12-006.09B Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, and reproducible assessment of each resident's functional capacity to identify the resident's abilities and needs. The assessment must include documentation of:

1. Medical conditions (diagnoses) and prior medical history;

2. Medical status measurements, including:
   a. Height;
   b. Weight;
   c. Blood pressure; and
   d. Laboratory findings (i.e., hemoglobin, hemocrit, sodium, potassium, blood sugar, etc.);

3. The resident's capability to perform daily life functions and significant impairments in functional capacity;

4. Physical and mental functional status;

5. Sensory and physical impairments;

6. Nutritional status and requirements, including:
   a. Observations for signs of nutritional deficiency;
   b. Feeding and swallowing problems;
   c. Food preferences and tolerances;
   d. Nutritional implications of medicines prescribed; and
   e. Evaluation of the current height and weight status;

7. Special treatments or procedures;

8. Mental and psychosocial status, including:
   a. Medically related social services needs of resident;
   b. Evaluation of resident's physical, mental and psychosocial functioning, and social service support needs; and
c. Evaluation of outside contacts, frequency of visitors, use of free time, communication, orientation, and behavior;

9. Discharge potential, including:
   a. Status of independent functioning;
   b. Availability of support personnel at home;
   c. Services needed; and
   d. Financial resources;

10. Dental condition;

11. Activities potential, including:
   a. Individual activity interests and physical, mental, and psychosocial abilities;
   b. Preadmission hobbies and interests;
   c. Participation in activities;
   d. Daily activity needs to stimulate and promote physical, spiritual, social, emotional, and intellectual well-being of each resident; and
   e. The interest and needs of bedridden residents and those otherwise unable or unwilling to participate in group activities;

12. Rehabilitation potential;

13. Cognitive status; and


12-006.09B1 Frequency: The facility must ensure that a comprehensive assessment is completed:

   1. No later than 14 days after the date of admission;
   
   2. By the end of the 14th calendar day following the determination that a significant change has occurred; and
   
   3. In no case less often than once every twelve months.

12-006.09B2 Review of Assessments: The facility must complete an assessment of each resident no less than once every 3 months, and as appropriate, revise the resident’s assessment to ensure accuracy of the assessment.
12-006.09C Comprehensive Care Plans: The facility must develop and implement a comprehensive interdisciplinary care plan for each resident to ensure that there is provision of quality care. The comprehensive care plan must be designed to permit achievement and maintenance of optimal functional status and independence. The care plan must include and specify:

1. An interdisciplinary evaluation of resident needs;
2. Measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment;
3. The services that are to be furnished to attain or maintain the resident's highest practicable well-being;
4. Goals for the residents that are time limited and measurable;
5. A discharge plan based on the needs of the individual; and
6. The discipline(s) responsible for providing specific care and the frequency of the interventions.

12-006.09C1 Frequency of Care Plans: The facility must develop and implement care plans in accordance with the following time frames:

12-006.09C1a Preliminary Nursing Care Plan: The facility must develop a preliminary nursing assessment and nursing care plan in accordance with the medical practitioner's admission orders within 24 hours of the resident's admission.

12-006.09C1b Comprehensive Care Plan: The facility must develop a comprehensive interdisciplinary care plan and discharge plan within seven days after the completion of the comprehensive assessment.

12-006.09C1c Review and Revision: The facility must review and revise the care plan at least quarterly or with change in condition or services provided. Review of the care plan must include an interdisciplinary evaluation of the resident's progress relative to the goals established.
12-006.09C2 Discharge Planning: The facility must develop a post discharge plan of care for any resident when there is anticipated discharge to a home, same level, or a different level of care. The discharge plan of care must be developed with the participation of the resident and resident’s family. The post discharge plan of care is developed to assist the resident in planning for post discharge needs and assist the resident to adjust to new living environment.

12-006.09C3 Discharge Summary: When the facility discharges a resident, the facility must have a discharge summary. The facility must ensure the discharge summary includes the resident’s status at time of discharge, which is available for release to authorized persons and agencies with the consent of the resident or resident’s designee. The discharge summary must include:

1. Resident’s full name;
2. Medical record number;
3. Admission date;
4. Discharge date;
5. Name of attending medical practitioner;
6. Date and time of discharge;
7. Recapitulation of resident’s stay;
8. Final diagnosis;
9. Date summary completed; and
10. Signature of the person completing the summary.

12-006.09C3a Discharge to Another Setting: When the facility discharges a resident to a different facility setting or service, in addition to 1-10 above, the discharge summary must also include:

1. Medically defined conditions;
2. Medical status measurement;
3. Functional status;
4. Sensory and physical impairments;
5. Nutritional status and requirements;
6. Special treatments and procedures;
7. Psychosocial status;
8. Discharge potential;
9. Dental condition;
10. Activities potential;
11. Rehabilitation potential;
12. Cognitive status; and
13. Drug therapy, including education.