

## COLORADO

### **Part 5. RESIDENT CARE**

5.1 RESIDENT CARE. Residents shall receive the care necessary to meet individual physical, psycho-social, and rehabilitative needs and assistance to achieve and maintain their highest possible level of independence, self-care, and self-worth and well-being. Provision of care shall be documented in the health record.

5.1.1 QUALITY OF LIFE. Residents shall be provided: a safe, supportive, comfortable, homelike environment; freedom and encouragement to exercise choice over their surroundings, schedules, health care, and life activities; the opportunity to be involved with the members of their community inside and outside the nursing home; and treatment with dignity and respect.

5.1.2 PRESSURE ULCER PREVENTION AND CARE. (See also 7.7)

(1) For residents whose pressure ulcers developed while the resident was in the facility, the facility shall have:

(a) assessed the potential for skin breakdown, and

(b) provided preventive measures before the ulcer developed to residents identified in the assessment required in section 5.2 as at risk of pressure ulcers (i.e., a resident exhibiting three or more of the following symptoms: underweight, incontinence, dehydration, disorientation or unconsciousness, or limited mobility).

(2) For all residents with pressure ulcers, the facility shall:

(a) have developed an individualized treatment plan (as prescribed by section 5.7) designed to alleviate the condition;

(b) be providing active treatment to improve the condition in accordance with the treatment plan;

(c) be evaluating the resident's progress and treatment at least weekly and revising the treatment plan as needed and required by section 5.7;

(d) be providing proper nutrition and hydration to promote healing and prevent further breakdown.

5.1.3 ACCIDENT PREVENTION AND ATTENTION.

(1) The facility shall:

(a) investigate causes of accidents;

(b) monitor the resident's response to the accident, and obtain physician's or mental health evaluation, if needed;

(c) have developed and implemented an individualized plan as part of the care plan prescribed by Section 5.7 for prevention of future accidents;

(d) evaluate and revise the plan as needed.

(2) For residents at high risk for accidents, the facility shall have identified the risk in the care plan and taken reasonable precautions to prevent common accidents before the accident occurred. Residents at high risk of accidents include the blind, the deaf, those with seizure disorders, those with accidents in the last 6 months, the totally confused but ambulatory, new amputees, and residents on psychoactive drugs.

#### 5.1.4 BEHAVIOR PROBLEM CARE.

(1) For residents with behavior problems the facility shall:

(a) have noted the behavioral problem and evaluated it in the initial assessment required by Section 5.2;

(b) develop and implement an individualized treatment plan as part of the care plan prescribed by Section 5.7;

(c) develop and implement a behavior management plan as part of the care plan prescribed by Section 5.7;

(d) obtain a mental health evaluation in appropriate cases;

(e) evaluate the resident's progress and revise the plan, as needed and required by Section 5.7;

(2) For residents receiving behavior modification drugs, the facility shall indicate in nurses' notes both positive and/or negative effects of the drug and that alternatives or adjuncts to the drugs in care planning were considered. These evaluations shall meet requirements of Section 7.10.8.

#### 5.1.5 CONTRACTURE CARE. (See also 7.7)

(1) For residents with contractures upon admission, the facility shall have noted the problem, evaluated it, and undertaken restorative nursing intervention.

(2) For residents with contractures that occurred while in the facility, the facility shall have documented that range of motion and/or repositioning was performed before the contracture developed; if the resident refused treatment or preventive measures, the facility shall have documented that such measures and the consequences of the refusal were explained to the resident.

(3) For all other residents with the potential for contracture, the facility shall have developed and be implementing an individualized treatment plan as part of the care plan prescribed in Section 5.7 to prevent or manage contractures and be periodically evaluating the progress. The plan shall be reviewed and revised at least annually as needed.

#### 5.1.6 PROMOTION OF MOBILITY. (See also 7.7)

(1) For all residents, the facility shall have assessed each resident's ambulation potential and capability at least monthly, designed a plan of care as part of the care plan prescribed in section 5.7 to encourage mobility, be implementing the plan, regularly evaluate progress and revise the plan as needed.

(2) For residents requiring devices and/or personal assistance to ambulate, the facility shall provide and maintain devices in good repair, assist the resident to obtain appropriate footwear, and provide assistance to residents to move and transfer.

