Best Practices for Speech Evaluations

Question: If a patient has orders/clinical needs for both swallow and speech/language/cognition upon admission what is the best practice recommendations?

1. Day 1 – Complete a thorough dysphagia evaluation/POC in SMART
    a. Include standardized assessment, bedside evaluation
    b. Bill both evaluation and treatment codes for this session as clinically indicated
2. Day 2 – complete thorough speech language/cognition evaluation
    a. Initiate a Supplemental Plan of Care in SMART
    b. Complete the evaluation and bill both the evaluation and treatment codes as clinically indicated
    c. Include standardized assessment
    d. Provide treatment for dysphagia as clinically indicated
    e. Evaluation minutes for the speech language/cognition will NOT count toward MDS minutes
3. Day 3 – proceed with treatment for both
    a. Bill treatment CPT codes for both dysphagia and cog/speech language as clinically indicated
    b. All treatment minutes will count toward the MDS submission

Question: How do I add assessment information if I receive orders for Dysphagia after I have initiated the POC for Cognition/Speech language – or in reverse?

1. Initiate a Supplemental Plan of Care in SMART
2. Complete a comprehensive assessment
3. All goals/information from initial POC and Supplemental POC will merge together on the next schedule document (Progress Note or UPOC).
4. If a UPOC is due at the same time you are completing the new evaluation (SPOC) then you need to complete the SPOC first.
    ✓ After completing SPOC – sync/save and then initiate the UPOC (with goals from both original POC and SPOC) – which will establish the new certification period

Critical Element Pathways Resources: CMS has updated the Critical Element Pathways to align with the new regulations and survey process. The Critical Element Pathways focus on care and services provided. These are the tools that surveyors will follow.

- Nutrition Critical Element Pathway
- Specialized Rehabilitative or Restorative Services Critical Element Pathway
- Hydration Critical Element Pathway
- Tube Feeding Status Critical Element Pathway
- Dementia Care Critical Element Pathway
- Behavioral and Emotional Status Critical Element Pathway

Nutrition Critical Element Pathway

Use this pathway for a resident who is not maintaining acceptable parameters of nutritional status or is at risk for impaired nutrition to determine if facility practices are in place to identify, evaluate, and intervene to prevent, maintain, or improve the resident's nutritional status, unless the resident's clinical status demonstrates that this is not possible, or resident preferences indicate otherwise.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, G – Functional Status-eating ability (G0110H), K – Swallowing/Nutritional Status, L – Oral/Dental Status, and O – Special Treatment/Proc/Prog-SLP (O0400A) and OT (O0400B).
- ☐ Physician's orders (e.g., food allergies/intolerances and preferences, nutritional interventions [e.g., supplements], assistance with meals, type of diet [e.g., mechanically altered], therapeutic diet [e.g., low sodium diet], weight monitoring, meds [e.g., psychotropic meds, diuretics], and labs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., nutritional interventions, assistance with meals, assistive devices needed to eat, type of diet, therapeutic diet, food preferences, or pertinent labs).

Observations:

- ☐ Observe the resident at a minimum of two meals:
  - o Are the resident's hands cleaned before the meal if assisted by staff;
  - o Is the diet followed (texture, therapeutic, and preferences);
  - o Are proper portion sizes given (e.g., small or double portions);
  - o Is the resident assisted (with set-up and eating, positioning, supervision, etc.), cued, and encouraged as needed;
  - o Are assistive devices in place and used correctly (e.g., plate guard, modified utensils, sippy cups);
  - o If the resident isn't eating or refuses: What does staff do (e.g., offer substitutes, encourage, or assist the resident); and
  - o How is the dignity of the resident maintained?
- ☐ Are care-planned and ordered interventions in place?
- ☐ Is the call light in reach if the resident is eating in their room?
- ☐ Are there environmental concerns that may affect the resident during meals, such as loud or distracting noises, the inability to reach snacks kept in their room, or other concerns?
- ☐ Does the resident's physical appearance indicate the potential for an altered nutritional status (e.g., cachectic, dental problems, edema, no muscle mass or body fat, decreased ROM, or coordination in the arms/hands)?
- ☐ How physically active is the resident (e.g., pacing or wandering)?
- ☐ Are supplements provided and consumed at times that don't interfere with meal intake (e.g., supplement given right before the meal and the resident doesn't eat the meal)?
- ☐ Are snacks given and consumed as care planned?
- ☐ Is the resident receiving OT, SLP, or restorative therapy services? If so, are staff following their instructions (e.g., head position or food placement to improve swallowing)?
- ☐ Is there any indication that the resident could benefit from therapy services that are not currently being provided (difficulty grasping utensils, difficulty swallowing)?
- ☐ If a resident is receiving nutrition with a feeding tube, observe for positioning, type of tube feeding, whether a pump or gravity is being used, and the rate and amount being provided.

