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12VAC5-371-250. Resident assessment and care planning.

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

14. Any known advance directives.

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.

Statutory Authority

§§32.1-12 and 32.1-127 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997.
