Social Services And CMS' Requirements Of Participation

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F745 Medically-related Social Services

§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

INTENT §483.40(d)

To assure that sufficient and appropriate social services are provided to meet the resident's needs.

DEFINITIONS §483.40(d)

Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being.

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

F850 - Social Worker

- §483.70(p) Social worker.
  Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:
- §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and
- §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals.

F850 - Social Worker

GUIDANCE §483.70(p)

- The regulations do not require a Social Worker when a facility has equal to or less than 120 beds.
- If the facility has more than 120 beds and its full-time social worker does not provide on-site coverage on a full-time basis determine how these services are provided to meet the individual needs of the resident whenever needed. If social services deficiencies are identified refer to §483.40(d), F745, regardless of the number of beds.

F658 - Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality.

"Professional standards of quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature.

F658 - Comprehensive Care Plans

Possible reference sources for standards of practice include:

- Current manuals or textbooks on nursing, social work, physical therapy, etc.
- Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.
- Clinical practice guidelines published by the Agency for Healthcare Research and Quality.
- Current professional journal articles.

F725 - Nursing Services/Sufficiency

§483.35 Nursing Services
The facility must have sufficient nursing staff 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 the facility assessment required at §483.70(e).

Survey Process

- Observations
- Interview
- Record Review

Findings are based on resident outcomes.

Survey Process

Outcomes:

1. **Improvement**
2. **Maintenance**
3. **Decline or Deterioration**

Social History

1. **Name**
2. **Birthdate**
3. **Birthplace**
4. **Informants: who provided the information (including resident), relationship, and attitudes**
5. **Childhood history: significant relationships, experiences, and background**

Social History

6. **Education**
7. **Significant health history: major health impairing incidents (e.g. disease, accidents and chronic disabilities), and social, behavioral and emotional impact**
8. **Work history**
9. **Living arrangements: past & current**
10. **Financial Status**

Social History

11. **Marital relations: list marriages and note quality of relationships**
12. **Children: names, ages, quality of relationship to resident**
13. **Extended family: note significant relationships**
14. **Non-familial relations: range and number of friends and quality of relationships**

Social History

15. Organizational memberships and community activities
16. Recreation, hobbies and interests
17. Retirement: date, reason and reaction of resident
18. Old age: note particular and significant changes from previous functioning levels, when they were noticed, and the response to these changes of persons in the resident's surroundings. (Self-care, sensory perception, awareness of self, others, and the world, memory, personality, anticipation of death)

13

Social Assessment

The Social Assessment is the Social Worker's overall impression of the resident at present. The Assessment should include, but not be limited to:

- Description: mobility, speech, dress, affect and responsiveness
- Current social functioning
- Emotional/Mental status
- Behavioral issues
- Special coping mechanisms: identify how the resident deals with problems, accepts changes, faces crises, activities of daily living, etc.
- Orientation
- Family support/involvement

14

CMS Psychosocial Negative Outcomes Guide (Part 1)

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15

15

"Your" Quality of Life

Write down five aspects of daily living that contribute to your own quality of life.

Which items would you lose or have to "give up" as you grow older? And why?

16

16

F675 – Quality of Life

§ 483.24 Quality of life

- Quality of life is a fundamental principle that applies to all care and services provided to facility residents.
- Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

17

17

F675 – Quality of Life

§ 483.24 Quality of life

- Intent: The intent of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:
  - ✓ Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and
  - ✓ Ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

18

18

Quality of Life Issues

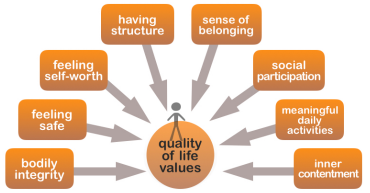
- The Institute of Medicine "Improving the Quality of Care in Nursing Homes," became the basis for the *Nursing Home Reform* part of OBRA '87, and the current CMS Requirements of Participation.
- The IOM Report stated, "The quality of life experience by anyone is related to that person's sense of well being, level of satisfaction with life, and feeling of self worth and self esteem."

19

19

Quality of Life Issues

- The Abt Associates Study found that residents "overwhelmingly assigned priority to dignity…"
- The researchers determined that the two main components of dignity, in the words of these residents, were "independence" and "positive self-image."
- Residents listed "choice of activities" as important elements under the category of independence.



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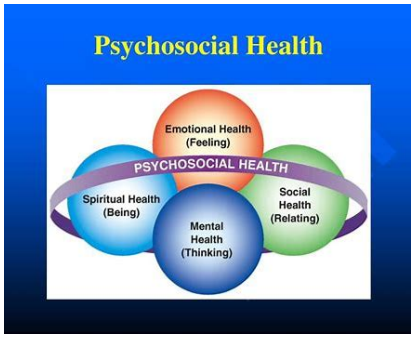
Quality of Life Issues

- The report also identified that a sense of well-being, self-esteem, and self-worth was enhanced by personal control over choices, such as mealtimes, activities, clothing, and bedtime; privacy during visits, and treatments; and "opportunities to engage in religious, political, civic, recreational or other social activities.

21

"Psychosocial"



- Refers to the combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness.

22

Principles of Quality of Life

- Facilities must create and sustain an environment that humanizes and promotes each resident's well-being, and feeling of self-worth and self-esteem. This requires nursing home leadership to establish a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices, such as mealtimes, activities, clothing, and bedtime; privacy during visits, and treatments; and opportunities to engage in religious, political, recreational or other social activities.

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23

Principles of Quality of Life

- Facility leadership must be aware of the culture that exists in its facility and may use various methods to assess the attitudes and values prevalent amongst staff. These methods include, reviewing complaints or grievances, which could reasonably impact a resident's quality of life, or allegations of abuse, neglect or mistreatment. In order to identify whether staff supports each resident's quality of life, leadership should observe and evaluate verbal and nonverbal interactions between staff and residents.

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24

Principles of Quality of Life

Negative observations could include staff actions such as, but not limited to, the following:

- Verbalizing negative or condescending remarks, or refusing to provide individualized care to a resident due to his/her age, race, or cognitive or physical impairments, his/her political or cultural beliefs, or sexual preferences;
- Dehumanizing an individual through verbal and nonverbal actions such as talking to others over a resident without acknowledging his/her presence, treating the resident as if he/she were an object rather than a human being, mistreating, or physically, sexually or mentally abusing a resident.

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25

Principles of Quality of Life

CMS CENTERS for MEDICARE & MEDICAID SERVICES

In order to achieve a culture and environment that supports quality of life, the facility must ensure that all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident and that the care and services that are provided by the facility are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

26

Psychosocial Well-Being

- Well-being refers to feelings about self and social relationships.
- Positive attributes include initiative and involvement in life
- Negative attributes include distressing relationships and concern about loss of status.
- On average, 30% of residents in a typical nursing facility will experience problems in this area, two-thirds of whom will also have serious behavior and/or mood problems.

27

Psychosocial Well-being

- Is an aspect of Quality of Life
- Involves choices and decision making
- Is based on the same dimensions as it is for people outside the nursing home
- Is observable in residents who are cognitively intact and those with cognitive impairment

28

What's important to the resident?

- Choices
- Customary routine
- Being treated with dignity
- Independence
- Spirituality
- Meaningful & purposeful activities
- Input to care and nursing home life

29

29

Facility Practice

GROUP WORK:

Make a list of actions, facility practice and/ or delivery of direct resident care that have the potential for negative psychosocial outcomes.

30

30

Well-being in a nursing home is influenced by

- Conformity pressures
- Loss of control over events
- Loss of feelings of being valued as a person

31

31

Well-being in a nursing home is influenced by

- problems related to facility living and the aging process
- the resident's ability to relate himself and his individual needs to the complex of services and programs
- orientation to the facility's services and help in enabling him to avail himself of them on a continuing basis

32

32

Well-being in a nursing home is influenced by

- maintenance of ties with the community: family, friends, previous group member-ships, visits to family, attendance at family events
- previous life roles or finding substitute roles
- significant changes in resident's life situation, such as preparation for moves within the facility or hospital, roommate changes, transfer (permanent or temporary) to other community facilities

33

Well-being in a nursing home is influenced by

Interpersonal & emotional difficulties & problems in social adjustment such as:

- Difficulties in relationships with other residents, family & staff
- Emotional problems connected with or exacerbated by changing physical & mental capacities, concerns about bodily functions, and illnesses

34

Well-being in a nursing home is influenced by

Problems related to use of the facility's services:

- refusal to follow prescribed medical regimen
- inability or lack of motivation to participate in appropriate activities and programs
- complaints about food, laundry, housekeeping, or other services

35

Well-being in a nursing home is influenced by

- Behavior which presents problems in management or is disturbing to other residents
- Difficulties in adjusting to current or new routines
- Changes in affect, behavior, or personality such as depression, anxiety, withdrawal, uncontrolled aggression

36

Dignity Issues

- Grooming resident as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped
- Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences
- Assisting residents to attend activities of their own choosing
- Labeling each resident's clothing in a way that respects his or her dignity

37

Dignity Issues

- Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware, bibs instead of napkins, dining room conducive to pleasant dining, aides not yelling)
- Respecting resident's private space and property (e.g., not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possessions without permission)

38

Dignity Issues

- Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in community setting)
- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services.

39

F561 – Self-determination & Participation

The resident has the right to—

- Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
- Interact with members of the community both inside and outside the facility; and
- Make choices about aspects of his or her life in the facility that are significant to the resident.

40

F561 – Participation in other Activities

A resident has the right to participate in social, religious, and community activities that do not interfere with rights of other residents in the facility.

- Does facility accommodate individual needs and choices?
- Do residents receive assistance/ support to pursue activity outside the facility?

41

F558 – Accommodation of Needs

- Reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
- Do residents receive services to meet needs?

42

F559

- The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
- The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
- The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

43

F679

- The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

44

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.
- This Tag is not limited to the Social Service department. The facility is to provide social services to the resident.

45

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F745 - 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;
- Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs;

46

46

F745 - Medically-Related Social Services

- 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;
- 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;

47

47

F745 - 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);

48

48

F745 - 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);

49

F745 - 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;
- Encouraging staff to maintain or enhance each resident's dignity in recognition of each resident's individuality;

50

F745 - 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);
- Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident; and
- Meeting the needs of residents who are grieving from losses and coping with stressful events.