Nutrition Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How did the facility involve you in the development of your care plan and goals?
- ☐ Have you lost weight in the facility? If so, why do you think you've lost weight (e.g., taste, nausea, dental, grief, or depression issues)?
- ☐ What is the facility doing to address your weight loss? (Ask about specific interventions – e.g., supplements.)
- ☐ Do they give you the correct diet, snacks, supplements, and honor your food preferences/allergies? If not, describe.
- ☐ If you don't want the meal, does staff offer you a substitute?
- ☐ Does staff set up your meal, assist with eating, or encourage you as needed? If not, describe.
- ☐ Do you have difficulty chewing or swallowing your food? If so, how is staff addressing this?
- ☐ Do they give you assistive devices so you can be as independent as possible? If not, describe.
- ☐ Do they give you enough time to eat? If not, describe.
- ☐ Do your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances? If not, describe.
- ☐ How does staff involve you in decisions about your diet, food preferences, and where to eat?
- ☐ If you know the resident has refused: What did the staff tell you about what might happen if you don't follow your plan to help maintain your weight?
- ☐ Are you continuing to lose weight? If so, why do you think that is?

Nursing Aide, Dietary Aide or Paid Feeding Assistant:

- ☐ Are you familiar with the resident's care?
- ☐ Where does the resident eat?
- ☐ How much assistance does the resident need with eating?
- ☐ How do you encourage the resident to feed him/herself when possible?
- ☐ Are any supplements given with the meal?
- ☐ How are meal intakes, supplements and weights monitored?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Do you know if the resident has lost weight? Has the treatment plan changed?
- ☐ Have you reported any changes in the resident's weight or intake? Who would you report this to?
- ☐ Ask about identified concerns.

Nurse:

- ☐ Are you familiar with the resident's care?
- ☐ How much assistance does the resident need with eating?
- ☐ How are meal intakes, supplements, and weights monitored? Where is it documented?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Has the resident lost weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Nutrition Critical Element Pathway

Registered Dietitian or Dietary Manager:

- ☐ Who is involved in evaluating and addressing any underlying causes of nutritional risks or impairment?
- ☐ Does the resident require any assistance with meals?
- ☐ Is the resident at risk for impaired nutritional status? If so, what are the risk factors?
- ☐ Has the resident had a loss of appetite, or any GI, or dental issues? If so, what interventions are in place to address the problem?
- ☐ Has the resident lost any weight recently? When did the weight loss occur? What caused it?
- ☐ If the resident's weight loss is recent: Who was notified and when were they notified?
- ☐ Were any interventions in place before the weight loss occurred?
- ☐ Have you seen the resident eat? What meal? Did he/she eat all the meal?
- ☐ What are you doing to address the weight loss?
- ☐ How often is the resident's food/supplement intake, weight, eating ability monitored? Where is it documented?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident/representative in decisions regarding treatments? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident continuing to lose weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you communicate nutritional interventions to the staff?
- ☐ Ask about identified concerns.
- ☐ Who from the Food and Nutrition staff attends the interdisciplinary team meetings?

Practitioner or other Licensed Health Care Practitioner Interviews: If the interventions defined, or the care provided, appear to be inconsistent with current standards of practice, orders, or care plan, interview one or more practitioners or other licensed health care practitioners who can provide information about the resident's nutritional risks and needs.

- ☐ What was the rationale for the chosen interventions?
- ☐ How is the effectiveness of the current interventions evaluated?
- ☐ How have staff managed the interventions?
- ☐ How does the interdisciplinary team decide to maintain or change interventions?
- ☐ What is the rationale for decisions not to intervene to address identified needs?

Nutrition Critical Element Pathway

Record Review:

- ☐ Review the MDS and CAAs, nursing notes, nutritional assessment and notes, rehab, social service, and physician's progress notes.
  - o Have the resident's nutritional needs been assessed (e.g., calories, protein requirement, UBW, weight loss, desired weight range);
  - o Was the cause of the weight loss identified; and/or
  - o Is the rationale for chosen interventions or no interventions documented?
- ☐ Are the underlying risk factors identified (e.g., underlying medical, psychosocial, or functional causes)?
- ☐ Have the medications been reviewed for any impact affecting food intake?
- ☐ Have relevant care plan interventions been identified and implemented to try to stabilize or improve nutritional status?
- ☐ Does the care plan identify the resident's individualized goals, preferences, and choices?
- ☐ How often are food/supplement intakes monitored and documented? Are deviations identified?
- ☐ How often are weights monitored and documented? Are deviations identified?
- ☐ Are preventative measures documented prior to the weight loss?
- ☐ Was a health care provider's order obtained for a therapeutic diet, if applicable?
- ☐ Review laboratory results pertinent to nutritional status (e.g., albumin and pre-albumin) if ordered or available.
- ☐ Has the care plan been revised to reflect any changes in nutritional status?
- ☐ Do your nutritional observations match the description in the clinical record? If no, interview pertinent staff to investigate the potential discrepancy(ies).
- ☐ 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?
- ☐ Review the facility policy with regard to nutritional status.
- ☐ If there is a pattern of residents who have not maintained acceptable parameters of nutritional status without adequate clinical justification, determine if Quality Assurance and Performance Improvement (QAPI) activities were initiated to evaluate the facility's approaches to nutrition and weight concerns.

