sometimes feeling sad about not participating in activities he/she expressed interest in attending.
- An inaccurate or incomplete care plan resulted in facility staff providing one staff to assist the resident, when the resident required the assistance of two staff, which had the potential to cause more than minimal harm.

An example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, includes, but is not limited to:

For one or more care plans, the staff did not include a measurable objective, which resulted in no more than a minor negative impact on the involved residents.

F657
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.21(b) Comprehensive Care Plans
§483.21(b)(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 but is not limited to--**
  - **(A) The attending physician.**
  - **(B) A registered nurse with responsibility for the resident.**
  - **(C) A nurse aide with responsibility for the resident.**
  - **(D) A member of food and nutrition services staff.**
  - **(E) To the extent practicable, the participation of the resident 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.**
  - **(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.**
- **(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.**

INTENT of §483.21(b)(2)
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.

DEFINITIONS
"Non-physician practitioner (NPP)" is a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).

GUIDANCE §483.21(b)(2)
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 advisor. 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.

NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing. The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident's needs between required RAI assessments should be addressed at §483.35 Nursing Services, F726 (competency and skills to identify and address a change in condition), and the relevant outcome tag, such as §483.12 Abuse, §483.24 Quality of Life, §483.25 Quality of Care, and/or §483.40 Behavioral Health.

For concerns related to the resident's rights to participate in planning and implementing his or her care, see requirements at §483.10(c).

INVESTIGATIVE SUMMARY AND PROBES §483.21(b)(2)

Use the Critical Element (CE) Pathway associated with the issue under investigation, or if there is no specific CE Pathway, use the General Critical Element Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement for timely completion and IDT and resident involvement in the development of the Comprehensive Care Plan. If systemic concerns are identified with timeliness and IDT/resident involvement in the development of Comprehensive Care Plans, use the probes below to assist in your investigation.

- Was a comprehensive plan of care developed within seven days of completion of the resident's comprehensive assessment?
- Is there evidence of participation in the care planning process by required IDT members?

- Ask required members of the IDT how they participate in the development, review and revision of care plans.
- Based on the resident's goals and needs, were other appropriate staff or professionals' expertise utilized to develop a plan to improve the resident's functional abilities?

For example:

a. Did an occupational therapist recommend needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?
b. Did the dietitian and speech therapist determine the optimum textures and consistency for the resident's food that is nutritionally adequate and compatible with the resident's oropharyngeal capabilities and food preferences?

- Is there evidence of attending physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls, written communication)?
- How do staff make an effort to schedule care plan meetings at the best time of the day for residents and if applicable, the resident representatives?
- How do staff make the care plan process understandable to the resident and resident representative, if applicable?
- Ask the resident and resident representative, if applicable if he or she actively participates in the care planning process? If not, what have been the barriers to participation?
- Ask the resident and if applicable, the resident representative if he or she has requested the participation of additional individuals care planning process. If so, was the request respected?
- In what ways does staff involve the resident and if applicable, the resident representative in care planning? If staff determine that the resident and/or resident representative involvement in care planning is not practicable, is the reason and the steps the facility took to include the resident and/or resident representative documented in the medical record?
- Is there evidence that the care plan is evaluated for effectiveness and revised following each required assessment, except discharge assessments, and as needed?

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to:

- The resident's care plan was not revised following a significant change assessment which identified an occurrence of resident-to resident sexual abuse, placing the abused resident and other residents at risk for serious injury, impairment or death.

An example of Level 3, actual harm that is not immediate jeopardy includes, but is not limited to:

- The facility failed to develop the comprehensive care plan within seven days of completion of the comprehensive assessment. This resulted in the resident sustaining a laceration requiring stitches due to a fall because appropriate fall prevention interventions were not implemented timely.

Examples of Level 2, no actual harm with potential for than more than minimal harm that is not immediate jeopardy, include, but are not limited to: