NV

449.74433 Comprehensive assessment of needs of patient

1.

A facility for skilled nursing shall conduct a comprehensive assessment of the needs of each patient in the facility using the assessment instrument specified by the Bureau.

2.

A comprehensive assessment must include, without limitation: (a) Demographic and other pertinent information required to identify the patient; (b) The customary routine of the patient; (c) The cognitive patterns of the patient; (d) An analysis of the communication skills of the patient; (e) An analysis of the vision of the patient; (f) The mood and behavior patterns of the patient; (g) An analysis of the psychosocial well-being of the patient; (h) Any problems related to the functional or structural physical condition of the patient; (i) The patient's pattern of continence; (j) The physical condition of the patient, including the diagnosis of any diseases which the patient may have; (k) An analysis of the nutritional needs of the patient; (l) The dental condition of the patient; (m) The condition of the patient's skin; (n) Activities in which the patient is interested; (o) Medications required to be taken by the patient; (p) Any special treatments and procedures required by the patient; (q) The probability of discharging the patient from the facility and any other information related to the discharge of the patient from the facility; (r) Documentation of summary information relating to any additional assessment

performed in accordance with the patient's assessment protocols; and (s) Documentation of the patient's participation in the assessment.

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(b)

The customary routine of the patient;

(c)

The cognitive patterns of the patient;

(d)

An analysis of the communication skills of the patient;

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An analysis of the vision of the patient;

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The mood and behavior patterns of the patient;

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An analysis of the psychosocial well-being of the patient;

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Any problems related to the functional or structural physical condition of the patient;

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The patient's pattern of continence;

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The physical condition of the patient, including the diagnosis of any diseases which the patient may have;

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An analysis of the nutritional needs of the patient;

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The dental condition of the patient;

(m)

The condition of the patient's skin;

(n)

Activities in which the patient is interested;

(o)

Medications required to be taken by the patient;

(p)

Any special treatments and procedures required by the patient;

(q)

The probability of discharging the patient from the facility and any other information related to the discharge of the patient from the facility;

(r)

Documentation of summary information relating to any additional assessment performed in accordance with the patient's assessment protocols; and

(s)

Documentation of the patient's participation in the assessment.

3.

The information to be included in a comprehensive assessment must be obtained from the direct observation of and communication with the patient and from communications with the members of the staff who care for the patient.

4.

A comprehensive assessment must be conducted: (a) Within 14 days after the patient's admission to the facility. The provisions of this paragraph do not require a comprehensive assessment of a patient who is readmitted to the facility following a temporary absence from the facility for hospitalization or therapeutic leave if there

is not a significant change in the physical or mental condition of the patient. (b) Within 14 days after there has been a significant decline or improvement in the physical or mental condition of the patient that: (1) Requires intervention by a member of the facility's staff or further medical treatment; (2) Has affected more than one aspect of the patient's health; and (3) Requires review by an interdisciplinary team or a revision of the patient's plan of care, or both. (c) At least once every 12 months, but in no event later than 365 days after the completion of the most recent comprehensive assessment.

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(2)

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(3)

Requires review by an interdisciplinary team or a revision of the patient's plan of care, or both.

(c)

At least once every 12 months, but in no event later than 365 days after the completion of the most recent comprehensive assessment.

5.

A comprehensive assessment must accurately reflect the physical, mental and psychosocial health of the patient.