51

F745 - 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;
  - ✓ 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;

52

F745 - 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;
  - ✓ Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);
  - ✓ 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.

53

F353

- The facility must have sufficient nursing staff 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 the facility assessment required at §483.70(e).

54

The Team Approach

- Potential Barriers to this concept?
- Attitude Adjustment
- "Territorial Turf" issues
- Natural evolvement of our industry and services

55

ASSESSMENT OF PSYCHOSOCIAL WELL-BEING & OUTCOMES

Although much attention is paid to the physical outcomes of non-compliance to nursing home residents, it is also important to consider the negative psychosocial (i.e., mood and behavior) outcome of such practices.

56

ASSESSMENT OF PSYCHOSOCIAL WELL-BEING & OUTCOMES

A critical factor in determining the severity of a finding of non-compliance (deficiency) is the extent to which the non-compliance compromises or affects the resident's ability to maintain and/or reach his or her highest practicable physical, mental, and psychosocial well-being.

57

57

What do you need to know about each resident?

What would you want people to know about you if you lived in a nursing home?

58

58

Psychosocial Outcomes

Anger

Anger refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

59

59

Psychosocial Outcomes

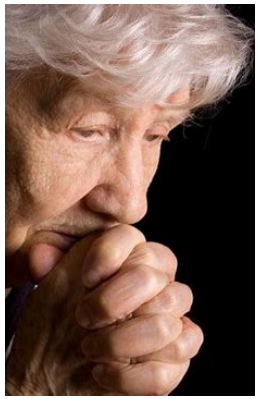
Apathy

Apathy refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

60

60

Psychosocial Outcomes



Anxiety

Anxiety refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper- vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

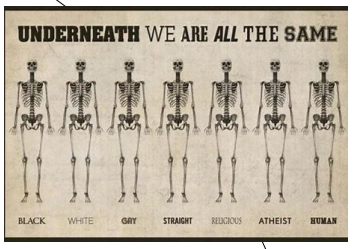
61

61

Psychosocial Outcomes

Dehumanization

- Dehumanization refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility.
- Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.



62

62

Psychosocial Outcomes

Depressed Mood

Depressed Mood (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

63

63

Psychosocial Outcomes

Fear

Fear is defined as an unpleasant often strong emotion caused by anticipation or awareness of danger.

64

64

Psychosocial Outcomes

Humiliation

Humiliation refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

65

Psychosocial Outcome Severity Guide

- **The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag, including how to determine the severity of the outcome when the impact on the resident may not be apparent or documented.**
- **The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in, or may result in, a negative psychosocial outcome.**

66

Psychosocial Outcome Severity Guide

- **This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome.**
- **The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome.**

67

Psychosocial Outcome Severity Guide

- **For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, as demonstrated by fear, agitation, and/or withdrawal.**
- **Another example is when a staff member physically assaults a resident with no resulting physical harm, but the resident only demonstrates indifference to the incident at the time of the survey; however, it is likely that this caused a greater psychosocial outcome.**
- **In these cases, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency as it would reflect the highest level of harm or potential for harm..**

68

Psychosocial Outcome
Severity Guide: Surveyor Guidance

- To determine the severity of the psychosocial outcome, the team should obtain evidence through observation, interview, and record review.
- For example, the team should interview the resident, and collect information regarding the resident's verbal and non-verbal responses.
- If a psychosocial outcome is identified, compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) and mood before and after the noncompliance, and any identified history of similar incidents.

69

69

Psychosocial Outcome
Severity Guide: Surveyor Guidance

- When a surveyor cannot conduct an interview with the resident for any reason, or there are no apparent or documented changes to behavior, the surveyor should attempt to interview other individuals who are familiar with the resident's routine or lifestyle, such as the resident's representative, the resident's family, Ombudsman, the resident's direct care staff, and/or medical professionals, to assess the psychosocial impact on the resident.
- If no such changes are apparent or documented, the surveyor should consider the response as a reasonable person in the resident's position would exhibit in light of the triggering event.

70

70

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- The "reasonable person concept" refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome the deficiency may have had on a reasonable person in the resident's position.

71

71

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- There are circumstances in which the survey team should apply the "reasonable person concept" to determine the outcome and the severity of the deficiency, such as when a resident's psychosocial outcome may not be readily determined through the investigative process.

72

72

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- The following are examples of circumstances in which a resident's psychosocial outcome may not be readily determined through the investigative process and the reasonable person concept should be used:
  1. When a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

73

73

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- The following are examples of circumstances in which a resident's psychosocial outcome may not be readily determined through the investigative process and the reasonable person concept should be used:
  2. When a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person in the resident's position would have to the deficient practice.

74

74

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance).

75

75

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- The survey team should consider the following regarding the resident's position, which may include, but is not limited to:
  - ✓ The resident may consider the facility to be his/her "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.
  - ✓ The resident trusts and relies on facility staff to meet his/her needs.
  - ✓ The resident may be frail and vulnerable.

76

76

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- ⇨ The surveyor should document the resident's actual response and the perspectives of someone familiar with the resident.
- ⇨ In addition to the evidence gathered by the surveyor, the use of the reasonable person concept should be applied and may reveal that the resident is likely to, or may potentially, suffer a greater psychosocial outcome.

77

Psychosocial Outcome
Severity Guide: Reasonable Person Concept

- ⇨ For example, in the case of a sexual assault, the resident did not exhibit a change in behavior as a result of the incident. In addition, the resident's relative presumed that the resident would be upset by the situation. The evidence gathered by the surveyor should still be documented, but the determination of severity would be based on how the reasonable person would experience serious psychosocial harm (immediate jeopardy) as a result of a sexual assault.
- ⇨ The survey team should document on the CMS-2567 when it applies the reasonable person concept in determining the psychosocial outcome(s) for a deficiency.

78

Psychosocial Outcome
Severity Guide
Severity Determination Levels

- Level 4: Immediate Jeopardy to resident health or safety
- Level 3: Actual harm that is not immediate jeopardy
- Level 2: No actual harm with potential for more than minimal harm that is not immediate jeopardy
- Level 1: No actual harm with potential for minimal harm

79

Harm Level 4
Immediate Jeopardy

Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation:

- Has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.
- Requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

80

Immediate Jeopardy – Harm Level 4
Negative Psychosocial Outcomes Examples

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself, hoarding medications with the expressed intent of suicide.
- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., attempting to cut oneself, banging head against wall).

81

81

Immediate Jeopardy – Harm Level 4
Negative Psychosocial Outcomes

- Anger, agitation, or distress that has caused aggression that can be manifested by self-directed responses or hitting, shoving, biting, scratching others, threatening, screaming, or cursing.
- Crying, moaning, screaming, or combative behavior that is above the resident's baseline.
- Expressions (verbal and/or non-verbal) of avoidable pain that is severe, and more than transient. Pain is considered avoidable when there is a failure to assess, reassess, and/or take steps to manage the resident's pain;

82

82

Immediate Jeopardy – Harm Level 4
Negative Psychosocial Outcomes

- Fear/anxiety that may be manifested as panic, immobilization, screaming, and/or agitated behavior(s) (e.g., trembling, cowering); avoidance of the situation(s), person(s) or place; preoccupation with fear; resistance to care and/or social interaction; sleeplessness; fear of speaking, and/or verbal expressions of fear.

83

83

Immediate Jeopardy – Harm Level 4
Negative Psychosocial Outcomes

- Expressions of feelings of hopelessness, worthlessness or guilt (not merely self-reproach or guilt about being sick or needing care);
- Expressions of dehumanization or humiliation in response to an identifiable situation.
- Withdrawal from former social patterns, such as isolation from staff, friends and family.

84

84

Harm Level 3
Actual Harm that is not IJ

Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being.

85

85

Actual Harm – Harm Level 3
Negative Psychosocial Outcomes

Examples Of Outcomes To A Deficient Practice:

- **Decline from former social patterns that does not rise to a level of immediate jeopardy.**

86

86

Actual Harm – Harm Level 3
Negative Psychosocial Outcomes

Depressed mood that may be manifested by verbal and nonverbal symptoms such as:

- **Decreased engagement in social activities; apathy; tearfulness; crying; moaning;**
- **Change of interest or ability to experience or feel pleasure as usual;**
- **Psychomotor movements (e.g., inability to sit still pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects);**

87

87

Actual Harm – Harm Level 3
Negative Psychosocial Outcomes

Depressed mood that may be manifested by verbal and nonverbal symptoms such as:

- **Change in psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering) unrelated to medical diagnosis;**
- **Verbal expressions (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), that may be accompanied by a sad tone;**
- **Diminished ability to think or concentrate.**

88

88

Actual Harm – Harm Level 3
Negative Psychosocial Outcomes

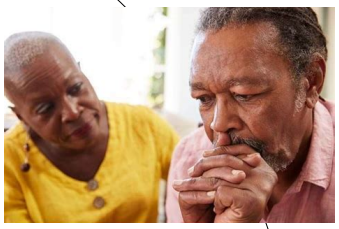
- Expressions (verbal and/or non-verbal) of moderate pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, or loss in interest for eating. Pain or physical distress has become a central focus of the resident's attention, but it is not severe or overwhelming (as in Severity Level 4).

89

89

Actual Harm – Harm Level 3
Negative Psychosocial Outcomes

- Distress (e.g., under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something), unrelated to medical diagnosis.



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Negative Psychosocial Outcomes

Compromise is the key factor that determines the difference between Level 3 and outcome at Level 2 which is limited to outcome to the level of discomfort.

91

91

Harm Level 2
No Actual Harm with Potential for More Than Minimal Harm that is not IJ

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided.

92

92

No Actual Harm with Potential for More Than Minimal Harm
Harm that is not IJ
Harm Level 2
Negative Psychosocial Outcomes

- Sadness, as reflected in facial expression and/or demeanor, or verbal/vocal disappointment.
- Feelings and/or complaints of discomfort or irritability.
- Complaints of boredom and/or reports that there is nothing to do.

