LONG TERM CARE
SOCIAL WORKERS OF IOWA

SPRING CONFERENCE 2018

Gateway Hotel and Conference Center ~ Ames, Iowa
Thursday, April 5, 2018

New CMS Requirements of Participation (ROP) and Social Services

Catherine "Cat" Selman

Authority in Aging Services

AGENDA

Thursday, April 5, 2018

8:00 - 8:25 a.m.	Registration – Coffee, Fruit, Pastries
8:25 - 8:30 a.m.	Announcements
8:30 - 10:00 a.m.	*New CMS Requirements – Cat Selman*
10:00 - 10:15 a.m.	Break
10:15 -11:45 p.m.	*New CMS Requirements ~ Continued – Cat Selman*
11:45 -12:30 p.m.	Lunch
12:30 - 2:00 p.m.	*New CMS Requirements ~ Continued – Cat Selman*
2:00 - 2:15 p.m.	Break
2:15 - 3:45 p.m.	*New CMS Requirements ~ Continued – Cat Selman*
3:45 p.m.	Evaluations and Adjournment

This Program Complies with the Iowa Board of Social Worker Examiners Rules For Continuing Education, meeting 6.0 general continuing education contact hours.

LTCSWI 2018 SPRING CONFERENCE

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This intensive 1-day training will provide you with the information you need to be prepared for upcoming surveys, and familiarize you with the anticipated changes. Cat will be providing detailed instruction and guidance regarding specific survey focus for the new requirements, addressing facility practice and process. Learn as Cat provides guidance on systemic facility process and survey focus, as well as compliance and documentation recommendations. Cat has a reputation for explaining difficult topics in an easily understood, "common-sense," manner.

WORKSHOP GOALS AND OBJECTIVES

At the end of the session learner will be able to:

- Describe “medically-related social services” as defined by CMS.
- Describe the social service components of the Baseline Care Plan.
- Describe the social service components of the Comprehensive Care Plan.
- Describe the Social Worker’s responsibilities in regard to Discharge Planning.
- Describe the Social Worker’s responsibilities regarding Behavioral/Emotional Health & Reduction of Antipsychotics.

About Our Presenter…

Educator...Motivator... Communicator... Consultant...Author...

Catherine R. “Cat” Selman, BS, uses her dynamic personality and compelling presence to spread the message of positive, realistic, and common-sense strategies for the aging services professional. She presently serves as President and Co-owner of The Healthcare Communicators, Inc., a company specializing in continuing education for healthcare professionals. Ms. Selman received her degree from Trevecca Nazarene University, with continued graduate work at the University of Southern Mississippi. With over 35 years experience in management, education and consultation, Ms. Selman has trained providers and surveyors in all 50 states. Since 1989, she has often been requested by the Centers for Medicare and Medicaid Services (CMS) to sit on stakeholder/expert panels responsible for the revision of surveyor guidance and compliance issues. In demand, and on topic, she is considered an authority on aging services.

SOCIAL SERVICES & THE CMS ROP

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LTC REGULATION REVISIONS

1. Advances in theory
2. Practice of service delivery
3. Safety
4. Implement sections of the Affordable Care Act (ACA)
   Let's talk about this one and what the recent Presidential Executive Order means

LTC REGULATION REVISIONS

- These requirements have not been comprehensively updates since 1991, despite significant changes in the industry.
- The proposed rule received over 9,800 public comments, resulting in a number of revisions to the proposed requirements.

IMPROVEMENT

- Improve Key Areas of Residents' Life
  - ✓ Quality of Life
  - ✓ Health Care
  - ✓ Services
  - ✓ Patient Safety

Why Changes Have Been Made

- Substantial changes in the service and delivery of care
- Significant innovations in resident care
- Quality assessment practices
- More diverse residents
- Clinically complex residents

Themes of the Final Rule

- Person-Centered Care
- Quality
- Facility Assessment and Competency-Based Approach
- Competency of Staff
- Resident Rights
- Infection Control

Themes of the Final Rule

- Strengthened transfer/discharge protections
- Alignment with Current HHS Initiatives
- Comprehensive Review and Modernization
- Implementation of Legislation

PERSON-CENTERED CARE

Residents and Representatives: Informed, Involved and In Control.

- Existing protections maintained
- Choices
- Care & Discharge Planning

QUALITY

Quality of Care and Quality of Life - overarching principles for every service.

- Quality of Care and Quality of Life
  - ✓ Additional special care issues: restraints, pain management, bowel incontinence, dialysis services, and trauma-informed care.
- Quality Assurance and Performance Improvement
  - ✓ Based on the pilot.

FACILITY ASSESSMENT AND COMPETENCY-BASED APPROACH

Facilities need to know themselves, their staff, and their residents.

- Not a one-size fits all approach.
- Accounts and allows for diversity in populations and facilities.
- Focus on each resident achieving their highest practicable physical, mental, and psychosocial well-being.

Align with Current HHS Initiatives

Advancing cross-cutting priorities.

- Reducing unnecessary hospital readmissions,
- Reducing the incidences of healthcare-acquired infections,
- Improving behavioral healthcare, and
- Safeguarding nursing home residents from the use of unnecessary psychotropic (antipsychotic) medications.

