State Regulations Pertaining to Resident Assessment

Note: This document is arranged alphabetically by State. To move easily from State to State, click the “Bookmark” tab on the Acrobat navigation column to the left of the PDF document. This will open a Table of Contents for the document. The relevant federal regulations are at the end of the PDF.

ALABAMA

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420-5-10-.09 Resident Assessment.

(1) Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

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

(3) Comprehensive assessments. The facility must make a comprehensive assessment of a resident’s needs which:

(a) For Medicare/Medicaid certified facilities only, is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and

(b) Describes the resident's capability to perform daily life functions and significant impairments in a functional capacity.

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

(a) Medically defined conditions and prior medical history;

(b) Medical status measurement;

(c) Physical and mental functional status;

(d) Sensory and physical impairments;

(e) Nutritional status and requirements;

(f) Special treatments or procedures;

(g) Mental and psychosocial status;

(h) Discharge potential;

(i) Dental condition;
(j) Activities potential;
(k) Rehabilitation potential;
(l) Cognitive status; and
(m) Drug therapy.

(5) Frequency. Assessments must be conducted:
(a) No later than 14 days after the date of admission;
(b) Promptly after a significant change in the resident’s physical or mental condition; and
(c) In no case less often than once every 12 months.

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

(7) The results of the assessment are used to develop, review, and revise the resident’s comprehensive plan of care.

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

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

(a) 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, as specified by the Enforcement Regulations for SNFs and NFs as published in the Federal Register on November 10, 1994, and become effective on July 1, 1995.

(b) Use of independent assessors. If the State determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph 9(a) of this section, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(10) Comprehensive care plans. 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 plan of care must deal with the relationship of items or services ordered to be provided (or withheld) to the facility’s responsibility for fulfilling other requirements in these regulations.
(11) A comprehensive care plan must be:

(a) Developed within 7 days after the completion of the comprehensive assessment;

(b) Prepared by an interdisciplinary team, that 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 or the resident's legal representative; and

(c) Periodically reviewed and revised by a team of qualified persons after each assessment.

(12) 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.

(13) Discharge summary. When the facility anticipates discharge, a resident must have 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 paragraph (4)(a) through (m) of this section, 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.

(14) Pre-admission screening for mentally ill individuals and individuals with mental retardation. A nursing facility must not admit any new resident with:

(a) Mental illness as defined in paragraph (c)(1) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; and

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

2. If the individual requires such level of services, whether the individual requires specialized services for mental illness; or

(b) Mental retardation, as defined in paragraph (c)(2) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission; and

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
2. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(c) Definition. For purposes of this section:

1. An individual is considered to have "mental illness" if the individual has a serious mental illness as defined at 483.102(b)(1), of Title 42 Code of Federal Regulations revised 10/1/93.

2. An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in 483.102(b)(3) of Title 42 Code of Federal Regulations revised 10/1/93, or is a person with a related condition as described in 435.1009 of Title 42 Code of Federal Regulations revised 10/1/93.


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7 AAC 12.270. Staff duties

(a) The nursing facility staff shall encourage and assist residents to achieve and maintain their highest level of self-care and independence. A registered nurse, in conjunction with an interdisciplinary team, shall, within 14 days of admission of a resident, ensure completion of the comprehensive resident assessment instrument approved by the department. The assessment shall be reviewed by the nurse and interdisciplinary team no less frequently than quarterly and the plan of care revised as necessary. A reassessment shall be completed, by the nurse and interdisciplinary team, after any major permanent change in condition of the resident, but no less frequently than annually.

7 AAC 12.670. Nursing service

(a) A licensed nurse shall write a patient care plan for each patient in consultation with other patient care personnel and the patient.

(b) The patient care plan must reflect analysis of patient problems and needs, treatment goals, medication prescribed and, upon discharge, instructions given to the patient and the patient’s family regarding medication management, including any risks, side effects, and benefits expected, and including any recommended activities and diet.
R9-10-906. Nursing Services

...B. A director of nursing shall ensure that:

...5. At the time of a resident’s admission, an initial assessment is performed on the resident to ensure the resident’s immediate needs are met such as medication and food services;

6. A comprehensive assessment is performed by a registered nurse and coordinated by the registered nurse in collaboration with an interdisciplinary team and includes the information listed in subsection (B)(8);

7. The comprehensive assessment required in subsection (B)(6) is performed on a resident:

a. Within 14 days of admission to a nursing care institution; and

b. No later than 12 months from the date of the last comprehensive assessment;

8. A comprehensive assessment includes the resident’s:

a. Vital signs,

b. Diagnosis,

c. Medical history,

d. Treatment,

e. Dental condition,

f. Nutritional condition and nutritional needs,

g. Medications,

h. Clinical laboratory reports,

i. Diagnostic reports,

j. Capability to perform activities of daily living,

k. Psychosocial condition,

l. Cognitive condition,

m. Impairments in physical and sensory functioning,

n. Potential for recreational activities,
o. Potential for rehabilitation, and
p. Potential for discharge.

9. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, a physician's designee, or a registered nurse determines the resident has a significant change in condition;

10. A care plan is developed, documented, and implemented for a resident within seven days of completing the comprehensive assessment required in subsection (B)(6);

11. The care plan required in subsection (B)(10):
   a. Is reviewed and revised as necessary if a resident has had a significant change in condition; and
   b. Ensures that a resident is provided nursing services to maintain the resident's highest practicable well-being according to the resident's comprehensive assessment;

12. A resident's comprehensive assessment is reviewed by a registered nurse at least every three months from the date of the current comprehensive assessment and revised if there is a significant change in the resident's condition.

R9-10-908. Admission

An administrator shall ensure that:

...5. Within 30 days before admission or 10 days after admission, a medical history and physical examination is completed on a resident by:

   a. A physician; or

   b. A physician assistant or a registered nurse practitioner designated by the attending physician.

R9-10-909. Transfer or Discharge

...C. Except in an emergency, a director of nursing shall ensure that before a resident is transferred or discharged:

1. A written plan is developed with the resident or the resident's representative that includes:

   a. Information necessary to meet the resident's need for medical services and nursing services; and

   b. The state long-term care ombudsman's name, address, and telephone number;
2. A discharge summary is:
   a. Developed by a staff member providing direct care and authenticated by the resident’s attending physician or designee; and
   b. Documented in the resident’s medical records;

3. The discharge summary includes:
   a. The resident’s medical condition at the time of transfer or discharge;
   b. The resident’s medical and psychosocial history;
   c. The date of the transfer or discharge; and
   d. The location of the resident after transfer or discharge;

4. A copy of the written plan is provided to the resident or the resident’s representative and to the receiving health care institution.

**ARKANSAS**

**318 ADMISSION, TRANSFER, AND DISCHARGE POLICIES**

These policies shall include, as a minimum, the following:

318.1 Patients shall be admitted to the facility only on the recommendation of a physician licensed to practice medicine in the State of Arkansas.

318.2 All persons admitted to a nursing home shall have a history and physical examination at the time of admission or within seventy-two (72) hours following admission unless such examination was performed within fifteen (15) days prior to admission. A copy of the hospital history, physical, and discharge summary (after completion) will satisfy the requirement if the history and physical was completed within thirty (30) days. The examination will be for medical evaluation purposes and to determine if the patient is free from communicable diseases.

318.3 Recording shall be made of initial examination and all subsequent examinations, including findings, recommendations and progress notes. Hospital discharge summaries are to be obtained after each hospitalization.

318.4 Patients who are not receiving public assistance from the Division shall be classified, on admission and subsequently re-classified, by the attending physician as skilled care, intermediate care, or minimum care patients and a report shall be kept in the home and available to the Division. The classification shall be based upon the Division’s criterion.
Only those persons are accepted whose needs can be met by the facility directly or in cooperation with the community resources or other providers of care with which it is affiliated or has contracts.

903 ASSESSMENTS [Alzheimer’s Special Care Unit]

a. Psychosocial and Physical Assessments

1. Each resident shall receive a psychosocial and physical assessment which includes the resident’s degree or level of family support, level of activities of daily living functioning, cognitive level, behavioral impairment, and that identifies the resident’s strengths and weaknesses.

2. Prior to admission to the ASCU, the applicant must be evaluated by, and have received from a physician, a diagnosis of Alzheimer’s or related dementia.

b. Individual Assessment Team (IAT)

1. Within 30 days after admission, the IAT shall prepare for each resident an individual support plan. The ISP shall address specific needs of, and services required by, the resident resulting from the resident’s Alzheimer’s disease or related dementia. The plan shall include and identify professions, disciplines, and services that:

A. Identifies and states the resident’s medical needs, social needs, disabilities and their causes;

B. Identifies the resident’s specific strengths;

C. Identifies the resident’s specific behavioral management needs;

D. Identifies the resident’s need for services without regard to the actual availability of services;

E. Identifies and quantifies the resident’s speech, language, and auditory functioning;

F. Identifies and quantifies the resident’s cognitive and social development; and,

G. Identifies and specifies the independent living skills and other services provided by the ASCU to meet the needs of the resident.

2. The IAT shall perform accurate assessments or reassessments annually, and upon a change to a resident’s physical, mental, emotional, functional, or behavioral condition or status in which the resident:

A. Is regressing in, or losing, skills already gained;

B. Is failing to progress toward or maintain identified objectives in the ISP; or,

C. Is being considered for changes in the resident’s ISP.
c. Individual Support Plan (ISP)

1. The ISP shall include a family and social history. If the family and social history cannot be obtained, the ASCU personnel shall document attempts to obtain the information, including but not limited to, the names and telephone numbers of individuals contacted, or whom the facility attempted to contact, and the date and time of the contact or attempted contact.

2. The ISP shall be reviewed, evaluated for its effectiveness, and up-dated at least quarterly, and shall be updated when indicated by changing needs of the resident, or upon any reassessments by the IAT. In the event that the reassessment by the IAT documents a change of condition for which no change in services to meet resident needs are required, the ISP shall document the change of condition, and the reason or reasons why no change in services are required.

3. The ISP shall include:

   A. Expected behavioral outcomes;
   B. Barriers to expected outcomes;
   C. Services, including frequency of delivery, designed to achieve expected behavioral outcomes;
   D. Methods of assessment and monitoring. Monitoring shall occur no less than quarterly to determine progress toward the outcome;
   E. Documentation of results from services provided, and achievement towards expected outcomes or regression, and reasons for the regression; and,
   F. The resident's likes, dislikes, and if appropriate, his or her choices.

4. A copy of the ISP shall be made available to all staff that work with the resident, and the resident or his or her responsible party.

5. The ISP shall be implemented only with the documented, written consent of the resident or his or her responsible party.

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904 ADMISSIONS, DISCHARGES, TRANSFERS [Alzheimer’s Special Care Unit]

a. Criteria for Services

1. Each Alzheimer’s Special Care Unit shall have written policies setting forth pre-admission screening, admission, and discharge procedures.

2. Admission criteria shall require:

   A. A physician’s diagnosis of Alzheimer’s disease or related dementia;
   B. The facility's assessment of the resident’s level of needs; and,
C. A list of the services that the ASCU can provide to address the needs identified in 904(a)(2)(B).

**CALIFORNIA**

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**§ 72311. Nursing Service -General**

(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

**§ 72315. Nursing Service -Patient Care.**

(a) No patient shall be admitted or accepted for care by a skilled nursing facility except on the order of a physician.

**§ 72471. Special Treatment Program Service Unit--Patient Health Records and Plans for Care.**

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of
the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b) There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c) The patient care plan shall be approved, signed and dated by the attending physician.

(d) There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e) At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.

s 72513. Administrator.

...(f) The administrator or designee shall be responsible for screening patients for admission to the facility to ensure that the facility admits only those patients for whom it can provide adequate care. The administrator, or designee, shall conduct preadmission personal interviews as appropriate with the patient's physician, the patient, the patient's next of kin or sponsor or the representative of the facility from which the patient is being transferred. A telephone interview may be substituted when a personal interview is not feasible.
Part 5. RESIDENT CARE

5.2 RESIDENT ASSESSMENT.

Within twenty-four hours of admission to the long-term care facility, a licensed nurse shall assess each resident's physical, mental, and functional status, including strengths, impairments, rehabilitative needs, special treatments, capability for self-administration of medications, and dependence and independence in activities of daily living. The initial assessment shall form the basis of the preliminary care plan. Within seven days of admission, the nurse shall also collaborate with social services staff in assessing discharge potential and shall coordinate assessments with social services, dietetic, and activity staff. These assessments shall form the basis of the interdisciplinary care plan prescribed by Section 5.7

5.2.1 The continuing assessment shall at all times reflect resident status.

5.2.2 The assessment shall be updated at least at three month intervals, but in any event whenever a significant change of resident condition occurs.

5.2.3 The current resident assessment shall be a part of the resident's health record and available for all direct care staff to use.

5.3 NURSING CARE PLANNING. A licensed nurse shall prepare an individualized nursing care plan for each resident based on the resident assessment prescribed by Section 5.2 and applicable physician treatment orders. The purpose of the care plan is to create an individualized tool for carrying out preventive, therapeutic, and rehabilitative nursing care.

5.3.1 Within 24 hours of admission, nursing staff shall prepare and implement a preliminary nursing care plan to meet each resident's immediate needs.

5.3.2 Within one week of admission, nursing staff shall prepare and implement a comprehensive nursing care plan for each resident.

5.3.3 The plan shall meet each resident's unique needs, problems, and strengths by identifying resident strengths, needs, and problems; specifying care interventions to capitalize on the strengths and meet those needs or problems; and defining the frequency of each intervention.

5.3.4 The nursing care plan shall be current and evaluated and revised following each assessment and whenever the resident's condition changes.

5.4 SOCIAL SERVICES CARE PLANNING. Social services staff shall assess social services needs within one week of admission and develop a social services care plan to meet each resident's needs.

5.5 ACTIVITIES CARE PLANNING. Activities staff shall assess activities needs within one week of admission and shall develop an activities care plan to meet each resident's needs.
5.6 NUTRITIONAL CARE PLANNING.

(a) The Dietary supervisor or consultant shall prepare an initial nutritional history and assessment for each resident within two weeks of admission that includes special needs, likes and dislikes, nutritional status, and need for adaptive cutlery and dishes and develop a plan of care to meet these needs.

(b) In the event the facility elects to utilize paid feeding assistants or feeding assistant volunteers pursuant to Part 11.001 of this Chapter V, as part of the history and assessment conducted pursuant to paragraph (a) of this 5.6, the interdisciplinary team shall evaluate each resident regarding the suitability of the resident to be fed and hydrated by a feeding assistant. Such evaluation shall include, but need not be limited to each resident’s level of care, functional status concerning feeding and hydration, and, the resident’s ability to cooperate and communicate with staff.

5.7 INTERDISCIPLINARY CARE PLANNING. Within two weeks of admission, an interdisciplinary long-term care facility staff team shall develop a personalized overall care plan for each resident based on the resident assessments and applicable physician orders.

5.7.1 The overall care plan shall contain a list of resident problems and the discipline that will address each problem in its own more detailed plan of care.

5.7.2 The overall care plan shall be evaluated according to the goals set out in the plan, following each assessment and whenever the resident’s condition changes.

5.7.3 The interdisciplinary team shall consist of representatives of resident services inside and outside the facility, as appropriate, including at least nursing, social services, activities, and dietetic staff. Other persons, such as medical, pharmacy, and special therapies, shall be included as appropriate. Residents and their representatives shall be invited to participate in care planning. Refusal to participate shall be documented.

Part 8. SOCIAL SERVICES

8.1.7 Social services staff shall participate in resident assessment and care planning as prescribed by 5.2, 5.4, and 5.7, and shall provide social services to residents. Staff shall review and update the assessment and care plan at least every six months.

Part 19. SECURE UNITS

19.4 PRE-ADMISSION SCREENING AND PLACEMENT. The facility shall not place a resident into a secure unit unless the requirements of this section are met:

19.4.1 An evaluation team finds, based on available evidence, that:

(1) the resident is a serious danger to self or others, or
(2) the resident habitually wanders or would wander out of buildings and is unable to find the way back, or

(3) the resident has a significant behavior problem that seriously disrupts the rights of other residents; and in all cases

(4) less restrictive alternatives have been unsuccessful in preventing harm to self or others; and

(5) legal authority for such restrictive authority has been established.

19.4.2 The evaluation team shall consist of at least the Director of Nursing, Social Services staff member, member of the facility’s utilization control committee, if any, and a person with mental health or social work training (as appropriate to the needs of the unit’s residents) who is not a facility staff member. Such non-staff member need not participate in prior review of admissions. A facility that is a mental health “placement facility” under 27-10-101, C.R.S., et seq. shall have a person from its contracting “designated facility” on the evaluation team for evaluations of clients referred by the designated facility.

19.4.3 Written findings and their factual basis shall be documented in the health record.

19.4.4 The resident or his/her legally responsible and authorized representative gives informed, written consent, and

19.4.5 A physician has authenticated the placement.

CONNECTICUT

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19-13-D8t. Chronic and convalescent nursing homes and rest homes with nursing supervision

...(d) General Conditions.

(1) Patient admission.

(A) Patients shall be admitted to the facility only after a physician certifies the following:

(i) That a patient admitted to a chronic and convalescent nursing home has uncontrolled and/or unstable and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision or has chronic conditions requiring substantial assistance with personal care, on a daily basis...

...(n) Medical and professional services.
(1) A comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours of admission; however, if the physician who attended the patient in an acute or chronic care hospital is the same physician who will attend the individual in the facility, a copy of a hospital discharge summary completed within five (5) working days of admission and accompanying the patient may serve in lieu of this requirement. A patient assessment shall be completed within fourteen (14) days of admission and a patient care plan shall be developed within seven (7) days of completion of the assessment.

(A) The comprehensive history shall include, but not necessarily be limited to:
(i) chief complaints;
(ii) history of present illness;
(iii) review of systems;
(iv) past history pertinent to the total plan of care for the patient;
(v) family medical history pertinent to the total plan of care for the patient; and
(vi) personal and social history.

(B) The comprehensive examination shall include, but not necessarily be limited to:
(i) blood pressure;
(ii) pulse;
(iii) weight;
(iv) rectal examination with a test for occult blood in stool, unless done within one (1) year of admission;
(v) functional assessment; and
(vi) cognitive assessment, which for the purposes of these regulations shall mean an assessment of a patient’s mental and emotional status to include the patient’s ability to problem solve, decide, remember, and be aware of and respond to safety hazards.

(C) The patient assessment and patient care plan shall be developed in accordance with subparagraphs (H) and (I) of subsection (o) (2) of this section.

(3) The attending physician shall record a summary of findings, problems and diagnoses based on the data available within seven (7) days after the patient’s admission, and shall describe the overall treatment plan, including dietary orders and rehabilitation potential and, if indicated, any further laboratory, radiologic or other testing, consultations, medications and other treatment, and limitations on activities.

(4) The following tests and procedures shall be performed and results recorded in the patient’s medical record within thirty (30) days after the patient’s admission:
(A) unless performed within one (1) year prior to admission;
(i) hematocrit, hemoglobin and red blood cell indices determination;
(ii) urinalysis, including protein and glucose qualitative determination and microscopic examination;
(ii) dental examination and evaluation;
(iii) tuberculosis screening by skin test or chest X-ray;
(iv) blood sugar determination; and
(v) blood urea nitrogen or creatinine;
(B) unless performed within two (2) years prior to admission:
(i) visual acuity, grossly tested, for near and distant vision; and
(ii) for women, breast and pelvis examinations, including Papanicolau smear, except the Papanicolau smear may be omitted if the patient is over sixty (60) years of age and has had documented repeated satisfactory smear results without important atypia performed during the patient’s sixth decade of life, or who has had a total hysterectomy;
(C) unless performed within five (5) years prior to admission:
(i) tonometry on all sighted patients forty (40) years or older; and
(ii) screening and audiometry on patients who do not have a hearing aid; and
(D) unless performed within ten (10) years prior to admission:
(i) tetanus-diphtheria toxoid immunization for patients who have completed the initial series, or the initiation of the initial series for those who have not completed the initial series; and
(ii) screening for syphilis by a serological method.

...(7) Annually, each patient shall receive a comprehensive medical examination, at which time the attending physician shall update the diagnosis and revise the individual’s overall treatment plan in accordance with such diagnosis. The comprehensive medical exam shall minimally include those services required in subdivision (1) (B) of this subsection.

