Regulation Review - Care Planning

F655 - Baseline Care Plan

- Facility must be developed and implemented *within 48 hours of admission*
- Required to contain necessary healthcare information to be able to provide proper care to residents immediately upon admission
- Must include at a minimum:
    - Initial goals based on admission orders
    - Physician Orders
    - **Dietary Orders**
    - Therapy Services
    - Social Services
    - PASARR Recommendations (if applicable)
- Copy of baseline care plan should be provided to resident/resident representative

F656 - Develop/Implement Comprehensive Care Plans

- Care planning drives the type of care and services a resident receives
- Facilities are required to develop care plans that describe the resident's medical, nursing, physical, mental and psychosocial need and preferences and how the facility will assist in meeting these needs and preferences.
    - Person-specific, measurable objectives and time frames in order to evaluate the resident's progress toward his/her goals
- Must include at a minimum:
    - Services to be provided to attain or maintain the residents highest practicable physical, mental and psychosocial well being
    - Resident's goals for admission and desired outcomes
    - Resident preference and potential for future discharge
    - Discharge plans if appropriate
- Care plan updating should be ongoing - do not wait until required MDS assessments are due. Standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing
- If a resident refuse treatment, the comprehensive care plan should show the facility's effort to provide alternative choices

- F656 CMS Investigative Summary/Probes:
    - Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?
    - Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?
    - Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?
    - Is there evidence that the care plan interventions were implemented consistently across all shifts?
    - Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?
    - Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.
    - Evaluate whether the care plan reflects the facility's efforts to find alternative means to address care of the resident if he or she has refused treatment.

F657 - Care Plan Timing and Revision

- Comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment
    - Prepared by IDT team the includes at a minimum: Attending physician, registered nurse with responsibility for resident, nurse aide with responsibility for resident, **member of food and nutrition services staff**, participation of the resident/resident representative
    - No more than 21 days after admit
- Care plan must be revised after each RAI or MDS Assessment (except for discharge assessments)