10.07.02.35 Resident Care Management System.

A. Each comprehensive care facility and extended care facility shall establish and maintain a resident care management system.

B. The resident care management system shall be comprised of three interrelated components:

   (1) Resident status assessment and data gathering;
   (2) Care planning; and
   (3) Actions in response to care plan approaches.

10.07.02.36 Resident Status Assessment.

A. Disciplines shall record all assessments on a form approved by the Department.


C. A facility shall use the following forms and procedures for resident assessment as described in the State Operations Manual for Provider Certification:

   (1) Minimum Data Set (MDS) version as determined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, in Transmittal No. 22, referenced in §B of this regulation;
   (2) Resident Assessment Protocol Summary;
   (3) MDS Quarterly Assessment Form;
   (4) Maryland Monthly Assessment; and
   (5) Care plans.

D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343.
E. All facilities certified for participation in Medicare or Medicaid shall complete and electronically submit the assessment to the Department not later than 31 days after completion of the assessment.

F. A facility as a comprehensive or extended care facility but not certified for participation in the Medicare or Medicaid Program shall comply with the State Operations Manual for Provider Certification, except that data may not be electronically submitted to the Department.

10.07.02.37 Care Planning.

A. An interdisciplinary team shall complete a resident specific care plan for each resident within 7 calendar days following completion of all assessments.

B. A care plan under this regulation shall be based upon assessments conducted at the following times:

(1) Admission;

(2) Annual;

(3) Quarterly; and

(4) Significant change in the resident's condition.

C. A facility shall give a family member or resident's representative 7 calendar days advance notice, in writing, of the location, date, and time of the care planning conference for a resident for whom a family member or representative is interested. The notification shall include an invitation for the family member or resident's representative to attend the conference.

D. The facility shall hold the care planning conference not later than 7 calendar days after completion of the assessment, but may hold the conference earlier if agreed to by the resident, a family member, or a resident's representative.

E. Organization of Care Plan.

(1) Problems and needs shall be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan.

(2) The team shall establish goals for each problem or need identified. The goal shall be realistic, practical, and tailored to the resident's needs. Goal outcome shall be measurable in time or degree, or both.

(3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how frequently it is to be performed.
F. Disciplines shall update the care plans as the resident’s assessment warrants, but not less than quarterly.

G. Availability of Resident Care Plan. Resident care plans shall be readily available for use by all health care personnel.

10.07.02.38 Special Skin Record.

A. The facility shall establish a skin care record documenting skin, hair, and nail condition on admission, if any abnormal conditions exist.

B. The staff shall document progression of the condition or conditions weekly until the condition or conditions have healed.

C. At any time that a skin condition persists for more than 7 days, staff shall add the condition to the skin record.