6.3 Nursing Administration

6.3.3 Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs. This assessment shall include, at a minimum, the following information:

6.3.3.1 Identification, background and demographic information
6.3.3.2 Customary routine
6.3.3.3 Cognitive patterns
6.3.3.4 Communication
6.3.3.5 Vision
6.3.3.6 Mood and behavior patterns
6.3.3.7 Psychosocial well-being
6.3.3.8 Physical functioning and structural problems
6.3.3.9 Continence
6.3.3.10 Disease diagnoses and health conditions
6.3.3.11 Dental and nutritional status
6.3.3.12 Skin condition
6.3.3.13 Activity pursuits
6.3.3.14 Medications
6.3.3.15 Special treatments and procedures
6.3.3.16 Discharge potential

6.3.4 The resident assessment shall include a screening instrument for mental illness, mental retardation, and developmental disabilities to assess if an individual has an active treatment need for one of these conditions.

6.3.5 Based on the physician's admission orders and the admission information for each resident, an interim individual nursing care plan shall be developed within 24 hours of admission pending the completion of a comprehensive resident assessment.
6.3.6 A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.

6.3.7 The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.

6.3.8 The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

6.3.8.1 The resident’s comprehensive assessment shall document the medical symptom(s) potentially requiring the use of restraints.

6.3.8.2 The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.

6.3.8.3 The resident’s care plan shall document the facility’s use of interventions, such as modifying the resident’s environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.

6.5 Food Service

6.5.3 Nutritional Assessment

6.5.3.1 The immediate nutritional needs of each resident shall be addressed upon admission.

6.5.3.2 A comprehensive nutritional assessment which includes an evaluation of each resident's caloric, protein, and fluid requirements shall be completed within 14 days of admission in consultation with a dietitian.

6.5.3.3 The facility shall have an ongoing evaluation and assessment program to meet the nutritional needs of all residents.