SECTION .2300 - PATIENT AND RESIDENT CARE AND SERVICES

10A NCAC 13D .2301 PATIENT ASSESSMENT AND PLAN OF CARE

(a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient's immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse and measures implemented as appropriate.

(b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient's capability to perform daily life functions. This comprehensive assessment shall be coordinated by a registered nurse and shall include at least the following:

(1) current medical diagnoses;
(2) medical status measurements, including current cognitive status, stability of current conditions and diseases, vital signs, and abnormal lab values and diagnostic tests that are a part of the medical history;
(3) the patient's ability to perform activities of daily living, including the need for staff assistance and assistive devices, and the patient's ability to make decisions;
(4) presence of neurological or muscular deficits;
(5) nutritional status measurements and requirements, including but not limited to height, weight, lab work, eating habits and preferences, and any dietary restrictions;
(6) special care needs, including but not limited to pressure sores, enteral feedings, specialized rehabilitation services or respiratory care;
(7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other psychosocial needs;
(8) facility's expectation of discharging the patient within the three months following admission;
(9) condition of teeth and gums, and need and use of dentures or other dental appliances;
(10) patient's ability and desire to take part in activities, including an assessment of the patient's normal routine and lifetime preferences;
(11) patient's ability to improve in functional abilities through restorative care;
(12) presence of visual, hearing or other sensory deficits; and
(13) drug therapy.

(c) The facility shall develop a comprehensive plan of care for each patient and shall include measurable objectives and timetables to meet needs identified in the comprehensive assessment. The facility shall ensure the comprehensive plan of care is developed within seven days of completion of the comprehensive assessment by an interdisciplinary team. To the extent practicable, preparation of the comprehensive plan of care shall include the participation of the patient and the patient's family or legal representative. The physician may participate by alternative methods, including, but not limited to, telephone or face-to-face discussion, or written notice.

(d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days and make necessary revisions to ensure accuracy.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. February 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.