TOOL:
Care Planning §483.21

Baseline Care Plan

Purpose & Intent: To develop a baseline care plan within 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident while the comprehensive care plan is developed. Key features to be aware of include:

- There are no exceptions to 48 hours for admissions occurring on the weekend or holidays.
- The baseline care plan documents the interim approaches for meeting the resident's immediate needs
  - *Note: This means that the baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.*
- It must also reflect changes to care resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.
- A written copy needs to be provided to resident and their representative.

The checklist below captures the required steps and content. You may want to customize or add additional steps. You should also review Appendix PP interpretive guidance for F-Tag F-655 for details and unique situations. NOTE: *Facilities may complete a comprehensive care plan instead of the baseline care plan if completed within 48 hours)*.

Baseline Care Plan (Checklist Audit)

AHCA provides this checklist to use as an audit to ensure each resident has a baseline care plan with all of the required components and that the Center followed the necessary steps.

- ☐ Does Baseline Care plan include, at a minimum:
  - Initial goals based on admission orders
  - All physician orders
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendation(s), if PASARR was completed
- ☐ Does it:
  - Reflect resident's stated goals and objectives
  - Address resident-specific health and safety concerns to prevent decline or injury
  - Identify needs for supervision
  - Behavioral interventions
  - Assistance with activities of daily living
- ☐ Is it completed within 48 hours of admission?
- ☐ Did resident (and their representative) receive a written summary of the Baseline Care Plan in a manner they can understand that includes:
  - The initial goals for the resident
  - A list of current medications and dietary instructions
  - Services and treatments to be administered by the facility or contractor
  - Documentation in the medical record that the care plan was shared with the resident
- ☐ Was the Baseline care plan updated if there were any changes to the resident's goals, condition or care made prior to the comprehensive care plan was developed?

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Comprehensive Care Plan

Purpose & Intent: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

Key Features of Comprehensive Care Plan Include:

- Greater emphasis on involving the resident and/or representative in the care planning process to incorporate resident choice and preferences which must be reflected in the care plan. This includes:
    - Resident's preference for future discharge.
    - Advance notice of care planning conferences must be provided to the resident and resident representative to enable resident/resident representative participation.
    - Resident's choice to decline care or treatment (e.g., due to preferences, maintaining autonomy, etc.) poses a risk to the resident's health or safety. If a resident is declining care, the comprehensive care plan must identify the care or service being declined, the risk the declination poses, efforts to educate the resident and the representative, and attempts to find alternative means to address the identified risk.
    - The facility must determine how the resident's decisions may increase risks to health and safety and evaluate the resident's decision-making capacity.
- Goals must be objective, measurable and have timeframes.
    - Resident's progress toward his/her goal(s) must be evaluated and care plan updated accordingly.
- A Discharge Plan (see Discharge Plan tool for required content and steps).
- Care practices associated with each goal need to be evidence-based, whenever possible.
    - Care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting.
    - Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body, or other regulatory agency.
- Greater focus on PASARR.
    - PASARR recommendations must be incorporated into the care plan and address any specialized services or specialized rehabilitation services the facility will provide or arrange. If the interdisciplinary team (IDT) disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
- Assess staff utilization/awareness of the care plan.
    - Can each member of IDT explain their role in developing the care plan to the surveyor?
    - 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?

You should also review Appendix PP interpretive guidance for F-Tags **F656, F657, F658 & F659** for details and unique situations. Access Appendix PP and Relevant Critical Element Pathways under "CMS Resources" Section here.

TOOL:
Care Planning §483.21

Comprehensive Care Plan (Checklist Audit)

AHCA developed this checklist to use as an audit to ensure each resident has a comprehensive care plan with all of the required components and that the Center followed all of the necessary steps.

Does comprehensive care plan include, at a minimum:

- ☐ Summary of the resident's
  - desired goals
  - personal and cultural preferences
  - needs & strengths
  - MDS findings including Critical Area Assessment (CAA) triggers
  - PASARR findings
- ☐ Services needed with **measurable objectives and timeframes** to meet a resident's medical, nursing, and mental and psychosocial needs consistent with services covered and the *care and* services are provided according to accepted standards of clinical practice.
  - CAA triggered
  - § 483.24 (Quality of Life)
  - § 483.25 (Quality of Care)
  - § 483.40 (Behavioral Health services)
  - PASARR recommendations. If not adopted, the rationale for not following PASARR recommendations.
  - Any changes to the care plan including the type, amount, frequency, and duration of care.
  - *Is there evidence that the care plan is evaluated for effectiveness against the goals?*
- ☐ *Are the services identified in the comprehensive care plan being provided by qualified persons?*
  - *Do staff have the skills, experience, and knowledge to provide care that meets the resident's needs?*
- ☐ What the resident and/or resident representative specified for their:
  - Goals and desired outcomes
  - Desire to participate in care plan development
    - *If applicable, the family/representative is provided advance notice of care planning conferences, and* ***an explanation is included in the medical record if their participation was not possible.***
  - Preferences and potential for future discharge
  - Desire to return to the community
  - Any refusal to receive any recommended services or treatments. If refused, *action taken by facility staff to educate the resident and resident representative, if applicable, regarding consequences and alternatives.*
- ☐ Discharge plans (see Discharge Plan Tool for required content)
- ☐ Did the resident (and their representative) see or receive a copy of the care plan?
- ☐ Is it developed within 7 days of completion of the comprehensive assessment?
- ☐ Is it prepared by an interdisciplinary team that at a minimum includes:
  - Attending physician (Note: may designate NPP/PA if within scope of practice within your state)
  - Registered nurse with responsibility for the resident
  - Nurse aide with responsibility for the resident
  - Member of food and nutrition services staff
  - Other staff or professionals as determined by the resident's needs or as requested by the resident
- ☐ *Can members of the IDT describe how they participate in the development, review, and revision of care plans?*
- ☐ Reviewed and updated after each quarterly and comprehensive MDS assessment.