§483.21 Comprehensive Person-Centered Care Planning

BASELINE CARE PLAN

DEVELOPMENT OF BASELINE CARE PLAN

Must be developed within 48 hours

Must include:

- At least minimum healthcare information necessary to "properly" care for the resident
- Initial goals
- Orders from the physician, dietary team, therapy, social services, and PASARR (if applicable)

DELIVERY OF SUMMARY TO RESIDENT

Must include:

- Initial goals
- Summary of medications and dietary instructions
- List of any services and treatments to be administered by personnel of the facility or on the facility's behalf
- Notification of updated information based on the details of the comprehensive care plan as necessary

COMPREHENSIVE CARE PLAN REQUIREMENTS

Care plan must be prepared by:

- Attending physician
- A registered nurse with responsibility for the resident
- A nurse aide with responsibility for the resident
- A member of food and nutrition services staff
- The resident and the resident's representative(s) (An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan)
- Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident

RESIDENT CONSULTATION

Care plan must include:

- The resident's goals for admission and desired outcomes
- The resident's preference and potential for future discharge
- Documentation regarding whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities
- Discharge plans

COMPLETION & STRUCTURE

Care plan must be:

- Developed within seven days after completion of the comprehensive assessment
- Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments

DISCHARGE PROCESS

DISCHARGE PLANNING PROCESS

Focuses on resident's discharge goals

Prepares the resident to be an active partner

PROCESS TO INCLUDE

Re-evaluation (as necessary)

Consideration of needs including caregiver support, capacity, and capabilty

DISCHARGE CARE PLAN

Involves resident and resident representative

Addresses resident care goals and treatment preferences

DOCUMENTATION

Completed on a timely basis based on resident need and included in clinical record

Includes evaluation of the resident's discharge needs and discharge plan (Results of the evaluation must be discussed with the resident or resident's representative)

Includes notes about resident's interest in receiving information regarding returning to the community and facility's follow-up

If discharge is not feasible, includes why and whom made this determination

AADNS-LTC.org I 844.796.9634 I 400 S. Colorado Blvd, Ste. 600, Denver, CO 80246