...(9) The requirements in this subsection for tests, procedures and immunizations need not be repeated if previously done within the time period prescribed in this subsection and documentation of such is recorded in the patient’s medical record. Tests and procedures shall be provided to the patient given the patient's consent provided no medical reason or contraindication exists, or the attending physician determines that the test or procedure is not medically necessary. Immunizations against influenza and pneumococcal disease shall be provided in accordance with the recommendations of the Advisory Committee on Immunization Practices, established by the United States Secretary of Health and Human Services unless medically contraindicated or the patient objects on religious grounds. Documentation of tests, procedures and immunizations provided or reasons for not providing said tests, procedures and immunization shall be so noted by the attending physician in the patient’s medical record.
6.3 Nursing Administration

6.3.3 Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs. This assessment shall include, at a minimum, the following information:

6.3.3.1 Identification, background and demographic information

6.3.3.2 Customary routine

6.3.3.3 Cognitive patterns

6.3.3.4 Communication

6.3.3.5 Vision

6.3.3.6 Mood and behavior patterns

6.3.3.7 Psychosocial well-being

6.3.3.8 Physical functioning and structural problems

6.3.3.9 Continence

6.3.3.10 Disease diagnoses and health conditions

6.3.3.11 Dental and nutritional status

6.3.3.12 Skin condition

6.3.3.13 Activity pursuits

6.3.3.14 Medications

6.3.3.15 Special treatments and procedures

6.3.3.16 Discharge potential

6.3.4 The resident assessment shall include a screening instrument for mental illness, mental retardation, and developmental disabilities to assess if an individual has an active treatment need for one of these conditions.

6.3.5 Based on the physician's admission orders and the admission information for each resident, an interim individual nursing care plan shall be developed within 24 hours of admission pending the completion of a comprehensive resident assessment.

6.3.6 A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care
plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.

6.3.7 The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.

6.3.8 The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

6.3.8.1 The resident's comprehensive assessment shall document the medical symptom(s) potentially requiring the use of restraints.

6.3.8.2 The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.

6.3.8.3 The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.

6.5 Food Service

6.5.3 Nutritional Assessment

6.5.3.1 The immediate nutritional needs of each resident shall be addressed upon admission.

6.5.3.2 A comprehensive nutritional assessment which includes an evaluation of each resident's caloric, protein, and fluid requirements shall be completed within 14 days of admission in consultation with a dietitian.

6.5.3.3 The facility shall have an ongoing evaluation and assessment program to meet the nutritional needs of all residents.

DISTRICT OF COLUMBIA

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3207. PHYSICIAN SERVICES AND MEDICAL SUPERVISION OF RESIDENTS

3207.11 Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident’s medical record.

59A-4.109 Resident Assessment and Care Plan.

(1) Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of:

(a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.

(b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission.

(c) A complete, comprehensive, accurate and reproducible assessment of each resident’s functional capacity which is standardized in the facility, and is completed within 14 days of the resident’s admission to the facility and every twelve months, thereafter. The assessment shall be:

1. Reviewed no less than once every 3 months,

2. Reviewed promptly after a significant change in the resident’s physical or mental condition,

3. Revised as appropriate to assure the continued accuracy of the assessment.

(2) The facility is responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.

(3) At the resident’s option, every effort shall be made to include the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the resident plan of care.
(4) All staff personnel who provide care, and at the resident's option, private duty nurses or non employees of the facility, shall be knowledgeable of, and have access to, the resident's plan of care.

(5) A summary of the resident's plan of care and a copy of any advanced directives shall accompany each resident discharged or transferred to another health care facility, licensed under Chapter 400, Part II, F.S., or shall be forwarded to the receiving facility as soon as possible consistent with good medical practice.

Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23 FS. History–New 4-1-82, Amended 4-1-84, Formerly 10D-29.109, Amended 4-18-94, 1-10-95.

400.141 Administration and management of nursing home facilities.

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

...(p) Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

290-5-8.10 Medical, Dental and Nursing Care.

...(8) Nursing care shall be provided each patient according to his needs and in accordance with his patient care plan.
§11-94-11 Dietetic services.

...(e) A nutritional assessment and plan for each patient shall be recorded in the medical record. The plan should be incorporated in the overall plan of care and reviewed regularly.

§11-94-23 Nursing services.

(b) Nursing services shall include at least the following:

(1) Assessment of each patient and development and implementation of an appropriate plan of care.

(2) A nursing care plan incorporated in the overall patient care plan and reviewed at least as often as the patient is certified and recertified for a level of care.

(3) Nursing observations and summaries of the patient’s status recorded monthly or more frequently if appropriate due to changes in patient’s condition.

...(10) Coordination of an overall plan of care for each patient, consonant with the attending physician’s medical care plan, and developed by the disciplines providing services in the facility.

§11-94-28 Physician’s services.

...(d) Physicians shall participate as appropriate in the interdisciplinary evaluation of patients and their plan of care.

(e) Physicians shall provide an annual health evaluation of each patient.

(g) Each patient shall have a physical examination by a physician within five days prior to admission or within one week after admission, and shall have had tuberculosis clearance as required by section 11-94-15(c)(10) and (11) within the previous year.

§11-94-29 Rehabilitative services.

...(b) A written rehabilitative plan of care shall be provided which is based on the attending physician’s orders and assessment of patient’s needs in regard to specialized rehabilitative procedures. It shall be incorporated in and regularly reviewed in conjunction with the overall patient care plan.
04. Admission Policies.

a. The administrator shall not accept or keep patients/residents for whom the appropriate care level and services are not provided, or for which the facility is not licensed except in an emergency. (1-1-88)

b. All patients/residents must be admitted by a physician, and all care rendered under his direction. (1-1-88)

c. A history and physical examination shall be recorded within forty-eight (48) hours after admission to the facility, unless the patient/resident is accompanied by a record of a physical examination completed by a physician not more than five (5) days medical and/or psycho-social diagnosis, physician’s plan of care, the patient’s/resident’s activity limitation and the rehabilitation potential, and shall be dated and signed by the physician. (1-1-88)

154. MEDICAL DIRECTION.

...02. Physician Supervision. (7-1-93)

...d. The physician shall provide the facility with medical information necessary to care for the patient/resident which includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information shall include diagnosis, medical findings, activity limitations, and rehabilitation potential. (1-1-88)

e. A physician’s plan of care shall be provided to the facility upon admission of the patient/resident which reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the patient/resident. (1-1-88)

f. The physician’s plan of care for the patient/resident shall be reviewed by the physician:
   (1-1-88)

i. Every thirty (30) to sixty (60) days for skilled care patients/residents depending upon the visit schedule authorized. (1-1-88)

ii. At least every ninety (90) days for intermediate care patients/residents. (1-1-88)

iii. The plan of care shall be reordered with any changes included by the physician and signed and dated by the physician at the time of the review. (1-1-88)

200. NURSING SERVICES
01. Director of Nursing Services. A registered nurse currently licensed by the state of Idaho and qualified by training and experience shall be designated Director of Nursing Services in each SNF and ICF and shall be responsible and accountable for: (1-1-88)

...e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; (1-1-88)

03. Patient/Resident Care. (7-1-93)

a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: (1-1-88)

i. Developed from a nursing assessment of the patient’s/resident’s needs, strengths and weaknesses; (1-1-88)

ii. Developed in coordination with other patient/resident care services provided to the patient/resident; (1-1-88)

iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; (1-1-88)

iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; (1-1-88)

v. Available for use by all personnel caring for the patient/resident. (1-1-88)

...c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/ resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient’s/resident’s condition and reactions to care shall be written by a licensed nursing staff person. (1-1-88)
b) All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. (Section 2-201.5(a) of the Act) A screening assessment is not required provided one of the conditions in Section 140.642(c) of the rules of the Department of Healthcare and Family Services titled Medical Payment (89 Ill. Adm. Code 140.642(c)) is met.

d) Screening shall be administered through procedures established by administrative rule by the agency responsible for screening. (Section 2201.5(a) of the Act) The Illinois Department on Aging is responsible for the screening required in subsection (b) of this Section for individuals 60 years of age or older who are not developmentally disabled or do not have a severe mental illness. The Illinois Department of Human Services is responsible for the screening required in subsection (b) of this Section for all individuals 18 through 59 years of age and for individuals 60 years of age or older who are developmentally disabled or have a severe mental illness. The Illinois Department of Healthcare and Family Services or its designee is responsible for the screening required in subsection (c) of this Section.

e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident’s name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

Section 300.625 Identified Offenders

If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:

l) The facility shall incorporate the Criminal History Analysis Report into the identified offender’s care plan. (Section 2-201.6(f) of the Act)

Section 300.662 Resident Attendants

As part of the comprehensive assessment (see Section 300.1220), each resident shall be evaluated to determine whether the resident may or may not be fed, hydrated or provided personal hygiene by a resident attendant. Such evaluation shall include, but not be limited to, the resident’s level of care; the resident’s functional status in regard to feeding, hydration, and personal hygiene; the resident’s ability to cooperate and communicate with staff.

Section 300.1220 Supervision of Nursing Services

The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.7010 Admission Criteria [Alzheimer's Special Care]

... c) Unit staff shall complete a comprehensive evaluation of the resident before the resident is admitted. The evaluation shall include, but not be limited to, the prospective resident's health status, life-style, behavior, interests, and history. In addition to appropriate medical, behavioral, and social service professionals, the resident, the resident's family, the resident's representative, and the resident's most recent care giver shall have the opportunity to provide information for this evaluation. This information shall be available to staff before admission and shall be used in the assessment process after admission.

... d) A resident may be admitted to the unit without a comprehensive evaluation in situations where a sudden change in circumstances renders the primary care giver unable to continue to provide care (e.g., death or incapacitating illness of the care giver; treatment and release of the prospective resident from a hospital emergency room). A plan shall be put in place prior to admission to meet the resident's needs on admission. In these situations, a comprehensive evaluation shall be initiated within 24 hours after admission and shall be completed within seven days after admission.

Section 300.7020 Assessment and Care Planning [Alzheimer's Special Care]

a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.

1) Assessments shall include at least a behavioral and a functional assessment, as well as direct observations of the resident. The facility shall attempt to interview the resident, the resident's family, the resident's representative, and recent and current direct care givers. This attempt shall be documented.
2) Assessments shall include at least the following:

A) daily routine;

B) dining, mealtime approaches, and non-mealtime nutrition and hydration needs;

C) dressing, toileting, grooming, preference in bathing (e.g., bathing, showering, a.m./p.m.) and other personal care abilities;

D) ambulation and transferring abilities;

E) behavior triggers; effective calming approaches; and an analysis of each of the resident’s patterns of dementia-related behaviors, such as wandering, agitation, anxiety, and safety issues; and

F) adaptive equipment or activities that allow the resident to function at the highest practical level.

3) Assessments shall be conducted by a nurse, physical therapist, occupational therapist, social worker or unit director who has at least two years of experience working with residents with dementia and who has training in conducting behavioral or functional assessments.

4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2).

b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident’s needs, the resident, the resident’s representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident’s direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident.

1) The care plan shall be ability centered in focus (see Section 300.7030) and shall define how the identified abilities, strengths, interests, and preferences will be encouraged and used by addressing the resident's physical and mental well-being; dignity, choice, security, and safety; use of retained skills and abilities; use of adaptive equipment; socialization and interaction with others; communication, on whatever level possible (verbal and nonverbal); healthful rest; personal expression; ambulation and physical exercise; and meaningful work.

2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan.

3) The resident’s care plan shall be reviewed by the unit director 30 and 60 days after the initial care plan’s development and shall be modified, as needed, with the participation of the interdisciplinary team.

4) The care plan shall be reviewed at least quarterly.
5) All appropriate staff shall have access to and shall use the information in the care plan in order to integrate the care plan into the daily care of the resident.

6) The care plan shall be implemented and followed by staff who care for the resident.

7) Revisions may be made to the care plan at any time, with input from the resident, resident's family, and resident's representative, the care coordinator, and, if appropriate, the physician.

8) The resident and the resident's representative shall be given the opportunity to participate in care plan development and modification. If they are unable to attend, a copy or summary of the care plan or modifications shall be provided to the resident and resident's representative.

c) The facility shall include the resident's family (other than the resident's representative) in the interdisciplinary team and in care planning and shall provide information to the family about the resident and the resident's care plan, with the consent of the resident or, as appropriate, the resident's representative.

d) When a resident is moved within the facility or different direct care staff are newly assigned, discharging and receiving staff shall communicate verbally and with written documentation to the newly assigned staff about the care plan and the needs of the resident.

e) The unit shall have and follow a written plan for communicating information within departments, between shifts, between units, and with resident's family and resident's representative.

f) The unit shall have a procedure that is implemented and monitored for safeguarding residents' adaptive equipment, such as hearing aids, glasses, dentures, and feeding and ambulation equipment.

(Source: Added at 28 Ill. Reg. 14623, effective October 20, 2004)

Section 300.7030  Ability-Centered Care [Alzheimer's Special Care]

a) Ability-centered care programming, also called activity-focused programming, recognizes the resident's abilities and competencies in care planning. Tasks are adapted and modified to provide for the resident's involvement at the maximum level of the resident’s ability. Ability-centered care programming embraces the following concepts: activities are every event, encounter, and exchange with a staff member, volunteer, relative, or other individuals; activities are redefined as traditional (i.e., work related, recreational) and nontraditional (i.e., bathing, eating, walking); both independent and structured events are used.

b) Flexibility is allowed in traditional staff roles and staff are encouraged to develop relationships with residents. The use of staff in nontradictional roles shall be documented in the unit's policies and procedures. Non-licensed staff who are not certified nursing
assistants shall not provide nursing or personal care but are limited to assisting with activities of daily living and providing verbal cueing, for which the staff have been trained.

c) Unit directors and activity professionals for units established before January 1, 2005 shall participate in ability-centered care training before July 1, 2005. Unit directors and activity professionals for units established after January 1, 2005 shall have had course work in ability-centered care programming.

d) The unit shall use a distinct approach to resident care that is designed for persons with Alzheimer's disease and related dementia. The use of ability-centered care is recommended. If the facility uses an alternative approach, this approach shall be reviewed by the Department to determine if the care goals of the ability-centered care have been satisfied. Alternative methodologies shall not be implemented until the Department has approved them.

e) Dining and mealtime approaches shall address the special needs of individuals with dementia.

(Source: Added at 28 Ill. Reg. 14623, effective October 20, 2004)
(c) For purposes of IC 16-28-5-1, a breach of:

(1) subsection (a) is an offense; and

(2) subsection (b) is a deficiency. (Indiana State Department of Health; 410 IAC 16.2-3.1-29; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1551, eff Apr 1, 1997; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; filed Jul 22, 2004, 10:05 a.m.: 27 IR 3997; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA)

410 IAC 16.2-3.1-30 Admission orders

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 16-28-5-1

Sec. 30. (a) At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care that are based on a physical examination that shall be performed by the attending physician or the attending physician’s designee on the day of admission or not earlier than thirty (30) days prior to admission. The physical information shall be updated to include new medical information if the resident’s condition has changed since the physical examination was completed. Written admission orders and the physical examination, both signed by the physician, shall be on the resident’s record on admission or within forty-eight (48) hours after the resident is admitted to the facility. The use of facsimile is acceptable.

(b) For purposes of IC 16-28-5-1, a breach of subsection (a) is a deficiency. (Indiana State Department of Health; 410 IAC 16.2-3.1-30; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1552, eff Apr 1, 1997; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA)

410 IAC 16.2-3.1-31 Comprehensive assessments

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 12-10-12; IC 16-28-5-1

Sec. 31. (a) The facility must make a comprehensive assessment of each resident’s needs that describes the resident’s capability to perform daily life functions and significant impairments in functional capacity.

(b) Comprehensive facilities must use an assessment instrument based on the uniform data set specified by the division. Facilities which are not certified by Medicare or Medicaid must comply with this subsection by April 1, 1999.

(c) 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.
(13) Drug therapy.

(d) The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as follows:

(1) Assessments must be conducted no later than fourteen (14) days after the date of admission, and promptly after a significant change in the resident's physical or mental condition.

(2) Assessments shall be conducted at least once every twelve (12) months.

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

(e) The results of the assessment are used to develop, review, and revise the resident's comprehensive care plan.

(f) The facility must coordinate assessments with the state required preadmission screening program under IC 12-10-12 to the maximum extent practicable to avoid duplicative testing and effort.

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

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

(i) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
(j) For purposes of IC 16-28-5-1, a breach of:

(1) subsection (a), (c), (d), or (e) is a deficiency; and

(2) subsection (b), (f), (g), (h), or (i) is a noncompliance.

410 IAC 16.2-3.1-35 Comprehensive care plan

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 16-28-5-1

Sec. 35. (a) The facility must develop a written comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

(b) 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.

(2) Any services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

(c) A comprehensive care plan must be:

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

(2) prepared by an interdisciplinary team that includes:

(A) the attending physician;

(B) a registered nurse with responsibility for the resident; and

(C) other appropriate staff in disciplines as determined by the resident's needs; and to the extent practicable with the participation of the resident and the resident's family.

(d) The written care plan shall indicate the following:

(1) Resident care priorities.

(2) Plans of action to achieve identified goals as follows:
(A) For each goal, the disciplines responsible for assisting in achieving these goals.

(B) Periodically reviewed and revised at a care plan conference by a team of qualified persons, with the participation of the resident and the resident's family to the extent practicable, after each assessment or assessment review.

(e) Documentation of care plan reviews shall indicate the date of the review and the initials of each reviewer present and that the goals and approaches have been updated in accordance with the resident's condition.

(f) The resident's care plan shall be available for use by all personnel caring for the resident.

(g) The services provided or arranged by the facility must:

1. meet professional standards of quality; and
2. be provided by qualified persons in accordance with each resident's written care plan.

(h) For purposes of IC 16-28-5-1, a breach of:

1. subsection (a), (b), (f), or (g) is a deficiency; and
2. subsection (c), (d), or (e) is a noncompliance. (Indiana State Department of Health; 410 IAC 16.2-3.1-35; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1554, eff Apr 1, 1997; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA)

410 IAC 16.2-3.1-36 Discharge summary

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 16-28-5-1

Sec. 36. (a) When the facility anticipates discharge, a resident must have a discharge summary that includes the following:

1. A recapitulation of the resident's stay.
2. A final summary of the resident's status to include the components of the comprehensive assessment, 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.
3. A postdischarge care plan 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. The postdischarge plan must be presented both orally and in writing and in a language that the resident and family understand.
(b) A postdischarge plan identifies specific resident needs after discharge, such as personal care, sterile dressings, and physical therapy, and describes resident/caregiver education needs and provides instructions where applicable, to prepare the resident for discharge.

(c) For purposes of IC 16-28-5-1, a breach of subsection (a) or (b) is a noncompliance.

Indiana State Department of Health; 410 IAC 16.2-3.1-36; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1555, eff Apr 1, 1997; errata filed Apr 10, 1997, 12:15 p.m.: 20 IR 2414; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234; readopted filed May 22, 2007, 1:44 p.m.: 20070613-IR-410070141RFA)

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

...58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident’s family or the resident’s legal representative, and others in accordance with instructions of the attending physician as follows:

a. The written health care plan, based on the assessment and reassessment of the resident’s health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)

b. The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)

c. The health care plan is readily available for use by all personnel caring for the resident; (III)

...58.20(15) Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning. (III)

481—58.54 (73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).
Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)


Each nursing facility shall conduct at the time of admission, and periodically thereafter, a comprehensive assessment of a resident's needs on an instrument approved by the secretary of health and environment.

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

(1) Current medical condition and prior medical history;
(2) measurement of the resident's current clinical status;
(3) physical and mental functional status;
(4) sensory and physical impairments;
(5) nutritional status and impairments;
(6) special treatments and 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.

(b) A comprehensive assessment shall be completed:

(1) Not later than 14 days after admission;

(2) not later than 14 days after a significant change in the resident's physical, mental, or psychosocial condition; and;

(3) at least once every 12 months.

(c) The nursing facility staff shall examine each resident at least once every three months, and as appropriate, revise the resident’s assessment to assure the continued accuracy of the assessment.

(d) Changes in a resident’s condition which are self-limiting and which will not affect the functional capacity of the resident over the long term do not in themselves require a reassessment of the resident.

(e) The nursing facility shall use the results of the comprehensive assessment to develop, review, and revise the resident’s comprehensive plan of care under subsection (h).

(f) The nursing facility shall conduct or coordinate each assessment with the participation of appropriate health professionals.

(g) A registered professional nurse shall conduct or coordinate each comprehensive assessment and shall sign and certify that the assessment has been completed.

(h) Comprehensive care plans.

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

(2) The comprehensive care plan shall be:

(A) Developed within seven days after completion of the comprehensive assessment; and

(B) prepared by an interdisciplinary team including the attending physician, a registered nurse with responsibility for the care of the resident, and other appropriate staff in other disciplines as determined by the resident’s needs, and with the participation of the resident, the resident’s legal representative, and the resident's family to the extent practicable.

