

### **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 timeframe specified by the department.

History: Effective July 1, 1996.

General Authority: NDCC 23-01-03, 28-32-02

Law Implemented: NDCC 23-16-01, 28-32-02