Comprehensive Review and Modernization

Bringing it into the twenty-first century.

- Reorganized
- Updated
- Consistent with current health and safety knowledge

Regulation will be implemented in 3 phases

- **Phase 1**: Existing requirements that are relatively straightforward to implement and require minor changes to survey process *(November 28, 2016)*
- **Phase 2**: All Phase 1 requirements and those providers need more time to develop, foundational elements, and a new survey process to assess compliance *(November 28, 2017)*
- **Phase 3**: All Phase 1 and 2 components and requirements that need more time to implement (personnel hiring and training, implementation of systems approaches to quality) *(November 28, 2019)*

IMPLEMENTATION GRID

Implementation Date	Type of Change	Details of Change
Phase 1: November 28, 2016 (Implemented)	Nursing Home Requirements for Participation	New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags
Phase 2: November 28, 2017	F Tag numbering Interpretive Guidance (IG) Implement new survey process	New F Tags Updated IG Begin surveying with the new survey process
Phase 3: November 28, 2019	Requirements that need more time to implement	Requirements that need more time to implement

Regulatory Sections Overview

Key:
Fully Implemented in Phase 1
New Regulatory Section
Partially Implemented in Phase 1
No implementation in Phase 1

Resident Rights	Freedom from Abuse, Neglect & Exploitation	Admission, Transfer and Discharge Rights
Resident Assessment	Comprehensive, Person-Centered Care Planning	**Quality of Life**
Quality of Care	**Physician Services**	Nursing Services
Behavioral Health Services	Pharmacy Services	**Laboratory, radiology and other diagnostic services**
Dental Services	Food and Nutrition Services	**Specialized Rehabilitation Services**
Administration	Quality Assurance & Performance Improvement	Infection Control
Compliance & Ethics Program	Physical Environment	Training Requirements

PHASE 2 OF LTC REGULATIONS

- Implement by November 28, 2017
- Providers must be in compliance with Phase 2 regulations
- All States will use new computer–based survey process for LTC surveys
- All training on new survey process needs to be completed before go live date

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PHASE 2 OF LTC REGULATIONS (CONTINUED)

Phase 2 includes:

- Behavioral Health Services
- Quality Assurance and Performance Improvements (QAPI Plan Only)
- Infection Control and Antibiotic Stewardship
- Physical Environment – smoking policies

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PHASE 2 OF LTC REGULATIONS, CONTINUED

Phase 2 includes, but is not limited to:

- Resident Rights and Facility Responsibilities – Required Contact Information-
- Freedom from Abuse, Neglect, and Exploitation – 1150B Requirements of SS Act (reporting reasonable suspicion of a crime)
- Admission, Transfer, and Discharge Rights – Transfer/ Discharge Documentation

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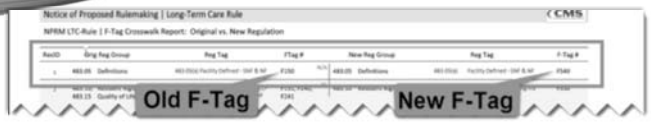
PHASE 2 OF LTC REGULATIONS, CONTINUED

Phase 2 includes, but is not limited to:

- Comprehensive Person-Centered Care Planning (Baseline Care Plan)
- Pharmacy Services – psychotropic medications (Drug regimen review and reporting – review of medical chart, definition of psychotropic medications)
- Dental Services – replacing dentures
- Administration – Facility Assessment – tied to sufficient and competent staff requirements

F TAG RENUMBERING



The image above is the F Tag Crosswalk currently under development. Will be available fall of 2017.

- The original regulatory grouping and the new associated grouping
- The original regulation number and the new associated regulation number
- The original F Tag and the associated new F Tag

F TAG RENUMBERING, CONTINUED


Notice of Proposed Rulemaking | Long-Term Care Rule

NPRM LTC-Rule | F-Tag Crosswalk Report: Original vs. New Regulation

RevID	Orig Reg Group	Reg Tag	FTag #		New Reg Group	Reg Tag	F-Tag #
1	483.05 Definitions	483.05(b)(c) Facility Defined - SNF & NF	F150	N/A	483.05 Definitions	483.05(b) Facility Defined - SNF & NF	F640
2	483.10, 483.15 Resident Rights; Quality of Life	483.10 Resident Rights; 483.10(a)(1)-(2) Right to Exercise Rights Free of Reprisal; 483.15 Care and Environment Promotes Quality of Life; 483.15(a) Dignity and Respect of Individuality	F151, F240, F241	F1	483.10 Resident Rights	483.10, 483.10(a)(1)-(2), 483.15(a) Resident Rights and Dignity	F550
3	483.10 Resident Rights	483.10(a)(3)-(4) Rights Exercised by Representative	F152	F2	483.10 Resident Rights	483.10(d)(3) Rights Exercised by Representative	F553
4	483.10 483.10 Resident Rights	483.10(b)(1) Informed of Health Status, Care & Treatments;483.10(b)(4) Right to Refuse; Formulate Advance Directives	F154, F155	F3	483.10 Resident Rights	483.10(c)(1), (4),(5) Right to be Informed/Make Treatment Decisions	F552
5	483.10, 483.20 Resident Rights Resident Assessment	483.10(b)(1) Informed of Health Status, Care & Treatments; 483.10(b)(3), Right to Participate Planning Care- Revise CP	F154, F280	F4	483.10 Resident Rights	483.10(c)(2) Right to Participate Planning Care	F553
6	483.10 Resident Rights	483.10(c) Resident Self-Administer Drugs if Deemed Safe	F176	F5	483.10 Resident Rights	483.10(c)(7) Resident Self-Administer Drugs if Deemed Safe	F554
7	483.10 Resident Rights	483.10(b)(4) Notice of Rights, Rules, Services, Charges; 483.10(d)(1) Right to Choose a Personal Physician	F156, F163	F6	483.10 Resident Rights	483.10(c)(6) Right to Choose/Be Informed of Personal Phys	F555
8	483.10 Resident Rights	483.10(e)	None	F7	483.10 Resident Rights	483.10(e)(1) Right to Have Personal Property	F557