93

Harm Level 2

- Indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being.

94

Harm Level 2

The potential exists for greater harm to occur if interventions are not provided.

They are a lesser level of outcome than the bullets that describe Level 3. Here the resident shows a reaction of discomfort that has not compromised functioning.

95

Severity Level 1
Potential for Minimal Harm

Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

96

Negative Psychosocial Outcomes

While the survey team may find negative psychosocial outcomes related to any of the regulations, the following areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome.

97

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.10 Resident Rights

- ➡ F557, Respect, Dignity/Right to Have Personal Property;
- ➡ F558, Reasonable Accommodation of Needs/Preferences;

98

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.12 Freedom from Abuse, Neglect, and Exploitation

- ➡ F600 Free from Abuse and Neglect;
- ➡ F602 Free from Misappropriation/Exploitation;
- ➡ F603, Free from Involuntary Seclusion;
- ➡ F604, Right to be Free from Physical Restraints;
- ➡ F605, Right to be Free from Chemical Restraints;
- ➡ F607, Develop/Implement Abuse/Neglect, etc. Policies;
- ➡ F609, Reporting of Alleged Violations;
- ➡ F610, Investigate/Prevent/Correct Alleged Violation;

99

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.21 Comprehensive Resident Centered Care Plans

- ➡ F656, Develop/Implement Comprehensive Care Plan;
- ➡ F657 Care Plan Timing and Revision;

100

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.24 Quality of Life

- ➡ F675, Quality of Life
- ➡ F679, Activities Meet Interest/Needs of Each Resident;

101

101

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.25 Quality of Care

- ➡ F699, Trauma-Informed Care

102

102

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.40 Behavioral Health Services

- ➡ F740, Behavioral Health Services;
- ➡ F741 Sufficient/Competent Staff – Behavioral Health Needs;
- ➡ F742, Treatment/Services for Mental/Psychosocial Concerns;
- ➡ F743, No Pattern of Behavioral Difficulties Unless Unavoidable;
- ➡ F745, Provision of Medically Related Social Services;

103

103

Negative Psychosocial Outcomes

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

✓ 483.45 Pharmacy Services

- ➡ F757, Drug Regimen is Free from Unnecessary Drugs; and
- ➡ F758, Free from Unnecessary Psychotropic Medications/PRN Use.

104

104

CMS PSYCHOSOCIAL NEGATIVE OUTCOMES GUIDE

Cat Selman, BS

105

F550 RESIDENTS' RIGHTS

- §483.10(a) Resident Rights.
  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.
- §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
- §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.
- §483.10(b) Exercise of Rights.
  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
- §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
- §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

106

F550 RESIDENTS' RIGHTS
Procedures

- Deficient practices cited under Resident rights tags may also have negative psychosocial outcomes for the resident. The survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to dignity. **Refer to the Psychosocial Outcome Severity Guide in Appendix P.**

107

F550 RESIDENTS' RIGHTS
Surveyor Procedures

- Observe if staff show respect for each resident and treat them as an individual.
- Do staff respond in a timely manner to the resident's requests for assistance?
- Do staff explain to the resident what care is being provided or where they are taking the resident? Is the resident's appearance consistent with his or her preferences and in a manner that maintains his or her dignity?
- Do staff know the resident's specific needs and preferences?
- Do staff make efforts to understand the preferences of those residents, who are not able to verbalize them, due to cognitive or physical limitations?

108

F550 RESIDENTS' RIGHTS

Examples of noncompliance:

- A resident has not been treated equally as compared to others based on his or her diagnosis, severity of condition, or payment source.
- Prohibiting a resident from participating in group activities as a form of reprisal or discrimination. This includes prohibiting a resident from group activities without clinical justification or evaluation of the impact the resident's participation has on the group.
- A resident's rights, not addressed elsewhere (for example, religious expression, voting, or freedom of movement outside the facility in the absence of a legitimate clinical need) are impeded in some way by facility staff.
- Requiring residents to seek approval to post, communicate or distribute information about the facility (for example, social media, letters to the editor of a newspaper).
- Acting on behalf of the pertinent law enforcement or criminal justice supervisory authority by enforcing supervisory conditions or reporting violations of those conditions to officials for justice involved residents.

109

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

- The facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity.
- Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.

110

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

Two new examples:

- Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;
- Failure of administration to effectively and efficiently use its resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being; and

111

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

The failure to provide necessary care and services resulting in neglect may not only result in a negative physical outcome, but may also impact the psychosocial well-being of the resident, with outcomes such as mental anguish, feelings of despair, abandonment, and fear. **(Refer to Psychosocial Outcome Severity Guide)**

112

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- ➡ In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Psychosocial Outcome Severity Guide).
- ➡ As the Psychosocial Outcome Severity Guide, located in the Nursing Home Survey Resources Folder, describes, to apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in the resident's similar situation to suffer as a result of the noncompliance).

113

113

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

Generally, when applying the reasonable person concept, the survey team should consider the following as it determines the outcome to the resident, which include, but is not limited to:

- *The resident may consider the facility to be their "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.*
- *The resident trusts and relies on facility staff to meet his/her needs.*
- *The resident may be frail and vulnerable.*

114

114

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- *Determining the severity of psychosocial outcomes for abuse can present unique challenges to surveyors.*
- *Given that the psychosocial outcome of abuse may not be apparent at the time of the survey, it is important for the survey team to apply the reasonable person concept in evaluating the severity of psychosocial outcomes.*
- *It is important for the surveyor to gather and document any information that identifies any psychosocial outcomes resulting from the noncompliance; for abuse, surveyors should also consider that the psychosocial outcome of abuse may not be apparent at the time of the survey.*
- *When a nursing home resident is treated in any manner that does not uphold a resident's sense of self-worth and individuality, it dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive situation for the resident(s).*

115

115

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- *There are situations that are likely to cause psychosocial harm which may sometimes take months or years to manifest and have long-term effects on the resident and his/her relationship with others.*
- *Therefore, during a survey, "Immediate Jeopardy" or "Actual Harm," may be supported when there is not an observed or documented negative psychosocial outcome, or a description of resident impact from the resident's representative or others who know the resident.*

116

116

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- *Numerous situations involving abuse are likely to cause serious psychosocial harm (i.e. Immediate Jeopardy) to a resident who is a victim of these types of actions; these situations include, but are not limited to:*
  - ✓ *Sexual assault (e.g., rape)*
  - ✓ *Unwanted sexual touching*
  - ✓ *Sexual harassment*
  - ✓ *Any staff to resident physical, sexual, or mental/verbal abuse [NOTE: Sexual abuse does not include the rare situation where a nursing home employee has a pre-existing and consensual sexual relationship with an individual (i.e., spouse or partner) who is then admitted to the nursing home unless there are concerns about the relationship not being consensual]*

117

117

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- *Numerous situations involving abuse are likely to cause serious psychosocial harm (i.e. Immediate Jeopardy) to a resident who is a victim of these types of actions; these situations include, but are not limited to:*
  - ✓ *Staff posting or sharing demeaning or humiliating photographs or videos of nursing home residents*
  - ✓ *When facility staff, as punishment, threaten to take away the resident's rights, privileges, or preferred activities, or withhold care from the resident*
  - ✓ *Any resident to resident physical abuse that is likely to result in fear or anxiety*

118

118

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION

- *According to the Social Security Act [Sections §§1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii)], every resident has the right to be free from mental or physical abuse.*
- *A reasonable person would not expect that they would be harmed in his/her own "home" or a health care facility and would experience a negative psychosocial outcome (e.g. fear, anxiety, anger, humiliation, a decline from former social patterns).*
- *In incidents in which one resident abuses another resident, if a reasonable person would likely suffer actual harm as a result of the incident, the incident should not be cited below Severity Level 3 (Actual Harm).*

119

119

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- *The facility failed to protect a resident from sexual abuse when Resident 1 was found in Resident 2's bedroom. Resident 1 was holding Resident 2, whose clothes had been partially removed and her breasts were exposed. Resident 2 was severely cognitively impaired. Resident 1 had a known history of sexually inappropriate behaviors, but there was no evidence that the facility had assessed and revised the care plan to identify the potential risks to other residents related to the behaviors; there was no evidence that Resident 2 could consent to sexual activity with other residents. Based on interview with Resident 2's daughter, the daughter described her shock about the incident and how her mother would have been upset.*
- *Because this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm-dehumanization, and humiliation - as a result of the sexual abuse.*

120

120

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- *The facility failed to ensure that a resident was free from physical abuse. A resident, who required 1:1 supervision due to physical aggression, was observed to have escalating behaviors, resulting in striking out at staff and residents in the vicinity. The staff failed to ensure that residents in the vicinity were safe, and the resident pushed another resident who was walking to his/her room while unsupervised by staff, as described by housekeeping staff who witnessed the incident. The victim fell to the floor with a resulting fracture to her arm that required treatment at the hospital, placement of a cast, and was in moderate pain due to the fracture.*
- *Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the physical abuse, since a reasonable person would not expect to be injured in this manner in his/her own home or a health care facility.*

121

121

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- *The facility failed to ensure that a resident was free from mental abuse and corporal punishment. A resident who had a cognitive disability carried a doll around with her throughout the day. During an activity, the resident placed the doll in a chair next to her and refused to allow another resident to use the chair. The staff slapped the resident's hand and removed the doll so the other resident could sit down. The staff told the resident she could not attend any more activities with the doll, or he would get rid of it and the resident would never see it again. The resident began to scream, cry for her doll, and left the room. The resident will not leave her room to attend any activities for fear that the staff person will take her doll.*
- *The resident's behavior has declined and now cries and expresses fear when taken for bathing and meals without her doll. Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the mental abuse and corporal punishment.*

122

122

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- *The facility deprived residents of care related to the failure of staff to respond timely to residents' requests and treat residents with dignity and respect which resulted in ongoing embarrassment, humiliation, and the failure to provide incontinence care as needed to meet the needs of several residents. Based on family and resident group interviews, other residents and their family members complained that residents often waited a long time (up to an hour) before staff took them to the bathroom, resulting in residents urinating in their beds and lying in urine for long periods of time. Residents indicated that this is a problem, especially on the night shift. Residents were told by nurse aides to just urinate on their beds and staff would change the sheets in the morning. Two night-shift staff members confirmed that they had seen other staff disconnect call lights in residents' rooms so that they were not functioning.*
- *After investigation, it was determined that the nursing home failed to provide the necessary care. [**NOTE**: In this example, the surveyor had already identified noncompliance at dignity (F550) and urinary incontinence (F690)] It can be determined that the reasonable person in the residents' position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation) as a result of the abuse.*

123

123

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- *The facility deprived a resident of care by failing to provide access for resident communication and response to resident's requests for necessary care resulting in the resident's ongoing fear and anxiety. During a survey, the surveyor observed that a resident's call light was pinned to a privacy curtain that was out of reach of the resident. The resident stated that the staff removes the call light at night because the nursing staff said he used it too much and they did not have time to answer the light all the time. The resident began crying and expressed fear that something would happen and he would have no way of getting assistance as staff would not come if he called out for help.*
- *Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the deprivation of care.*

124

124

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- The facility failed to protect a resident from sexual abuse resulting in serious psychosocial harm. A resident, with moderate confusion and who was dependent on staff for care, reported to staff that she was "touched down there" and identified the alleged perpetrator. However, staff, who thought the resident was confused, did not report her allegation to facility administration and failed to provide protection for the resident allowing ongoing access to the resident by the alleged perpetrator. The resident expressed recurring fear whenever the perpetrator approached the resident, exhibited crying and agitation, and declined to leave her room.
- *Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the sexual abuse.*

125

125

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- The facility failed to protect two residents from mental abuse and extreme humiliation perpetuated by two staff who posted videos and photographs on social media, of the residents during bathing, using the bathroom, and grooming, which included nude photos and photos of genitalia. In addition, on the videos, the two staff verbally taunted and made cruel remarks to the residents including making fun of the way the resident looked and acted. One resident who was cognitively impaired was shown on the video to be crying in response to the remarks made to her by the staff. One resident, who was cognitively intact, told surveyors that he was extremely humiliated and angry when he found out that these items were posted.
- *Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the mental abuse.*

126

126

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4 - IJ

- The facility failed to ensure that a resident was free from neglect when it did not have the structures to provide necessary goods and services to residents. During facility tour, the surveyor noted a strong urine odor. Residents were observed to be in bed with soiled clothes and linens. Residents told the surveyor that they did not get out of bed or dressed since there were not enough nurse aides to assist them. During interviews with nurse aides, it was reported that the facility lacked supplies, such as incontinence briefs, laundry/housekeeping supplies, gloves and food. Interview with the Director of Nurses revealed that the medical supply vendor was suspended and no longer providing supplies to the facility due to non-payment. Multiple staff also reported not receiving their last paychecks. During interviews with residents, residents reported mice in their rooms. During observation of the kitchen and interview with the dietary manager, there was evidence of rodent infestation, including staff seeing rodents eating and finding torn bags and crumbs on the floor. The administrator reported that the pest control company had visited the facility recently, but there was no record of the visit or proposal for remediation. Also, there was no sanitizer for the dishwasher and no alternative method for sanitizing dishes.
- *It can be determined that the reasonable person in the residents' position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation, anxiety) as a result of neglect.*

127

127

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 3 - ACTUAL HARM

- *The facility failed to protect a resident from physical abuse when Resident 1 slapped Resident 2 in the face. Based on resident and staff interviews, Resident 1 had previously exhibited an aggressive tone towards other residents. Based on the interview with the nurse aide, Resident 2 was talking loudly to Resident 1 in the hallway. Resident 1 shouted profanity to Resident 2, followed by: "If you say one more word, you're going to be sorry." The nurse aide was the only staff present in the area and was transferring another resident; the nurse aide could not intervene and did not call for assistance from other staff. Resident 2 continued to talk loudly. Resident 1 then reached out, slapped Resident 2 on the left side of his face, and backed his wheelchair away from Resident 2. Based on the assessment of Resident 2, his left cheek exhibited some redness in the area that was slapped, but there were no other physical injuries. Based on the survey team's interview with Resident 1, Resident 1 was also able to recall the incident and said, "He [Resident 2] just won't stop talking…I don't know what came over me." Resident 2 was moderately cognitively impaired and when interviewed, could not recall the incident. The survey team interviewed Resident 2's son, who said that his father would have been mad after an incident like this.*
- *Therefore, by using the reasonable person concept, the survey team would conclude that Resident 2 would have experienced psychosocial harm (e.g. anger directed at the action or at a person) as a result of the physical abuse since there is an expectation that the resident would not be slapped in the face in the facility.*

128

128

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 3 - ACTUAL HARM

- The facility neglected to provide supervision and monitoring to assure that continence care is provided with dignity, respect and meets the needs of a resident. During a complaint survey, the investigation revealed that a cognitively-impaired resident had been left with his body *partially* uncovered, and unattended for several hours. Also, the investigation also identified that his catheter bag had been left lying flat on the bed so that urine could not flow freely or drain, resulting in expressions of pain and *distress*. Interview with the charge nurse revealed that she was the only nurse in the building during the night shift and stated that the she was unable to monitor the nurse aides' provision of care because she was providing treatments on other units. It was identified that insufficient nurse staffing has been reported to the administration and that this was an ongoing concern.
- *Based on the resident's behavior, it can be determined that the resident experienced psychosocial harm as a result of neglect.*

129

129

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 2 - NO ACTUAL HARM, POTENTIAL FOR MORE THAN MINIMAL HARM

- *The facility failed to protect Resident 2 from verbal abuse. During the interview with Resident 2, she mentioned that she does not get along with Resident 1. Based on an interview with staff, Resident 1 previously demanded Resident 2 to sit up at the table and that there was something wrong with her. However, staff would re-direct the residents to separate tables to prevent any situation from escalating. According to interviews with other residents, one weekend, residents recall that temporary staff had placed Resident 1 and 2 at the same table for a group activity. Resident 1 yelled to Resident 2 to sit up straight a few times. However, staff in the room would not intervene. Resident 1 called Resident 2 a derogatory name. Upon review of Resident 1 and 2's records, there was no documentation related to altercations. Even though Resident 2 did not have a reaction, it can be determined that the reasonable person would experience no actual harm with the potential for more than minimal psychosocial harm as a result of the verbal abuse.*

130

130

F600 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- Severity Level 1: No Actual Harm with Potential for Minimal Harm
- The failure of the facility to prevent abuse or neglect is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.
- All deficiencies at these mandates will be at Harm Level 2 or higher for psychosocial harm.

131

131

F602 FREE FROM ABUSE, NEGLECT, MISAPPROPRIATION OF RESIDENT PROPERTY

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility failed to assure that a resident's personal property was safeguarded and that staff did not misappropriate resident's property. A resident, who had a medical condition in which she had loss of hair, owned two wigs which were personalized for her needs which she used consistently during the daytime hours. Staff documented that the resident was "crying loudly, shouting and was hysterical" and when investigated, she stated someone had stolen her wigs over the weekend. She stated she told staff and they discounted her complaints. The resident refused to leave her room or see anyone, was extremely agitated, and wanted the police called. During the facility investigation, two employees who had worked the evening shift over the weekend, were heard by other staff members, talking and laughing about how they had taken the resident's wigs.

132

132

F602 FREE FROM ABUSE, NEGLECT, MISAPPROPRIATION OF RESIDENT PROPERTY

DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility had failed to protect residents from misappropriation of resident property, had failed to immediately report and investigate alleged violations, and had failed to implement policies and procedures for reporting the possible crime to law enforcement. A resident reported to staff that she was missing a gold necklace. She had last seen the necklace in a nightstand drawer next to her bed. The resident was tearful, since she had received the necklace from her children who had purchased it for her 80th birthday. The resident was worried that she had carelessly lost the necklace and did not want her children to be angry at her. The resident discontinued attending activities, since she did not want to leave her room so that she could protect her belongings. During the facility's investigation, during an interview, CNA #1 stated that she had noticed that CNA #2 had a new necklace that looked familiar. CNA #1 said that CNA#2 quickly evaded questions as to how she had acquired the necklace, until she said that a new boyfriend had given it to her. CNA #1 stated that she did not want to cause any trouble and did not report anything about the necklace until a week later, when it was brought to the Director of Nursing's attention that a resident's necklace was missing. Also, during the investigation, the facility received more reports from staff of stolen jewelry from five other residents, but no staff reported any of the incidents to law enforcement or the State survey agency.

133

133

F602 FREE FROM ABUSE, NEGLECT, MISAPPROPRIATION OF RESIDENT PROPERTY

DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- The facility had failed to protect a resident from misappropriation of resident property when a radio was stolen from a resident's room. The resident, who was cognitively impaired, also had severe confusion and was unable to communicate. The resident had an activity program for listening to classical music in his room. On Monday afternoon, it was reported that the activity staff came into the resident's room to provide the activity but were unable to locate the radio and subsequently reported the loss to the Administrator. Staff stated the radio had been in the room when they had left on Friday after the afternoon activity. The Administrator contacted the resident's son, and confirmed that the family had not removed the radio during a visit over the weekend and had no knowledge of where it might be. The facility replaced the radio. The Administrator reported the incident to the SA. Although the resident could not articulate what had occurred with the radio, the family wished to have the music therapy continue as the resident had a lifelong interest in classical music and they felt, even though the resident could no longer communicate and was confused, that the music provided a sense of comfort. The facility completed the investigation, and identified that a temporary staff member had stolen the radio. The temporary staff member was not allowed to work in the facility again.