(i) The services provided or arranged by the facility shall:

(1) Meet professional standards of quality; and

(2) be provided by qualified persons in accordance with each resident’s written plan of care.
(j) Discharge summary. When the facility anticipates discharge of a resident, a discharge summary shall be developed which includes the following:

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

(2) a final summary of the resident's status which includes the items found in the comprehensive assessment, K.A.R. 28-39-151

(a). This summary shall be available for release at the time of discharge to authorized persons and agencies, with the consent of the resident or the resident's legal representative; and

(3) a post-discharge plan to assist the resident in the adjustment to a new environment. The resident, and when appropriate, the resident's family, shall participate in the development of the plan.

(Authorized by and implementing K.S.A. 39-932; effective Nov. 1, 1993; amended Feb. 21, 1997.)

28-39-160. Other resident services.

(a) Special care section. A nursing facility may develop a special care section within the nursing facility to serve the needs of a specific group of residents.

...(12) The comprehensive resident assessment shall indicate that the resident would benefit from the program offered by the special care section.

(13) The resident comprehensive care plan shall include interventions that effectively assist the resident in correcting or compensating for the identified problems or need.

...(c) Respite care. A nursing facility may provide respite care to individuals on a short-term basis of not more than 30 consecutive days.

(3) The facility may obtain an order from the resident's physician indicating that the resident may return to the facility at a later date for respite care.

...(B) Each time the resident returns to the facility for subsequent respite services, the resident's physician shall review the physician plan of care and shall indicate any significant change that has occurred in the resident's medical condition since the previous stay.

(C) The facility shall review and revise the comprehensive assessment and care plan, if needed.

(D) The facility shall conduct a comprehensive assessment after any significant change in the resident's physical, mental, or psychosocial functioning and not less often than once a year.
Section 7. Resident Assessment [nursing facilities].

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

(1) Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

(a) The facility shall make a comprehensive assessment of a resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

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

1. Medically defined conditions and prior medical history;
2. Medical status measurement;
3. Functional status;
4. Sensory and physical impairments;
5. Nutritional status and requirements;
6. Special treatments or procedures;
7. Psychosocial status;
8. Discharge potential;
9. Dental condition;
10. Activities potential;
11. Rehabilitation potential;
12. Cognitive status; and

(c) Frequency. Assessments shall be conducted:
1. No later than fourteen (14) days after the date of admission;

2. For current residents of a facility, not later than October 1, 1991;

3. Promptly after a significant change in the resident’s physical or mental condition; and

4. In no case less often than once every twelve (12) months.

(d) Review of assessments. The nursing facility shall examine each resident no less than once every three (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 subsection (4) of this section.

(f) Coordination. The facility shall coordinate assessments with the Kentucky required preadmission screening and annual review program to the maximum extent practicable to avoid duplicative testing and effort.

(3) Accuracy of assessments.

(a) Coordination. Each assessment shall be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment with the appropriate participation of health professionals.

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

(4) Comprehensive care plans.

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

(b) A comprehensive care plan shall be:

1. Developed within seven (7) days after completion of the comprehensive assessment;

2. Prepared by an interdisciplinary team, that 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 with the participation of the resident, the resident’s family or legal representative, to the extent practicable; and

3. Periodically reviewed and revised by a team of qualified persons after each assessment.

(c) The services provided or arranged by the facility shall:

1. Meet professional standards of quality; and

2. Be provided by qualified persons in accordance with each resident’s written plan of care.
(5) Discharge summary. When the facility anticipates discharge, a resident shall have 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 (2)(b) 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

(c) A post discharge plan of care that 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.

(6) Preadmission screening for mentally ill individuals and individuals with mental retardation. A nursing facility shall not admit any new resident in conflict with the Kentucky preadmission screening and annual review program.

LOUISIANA

§9725. Assessments and Care Plans

A. An initial assessment of the resident's needs/problems shall be performed and documented in each resident's clinical record by a representative of the appropriate discipline.

B. The assessment shall be used to develop the resident's plan of care.

C. The assessment and care plan shall be completed within 21 days of admission.

D. The care plan shall be revised, as necessary, and reviewed, at least annually, by the personnel involved in the care of the resident.

MAINE

Downloaded January 2011
12.A. Pre-Admission Screening

Facilities may not admit any resident who has not had a pre-admission screening for mental illness and/or mental retardation.

12.A.1. Definition: For the purposes of this Chapter:

a. Mental Illness

An individual is considered to be mentally ill if the individual has a primary or secondary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistic Manual (DSM-III 1R), 4th edition, and which does not include dementia.

b. Mental Retardation

An individual is considered to be "mentally retarded" if there is "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period".

12.A.2. Individuals With a Diagnosis or Suspicion of Mental Illness

Prior to admission, the state mental health authority must determine, based on biopsychosocial evaluation performed by a person or entity other than the State mental health authority whether the individual has a diagnosis of mental illness and whether the individual requires acute and/or "specialized services".

12.A.3. Individuals With Mental Retardation or Related Condition(s)

The Department of Mental Health, Mental Retardation and Substance Abuse Services determines prior to admission whether the individual requires "specialized services" for mental retardation.

12.B. Comprehensive Assessment

Each resident of a nursing facility shall have a comprehensive assessment which will enable facility staff to develop a plan of care designed to assist the resident to reach the highest practicable level of physical, mental, and psychosocial functioning.

12.B.1. Definitions

a. Comprehensive Assessment

1. The comprehensive assessment includes the resident's medical, nursing and psychosocial history before admission and current medical diagnoses.

2. The comprehensive assessment must include:

a. Identification and demographic information:

b. Customary routine;
c. Cognitive patterns;
d. Communication;
e. Vision;
f. Mood and behavior patterns;
g. Psychosocial well-being;
h. Physical functioning and structural problems;
i. Continence;
j. Disease diagnosis and health conditions;
k. Dental and nutritional status;
l. Skin conditions;
m. Activity pursuit;
n. Medications;
o. Special treatments and procedures;
p. Discharge potential;
q. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols;
r. Documentation of participation in assessment.

b. Minimum Data Set (MDS)

The Minimum Data Set (MDS) is the state approved assessment instrument which is the current core set of screening, clinical and functional status elements that forms the foundation of the comprehensive assessment for all residents in nursing facilities.

The MDS must be completed up to, and no later than, fourteen (14) calendar days after the date of admission. The assessment is conducted or coordinated by a Registered Professional Nurse with participation by other appropriate health professionals. Upon completion, the Registered Professional Nurse must sign, date and certify the completion of the assessment. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

c. Resident Assessment Protocol (RAPs)

A component of the utilization guidelines, the RAPs are structured, problem-oriented frameworks for organizing MDS information and examining additional clinically relevant
information about an individual. RAPs help identify social, medical and psychological problems and form the basis for individualized care planning. The Resident Assessment Protocols must be completed by the 14th calendar day after the admission, or according to other Federal and State requirements. Upon completion, the Registered Professional Nurse must sign and date the RAP summary sheet.

12.B.2. Frequency of Assessments

a. The annual comprehensive assessment must be completed within twelve (12) months of the most recent full assessment. The annual reassessment may be initiated at any point prior to the end of the 1-year follow-up date, but must be completed by the end of the 365th calendar day after the most recent comprehensive assessment. If a significant change reassessment is completed in the interim, the clock “restarts”, with the next assessment due within 365 days of the significant change reassessment. Routinely scheduled comprehensive assessments may be scheduled early if a facility wants to stagger due dates for assessments.

b. Nursing facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental and psychological well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident’s condition, they should share this information with the resident’s physician, whom they may consult about the permanency of change. The facility’s medical director may also be consulted when differences of opinion about a resident’s status occur among team members.

Document the initial identification of a significant change in terms of the resident’s clinical status in the progress notes. Complete a full comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case, later than fourteen (14) days after determining that a significant change has occurred.

A “significant change” is defined as a major change in the resident’s status that:

1. Is not self-limiting. A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions;

2. Impacts on more than one area of the resident's health status; and

3. Requires interdisciplinary review or revision of the care plan.

c. If a resident returns to a facility following a temporary absence for hospitalization or therapeutic leave, it is considered a readmission. Facilities are not required to assess a resident if they are readmitted, unless a significant change (as defined in Chapter 12.B.2.b.) in the resident’s condition has occurred.

d. The quarterly assessment is used to track resident status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, three (3) quarterly reviews and one full assessment are required in each 12 month period.
12.C. Comprehensive Care Plan

12.C.1. Definitions

“Comprehensive Care Plan” is the specific document which has been developed by the multidisciplinary team (including the resident or guardian) to address residents’ medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The comprehensive care plan must include measurable objectives and timetables. Before completion of a comprehensive care plan, there must be evidence of ongoing assessments and care planning to assure care and services are being provided from the date of admission/readmission.

12.C.2. Each resident shall have an integrated comprehensive care plan that is developed by a multidisciplinary team (including the resident and/or guardian) and which is based on a comprehensive assessment using the MDS resident assessment protocols, the utilization guidelines and other assessments as necessary.

12.C.3. The comprehensive care plan shall be developed by a multidisciplinary team consisting of physician, registered Professional Nurse, and other appropriate staff in conjunction with the resident, resident’s family or legal representative as appropriate.

12.C.4. The comprehensive care plan shall be developed within seven (7) days after the completion of the Resident Assessment Protocols and:

a. is periodically reviewed and revised as necessary by the multidisciplinary team after each assessment and reassessment;

b. must have measurable goals and timeframes, as appropriate, for the highest practicable level of functioning the resident may achieve;

c. must accurately reflect the resident’s assessment;

d. must be oriented toward preventing decline in functioning and/or functional levels within the parameters of normal aging and any disease processes which are present;

e. must address identified risk factors;

f. must reflect standards of current professional practice.

g. must reflect a multidisciplinary team approach to maintain or improve functional abilities of the resident.

12.C.5. The comprehensive care plan must be continually and actively implemented by all staff.

12.C.6. The comprehensive care plan must be available at the nurses station for review and implementation as appropriate by staff on each shift. The procedures to implement the care plan need not be included in the care plan, but there must be a format, as chosen by the facility, which provides direction to the resident care staff of each shift.

12.D. Documentation
12.D.1. There must be ongoing documentation as necessary, but at least monthly, which reflects the resident’s condition, implementation and effectiveness of the care plan and interventions by the staff.

12.D.2. There must be documentation by the CNA of the specific tasks carried out to implement the part of the care plan assigned to the CNA.

23.C.4. Assessments and Individual Care Plans [Alzheimer’s/Dementia Care Units]

Specific methods and interventions to be used to accomplish the desired outcomes shall be disclosed in the care plan. Interventions used may include support groups, recreational therapy, occupational therapy, physical therapy and a variety of treatment modalities as indicated by the resident’s particular needs. Outcomes for the individual care of each resident shall include:

a. Promoting remaining abilities for self-care;

b. Encouraging independence while recognizing limitations;

c. Providing safety and comfort;

d. Maintaining dignity by respecting the need for privacy, treating the resident as an adult and avoiding talking as if the resident is not present; and

e. Any issue of a psychosocial nature related to the resident’s preferred manner of living and receiving care.

MARYLAND

Downloaded January 2011

10.07.02.35 Resident Care Management System.

A. Each comprehensive care facility and extended care facility shall establish and maintain a resident care management system.

B. The resident care management system shall be comprised of three interrelated components:

(1) Resident status assessment and data gathering;

(2) Care planning; and

(3) Actions in response to care plan approaches.
10.07.02.36 Resident Status Assessment.

A. Disciplines shall record all assessments on a form approved by the Department.


C. A facility shall use the following forms and procedures for resident assessment as described in the State Operations Manual for Provider Certification:

(1) Minimum Data Set (MDS) version as determined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, in Transmittal No. 22, referenced in §B of this regulation;

(2) Resident Assessment Protocol Summary;

(3) MDS Quarterly Assessment Form;

(4) Maryland Monthly Assessment; and

(5) Care plans.

D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343.

E. All facilities certified for participation in Medicare or Medicaid shall complete and electronically submit the assessment to the Department not later than 31 days after completion of the assessment.

F. A facility as a comprehensive or extended care facility but not certified for participation in the Medicare or Medicaid Program shall comply with the State Operations Manual for Provider Certification, except that data may not be electronically submitted to the Department.

10.07.02.37 Care Planning.

A. An interdisciplinary team shall complete a resident specific care plan for each resident within 7 calendar days following completion of all assessments.

B. A care plan under this regulation shall be based upon assessments conducted at the following times:

(1) Admission;

(2) Annual;
(3) Quarterly; and

(4) Significant change in the resident’s condition.

C. A facility shall give a family member or resident’s representative 7 calendar days advance notice, in writing, of the location, date, and time of the care planning conference for a resident for whom a family member or representative is interested. The notification shall include an invitation for the family member or resident’s representative to attend the conference.

D. The facility shall hold the care planning conference not later than 7 calendar days after completion of the assessment, but may hold the conference earlier if agreed to by the resident, a family member, or a resident’s representative.

E. Organization of Care Plan.

(1) Problems and needs shall be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident’s special care requirements necessary to improve or maintain the resident’s status. The interdisciplinary team shall incorporate resident input into the care plan.

(2) The team shall establish goals for each problem or need identified. The goal shall be realistic, practical, and tailored to the resident’s needs. Goal outcome shall be measurable in time or degree, or both.

(3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how frequently it is to be performed.

F. Disciplines shall update the care plans as the resident’s assessment warrants, but not less than quarterly.

G. Availability of Resident Care Plan. Resident care plans shall be readily available for use by all health care personnel.

10.07.02.38 Special Skin Record.

A. The facility shall establish a skin care record documenting skin, hair, and nail condition on admission, if any abnormal conditions exist.

B. The staff shall document progression of the condition or conditions weekly until the condition or conditions have healed.

C. At any time that a skin condition persists for more than 7 days, staff shall add the condition to the skin record.
150.007 Nursing Services

(D) Nursing Care.

...(2) Nursing Care Plan: In facilities that provide Level I, II or III care, the nursing care shall include a comprehensive, nursing care plan for each patient developed by the nursing staff in relation to the patient’s total health needs.

(a) The nursing care plan shall be an organized, written daily plan of care for each patient. It shall include: diagnoses, significant conditions or impairments, medication, treatments, special orders, diet, safety measure, mental condition, bathing and grooming schedules, activities of daily living, the kind and amount of assistance needed, long-term and short-term goals, planned patient teaching programs, encouragement of patient’s interests and desirable activities. It shall indicate what nursing care is needed, how it can best be accomplished, and what methods and approaches are most successful. This information shall be summarized on a cardex and be available for use by all personnel involved in patient care.

(b) The nursing care plan shall be initiated on admission and shall be based on the physician's or physician-physician assistant team's or physician-nurse practitioner team's medical care plan and the nursing assessment of patient needs.

(c) The plan shall be the responsibility of the director or supervisor of nurses and shall be developed in conjunction with the nursing staff and representatives of other health disciplines where appropriate.

(d) All personnel who provide care to a patient shall have a thorough knowledge of the patient’s condition and the nursing care plan.

(e) The plan shall specify priorities of nursing need, which shall be determined through communication with the patient, the physician or physician-physician assistant team or physician-nurse practitioner team, other staff and the family.

(f) The plan shall reflect the patient’s psycho-social needs and ethnic, religious, social, cultural or other preferences.

(g) Nursing care plans shall be reviewed, revised and kept current so that patient care constantly meets patient needs. Plans shall show written evidence of review and revision at least every 30 days in facilities that provide Level I or II care, and every 90 days in facilities that provide Level III care. Reviews of nursing care plans shall be performed in conjunction with reviews of other aspects of the patient’s total health care.

(h) For residents in certified facilities with MR or DD/ORC nursing care plans shall include the carry-over services that integrate all relevant specialized services contained in the resident’s DMR Rolland Integrated Services Plan and Specialized Services Provider plan. The plan shall be developed in conjunction with the resident, and/or guardian, representatives of DMR or a case manager designated by DMR and the Specialized Service providers, reviewed not less frequently than every three
months, annually and at the time of significant change.

(i) Relevant information from the nursing care plan shall be included with other health information when a patient is transferred or discharged.

R 325.20709 Patient care planning.

Rule 709.

(1) Nursing care provided to each patient in a nursing home shall be based on all of the following:

(a) Written assessment of the patient.
(b) Identification of health problems.
(c) A written plan of care or intervention.
(d) Implementation of the care plan.
(e) Evaluation of the results of the planned care or intervention.

(2) An assessment of a patient shall be initiated by licensed nursing personnel within 24 hours of admission, and the results of the assessment shall be documented in the patient’s clinical record.

(3) The written plan of care shall be available to all individuals involved in the care of the patient and shall document all of the following:

(a) The patient’s problems and needs.
(b) Goals and objectives of care.
(c) Methods of approach to care.
(d) Treatment and orders. The disciplines responsible for each element of care shall be identified in the plan. The written plan of care for a patient shall be considered to be part of the patient’s clinical record and shall be included with the record at the time of discharge.

(4) The patient care plan shall be reviewed and the care shall be evaluated periodically, as required, to reflect the patient's current condition.
(5) The nursing home shall make reasonable efforts to discuss the patient care plan with the patient, next of kin, guardian, or designated representative so that such parties can contribute to the plan’s development and implementation.

(6) A patient care conference shall be held periodically, but not less than once every 90 days, to evaluate a patient’s needs and to provide for the appropriate revision of the patient care plan while promoting continuity of care. The patient care conference shall include representatives from the professional disciplines providing services to the patient, and observations and recommendations of the health professionals participating in the patient care conferences shall be summarized in the patient’s clinical record or plan of care.

History: 1981 AACS; 1983 AACS; 1984 AACS.

R 325.20710 Discharge planning.

Rule 710. Discharge planning shall be provided for each patient in conjunction with patient care planning.

History: 1981 AACS.

MINNESOTA

4658.0400 COMPREHENSIVE RESIDENT ASSESSMENT.

Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident’s needs, which describes the resident’s capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident’s comprehensive plan of care as defined in part 4658.0405.

Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information:

A. medically defined conditions and prior medical history;

B. medical status measurement;

C. physical and mental functional status;
D. sensory and physical impairments;
E. nutritional status and requirements;
F. special treatments or procedures;
G. mental and psychosocial status;
H. discharge potential;
I. dental condition;
J. activities potential;
K. rehabilitation potential;
L. cognitive status;
M. drug therapy; and
N. resident preferences.

Subp. 3. Frequency. Comprehensive resident assessments must be conducted:
A. within 14 days after the date of admission;
B. within 14 days after a significant change in the resident's physical or mental condition; and
C. at least once every 12 months.

Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.

STAT AUTH: MS s 144A.04; 144A.08; 256B.431
HIST: 20 SR 303: L 1999 c 172 s 18
Current as of 01/19/05

4658.0405 COMPREHENSIVE PLAN OF CARE.

Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that 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, with the participation of the resident, the resident's legal guardian or chosen representative.
Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).

Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.

Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that 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, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.

STAT AUTH: MS s 144A.04; 144A.08; 256B.431

HIST: 20 SR 303

Current as of 01/19/05

119 REQUIREMENTS FOR ADMISSION

119.01 Physical Examination Required. Each resident shall be given a complete physical examination 30 days prior to admission and annually thereafter, including a history of tuberculosis exposure and an assessment for signs and symptoms of tuberculosis, by a licensed physician or nurse practitioner. The findings shall be entered as part of the Admission Record. The report of the examination shall include:

1. Medical history (previous illnesses, drug reaction, emotional reactions, etc.).

2. Major physical and mental condition.

4. Orders, dated and signed, by a physician or nurse practitioner for the immediate care of the resident to include medication treatment, activities, and diet.

102 ASSESSMENT AND INDIVIDUAL CARE PLANS [Alzheimer's Disease/Dementia Care Unit]

102.01 Assessments. Prior to admission to the A/D Unit, each individual shall receive a medical examination and assessment from a licensed physician or nurse practitioner. In addition, prior to admission, each individual shall be assessed by a licensed practitioner whose scope of practice includes assessment of cognitive, functional, and social abilities, and nutritional needs. These assessments shall include the individual's family supports, level of activities of daily living functioning and level of behavioral impairment. The functional assessment shall demonstrate that the individual is appropriate for placement.

102.02 Care Plans. Individual care plans shall be developed by the staff for each resident.

102.03 Family Involvement. Whenever possible and appropriate, the family shall be involved in the development of a resident's care plan. The family shall be provided with information regarding social services, such as support groups for families and friends. A designated family member shall be notified in a timely manner of care plan sessions. Documentation of such notification shall be kept by the licensed facility.

102.04 Review of Care Plans. Each care plan and functional assessment, developed upon admission to determine the resident’s appropriateness for placement, shall be reviewed, evaluated for its effectiveness, and updated at least quarterly or more frequently if indicated by changing needs of the resident.

