

310_675-9-5.1 Assessment and care plans

(a)

A resident assessment and an individual care plan shall be completed and implemented for each resident. The care plan shall indicate the resident's current status and accurately identify the resident's needs.

(b)

The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates.

(c)

Efforts shall be made to include the resident and resident's representative in development and implementation of the care planning process. (1) Resident assessment (A) The facility shall conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment for each resident's functional capacity. (B) Each resident shall have an assessment coordinated or conducted by a registered nurse. (C) Each individual completing a portion of the assessment shall sign, date, and certify the accuracy of that portion. (D) An assessment shall be completed within fourteen days after admission of the resident. (E) The resident assessment shall include a minimum data set (MDS) in the form required under 42 CFR 483.20. Each facility, with the exception of Intermediate Care Facilities for the Mentally Retarded (ICF/MR), accurately shall complete the MDS for each resident in the facility, regardless of age, diagnosis,

length of stay or payment category. (F) The MDS form shall require the following, as applicable: (i) Admission assessment; (ii) Annual assessment; (iii) Significant change in status assessment; (iv) Significant correction of prior full assessment; (v) Significant correction of prior quarterly assessment; (vi) Quarterly review; and (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (2)

Resident pain assessment(A) Residents shall be screened for the presence of pain

at least once every 30 days and whenever vital signs are taken. (i) Licensed nursing staff shall perform the screening at least once every 30 days. Certified nurse aides may perform the screening more frequently as needed. (ii) The

screening instrument shall grade the intensity and severity of pain using a resident-specific pain scale; (B) An individualized pain assessment shall be

conducted by a registered nurse for each resident: (i) In conjunction with the admission, quarterly and annual assessments required at OAC

310:675-9-5.1.(c)(1)(F); and (ii) With onset of pain not previously addressed in a care plan or physician's orders. (C) The goal is to alleviate or minimize pain while

assisting the resident to maintain as high a level of functioning as possible. The pain assessment shall include, but not be limited to: (i) A statement of how the

resident describes the pain; (ii) Intensity and severity of pain graded using a resident-specific pain scale; (iii) Recent changes in pain; (iv) Location(s); (v) Onset

and duration of pain, such as new pain within the last 3 days, recent pain within the last 3 months, or more distant pain greater than 3 months; (vi) Type of pain

reported or represented by resident, such as constant or intermittent, and duration or frequency of pain; (vii) Current pain measured at its least and greatest levels;

(viii) Aggravating and relieving factors; (ix) Treatment including a review of all therapies, including medication, and the regimen used to minimize pain; (x) Effects

of pain and effectiveness of therapy on physical and social functions; (xi) Resident's

treatment preferences and emotional responses to pain, including resident's expectations and how resident coped with pain; and (xii) If applicable, refer to pain assessment tool for the cognitively impaired. (D) Results shall be recorded in the resident's clinical record showing changes in pain scale and changes in level of functioning. The physician shall be contacted as necessary. (E) Pain shall be treated promptly, effectively and for as long as necessary. (3) Individual care plan (A) An individual care plan shall be developed and implemented for each resident to reflect the resident's needs. (B) The care plan shall be developed by an interdisciplinary team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines determined by the resident's needs. (C) The care plan shall include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the assessment. (D) The care plan shall be available to appropriate personnel providing care for the resident. (E) An initial care plan shall be completed at the time of admission. The individualized care plan shall be completed within twenty-one days after admission. (F) A care plan shall be completed within seven calendar days after the completion of the assessment.

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