134

134

F602 FREE FROM ABUSE, NEGLECT, MISAPPROPRIATION OF RESIDENT PROPERTY

DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- The failure of the facility to prevent misappropriation of resident property and exploitation is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

135

135

F603 FREEDOM FROM…INVOLUNTARY SECLUSION

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility failed to assure that a resident was free from involuntary seclusion. The resident with a history of suicidal ideation and displaying behavioral symptoms which included episodic periods of yelling and screaming, especially towards the end of the day and during the night. According to the resident's record, after dinner last evening, the resident was placed by staff in her recliner with a tray attached by the nurse's station. It was documented and corroborated by staff interviews that they heard the resident yell and scream loudly, pounding on her tray. Several residents began complaining about the noise. A nurse aide transferred the resident to a wheelchair, and placed the resident, who was at risk for suicidal ideation, in a housekeeping supply room, which was used for storage of chemicals. The nurse aide closed the door and went back to the floor. The resident began crying loudly, banging on the doors and yelling for help. Another staff person thought that she heard a resident yelling, but was busy completing tasks for another resident. Afterwards, she heard the yelling continue, found the resident, and removed the resident from the room, the resident was sweating profusely, her face was reddened, and was shaking and sobbing incoherently. Upon interview, the nurse aide who had secluded the resident stated that she did not have the time to deal with the yelling, and she had to get other residents to bed. She moved the resident to the supply room to quiet her down.

136

136

F603 FREEDOM FROM…INVOLUNTARY SECLUSION DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility failed to assure that a resident was free from involuntary seclusion. A resident was admitted to a secured area at the request of his representative. After admission, the resident requested the security codes in order to go in and out of the area, but staff refused to provide the codes. The resident then requested to be transferred, but staff refused his request. The staff then contacted the resident's attending physician, who made the determination that was not any clinical reason for the resident to be located in the secured area; once the physician made this determination , he notified the facility, which immediately transferred the resident to a room not located in the secured area. During interview with the resident, he stated that he was still angry that he had been placed in the secured area against his will for his first day in the facility, and felt afraid to leave his room except for meals or else staff would place him again in the secured area, even though staff attempted to regain his trust.

137

137

F603 FREEDOM FROM…INVOLUNTARY SECLUSION DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- The facility failed to assure that a resident was free from involuntary seclusion. Based on resident and staff interviews, it was stated that a nurse aide was transporting him to an activity. The resident, who was dependent on staff for mobility in his wheelchair, said that he was annoyed that he was late to the activity. He began to insult the nurse aide. The nurse aide transported the resident in his wheelchair to an unused shower room, instead of to the activity room and the nurse aide told the resident that when he stopped insulting her, she would take him to the activity. The nurse aide stood outside the door to supervise the resident and when the resident became quiet, she took the resident back to the activity. Afterwards, the resident reported what had happened to the activity director and said that he did not want the aide working with him anymore. During interview, the resident stated that this was the only time something like this happened.

138

138

F603 FREEDOM FROM…INVOLUNTARY SECLUSION DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- The failure of the facility to prevent involuntary seclusion is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

139

139

F604 FREEDOM FROM…PHYSICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility failed to assure that a restraint was an intervention to treat a medical symptom and was not being used for staff convenience. Facility staff had placed a resident in a bean bag chair from which he could not rise. Based on staff interview, the resident was ambulatory, but had fallen in the past when attempting to stand up. The facility staff did not recognize that the bean bag was a physical restraint; thus, the staff did not conduct any assessment to identify any medical symptoms that would necessitate a restraint. Staff stated that they placed the resident in the bean bag chair while caring for other residents. The resident reported being placed and left in the bean bag chair every day in the afternoon and was not able to stand to walk to his room or to activities. The resident said that he felt humiliated that he is not able to get out of the chair himself, when he wants to, especially since he enjoys talking with the other residents. The surveyor observed the resident struggling to get up, but was not able.

140

140

F604 FREEDOM FROM…PHYSICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- The failure of the facility to assure residents are free from physical restraints not required to treat the resident's symptoms is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

141

141

F604 FREEDOM FROM….CHEMICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility administered a medication to a resident for staff convenience without a medical symptom identified. The resident was admitted to a secured area of the facility two months prior to the survey. During observations the resident was observed lying in a reclining chair, sleeping and staff had difficulty arousing the resident for meals. The staff had to provide one to one assistance to assist the resident to eat. The resident was unable to hold the utensils, and was being fed a pureed meal. The resident required a two-person assist to transfer from bed to chair and required total assistance for activities of daily living. The resident's record revealed that on admission, the resident was independent in mobility and ambulation and did not require assistance to eat. Staff interviewed stated that they had difficulty monitoring the resident as they were taking care of other residents. They stated that there were no identified interventions or activities to address these behaviors. As a result, staff requested a medication from the physician for the wandering behavior. The physician was interviewed and stated that the medication was being administered for wandering, but that he was not aware that the resident was sedated and the resident's decline in walking and activities of daily living. There was no other evidence in the resident's record or from interviews with staff and the physician that indicate a medical reason for the decline and sedating effect.

142

142

F604 FREEDOM FROM….CHEMICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility failed to assure that a medication it administered to a resident was being used to treat a medical symptom and not for staff convenience. The resident was admitted for post-surgical rehabilitation of a fractured hip. During an interview, the resident's representative stated that prior to admission, the resident had been alert, was able to recognize her family members, was used to sitting with the family after the evening meal at home, and, although pleasantly confused, enjoyed a warm bath prior to bedtime and slept through the night. However, after admission, there had been a significant change in the resident's status. The resident's record reflected that the resident, after admission, was immediately put to bed after the evening meal every day; subsequently, the resident began yelling out for help, wanted to get out of bed, and disrupted other residents' sleep. During an interview with the practitioner, staff had contacted him and requested an antipsychotic medication to keep the resident quiet during the night hours as she was disruptive and agitated. The practitioner ordered an antipsychotic medication twice a day, but did not provide documentation of a medical symptom being treated with the medication. Observations throughout the survey revealed the resident seated in a wheelchair, subdued or sleeping, sucking on her hand, mumbling to self, and not aware of surroundings or visitors. Staff interviewed corroborated that there had been a decline in the resident's condition since the administration of the medication. Due to the significant change in the resident's status related to the initiation and use of a chemical restraint, serious harm occurred to the resident.

143

143

F604 FREEDOM FROM….CHEMICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility administered a medication that was not being used to treat medical symptoms, the facility did not attempt any less restrictive interventions, and the medication was used for the convenience of staff. As a result of this noncompliance, the resident was sedated into the morning hours. The resident was unable to be aroused sufficiently to eat breakfast in the dining room where he normally eats meals, and now required assistance by staff to eat breakfast. The resident was observed to attend and participate in his other meals and activities for the rest of the day. The record did not indicate any falls or any decline in other activities of daily living. The resident, diagnosed with Alzheimer's disease, had displayed night time behaviors that frustrated other residents and nursing staff, such as wandering into other resident's rooms, and rummaging through drawers and closets. To address the resident's behavior, staff contacted the attending physician to discuss the issue and request a long-acting anti- anxiety medication. No other attempts of non-pharmacological interventions were identified or implemented prior to the use of the chemical restraint. Staff stated that they did not have the time to implement other interventions. The resident's record did not indicate a medical symptom being treated, nor a reduction of the medication when the resident's functional status declined.

144

144

F604 FREEDOM FROM….CHEMICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- The facility failed to assure that an antianxiety medication was being administered to treat a medical symptom and not for the convenience of staff. Although the resident has not experienced falls or other adverse consequences in relation to the administration of the medication, the potential exists for more than minimal harm with the continued use of the anti-anxiety medication in the absence of a medical symptom. Interviews and record review revealed that the facility was giving a resident anti-anxiety medication prior to the resident taking showers occasionally on weekends. Staff indicated that the resident had occasionally declined showers not because she was anxious, but because she found bed baths to be more relaxing than the shower environment. The staff interviewed stated that the nurse aides, who worked the daytime weekend shift, were upset about the resident refusing the shower as they did not have time to come back and shower the resident at another time not realizing that this was not the resident's preference. The weekend nurse contacted the physician for a medication to alleviate the resident's "anxiety to taking a shower." A nursing assistant who was assigned to provide the resident's care during the week, stated that sometimes the resident does not want to take a shower and on those occasions, she would give the resident a bed bath. The nursing assistant said the resident is not resistive or combative.

145

145

F604 FREEDOM FROM…PHYSICAL/CHEMICAL RESTRAINTS DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- The failure of the facility to assure residents are free from physical restraints not required to treat the resident's symptoms is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

146

146

F609 …REPORTING OF A REASONABLE SUSPICION OF A CRIME DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility failed to implement policies and procedures for covered individuals to identify and report a suspected crime to local law enforcement and the SA, resulting in failure to protect a resident from further potential criminal activity by an alleged perpetrator. *In addition, the facility had failed to report the alleged violation of abuse to the Administrator, as well as the State Survey Agency.* A resident, with a cognitive impairment who was dependent on staff for care, reported to family members that she was "touched down there" and identified the alleged perpetrator. Family members reported this to the licensed staff person on duty; however, the staff told the family that the resident was confused. Staff did not report the family's allegation to anyone and failed to provide protection for the resident allowing ongoing access to the resident by the alleged perpetrator. The resident had emotional changes including crying and agitation and cowered with fear whenever the alleged perpetrator approached the resident. The resident subsequently developed a sexually transmitted disease (STD). Based on interviews with various staff members, these covered individuals were not aware of their reporting responsibilities for a suspected crime, *even though they had participated in abuse prevention training and had received their annual notification of their reporting obligations. Each staff member* assumed that this did not need to be reported because the resident was confused; therefore the facility had failed to ensure reporting.

147

147

F609 …REPORTING OF A REASONABLE SUSPICION OF A CRIME DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility failed to implement policies and procedures for covered individuals to report to local law enforcement, the suspicion of a crime related to drug diversion. A resident was prescribed opioid pain medication to manage severe pain following recent surgery for a fractured hip. A resident had requested that staff review his pain medication as it was not effective over the weekend. The resident informed staff that he was unable to attend weekend daytime activities due to discomfort and lack of sleep from having pain at night. The resident stated that he received a different colored pill during the weekend, but it did not seem to work like the medication that was given during the weekdays. The facility's investigation revealed that the same staff nurse worked on each of the weekend night shifts when the resident was identified to have unrelieved pain. This staff nurse had access to the controlled medications for residents on that unit. During interview with the nurse aide who worked on the same shift as the nurse, the nurse aide stated that she saw the nurse coming out of the resident's room with the medication cup, and the nurse had told her that the resident was sleeping and she would give the medication later. The nurse aide reported that she then saw the nurse take the medication herself. She stated that she was afraid to report what she had seen since she did not want to jump into any conclusions or cause any trouble for the nurse. Interviews with other staff revealed they were not aware of facility policies or of their obligations to report a suspected crime including possible drug diversion.

