PART 5. RESIDENT CARE

5.2 RESIDENT ASSESSMENT.

Within twenty-four hours of admission to the long-term care facility, a licensed nurse shall assess each resident’s physical, mental, and functional status, including strengths, impairments, rehabilitative needs, special treatments, capability for self-administration of medications, and dependence and independence in activities of daily living. The initial assessment shall form the basis of the preliminary care plan. Within seven days of admission, the nurse shall also collaborate with social services staff in assessing discharge potential and shall coordinate assessments with social services, dietetic, and activity staff. These assessments shall form the basis of the interdisciplinary care plan prescribed by Section 5.7

5.2.1 The continuing assessment shall at all times reflect resident status.

5.2.2 The assessment shall be updated at least at three month intervals, but in any event whenever a significant change of resident condition occurs.

5.2.3 The current resident assessment shall be a part of the resident’s health record and available for all direct care staff to use.

5.3 NURSING CARE PLANNING. A licensed nurse shall prepare an individualized nursing care plan for each resident based on the resident assessment prescribed by Section 5.2 and applicable physician treatment orders. The purpose of the care plan is to create an individualized tool for carrying out preventive, therapeutic, and rehabilitative nursing care.

5.3.1 Within 24 hours of admission, nursing staff shall prepare and implement a preliminary nursing care plan to meet each resident’s immediate needs.

5.3.2 Within one week of admission, nursing staff shall prepare and implement a comprehensive nursing care plan for each resident.

5.3.3 The plan shall meet each resident’s unique needs, problems, and strengths by identifying resident strengths, needs, and problems; specifying care interventions to capitalize on the strengths and meet those needs or problems; and defining the frequency of each intervention.

5.3.4 The nursing care plan shall be current and evaluated and revised following each assessment and whenever the resident’s condition changes.

5.4 SOCIAL SERVICES CARE PLANNING. Social services staff shall assess social services needs within one week of admission and develop a social services care plan to meet each resident’s needs.
5.5 ACTIVITIES CARE PLANNING. Activities staff shall assess activities needs within one week of admission and shall develop an activities care plan to meet each resident’s needs.

5.6 NUTRITIONAL CARE PLANNING.

(a) The Dietary supervisor or consultant shall prepare an initial nutritional history and assessment for each resident within two weeks of admission that includes special needs, likes and dislikes, nutritional status, and need for adaptive cutlery and dishes and develop a plan of care to meet these needs.

(b) In the event the facility elects to utilize paid feeding assistants or feeding assistant volunteers pursuant to Part 11.001 of this Chapter V, as part of the history and assessment conducted pursuant to paragraph (a) of this 5.6, the interdisciplinary team shall evaluate each resident regarding the suitability of the resident to be fed and hydrated by a feeding assistant. Such evaluation shall include, but need not be limited to each resident’s level of care, functional status concerning feeding and hydration, and, the resident’s ability to cooperate and communicate with staff.

5.7 INTERDISCIPLINARY CARE PLANNING. Within two weeks of admission, an interdisciplinary long-term care facility staff team shall develop a personalized overall care plan for each resident based on the resident assessments and applicable physician orders.

5.7.1 The overall care plan shall contain a list of resident problems and the discipline that will address each problem in its own more detailed plan of care.

5.7.2 The overall care plan shall be evaluated according to the goals set out in the plan, following each assessment and whenever the resident’s condition changes.

5.7.3 The interdisciplinary team shall consist of representatives of resident services inside and outside the facility, as appropriate, including at least nursing, social services, activities, and dietetic staff. Other persons, such as medical, pharmacy, and special therapies, shall be included as appropriate. Residents and their representatives shall be invited to participate in care planning. Refusal to participate shall be documented.

PART 8. SOCIAL SERVICES

8.1.7 Social services staff shall participate in resident assessment and care planning as prescribed by 5.2, 5.4, and 5.7, and shall provide social services to residents. Staff shall review and update the assessment and care plan at least every six months.

PART 19. SECURE UNITS

19.4 PRE-ADMISSION SCREENING AND PLACEMENT. The facility shall not place a resident into a secure unit unless the requirements of this section are met:

19.4.1 An evaluation team finds, based on available evidence, that:
(1) the resident is a serious danger to self or others, or

(2) the resident habitually wanders or would wander out of buildings and is unable to find the way back, or

(3) the resident has a significant behavior problem that seriously disrupts the rights of other residents; and in all cases

(4) less restrictive alternatives have been unsuccessful in preventing harm to self or others; and

(5) legal authority for such restrictive authority has been established.

19.4.2 The evaluation team shall consist of at least the Director of Nursing, Social Services staff member, member of the facility’s utilization control committee, if any, and a person with mental health or social work training (as appropriate to the needs of the unit’s residents) who is not a facility staff member. Such non-staff member need not participate in prior review of admissions. A facility that is a mental health “placement facility” under 27-10-101, C.R.S., et seq. shall have a person from its contracting “designated facility” on the evaluation team for evaluations of clients referred by the designated facility.

19.4.3 Written findings and their factual basis shall be documented in the health record.

19.4.4 The resident or his/her legally responsible and authorized representative gives informed, written consent, and

19.4.5 A physician has authenticated the placement.