

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.

i. Additional information is available from the MDS Automation Program, 609-984-8204 and at <http://www.hcfa.gov/medicaid/mds20/mds20.pdf>.

(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.