SECTION 415.11 - RESIDENT ASSESSMENT AND CARE PLANNING

415.11 Resident assessment and care planning. Upon admission and periodically thereafter the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity. Based on the results of these assessments, the facility shall develop and keep current an individualized comprehensive plan of care to meet each resident’s needs.

(a) Comprehensive assessments. (1) The facility shall conduct a comprehensive assessment of each resident’s needs, which describes the resident’s capability to perform daily life functions and identifies significant impairments in functional capacity. All comprehensive assessments completed after April 1, 1991 shall be recorded on a uniform data instrument designated by the Department of Health.

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

(i) medically defined conditions and prior medical history,

(ii) medical status measurement,

(iii) physical and mental functional status

(iv) sensory and physical impairments,

(v) nutritional status and requirements,

(vi) special treatments or procedures,

(vii) discharge potential,

(viii) mental and psychosocial status,

(ix) dental condition,

(x) activities potential,

(xi) rehabilitation potential,

(xii) cognitive status, and

(xiii) drug therapy.

(3) Frequency. Comprehensive assessments shall be conducted:

(i) no later than 14 days after the date of admission;
(ii) promptly after a significant improvement or decline in the resident’s physical, mental or psychosocial status in accordance with generally accepted standards of care and services; and

(iii) in no case less often than once every 12 months for each resident.

(4) Review of assessments. Professional staff shall examine each resident no less than once every 3 months, and as appropriate, revise the resident’s comprehensive assessment to assure the continued accuracy of the assessment.

(5) Use. The results of the comprehensive assessment shall be used by the interdisciplinary care team as defined in subparagraph (ii) of paragraph (2) of subdivision (c) of this section to develop, review, and revise the resident’s comprehensive plan of care, under subdivision (c) of this section.

(b) Accuracy of assessments. (1) Coordination. (i) Each assessment shall be conducted or coordinated, with the participation of appropriate health professionals.

(ii) Each assessment shall be conducted, or coordinated, by a registered professional nurse who signs and certifies the completion of the assessment.

(2) Certification. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.

(3) Penalty for falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment shall be subject to civil money penalties under federal statutes and regulations.

(4) Use of independent assessors. If the department determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (3) of this subdivision, the department shall require remedial measures, which may include but not be limited to requiring that resident assessments under this section be conducted and certified at the facility’s expense by individuals who are independent of the facility and who are approved by the department.

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

(i) The care plan shall reflect a consideration of the resident’s ability to self-administer drugs safely.

(ii) The facility shall clearly document those instances in which recommended items or services are not made part of the comprehensive care plan due to the stated contrary wishes of a competent resident or a designated representative who has the authority to make health care decisions for a resident who lacks capacity.

(2) A comprehensive care plan shall be:

(i) developed within 7 working days after completion of the comprehensive assessment;
(ii) prepared by an interdisciplinary team that includes the attending physician, a registered professional nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and with the participation of the resident and the resident's family or legal representative to the extent practicable; and

(iii) periodically reviewed and revised as necessary by an interdisciplinary team of qualified persons after each comprehensive assessment or reassessment. (3) The services provided or arranged by the facility shall:

(i) meet generally accepted standards of care and service; and

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

(d) Discharge summary. When the facility anticipates discharge, the facility shall prepare a discharge summary that includes:

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

(2) a final summary of the resident's status to include information set forth in paragraph (2) of subdivision (a) of this section, at the time of the discharge that shall be available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) a post-discharge plan of care that shall be developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident.

(e) Patient assessment and annual resident review (PASARR). The facility shall conduct, at least annually, a review of residents with known or suspected mental impairment or mental retardation utilizing the pertinent portions of the SCREEN instrument set forth in section 400.12 of this Title. Residents screened as mentally impaired or mentally retarded by this process shall be referred to the commissioner's designee for evaluation of the need for active treatment for mental impairment or mental retardation and for need for nursing home services.

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(i) Admission Policies and Practices.

(1) The nursing home shall:

(i) admit a resident only on physician's orders and in accordance with the resident assessment criteria and standards as promulgated and published by the department, and specified in sections 86-2.30(i) and 400.12 of this Title, which shall include, as a minimum:

(a) an assessment, performed prior to admission by or on behalf of the agency or person seeking admission for the resident of the resident's level of care needs according to the
resident assessment criteria and standards promulgated and published by the department (and specified in sections 86-2.30(i) and 400.12 of this Title)...