Clinical	Care Plans Comprehensive		
	Effective Date: 11/16/2022	**Last Reviewed: 11/16/22**	**Last Revised: 11/8/22**

POLICY STATEMENT

To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.

Guideline

Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment.

"After each assessment" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS) as required by §483.20, except discharge assessments.

For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.

As used in this requirement, "Interdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach.

The mechanics of how the interdisciplinary team (IDT) meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility.

In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.

The IDT must, at a minimum, consist of the resident's attending physician, a registered nurse and nurse aide with responsibility for the resident, a member of the

food and nutrition services staff, and to the extent possible, the resident and resident representative, if applicable.

If the attending physician is unable to participate in the development of the care plan, he/she may delegate participation to an NPP who is involved in the resident's care, to the extent permitted by state law, or arrange alternative methods of providing input in the development and revision of the care plan, such as one-on-one discussions, videoconferencing and conference calls with the IDT.

The determination of other appropriate staff or professionals' participation in the IDT should be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, social workers, and other professionals, such as developmental disabilities specialists or spiritual advisors.

Involvement of other individuals is dependent upon resident request and/or needs.

Each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review, and revision of his/her care plan.

Residents also have the right to refuse treatment.

Facility staff have a responsibility to assist residents to engage in the care planning process, e.g., helping residents and resident representatives, if applicable understand the assessment and care planning process; holding care planning meetings at the time of day when the resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's representative to participate in care planning and attend care planning conferences.

The facility must provide the resident and resident representative, if applicable, with advance notice of care planning conferences to enable resident/resident representative participation.

Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing.

Facilities are expected to facilitate the residents' and if applicable, the resident representatives' participation in the care planning process. There are limited circumstances in which the inclusion of the resident and/or resident representative may not be practicable (or feasible). An example may be the case of a severely cognitively impaired resident who is unable to understand or participate in care plan development, and the resident's representative does not respond to facility attempts to make contact. If the facility determines that the inclusion of the resident and/or

resident representative is not practicable, documentation of the reasons, including the steps the facility took to include the resident and/or resident representative, must be included in the medical record.

While Federal regulations at §483.10(c) affirm the resident's right to participate in care planning, request and/or refuse treatment, the regulations do not create the right for a resident or resident representative, if applicable, to demand that the facility use specific medical interventions or treatments that the facility deems not medically necessary and/or reasonable.

The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

RESOURCE DOCUMENTS	RESOURCE DOCUMENTS	ORIGINATION DATE	DATE REVISED	DATE REVIEWED
Administrator, Director of Nursing, Licensed Nurse, Department Managers			11/8/22	11/16/22