

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.

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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.

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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.

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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.

12.E. Specialized Therapy Services

Based upon the resident's comprehensive assessment, the facility must provide or obtain specialized therapy services, i.e., physical therapy, speech/language therapy, occupational therapy, and mental health services for each resident as needed and prescribed in the plan of care.

12.E.1. Care Plan

a. Based on the resident's comprehensive assessment, these services shall be integrated into the resident's comprehensive multidisciplinary care plan, as necessary.

b. The resident's care plan, progress and continued need for specialized therapy is reevaluated as necessary, and recommendations made to the physician and the multidisciplinary team.

12.E.2. Therapists' Responsibilities

a. Specialized therapy is provided only on written orders of the physician.

b. The therapist shall evaluate each resident referred and recommend a rehabilitative treatment regimen, if appropriate.

c. The therapist, in consultation with the physician, shall initiate the therapy and reevaluate the continuing need for therapy as needed.

d. The therapist shall provide training for staff and supervise the provision of care to assure acceptable level of performance for qualified support personnel.

e. The therapist shall document each treatment and progress noted in the residents' records.

12.E.3. Space and Equipment

a. Space that shall serve the needs of the residents shall be made available for specialized therapies.

b. Equipment necessary for the provision of specialized therapy services shall be available and used as needed.