Critical Element Decisions:

1) Did the facility provide care and services to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible, and did the facility ensure that the resident is offered and ordered a therapeutic diet if there is a nutritional problem?
   If No, cite F692

2) If there was a change in the resident's nutritional status, did the physician evaluate and address medical and nutritional issues related to the change?
   If No, cite F710

Nutrition Critical Element Pathway

3) 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.

4) 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.

5) 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.

6) 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

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a 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.

8) 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.

Nutrition Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to Refuse F578, Notification of Change F580, Choices (CA), Accommodation of Needs (Environment Task), Parenteral/IV fluids F694, Physician Delegation to a Dietitian F715, Social Services F745, Admission Orders F635, Professional Standards F658, Advance Directives (CA), ADLs (CA), Behavioral-Emotional Status (CA), Accidents (CA), Tube Feeding (CA), Hydration (CA), Unnecessary/Psychotropic Medications (CA), Provides Diet to Meet Needs F800, Qualified Dietary Staff F801, Food in Form to Meet Needs F805, Therapeutic Diet Ordered F808, Assistive Devices F810, Paid Feeding Assistant F811, Physician Services F710, Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Use this pathway for a resident to ensure the facility obtains and provides necessary rehabilitative or restorative services.

As referenced in 42 CFR §483.65 - Specialized rehabilitative services include but are not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), and are required in the resident's comprehensive plan of care.

As referenced in Section O of the MDS/RAI manual - Restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C - Cognitive Patterns, G – Functional Status, H – Bladder and Bowel, J – Health Conditions-Pain, and O – Special Treatment/Proc/Prog-Therapies (O0400) and Restorative Nursing Programs (O0500).
- ☐ Physician's orders (e.g., therapy which includes type of treatment, frequency and duration, restorative, ADL, and contracture needs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., ADL assistance, premedication prior to therapy, therapy interventions, or restorative approach).

Observations:

- ☐ As soon as possible, observe resident receiving therapy services as required per their assessment and plan of care:
  - Were the services provided as prescribed in the care plan and as ordered?
  - How did the therapy staff take into account the resident's risk factors when providing services (e.g., orthostatic hypotension, hip replacement precautions)?
  - How does staff encourage the resident to participate to the extent possible?
  - How are staff interacting with the resident when providing these services?
  - How much staff assistance is provided to perform tasks?
- ☐ If assistive devices are needed per the care plan and orders, are these devices used correctly and assist the resident to maximize his/her independence? How are residents encouraged to use these devices on a regular basis?
- ☐ If Passive Range of Motion (PROM) exercises are performed, are resident's joints supported and extremities moved in a smooth steady manner to the point of resistance? If not, describe.
- ☐ If a resident expressed that he/she was experiencing pain during these services, how did staff address this?
- ☐ Are therapists treating more than one resident at a time? If so, how is the resident receiving the ordered services needed to improve the resident's function (e.g., therapy is doing exercises in a group and the resident only received two minutes of devoted time)?

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How and by whom were you informed regarding the therapy services you need?
- ☐ What services are your receiving and do you understand why you are receiving these services?
- ☐ With who and how did staff discuss your treatment plan and goals with you and were you allowed to provide input or changes to this plan and the goals?
- ☐ If you refused any of these services, did someone speak with you about the consequences of not receiving these services? If so, who spoke with you?
- ☐ How often and for how long do you receive these services and do you feel you have enough time during therapy to assist you in achieving your goals?
- ☐ Do you feel these services are helping you to improve? If not, why?
- ☐ Do you experience pain during therapy services? If so, what does staff do to help you relieve your pain and is this effective?
- ☐ If staff provided you with assistive devices (e.g., reacher, mobility devices, communication devices, special eating utensils):
  - o Did someone show you how to use the device? If so, who?
  - o Do you use it? If not, why not?
  - o Do you have these devices when you need them? If not, why not?
  - o Does staff encourage you to use the device?