105 NUTRITIONAL SERVICES [Alzheimer's Disease/Dementia Care Unit]

105.01 Nutritional Services. A nutritional assessment shall be completed for each resident. If the nutritional assessment identifies therapeutic nutritional needs, or is ordered by the resident’s physician, a registered dietician shall assess and plan a diet for the resident’s nutritional needs.
PURPOSE: This rule designates the resident assessment instrument to be used by nursing facilities certified under the Title XIX (Medicaid) program and Title XVIII (Medicare) program for all residents in certified beds.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Effective January 1, 1991 a resident assessment instrument (RAI) shall be utilized by all nursing facilities (NFs) certified under Title XIX (Medicaid) and Title XVIII (Medicare) to perform uniform resident assessments for all residents in certified beds, regardless of payment source, as required by Title 42 U.S.C. Section 1396(r)(3)(A) of the Social Security Act.

(2) The RAI utilized shall be the one designated by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS). It is comprised of three (3) parts—

(A) The utilization guidelines, which are instructions concerning when and how to use the RAI;

(B) The minimum data set (MDS) of core elements and definitions, which is a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies; and

(C) The resident assessment protocols (RAPs), which are structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning.

(3) Resident assessments shall be documented on the MDS and the RAPs shall be utilized.

(4) Frequency of Assessments.

(A) A newly admitted resident to a certified bed shall have an assessment within fourteen (14) days of admission to the facility.

(B) Each resident in a certified bed shall have an updated assessment within fourteen (14) days after a significant change in the resident’s physical or mental condition.
(C) Each resident shall be examined quarterly and the MDS core elements specified in the utilization guidelines shall be reviewed and any changes documented.

(D) Each resident in a certified bed shall have a full annual assessment no later than twelve (12) months following the last full assessment. Residents in certified beds on October 1, 1990 shall have a full assessment completed by October 1, 1991.

(5) The division shall provide each certified facility with a copy of the RAI, including guidelines for completion. Facilities may then duplicate the RAI or purchase the instrument either in paper or computerized form from a private supplier for use when performing assessments.

(6) A paper copy of all MDSs and RAP summary sheets completed for each resident shall be in the resident's record. A facility may document on the MDS form additional information regarding a resident which is not included in the standard MDS, or may use a version of the MDS which has special codes or notations, but if information is added, the additional information shall be either in an appendix or the facility shall provide a copy of the MDS in its standard form without the additional information for use in review. All MDSs and RAP summary sheets completed within the last two (2) years must be easily retrievable from the resident's record if requested by a representative of the Division of Aging or the federal survey and certification agency.

(7) All resident assessments shall be performed and the MDSs and RAPs shall be completed in accordance with the utilization guidelines, the definitions and all other directions as given on the forms.

(8) Whenever a resident assessment is completed on any resident in a Medicaid- or Medicare-certified bed, a legible copy of the fully completed MDS portion of the RAI shall be sent to the division within thirty (30) calendar days of completion. Forms shall be sent to: Missouri Division of Aging, Attention: MDS Unit, P.O. Box 1337, Jefferson City, MO 65102. The forms shall be submitted by each facility as a group once per month for all residents assessed in the last thirty (30) days and submitted in paper form unless the facility has requested in writing and has received written permission from the division to submit the MDS information on a properly formatted computer disk by mail or electronically.

(9) Effective June 1, 1993, all facilities shall send to the Missouri Division of Aging, to either the Attention of the MDS Unit, P.O. Box 1337, Jefferson City, MO 65102 or the appropriate regional Division of Aging office, at the same time the monthly MDS form or MDS data are being mailed, a list of names of all residents who have died or who have been discharged from the facility (and not readmitted) during the preceding month. In addition, included with the mailing at the end of June, the facility shall submit a list of those residents who have died or who were discharged from the facility since August 1, 1992. This listings shall include the complete name of the resident, as well as some specific identifying information for each, such as the Social Security number, the birthdate or the department client number (DCN).


**19 CSR 30-81.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants in Long-Term Care Facilities**

**PURPOSE:** This rule sets the requirements for the periodic evaluation and assessments of residents in long-term care facilities in relationship to evaluation and assessment processes, level-of-care needed by individuals, and appropriate placement of individuals in order to receive this care.

**PUBLISHER’S NOTE:** The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) For purposes of this rule only, the following definitions shall apply:

(A) Applicant—any resident or prospective resident of a certified long-term care facility who is seeking to receive inpatient Title XIX assistance;

(B) Certified long-term care facility—any long-term care facility which has been approved to participate in the inpatient program and receives Title XIX funding for eligible recipients;

(C) Initial assessment forms—the forms utilized to collect information necessary for a determination of level-of-care need pursuant to 19 CSR 30-81.030 and designated Forms DA-124 A/B (dated 6-05) and DA-124 C (dated 4-05) and Notice To Applicant Form, DA-124C ATT. (attachment) (dated 12-01), incorporated by reference in this rule and available through the Department of Health and Senior Services website: www.dhss.mo.gov or by mail at: Department of Health and Senior Services Warehouse, Attention General Services Warehouse, PO Box 570, Jefferson City, Missouri 651020570; telephone: (573) 526-3861; fax: (573) 751-1574, shall be considered the approved Initial Assessment Forms. This rule does not incorporate any subsequent amendments or additions.

(D) Inpatient Title XIX assistance—Title XIX payments for intermediate or skilled nursing care in a certified long-term care facility;
(E) Level-of-care assessment—the determination of level-of-care need based on an assessed point count value for each category cited in subsection (4)(B) of this rule;

(F) Level-of-care need—the decision whether an individual qualifies for long-term care facility care;

(G) Long-term care facility—a skilled nursing facility (SNF), an intermediate care facility (ICF), or a hospital which provides skilled nursing care or intermediate nursing care in a distinct part or swing bed under Chapter 197, RSMo;

(H) Pro re nata (PRN)—medication or treatment ordered by a physician to be administered as needed, but not regularly scheduled;

(I) Recipient—any resident in a certified long-term care facility who is receiving inpatient Title XIX assistance;

(J) Redetermination of level-of-care—the periodic assessment of the recipients’ continued eligibility and need for continuation at the previously assigned level-of-care. Periodic assessment includes but it not limited to the following:

1. Assessment of new admissions to a long-term care facility;

2. Assessment of a change in mental and or physical status for a resident who is being readmitted to a long-term care facility after transfer to an acute care facility, and the previous DA-124 A/B or C forms do not reflect the resident’s current care needs; and

3. Assessment of DA-124 forms as requested by Department of Social Services, Family Support Division;

(K) Resident—a person seventeen (17) years or older who by reason of aging, illness, disease, or physical or mental infirmity receives or requires care and services furnished by a long-term care facility and who resides in, is cared for, treated or accommodated in such long-term care facility for a period exceeding twenty-four (24) consecutive hours; and

(L) The department—Department of Health and Senior Services.

(2) Initial Determination of Level-of-Care Needs Requirements.

(A) For the purpose of making a determination of level-of-care need and in accordance with 42 CFR sections 456.370 and 483.104, the department or its designated agents, or both, will conduct a review and assessment of the evaluations made by the attending physician for an applicant in or seeking admission to a long-term care facility. The review and assessment shall be conducted using the criteria in section (5) of this rule.

(B) The department shall complete the assessment within ten (10) working days of receipt of all documentation required by section (5) of this rule unless further evaluation by the State Mental Health Authority is required by 42 CFR 483.100 to 483.138.

(3) Redetermination of Level-of-Care Requirements.
(A) Redetermination of level-of-care of individual recipients who are eligible for placement in long-term care facilities shall be conducted by the department through a review and assessment of the DA-124 A/B and C forms and any documentation provided by the resident’s attending physician.

(B) Required documentation on the DA124 C form shall include the resident’s physician’s signature and his or her Physician Identification Number.

(4) Level-of-Care Criteria for Long-Term Care Facility Care—Qualified Title XIX Recipients and Applicants.

(A) Individuals will be assessed with the ultimate goal to achieve placement for these individuals in the least restrictive environment possible, yet enable them to receive all services required by their physical/mental condition.

(B) The specific areas which will be considered when determining an individual’s ability or inability to function in the least restrictive environment are—mobility, dietary, restorative services, monitoring, medication, behavioral, treatments, personal care and rehabilitative services.

(C) To qualify for intermediate or skilled nursing care, an applicant or recipient shall exhibit physical impairment, which may be complicated by mental impairment or mental impairment which may be complicated by physical impairment, severe enough to require intermediate or skilled nursing care.

(5) Assessed Needs Point Designations Requirements.

(A) Applicants or recipients will be assessed for level-of-care by the assignment of a point count value for each category cited in subsection (4)(B) of this rule.

(B) Points will be assessed for the amount of assistance required, the complexity of the care and the professional level of assistance necessary, based on the level-of-care criteria. If the applicant’s or recipient’s records show that the applicant’s or recipient’s attending physician has ordered certain care, medication or treatments for an applicant or recipient, the department will assess points for a PRN order if the applicant or recipient has actually received or required that care, medication or treatment within the thirty (30) days prior to review and evaluation by the department.

(C) For individuals seeking admission to a long-term care facility on or after July 1, 2005, the applicant or recipient will be determined to be qualified for long-term care facility care if he or she is determined to need care with an assessed point level of twenty-one (21) points or above, using the assessment procedure as required in this rule.

(D) For individuals seeking admission to a long-term care facility on or after July 1, 2005, an applicant with eighteen (18) points or lower will be assessed as ineligible for Title XIX-funded long-term care in a long-term care facility, unless the applicant qualifies as otherwise provided in subsections, (5)(E) and/or (F) of the rule.

(E) Applicants or recipients may occasionally require care or services, or both, which could qualify as long-term care facility services. In these instances, a single nursing service
requirement may be used as the qualifying factor, making the individual eligible for long-term care facility care regardless of the total point count. The determining factor will be the availability of professional personnel to perform or supervise the qualifying care services. Qualifying care services may include, but are not limited to:

1. Administration of Levine tube or gastrostomy tube feedings;
2. Nasopharyngeal and tracheotomy aspiration;
3. Insertion of medicated or sterile irrigation and replacement catheters;
4. Administration of parenteral fluids;
5. Inhalation therapy treatments;
6. Administration of injectable medications other than insulin, if required other than on the day shift; and
7. Requirement of intensive rehabilitation services by a professional therapist at least five (5) days per week.

(F) An applicant or recipient will be considered eligible for inpatient Title XIX assistance regardless of the total point count if the applicant or recipient is unable to meet physical/mental requirements for residential care facility (RCF) residency as specified by section 198.073, RSMo. In order to meet this requirement, an applicant or recipient must be able to reach and go through a required exit door on the floor where the resident is located by—

1. Responding to verbal direction or the sound of an alarm;
2. Moving at a reasonable speed; and
3. If using a wheelchair or other assistive device, such as a walker or cane, being able to transfer into the wheelchair or reach the assistive device without staff assistance.

(G) Points will be assigned to each category, as required by subsection (4)(B) of this rule, in multiples of three (3) according to the following requirements:

1. Mobility is defined as the individual’s ability to move from place-to-place. The applicant or recipient will receive—

   A. Zero (0) points if assessed as independently mobile, in that the applicant or recipient requires no assistance for transfers or mobility. The applicant or recipient may use assistive devices (cane, walker, wheelchair) but is consistently capable of negotiating without assistance of another individual;
B. Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient is independently mobile once the applicant or recipient receives assistance with transfers, braces or prosthesis application or other assistive devices, or a combination of these (example, independent use of wheelchair after assistance with transfer). This category includes individuals who are not consistently independent and need assistance periodically;

C. Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient is mobile only with direct staff assistance. The applicant or recipient must be assisted even when using canes, walker or other assistive devices; and

D. Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient is totally dependent upon staff for mobility. The applicant or recipient is unable to ambulate or participate in the ambulation process, requires positioning, supportive device, application, prevention of contractures or pressure sores and active or passive range of motion exercises;

2. Dietary is defined as the applicant’s or recipient’s nutritional requirements and need for assistance or supervision with meals. The applicant or recipient will receive—

A. Zero (0) points if assessed as independent in dietary needs, in that the applicant or recipient requires no assistance to eat. The applicant or recipient has physician’s orders for a regular diet, mechanically altered diet or requires only minor modifications (example, limited desserts, no salt or sugar on tray);

B. Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient requires meal supervision or minimal help, such as cutting food or verbal encouragement. Calculated diets for stabilized conditions shall be included;

C. Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient requires help, including constant supervision during meals, or actual feeding. Calculated diets for unstable conditions are included; and

D. Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient requires extensive assistance for special dietary needs or with eating, which could include enteral feedings or parenteral fluids;

3. Restorative services are defined as specialized services provided by trained and supervised individuals to help applicants or recipients obtain and/or maintain their optimal highest practicable functioning potential. Each applicant or recipient must have an individual overall plan of care developed by the provider with written goals and response/progress documented. Restorative services may include, but are not limited to: applicant or recipient teaching program (selftransfer, self-administration of medications, self-care), range of motion, bowel and bladder program, remotivational therapy, validation therapy, patient/family program and individualized activity program. The applicant or recipient will receive—

A. Zero (0) points if restorative services are not required;
B. Three (3) points if assessed as requiring minimum services in order to maintain level of functioning;  

C. Six (6) points if assessed as requiring moderate services in order to restore the individual to a higher level of functioning; and  

D. Nine (9) points if assessed as requiring maximum services in order to restore to a higher level of functioning. These are intensive services, usually requiring professional supervision or direct services;  

4. Monitoring is defined as observation and assessment of the applicant’s or recipient’s physical and/or mental condition. This monitoring could include assessment of— routine laboratory work, including but not limited to, evaluating digoxin and coumadin levels, measurement and evaluation of blood glucose levels, measurement and evaluation of intake and output of fluids the individual has received and/or excreted, weights and other routine monitoring procedures. The applicant or recipient will receive—  

A. Zero (0) points if assessed as requiring only routine monitoring, such as monthly weights, temperatures, blood pressures and other routine vital signs and routine supervision;  

B. Three (3) points if assessed as requiring minimal monitoring, in that the applicant or recipient requires periodic assessment due to mental impairment, monitoring of mild confusion, or both, or periodic assessment of routine procedures when the recipient’s condition is stable;  

C. Six (6) points if assessed as requiring moderate monitoring, in that the applicant or recipient requires recurring assessment of routine procedures due to the applicant’s or recipient’s unstable physical or mental condition; and  

D. Nine (9) points if assessed as requiring maximum monitoring, which is intensive monitoring usually by professional personnel due to applicant’s or recipient’s unstable physical or mental condition;  

5. Medication is defined as the drug regimen of all physician-ordered legend medications, and any physician-ordered nonlegend medication for which the physician has ordered monitoring due to the complexity of the medication or the condition of the applicant or recipient. The applicant or recipient will receive—  

A. Zero (0) points if assessed as requiring no medication, or has not required PRN medication within the thirty (30) days prior to review and evaluation by the department;  

B. Three (3) points if assessed as requiring any regularly scheduled medication and the applicant or recipient exhibits a stable condition;  

C. Six (6) points if assessed as requiring moderate supervision of regularly scheduled medications, requiring daily monitoring by licensed personnel; and  

D. Nine (9) points if assessed as requiring maximum supervision of regularly scheduled medications, a complex medication regimen, unstable physical or mental status or use of medications requiring professional observation and assessment, or a combination of these;
6. Behavioral is defined as an individual's social or mental activities. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring little or no behavioral assistance. Applicant or recipient is oriented and memory intact;

B. Three (3) points if assessed as requiring minimal behavioral assistance in the form of supervision or guidance on a periodic basis. Applicant or recipient may display some memory lapses or occasional forgetfulness due to mental or developmental disabilities, or both. Applicant or recipient generally relates well with others (positive or neutral) but needs occasional emotional support;

C. Six (6) points if assessed as requiring moderate behavioral assistance in the form of supervision due to disorientation, mental or developmental disabilities or uncooperative behavior; and

D. Nine (9) points if assessed as requiring maximum behavioral assistance in the form of extensive supervision due to psychological, developmental disabilities or traumatic brain injuries with resultant confusion, incompetency, hyperactivity, hostility, severe depression, or other behavioral characteristics. This category includes residents who frequently exhibit bizarre behavior, are verbally or physically abusive, or both, or are incapable of self-direction. Applicants or recipients who exhibit uncontrolled behavior that is dangerous to themselves or others must be transferred immediately to an appropriate facility;

7. Treatments are defined as a systematized course of nursing procedures ordered by the attending physician. The applicant or recipient will receive—

A. Zero (0) points if no treatments are ordered by the physician;

B. Three (3) points if assessed as requiring minimal type-ordered treatments, including nonroutine and preventative treatments, such as whirlpool baths and other services;

C. Six (6) points if assessed as requiring moderate type-ordered treatments requiring daily attention by licensed personnel. These treatments could include: daily dressings, PRN oxygen, oral suctioning, catheter maintenance care, treatment of stasis or pressure sore ulcers, wet/moist packs, maximist and other such services; and

D. Nine (9) points if assessed as requiring maximum type-ordered treatments of an extensive nature requiring provision, direct supervision, or both, by professional personnel. These treatments could include: intratrachial suctioning; insertion or maintenance of suprapubic catheter; continuous oxygen; new or unregulated ostomy care; dressings of deep draining lesions more than once daily; care of extensive skin disorders, such as advanced pressure sore or necrotic lesions; infrared heat and other services;

8. Personal care is defined as activities of daily living, including hygiene; personal grooming, such as dressing, bathing, oral and personal hygiene, hair and nail care, shaving; and bowel and bladder functions. Points will be determined based on the amount of assistance required and degree of assistance involved in the activity. The applicant or recipient will receive—
A. Zero (0) points if assessed as requiring no assistance with personal care in that the applicant or recipient is an independent, self-care individual. No assistance is required with personal grooming; the applicant or recipient has complete bowel and bladder control;

B. Three (3) points if assessed as requiring minimal assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, and/or exhibits infrequent incontinency (once a week or less);

C. Six (6) points if assessed as requiring moderate assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, requiring close supervision or exhibits frequent incontinency (incontinent of bladder daily but has some control or incontinent of bowel two (2) or three (3) times per week), or a combination of these; and

D. Nine (9) points if assessed as requiring maximum assistance with personal care, in that the applicant or recipient requires total personal care to be performed by another individual, and/or exhibits continuous incontinency all or most of the time; and

9. Rehabilitation is defined as the restoration of a former or normal state of health through medically-ordered therapeutic services either directly provided by or under the supervision of a qualified professional. Rehabilitation services include, but are not limited to: physical therapy, occupational therapy, speech therapy and audiology. If ordered by the physician, each resident must have an individually planned and implemented program with written goals and response/progress documented. Points will be determined by intensity of required services and the applicant's or recipient's potential for rehabilitation as determined by the rehabilitation evaluation. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no ordered rehabilitation services;

B. Three (3) points if assessed as requiring minimal-ordered rehabilitation services of one (1) time per week;

C. Six (6) points if assessed as requiring moderate-ordered rehabilitative services of two (2) or three (3) times per week; and

D. Nine (9) points if assessed as requiring maximum-ordered rehabilitative services of four (4) times per week or more.

37.40.202 PREADMISSION SCREENING, GENERAL REQUIREMENTS

(1) This rule provides the preadmission screening requirements of the Montana Medicaid program for applicants to nursing facilities participating in the Montana Medicaid program.

(2) Nursing facility applicants must undergo a level I screening prior to admission to a nursing facility.

(a) A level I screening may result in the following determinations which will apply as indicated:

(i) a nursing facility applicant who has no diagnosis or any indications of mental retardation or mental illness will:

(A) if not a medicaid recipient, receive a copy of the level I screen. No further action will be taken by the department; and

(B) if a medicaid recipient, undergo a level of care determination for nursing facility services.

(ii) a nursing facility applicant who has a diagnosis or indications of mental retardation or mental illness will be referred to either the state mental health authority or the mental retardation authority for a level II screening unless determined by the level I screening to be within one of the exceptions provided for in (3)(a) of this rule.

(3) A nursing facility applicant who has a diagnosis or indications of mental retardation or mental illness may enter a nursing facility only if the applicant is determined to be in need of nursing facility services and is allowed to enter as provided for in (3)(a) or (b) of this rule;
(a) A person with a diagnosis or indications of mental retardation or mental illness who is in need of nursing facility services may enter a nursing facility without a level II screening or a determination of appropriate active treatment, if either:

(i) the person is being discharged from an acute care facility and admitted to a nursing facility for recovery from an illness or surgery for a period not to exceed 120 days and is not a danger to self or others;

(ii) the person is certified by a physician to be terminally ill (prognosis of a life expectancy of six months or less) and is not a danger to self or others;

(iii) the person is comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having chronic obstructive pulmonary disease, severe Parkinson's disease, Huntington's Chorea, amyotrophic lateral sclerosis, congestive heart failure or other similar diagnosis which prohibits the person from participating in active treatment; or

(iv) the person has a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, based on a neurological examination.

