Purpose & Intent: To develop a baseline care plan within 48 hours of admission to direct the care team while a comprehensive care plan is developed that incorporates the resident’s goals, preferences, and services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.

The checklist below captures the required steps and content. You may want to customize or add additional steps, but this is intended to meet the requirements. However, please note that CMS has not yet issued its interpretative guidance for this new RoP. When they do, some of the items on this checklist may need to be updated.

Baseline Care Plan (Checklist Audit)

To assure that the center has followed the required steps in developing the Baseline Care Plan, AHCA staff recommend you use a checklist to audit that each resident has a baseline care plan with all the required components and that the necessary steps were followed.

Note: The goal of the Baseline Care Plan is to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

☐ Does it include, at a minimum:
  - Initial goals based on admission orders
  - All physician orders, which includes medications and administration schedule
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendation(s), if PASARR was completed

☐ Are the discharge needs of the resident identified (that help develop the discharge plan)?

☐ Is it completed within 48 hours of admission?

☐ Did resident (and their representative) receive at least the summary of the Baseline Care Plan that included:
  - The initial goals of the resident
  - A summary of the resident’s medications and dietary instructions
  - Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
  - Any updated information based on the details of the comprehensive care plan, as necessary
Comprehensive Care Plan (Checklist Audit)

To assure that the Center has followed all the required steps in developing the Comprehensive Care Plan, AHCA staff recommend you use a checklist to audit that each resident has a baseline care plan with all the required components and that the necessary steps were followed.

Does it include, at a minimum:

- Summary of comprehensive assessment of resident’s
  - needs
  - strengths
  - goals
  - life history
  - personal and cultural preferences
  - MDS findings
  - 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 in
  - § 483.24 (Quality of Life),
  - § 483.25 (Quality of Care), or
  - § 483.40 (Behavioral Health services)
  - PASARR recommendations
    - If not adopted, the rationale for not following PASARR recommendations

- The resident’s specified
  - Goals for admission and desired outcomes
  - Individuals they want to participate in care plan development
  - Preference and potential for future discharge
  - Desire to return to the community was assessed
  - Any referrals to local contact agencies and/or other appropriate entities, to assess potential for discharge to community
  - Refusal to receive any recommended services or treatments
  - Any changes to the care plan including the type, amount, frequency, and duration of care

- Discharge plans (see discharge plan required content)
  - Resident (and their representative) participated in development
    - If not, was an explanation provided if their participation is determined not practicable for the development of the resident’s care plan?

- Did resident (and their representative) see or receive a copy of the care plan?

- Is it completed within 7 days after completion of the comprehensive assessment?

- Prepared and signed by an interdisciplinary team, that at minimum includes:
  - Attending physician
  - 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

-Reviewed and Updated after each Quarterly and comprehensive MDS assessment

As AHCA identifies and develops additional resources, including updates to this material, they will be posted on ahcancalED. Please make sure to visit ahcancalED for the most up-to-date information.
Baseline Plan of Care (Phase II)

The **RoP language** for 483.21(a) is as follows:

✓ (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—
  o Be developed within 48 hours of a resident’s admission.
  o 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—
  o (i) Is developed within 48 hours of the resident’s admission.
  o (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). [Note: paragraph (b) is all the content required in a comprehensive care plan except (b)(2)(i) which specifies 7 days to be completed.]

✓ (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:
  o The initial goals of the resident.
  o A summary of the resident’s medications and dietary instructions.
  o Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
  o Any updated information based on the details of the comprehensive care plan, as necessary.

As AHCA identifies and develops additional resources, including updates to this material, they will be posted on ahcancalED. Please make sure to visit ahcancalED for the most up-to-date information.
Comprehensive Care Plan (Phase I)

The RoP language for 483.21(b) is as follows:

✓ (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes 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:
  o (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 § 483.24, § 483.25, or § 483.40; and
  o (ii) Any services that would otherwise be required under § 483.24, § 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(c)(6).
  o (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.
  o (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—
  o (i) Developed within 7 days after completion of the comprehensive assessment.
  o (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.
  o (iii) Reviewed and revised by the interdisciplinary team 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—
  o (i) Meet professional standards of quality.
  o (ii) Be provided by qualified persons in accordance with each resident’s written plan of care.
  o (iii) Be culturally-competent and trauma–informed. [Note: Phase III]