## 42 C.F.R. § 483.21. Comprehensive person-centered care planning.[SAE62]

(a) Baseline care plans.

(1) The facility must develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.

(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

(b[SAE63]) Comprehensive care plans.

(1) The facility must develop a comprehensive person-centered care plan for each resident, consistent with § 483.10(b)(1) and § 483.11(b)(1), that includes measurable objectives and timetables 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—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25 or § 483.40; and

(ii) Any services that would otherwise be required under § 483.25 or § 483.40 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) 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.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment~~;~~.

(ii) Prepared by an interdisciplinary team, that includes ~~the~~ but is not limited to—

(A) The attending physician~~, a~~.

(B) A registered nurse with responsibility for the resident~~, and other appropriate staff in disciplines as determined by the resident's needs, and, to~~.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) A social worker.

(F) To the extent practicable, the participation of the resident~~, the resident's family or the resident's legal representative; and~~ and the resident's representative(s). An explanation must be included in a

resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(G) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) ~~Periodically r~~eviewed and revised by ~~a~~the interdisciplinary team ~~of qualified persons~~ after each assessment, including both the comprehensive and quarterly review assessments.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality~~; and~~ .

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(iii) Be culturally-competent and trauma-informed.

(c) Discharge planning[SAE64]—

(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals and preparing residents to be active partners in post-discharge care, effective transition of the resident from SNF to post-SNF care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by § 483.20(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.Show citation box

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1~~2~~) of ~~this section~~§ 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or ~~legal~~resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, his or her family, which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.[SAE65]