(b) A level II screening may result in the following determinations which will apply as indicated:

(i) Any person with mental retardation or mental illness determined not to be in need of nursing facility services, whether or not active treatment services are required, shall be considered inappropriate for placement or continued residence in a nursing facility;

(ii) Any person with mental retardation or mental illness determined to be in need of active treatment services shall be considered inappropriate for placement or continued residence in a nursing facility;

(iii) Any person with mental retardation or mental illness determined to be in need of nursing facility services but not to be in need of active treatment services shall be considered appropriate for placement or continued residence in a nursing facility;

(iv) Any person with mental retardation or mental illness determined to be in need of both nursing facility services and active treatment, who is of advanced years, competent to make an independent decision and who is not a danger to self or others shall be considered appropriate for placement or continued residence in a nursing facility if the person so chooses.

(4) Medicaid recipients must be determined by a preadmission screening team to require nursing facility services before Medicaid payment for services in a nursing facility or the home and community services program will be authorized.

(a) If a person is Medicaid eligible prior to admission to a nursing facility, a nursing facility screening must be requested prior to admission. Payment for nursing facility care shall be effective on the date of entry to the nursing facility if the applicant meets all eligibility requirements.
(b) If the person applies for Medicaid while a resident of a nursing facility, the nursing facility screening must be done prior to initial Medicaid payment. Payment shall be effective on the date of the nursing facility screening or the date of referral to the preadmission screening team, whichever is earlier.

(5) Retroactive approval for nursing facility services is available only if:

(a) the applicant is determined to be financially eligible for Medicaid during the retroactive period; and

(b) the applicant had undergone a determination of need for nursing facility services either by the preadmission screening team or for purposes of Medicare payment; and

(c) the applicant was determined to be in need of nursing facility services as a result of the screenings.

(6) A nursing facility applicant who is not a Medicaid recipient may request that a nursing facility screening be conducted. This screening will be performed by the preadmission screening team.

(7) Preadmission screening will be performed by persons the department determines are qualified to conduct the various elements of the screening.

(8) A nursing facility admitting a nursing facility applicant for whom a level I screening or a nursing facility screening has not been conducted may be subject to the sanctions provided at ARM 37.85.502 and to any other measures that federal or state authorities deem appropriate and necessary for the purposes of the federal Social Security Act. (History: Sec. 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; EMERG, NEW, 1989 MAR p. 439, Eff. 4/14/89; TRANS, from SRS, 2000 MAR p. 489.)

37.40.205 PREADMISSION SCREENING, NURSING FACILITY SERVICES

(1) For elderly persons and physically disabled persons, the need for nursing facility service will be determined based upon the following criteria:

(a) The services of a skilled nursing facility (SNF) are needed when a person meets the criteria for skilled care as defined by Title XVIII of the Social Security Act.

37.40.206 PREADMISSION SCREENING, REDETERMINATION OF NEED FOR NURSING FACILITY SERVICES
(1) For a person who is identified as in need of nursing facility services, and is enrolled in the home and community services program, a redetermination of the need for nursing facility services will take place 90 days after enrollment and every 180 days thereafter.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA; EMERG, NEW, 1989 MAR p. 439, Eff. 4/14/89; TRANS, from SRS, 2000 MAR p. 489.)
37.40.320 MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS
IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX
CALCULATION

(1) Nursing facilities shall submit all minimum data set assessments and tracking
documents to the centers for Medicare and Medicaid services (CMS) database as required
by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet
minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the
department of public health and human services. Back up tapes of each rate setting period
will be maintained for a period of five years.

(4) Assessments not containing sufficient in-range data to perform a resource utilization
group-III (RUG-III) algorithm will not be included in the case mix calculation during the
transition period.

(5) All current assessments in the database older than six months will be excluded from the
case mix index calculation.

(9) Facilities will be required to comply with the data submission requirements specified in
this rule and ARM 37.40.321. The department will utilize medicaid case mix data in the
computation of rates for the period July 1, 2001 through June 30, 2002 and for rate years
thereafter.

(History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-
111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000
MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02;
AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.302 DEFINITIONS

(6) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax
year.

(9) "Minimum data set (MDS)" means the assessment form approved by the centers for
Medicare and Medicaid services (CMS), and designated by the department to satisfy
conditions of participation in the Medicaid and Medicare programs.

(10) "Minimum data set RUG-III quarterly assessment form" means the three page

(18) "Resident" means a person admitted to a nursing facility who has been present in the
facility for at least one 24-hour period.
(20) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident.


NEBRASKA

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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.

**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.

NEW HAMPSHIRE

He-P 803.15 Required Services

...(i) Assessments utilizing the 3.0 version of the Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI) including the minimum data set (MDS) with care area assessment (CAA) shall be completed on each resident as follows:

(1) A comprehensive MDS shall be completed within 14 days after admission;

(2) A comprehensive MDS shall be repeated annually or after any significant change, as defined in He-P 803.03(bh); and

(3) A quarterly MDS shall be completed at least every 3 months.

(j) The care plan portion of the RAI shall be developed within 14 days of the MDS and revised based on needs identified by the MDS.

(k) An initial nursing care plan shall be initiated upon admission and completed within 24 hours of the resident’s admission.

(l) The nursing care plan shall:

(1) Be updated following the completion of each future assessment in (i) above;

(2) Be made available to personnel who assist residents in the implementation of the plan; and

(3) Address the needs identified by (h) and (i) above.
SUBCHAPTER 11. MANDATORY RESIDENT ASSESSMENT AND CARE PLANS

8:39-11.1 Mandatory completion of resident assessment and coordination of care plans

A registered professional nurse (RN) shall assess the nursing needs of each resident, coordinate the written interdisciplinary care plan, sign and date the assessment to certify that it is complete, and ensure the timeliness of all services.

8:39-11.2 Mandatory policies and procedures for resident assessment and care plans

(a) A physician or advanced practice nurse shall provide orders for each resident's care beginning on the day of admission.

(b) Each physician or advanced practice nurse order shall be executed by the nursing, dietary, social work, activities, rehabilitation or pharmacy service, as appropriate in accordance with professional standards of practice.

(c) Each resident shall be examined by a physician or advanced practice nurse within five days before, or 48 hours after, admission.

(d) An initial assessment and care plan shall be developed on the day of admission and shall address all immediate needs, including, but not limited to, personal hygiene, dietary needs, medications, and ambulation.

(e) A comprehensive assessment shall be completed for each resident within 14 days of admission, utilizing the Standardized Resident Assessment Instrument (Minimum Data Set 2.0, or version current as of time of assessment, incorporated herein by reference).

1. The complete assessment and care plan shall be based on oral or written communication and assessments provided by nursing, dietary, resident activities, and social work staff; and when ordered by the physician or advanced practice nurse, assessments shall also be provided by other health professionals.

2. The care plan shall include measurable objectives with interventions based on the resident's care needs and means of achieving each goal.

3. Each facility shall have the equipment and software necessary to enter, store, and transmit each resident's Standardized Resident Assessment Instrument (MDS 2.0 or most current version) electronically to the Department and shall transmit such data to the Department. The facility shall use software which meets technical specifications for the MDS
2.0 (or the version current at the time of assessment) as required by the U.S. Health Care Financing Administration at 42 CFR 483.20(b), and published in the Federal Register at 63 FR 2896.


(f) The complete care plan shall be established and implementation shall begin within 21 days, and shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.

(g) If a resident is discharged to a hospital and returns to the facility within 30 days of discharge, reassessment shall be conducted in those areas where the resident's needs have changed substantially. A complete reassessment shall be performed if the resident was discharged for more than 30 days.

(h) There shall be a scheduled comprehensive reassessment in each service involved in the initial assessment, plus other areas which the physician, advanced practice nurse, or interdisciplinary team indicates are necessary. Reassessments shall be performed according to time frames established in the previous care plan.

(i) A reassessment shall be performed in response to all substantial changes in the resident's condition, such as fractures, onset of debilitating chronic diseases, loss of a loved one, or recovery from depression.

(j) The facility shall have a written transfer agreement with one or more hospitals for emergency care and inpatient and outpatient services.

SUBCHAPTER 12. ADVISORY RESIDENT ASSESSMENT AND CARE PLANS

8:39-12.1 Advisory policies and procedures for resident assessment and care plan

(a) The resident care plan is developed at a meeting held by an interdisciplinary team that includes professional and/or ancillary staff from each service providing care to the resident.

(b) The facility makes care planning meetings available at mutually agreeable times, including evenings and weekends, for the convenience of families and significant others.

8:39-12.2 Advisory resident services for off-site services

The facility provides and/or arranges for someone to accompany each resident to scheduled visits to off-site health care services.

8:39-13.2 Mandatory resident communication services
(a) Residents and their families shall be given the opportunity to participate in the development and implementation of the care plan, and their involvement shall be documented in the resident's medical record.

NEW MEXICO

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7.9.2.37 PROCEDURES FOR ADMISSION OF RESIDENTS:

...C. “MEDICAL EXAMINATION AND EVALUATION”:

(1) Examination: Each resident shall have a physical examination by a physician or physician extender within forty-eight (48) hours following admission unless an examination was performed within fifteen (15) days before admission.

(2) Evaluation: Within forty-eight (48) hours after admission the physician or physician extender shall complete the resident's medical history and physical examination record. If copies of previous evaluations are used, the physician must authenticate such findings within forty-eight (48) hours of admission.

D. “RESIDENT ASSESSMENT”: A comprehensive accurate assessment of each resident's functional capacity and impairment, as basis for care delivery, shall be conducted by designated qualified staff. A preliminary assessment shall be completed within forty-eight (48) hours of admission, a comprehensive assessment within thirty (30) days of admission, after significant change and repeated at least annually. [7-1-60, 5-2-89; 7.9.2.37 NMAC - Rn, 7 NMAC 9.2.37, 8-31-00]

7.9.2.47 RESIDENT CARE PLANNING:

A. DEVELOPMENTAL AND CONTENT OF CARE PLANS: Except in the case of a person admitted for short-term care, within two (2) weeks following admission a written care plan shall be developed, based on the resident's history and assessments from all appropriate disciplines and the physician's evaluations and orders, which shall include:

(1) Measurable goals with specific time limits for attainment.

(2) The specific approaches for delivery needed care, and indication of which professional disciplines are responsible for delivering the care.

B. EVALUATIONS AND UPDATES: The care of each resident shall be reviewed by each of the services involved in the resident's care and the care plan evaluated and updated no less than quarterly or more often as needed.
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.

Volume: C

(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’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)...

10A NCAC 13D .2301 PATIENT ASSESSMENT AND CARE PLANNING

(a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient’s immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse and measures implemented as appropriate.

(b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient’s capability to perform daily life functions. This comprehensive assessment shall be coordinated by a registered nurse and shall include at least the following:

(1) current medical diagnoses;

(2) medical status measurements, including current cognitive status, stability of current conditions and diseases, vital signs, and abnormal lab values and diagnostic tests that are a part of the medical history;

(3) the patient’s ability to perform activities of daily living, including the need for staff assistance and assistive devices, and the patient’s ability to make decisions;

(4) presence of neurological or muscular deficits;

(5) nutritional status measurements and requirements, including but not limited to height, weight, lab work, eating habits and preferences, and any dietary restrictions;

(6) special care needs, including but not limited to pressure sores, enteral feedings, specialized rehabilitation services or respiratory care;
(7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other psychosocial needs;

(8) facility's expectation of discharging the patient within the three months following admission;

(9) condition of teeth and gums, and need and use of dentures or other dental appliances;

(10) patient's ability and desire to take part in activities, including an assessment of the patient's normal routine and lifetime preferences;

(11) patient's ability to improve in functional abilities through restorative care;

(12) presence of visual, hearing or other sensory deficits; and

(13) drug therapy.

(c) The facility shall develop a comprehensive care plan for each patient and shall include measurable objectives and timetables to meet needs identified in the comprehensive assessment. The facility shall ensure the comprehensive care plan is developed within seven days of completion of the comprehensive assessment by an interdisciplinary team that includes a registered nurse with responsibility for the patient and representatives of other appropriate disciplines as dictated by the needs of the patient. To the extent practicable, preparation of the comprehensive care plan shall include the participation of the patient and the patient's family or legal representative. The physician may participate by alternative methods, including, but not limited to, telephone or face-to-face discussion, or written notice.

(d) The facility shall review comprehensive assessments and care plans no less frequently than once every 90 days and make necessary revisions to ensure accuracy.
...b. Ensure a resident assessment is completed and a comprehensive care plan is established in coordination with the resident or legal representative within the required timeframes.

c. Ensure care plans are implemented so as to assist each resident to attain and maintain their highest level of functioning.

33-07-03.2-15. Resident assessment and care plan.

1. The facility shall complete and maintain an up-to-date comprehensive resident assessment for each resident by using the resident assessment instrument, the utilization guidelines, the minimum data set of core elements and common definitions, and the resident assessment protocol summary with triggers as specified by the department and approved by health care financing administration and published in the state operations manual.

2. In coordination with the resident or resident's legal representative and staff providing resident care services, a comprehensive written resident care plan for each resident must be developed and maintained consistent with each resident's individual needs and licensed health care practitioner's plan of medical care. An initial care plan must be implemented upon admission and revised within seven days after the completion of the resident assessment instrument.

3. A care plan must be individualized to meet the needs of the resident and must include problem and strength identification, measurable resident-centered goals, plans of action, and which professional service is responsible for each element of care. Goals must be measurable, behavior oriented, time-limited, and achievable.

4. Resident assessment and quarterly assessment information on each resident must be submitted electronically to a location specified by the department in a time frame specified by the department.


OHIO

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3701-17-10 Resident assessments; tuberculosis testing.

(A) Each nursing home, in accordance with this rule, shall require written initial and periodic assessments of all residents. The different components of the assessment may be
performed by different licensed health care professionals, consistent with the type of information required and the professional’s scope of practice, as defined by applicable law, and shall be based on personal observation and judgment. This paragraph does not prohibit the licensed health professional from including in the assessment resident information obtained by or from unlicensed staff provided the evaluation of such information is performed by that licensed health professional in accordance with the applicable scope of practice.

(B) Prior to admission, the nursing home shall obtain from the prospective resident’s physician, other appropriate licensed health professionals acting within their applicable scope of practice, or the transferring entity, the current medical history and physical of the prospective resident, including the discharge diagnosis, admission orders for immediate care, the physical and mental functional status of the prospective resident, and sufficient additional information to assure care needs of and preparation for the prospective resident can be met. This information shall have been updated no more than five days prior to admission.

(C) Upon admission, the nursing home shall assess each resident in the following areas:

(1) Cardiovascular, pulmonary, neurological status including auscultation of heart and lung sounds, pulses and vital signs; and

(2) Hydration and nutritional status; and

(3) Presenting physical, psycho-social and mental status. The nursing home shall also review each resident’s admission orders to determine if the orders are consistent with the resident’s status upon admission as assessed by the nursing home and shall reconfirm, as applicable, the orders with the attending physician or other licensed health care professional acting within the applicable scope of practice. The nursing home shall obtain any special equipment, furniture or staffing that is needed to address the presenting needs of the resident. The nursing home shall provide services to meet the specific needs of each resident identified through this admission assessment until such time as the care plan required by rule 3701-17-14 of the Administrative Code is developed and implemented.

(D) The nursing home shall perform a comprehensive assessment meeting the requirements of paragraph (E) of this rule on each resident as follows:

(1) For an individual beginning residence in the nursing home after the effective date of this rule, the comprehensive assessment shall be performed within fourteen days after the individual begins to reside in the facility.

(2) For a resident living in the nursing home on the effective date of this rule, a comprehensive assessment shall be performed within ninety days of the effective date of this rule. If the resident had a comprehensive assessment meeting the requirements of paragraph (E) of this rule no more than three months before the effective date of this rule, the nursing home is not required to perform another comprehensive assessment;

(3) Subsequent to the initial comprehensive assessment, a comprehensive assessment shall be performed at least annually thereafter. The annual comprehensive assessment shall be
performed within thirty days of the anniversary date of the completion of the resident’s last comprehensive assessment.

(E) The comprehensive assessment shall include documentation of the following:

(1) Medical diagnoses;

(2) Psychological, and mental retardation and developmental diagnoses and history, if applicable;

(3) Health history and physical, including cognitive functioning, and sensory and physical impairments;

(4) Psycho-social history and the preferences of the resident including hobbies, usual activities, food preferences, bathing preferences, sleeping patterns, and socialization and religious preferences;

(5) Prescription and over-the-counter medications;

(6) Nutritional requirements and need for assistance and supervision of meals;

(7) Height and weight;

(8) A functional assessment which evaluates the resident’s ability to perform activities of daily living;

(9) Vision, dental and hearing function; and

(10) Any other alternative remedies and treatments the resident is taking or receiving. The documentation required by this paragraph shall include the name and signature of the individual performing the assessment, or component of the assessment, and the date the assessment was completed.

(F) Subsequent to the initial comprehensive assessment, the nursing home shall periodically reassess each resident, at minimum, every three months, unless a change in the resident’s physical or mental health or cognitive abilities requires an assessment sooner. The nursing home shall update and revise the assessment to reflect the resident’s current status. This periodic assessment shall include documentation of at least the following:

(1) Changes in medical diagnoses;

(2) Updated nutritional requirements and needs for assistance and supervision of meals;

(3) Height and weight;

(4) Prescription and over-the-counter medications;

(5) A functional assessment as described in paragraph (E)(8) of this rule;

(6) Any changes in the resident’s psycho-social status or preferences as described in paragraph (E)(4) of this rule; and
Any changes in cognitive, communicative or hearing abilities or mood and behavior patterns.

...[I] Nursing homes that conduct resident assessments in accordance with 42 C.F.R. 483.20, using the resident assessment instrument specified by rule 5101:3-3-40 of the Administrative Code, shall be considered in compliance with paragraphs (D), (E) and (F) of this rule.

3701-17-14 Plan of care; treatment and care: discharge planning.

(A) The nursing home shall assure that development of a plan of care is initiated upon admission and completed and implemented for each resident within seven days of completion of the initial comprehensive assessment, required by rule 3701-17-10 of the Administrative Code. The plan shall be prepared by an interdisciplinary team that includes the attending physician or the attending advance practice nurse, or both, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the needs of the resident and, to the extent practicable, the resident and the family or sponsor of the resident unless the resident does not wish them to be involved.

(1) The plan of care shall be consistent with the comprehensive assessment with recognition of the capabilities and preferences of the resident, and shall contain a written description of what services, supplies and equipment, are needed, when, how often, and by whom services, supplies and equipment will be provided and the measurable goals or outcomes.

(2) The plan of care shall be reviewed whenever there is a change in the resident’s condition and the needs of the resident warrants a change in the services, supplies or equipment to be provided, and at least quarterly, by the nursing home and the resident, or sponsor, or both, and shall be updated, as appropriate.

(3) Each resident shall have access to his or her assessment and plan of care at any time upon request.

(B) All skilled nursing care shall be provided by a nurse except a nurse may delegate certain tasks as authorized by Chapter 4723. of the Revised Code in accordance with the applicable rules adopted under that chapter.

(C) The nursing home shall provide all residents who cannot give themselves adequate personal care with such care as is necessary to keep them clean and comfortable.

(D) All services, supplies and equipment provided or arranged for by the nursing home shall be provided, in accordance with acceptable standards of practice and the written plans of care, by individuals who meet the applicable qualifications of this chapter.
(E) The nursing home shall assure that all residents receive adequate, kind, and considerate care and treatment at all times.

(F) The nursing home shall transfer and discharge a resident in an orderly and safe manner in accordance with Chapter 3701-61 of the Administrative Code. In anticipation of a discharge, the nursing home shall prepare the following information to be shared with appropriate persons and agencies upon consent of the resident, except the resident's right to refuse release of such information does not apply in the case of transfer to another home, hospital, or health care system, if the release is required by law or rule or by a third-party payment contract:

1. An updated assessment that addresses the criteria outlined in paragraph (E) of rule 3701-17-10 of the Administrative Code and accurately identifies the resident's condition and continuing care need at the time of transfer and discharge;

2. A plan that is developed with the resident and family members, with the consent of the resident, that describes what services, supplies and equipment are needed, how needed services, supplies and equipment can be accessed, and how to coordinate care if multiple care givers are involved. The plan shall also identify need for the resident and care givers' education, including resident and care giver instruction on the proper use of grab rails and other safety devices, and any accommodations to the physical environment to meet the needs of the resident; and

3. The nursing home shall, with the consent of the resident, arrange or confirm the services, equipment and supplies in advance of discharge or transfer of the resident.