Staff Interviews (Nursing Aides, Nurse, Therapy, DON):

- ☐ What are the current goals and interventions for the resident?
- ☐ How were the interventions determined to ensure they were suitable for the resident's needs?
- ☐ How was the resident/representative involved in decisions regarding their goals, interventions, and treatments?
- ☐ How and by whom were you trained on the resident's therapy or restorative program needs?
- ☐ How and by whom are therapy and nursing staff supervised and monitored to ensure they are implementing care planned interventions?
- ☐ How much assistance from staff does the resident need with their therapy or restorative services?
- ☐ How do you promote and encourage the resident's participation in these services?
- ☐ How often and how is the resident assessed (e.g., quarterly therapy screen) for a change in function and where is it documented?
- ☐ Does the resident have pain or shortness of breath? If so, who do you report it to and how is it being treated?
- ☐ Does the resident ever refuse therapy or restorative services? If so, why and how is this handled?
- ☐ How do you assess if the resident's ability is maintained, improving, or getting worse?
- ☐ If a resident is declining, when did this decline begin? What might have caused this decline? To whom and when was this decline reported and did the treatment plan change?
- ☐ Were there any therapy or restorative interventions in place before the decline developed? If so, what were these interventions and why did they not prove to be effective?
- ☐ Does the resident use any assistive devices? If so, what are these devices and why are they used? How is the resident educated and encouraged to use these devices?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Record Review:

- ☐ How did facility staff assess the resident's therapy and restorative status and needs?
  - o Has the resident's progress including improvement or decline been assessed and documented?
  - o Were the care plan and interventions revised to reflect any changes needed?
- ☐ Were therapy or restorative services provided and implemented as ordered?
- ☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- ☐ 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?
- ☐ Does your observation of therapy or restorative services match the level of assistance described in the resident's plan of care and clinical record? If not, describe.
- ☐ Were changes in the resident's status or other risks correctly identified and communicated with the resident, staff, and the attending practitioner?

Critical Element Decisions:

1. Based on observations, interviews, and record review, did the facility provide or obtain the required specialized rehabilitative services?
   If No, cite F825
   NA, the resident does not require specialized rehabilitation services.

2. Based on observations, interviews, and record review, did the facility provide the appropriate treatment and services as outlined in the resident's plan of care to maintain, restore or improve the functional ability for the resident?
   If No, cite F676
   NA, the resident does not have a potential to maintain or improve ADL functioning.

3. 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.

4. 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.

5. 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.

6. 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

7. 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.

8. 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

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed F552, Choices (CA), Notification of Change F580, Privacy (CA), Abuse (CA), Dignity (CA), Social Services F745, Admission Orders F635, Professional Standards F658, Community Discharge (CA), Pain (CA), Positioning/ROM (CA), ADLs (CA), Behavioral-Emotional Status (CA), Sufficient and Competent Staff (Task), Physician Delegation to Therapist F715, Qualified Rehab Person F826, Infection Control (Task), Resident Records F842, QAA/QAPI (Task).

Hydration Critical Element Pathway

Use this pathway for a resident at risk for or who has experienced dehydration.

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 C - Cognitive Patterns, G - Functional Status, J – Health Conditions-Problem Conditions (J1550), K – Swallowing/Nutritional Status, L – Oral/Dental Status, N – Medications, and O – Special Treatment/Proc/Prog-Hospice (O0100K) or dialysis (O0100J).
- ☐ Physician's orders (e.g., fluid restrictions, intake and output monitoring, IV (parenteral) fluids, fluid consistency, labs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., risk factors, preventative care to promote a specific amount of fluid intake each day, monitoring of daily fluid intake and when to report deviations, staff assistance or encouragement needed to meet hydration needs, minimizing aspiration risk, assistive devices needed for drinking skills, hydration interventions to provide fluid intake between and with meals that account for resident preferences and assessment, rehab or restorative to promote improvement in ability to drink, interventions to accommodate fluid restrictions or intolerances, and interventions to address refusals).

Observations:

- ☐ Observe for signs that indicate altered hydration status:
  - o Decreased, absent, or concentrated urine output
  - o Complaints of dry eyes
  - o Poor oral health
  - o Poor skin elasticity
  - o Dry chapped lips, tongue dryness, longitudinal tongue furrows, dryness of mucous membranes
  - o Sunken eyes
- ☐ How are care planned and ordered interventions implemented?
- ☐ Are IV fluids being given? If so, are staff following the order?
- ☐ Are residents able to access fluids (e.g., fluids at the bedside, staff offering and encouraging fluids throughout the day, opening fluids at meals)?
- ☐ Does staff assist the resident to drink fluids if needed during meals and throughout the day? If not, describe.
- ☐ Are assistive drinking cups provided, if needed? If not, describe.
- ☐ How does staff respond if the resident refuses fluids or assistance?
- ☐ Are staff alert to the reduced fluid intake and how do they respond?