NEW INTERPRETIVE GUIDANCE (IG)

- CMS is in the process of updating information for Appendices P and PP. Once the guidance is approved it will be available in the SOM.
- States should ensure surveyors use the most recent version of the regulation and IG
- CMS plans to release the Guidance in early summer 2017

WHY IS CMS CHANGING THE LTC SURVEY PROCESS?

- Two different survey processes existed to review for the Requirements of Participation (Traditional and QIS)
- Surveyors identified opportunities to improve the efficiency and effectiveness of both survey processes.
- The two processes appeared to identify slightly different quality of care/quality of life issues.
- CMS set out to build on the best of both the Traditional and QIS processes to establish a single nationwide survey process.

GROUP INTERVIEWS

Traditional	QIS	New Survey Process
• Meet with Resident Group/Council • Includes Resident Council minutes review to identify	• Interview with Resident Council President or Representative • Includes Resident Council minutes	• Resident Council Meeting with ***active*** members • Includes Resident Council minutes

RESIDENT COUNCIL MEETING

- Group interview with active members of the council
- Complete early to ensure investigation if concerns identified
- Refer to updated Pathway

RESIDENT COUNCIL MEETING

- The questions that are asked of the residents are different from the Traditional or QIS.
- The interview is focused on specific areas related to the functioning of the council and a few resident specific areas, such as abuse and sufficient staffing.
- In addition, surveyors can ask the group about any identified concerns from the survey.

Admission, Transfer, & Discharge

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Definitions

- **"Facility-initiated transfer or discharge":** A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.
- **"Resident-initiated transfer or discharge":** Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

Definitions

- **"Transfer and Discharge":** Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
- Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.
- Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

Transfers & Discharges

- In the following limited circumstances, facilities may initiate transfers or discharges**:**
  1. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.
  2. The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.
  3. The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.

Transfers & Discharges

- In the following limited circumstances, facilities may initiate transfers or discharges**:**
  4. The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.
  5. The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.
  6. The facility ceases to operate.

Transfers & Discharges

- Required documentation**:**
  - ✓ To demonstrate that any of the cirmcumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge.
  - ✓ This documentation must be made before, or as close as possible to the actual time of transfer or discharge.

Transfers & Discharges

Required documentation**:**

- For circumstances 1 and 2 above for permissible facililty-initiated transfer or discharge, the **resident's physician** must document information about the basis for the transfer or discharge.
- Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the **resident's physician must** include:

✓ The specific resident needs the facility could not meet;

✓ The facility efforts to meet those needs; and

✓ The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

Transfers & Discharges

Required documentation**:**

- In circumstances 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.
- **NOTE**: Documentation of the transfer or discharge may be completed by a non-physician practitioner (NPP) in accordance with State law.

F660 Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

F660 Discharge Planning Process

The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
- Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
- Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

F660 Discharge Planning Process

The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
- Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
- Address the resident's goals of care and treatment preferences.

F660 Discharge Planning Process

The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- Document that a resident has been asked about their interest in receiving information regarding returning to the community.
  - ✓ If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
  - ✓ Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
  - ✓ If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

F660 Discharge Planning Process

The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post- acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

F660 Discharge Planning Process

The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

- Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

Discharge Planning

- Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan.
- It involves the interdisciplinary team (as defined in §483.21(b)(2)(ii) working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting.
- Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge.

Discharge Planning

- It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions.
- A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition.
- An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.

Discharge Planning

- The discharge care plan is part of the comprehensive care plan and must:
  - ✓ Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;
  - ✓ Address the resident's goals for care and treatment preferences;

Discharge Planning

- The discharge care plan is part of the comprehensive care plan and must:
  - ✓ Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;
  - ✓ Be re-evaluated regularly and updated when the resident's needs or goals change;
  - ✓ Document the resident's interest in, and any referrals made to the local contact agency;
  - ✓ Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance.

F661 - Discharge Summary

- When the facility anticipates discharge, a resident must have a discharge summary that includes, *but is not limited to, the following*:
  - ✓ A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
  - ✓ A final summary of the resident's status to include items in paragraph *(b)(1) of §483.20,* at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
  - ✓ Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

F661 - Discharge Summary

- When the facility anticipates discharge, a resident must have a discharge summary that includes, *but is not limited to, the following*:
  - ✓ A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non- medical services.

F661 - Discharge Summary

- Content of Discharge Summary:
  - ✓ Recapitulation of the resident's stay describes the resident's course of treatment while residing in the facility. The recapitulation includes, but is not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results.

F661 - Discharge Summary

- Final Summary of Resident Status:
  - ✓ Identification and demographic information;
  - ✓ Customary routine;
  - ✓ Cognitive patterns;
  - ✓ Communication;
  - ✓ Vision;
  - ✓ Mood and Behavior patterns;

F661 - Discharge Summary

- Final Summary of Resident Status:
  - ✓ Psychosocial well-being;
  - ✓ Physical functioning and structural problems;
  - ✓ Continence;
  - ✓ Disease diagnoses and health conditions;
  - ✓ Dental and nutritional status
  - ✓ Skin condition;
  - ✓ Activity pursuit;

F661 - Discharge Summary

- Final Summary of Resident Status:
  - ✓ Medications;
  - ✓ Special treatments and procedures;
  - ✓ Discharge planning (as evidenced by most recent discharge care plan);
  - ✓ Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and
  - ✓ Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/ direct access staff members on all shifts.

F661 - Discharge Summary

- In addition to the above, pursuant to §483.15(c)(2)(iii), the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility:
  - ✓ Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident;
  - ✓ Resident representative information, if applicable, including contact information;
  - ✓ Advance directive information;
  - ✓ All special instructions or precautions for ongoing care, as appropriate;
  - ✓ Comprehensive care plan goals; and
  - ✓ All other necessary information, including a copy of the resident's discharge summary, consistent with 483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

Post-Discharge Plan of Care

- The post-discharge plan of care details the arrangements that facility staff have made to address the resident's needs after discharge, and includes instructions given to the resident and his or her representative, if applicable.
- The post-discharge plan of care must be developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the resident's representative.
- At the resident's request, a representative of the local contact agency may also be included in the development of the post-discharge plan of care.

Post-Discharge Plan of Care

- The post-discharge plan of care should show what arrangements have been made regarding:
  - ✓ Where the resident will live after leaving the facility;
  - ✓ Follow-up care the resident will receive from other providers, and that provider's contact information;
  - ✓ Needed medical and non-medical services (including medical equipment); • Community care and support services, if needed; and
  - ✓ When and how to contact the continuing care provider.

F622 - Transfer & Discharge

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- ✓ **The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
- ✓ **The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;**
- ✓ **The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;**

F622 - Transfer & Discharge

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- ✓ **The health of individuals in the facility would otherwise be endangered;**
- ✓ **The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or**
- ✓ **The facility ceases to operate.**

F623 - Notice before Transfer

Before a facility transfers or discharges a resident, the facility must—

- ✓ **Notify the resident and the *resident's* representative*(s)* of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**
- ✓ **Record the reasons for the transfer or discharge in the resident's medical record in *accordance with paragraph (c)(2) of this section*; and**
- ✓ **Include in the notice the items described in paragraph *(c)(5)* of this section.**

F623 - Notice before Transfer

Timing of Notice:

- ✓ **Except *as* specified in paragraphs *(c)(4)(ii) and (c)(8)* of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.**
- ✓ **Notice must be made as soon as practicable before transfer or discharge when—**
  - **The safety of individuals in the facility would be endangered under paragraph *(c)(1)(i)(C)* of this section;**
  - **The health of individuals in the facility would be endangered, under *paragraph (c)(1)(i)(D)* of this section;**

F623 - Notice before Transfer

Timing of Notice:

- ✓ **Notice must be made as soon as practicable before transfer or discharge when—**
  - **The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph *(c)(1)(i)(B)* of this section;**
  - **An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph *(c)(1)(i)(A)* of this section; or**
  - **A resident has not resided in the facility for 30 days.**

Discharge Critical Element Pathway

- Surveyors will use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident's discharge plan meets the need of the resident.

Discharge Critical Element Pathway

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – Discharge Status (A2100), C – Cognitive Patterns, G – Functional Status, and Q – Participation in Assessment and Goal Setting.
- Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).

Discharge Critical Element Pathway

Review the Following in Advance to Guide Observations and Interviews:

- Pertinent diagnoses.
- Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).

Discharge Critical Element Pathway

Observations:

- Does staff provide care for the resident as listed in the discharge plan? If not, what is different?
- How are staff providing education regarding care and treatments in the care plan?
- How does the resident perform tasks or demonstrate understanding after staff provides education?

Discharge Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- What are your discharge plans?
- What has the facility discussed with you about returning to the community or transitioning to another care setting?
- Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?

Discharge Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- What was your involvement in the development of your discharge plan?
- What has the facility talked to you about regarding post-discharge care?
- Ask about any discrepancies between the resident's discharge plan and the facility's discharge plan.

