care plan according to the methods indicated. Each patient’s care shall be based on this plan.

(a) No patient shall be admitted or accepted for care by a skilled nursing facility except on the order of a physician.

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient’s care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.
(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b) There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c) The patient care plan shall be approved, signed and dated by the attending physician.

(d) There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e) At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.

S 72513. ADMINISTRATOR.

...(f) The administrator or designee shall be responsible for screening patients for admission to the facility to ensure that the facility admits only those patients for whom it can provide adequate care. The administrator, or designee, shall conduct preadmission personal interviews as appropriate with the patient's physician, the patient, the patient's next of kin or sponsor or the representative of the facility from which the patient is being transferred. A telephone interview may be substituted when a personal interview is not feasible.