Resident, Resident Representative, or Family Interview:

- ☐ Do you have any concerns with persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions, or acute illness? If so, describe.
- ☐ Can you tell me about any recent change in your condition or how you feel (e.g., sudden confusion)?
- ☐ Are you taking meds that affect your taste (e.g., chemotherapy, digoxin, antibiotics)? Have your meds changed recently?
- ☐ How did the facility ensure your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances?
- ☐ Does staff encourage you or help you, as necessary, to drink throughout the day? Please explain.
- ☐ Has your ability to drink changed? Are you getting therapy or restorative to help increase your ability to drink on your own? How is it going?

Hydration Critical Element Pathway

- ☐ Can you tell me about any dental issues, oral pain or other pain that is interfering with your fluid consumption?
- ☐ If the resident was treated for dehydration or has poor fluid intake: Why do you think you were dehydrated or don't drink enough?
- ☐ How did the facility involve you in the development of the care plan and goals?
- ☐ Do they provide you with assistive devices if you need it? If not, what concerns are you having?
- ☐ If you refuse fluids, what does staff do? What education have they provided on consequences of refusing fluids?

Staff Interviews (Nursing Aides, Dietary Staff, Nurses, DON):

- ☐ How do you monitor the resident's fluid intake, including enteral feeding if applicable?
- ☐ What potential hydration deficits has the resident experienced (skin lacks elasticity, persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions or acute illness, reduced sense of thirst, poor fluid intake)?
- ☐ What other limitations or factors impact the resident's hydration (e.g., difficulty getting to the bathroom, medications (diuretics), dialysis, restraint use, fluid restriction, or end of life)?
- ☐ How much assistance or encouragement does the resident need to drink?
- ☐ How do you ensure the resident is provided with adequate fluids?
- ☐ What, when, and to whom do you report changes in fluid intake?
- ☐ What have you done to address the resident's refusal to drink (e.g., provide liquids in a different form like popsicles, or soup)?
- ☐ Who from the dietary staff attends the IDT meetings?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Record Review:

- ☐ What new or existing conditions or diagnoses does the resident have that affect overall intake?
  - o Malnutrition, dehydration, cachexia, or failure-to-thrive.
  - o Problems with teeth, mouth, gums, or swallowing problems.
  - o Decreased kidney function or urine output, renal disease.
  - o Decreased thirst perception, increased thirst, change in appetite, anorexia.
  - o Cognitive or functional impairment (e.g., dysphagia, dependency on the staff for ADLs, inability to communicate needs).
  - o Terminal, irreversible, or progressive conditions (e.g., incurable cancer, severe organ injury or failure, AIDS).
  - o Constipation, impactions or diarrhea.
- ☐ Did the facility adequately assess the resident's hydration status?
  - o Baseline hydration status (height, weight, BMI).
  - o Underlying factors affecting hydration status.
  - o Calculation of fluid needs based on clinical condition, including free water for enteral feedings.
  - o Adequacy of fluid intake.
- ☐ Do lab values suggest dehydration (ratios of BUN to creatinine of 25 or more, serum sodium level greater than 148 mmol/L)? If so, describe.
- ☐ What interventions were implemented to address the dehydration (e.g., IV fluids)?

Hydration Critical Element Pathway

- Pressure ulcers and other chronic wounds, fractures.
- COPD, pneumonia, diabetes, cancer, hepatic disease, CHF, infection, fever, nausea/vomiting, orthostatic hypotension, hypertension.
- Psychiatric concerns, significant changes in behavior or mood.
- Lethargy or confusion.

☐ 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?

☐ Did the facility identify the factors contributing to or causing the resident to refuse? What alternative efforts were made to address hydration needs?

☐ How does staff monitor I&O if the resident is on fluid restrictions and it's ordered?

☐ How are staff monitoring the resident's fluid intake at meals?

☐ Is the resident receiving therapy or restorative as ordered? If not, describe.

☐ Is the care plan comprehensive? How did the resident respond to care planned interventions? If interventions weren't effective, was the care plan revised?

Critical Element Decisions:

1. Based on observation, interviews, and record review, did the facility provide each resident with sufficient fluid intake to maintain proper hydration and health?
   If No, Cite F692

2. 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 or 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.

3. 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.

4. 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.

5. 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

6. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a 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.

7. 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.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Participate in Planning Care F553, Notification of Changes F580, Parenteral/IV Fluids (F694), Advanced Directives (CA), ADLs (CA), Physician Supervision F710, Physician Delegation to Dietitian/Therapist F715, Food and Drink F807, Resident Records F842, QAA/QAPI (Task).