Discharge Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- If discharge is planned:
  - ✓ How did the facility involve you in selecting the new location? Did you have a trial visit, if feasible? How did it go;
  - ✓ How were your goals, choices, and treatment preferences taken into consideration;
  - ✓ What are your plans for post-discharge care (e.g., self-care, caregiver assistance);

Discharge Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- If discharge is planned:
  - ✓ What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable; and
  - ✓ What discharge instructions (e.g., medications, rehab, durable medical equipment needs, labs, contact info for home health, wound treatments) has the facility discussed with you? Were you given a copy of the discharge instructions? If applicable, did the facility have you demonstrate how to perform a specific procedure so that you can do it at home?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- What is the process for determining whether a resident can be discharged back to the community? How do you involve the resident or resident representative in the discharge planning? Do you make referrals to the Local Contact Agency when the resident expresses an interest in being discharged?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated?
- What is the resident's discharge plan, including post-discharge care?
- Why is the resident being discharged (i.e., for the resident's welfare and the resident's needs cannot be met in the facility, because the resident no longer required services provided by the facility, because the health or safety of the individual was endangered, or due to non-payment)?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? What does the new facility offer that can meet the resident's needs that you could not offer?
- Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location?
- For discharge summary concerns are noted, interview staff responsible for the discharge summary.
- How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?

Discharge Critical Element Pathway

Record Review:

- Did the facility ask the resident about their interest in receiving information regarding returning to the community? If not, why not?
- If the resident wants to return to the community, was there a referral to the local contact agency or other appropriate entities?
- If referrals were made, did the facility update the discharge plan in response to information received?
- If the resident cannot return to the community, who made the determination and why?

Discharge Critical Element Pathway

Record Review:

- Does the care plan adequately address the resident's discharge planning? Does it address identified needs, measureable goals, resident and/or resident representative involvement, treatment preferences, education, and post-discharge care? Has the care plan been revised to reflect any changes in discharge planning?
- Who from the IDT was involved in the ongoing process of developing the discharge plan?

Discharge Critical Element Pathway

Record Review:

- What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate?
- Is there documentation of the specific needs that could not be met, the attempts the facility made to meet the resident's needs, and the specific services the new facility will provide to meet the resident's needs?

Discharge Critical Element Pathway

Record Review:

- If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences.

Discharge Critical Element Pathway

Record Review:

- Did the facility provide a discharge summary to the receiving provider, which includes all required components at F661?
- Does the discharge summary include a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications? If not, describe what is missing.
- For residents discharged to the community, does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

Discharge Critical Element Pathway

Critical Element Decisions:

- Did the facility:
  - ✓ Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support;
  - ✓ Document that the resident was asked about their interest in receiving information about returning to the community;
  - ✓ Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital); and/or
  - ✓ If No, cite F660 (Discharge Planning Process)

Discharge Critical Element Pathway

Critical Element Decisions:

- Did the facility:
  - ✓ Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
  - ✓ Develop a post-discharge plan of care, including discharge instructions?
  - ✓ If No, cite F661 (Discharge Summary)

Discharge Critical Element Pathway

Critical Element Decisions:

- Does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., for the resident's welfare, the resident's needs could not be met in the facility, the resident no longer required services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates)? If No, cite F622 (Transfer & Discharge Requirements)

Discharge Critical Element Pathway

Critical Element Decisions:

- Was required discharge information documented in the resident's record and communicated to the receiving facility? If No, cite F622 (Discharge & Transfer Requirements)
- If this was a facility-initiated discharge, was the resident and resident representative notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)? If No, cite F623 (Notice before transfer)

Discharge Critical Element Pathway

Other Tags, Care Areas (CA) and Tasks to Consider:

- F 553 Participate in Care Plan
- F 580 Notification of Change
- F658 Professional Standards
- F745 Medically Related Social Services
- F842 Resident Records F842
- QAA/QAPI (Task)
- F624 Orientation for Transfer or Discharge

Deficiency Categorization - F660

Harm Level 4 - Immediate Jeopardy

- The facility failed to ensure that the post-discharge destination and continuing care provider could meet the resident's needs prior to the discharge of a resident with a feeding tube to a residential group facility. The surveyor discovered that within 24 hours of discharge, the resident was transferred to the hospital for aspiration, was intubated for respiratory distress and diagnosed with brain death. Review of medical records showed no documentation of the resident's tube feeding needs in the discharge plan, or whether the nursing home informed the receiving facility of the presence of the feeding tube and the need for aspiration precautions. It was also unclear whether the nursing home had determined that the receiving facility had the ability to care for a resident with a feeding tube prior to placement of the individual.

Deficiency Categorization - F660

Harm Level 3 - Actual Harm

- The facility failed to develop and/or implement a discharge care plan for a resident who had expressed a desire to return home as soon as possible once she completed rehabilitation for a fractured hip. The medical record revealed the therapist had discontinued the active treatment one week ago. The resident stated and the medical record verified that the facility had not developed plans for her care after her discharge and had not contacted any community providers to assist in her discharge. She indicated that she has not slept well due to worrying about returning to her home and paying the rent while in the facility. The resident's home was over an hour away. She stated she was depressed over having to remain in the nursing home, and spent most of the day in her room as it was too far for her friends to visit.

Deficiency Categorization - F660

Harm Level 3 - Actual Harm

- A facility failed to develop discharge plans to meet the needs and goals of each resident, resulting in significant psychosocial harm, when the facility determined it would be closing, necessitating the discharge of all residents. The facility notified residents and resident representatives it would assist with relocation. Interviews with residents and observations showed residents were agitated, fearful, and in tears over the impending move. Residents indicated they were not asked their preferences and many would be relocated far away from family. Residents also indicated they were not given opportunities to provide input into the discharge planning process, specifically regarding discharge location. Record review showed no evidence of interaction with residents or resident representatives related to discharge planning. This was cross-referenced and cited at F845, Facility Closure.