(G) If the nursing home resident is also a patient of a hospice care program, the nursing home shall communicated and work with the hospice in development and implementation of a coordinated plan of care between the nursing home and hospice. This coordinated plan of care shall:

1. Reflect the hospice philosophy;

2. Be based on the assessment of the resident and the unique living situation in the nursing home; and

3. Identify the services, supplies, and equipment to be provided by the nursing home and those to be provided by the hospice care program. The nursing home shall allow the hospice care program to retain professional management of the resident’s plan of care related to the resident’s terminal illness pursuant to Chapter 3701-19 of the Administrative Code as long as the resident is receiving hospice care. The nursing home shall take directions from the hospice regarding implementation of the coordinated plan of care related to the resident's terminal illness.
310:675-9-5.1. Assessment and care plans

(a) A resident assessment and an individual care plan shall be completed and implemented for each resident. The care plan shall indicate the resident's current status and accurately identify the resident's needs.

(b) The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates.

(c) Efforts shall be made to include the resident and resident's representative in development and implementation of the care planning process.

(1) Resident assessment

(A) The facility shall conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment for each resident's functional capacity.

(B) Each resident shall have an assessment coordinated or conducted by a registered nurse.

(C) Each individual completing a portion of the assessment shall sign, date, and certify the accuracy of that portion.

(D) An assessment shall be completed within fourteen days after admission of the resident.

(E) The resident assessment shall include a minimum data set (MDS) in the form required under 42 CFR 483.20. Each facility, with the exception of Intermediate Care Facilities for the Mentally Retarded (ICF/MR), accurately shall complete the MDS for each resident in the facility, regardless of age, diagnosis, length of stay or payment category.

(F) The MDS form shall require the following, as applicable:

(i) Admission assessment;

(ii) Annual assessment;

(iii) Significant change in status assessment;
(iv) Significant correction of prior full assessment;
(v) Significant correction of prior quarterly assessment;
(vi) Quarterly review; and
(vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(2) Resident pain assessment

(A) Residents shall be screened for the presence of pain at least once every 30 days and whenever vital signs are taken.

(i) Licensed nursing staff shall perform the screening at least once every 30 days. Certified nurse aides may perform the screening more frequently as needed.

(ii) The screening instrument shall grade the intensity and severity of pain using a resident-specific pain scale;

(B) An individualized pain assessment shall be conducted by a registered nurse for each resident:

(i) In conjunction with the admission, quarterly and annual assessments required at OAC310:675-9-5.1.(c)(1)(F); and

(ii) With onset of pain not previously addressed in a care plan or physician's orders.

(C) The goal is to alleviate or minimize pain while assisting the resident to maintain as high a level of functioning as possible. The pain assessment shall include, but not be limited to:

(i) A statement of how the resident describes the pain;

(ii) Intensity and severity of pain graded using a resident-specific pain scale;

(iii) Recent changes in pain;

(iv) Location(s);

(v) Onset and duration of pain, such as new pain within the last 3 days, recent pain within the last 3 months, or more distant pain greater than 3 months;

(vi) Type of pain reported or represented by resident, such as constant or intermittent, and duration or frequency of pain;

(vii) Current pain measured at its least and greatest levels;

(viii) Aggravating and relieving factors;
(ix) Treatment including a review of all therapies, including medication, and the regimen used to minimize pain;

(x) Effects of pain and effectiveness of therapy on physical and social functions;

(xi) Resident’s treatment preferences and emotional responses to pain, including resident’s expectations and how resident coped with pain; and

(xii) If applicable, refer to pain assessment tool for the cognitively impaired.

(D) Results shall be recorded in the resident’s clinical record showing changes in pain scale and changes in level of functioning. The physician shall be contacted as necessary.

(E) Pain shall be treated promptly, effectively and for as long as necessary.

(3) Individual care plan

(A) An individual care plan shall be developed and implemented for each resident to reflect the resident’s needs.

(B) The care plan shall be developed by an interdisciplinary team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines determined by the resident’s needs.

(C) The care plan shall include measurable objectives and timetables to meet the resident’s medical, nursing, mental and psychosocial needs identified in the assessment.

(D) The care plan shall be available to appropriate personnel providing care for the resident.

(E) An initial care plan shall be completed at the time of admission. The individualized care plan shall be completed within twenty-one days after admission.

(F) A care plan shall be completed within seven calendar days after the completion of the assessment.[Source: Added at 9 OkReg3163, eff 7-1-92 (emergency); Added at 10 OkReg 1639, eff 6-1-93; Amended at 16 Ok Reg 3493, eff 7-30-99 (emergency); Amended at 17 Ok Reg 2072, eff 6-12-00; Amended at 20 Ok Reg 2399, eff 7-11-03; Amended at 23 Ok Reg 156, eff 10-6-05 (emergency); Amended at 23 Ok Reg 2415, eff 6-25-06; Amended at 27 OkReg 2545, eff 7-25-10]
411-070-0040 Client Screening, Assessment and Review

(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service needs and preferences and must receive information about community-based, alternative services, and resources that can meet the individual’s service needs and are safe, least restrictive, and potentially less costly than comparable nursing facility services.

(2) PRE-ADMISSION SCREENING. A pre-admission screening (PAS) as defined in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.

(a) PAS includes:

(A) An assessment;

(B) The determination of an individual’s service eligibility for Medicaid-paid long term care or post-hospital extended care services in a nursing facility;

(C) The identification of individuals who can transition to community-based service settings;

(D) The provision of information about community-based services and resources to meet the individual’s needs; and

(E) Transition planning assistance as needed.

(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.

(c) The PAS assessment shall be conducted by a case manager or other qualified SPD or AAA representative using SPD’s Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.

(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

(e) Payment for nursing facility services may not be authorized by SPD until PAS has established that nursing facility services are required based on the individual’s service needs and Medicaid financial eligibility has been established.
(3) PRIVATE ADMISSION ASSESSMENT. A private admission assessment (PAA) is required for individuals with private funding who are referred to Medicaid-certified nursing facilities established by ORS 410.505 through 410.545 and OAR chapter 411, division 071.

(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A pre-admission screening and resident review (PASRR) as described in OAR 411-070-0043 is required for individuals, regardless of payment source, with either mental illness or developmental disabilities who need nursing facility services.

(5) RESIDENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

  (a) Staff associated with SPD are required to maintain service plans on all SPD residents in nursing facilities. The frequency of their service plan update shall vary depending on such factors as the resident’s potential for transition to home or community-based care and federal or state requirements for resident review.

  (b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care, or alleged abuse. SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility’s property as required to carry out the above responsibilities.

  (c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities.

  (d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.


411-070-0043 Pre-Admission Screening and Resident Review (PASRR)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or mental retardation or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical
determination, as described in section (2) of this rule, are groupings of individuals with mental illness or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or SPD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual’s source of payment. The purpose of the screening is to identify indicators of mental illness or mental retardation or developmental disabilities that may require further evaluation {42 CFR

(A) PASRR Level I screening is performed by AAA/SPD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a SPD-designated form.

(C) If there are no indicators of mental illness or mental retardation or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.
(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMHD and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of mental retardation or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact SPD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual’s resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or SPD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident’s clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or mental retardation or developmental disabilities who does not meet categorical determination criteria (42 CFR 483.128).

(A) Individual’s identified with indicators or mental illness or mental retardation or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMHD for individuals with mental illness or by SPD for individuals with mental retardation or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual’s need for nursing facility services and specialized services {42 CFR 483.128-136} consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:

(i) Whether a nursing facility level of services is needed;
(ii) Whether specialized services are needed;

(iii) The placement options that are available to the individual consistent with these determinations; and

(iv) The rights of the individual to appeal the determination.

(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.

(F) Denials of nursing facility service are subject to appeal {OAR 137-003, 461-025 & 42 CFR Subpart E}.

(c) RESIDENT REVIEW. Resident reviews are conducted by AMHD for individuals with indicators of mental illness or SPD for individuals with mental retardation or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMHD, in accordance with OAR 411-086-0060.

(B) All individuals identified as having mental retardation or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident’s needs or desires.

(i) The resident review must be completed by SPD or designee.

(ii) The resident review must be completed using forms designated by SPD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.
(b) Specialized services for individuals with mental retardation or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.

(c) Specialized services for individuals with mental retardation or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with mental retardation or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

[ED. NOTE: Forms referenced are available from the agency.] [Publications: Publications referenced are available from the agency.]


411-071-0000 Purpose

(1) The purpose of Private Admission Assessment is to ensure that non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility receive information regarding appropriate service and placement alternatives.

(2) These rules establish procedures and requirements for admission assessment of non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility as required in ORS 410.505 to 410.545. The admission assessment includes mandatory services necessary to comply with the federal pre-admission screening requirements established by the Health Care Financing Administration. It also provides optional information regarding appropriate care settings and services, including nursing facilities and community-based options such as adult foster care, assisted living, residential care, in-home services, and other community-based services.

(3) These rules establish a certification process for programs henceforth called "certified programs," to perform admission assessments to individuals seeking admission to nursing facilities with a Medicaid contract. These rules establish standards for assessments performed by certified programs, local Area Agencies on Aging and Department personnel. Recommendations made during the admission assessment are not binding. Each individual has the right to choose from any of the long-term care options available.

411-071-0010 Assessment Requirements

(1) An admission assessment must be provided prior to admission for all non-Medicaid eligible individuals applying as new admissions to a Medicaid certified nursing facility except as provided in OAR 411-071-0015. The admission assessment must occur no more than 90 days prior to the date of admission.

(2) Admission assessments are to be performed by certified programs.

(3) If the assessment is performed by personnel from a certified program, such personnel must make a good faith effort to determine whether the individual receiving the assessment is or appears to be Medicaid eligible based on a review of optional income and asset information provided by the individual. If the individual appears to be Medicaid eligible or may become Medicaid eligible within 60 days, the certified program must contact and coordinate with the local Area Agency on Aging/Seniors and People with Disabilities unit to provide further assessment services.


Exemptions

(1) The criteria under which an individual is exempted must be clearly indicated on the form designated by the Department.

(2) An exemption from the full assessment process may be granted for an individual who meets one of the following criteria:

(a) An individual seeking temporary admission to a nursing facility from a hospital and meets all of the following criteria as certified by the attending physician:

(A) Seeks admission directly from a hospital, or within 30 days of discharge from the hospital, after receiving acute inpatient care at the hospital; and

(B) Requires nursing facility services for the condition for which he or she received care in the hospital; and

(C) Requires nursing facility services for 30 days or less.

(b) An individual has a medical prognosis with life expectancy of 30 days or less;

(c) An individual seeking temporary admission for respite services with expected length of stay of 30 days or less;

(d) A resident of a continuing care retirement community who is seeking admission to a Medicaid certified nursing facility that is part of the same continuing care retirement community; or
(e) An individual certified by the attending physician that he/she must be admitted from the community or hospital emergency room without delay due to a serious and immediate threat to the individual’s health and safety.

(3) The assessment must be completed and signed by a certified program, the attending physician, or a professional medical staff person working directly under the supervision of the attending physician for individuals admitted under an exemption criteria.

(4) An individual admitted to a nursing facility under an exemption under subsections (2)(a), (b), or (c) of this rule must receive an assessment within 7 days after the 30th day of admission.

(5) An individual temporarily admitted to a nursing facility under subsection (2)(e) of this rule must receive an assessment within seven days from the date of admission.

(6) No assessment or exemption is required for:

(a) An individual returning to a nursing facility after having entered a hospital from the same nursing facility; or

(b) An individual transferring from one Oregon nursing facility to another Oregon nursing facility with or without an intervening hospital stay.


411-071-0020 Assessment Process

(1) The Department must develop and provide to certified programs an assessment instrument to be used for all admission assessments.

(2) The admission assessment must consist of:

(a) Information necessary to comply with federal pre-admission screening requirements as established by the Centers for Medicare Services;

(b) Recommendations regarding appropriate care settings and services based on the individual’s personal, family, and community support system, discussion of the individual’s lifestyle preferences and goals, and other information. An individual or the individual’s representative must indicate on the assessment form provided by the Department whether the individual has received information about care options or does not want the information. An individual may not be required to receive this information. Documentation by non-hospital based programs must be on the form designated by the Department. Hospital based programs must document information regarding appropriate care settings and services in their own discharge planning documents for all individuals assessed.
Appropriate information about care settings and services may be made available to individuals choosing to receive such information, including information on community-based care services, nursing facility options, and additional information as may be appropriate to a particular geographic area.

The recommendations of the admission assessment are not binding; an individual has the right to choose any or none of the available options. An individual may designate someone to participate in the assessment process.

As part of the admission assessment process, the individual or the individual’s representative, as specified in section (6) of this rule,

The following descending hierarchy is to be observed when certifying the information required in sections (5) and (6) of this rule and signing the assessment form:

(a) The individual, if the individual is capable at the time the assessment is performed;

(b) The individual’s legally designated representative (as defined in OAR 411-071-0005) if the individual is not capable at the time the admission assessment is performed;

(c) The individual's next of kin or, if appropriate, a knowledgeable friend if the individual has no legally designated representative and is not capable at the time the admission assessment is performed;

(d) The person performing the assessment if a good faith effort fails to locate the individual’s next of kin or appropriate friend, the individual has no legally designated representative, and is not capable at the time the admission assessment is performed;

(e) The person performing the assessment if the individual is capable at the time the assessment is performed but refuses to sign.

411-071-0043 Qualifications for Personnel Performing Admission Assessments

Except as provided in section (2) of this rule, all persons performing admission assessments shall meet one of the following criteria:

(a) Be a registered nurse licensed by the State of Oregon;

(b) Have a master of social work degree from an accredited institution of higher education; or

(c) Have a bachelor's degree from an accredited institution of higher education and have experience in gerontology, health care, long-term care, or other relevant human services.
Any applicant or Certified Program may request that the Division allow an employee who meets the following conditions to perform admission assessments:

(a) The employee for whom the exception is being requested works directly under the supervision of someone qualifying under section (1) of this rule; and

(b) One or more of the following apply:

(A) The employee has at least one year of experience performing functions substantially similar to admission assessments;

(B) The employee has other work or educational experiences that provide clear and convincing evidence of the person’s ability to perform admission assessments.

Responsibilities of Nursing Facilities

(1) A Medicaid eligible individual must have an AAA/Seniors and People with Disabilities Pre-Admission Screening and prior authorization of payment prior to admission to a nursing facility. A nursing facility must not admit a Medicaid eligible individual based on a Private Admission Assessment.

(2) A nursing facility receiving an application for admission from an individual who is subject to the admission assessment requirement but has not had an assessment performed within the preceding 90 days must provide the individual with information on the admission assessment process and a list of certified programs provided by the Department or the area agency on aging/Seniors and People with Disabilities office.

(3) Except as provided in section (4) of this rule, nursing facilities must not admit an individual without a completed and signed assessment form in the client record. Such forms are to be maintained as a permanent part of the client record.

(4) A nursing facility may admit an individual without a completed and signed assessment form in the client record provided the facility has received verbal confirmation from a certified program that an assessment has been completed for the individual within the preceding 90 days and a copy of the assessment form will be sent to the facility as soon as is reasonably possible. The facility must note in the client record the name of the certified program, the name and title of the person providing the verbal confirmation, and the date and time confirmation was provided.

(5) If a nursing facility admits an individual under an exempted hospital discharge set forth in OAR 411-071-0015(3)(a) for the purpose of rehabilitative and/or nursing services for 30 days or less, the nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days after the 30th day of admission.
(6) If a nursing facility admits an individual under an emergency exemption set forth in OAR 411-071-0015(3)(e), the nursing facility must contact a certified program and must ensure a Private Admission Assessment is completed within seven days of admission.

(7) A nursing facility receiving an application from an individual who is not an Oregon resident, or from an individual who is being discharged from a hospital that is not a certified program, or from an individual currently residing in a nursing facility outside the state of Oregon must immediately notify the local Area Agency on Aging/Seniors and People with Disabilities unit of the need for the individual to receive an admission assessment. The nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days of admission.

(8) The nursing facility is responsible for assuring that an individual subject to the Level II pre-admission screening evaluation required by the federal pre-admission screening requirements has been referred to the Seniors and People with Disabilities of the Department of Human Services.

(9) The Department may disallow payment for nursing services provided to an individual who has not been screened in compliance with the federal pre-admission screening requirements or an individual who is subject to the Level II evaluation and determination but who has not received such a determination within the time limits established in the federal pre-admission requirements.

(10) A nursing facility failing to comply with these rules may be subject to administrative sanctions as provided in ORS 410.540 and/or civil penalties as provided in OAR 411-071-0105.


411-086-0040 Admission of Residents

(1) Admission Conditions:

...(e) No facility shall admit an individual who is mentally ill or mentally retarded unless the Division or local representative thereof has determined that such placement is appropriate.

(2) Admission Status, Preliminary Care Plan, Preliminary Nursing Assessment:

(a) A licensed nurse shall document the admission status of the resident within eight hours, including but not limited to skin condition, nutritional status, hydration status, mental status, vital signs, mobility, and ability to perform ADLs. This review of resident status shall be sufficient to ensure that the immediate needs of the resident are met;

(b) A licensed nurse shall develop a preliminary resident care plan within 24 hours of admission. Staff providing care for the resident shall have access to, be familiar with, and follow this plan;
(c) Social services shall be provided to the resident in accordance with the preliminary resident care plan not later than three days after admission;

(d) A registered nurse shall complete and document a comprehensive nursing assessment within 14 days of admission;

(e) A resident care plan shall be completed pursuant to OAR 411-086-0060.

411-086-0060 Comprehensive Assessment and Care Plan

(Effective 10/01/1993)

(1) COMPREHENSIVE ASSESSMENT.

(a) An RN shall ensure completion and documentation of a comprehensive assessment of the resident's capabilities and needs for nursing services within fourteen days of admission. Comprehensive assessments shall be updated promptly after any significant change of condition and reviewed no less often than quarterly. This assessment shall be on a form specified by the Division. The assessment shall include the following:

(A) Medically defined conditions and medical history;

(B) Medical status measurement;

(C) Functional status;

(D) Sensory and physical impairments;

(E) Nutritional status and requirements;

(F) Treatments and procedures;

(G) Psychosocial status (see OAR 411-086-0240);

(H) Discharge potential (see OAR 411-086-0160);

(I) Dental condition;

(J) Activities potential (see OAR 411-086-0230);

(K) Rehabilitation and restorative potential (see OAR 411-086-0150 and 411-086-0220);

(L) Cognitive status; and

(M) Drug therapy.

(b) Social services, activities and dietary personnel shall complete an assessment within fourteen days of admission.
(2) CARE PLAN PREPARATION and IMPLEMENTATION. The facility, through the nursing services department and the interdisciplinary staff, shall provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written, dated, care plan.

(a) The plan shall be completed within seven days after completion of the comprehensive assessment. The care plan shall be reviewed and updated whenever the resident's needs change, but no less often than quarterly.

(b) The care plan shall describe the medical, nursing, and psychosocial needs of the resident and how the facility will actively meet those needs. This description of needs shall include measurable objectives and time frames in which the objectives will be met.

(c) The plan shall provide for and promote personal choice and independence of the resident.

(d) The plan shall be reviewed and completed at an interdisciplinary care planning conference with participation from the resident's RN care manager and personnel from dietary, activities and social services. The resident's attending physician will participate in the development and any revision of the care plan. Physician participation may be in person, through communication with the DNS or RN Care Manager, or via telephone conference.

(e) The resident, the resident's legal representative, and anyone designated by the resident shall be requested to participate. The request shall be documented in the resident's clinical record.

(f) The plan shall be prepared and implemented with participation of the resident and in accordance with the resident's wishes.

(g) The plan shall include an assessment of the resident's potential for discharge and the facility's efforts to work toward discharge.

(h) The plan shall be available to and followed by all staff involved with care of the resident.

(3) DOCUMENTATION.

(a) The care plan shall be written in ink and made a part of the resident's clinical record;

(b) Participation in development of the care plan by interdisciplinary staff will be clearly documented.


Stats. Implemented: ORS 441.055 & 441.615

411-086-0160 Nursing Services: Discharge Summary
(1) Discharge Summary Required. A discharge summary shall be completed for each resident before discharge.

(2) Contents. The discharge summary shall include:

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

(b) A final summary of the resident's status, including the most recent nursing assessment as defined in OAR 411-086-0060; and

(c) A post-discharge plan of care developed in accordance with OAR 411-086-0060 which will assist the resident to adjust to his/her new living environment. A post-discharge plan is not required when the resident is discharged to acute care or to the morgue.