#### 5.1.7 INDWELLING CATHETER CARE.

(1) For residents with any indwelling catheter, the facility shall have:

(a) evaluated appropriateness of continued use at least monthly;

(b) assessed the reason for the incontinence;

(c) evaluated the potential of bladder retraining, implementing it, if indicated, or documenting reasons if retraining was not indicated;

(d) implemented any physician order for irrigation or catheter replacement.

(2) For residents exhibiting signs or symptoms of urinary tract infection, the facility shall have notified the physician, obtained orders for treatment and implemented such treatment plan.

#### 5.1.8 WEIGHT CHANGES. The facility shall:

(1) evaluate the resident to determine the cause of the weight change;

(2) develop and implement an individualized plan of care as part of the care plan prescribed by Section 5.7 (including appropriate intervention by other appropriate disciplines); evaluate resident progress as required by Section 5.7, and revise the plan, as needed;

(3) observe food and fluid intake and provide encouragement to residents with eating problems;

(4) provide reasonable choices of foods to meet personal preferences and religious needs;

(5) if nourishments are provided as part of the care plan, between meals and at bedtime, document the nourishments provided and whether they are consumed;

(6) provide assistance in eating or adaptive eating devices and assist residents in obtaining dentures, or dental care, as appropriate to the individual resident;

(7) for residents with mouth or gum problems, meet the requirements of part 10.

#### 5.1.9 GROOMING.

(1) The facility shall assist the resident to obtain appropriate materials for personal care for the resident, provide personal care in a manner that preserves resident dignity and privacy, and provide social services intervention, if needed.

(2) For residents with inappropriate, unclean, or poorly maintained clothing and/or assistive devices, the facility shall assist the residents to obtain clothing, shoes and devices. Such clothing, shoes and devices shall fit properly, be clean, and be in good repair.

(3) For residents with poor oral hygiene, the facility shall meet the requirements of Part 10.

#### 5.1.10 EXCORIATION PREVENTION AND CARE. (See also 7.7)

(1) For all residents who are incontinent or immobile, have impaired sensation, compromised nutritional or fluid status, or inadequate hygiene, the facility shall:

(a) have completed an initial skin evaluation upon admission and re-evaluated the condition at least weekly;

(b) be providing measures to prevent the excoriation, including:

(1) maintenance of clean, dry well lubricated skin;

(2) taking incontinent residents to the bathroom on a regular individualized schedule;

(3) evaluating the need for daily baths;

(4) determining potential trouble spots where microbial growth may occur (breasts, gluteal folds, skin folds).

(2) For residents with excoriations, the facility shall:

(a) develop and be implementing an individualized treatment plan as part of the care plan prescribed by Section 5.7 for the excoriation;

(b) evaluate the resident's progress at least daily and review and revise the treatment plan as needed;

(c) enter a progress note at least weekly in the health record.

#### 5.1.11 FLUID MANAGEMENT. The facility shall provide fluid in quantities needed to maintain hydration and body weight and shall:

(1) assess each resident's hydration needs;

(2) observe and evaluate food and fluid intake daily and record and report deviations from sufficient food and fluid intake;

(3) provide assistance and encouragement to residents requiring assistance to meet their food and fluid requirements;

(4) provide self-help adaptive devices and encourage their use.

#### 5.1.12 PERSONAL ENVIRONMENT. The facility shall allow for personalization of rooms through the use of residents' personal furniture, appliances, decorations, plants, and memorabilia. The facility may limit the number of furniture items in resident rooms if to do so is

necessary to accommodate roommate preferences, fire codes, housekeeping, or safe movement in the room.

5.1.13 PERSONAL CHOICE. The facility shall:

- (1) make reasonable efforts to accommodate preferences of roommate, including the right of each resident so requesting to be assigned to a room with non-smokers;
- (2) allow residents flexibility in times to eat main meals, consistent with requirements of Section 11.2 and with its own reasonable staffing and scheduling requirements;
- (3) allow residents flexibility in times to bathe, rise and retire, consistent with its own reasonable staffing and scheduling requirements;
- (4) provide at least one alternative menu choice for each meal of similar nutritive value. The same alternative shall not be used for two consecutive meals.

5.1.14 PROBLEM RESOLUTION. The facility shall inform residents of the resident council and grievance procedures, the name, address, and phone number of the Long-Term Care Ombudsman, and the phone number and address of the Departments of Health and Social Services and the Colorado Foundation for Medical Care. Staff shall assist residents in raising problems to the facility's administration or appropriate outside agencies.

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.