Deficiency Categorization - F660

Harm Level 2 - No Actual Harm

- Facility failed to develop a discharge care plan that addressed all of the needs for a resident being discharged home. Specifically, the care plan did not address the resident's need for an oxygen concentrator at home. After the resident was discharged to his home, a family member had to contact the physician to obtain the order and make arrangements for delivery of the equipment. Although there was a delay in obtaining the oxygen concentrator, the resident did not experience harm, however this four-hour delay had a potential for compromising the residents' ability to maintain his well-being.
- Severity Level 1 does not apply for this regulatory requirement.

Behavioral Health & Emotional Status

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F740 - Behavioral Health Services

- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

F740 - Behavioral Health Services

The facility must provide necessary behavioral health care and services which include:

- Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;
- Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.

F740 - Behavioral Health Services

The facility must provide necessary behavioral health care and services which include:

- Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;

F740 - Behavioral Health Services

The facility must provide necessary behavioral health care and services which include:

- Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;
- Ensuring that pharmacological interventions are only used when non- pharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.

F740 - Behavioral Health Services

In addition to the facility-wide approaches that address residents' emotional and psychosocial well-being, facilities are expected to ensure that residents' individualized behavioral health needs are met, through the Resident Assessment Instrument (RAI) Process.

F740 - Behavioral Health Services

All areas are to be addressed through the:

- ✓ Minimum Data Set (MDS);
- ✓ Care Area Assessment Process;
- ✓ Care Plan Development;
- ✓ Care Plan Implementation; and
- ✓ Evaluation

F740 - Behavioral Health Services

Sections of the MDS related to behavioral health needs that may be helpful include, but are not limited to:

- ✓ Section C. Cognitive Patterns;
- ✓ Section D. Mood;
- ✓ Section E. Behavior; and
- ✓ Section F . Activities.

F740 - Behavioral Health Services

- Utilizing Care Areas such as Psychosocial Well-Being, Mood State, and Behavioral Symptoms will also help to ensure the assessment and care planning processes are accomplished.
- It is also important for the facility to use an interdisciplinary team (IDT) approach that includes the resident, their family, or resident representative.

F740 - Behavioral Health Services

To cite deficient practice at F740, the surveyor's investigation will generally show that the facility failed to:

- ✓ Identify, address, and/or obtain necessary services for the behavioral health care needs of residents;
- ✓ Develop and implement person-centered care plans that include and support the behavioral health care needs, identified in the comprehensive assessment;
- ✓ Develop individualized interventions related to the resident's diagnosed conditions (e.g., assuring residents have access to community substance use services);

F740 - Behavioral Health Services

To cite deficient practice at F740, the surveyor's investigation will generally show that the facility failed to:

- ✓ Review and revise behavioral health care plans that have not been effective and/or when the resident has a change in condition;
- ✓ Learn the resident's history and prior level of functioning in order to identify appropriate goals and interventions;
- ✓ Identify individual resident responses to stressors and utilize person-centered interventions developed by the IDT to support each resident; or
- ✓ Achieve expected improvements or maintain the expected stable rate of decline based on the progression of the resident's diagnosed condition.

F740 - Deficiency Categorization

Harm Level 4 - Immediate Jeopardy

- ✓ The surveyor was able to determine through an interview with a certified nurse aide (CNA), that the resident often became anxious and agitated in the evenings and attempted to leave the facility on multiple occasions over the last three months. Last week, he left the facility for 30 minutes before being found by facility staff. While outside the nursing home, he fell, resulting in several abrasions and a laceration on his forehead and right knee, which required transfer to acute care. Review of the resident's record neglected to provide documentation of potential underlying causes for his anxiety and agitation.

F740 - Deficiency Categorization

Harm Level 4 - Immediate Jeopardy

- ✓ Nor did his care plan include any interventions to reduce his expressions of distress and deter elopement. This was confirmed through interviews with the social worker, director of nursing, and medical director. The attending physician also confirmed that the IDT had not discussed potential causes for the resident's anxiousness and agitation and had not developed interventions to resolve these concerns.
- ✓ The facility failed to investigate underlying causes of the resident's anxiety and agitation and failed to develop and implement individualized interventions for the resident, which led to numerous elopement episodes and injury.

F740 - Deficiency Categorization

Harm Level 3 - Actual Harm

- ✓ A resident was admitted to the facility with a diagnosis of post-traumatic stress disorder, from war related trauma. The resident assessment identified that certain environmental triggers such as loud noises and being startled caused the resident distress and provoked screaming. The resident's care plan identified that his environment should not have loud noises and that staff should speak softly to the resident. Observations in the home revealed that the entry and exit doors had alarms that sounded with a loud horn each time they were opened.

F740 - Deficiency Categorization

Harm Level 3 - Actual Harm

- ✓ Additionally, staff were observed approaching the resident from behind and shaking his shoulder to get his attention. The resident was startled and screamed for fifteen minutes. The director of nursing (DON) stated that they hoped he would eventually get used to living in the home.
- ✓ The facility identified triggers that were known to cause the resident distress and developed a care plan to support the resident's behavioral health care needs. However, the facility failed to implement the care planned approaches to care.

