44:04:06:05. Patient or resident care plans and programs. The nursing service of a
health care facility must provide safe and effective care from the day of admission
through the ongoing development and implementation of written care plans for
each patient or resident. The care plan must address medical, physical, mental, and
emotional needs of the patient or resident. The health care facility must establish
and implement procedures for assessment and management of symptoms including
pain. The care plan for nursing facility residents must be based on the resident
assessments required in §§ 44:04:06:15 and 44:04:06:16 and must be developed
and approved by the resident’s physician; the resident, the resident’s family, or the
resident’s legal representative; the interdisciplinary team consisting of at least a
licensed nurse, the facility’s social worker or social service designee, the dietary
manager or dietician, the activities coordinator, and other staff in disciplines
determined by the resident’s needs. The care plan shall describe the services
necessary to meet the resident’s medical, physical, mental or cognitive, nursing, and
psychosocial needs and shall contain objectives and timetables to attain and
maintain the highest level of functioning of the resident. The care plan must be
completed within seven days after the completion of each resident assessment
required in §§ 44:04:06:15 and 44:04:06:16. Each nursing facility must provide
restorative care services to meet resident needs.

Source: SL 1975, ch 16, § 1; 4 SDR 14, effective September 14, 1977; 6 SDR 93, effective
July 1, 1980; 14 SDR 81, effective December 10, 1987; 17 SDR 122, effective February
24, 1991; 22 SDR 70, effective November 19, 1995; 26 SDR 96, effective January 23,
Law Implemented: SDCL 34-12-13. Cross-Reference: Record content, §
44:04:09:05(4).

44:04:06:15. Resident assessments. Each nursing facility must make a comprehensive
assessment of the functional, medical, mental, nursing, and psychosocial needs of each
resident within 14 calendar days after the date of admission. The facility must use the
resident assessment instrument described in the Long Term Care Resident Assessment
Instrument User’s Manual or an instrument substantially equivalent as determined by the
department. The resident assessment must be completed with participation of the
interdisciplinary team, the resident, and the resident’s family or legal representative. A
registered nurse must conduct or coordinate the completion of the resident assessment
process. The registered nurse must receive resident assessment instrument training
provided or approved by the department and the Department of Social Services. The facility
must ensure that staff who participate in the assessment process are trained to complete an
accurate and comprehensive assessment. Each individual who completes a portion of the
resident assessment instrument must sign that portion of the assessment and certify to its
accuracy.
44:04:06:16. Resident assessment reviews. A nursing facility must periodically reassess each resident by conducting a resident assessment review that meets the requirements in § 44:04:06:15. Resident assessment reviews must be completed on the following schedule:

(1) Every 90 days after the date of admission or significant change;

(2) Within 14 days after the determination of a significant change by the interdisciplinary team. A significant change determination may be considered if there is a deterioration in physical functioning; in cognition, behavior, mood, or relationships; or other deterioration in health indicating an interdisciplinary review and revision of the care plan is necessary; and

(3) Within 14 days after a marked or sudden improvement in the resident’s health.