NAC 449.74431 SUMMARY OF DISCHARGE. (NRS 449.037)

1. A facility for skilled nursing shall prepare a summary of discharge for each patient discharged from the facility.

2. A summary of discharge must include:
   (a) A summary of the pertinent information relating to the patient’s stay at the facility;
   (b) A final summary of the patient’s physical, mental and psychosocial health at the time of discharge, including, without limitation, the information required to be included in a comprehensive assessment of the patient pursuant to subsection 2 of NAC 449.74433; and
   (c) A plan of care for the patient after his discharge that assists the patient in adjusting to his new living environment. The plan of care must be developed with the participation of the patient and members of his family.

3. A facility for skilled nursing may release a summary of discharge to persons and under the circumstances approved by the patient who is the subject of the summary or his legal representative.

(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

NAC 449.74433 COMPREHENSIVE ASSESSMENT OF NEEDS OF PATIENT. (NRS 449.037)

1. A facility for skilled nursing shall conduct a comprehensive assessment of the needs of each patient in the facility using the assessment instrument specified by the Bureau.

2. A comprehensive assessment must include, without limitation:
   (a) Demographic and other pertinent information required to identify the patient;
   (b) The customary routine of the patient;
   (c) The cognitive patterns of the patient;
   (d) An analysis of the communication skills of the patient;
   (e) An analysis of the vision of the patient;
   (f) The mood and behavior patterns of the patient;
(g) An analysis of the psychosocial well-being of the patient;
(h) Any problems related to the functional or structural physical condition of the patient;
(i) The patient’s pattern of continence;
(j) The physical condition of the patient, including the diagnosis of any diseases which the patient may have;
(k) An analysis of the nutritional needs of the patient;
(l) The dental condition of the patient;
(m) The condition of the patient’s skin;
(n) Activities in which the patient is interested;
(o) Medications required to be taken by the patient;
(p) Any special treatments and procedures required by the patient;
(q) The probability of discharging the patient from the facility and any other information related to the discharge of the patient from the facility;
(r) Documentation of summary information relating to any additional assessment performed in accordance with the patient’s assessment protocols; and
(s) Documentation of the patient’s participation in the assessment.

3. The information to be included in a comprehensive assessment must be obtained from the direct observation of and communication with the patient and from communications with the members of the staff who care for the patient.

4. A comprehensive assessment must be conducted:

(a) Within 14 days after the patient’s admission to the facility. The provisions of this paragraph do not require a comprehensive assessment of a patient who is readmitted to the facility following a temporary absence from the facility for hospitalization or therapeutic leave if there is not a significant change in the physical or mental condition of the patient.

(b) Within 14 days after there has been a significant decline or improvement in the physical or mental condition of the patient that:

(1) Requires intervention by a member of the facility’s staff or further medical treatment;
(2) Has affected more than one aspect of the patient’s health; and
(3) Requires review by an interdisciplinary team or a revision of the patient’s plan of care, or both.

(c) At least once every 12 months, but in no event later than 365 days after the completion of the most recent comprehensive assessment.
5. A comprehensive assessment must accurately reflect the physical, mental and psychosocial health of the patient.

(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

**NAC 449.74435 QUARTERLY ASSESSMENT OF PATIENT. (NRS 449.037)**

1. A facility for skilled nursing shall, not less than every 3 months, conduct an assessment of each patient in the facility using the quarterly assessment instrument approved by the Bureau.

2. Each quarterly assessment must accurately reflect the physical, mental and psychosocial health of the patient.

(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

**NAC 449.74437 CONDUCT OF ASSESSMENTS. (NRS 449.037)**

1. The assessments required by NAC 449.74433 and 449.74435 must be conducted by a registered nurse or coordinated by a registered nurse with the participation of other appropriate health care professionals. Each person who completes a portion of the assessment shall certify the accuracy of that portion. The registered nurse shall certify that the assessment is completed.

2. A facility for skilled nursing shall coordinate the assessments required by NAC 449.74433 and 449.74435 with other screening programs required to be conducted upon the patient’s admission to the facility to the extent practicable to avoid the duplication of efforts.

3. Each assessment required by NAC 449.74433 and 449.74435 must be:

   (a) Maintained in the medical record of the patient for at least 15 months after the assessment is conducted.

   (b) Used to develop, review and revise the patient’s plan of care.

(Added to NAC by Bd. of Health by R051-99, eff. 9-27-99)

**NAC 449.74439 COMPREHENSIVE PLAN OF CARE. (NRS 449.037)**

1. A facility for skilled nursing shall develop for each patient in the facility a comprehensive plan of care.

2. A comprehensive plan of care must include:

   (a) Measurable objectives and timetables to meet the physical, mental and psychosocial needs of the patient that are identified in the comprehensive assessment required by NAC 449.74433:
(b) A description of the services that will be provided to the patient to attain or maintain his highest practicable physical, mental and psychosocial well-being; and

(c) A description of the services that would otherwise be provided to the patient, but will not be provided because of the patient’s refusal to accept those services.

3. A comprehensive plan of care must be:

(a) Developed within 7 days after the completion of the initial comprehensive assessment required by NAC 449.74433 and periodically reviewed and revised after each subsequent assessment; and

(b) Prepared by an interdisciplinary team that includes the patient’s attending physician, a registered nurse who is responsible for the care of the patient and such other members of the staff of the facility as are appropriate to provide services in accordance with the needs of the patient. To the extent practicable, the patient, his legal representative and members of his family must be allowed to participate in the development of the plan of care.

4. Services provided to a patient in a facility for skilled nursing must:

(a) Comply with the professional standards of quality applicable to those services; and

(b) Be provided by qualified persons in accordance with the patient’s plan of care.