148

148

F609 …REPORTING OF A REASONABLE SUSPICION OF A CRIME

DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The facility failed to provide annual notification to staff on their obligations to report suspected crimes and to post signage of employee rights related to retaliation against the employee for reporting a suspected crime. During the investigation, the surveyors did not see any signage related to employee rights related to retaliation. Based on interviews with five staff members, they had not received their annual notification from the facility regarding their obligations to report suspected crimes to law enforcement and to the State Survey Agency, without fear of retaliation. However, the staff members were knowledgeable about their obligations. *Additionally, two other staff members who were recently hired within the last 30 days, were not knowledgeable of their reporting obligations or rights to report a suspected crime without retaliation.*

149

149

F609 …REPORTING OF A REASONABLE SUSPICION OF A CRIME

DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- The failure of the facility to meet the requirements under this Federal requirement is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

150

150

F622 TRANSFER AND DISCHARGE

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- *Facility initiated a discharge on the basis that the resident's health had improved, however, the resident and her family disagreed and filed an appeal. The facility did not allow the resident to remain in the facility while the appeal was pending and dropped her off at her daughter's home. The resident's daughter previously stated she could not care for her mother at her home where needed medical equipment and wound care was not available. The resident developed sepsis from inadequate wound management, and remains hospitalized post-amputation of the infected limb.*

151

151

F622 TRANSFER AND DISCHARGE

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- *A facility initiated a discharge based on the facility's inability to meet a resident's needs. However, upon complaint investigation, it was determined by interview and record review that, while the resident was depressed and had challenging behavior requiring staff attention, he did not have needs which could not be met in that facility, and there was evidence that the facility was caring for other residents with similar challenging behaviors. The resident was discharged to the street and found by a passerby in the street, rolled up in a tarp, and in a health condition requiring immediate medical attention.*

152

152

F622 TRANSFER AND DISCHARGE
DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- *The facility failed to allow a resident to remain in the facility after his skilled rehabilitation ended and while his application for Medical Assistance was pending. The resident consequently was discharged to another facility that was located further from the resident's family, resulting in the resident expressing persistent sadness and withdrawal from social activities.*

153

153

F622 TRANSFER AND DISCHARGE
DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- *A facility initiated a resident's discharge after the resident attempted to hit a staff member during morning care over several days. The facility discharged the resident claiming the resident was a danger to others. Upon investigation of a complaint, it was determined the facility had been failing to provide the resident with pain medication prior to morning care in accordance with the care plan. Evidence also showed the resident had never attempted to hit staff when pain was managed according to the care plan, therefore the resident was not actually a danger to others. There was also no documentation of the facility's attempts to meet the resident's needs or what services the new receiving facility had in order to meet the resident's needs. During an interview with the resident, the surveyor found the resident was not happy in the new facility and was no longer participating in activities or therapy, resulting in a significant decreased ability to perform ADLs.*

154

154

F622 TRANSFER AND DISCHARGE
DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- *A facility transferred a resident to the hospital emergently due to a change in condition. The facility failed to provide the hospital with contact information for the practitioner responsible for the resident's care leading to a delay in admitting the resident.*

155

155

F622 TRANSFER AND DISCHARGE
DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- *An example of Severity Level 1 noncompliance: The failure to permit the resident to remain in the facility, document the resident's transfer or discharge, and communicate necessary information to the receiving provider places the resident at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.*

156

156

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- Facility failed to allow a resident to return following therapeutic leave to a family member's home, resulting in the resident being found living on the street, without adequate food *and* shelter, and susceptible to serious accidents.

157

157

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- Facility failed to allow a resident to return to *an available* bed in the same location of the composite distinct part *in* which they resided previously. The new location was *not on the same campus where the resident previously resided, and was farther* from the resident's family, resulting in the resident expressing sustained and persistent sadness and withdrawal.

158

158

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- *After transfer to a behavioral health hospital, a facility failed to allow a resident to return to the facility where the resident had lived for several months. The facility then refused to allow the resident to return to the facility when the hospitalization ended, resulting in the resident being transferred from the hospital to a different nursing home 40 minutes away, where he did not know anyone, and where he developed increased anxiety and depression.*

159

159

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- Facility failed to allow a resident to return to his/her previous room (even though it was available) upon return from the hospital, which resulted in no more than minimal harm as the resident adjusted to the new room. This noncompliance has the potential to cause more than minimal psychosocial harm.

160

160

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- A facility which is a composite distinct part permitted a resident to return following hospitalization or therapeutic leave, however, the resident returned to a different location in the composite distinct part even though a bed was available in the same location where the resident had resided prior to transfer. The resident did not express displeasure with the situation.

161

161

F626 PERMITTING RESIDENTS TO RETURN TO FACILITY

DEFICIENCY CATEGORIZATION: HARM LEVEL 1

- A facility which is a composite distinct part permitted a resident to return following hospitalization or therapeutic leave, however, the resident returned to a different location in the composite distinct part even though a bed was available in the same location where the resident had resided prior to transfer. The resident did not express displeasure with the situation.

162

162

F624 …PREPARATION FOR TRANSFER NOT REQUIRING DISCHARGE PLANNING

DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- 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.

163

163

F624 …PREPARATION FOR TRANSFER NOT REQUIRING DISCHARGE PLANNING

DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- 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.

164

164

F740 BEHAVIORAL HEALTH SERVICES
DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- A resident was admitted to the facility one month ago with diagnoses of major depression, SUD, and a history of a suicide attempt. After admission, the resident continuously expressed wanting to die and often yelled and cursed at staff members. The attending physician ordered a psychological evaluation, an antidepressant, and 30 minute checks which were implemented by the facility. Record review showed that the psychological evaluation recommended the use of several non-pharmacological behavioral health interventions, which were not implemented. During additional record review and an interview with the nurse it was revealed that the resident was found hanging from his closet bar with a sheet tied around his neck, and no pulse. CPR was started and the resident was resuscitated.
- The facility failed to adequately meet a resident's mental health needs when it did not address non-pharmacological approaches to care.

165

165

F740 BEHAVIORAL HEALTH SERVICES
DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- 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. 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.

166

166

F740 BEHAVIORAL HEALTH SERVICES
DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- 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. 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.

167

167

F743 ...NO DIAGNOSIS OF MENTAL/PSYCHOSOCIAL ADJUSTMENT DIFFICULTY
DEFICIENCY CATEGORIZATION: HARM LEVEL 4

- The facility failed to identify signs of distress exhibited by a resident who, according to the medical record, for the past month had begun rising from bed mid-morning and returning to bed immediately after dinner. This was a departure from her previous morning and night sleep patterns. Upon interview, staff communicated that as people age, they grow tired more easily and require more sleep. The staff also noted that the resident was often very tearful and seemed depressed, but again they felt that this was normal for older adults. Even though she experienced a significant weight loss and did not want to speak to a social worker when approached about these noted changes, the staff honored her wish to be left in bed. During the resident interview, she stated that she was tired and just wanted to sleep. She informed the surveyor that the last of her friends had just died, leaving her with no other childhood contacts or meaningful social relationships other than her family. She began crying and stated that she often cried, but tried not to in front of the staff because she was too proud. She felt that by sleeping a lot, she wouldn't have to face the fact that she also would die soon.
- The facility's failure to identify that the resident was in distress and needed a mental health assessment caused a delay in receiving appropriate services and a deterioration in the resident's psychosocial well-being.

168

168

F743 …NO DIAGNOSIS OF MENTAL/PSYCHOSOCIAL ADJUSTMENT DIFFICULTY
DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- During the tour of the facility, the surveyor noticed a resident sitting by the front door of the facility wringing his hands and staring out the window. While engaged in conversation, he stated that he was afraid that he would miss his group again. He had to come to the nursing home after his wife's death and was having a hard time adjusting to the change. He stated that he joined a grief support group that he was finding helpful, but had not been able to attend for a few weeks. He was unable to sleep at night because of the worry about missing the group sessions.
- His care plan indicated that the only intervention to address his grief was participation in a weekly support group meeting at the senior center. His goal was to attend group sessions, so he could better cope with the multiple losses he had experienced. An interview with the facility administrator revealed that the resident had been unable to attend group sessions for six weeks because the facility's only van was in the shop. During those weeks, the facility failed to provide alternative interventions and address the distress caused by the missed meetings. The resident's medical record reflected that in the past month, he appeared more anxious, depressed, and angry and staff described him as "not his pleasant self."
- The resident suffered a decline as a direct result of being unable to attend his weekly support group meetings and the facility did not seek any alternatives when transportation was unavailable.

169

169

F743 …NO DIAGNOSIS OF MENTAL/PSYCHOSOCIAL ADJUSTMENT DIFFICULTY
DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- After falling at home and fracturing her femur, a resident was admitted to the skilled nursing facility for rehabilitation services. She had no history of mental or psychosocial adjustment difficulty, trauma (other than the fall), and/or PTSD. When she was first admitted she was very involved in facility events and activities, and participated enthusiastically in therapy. During observation of the breakfast meal, the surveyor noticed that the resident appears quite tired and asked the physical therapist if therapy could be postponed until later in the afternoon so she could go back to bed. When questioned, the resident stated that she has not had a good night's sleep since admission, due to the woman in the next room yelling most of the night. The resident also stated that she does not want to complain since she knows that the woman yelling has dementia. However, it is getting harder for her to get enough rest and she finds herself feeling irritable and depressed from her lack of sleep. The physical therapist reported that the resident has not been progressing as well as she was when she was first admitted and when she attends therapy, she tires and becomes frustrated easily.
- The resident's lack of rest and feeling of sadness stemmed from the staff's inability to realize that the distress of another resident was affecting other residents. The resident's sleep pattern had already been disrupted for several nights and she was too tired to participate in therapy. If the situation continues, it could lead to a decline in the resident's clinical condition.

