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# Care Planning: Know Your Rights

## WHAT IS A CARE PLAN?

A care plan is a written plan of action that details a nursing home resident's personalized needs and level of care. Every resident has the right to receive and maintain the necessary care and services to achieve the "highest practicable physical, mental, and psychosocial well-being" through the design of a written care plan.

## RESIDENT RIGHTS

As the resident, you have the right to receive the best care possible, and be engaged in the care planning process, including the right to:

- Ask questions
- Engage your representatives
- Participate in care plan meetings
- Offer suggestions
- Review care plan documents
- Accept or refuse care
- Direct your own care plan
- Identify individuals to be included in the care planning process
- See the care plan
- Receive the care included in the plan
- Have personal and cultural preferences incorporated in the care plan
- Accept or refuse care at any time for any reason

## WHAT MAKES A CARE PLAN EFFECTIVE?

- It is comprehensive.
- It is person oriented.
- It is proactive and preventative.
- The resident participates in its formation.
- It is consistently monitored.

## DEVELOPING A CARE PLAN

**BASELINE CARE PLAN** – Facilities that participate in Medicare must complete a baseline care plan for each resident within 48 hours of admission.

**ASSESSMENT** – An assessment includes gathering information on the resident and must be done within 7 days of admission; reviews are held every 3 months.

**COMPREHENSIVE CARE PLAN** – This person-centered care plan replaces the baseline plan and must be established within 7 days of the assessment.

**DISCHARGE PLAN** – Facilities are required to develop and implement an effective discharge planning process.

## WHO SHOULD I CONTACT IF A PROBLEM PERSISTS?

- Your Nursing Home Administrator or Manager
- DC Health  
202-442-5955
- LCE Office of the DC Long-Term Care Ombudsman  
202-434-2190

[DCOmbuds@aarp.org](mailto:DCOmbuds@aarp.org)