F740 - Deficiency Categorization

Harm Level 2 - No Actual Harm

- ✓ A resident with a diagnosed anxiety disorder preferred staff to announce themselves before entering his room. His care plan identified the non- pharmacological approach of staff knocking on his door and requesting permission before entering. This had proved effective in reducing his anxiety. When interviewed, the resident indicated that facility staff usually followed this direction. He feels anxious on weekends when the workers from a temporary staffing agency provide care, because they frequently enter his room without asking permission.

F740 - Deficiency Categorization

Harm Level 2 - No Actual Harm

- ✓ Although this increases his anxiety, he tries to live with it, but wished the nursing home would do something about it. During an interview, the DON mentioned that he was not aware of the resident's concern and that it was difficult to control all staff interactions with the resident. However, the DON agreed to investigate the situation and work to find a resolution.
- ✓ The facility failed to ensure that all staff members, both those employed by the nursing home and those from the staffing agency, respected the privacy of each resident by announcing themselves prior to entering resident rooms. This led to increased anxiety for the resident.
- ✓ Harm Level 1 does not apply to this requirement.

F741 - Sufficient Staff

The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e).

F741 - Sufficient Staff

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs may include, but are not limited to:

- ✓ Ensuring adequate hydration and nutrition (e.g., enhancing taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); exercise; and pain relief;
- ✓ Individualizing sleep and dining routines, as well as schedules to use the bathroom, to reduce the occurrence of incontinence, taking into consideration the potential need for increased dietary fiber to prevent or reduce constipation, and avoiding, where clinically inappropriate, the use of medications that may have significant adverse consequences (e.g., laxatives and stool softeners);

F741 - Sufficient Staff

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs may include, but are not limited to:

- ✓ Adjusting the environment to be more individually preferred and homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);
- ✓ Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment);

F741 - Sufficient Staff

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs may include, but are not limited to:

- ✓ Supporting the resident through meaningful activities that match his/her individual abilities (e.g., simplifying or segmenting tasks for a resident who has trouble following complex directions), interests, and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns (e.g., providing an early morning activity for a farmer used to waking up early);
- ✓ Utilizing techniques such as music, art, massage, aromatherapy, reminiscing; and
- ✓ Assisting residents with substance use disorders to access counseling programs (e.g., substance use disorder services) to the fullest degree possible.

Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Critical Element Pathway

Review the Following in Advance to Guide Observations and Interviews:

- ✓ **Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/ Prog – Psychological Therapy (O0400D).**
- ✓ **Physician orders.**
- ✓ **Pertinent diagnoses.**

Critical Element Pathway

Review the Following in Advance to Guide Observations and Interviews:

- ✓ **Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).**

Critical Element Pathway

Observations Across Various Shifts:

- ✓ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ✓ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ✓ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ✓ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?

Critical Element Pathway

Observations Across Various Shifts:

- ✓ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ✓ How does staff monitor the effectiveness of the resident's care plan interventions?

Critical Element Pathway

Observations Across Various Shifts:

- ✓ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ✓ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ✓ Awareness of current conditions or history of conditions or diagnoses.
- ✓ How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?
- ✓ How does the facility ensure approaches to care reflect your/the resident's choices and preferences?
- ✓ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?

Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ✓ **How are the resident's individual needs being met through person- centered approaches to care?**
- ✓ **What are your or the resident's concerns, if any, regarding the resident's mood?**
- ✓ **Have you or the resident had a change in mood? If so, please describe.**
- ✓ **What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.**
- ✓ **What other non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.**

Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ✓ **What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?**
- ✓ **What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility- specific guidelines/protocols? What is the rational for each intervention?**
- ✓ **How are the interventions monitored?**

Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ✓ **How do you ensure care is provided that is consistent with the care plan?**
- ✓ **How, what, when, and to whom do you report changes in condition?**
- ✓ **What types of behavioral health training have you completed?**
- ✓ **Ask about any other related concerns the surveyor has identified.**
- ✓ **How do you monitor for the implementation of the care plan and changes in the resident's condition?**

Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ✓ **How are changes in both the care plan and condition communicated to the staff?**
- ✓ **How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?**
- ✓ **Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.**

Critical Element Pathway

Record Review:

- ✓ **Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.**
- ✓ **Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.**
- ✓ **What is the time, duration, and severity of the resident's expressions or indications of distress?**

Critical Element Pathway

Record Review:

- ✓ **What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?**
- ✓ **What non-pharmacological approaches to care are used to support the resident and lessen their distress?**
- ✓ **What PASARR Level II services or psychosocial services are provided, as applicable?**

Critical Element Pathway

Record Review:

- ✓ **Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?**
- ✓ **Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?**

Critical Element Pathway

Record Review:

- ✓ **Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?**
- ✓ **Was behavioral health training provided to staff?**

Critical Element Decisions

1. **Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care? If No, cite F740**
2. **Does the facility have sufficient and competent direct care staff to provide nursing and related services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment? If No, cite F741**

Critical Element Decisions

3. **Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD)?If No, cite F742**
   NA, the resident does not display or is not diagnosed with a mental or psychosocial adjustment difficulty, or does not have a history of trauma and/or PTSD.