170

170

F744 …DEMENTIA CARE
DEFICIENCY CATEGORIZATION: HARM LEVEL 3

- The care plan for a resident with an identified diagnosis of dementia included the need for close supervision to prevent the resident from wandering into the rooms of other residents. However, the review of the care plan indicated that the facility had failed to develop person-centered interventions to prevent the resident from wandering. The record review also provided information about a resident-to- resident altercation that had occurred a week prior to the survey. The altercation involved a sweater that was removed from the room of another resident, who slapped and scratched the resident living with dementia, because she refused to return the garment. The resident received minor lacerations and bruising, which was cared for by the direct care staff at the nursing home. The care plan was revised to reflect the need to closely supervise. During the survey, the resident was observed wandering in and out of resident rooms. When questioned, direct care staff were unaware that the resident required close supervision.
- The facility failed to develop and implement interventions to address the resident's dementia care needs, resulting in the resident's inability to achieve her highest level of functioning.

171

171

F744 …DEMENTIA CARE
DEFICIENCY CATEGORIZATION: HARM LEVEL 2

- A resident was observed standing in her doorway asking what day of the week it was. Two staff members were within hearing distance, but did not reply to the resident. The surveyor also noticed that there was no calendar in the resident's room. Review of the resident's record showed that she had a diagnosis of dementia. The care plan noted that the resident has a tendency to forget what day of the week it is and can become anxious when not reminded. Interventions include that staff are to ensure that a current calendar is on her bedroom wall and remind the resident what day it is when she wakes up each morning and when facility staff are asked.
- The facility failed to support the resident and implement care planned interventions to reduce her confusion, which had the potential to cause the resident anxiety.

172

172

F848 ARBITRATOR/VENUE SELECTION… GUIDANCE ON SEVERITY DETERMINATION

- *When determining the severity of noncompliance at F848, surveyors must always consider what impact the identified noncompliance had on the affected resident(s). However, unlike noncompliance at other tags, such as Abuse or Quality of Care, which may result in physical, mental, and/or psychosocial outcomes, noncompliance at F848 will almost exclusively have a psychosocial impact or outcome. Surveyors must gather sufficient evidence through interviews, record review and observation to demonstrate what the psychosocial impact was to the resident. In some cases, the surveyor may have to use the reasonable person concept to determine severity. Refer to the Psychosocial Severity Outcome Guide for further information.*

173

173

SURVEYOR GUIDANCE THROUGHOUT THE RoP

- **NOTE**: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).
- In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

174

174

RAI Process

Assessment (MDS 3.0)

Decision-Making (CAA)

Care Plan Development

Care Plan Implementation

Evaluation

175

RAI and Delivery of Care

- The intent is to develop an individualized plan of care based on the identified needs, strengths, and preferences of the resident.
- RAI consists of three basic components: MDS Version 3.0, the CAA process, and the RAI utilization guidelines.
- The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once care area issues/conditions have been identified.

176

What are the CAAs?

Care Area Assessment

- The MDS alone is not a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident issues/conditions, strengths, and preferences.
- Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.
- Therefore, the goal of the CAA process is to guide the IDT through a comprehensive assessment of a resident's functional status. **Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being**

177

What are the CAAs?

Care Area Assessment

- The CATs (Care Area Triggers) are specific response options from the MDS that are indicators of 20 particular care areas that affect nursing home residents.
- When a trigger is entered as the response on a resident's MDS, additional assessment and review of the care area are required to determine the status of the issue. Thus,
- The CATs and CAAs form a critical link between the MDS and care planning.

178

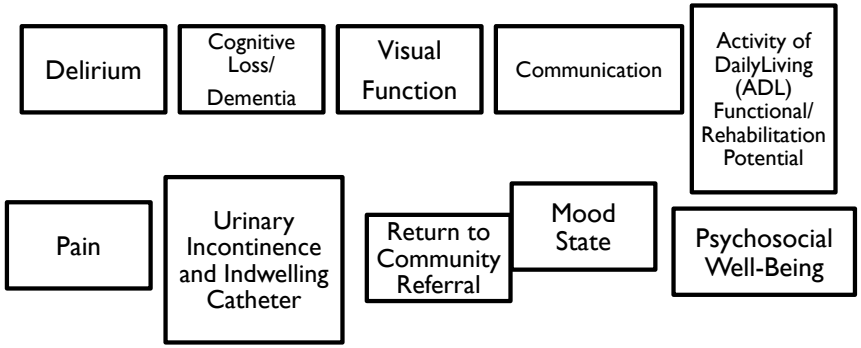
What are the CAAs?

Care Area Assessment

- Each care area comprises:
  (1) an introduction that provides general information about the issue or condition and
  (2) a list of items and responses from the MDS that are considered CATs for the issue or condition.
- Each triggered CAA **must be assessed further to facilitate care plan decision making, but it may or may not represent a condition that should be addressed in the care plan.**

179

What are the CAAs?



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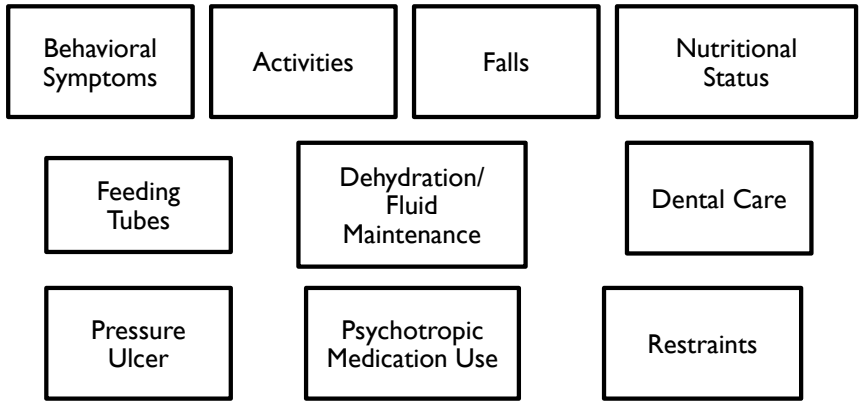
What are the CAAs?



181

CMS Requirement - F655 Baseline Care Plan

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.

182

Care Planning

1. **Identification of problems, needs, concerns, issues, preferences, interests & strengths**
2. **Development of goals:**
   - ✓ **Goal must deal with or address the problem/need that was identified;**
   - ✓ **Goal must be resident-directed;**
   - ✓ **Goal must be an observable action task;**
   - ✓ **Goal must be measurable.**
3. **Development of interventions/approaches**
   - ✓ **Must be individualized**
   - ✓ **Must be specific; consider them specific "assignments" to a staff person**

183

Easing into Care Plans

Choose an individual from your facility.

Now, ask yourself the following three questions:

1. **What do I do with and for this resident?**
2. **Why am I doing these things?**
3. **What outcome am I hoping to help the resident attain?**

184

Easing into Care Plans

1. Question 1 = Staff interventions
2. Question 2 = Resident risks, issues, concerns or preferences
3. Question 3 = The resident's goal.

Ambiguous Documentation

- Good, fair, poor, well
- Will monitor
- Will follow-up
- Referencing "adjustment issues" in general terms
- Appears

Ambiguous Documentation

- Appropriate/inappropriate
- Adequate/inadequate
- More/less
- Decrease/increase

Social Progress Notes

One of the most cited deficiencies that social service departments receive can be attributed to the lack of documentation in a resident's progress report.

For many, figuring out what needs to be documented, and what is considered "fluff" and unnecessary, can be a true dilemma.

Social Progress Notes - Content

- Carry out the social service interventions that were identified on the Comprehensive Care Plan.
- Note the resident's response to each intervention. If evidence cannot be found to support that the plan was actually implemented, it appears to surveyors that the plan was not implemented.

189

Social Progress Notes - Content

Update information regarding identified problems/needs and goals:

- If the problem/need has been resolved or met, and the goals have been attained, state as such.
- If the problem/need has not been resolved and you would like to continue the present goal and "plan of action," state as such.

  Reminder: before you can continue a goal for another time period, your progress note must indicate evidence of some progress towards the attainment of the goal, or resolution of the problem/need. Surveyors wonder why plans are continued when no progress has been noted.

190

Social Progress Notes - Content

Update information regarding identified problems/needs and goals:

- If the problem has not been resolved, or the need not met, and the goal is not feasible, state this and develop a new plan of action.
- If there is a new problem or need, identify those issues. Develop an appropriate plan of action to be incorporated into the Comprehensive Care Plan.

191

Social Progress Notes - Content

- Comment on problems/needs as they arise and note the outcome or resolution.
- Note the frequency of family contact, visits, and community visitors.
- Note referrals and follow-ups.
- Note resident's and family's adjustment to facility.

192

Social Progress Notes - Content

- Note resident's mental, physical, emotional, and psychosocial well-being during the past time period that you are reflecting in the progress note.
- Pay special attention to behavioral symptoms and symptoms of depression.

193

Social Progress Notes - Content

- Document deliverance of any social services (actual services that you, the Social Worker/Designee, have provided). While it is virtually impossible to document every little service that you provide to each individual resident, it is important to document the services that reflect implementation of the care plan.

194

Social Progress Notes - Content

- Note any changes in the resident's condition (improvement or decline/ deterioration); hospital stays; discharges; and room transfers.
- Other items or incidents that may occur and affect the care and psychosocial well-being of the resident.

195

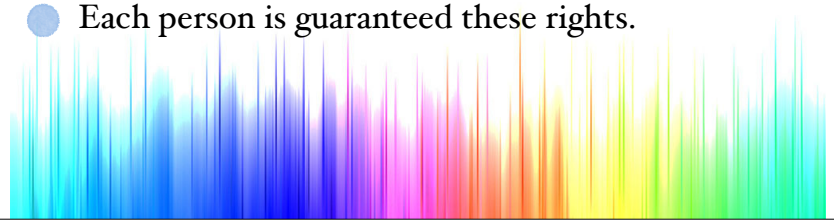
Residents' Rights, Choices, & Preferences: What's the Difference? And WHY Am I Being Cited??

