

'64-13-7. Comprehensive Care Plans.

7.1. Development of the Care Plan.

The nursing home shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

7.1.a. The comprehensive care plan shall describe the following:

7.1.a.1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under Section 8 of this rule; and

7.1.a.2. Any services that would otherwise be required under Sections 4 and 5 of this rule, but are not provided due to the resident's exercise of rights including the right to refuse treatment.

7.2. Timing of the Care Plan and Participation Requirements.

7.2.a. A comprehensive care plan shall be:

7.2.a.1. Developed within seven (7) days after the completion of the comprehensive assessment;

7.2.a.2. Prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident and the resident's family with the consent of the resident or the resident's legal representative; and

7.2.a.3. Periodically reviewed and revised by a team of appropriate persons after each assessment.

7.3. Services Provided Under a Care Plan.

7.3.a. The services provided or arranged by the nursing home shall:

7.3.a.1. Meet professional standards of quality; and

7.3.a.2. Be provided by qualified persons in accordance with each resident's written plan of care.

7.4. Plans for Care and Medical Records.

7.4.a. Plans for care.

7.4.a.1. The resident's plan of care shall be developed for each resident upon admission and maintained by the nursing service in cooperation with all other services.

7.4.a.2. The plan of care shall provide a profile of the needs of the individual resident, identify the role of each service in meeting those needs, and the supportive measures each service will use to complement each other service in the accomplishment of the overall goal of care.

7.4.a.3. The plan of care plan shall be in writing and contain at least the following:

7.4.a.3.A. The goals to be accomplished;

7.4.a.3.B. Individually designed activities to meet the goals;

7.4.a.3.C. Therapies;

7.4.a.3.D. Treatments, including diet requirements; and

7.4.a.3.E. A statement of which discipline, or professional service person is responsible for each element prescribed in the plan.

7.4.a.4. A nursing home shall have written policies and procedures to ensure that through the resident care conferences or other means of coordination, the resident care plan shall be reviewed and revised as needed, but at least quarterly. The review shall be noted in the medical record.

7.4.a.5. Policies and procedures shall delineate the rules and responsibilities of each service in relation to the resident care plan.

7.4.a.6. The resident care plan shall be available for use by all personnel caring for the resident.

7.4.a.7. Relevant information from the resident care plan shall be made available with other information that is conveyed when the resident is transferred to another nursing home, an acute care facility or referred for continuing care by other agencies upon discharge to the community.

7.4.a.8. The nursing home shall maintain a discharge plan for each resident and shall include at least the following:

7.4.a.8.A. An initial assessment including discharge potential and goals, completed at admission or within no more than seven (7) days after admission;

7.4.a.8.B. Relevant information concerning such areas as nursing assessment, social history, rehabilitation potential, resident=s needs at discharge and available community resources; and

7.4.a.8.C. Periodic review and re-evaluation on a monthly basis for the first three (3) months after admission and then at least quarterly.

7.4.b. Discharge.

7.4.b.1. General. When a resident is discharged to another nursing home or location or to his or her home, the nursing home shall prepare a discharge summary prior to the discharge. The summary shall be conveyed to the receiving nursing home or location at the time of discharge. The summary shall include:

7.4.b.1.A. The resident=s name and identifying number;

7.4.b.1.B. The name of the attending physician;

7.4.b.1.C. The date of admission;

7.4.b.1.D. The date of discharge;

7.4.b.1.E. A provisional and final diagnosis;

7.4.b.1.F. The course of treatment and care in the nursing home;

7.4.b.1.G. Pertinent diagnostic findings;

7.4.b.1.H. Essential information regarding the resident=s illness or problems;

7.4.b.1.I. Restorative procedures;

7.4.b.1.J. Medication instructions; and

7.4.b.1.K. The nursing home, agency or location to which the resident was discharged:

7.4.b.2. Anticipated Discharge. When a discharge is anticipated, a nursing home shall prepare for the resident a discharge summary that includes:

7.4.b.2.A. A recapitulation of the resident=s stay;

7.4.b.2.B. A final summary of the resident=s status to include items in Subdivision 6.2.b. of this rule, prepared at the time of the discharge, that is available for release to authorized persons and agencies with the consent of the resident or legal representative;

7.4.b.2.C. Thirty (30) day notification of the discharge as appropriate and in compliance with other provisions of this rule; and

7.4.b.2.D. If the resident is discharged to his or her home, the resident shall be given appropriate information concerning his or her needs for care and medications including a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

7.4.b.3. The death of a resident shall be reported immediately to the attending physician and to the resident=s legal representative and family as relevant.

7.4.b.3.A. The discharge summary shall include the requirements specified in this rule.

7.4.b.4. A nursing home shall complete medical records promptly within a time period specified in the nursing homes polices and procedures manual, not to exceed thirty (30) days after the resident is discharged.

7.4.b.4.A. The discharge summary shall contain a dated physician=s signature.

'64-13-8. Quality of Care.

8.1. Each resident shall receive, and the nursing home shall provide, the necessary care and services to attain or maintain the highest practicable physical, spiritual, mental, and psychosocial well-being of the residents, in accordance with the comprehensive assessment and plan of care.

8.2. Activities of Daily Living. Based on the comprehensive assessment of a resident, the nursing home