

**PROBES §483.20(k)(4)**

- When a significant change in status was identified in a resident with a mental disorder or intellectual disability, was the appropriate state mental health or intellectual disability authority promptly notified?
- Does the facility have a process in place to notify the appropriate state mental health or intellectual disability authority when a resident with a Level II PASARR has a significant change in his or her mental or physical status?

**F655**

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**§483.21 Comprehensive Person-Centered Care Planning**

**§483.21(a) Baseline Care Plans**

**§483.21(a)(1) The facility must develop and implement 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.**

**§483.21(a)(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).**

**§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:**

- (i) The initial goals of the resident.**
- (ii) A summary of the resident's medications and dietary instructions.**
- (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.**
- (iv) Any updated information based on the details of the comprehensive care plan, as necessary.**

**INTENT §483.21(a)**

Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home

staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

#### **GUIDANCE §483.21(a)**

Nursing homes are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. 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.

Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Baseline care plans are required to address, at a minimum, the following:

- Initial goals based on admission orders.
- Physician orders.
- Dietary orders.
- Therapy services.
- Social services.
- PASARR recommendation, if applicable.

The baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her current needs. It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan. Facility staff must implement the interventions to assist the resident to achieve care plan goals and objectives.

Facilities may complete a comprehensive care plan instead of the baseline care plan. In this circumstance, the completion of the comprehensive care plan will not override the RAI process, and must be completed and implemented within 48 hours of admission and comply with the requirements for a comprehensive care plan at §483.21(b), with the exception of the requirement at (b)(2)(i) requiring the completion of the comprehensive care plan within 7 days of completion

of the comprehensive assessment. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand.

If the facility completes a comprehensive care plan instead of the baseline care plan, review the requirements of the comprehensive care plan at §483.21(b). If the care plan does not meet the requirements of §483.21(b), cite at the appropriate corresponding tag(s):

- F656 Develop Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons

### **Baseline Care Plan Summary**

The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:

- Initial goals for the resident;
- A list of current medications and dietary instructions, and
- Services and treatments to be administered by the facility and personnel acting on behalf of the facility;

The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.

Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.

As the resident remains in the nursing home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident, however, these subsequent changes will not need to be reflected in the summary of the baseline care plan. Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes. Refer to §483.10(c) for guidance related to Resident Rights and Facility Responsibilities regarding Planning and Implementing Care.

### **INVESTIGATIVE SUMMARY AND PROBES §483.21(a)**