

## **R432-150-13 Resident Assessment**

### **(1)**

The facility shall upon admission obtain physician orders for the resident's immediate care.

### **(2)**

The facility must complete a comprehensive assessment of each resident's needs including a description of the resident's capability to perform daily life functions and significant impairments in functional capacity. (a) The comprehensive assessment must include at least the following information: (i) medically defined conditions and prior medical history; (ii) medical status measurement; (iii) physical and mental functional status; (iv) sensory and physical impairments; (v) nutritional status and requirements; (vi) special treatments or procedures; (vii) mental and psycho social status; (viii) discharge potential; (ix) dental condition; (x) activities potential; (xi) rehabilitation potential; (xii) cognitive status; and (xiii) drug therapy. (b) The facility must complete the initial assessment within 14 calendar days of admission and any revisions to the initial assessment within 21 calendar days of admission. (c) A significant change in a resident's physical or mental condition requires an interdisciplinary team review and may require the facility to complete a new assessment within 14 calendar days of the condition change. (d) At a minimum, the facility must complete three quarterly reviews and one full assessment in each 12 month period. (e) The facility shall use the results of the

assessment to develop, review, and revise the resident's comprehensive care plan.

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**(b)**

The facility must complete the initial assessment within 14 calendar days of admission and any revisions to the initial assessment within 21 calendar days of admission.

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A significant change in a resident's physical or mental condition requires an interdisciplinary team review and may require the facility to complete a new assessment within 14 calendar days of the condition change.

**(d)**

At a minimum, the facility must complete three quarterly reviews and one full assessment in each 12 month period.

**(e)**

The facility shall use the results of the assessment to develop, review, and revise the resident's comprehensive care plan.

**(3)**

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

**(4)**

The facility must develop a comprehensive care plan for each resident that includes

measurable objectives and timetables to meet a resident's medical, nursing, and mental and psycho-social needs as identified in the comprehensive assessment.

(a) The comprehensive care plan shall be: (i) developed within seven days after completion of the comprehensive assessment; (ii) prepared with input from an interdisciplinary team that includes the attending physician, the registered nurse having responsibility for the resident, and other appropriate staff in disciplines determined by the resident's needs, and with the participation of the resident, and the resident's family or guardian, to the extent practicable; and (iii) periodically reviewed and revised by a team of qualified persons at least after each assessment and as the resident's condition changes. (b) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with the resident's written care plan.

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periodically reviewed and revised by a team of qualified persons at least after each assessment and as the resident's condition changes.

**(b)**

The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with the resident's written care plan.

**(5)**

The facility must prepare at the time of discharge a final summary of the resident's status to include items in R432-150-13(2)(a). The final summary shall be available for release to authorized persons and agencies, with the consent of the resident or representative. (a) The final summary must include a post-discharge care plan developed with the participation of the resident and resident's family or guardian. (b) If the discharge of the resident is based on the inability of the facility to meet the resident's needs, the final summary must contain a detailed explanation of why the resident's needs could not be met.

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The final summary must include a post-discharge care plan developed with the participation of the resident and resident's family or guardian.

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If the discharge of the resident is based on the inability of the facility to meet the resident's needs, the final summary must contain a detailed explanation of why the resident's needs could not be met.