481—71.14 (135G) Treatment plan.

71.14(1) A treatment plan must be developed with each resident. The plan must be based on initial and ongoing assessment of need, be designed to resolve the acute or crisis mental health symptoms or the imminent risk of acute or crisis mental health symptoms, and be completed within six hours of admission.

71.14(2) The treatment plan must be documented in the resident's record and must include the following:

a. The resident's name.

b. The date the plan is developed.

c. Standardized diagnostic formulations, including but not limited to the current Diagnostic and Statistical Manual (DSM) or the current International Statistical Classification of Diseases and Related Health Problems (ICD).

d. Problems and strengths of the resident that are to be addressed.

e. Observable and measurable individual objectives that relate to the specific problems identified.

f. Interventions that address specific objectives, identification of staff responsible for interventions, and planned frequency of interventions.

g. Signatures of mental health professionals responsible for developing the plan, including the qualified prescriber.

h. Signatures of the resident and any parent, guardian, conservator, or legal custodian. Reasons for refusal to sign or inability to participate in treatment plan development must be documented.

i. A projected discharge date and anticipated postdischarge needs, including documentation of resources needed in the community.

j. Review of the treatment plan by the appropriate treatment staff at least daily and upon completion of the stated goals or objectives and documentation of the following:

(1) Progress toward each treatment objective, with revisions as indicated; and

(2) Status of discharge plans, including availability of resources needed by the resident in the community, with revisions as indicated.

[**ARC 1740C**, IAB 11/26/14, effective 12/31/14]