5. RESIDENT ASSESSMENT

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

5.1 Admission Orders

At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.

5.2 Comprehensive Assessments

(a) The facility must make a comprehensive assessment of the resident’s needs which

(1) is based on a uniform data set and instrument specified by the licensing agency; and

(2) describes the resident’s capability to perform daily life functions and any significant impairments in functional capacity.

(b) The comprehensive assessment must include at least the following information:

(1) medically defined conditions and prior medical history;

(2) medical status measurement;

(3) physical and mental functional status;

(4) sensory and physical impairments;

(5) nutritional status and requirements;

(6) special treatments or procedures;

(7) mental and psychosocial status;

(8) discharge potential;

(9) dental condition;

(10) activities potential;

(11) rehabilitation potential;

(12) cognitive status; and

(13) drug therapy.
(c) Frequency. Assessments must be conducted:

(1) no later than 14 days after the date of admission;

(2) promptly after a significant change in the resident’s physical or mental condition; and

(3) in no case less often than once every 12 months.

(d) Review of Assessments. The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident’s assessment to assure the continued accuracy of the assessment.

(e) Use. The results of the assessment are used to develop, review, and revise the resident’s comprehensive plan of care under Section 6 of these rules.

(f) Coordination. The facility must coordinate assessments with any state-required pre-admission screening program to the maximum extent practicable to avoid duplicative testing and effort.

5.3 Accuracy of Assessments

(a) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(b) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(c) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) 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 is subject to civil money penalties pursuant to 42 C.F.R. Part 1003.

(e) Use of independent assessors. If the licensing agency determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subsection 5.3(c) above, the licensing agency may require (for a period specified by the licensing agency) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the licensing agency.

6. COMPREHENSIVE CARE PLANS

6.1 Development of Care Plan

(a) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:

(1) the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental and psychosocial well-being as required under Section 7; and
(2) any services that would otherwise be required under Sections 3 and 4 but are not provided due to the resident’s exercise of rights including the right to refuse treatment.

6.2 Procedure for Preparation of Care Plan

(a) A comprehensive care plan must be:

(1) developed within 7 days after the completion of the comprehensive assessment;

(2) prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family and/or the resident’s legal representative; and

(3) periodically reviewed and revised by a team of qualified persons after each assessment.

6.3 Services Provided Under a Care Plan

The services provided or arranged by the facility must:

(a) meet professional standards of quality; and

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

6.4 Discharge Summary

When a discharge is anticipated, a facility must prepare for the resident a discharge summary that includes:

(a) a recapitulation of the resident’s stay;

(b) a final summary of the resident’s status to include items in subsection 6.2(b) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(c) a post-discharge plan of care that is 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.