21.3 As part of the initial resident admission and assessment process, the facility shall review and consider any notice provided to the facility as required in subsection 42-56-10(23) of the Rhode Island General Laws, as amended, concerning the resident’s or prospective resident’s status on parole and recommendations, if any, from the Department of Corrections regarding safety and security measures.

Section 25.0 Selected Nursing Care Procedures

25.1 Written resident care plans, including problems, measurable goals, interventions, and time frames, shall be developed and maintained for each resident consonant with the attending physician’s plan of medical care.

a) Resident care plans shall be reviewed, evaluated and revised by professional staff no less than every three months, or when there is a significant change in the resident’s health status.

SOUTH CAROLINA

803. Individual Care Plan (ICP) (II)

A. The facility shall develop an ICP with participation by, and as evidenced by the signatures of the resident or responsible party, or documentation that the facility attempted to obtain the signatures, and an interdisciplinary team of qualified individuals, within fourteen (14) days of admission. The ICP shall be reviewed and/or revised as changes in resident needs occur, but not less than quarterly by the interdisciplinary team.

B. The ICP shall describe:

1. The needs of the resident, including the services that are to be furnished, i.e., what assistance, how much, who will provide the assistance, how often, and when;

2. Advance directives and healthcare power-of-attorney, as applicable;

3. Recreational and social activities that are suitable, desirable, and important to the resident;

4. Dietary needs and preferences of resident as approved by a physician;

5. Discharge planning, to include assessing continuing care needs and developing a plan designed to assure the resident’s needs will be met after discharge or transfer.
SECTION 1200 - RESIDENT PHYSICAL EXAMINATION AND TUBERCULOSIS SCREENING

1201. General (I)

A. The admission physical examination shall be conducted by the attending physician within five (5) days prior to admission or within seven (7) business days after admission and shall address the physical condition and diagnosis of the resident. As an exception, physical examinations conducted by physicians licensed in states other than South Carolina are permitted for new admissions under the condition that residents obtain an attending physician licensed in South Carolina within thirty (30) days of admission to the facility. The physical examination information shall be updated to include new medical information if the resident's condition has changed since the last physical examination was completed.

B. The admission physical examination shall include tuberculosis screening (See Section 1804), as determined by the facility risk assessment (See Section 101.BBBB) in the manner designated by guidelines established by the Department.

C. In the event that a resident transfers from a healthcare facility licensed by the Department, as defined in S.C. Code Ann. Section 44-7-130(10) (1976, as amended), to a nursing home, an additional admission physical examination shall not be required, provided the resident transferring has had a physical examination conducted not earlier than three (3) months prior to the admission of the resident to the nursing home that addresses the physical condition and diagnosis of the resident, and meets the requirements specified in Section 1201.B unless the receiving facility has an indication that the health status of the resident has changed significantly. A discharge summary from a healthcare facility, which includes a physical examination, may be acceptable as the admission physical examination, provided the summary addresses the physical condition and diagnosis of the resident, meets the requirements specified in Section 1201.B, and the resident's physician attests to its accuracy by countersigning it. The receiving nursing home shall acquire a copy of the physical examination and tuberculosis screening, if applicable, from the licensed facility transferring the resident with the attending physician updating by signature and date.

SOUTH DAKOTA

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 dietitian, 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.

Source: 17 SDR 122, effective February 24, 1991, and April 1, 1991; transferred from §
44:04:04:13, 22 SDR 70, effective November 19, 1995; 26 SDR 96, effective January 23,
Implemented: SDCL 34-12-13. Reference: Long Term Care Resident Assessment Instrument
Phone: 1-800-247-2243. Cost: $29.95.

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.

illness or mental retardation before the resident makes a transition from the nursing home to a community-based care setting.

(d) The Texas Department of Mental Health and Mental Retardation shall use the information provided under Subsection (c) solely for the purposes of:

(1) determining the need for and funding levels of mental health and mental retardation services for residents making a transition from a nursing home to a community-based care setting;

(2) providing mental health or mental retardation services to an identified resident after the resident makes that transition; and

(3) referring an identified resident to a local mental health or mental retardation authority or private provider for additional mental health or mental retardation services.

(e) This section does not authorize the department to decide for a resident of a nursing home that the resident will make a transition from the nursing home to a community-based care setting.


Sec. 242.183. PLAN OF CARE.

(a) The institution and the person arranging the care must agree on the plan of care and the plan must be filed at the institution before the institution admits the person for the care.

(b) The plan of care must be signed by:

(1) a licensed physician if the person for whom the care is arranged needs medical care or treatment; or

(2) the person arranging for the respite care if medical care or treatment is not needed.

(c) The institution may keep an agreed plan of care for a person for not longer than six months from the date on which it is received. During that period, the institution may admit the person as frequently as is needed and as accommodations are available.


SUBCHAPTER I RESIDENT ASSESSMENT
RULE §19.801 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity. In Medicaid-certified and dually certified nursing facilities, admission, annual, quarterly, and significant change assessments must be transmitted electronically to the Texas Department of Human Services (DHS).

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

(2) Comprehensive assessments.

(A) A facility must make a comprehensive assessment of a resident’s needs, using the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), specified by DHS. Licensed-only facilities do not have to complete Medicaid-specific sections.

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

(ii) customary routine;
(iii) cognitive patterns;
(iv) communication;
(v) vision;
(vi) mood and behavior patterns;
(vii) psychosocial well-being;
(viii) physical functioning and structural problems;
(ix) continence;
(x) disease diagnoses and health conditions;
(xi) dental and nutritional status;
(xii) skin condition;
(xiii) activity pursuit;
(xiv) medications;
(xv) special treatments and procedures;
(xvi) discharge potential;
(xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(C) A facility must conduct a comprehensive assessment of a resident as follows:

(i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

(ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

(3) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by DHS and approved by the Centers for Medicare & Medicaid Services (CMS) not less frequently than once every three months.

(4) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care as specified in §19.802 of this title (relating to Comprehensive Care Plans).

(6) Automated data processing requirement for Medicaid-certified and dually certified facilities only.

(A) Encoding data. Within seven days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) admission assessment;

(ii) annual assessment updates;

(iii) significant change in status assessments;

(iv) quarterly review assessments;

(v) a subset of items upon a resident's transfer, reentry, discharge, and death, using the reentry tracking form and/or discharge tracking form; and

(vi) background (face-sheet) information, if there is no admission assessment.

(B) Transmitting data. Within seven days after a facility completes a resident's assessment, a facility must be capable of transmitting to DHS information for each resident contained in
the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and DHS.

(C) Monthly transmittal requirements. A facility must electronically transmit, at least monthly (within 31 days of the lock date), encoded, accurate, complete MDS data to DHS for all assessments conducted during the previous month, including the following:

(ii) annual assessment;

(iii) significant change in status assessment;

(iv) significant correction of prior full assessment;

(v) significant correction of prior quarterly assessment;

(vi) quarterly review;

(vii) a subset of items upon a resident's transfer, reentry, discharge, and death; and

(viii) background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(D) Data format. The facility must transmit data in the format specified by DHS and approved by CMS.

(E) Resident-identifiable information.

(i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(7) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(8) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(9) Certification.

(A) A registered nurse must sign and certify that the assessment is completed.

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

(10) Penalty for falsification in Medicaid-certified and dually certified facilities.

(A) An individual who willfully and knowingly:

(ii) causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.
(B) Clinical disagreement does not constitute a material and false statement.

(11) Use of independent assessors in Medicaid-certified facilities. If DHS determines, under a certification survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (10) of this section, DHS may require (for a period specified by DHS) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by DHS.

(12) Pediatric resident assessment.

(A) Pediatric assessments should be performed by licensed facility staff experienced in the care and assessment of children. Parents or guardians should be included in the assessment process. The potential for community transition should be discussed with the parents or guardians whenever an assessment occurs.

(B) The comprehensive assessment for children must include a record of immunizations, blood screening for lead, and developmental assessment. The local school district's developmental assessment may be used if available. See §19.1934 of this title (relating to Educational Requirements for Persons Under 22).

(C) Licensed facility staff should assess the child's functional status in relation to pediatric developmental levels, rather than adult developmental levels.

(2) any services that would otherwise be required under §19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §19.402(g) of this title (relating to Exercise of Rights).

RULE §19.802 Comprehensive Care Plans

(a) A facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. If a child is admitted to the facility, the comprehensive care plan must be based on the child's individual needs. The comprehensive 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 §19.901 of this title (relating to Quality of Care); and

(2) any services that would otherwise be required under §19.901 of this title but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §19.402(g) of this title (relating to Exercise of Rights).

(b) The comprehensive care plan must be:

(1) developed within seven days after completion of the comprehensive assessment;
(2) prepared by an interdisciplinary team that 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, with the participation of the resident, the resident’s family or legal representative; and

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

...(d) A comprehensive care plan may include a palliative plan of care. This plan may be developed only at the request of the resident, surrogate decision maker or legal representative for residents with terminal conditions, end stage diseases or other conditions for which curative medical interventions are not appropriate. The plan of care must have goals that focus on maintaining a safe, comfortable and supportive environment in providing care to a resident at the end of life.

...(f) The services provided or arranged by the facility must:

(1) meet professional standards of quality; and

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

(g) The care plan must be made available to all direct care staff.

RULE §19.803 Discharge Summary (Discharge Plan of Care)

(a) When the facility anticipates discharge, the resident must have a discharge summary that includes:

(1) a recapitulation of the overall course of the resident’s stay;

(2) a final summary of the resident’s status, including items in §19.801(2)(B) of this title (relating to Resident Assessment), must 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, developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment.

(b) The facility discharge summary must be available at the time of discharge when a resident is being discharged to a private residence, another nursing facility, a Medicare skilled nursing facility, another residential facility such as a board and care home, or an intermediate care facility for the mentally retarded.

RULE §19.804 Capacity Assessment for Self Care and Financial Management

(a) A facility will perform a Capacity Assessment for Self Care and Financial Management for persons who will be referred to a court for guardianship if the person:
(1) is elderly, which is defined as a person 60 years of age or older; or
(2) has mental retardation or a developmental disability; or
(3) is suspected of being a person with mental retardation or a developmental disability.

(b) The assessment will be completed when:

(1) a facility determines that a guardian of the estate, or the person, or both, may be appropriate and a referral to a court for guardianship is anticipated; or
(2) requested to do so by a court.

(c) The facility will use the Capacity Assessment for Self Care and Financial Management instrument developed by the Texas Department of Mental Health and Mental Retardation.

(d) The Capacity Assessment for Self Care and Financial Management will be performed by the facility social worker, with assistance from other professionals as requested by the social worker.


(1) The facility shall upon admission obtain physician orders for the resident's immediate care.

(2) The facility must complete a comprehensive assessment of each resident's needs including a description of the resident’s capability to perform daily life functions and significant impairments in functional capacity.

(a) The comprehensive assessment must 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) mental and psycho social status;
(viii) discharge potential;
(ix) dental condition;
(x) activities potential;
(xi) rehabilitation potential;
(xii) cognitive status; and
(xiii) drug therapy.

(b) The facility must complete the initial assessment within 14 calendar days of admission and any revisions to the initial assessment within 21 calendar days of admission.

(c) A significant change in a resident’s physical or mental condition requires an interdisciplinary team review and may require the facility to complete a new assessment within 14 calendar days of the condition change.

(d) At a minimum, the facility must complete three quarterly reviews and one full assessment in each 12 month period.

(e) The facility shall use the results of the assessment to develop, review, and revise the resident’s comprehensive care plan.

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

(4) 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 psycho-social needs as identified in the comprehensive assessment.

(a) The comprehensive care plan shall be:

(i) developed within seven days after completion of the comprehensive assessment;

(ii) prepared with input from an interdisciplinary team that includes the attending physician, the registered nurse having responsibility for the resident, and other appropriate staff in disciplines determined by the resident’s needs, and with the participation of the resident, and the resident’s family or guardian, to the extent practicable; and

(iii) periodically reviewed and revised by a team of qualified persons at least after each assessment and as the resident’s condition changes.

(b) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with the resident’s written care plan.

(5) The facility must prepare at the time of discharge a final summary of the resident’s status to include items in R432-150-13(2)(a). The final summary shall be available for
release to authorized persons and agencies, with the consent of the resident or representative.

(a) The final summary must include a post-discharge care plan developed with the participation of the resident and resident's family or guardian.

(b) If the discharge of the resident is based on the inability of the facility to meet the resident's needs, the final summary must contain a detailed explanation of why the resident's needs could not be met.

R432-200-13. Admission and Discharge. [small health care facilities]

(1) Admission Policies.

... (d) A resident shall be assessed within seven days of admission unless otherwise indicated by a program requirement. Admission policies shall define the assessment process including an identification of the resident's medical, nursing, social, physical, and emotional needs.

(e) A physical examination shall be performed, in accordance with R432-200-14(2), by the attending physician or by an individual licensed and so authorized.

(f) Upon admission, a brief narrative of the resident's condition including his temperature, pulse, respiration, blood pressure, and weight shall be documented.

R432-200-17. Resident-Care Plans. [small health care facilities]

(1) General Provisions.

(a) A written resident-care plan, coordinated with nursing and other services, shall be initiated for each resident upon admission.

(b) The resident-care plan shall be personalized and indicate measurable and time-limited objectives, the actual plan of care, and the professional discipline responsible for each element of care.

(c) The resident care plan shall be developed, reviewed, revised, and updated at least annually through conferences with all professionals involved in the resident's care. Such conferences shall be documented.

(d) Each resident's care shall be based on this plan.

(e) The resident-care plan shall be available to all personnel who care for the resident.

(f) The resident and family shall participate in the development and review of the resident's plan.

(g) Upon transfer or discharge of the resident, relevant information from the resident-care plan shall be available to the responsible institution or agency.
(h) A licensed nurse or other clinical specialist, where appropriate, shall summarize, each month, the resident’s status and problems identified in the resident-care plan.

(2) Resident-Care Plans Contents. The resident-care plan shall include at least the following:

(a) Name, age, and sex of resident;
(b) Diagnosis, symptoms, complaints;
(c) A description of the functional level of the individual;
(d) Care objectives and time frames for accomplishment, reevaluation, and completion;
(e) Discipline or person responsible for each objective;
(f) Discharge plan;
(g) Date of admission;
(h) Name of attending physician or medical practitioner.

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.


A. The nursing facility shall conduct an initial and periodic assessment of each resident’s needs. The assessment shall accurately describe the resident’s capability to perform daily life functions and significant impairments in functional capacity. This comprehensive assessment shall include, but is not limited to:

1. Medically defined conditions and prior medical history;

2. Medical status;

3. Physical and mental functional status;

4. Sensory and physical impairments;

5. Nutritional status and requirements;

6. Special treatments or procedures;

7. Psychosocial status;

8. Discharge potential;

9. Dental condition;
10. Activities potential;
11. Rehabilitative potential;
12. Cognitive status;
13. Drug therapy; and

B. The nursing facility shall conduct a complete assessment:
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 all cases, at least once every 12 months.

C. The nursing facility shall review each resident's assessment at least once every three months and shall update the plan of care as indicated.

D. Each assessment shall be coordinated by a registered nurse who signs, dates and certifies completion of the assessment.

E. Each assessment shall be conducted or coordinated with the participation of health professionals. Each person completing a portion of the assessment shall sign and date that portion of the assessment.

F. The nursing facility shall use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.

G. A comprehensive plan of care shall be developed for each resident. The plan shall include measurable objectives and timetables to meet the resident's medical, nursing, nutritional, and psychosocial needs identified in the comprehensive assessment. The plan shall also describe the services that are to be furnished to maintain or improve the resident's physical, mental, and psychosocial status.

H. The comprehensive plan of care shall be developed within seven days of completion of the comprehensive assessment.

I. The comprehensive plan of care shall be prepared by a multidisciplinary team. The multidisciplinary team shall include a registered nurse, the attending physician, to the extent practicable, and other staff in disciplines as determined by the resident's needs. The resident, the resident's family or legal representative shall also be provided a meaningful opportunity to participate in the care planning.
388-97-0100 Utilization review.

(1) To assure appropriate use of medicaid services, the nursing facility must determine whether each medicaid resident's health has improved sufficiently so the resident no longer needs nursing facility care.

(a) The nursing facility must base its determination on:

(i) An accurate, comprehensive assessment process; and

(ii) Documentation by the resident's physician.

(b) The nursing facility is not responsible to assess under WAC 388-97-1960, PASSR level II screening assessment.

388-97-1000 Resident assessment.

(1) The nursing home must:

(a) Provide resident care based on a systematic, comprehensive, interdisciplinary assessment, and care planning process in which the resident participates, to the fullest extent possible;

(b) Conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity;

(c) At the time each resident is admitted:

(i) Have physician's orders for the resident's immediate care; and

(ii) Ensure that the resident's immediate care needs are identified in an admission assessment.

(d) Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

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

(a) Identification and demographic information;

(b) Customary routine;

(c) Cognitive patterns;

(d) Communication;

(e) Vision;

(f) Mood and behavior patterns;
(g) Psychosocial well-being;
(h) Physical functioning and structural problems;
(i) Continence;
(j) Disease diagnosis and health conditions;
(k) Dental and nutritional status;
(l) Skin conditions;
(m) Activity pursuit;
(n) Medications;
(o) Special treatments and procedures;
(p) Discharge potential;
(q) Documentation of summary information regarding the assessment performed; and
(r) Documentation of participation in assessment.

(3) The nursing home must conduct comprehensive assessments:

(a) No later than fourteen days after the date of admission;
(b) Promptly after a significant change in the resident’s physical or mental condition; and
(c) In no case less often than once every twelve months.

(4) The nursing home must ensure that:

(a) Each resident is assessed no less than once every three months, and as appropriate, the resident’s assessment is revised to assure the continued accuracy of the assessment; and

(b) The results of the assessment are used to develop, review and revise the resident’s comprehensive plan of care under WAC 388-97-1020.

(5) The skilled nursing facility and nursing facility must:

(a) For the required assessment, complete the state approved resident assessment instrument (RAI) for each resident in accordance with federal requirements;

(b) Place copies of the completed state approved RAI in each resident’s clinical record, unless all charting is computerized;

(c) Maintain all copies of resident assessments completed within the resident’s active clinical record for fifteen months;

(d) Assess each resident not less than every three months, using the state approved assessment instrument; and

(e) Transmit all state and federally required RAI information for each resident to the department:

(i) In a manner approved by the department;

(ii) Within ten days of completion of any RAI required under this subsection; and

(iii) Within ten days of discharging or readmitting a resident.
388-97-1020 Comprehensive plan of care.

(1) The nursing home must develop a comprehensive plan of care for each resident that

(2) The comprehensive plan of care must:

   (a) Describe 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 WAC 388-9701060;

   (b) Describe any services that would otherwise be required, but are not provided due to the resident’s exercise of rights, including the right to refuse treatment (refer to WAC 388-97-0300 and 388-97-0260;

   (c) Be developed within seven days after completion of the comprehensive assessment;

   (d) Be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents needs;

   (e) Consist of an ongoing process which includes a meeting if desired by the resident or the resident’s representative; and

   (f) Include the ongoing participation of the resident to the fullest extent possible, the resident’s family or the resident’s surrogate decision maker.

(3) The nursing home must implement a plan of care to meet the immediate needs of newly admitted residents, prior to the completion of the comprehensive assessment and plan of care.

(4) The nursing home must:

   (a) Follow the informed consent process with the resident as specified in WAC 388-97-0260, regarding the interdisciplinary team's plan of care recommendations;

   (b) Respect the resident’s right to decide plan of care goals and treatment choices, including acceptance or refusal of plan of care recommendations;

   (c) Include in the interdisciplinary plan of care process:

   (i) Staff members requested by the resident; and

   (ii) Direct care staff who work most closely with the resident.

   (d) Respect the resident’s wishes regarding which individuals, if any, the resident wants to take part in resident plan of care functions;
(e) Provide reasonable advance notice to and reasonably accommodate the resident family

(f) Where for practical reasons any individuals significant to the plan of care process, including the resident, are unable to attend plan of care meetings, provide a method for such individuals to give timely input and recommendations.

(5) The nursing home must ensure that each comprehensive plan of care:

(a) Designates the discipline of the individuals responsible for carrying out the program; and

(b) Is reviewed at least quarterly by qualified staff, as part of the ongoing process of monitoring the resident's needs and preferences.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1020, filed 9/24/08, effective 11/1/08.]

388-97-1920 Preadmission screening — Level I.

(1) Preadmission screening (PAS) is a process by which individuals are evaluated:

(a) For the presence of a serious mental illness or a developmental disability, before admission to the nursing facility;

(b) For nursing facility level of care; and

(c) If the individual does have either a serious mental illness or a developmental disability, to determine whether there is a need for specialized services, or services of a lesser intensity.

