

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

CONSUMER FACTSHEET: RESIDENT ASSESSMENT & CARE PLANNING

There are many standards which nursing homes are required to follow in order to ensure that residents receive appropriate care, have a good quality of life and are treated with dignity. YOU can use these standards as a basis for advocating in your nursing home.

Following are two important standards for residents assessment and care planning with information that can help you understand and use them to advocate for your resident. [Note: The brackets provide the relevant federal regulation (CFR) and F-tag (category of deficiency).]

I. RESIDENT ASSESSMENT [42 CFR 483.20 F-636]

- *The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*
- *A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.*
- *The assessment must include at least the following:*
 - ✓ Identification and demographic information.
 - ✓ Customary routine.
 - ✓ Cognitive patterns.
 - ✓ Communication.
 - ✓ Vision.
 - ✓ Mood and behavior patterns.
 - ✓ Psychosocial well-being.
 - ✓ Physical functioning and structural problems.
 - ✓ Continence.
 - ✓ Disease diagnoses and health conditions.
 - ✓ Dental and nutritional status.
 - ✓ Skin condition.
 - ✓ Activity pursuit.
 - ✓ Medications.
 - ✓ Special treatments and procedures.
 - ✓ Discharge planning.
 - ✓ Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
- *Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.*

Use this checklist to identify what is important to YOU when you have a resident assessment!

II. COMPREHENSIVE PERSON-CENTERED CARE PLANNING [42 CFR 483.21 F-656]

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with... resident rights..., that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive care plan must describe the following:

- *The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...*
- *Any services that would otherwise be required... but are not provided due to the resident's exercise of rights..., including the right to refuse treatment...*
- *In consultation with the resident and the resident's representative(s)—*
 - *The resident's goals for admission and desired outcomes.*
 - *The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.*
 - *Discharge plans in the comprehensive care plan, as appropriate...*

A comprehensive care plan must be...Developed within 7 days after completion of the comprehensive assessment.

IMPORTANT NOTE: The new federal nursing home standards greatly expanded expectations for care planning. See the "LTCCC Factsheet Care Planning Requirements" for important details on how care plans must be developed and carried out.

BASIC CONSIDERATION TO KEEP IN MIND

- A facility must make an assessment of the resident's capacity, needs and preferences.
- The assessment must include a wide range of resident needs and abilities, including customary routine, cognitive patterns, mood, ability to and methods of communication, physical, dental and nutritional status.
- A facility is expected to primarily rely on direct observation and communication with the resident in order to assess his or her functional capacity.
- In addition to direct observation and communication with the resident, the facility must use a variety of other sources, including communication with care staff on all shifts.
- A resident's care plan "must describe... the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...."
- The care plan must be based on the assessment. In other words, it must come from the resident's needs and abilities, not the services or staffing levels which the nursing home decides to provide based on its financial (or other) priorities.

RESOURCES

WWW.NURSINGHOME411.ORG. LTCCC's website includes materials on the relevant standards for nursing home care, training materials and other resources.