Baseline Care Plan Checklist

Associated F-tag	F656
CFR Citation	***§483.21(a) Baseline Care Plans***
Effective Date	**November 28th, 2017 (Phase 2 RoP)**

The Rule

§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 meets professional standards of quality care.*

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.

Baseline care plans are required to address, at a minimum, the following:

- ☐ Initial goals based on admission orders.
- ☐ Reflect the resident's stated goals and objectives.
- ☐ Include interventions that address current needs.
- ☐ Physician orders.
- ☐ Dietary orders.
- ☐ Therapy services.
- ☐ Social services.
- ☐ PASARR recommendation, if applicable

Data Sources

- ☐ Transfer Documentation
- ☐ Admission Assessments
- ☐ Resident
- ☐ Residents Representative
- ☐ Care Data identifying change in condition

NOTE: You may choose to complete a comprehensive care plan instead of the baseline care plan but the comprehensive care plan must follow the RAI process and include the completion of a comprehensive MDS assessment and CAAs.

Baseline Care Plan Summary Checklist

Associated F-tag	F656
CFR Citation	***§483.21(a)(3) Baseline Care Plan Summary***
Effective Date	**November 28, 2017 (Phase 2 RoP)**
Recipient(s)	Resident and/or Resident Representative
What	A written summary of the baseline care plan, written in a language and conveyed in a manner the resident and/or representative can understand
When	By completion of the comprehensive care plan

Requirements:

Content

- ☐ Initial goals for the resident;
- ☐ A list of current medications and dietary instructions;
- ☐ Services and treatments to be administered by the facility and personnel acting on behalf of the facility;
- ☐ Any changes in the resident's goals, or physical, mental, or psychosocial functioning, captured in the comprehensive assessment and care plan not identified in the baseline care plan

Medical Record

- ☐ Must contain evidence that the summary was given to the resident and/or resident representative

Format:

- ☐ There is no specified format – it is left to the discretion of the facility.
- ☐ It must be legible and worded so that the resident or resident representative understands what they are reading.
- ☐ The facility may choose to provide a copy of the baseline care plan itself as the summary, if it meets all the requirements of the summary.