
Each nursing facility shall conduct at the time of admission, and periodically thereafter, a comprehensive assessment of a resident’s needs on an instrument approved by the secretary of health and environment.

(a) The comprehensive assessment shall include at least the following information:

(1) Current medical condition and prior medical history;
(2) measurement of the resident’s current clinical status;
(3) physical and mental functional status;
(4) sensory and physical impairments;
(5) nutritional status and impairments;
(6) special treatments and procedures;
(7) mental and psychosocial status;
(8) discharge potential;
(9) dental condition;
(10) activities potential;
(11) rehabilitation potential;
(12) cognitive status; and
(13) drug therapy.

(b) A comprehensive assessment shall be completed:

(1) Not later than 14 days after admission;
(2) not later than 14 days after a significant change in the resident’s physical, mental, or psychosocial condition; and;
(3) at least once every 12 months.

(c) The nursing facility staff shall examine each resident at least once every three months, and as appropriate, revise the resident’s assessment to assure the continued accuracy of the assessment.
(d) Changes in a resident's condition which are self-limiting and which will not affect the functional capacity of the resident over the long term do not in themselves require a reassessment of the resident.

(e) The nursing facility shall use the results of the comprehensive assessment to develop, review, and revise the resident's comprehensive plan of care under subsection (h).

(f) The nursing facility shall conduct or coordinate each assessment with the participation of appropriate health professionals.

(g) A registered professional nurse shall conduct or coordinate each comprehensive assessment and shall sign and certify that the assessment has been completed.

(h) Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment.

(2) The comprehensive care plan shall be:

(A) Developed within seven days after completion of the comprehensive assessment; and

(B) prepared by an interdisciplinary team including the attending physician, a registered nurse with responsibility for the care of the resident, and other appropriate staff in other disciplines as determined by the resident's needs, and with the participation of the resident, the resident's legal representative, and the resident's family to the extent practicable.

(i) The services provided or arranged by the facility shall:

(1) Meet professional standards of quality; and

(2) be provided by qualified persons in accordance with each resident's written plan of care.

(j) Discharge summary. When the facility anticipates discharge of a resident, a discharge summary shall be developed which includes the following:

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

(2) a final summary of the resident's status which includes the items found in the comprehensive assessment, K.A.R. 28-39-151

(a). This summary shall be available for release at the time of discharge to authorized persons and agencies, with the consent of the resident or the resident's legal representative; and

(3) a post-discharge plan to assist the resident in the adjustment to a new environment. The resident, and when appropriate, the resident's family, shall participate in the development of the plan.

(Authorized by and implementing K.S.A. 39-932; effective Nov. 1, 1993; amended Feb. 21, 1997.)
28-39-160. Other resident services.

(a) Special care section. A nursing facility may develop a special care section within the nursing facility to serve the needs of a specific group of residents.

...(12) The comprehensive resident assessment shall indicate that the resident would benefit from the program offered by the special care section.

(13) The resident comprehensive care plan shall include interventions that effectively assist the resident in correcting or compensating for the identified problems or need.

...(c) Respite care. A nursing facility may provide respite care to individuals on a short-term basis of not more than 30 consecutive days.

(3) The facility may obtain an order from the resident’s physician indicating that the resident may return to the facility at a later date for respite care.

...(B) Each time the resident returns to the facility for subsequent respite services, the resident’s physician shall review the physician plan of care and shall indicate any significant change that has occurred in the resident’s medical condition since the previous stay.

(C) The facility shall review and revise the comprehensive assessment and care plan, if needed.

(D) The facility shall conduct a comprehensive assessment after any significant change in the resident’s physical, mental, or psychosocial functioning and not less often than once a year.