Critical Element Decisions

4. **Did the facility ensure that the resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable? If No, cite F743**
   NA, the resident's assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

Critical Element Decisions

5. **For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand? If No, cite F655**
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

Critical Element Decisions

6. **If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition? If No, cite F636. NA, condition/ risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.**

Critical Element Decisions

7. **If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant? If No, cite F637**
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

Critical Element Decisions

8. **Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)? If No, cite F641**

Critical Element Decisions

9. **Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences? If No, cite F656**
   NA, the comprehensive assessment was not completed.

Critical Element Decisions

10. **Did the facility reassess the effectiveness of the interventions and, review and revise the resident's care plan (with input from the resident, or resident representative, to the extent possible), if necessary to meet the resident's needs?**
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Critical Element Decisions

Other Tags, Care Areas (CA), and Tasks (Task) to Consider:

- ✓ **F550 Resident Rights**
- ✓ **(CA) Abuse**
- ✓ **F635 Admission Orders**
- ✓ **F658 Professional Standards**
- ✓ **F659 Qualified Staff F659**
- ✓ **(CA) PASARR**
- ✓ **Sufficient and Competent Staff (Task)**
- ✓ **F745 Social Services**
- ✓ **Unnecessary/Psychotropic Medications (CA)**
- ✓ **F842 Resident Records**

CMS RoP and Surveyor Guidance for Medically-Related Social Services

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CMS Requirements

F745: The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

"Medically-related social services" means services are provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health.

- All facilities are required to provide medically-related social services for each resident.
- Facilities must identify the need for medically-related social services and ensure that these services are provided.
- It is not required that a qualified social worker necessarily provide all of these services, except as required by State law.

- 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:
  - ➡ Be developed within 48 hours of a resident's admission.
  - ➡ Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    - ✓ Initial goals based on admission orders.
    - ✓ Physician orders.
    - ✓ Dietary orders.
    - ✓ Therapy services.
    - ✓ Social Services.
    - ✓ PASARR recommendations, if applicable.

Examples of medically-related social services

- Advocating for residents and assisting them in the assertion of their rights within the facility in accordance with §483.10, Resident Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Transitions of Care, §483.20, Resident Assessments (PASARR), and §483.21, Comprehensive Person-Centered Care Planning;

Examples of medically-related social services

- Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs;
- Assisting or arranging for a resident's communication of needs through the resident's primary method of communication or in a language that the resident understands;

Examples of medically-related social services

- Making arrangements for obtaining items, such as clothing and personal items;
- Assisting with informing and educating residents, their family, and/or representative(s) about health care options and ramifications;

Examples of medically-related social services

- Making referrals and obtaining needed services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);
- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);

Examples of medically-related social services

- Transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);

Examples of medically-related social services

- Providing or arranging for needed mental and psychosocial counseling services;
- Identifying and seeking ways to support residents' individual needs through the assessment and care planning process;

Examples of medically-related social services

- Encouraging staff to maintain or enhance each resident's dignity in recognition of each resident's individuality;

Examples of medically-related social services

- Assisting residents with advance care planning, including but not limited to completion of advance directives (For additional information pertaining to advance directives, refer to §483.10(g)(12) (F578)), Advance Directives);

Examples of medically-related social services

- Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident; and

Examples of medically-related social services

- Meeting the needs of residents who are grieving from losses and coping with stressful events.

Examples of medically-related social services

Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following:

- Lack of an effective family *or community* support system *or legal representative*;

Examples of medically-related social services

- Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations;

Examples of medically-related social services

- Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);

Examples of medically-related social services

- Difficulty coping with change or loss (e.g., change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one); and
- Need for emotional support.

Examples of medically-related social services

- NOTE: When needed services are not covered by Medicaid, nursing facilities are still required to attempt to obtain these services on behalf of the resident (e.g., arranging transportation services).

Other requirements of possible impact…

- F559 - Right to share a room…
- F600 - Staff/visitor/family/ resident abuse of any type
- F684 - Quality of Care

Other requirements of possible impact…

- Care Planning - Activities/ Psychosocial Needs - Care plan interventions for activities must be based on the resident's assessment and include the resident's choices, personal beliefs, interests, ethnic/ cultural practices and spiritual values, as appropriate. In addition, the resident's assessment may identify psychosocial needs, such as fear, loneliness, anxiety, or depression. Interventions to address the needs must be included in the plan of care.

Other requirements of possible impact…

F698 - Dialysis

- A resident may choose to receive dialysis at a dialysis facility located off site or in a separately certified dialysis unit located within the facility. The choice of the dialysis provider is made by the resident/ resident representative. The nursing home must assist the resident to assure that arrangements are provided for safe transportation to and from the dialysis facility.

Other requirements of possible impact…

F791 - Dental Services

- Surveyor is to determine whether the facility provided medically-related social services by addressing any unmet needs related to dental/denture or oral care.

Other requirements of possible impact…

F849 - Hospice Services

- If an additional concern has been identified, the surveyor must investigate the identified concern. They will not cite any related or associated requirements before first conducting an investigation to determine compliance or non-compliance with the related or associated requirement.

Questions & Answers

Should any participant have questions regarding this topic, please send an email to catselman@aol.com. Cat will share Q & As with all participants.

We appreciate your participation in this webinar! We have MORE coming in 2018! Please keep checking our website for updates and additions. www.thehealthcarecommunicators.com

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