

Nursing Home Residents' Rights

Resident Assessment and Care Planning

When you enter a nursing home, you have a right to quality care and services which enable you to reach your highest levels of physical, mental, and emotional well-being, as defined in federal and state regulations. A thorough assessment and personalized care plan are the tools a nursing home is required to use to help you reach your maximum level of functioning. The assessment and care plan development are completed by a team of professionals, including your physician, a nurse, dietician, social worker, the activities director, and any other therapist involved in your care. This group of professionals is called an Interdisciplinary Team (IDT).

What is "Resident Assessment?"

Resident Assessment is a process by which nursing home staff identifies your health care needs, daily schedules and habits, and likes and dislikes. The process begins either before or at the time that you enter a nursing home, and



must be completed within 14 days of your admission. Nurses and other staff gather information from you, your physician, and your family so they can determine your current condition. This history-taking and examination process helps staff members understand your current health condition so they can help you live your life at your highest possible level of functioning.

What does the nursing home do with the information?

After staff members complete the resident assessment process, they use the confidential information to develop a plan for your care. This is referred to as a "care plan." The care planning conference occurs when you and your family meet with nursing staff and other specialists to develop a plan which sets measurable goals and recommends any necessary medical treatments to meet your needs. You and/or your family or representative are an important part of this process. Your nursing home must invite you and encourage you to be involved in the care planning process. You and/or your family or representative has the right to make choices about the care and treatment you receive, and may access your medical record if you desire.

Resident Assessment and Care Planning (*continued*)

For example:

- T Facility staff should tell you about your medical condition and if a change occurs.
- T You should be invited to attend those meetings where staff members will be discussing what they are planning to do to help you.
- T The nursing home must ask what your preferences are.
- T When you receive care, you must be told how the treatment will affect your condition.
- T If you take medications, you must be informed about what medications you receive, why you receive them, and what their likely side effects are.
- T If something is not going well for you in the nursing home, the staff should work with you to make changes in your care plan.
- T You must be given the opportunity to discuss any problems at group meetings involving other residents

without facility staff present unless the residents invite them.

What if my condition changes?

Your nursing home is required to review your overall health condition every three months (called the “quarterly assessment”) and revise the assessment and care plan accordingly. If your condition changes more frequently, they must discuss this with you and adjust the plan of care to meet your changing needs. Examples of possible changes in one’s condition could include the development of a pressure sore, depression, unintentional weight loss, or any other change that does not allow you to function at your maximum potential.

For additional information about resident assessment and care planning, please contact your local Department of Public Health, Licensing and Certification, District Office, or Ombudsman Program in your county. The telephone numbers for both agencies are posted in your nursing home.

[Licensing and Certification District Offices:](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx)
<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx>