(2) The referring hospital, physician, or other referral source must:

(a) Perform the identification screen using a standardized department-specified Level I screening form for all individuals seeking admission to a nursing facility unless they:

(i) Are being readmitted to the nursing facility from the hospital; or

(ii) Are being transferred from one nursing facility to another, with or without an intervening hospital stay.

(b) Identify whether the individual may have a serious mental illness or a developmental disability as defined under 42 C.F.R. § 483.102, or successor laws; and

(c) Refer all individuals identified as likely to have a serious mental illness or a developmental disability to the department for a nursing facility level of care assessment and a Level II screening.
388-97-1940 Advanced categorical determinations, not subject to preadmission screening — Level II.

Individuals identified as having symptoms of mental illness or a developmental disability and meeting any of the advanced categorical determinations do not need to be referred for a Level II screening. The determinations include that the individual:

1. Is admitted to the nursing facility for respite care as defined under WAC 388-97-1880, or convalescent care, following treatment in an acute care hospital, not to exceed thirty days;

2. Cannot accurately be diagnosed because of delirium. NOTE: The individual would be subject to a Level II screening when the delirium cleared;

3. Has been certified by a physician to be terminally ill as defined under section 1861(dd)(3)(A) of the Social Security Act;

4. Has been diagnosed with a severe physical illness such as coma, ventilator dependence, and is functioning at a brain stem level;

5. Has a severe level of impairment from diagnoses such as:
   (a) Chronic obstructive pulmonary disease;
   (b) Parkinson's disease;
   (c) Huntington's chorea;
   (d) Amyotrophic lateral sclerosis;
   € Congestive heart failure; or

6. Has a primary diagnosis of dementia, including Alzheimer's disease or a related disorder. NOTE: There must be evidence to support this determination.

388-97-1960 Preadmission screening — Level II.

For individuals likely to have a serious mental illness or developmental disability, the department must determine their need for nursing facility level of care. If they meet the nursing facility level of care, the department refers them to the department's designee, either the mental health PASRR contractor or the division of developmental disabilities, for a Level II screening.
In the Level II screening, the department’s designee will verify the diagnosis and determine whether the referred individuals need specialized services, or services of a lesser intensity:

"Specialized services" for an individual with mental retardation or related conditions is defined under 42 C.F.R. § 483.120 (a)(2), and 42 C.F.R. § 483.440 (a)(1), or successor laws. These specialized services do not include services to maintain a generally independent individual able to function with little supervision or in the absence of a treatment program; and

"Specialized services" for an individual with a serious mental illness is defined under 42 C.F.R. § 483.120 (a)(1), or successor laws. These services are generally considered acute psychiatric inpatient care, emergency respite care, or stabilization and crisis services.

The need for specialized services, for a nursing facility applicant, will be determined as follows:

If the individual is identified as likely to have a serious mental illness, a qualified mental health professional will verify whether the individual has a serious mental illness and, if so, will recommend whether the individual needs specialized services; and

If the individual is identified as likely to have a developmental disability, a licensed psychologist will verify whether the individual has a developmental disability and, if so, staff of the division of developmental disabilities will assess and determine whether the individual requires specialized services.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97]


After a resident’s admission the nursing facility must:

Review the Level I screening form for accuracy and make changes as needed if the resident develops a qualifying diagnosis or if the resident’s symptoms were undetected or misdiagnosed;

Refer residents who have qualifying diagnoses and who require further PASRR assessment to the mental health PASRR contractor or division of development disabilities;

Record the identification screen information or subsequent changes on the resident assessment instrument according to the schedule required under 42 C.F.R. § 483.20;

Maintain the identification screen form and PASRR assessment information, including recommendations, in the resident’s active clinical record; and

Promptly notify the mental health PASRR contractor or division of developmental disabilities after a significant change in the physical or mental condition of any resident that is mentally ill or mentally retarded.
388-97-2000 Preadmission screening and resident review (PASRR) determination and appeal rights.

(1) The resident has the right to choose to remain in the nursing facility and receive specialized services if:

   (a) He or she has continuously resided in a nursing facility since October 1, 1987; and

   (b) The department determined, in 1990, that the resident required specialized services for a serious mental illness or developmental disability but did not require nursing facility services.

(2) In the event that residents chose to remain in the nursing facility as outlined in subsection (1) above, the department, or designee, will clarify the effect on eligibility for medicaid services under the state plan if the resident chooses to leave the facility, including its effect on readmission to the facility.

(3) An individual applying for admission to a nursing facility or a nursing facility resident who has been adversely impacted by a PASRR determination may appeal the department’s determination that the individual is:

   (a) Not in need of nursing facility care as defined under WAC 388-106-0350 through 388-106-0360;

   Not in need of specialized services as defined under WAC 388-97-1960; or

   Need for specialized services as defined under WAC 388-97-1960.

(4) The nursing facility must assist the individual applying for admission or resident, as needed, in requesting a hearing to appeal the department’s PASRR determination.

(5) If the department’s PASRR determination requires that a resident be transferred or discharged, the department will:

   (a) Provide the required notice of transfer or discharge to the resident, the resident’s surrogate decision maker, and if appropriate, a family member or the resident’s representative thirty days or more before the date of transfer or discharge;

   (b) Attach a hearing request form to the transfer or discharge notice;

   (c) Inform the resident, in writing in a language and manner the resident can understand, that:

   (i) An appeal request may be made any time up to ninety days from the date the resident receives the notice of transfer or discharge;
(ii) Transfer or discharge will be suspended when an appeal request is received by the office of administrative hearings on or before the date of transfer or discharge set forth in the written transfer or discharge notice; and

(iii) The resident will be ineligible for medicaid nursing facility payment:

(A) Thirty days after the receipt of written notice of transfer or discharge; or

(B) If the resident appeals under subsection (1)(a) of this section, thirty days after the final order is entered upholding the department's decision to transfer or discharge a resident.

(6) The department's home and community services may pay for the resident's nursing facility services after the time specified in subsection (5)(c)(iii) of this section, if the department

(7) The department will:

(a) Send a copy of the transfer/discharge notice to the resident's attending physician, the nursing facility and, where appropriate, a family member or the resident's representative;

(b) Suspend transfer or discharge:

(i) If the office of administrative hearings receives an appeal on or before the date set for transfer or discharge or before the resident is actually transferred or discharged; and

(ii) Until the office of appeals makes a determination; and

(c) Provide assistance to the resident for relocation necessitated by the department's PASRR determination.

(8) Resident appeals of PASRR determinations will be in accordance with 42 C.F.R. § 431 Subpart E, chapter 388-02 WAC, and the procedures defined in this section. In the event of a conflict between a provision in this chapter and a provision in chapter 388-02 WAC, the provision in this chapter will prevail.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-2000, filed 9/24/08, effective 11/1/08.]

74.42.140 Prescribed plan of care — Treatment, medication, diet services.

The facility shall care for residents by providing residents with authorized medical services which shall include treatment, medication, and diet services, and any other services contained in the comprehensive plan of care or otherwise prescribed by the attending physician.

[1979 ex.s. c 211 § 14.]
74.42.150 Plan of care — Goals — Program — Responsibilities — Review.

(1) Under the attending physician's instructions, qualified facility staff will establish and maintain a comprehensive plan of care for each resident which shall be kept on file by the facility and be evaluated through review and assessment by the department. The comprehensive plan contains:

(a) Goals for each resident to accomplish;

(b) An integrated program of treatment, therapies and activities to help each resident achieve those goals; and

(c) The persons responsible for carrying out the programs in the plan.

(2) Qualified facility staff shall review the comprehensive plan of care at least quarterly. [1980 c 184 § 7; 1979 ex.s. c 211 § 15.]

64-13-6. Resident Assessment.

6.1. The nursing home shall conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity.

6.2. Admission Orders.

6.2.a. At the time each resident is admitted, the nursing home shall have physician orders for the resident's immediate care.

6.3. Comprehensive Assessments.

6.3.a. The nursing home shall make a comprehensive assessment of a resident's needs which:

6.3.a.1. Is based on a uniform data set and instrument specified by the director; and

6.3a.2. Describes the resident's capability to perform daily life functions and any significant impairments in functional capacity.

6.3.b. The comprehensive assessment shall include the resident=s:
6.3.b.1. Identification and demographic information;
6.3.b.2. Customary routine;
6.3.b.3. Cognitive patterns;
6.3.b.4. Communication;
6.3.b.5. Vision;
6.3.b.6. Mood and behavior patterns;
6.3.b.7. Psychosocial well-being;
6.3.b.8. Physical functioning and structural problems;
6.3.b.9. Continence;
6.3.b.10. Disease diagnosis and health conditions;
6.3.b.11. Dental and nutritional status;
6.3.b.12. Skin conditions;
6.3.b.13. Activity pursuit;
6.3.b.14. Medications;
6.3.b.15. Special treatments and procedures;
6.3.b.16. Discharge potential;
6.3.b.17. Documentation and summary information regarding the additional assessment performed through the resident assessment protocols.
6.3.b.18. Documentation of participation in assessment.

6.3.c. Frequency. Comprehensive assessments shall be conducted:
6.3.c.1. No later than fourteen (14) days after the date of admission;
6.3.c.2. Within fourteen (14) days after the facility determines, or should have determined that there has been a significant change in the resident’s physical or mental condition; and
6.3.c.3. In no case less often than every three hundred sixty-six (366) days.

6.3.d. Review of Assessments. A nursing home shall examine each resident no less than once every ninety-two (92) days, and as appropriate, revise the resident’s assessment to assure the continued accuracy of the assessment.

6.3.e. Use. The nursing home shall use the results of the assessment to develop, review, and revise the resident’s comprehensive plan of care under Section 7 of this rule.
6.3.f. Coordination. A nursing home shall coordinate assessments with any State-required pre-admission screening program to the maximum extent practicable to avoid duplicative testing and effort.

6.4. Accuracy of Assessments.

6.4.a. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals.

6.4.b. Each assessment shall be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

6.4.c. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.

6.4.d. Civil money penalty for falsification.

6.4.d.1. A person who willfully and knowingly certifies (or causes another person to certify) a material and false statement in a resident assessment is subject to civil money penalties.

6.4.e. Use of independent assessors.

6.4.e.1. If the director determines, under an inspection or otherwise, that there has been a knowing and willful certification of false statements under Subdivision 6.3.c. of this rule the director may require (for a period specified by the director) that resident assessments under this section be conducted and certified by persons who are independent of the nursing home and who are approved by the director.


7.1. Development of the Care Plan.

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

7.1.a. The comprehensive care plan shall describe the following:

7.1.a.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 8 of this rule; and

7.1.a.2. Any services that would otherwise be required under Sections 4 and 5 of this rule, but are not provided due to the resident’s exercise of rights including the right to refuse treatment.

7.2. Timing of the Care Plan and Participation Requirements.

7.2.a. A comprehensive care plan shall be:
7.2.a.1. Developed within seven (7) days after the completion of the comprehensive assessment;

7.2.a.2. Prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident and the resident's family with the consent of the resident or the resident's legal representative; and

7.2.a.3. Periodically reviewed and revised by a team of appropriate persons after each assessment.

7.3. Services Provided Under a Care Plan.

7.3.a. The services provided or arranged by the nursing home shall:

7.3.a.1. Meet professional standards of quality; and

7.3.a.2. Be provided by qualified persons in accordance with each resident's written plan of care.

7.4. Plans for Care and Medical Records.

7.4.a. Plans for care.

7.4.a.1. The resident's plan of care shall be developed for each resident upon admission and maintained by the nursing service in cooperation with all other services.

7.4.a.2. The plan of care shall provide a profile of the needs of the individual resident, identify the role of each service in meeting those needs, and the supportive measures each service will use to complement each other service in the accomplishment of the overall goal of care.

7.4.a.3. The plan of care plan shall be in writing and contain at least the following:

7.4.a.3.A. The goals to be accomplished;

7.4.a.3.B. Individually designed activities to meet the goals;

7.4.a.3.C. Therapies;

7.4.a.3.D. Treatments, including diet requirements; and

7.4.a.3.E. A statement of which discipline, or professional service person is responsible for each element prescribed in the plan.

7.4.a.4. A nursing home shall have written policies and procedures to ensure that through the resident care conferences or other means of coordination, the resident care plan shall be reviewed and revised as needed, but at least quarterly. The review shall be noted in the medical record.
7.4.a.5. Policies and procedures shall delineate the rules and responsibilities of each service in relation to the resident care plan.

7.4.a.6. The resident care plan shall be available for use by all personnel caring for the resident.

7.4.a.7. Relevant information from the resident care plan shall be made available with other information that is conveyed when the resident is transferred to another nursing home, an acute care facility or referred for continuing care by other agencies upon discharge to the community.

7.4.a.8. The nursing home shall maintain a discharge plan for each resident and shall include at least the following:

7.4.a.8.A. An initial assessment including discharge potential and goals, completed at admission or within no more than seven (7) days after admission;

7.4.a.8.B. Relevant information concerning such areas as nursing assessment, social history, rehabilitation potential, resident’s needs at discharge and available community resources; and

7.4.a.8.C. Periodic review and re-evaluation on a monthly basis for the first three (3) months after admission and then at least quarterly.

7.4.b. Discharge.

7.4.b.1. General. When a resident is discharged to another nursing home or location or to his or her home, the nursing home shall prepare a discharge summary prior to the discharge. The summary shall be conveyed to the receiving nursing home or location at the time of discharge. The summary shall include:

7.4.b.1.A. The resident’s name and identifying number;

7.4.b.1.B. The name of the attending physician;

7.4.b.1.C. The date of admission;

7.4.b.1.D. The date of discharge;

7.4.b.1.E. A provisional and final diagnosis;

7.4.b.1.F. The course of treatment and care in the nursing home;

7.4.b.1.G. Pertinent diagnostic findings;

7.4.b.1.H. Essential information regarding the resident’s illness or problems;

7.4.b.1.I. Restorative procedures;

7.4.b.1.J. Medication instructions; and

7.4.b.1.K. The nursing home, agency or location to which the resident was discharged:
7.4.b.2. Anticipated Discharge. When a discharge is anticipated, a nursing home shall prepare for the resident a discharge summary that includes:

7.4.b.2.A. A recapitulation of the resident’s stay;

7.4.b.2.B. A final summary of the resident’s status to include items in Subdivision 6.2.b. of this rule, prepared 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;

7.4.b.2.C. Thirty (30) day notification of the discharge as appropriate and in compliance with other provisions of this rule; and

7.4.b.2.D. If the resident is discharged to his or her home, the resident shall be given appropriate information concerning his or her needs for care and medications including 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.

7.4.b.3. The death of a resident shall be reported immediately to the attending physician and to the resident’s legal representative and family as relevant.

7.4.b.3.A. The discharge summary shall include the requirements specified in this rule.

7.4.b.4. A nursing home shall complete medical records promptly within a time period specified in the nursing homes polices and procedures manual, not to exceed thirty (30) days after the resident is discharged.

7.4.b.4.A. The discharge summary shall contain a dated physician’s signature.

§64-85-6. Assessments and Plans of Care. [ALZHEIMER’S/DEMENTIA SPECIAL CARE UNITS AND PROGRAMS]

6.1. Within three (3) days of admission, the unit coordinator, with input from at least the resident and/or the resident’s legal representative, shall review the immediate care needs of the resident and establish a preliminary care plan.

6.2. Within seven (7) days of admission, an interdisciplinary team including the unit coordinator, a social worker, the activities director, direct care staff and a registered nurse and other professional disciplines as appropriate, shall complete an initial assessment of a new resident which includes at a minimum: a social history; family supports; level of activities of daily living functioning; cognitive level; behavioral impairment; and nutritional status, including weight and nutritional requirements.

6.3. Within twenty-one (21) days of admission the interdisciplinary team and the resident and/or the resident’s legal representative, shall develop a written individualized care plan, signed by each member of the alzheimer’s/dementia special care unit or program staff, the resident and/or the resident’s legal representative which shall:

6.3.a. Reflect the resident as a person, with family history and interests;
6.3.b. Accurately describe specific needs, choices, problems and any inappropriate behaviors;

6.3.c. Describe specific desired outcomes and specific interventions to be used to achieve the desired outcomes;

6.3.d. Support the individual toward as much independence as possible;

6.3.e. Include opportunities for resident choice and self management; and

6.3.f. Contain the job titles of staff who are to be primarily responsible for implementing the care plan.

6.4. The facility shall make a copy of the consistent implementation.

6.5. The facility shall provide resident care in accordance with the care plan.

6.6. The interdisciplinary team shall review, evaluate for effectiveness and revise the resident’s assessment and care plan at least quarterly or more frequently as indicated by the changing needs of the resident.

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HFS 132.52 Procedures for admission.

(3) MEDICAL EXAMINATION AND EVALUATION. (a) Examination.

Each resident shall have a physical examination by a physician or physician extender within 48 hours following admission unless an examination was performed within 15 days before admission.

(b) Evaluation. Within 48 hours after admission the physician or physician extender shall complete the resident’s medical history and physical examination record.

Note: For admission of residents with communicable disease, see s. HFS 132.51

(2) (b).

(4) INITIAL CARE PLAN. Upon admission, a plan of care for nursing services based on an initial assessment shall be prepared and implemented, pending development of the plan of care required by s. HFS 132.60 (8).

Note: For care planning requirements, see s. HFS 132.60 (8).
(7) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (42), is available for the facility under s. HFS 10.71, the facility shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.04 (2g) to (2i), Stats., and s. HFS 10.73.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; renum. (1) to (5) to be (2) to (6) and am. (2) and (3), cr. (1), Register, January, 1987, No. 373, eff. 2−1−87; cr. (7), Register, October, 2000, No. 538, eff. 11−1−00; CR 03−033: am. (2) (c) Register December 2003 No. 576, eff. 1−1−04; CR 04−053: am. (2) (c) and (4) and r. (5) and (6) Register October 2004 No. 586, eff. 11−1−04.

HFS 132.60 Resident care.

...(8) RESIDENT CARE PLANNING.

(a) Development and content of care plans. Except in the case of a person admitted for short−term care, within 4 weeks following admission a written care plan shall be developed, based on the resident’s history and assessments from all appropriate disciplines and the physician’s evaluation and orders, as required by s. HFS 132.52, which shall include:

1. Realistic goals, with specific time limits for attainment; and

2. The methods for delivering needed care, and indication of which professional disciplines are responsible for delivering the care.

Note: For requirements upon admission, see s. HFS 132.52. For requirements for short−term care residents, see s. HFS 132.70 (2).

(b) Evaluations and updates. The care of each resident shall be reviewed by each of the services involved in the resident’s care and the care plan evaluated and updated as needed.

Note: For concurrent review of medications, see sub. (5) (a) 4.

(c) Implementation. The care plans shall be substantially followed.

(d) Assessment instrument. A resident’s care plan shall be developed based on the facility’s assessment required under s. 49.498 (2) (c), Stats., of the resident. The assessment shall be conducted by the facility using a form approved by the department which is based on a minimum data set specified under 42 USC 1395i−3 (f) (6) (A). The form shall cover resident identifying information; background information about the resident, including current payment sources, responsible party if not the resident, and any advance directives; the
residents diagnosis, condition and body control, cognitive patterns, hearing, vision, dental status, need for help to perform activities of daily living, continence, recent use of appliances, devices or programs, potential for rehabilitation, skin condition, psychological well-being, mood and behavior patterns, activities, medications use, and any special treatment or procedures the person is receiving such as chemotherapy.

Note: For copies of the resident assessment form, write to the Bureau of Quality Assurance, P.O. Box 309, Madison, WI

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WYOMING

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Wyoming regulations do not contain specific content for Resident Assessment.

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FEDERAL REGULATIONS

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§ 483.20 Resident assessment.

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

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

(b) Comprehensive assessments — (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident’s needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge potential.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.
(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review, and revise the resident’s comprehensive plan of care.

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(f) Automated data processing requirement — (1) Encoding data. Within 7 days after a facility completes a resident’s assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident’s transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident’s assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(g) Accuracy of assessments. The assessment must accurately reflect the resident’s status.

(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification. (1) A registered nurse must sign and certify that the assessment is completed.

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

(j) Penalty for falsification. (1) Under Medicare and Medicaid, an individual who willfully and knowingly—

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

(k) Comprehensive care plans. (1) 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—

(i) 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 §483.25; and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment;
(ii) Prepared by an interdisciplinary team, that 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 or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

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

(I) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—

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

(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, 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

(3) 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.

(m) Preadmission screening for mentally ill individuals and individuals with mental retardation. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—

(i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission—

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
(2) Definition. For purposes of this section—

(i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in §483.102(b)(1).

(ii) An individual is considered to be mentally retarded if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.