Tube Feeding Status Critical Element Pathway

Use this pathway for a resident who has a feeding tube.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C – Cognitive Patterns, G – Functional Status, J – Health Conditions, K – Swallowing/Nutritional Status, and O – Special Treatments, Procedures, and Programs.
- ☐ Physician's orders (e.g., kind of feeding and its caloric value, volume, rate, duration, and mechanism of administration [e.g., gravity or pump], water flushes, medications, therapy or restorative for swallowing or feeding skills).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., order for tube feeding; oral care; alternatives if the resident refuses or resists staff interventions to consume foods, fluids or enteral feedings; monitoring intake of foods and fluids daily and when to report deviations; how often weights are to be monitored if weight falls out of usual body weight parameters; rehabilitative/restorative interventions and specific measures, such as assistive devices, to promote involvement in improving functional skills; and the necessary interventions to prevent complications from the tube feeding such as aspiration, dislodgment, infection, pneumonia, fluid overload, fecal impaction, diarrhea, nausea, vomiting).

Observations:

- ☐ When does staff initiate, continue, and terminate feedings?
- ☐ Does the resident's level of alertness and functioning permit oral intake? If not, describe.
- ☐ Are assistive devices and call bells available for the resident who is able to use them? How does staff provide assistance for the resident who is dependent?
- ☐ How does staff try to minimize the risk for complications including:
  - o Physical complications (aspiration, leaking around the insertion site, intestinal perforation, abdominal wall abscess or erosion at the insertion site);
  - o Implementing interventions to minimize the negative psychosocial impact that may occur as a result of tube feeding;
  - o Providing mouth care, including teeth, gums, and tongue;
  - o Checking that the tubing remains in the correct location consistent with facility protocols;
  - o Elevating the head of bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated;
  - o Using standard precautions and clean technique and following the manufacturer's recommendations when stopping, starting, flushing, and giving medications through the feeding tube;
  - o Ensuring the cleanliness of the feeding tube, insertion site, dressing (if present) and nutritional product;
  - o Providing the type, rate, volume, and duration of the feeding as ordered by the practitioner and consistent with the manufacturer's recommendations;
  - o Checking gastric residual volumes (GRV) and contacting the resident's physician per facility policy or as ordered;
  - o Ensuring that additional water ordered for flushes or additional hydration is administered per order;
  - o Staff examining and cleaning the skin site around the feeding tube and equipment;
  - o Storing feeding syringes in a clean area. When reused should be labeled with resident's name and date opened; rinsed with hot water after each use; and disposed of within 24 hours.

Tube Feeding Status Critical Element Pathway

- ☐ How does staff respond if there is evidence of possible complications, such as diarrhea, nausea, vomiting, abdominal discomfort, nasal discomfort (if a nasogastric tube is being used); evidence of leakage or skin irritation at the tube insertion site; or risk of inadvertent removal of the tube?
- ☐ During the provision of care, what are staff practices for handling, hang-time, and changing tube-feeding bags? Is it consistent with standards of practice for infection control and manufacturer instructions?
  - o Does staff wash hands thoroughly and apply clean gloves before handling the formula, delivery system, or feeding tube;
  - o How does staff maintain a clean work area, equipment, and delivery system;
  - o Does staff not touch any part of delivery system that comes into contact with the formula? Do they maintain proper storage and handling of the formula;
  - o How does staff maintain proper temperature of formula during storage and delivery? Do they cover opened, unused formula, and store it in the refrigerator per facility policy; and
  - o Does staff avoid adding water, colorants, medications, or other substances directly to the formula? If not, describe.
- ☐ How are medications administered via the tube? Are staff following physician's orders and standards of practice?
- ☐ How does staff verify the amount of fluid and feeding administered independent of the flow rate established on a feeding pump, if used (e.g., labeling the formula with the date and time the formula was hung and flow rate)?
- ☐ How does staff implement care-planned interventions?
- ☐ How does staff provide therapy or restorative care to improve swallowing or feeding skills, if indicated?
- ☐ Is the resident resistant to assistance or refusing food or liquids? How does staff respond?

Tube Feeding Status Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How does staff involve you in the development of the care plan including goals and approaches?
- ☐ How does staff ensure the interventions reflect your choices and preferences?
- ☐ How have you responded to the tube feeding?
- ☐ How did staff try to maintain your food intake prior to inserting a feeding tube (e.g., identifying underlying causes of anorexia, hand feeding, changing food consistency, texture, form, offering alternate food choices, or providing assistive devices)?
- ☐ What did staff tell you about the relevant benefits and risks of tube feeding? How were you involved in discussing alternatives and making the decision about using a feeding tube?
- ☐ What significant physical, functional, or psychosocial changes have you experienced? What has staff done to address any concerns?
- ☐ Has staff talked to you about the continued necessity of the feeding tube?
- ☐ How have you felt since the feeding tube was placed?
- ☐ Have you had recent nausea, vomiting, diarrhea, abdominal cramping, inadequate nutrition, or aspiration? If so, what did staff do?
- ☐ What is the facility doing to help you eat again, if possible?
- ☐ Has the tube accidentally dislodged? If so, what happened? How did staff respond?
- ☐ If the resident has a naso-gastric tube: How long do you expect to have the naso-gastric tube? What did staff tell you about the possibility of a gastrostomy tube?

Staff Interviews (Nursing Aides, Nurse, DON, Practitioner)

- ☐ What was the cause of the decreased oral intake/weight loss or impaired nutrition? What attempts were made to maintain oral intake prior to the insertion of a feeding tube?
- ☐ What risks and benefits were discussed with the resident or resident representative before consent was obtained to insert tube? What alternatives to the feeding tube were discussed?
- ☐ What are the specific care needs for the resident (e.g., special positioning, personal care, insertion site care, amount of feeding taken in)?
- ☐ How did you determine what the resident's nutritional and hydration needs are? How do you ensure the resident's nutritional and hydration needs are being met, such as periodically weighing the resident? How did you decide whether the tube feeding was adequate to maintain acceptable nutrition and hydration parameters or when to reevaluate and make adjustments?
- ☐ What complaints have been voiced or exhibited by the resident? What physical or psychosocial complications has the resident experienced that may be associated with the tube feeding (e.g., nausea or vomiting, diarrhea, pain associated with the tube, abdominal discomfort, depression, withdrawal)? How have these concerns been addressed?
- ☐ How do you ensure the care plan is implemented correctly?

Tube Feeding Status Critical Element Pathway

- ☐ What periodic reassessment and discussion with the resident or resident representative has occurred regarding the continued appropriateness/necessity of the feeding tube?
- ☐ How do you monitor and check that the feeding tube is in the right location?
- ☐ How do you provide care for the feeding tube (e.g., how to secure a feeding tube externally, provision of needed personal, skin, oral, and nasal care to the resident, how to examine and clean the insertion site, and whether staff can define the frequency and volume used for flushing)?
- ☐ What conditions and circumstances would require a tube to be changed?
- ☐ How do you manage and monitor the rate of flow (e.g., use of gravity flow, use of a pump or period evaluation of the amount of feeding being administered for consistency with orders)?
- ☐ Are staff who are providing care and services to the resident who has a feeding tube aware of, competent in, and utilizing facility protocols regarding feeding tube nutrition and care? If not, describe.
- ☐ What, when, and to whom do you report concerns with tube feedings or potential complications from tube feeding?
- ☐ What do you do if the resident requests food or fluids and they are NPO?

Interview Staff Responsible for Oversight and Training:

- ☐ How did the facility determine the resident was at risk for impaired nutrition, identify and address causes of impaired nutrition, and determine that use of a feeding tube was clinically indicated?
- ☐ What circumstances led to the placement of the feeding tube (e.g., if/when the tube was placed in another facility)?
- ☐ What were the calculated nutritional needs for the resident? How do you ensure that the resident receives close to the calculated amount of nutrition daily?
- ☐ How does staff monitor the resident for the benefits and risks related to a feeding tube? How have you addressed adverse consequences of the feeding tube (e.g., altered mood, nausea and vomiting, pain, or restraint use to try to prevent the resident from removing the feeding tube)?
- ☐ How are staff trained and directed regarding management of feeding tubes, tube feedings in general, and in addressing any specific issues related to this individual resident?
- ☐ How does the facility periodically reassess the resident for the continued appropriateness/necessity of the feeding tube? How do you ensure the care plan was revised and implemented, as necessary, with input from the resident or resident representative?
- ☐ Note: If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.

Tube Feeding Status Critical Element Pathway

Record Review:

- ☐ Review MDS, CAAs, tube feeding records, interdisciplinary progress notes, and any other available assessments regarding the rationale for feeding tube insertion and the potential to restore normal eating skills, including the interventions tried to avoid using the feeding tube before its insertion, restore oral intake after tube insertion, and prevent potential complications.
- ☐ What is the clinically pertinent rationale for using the feeding tube?
  - o What was the assessment of the resident's nutritional status, which may include usual food and fluid intake, pertinent laboratory values, appetite, and usual weight and weight changes;
  - o What was the assessment of the resident's clinical status, which may include the ability to chew, swallow, and digest food and fluid; underlying conditions affecting those abilities (e.g., coma, stroke, esophageal stricture, potentially correctable malnutrition that cannot be improved sufficiently by oral intake alone); factors affecting appetite and intake (e.g., medications known to affect appetite, taste, or nutrition utilization); and prognosis;
  - o What relevant functional and psychosocial factors (e.g., inability to sufficiently feed self, stroke or neurological injury that results in loss of appetite, psychosis that prevents eating) does the resident have;
  - o What interventions were tried prior to the decision to use a feeding tube? What was the resident's response to them;
  - o What was the calculation of free water for residents being fed by a naso-gastric or gastrostomy tube;
  - o Are there plans for removal of a tube, including the functional status of the resident and anticipated level of participation with rehabilitation to improve nutrition, hydration, and restore eating skills? If not, why; and
  - o What review has occurred of medications known to cause a drug/nutrient interaction or having side effects potentially affecting food intake or enjoyment by affecting taste or causing anorexia, increasing weight, causing diuresis, or associated with GI bleeding such as Coumadin or NSAIDs?
- ☐ Is there documentation of informed consent? Was the resident or resident representative made aware of the risks and benefits of a feeding tube? Were alternatives to a feeding tube discussed?
- ☐ Prior to inserting a feeding tube, did the prescriber review the resident's choices, instructions, and goals, including all relevant information that may be identified in advance directives?
- ☐ How does staff monitor for actual or potential complications related to the tube feeding and how does staff address the complications?
- ☐ If a resident was admitted with a tube feeding, was a baseline care plan developed within the first 48 hours to meet the needs of the resident?
- ☐ Is the care plan comprehensive? Does it instruct staff on how to check for placement and how often? Does it address identified needs, measureable goals, resident involvement, treatment preferences, choices, and plan to restore eating skills if possible? Has the care plan been revised to reflect any changes?
- ☐ For a resident receiving hospice services, is the most recent hospice care plan included?
- ☐ Did staff notify the practitioner if they suspected or identified a concern with the resident's ability to maintain adequate oral intake or complications related to use of the feeding tube?
- ☐ Was the resident or resident representative notified of any changes in condition in relation to the feeding tube or inability to take nutrition orally?
- ☐ If concerns are identified, review the facility's policies and procedures for tube feedings, staffing, staff training, and functional responsibilities.
- ☐ Review records of incidents and corrective actions related to feeding tubes or documentation of staff knowledge and skills related to the aspects of administering tube feeding.

Tube Feeding Status Critical Element Pathway

Critical Element Decisions:

1) Did the facility provide appropriate treatment and services to:
   - Ensure that a resident is not fed by enteral methods unless the resident's clinical condition demonstrates that use of enteral feeding was unavoidable?
   - Prevent complications for a resident who receives enteral feeding?
   - Restore the resident's normal eating skills, if possible?

   If No, cite F693

2) Did the staff use appropriate hand hygiene practices and implement appropriate standard precautions when assisting with tube feeding?
   If No, cite F880

3) For the 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.

4) 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.

5) 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.

6) 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

Tube Feeding Status Critical Element Pathway

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a 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.

8) 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

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Right to be Informed F552, Right to Refuse and Advance Directives F578, Notice of Rights/Rules F572, Choices (CA), Notification of Change F580, Dignity (CA), Professional Standards F658, Nutrition (CA), Hydration (CA), Unnecessary Medications (CA), Sufficient and Competent Staffing (Task), Physician Supervision F710, Pharmacy F755, Resident Records F841, Physician Delegation to Dietitian/Therapist F715, QAA/QAPI (Task).

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Most current comprehensive and most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, E – Behavior and N – Medications.
- ☐ Physician orders.
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided? If so, what evidence was observed?
- ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice?
- ☐ Are staff using non-pharmacological interventions to attain or maintain the resident's well-being?
- ☐ How does the facility modify the environment to accommodate the resident's care needs?
- ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
- ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741.

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
- ☐ How did the facility involve you/the resident in the care plan and goal development process?
- ☐ How did the facility consider your/the resident's choices and preferences?

Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to determine what type of social services or referrals have been implemented.

Dementia Care 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?
- ☐ Can you tell me about the resident's care plan and his/her condition (including underlying causes)?
- ☐ What are the facility's dementia care guidelines and protocols?
- ☐ What types of dementia management training have you completed?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
- ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and include measurable objectives and timetables? Has the care plan been revised to reflect any changes?
- ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ Was dementia management training provided to staff?

Dementia Care Critical Element Pathway

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measureable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) 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 services was not necessary to be included in a baseline care plan.

3) 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 in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) 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 changed in status.

5) 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

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a 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.

7) 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.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, QOL F550 or F675, QOC F684, Physician Services F710, Social Services F745, Unnecessary/Psychotropic Medications (CA), Sufficient and Competent Staffing (Task).

Behavioral and Emotional Status 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.

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.
- ☐ 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).

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?
- ☐ 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?
- ☐ 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.)?

Behavioral and Emotional Status 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?
- ☐ 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.

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?
- ☐ 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?
- ☐ 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.

Behavioral and Emotional Status 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?
- ☐ 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?
- ☐ 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?
- ☐ 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

Behavioral and Emotional Status Critical Element Pathway

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.

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.

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.

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.

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.

Behavioral and Emotional Status Critical Element Pathway

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

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.

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.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Social Services F745, Unnecessary/Psychotropic Medications (CA), Resident Records F842.