Cat Selman, BS
www.catselman.com

196

Residents' Rights

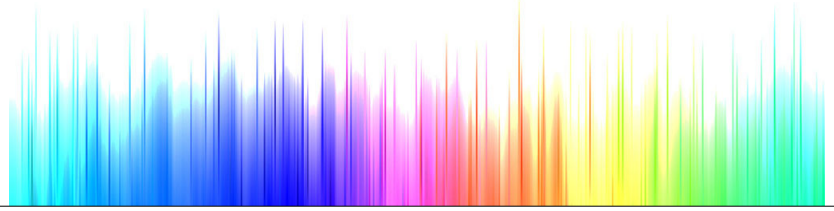
- Are guaranteed by the CMS Requirements of Participation (federal law).
- The law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination.
- Each person is guaranteed these rights.



197

Residents' Rights

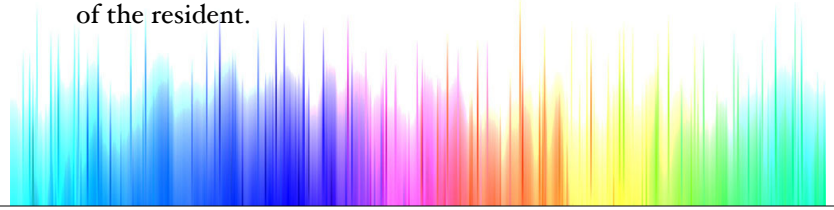
- "Choice" is the act of making a selection; liberty or freedom to choose.
- It is a matter of "control" for the resident.
- In a study utilized for the language in the CMS RoP, nursing home residents rated "choices" as being the top, single-most important item in their lives.



198

Residents' Rights

- The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, *including those specified in this section.*
- §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.



199

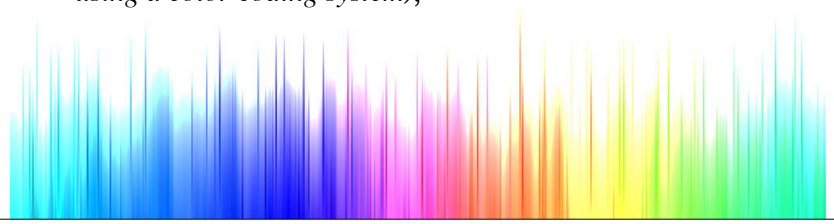
Residents' Rights

- Each resident has the right to be treated with dignity and respect.
- All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices.
- When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.

200

Examples…

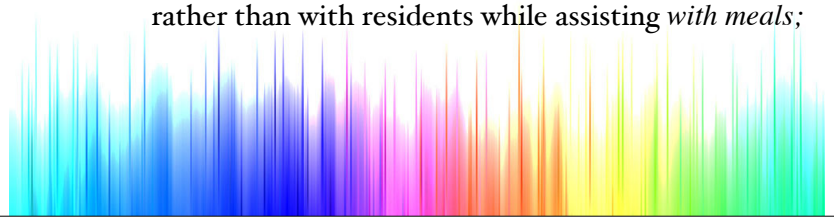
- Encouraging and assisting residents to dress in their own clothes, *rather than hospital- type gowns, and appropriate footwear for* the time of day and individual preferences;
- *Placing labels on* each resident's clothing in a way that *is inconspicuous and* respects his or her dignity (*for example*, placing labeling on the inside of shoes and clothing *or using a color coding system*);



201

Examples…

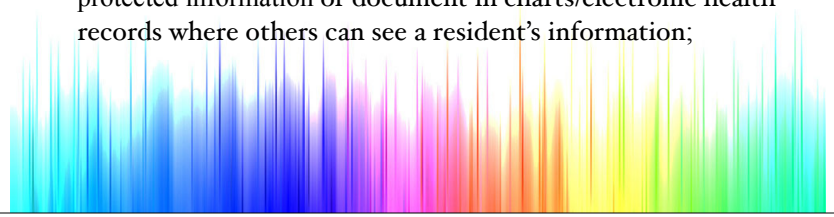
- Promoting resident independence and dignity while dining, such as avoiding:
  - ✓ *Daily* use of *disposable* cutlery and dishware;
  - ✓ Bibs *or* clothing protectors instead of napkins (except by resident choice);
  - ✓ *Staff s*tanding over residents while assisting them to eat;
  - ✓ *Staff i*nteracting/conversing only with each other rather than with residents while assisting *with meals;*



202

Examples…

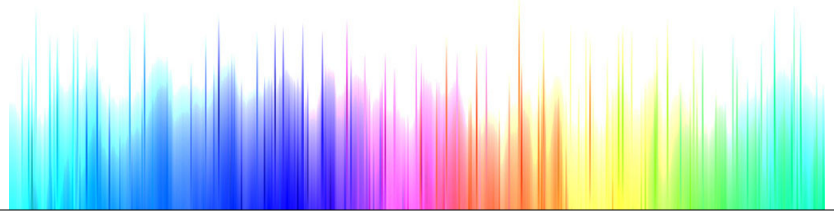
- Protecting and valuing residents' private space (for example, knocking on doors and requesting permission before entering, closing doors as requested by the resident);
- Staff should address residents with the name or pronoun of the resident's choice, avoiding the use of labels for residents such as "feeders" or "walkers."
- Residents should not be excluded from conversations during activities or when care is being provided, nor should staff discuss residents in settings where others can overhear private or protected information or document in charts/electronic health records where others can see a resident's information;



203

Examples…

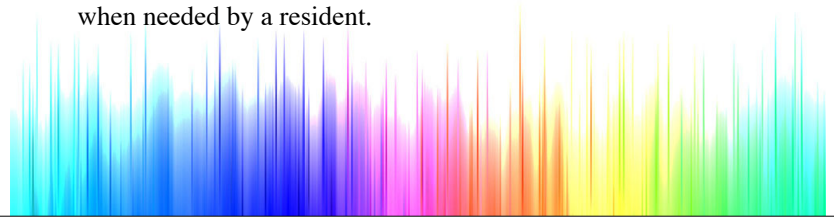
- Refraining from practices demeaning to residents such as leaving urinary catheter bags uncovered, refusing to comply with a resident's request for bathroom assistance during meal times, and restricting residents from use of common areas open to the general public such as lobbies and restrooms, unless they are on transmission-based isolation precautions or are restricted according to their care planned needs.



204

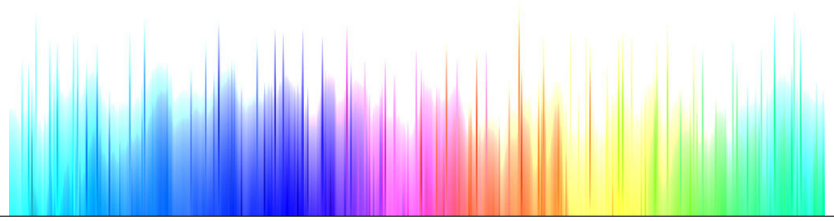
Examples…

- Consider the resident's life style and personal choices identified through their assessment processes to obtain a picture of his or her individual needs and preferences.
- Staff and volunteers must interact with residents in a manner that takes into account the physical limitations of the resident, assures communication, and maintains respect.
- For example, getting down to eye level with a resident who is sitting, maintaining eye contact when speaking with a resident with limited hearing, or utilizing a hearing amplification device when needed by a resident.



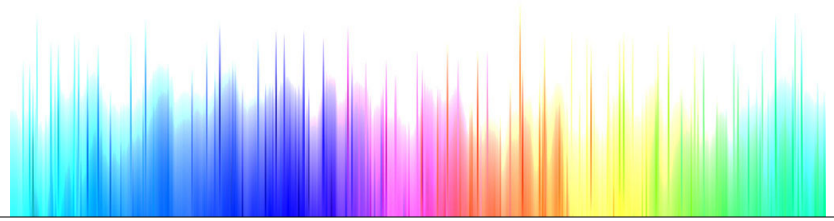
Surveyor Guidance

- Pay close attention to resident or staff interactions that may represent deliberate actions to limit a resident's autonomy or choice.
- These actions may indicate abuse.
- See F600, Free from Abuse, for guidance.



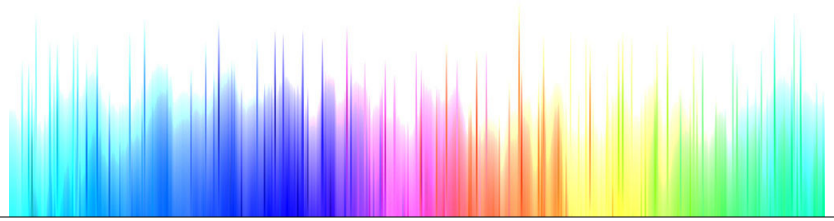
F561 §483.10(f) Self-determination.

- The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.



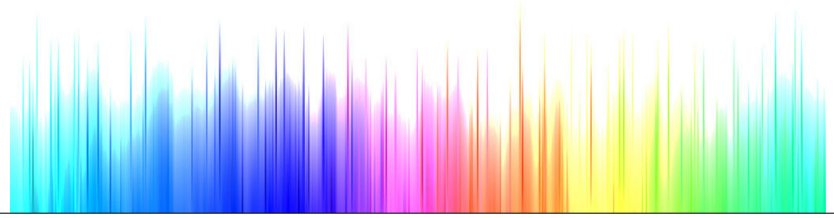
F561 §483.10(f) Self-determination.

- The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.



F561 §483.10(f) Self-determination.

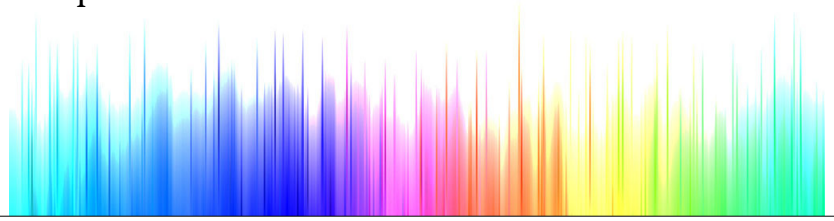
- The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.
- The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
- The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.



209

F561 §483.10(f) Self-determination.

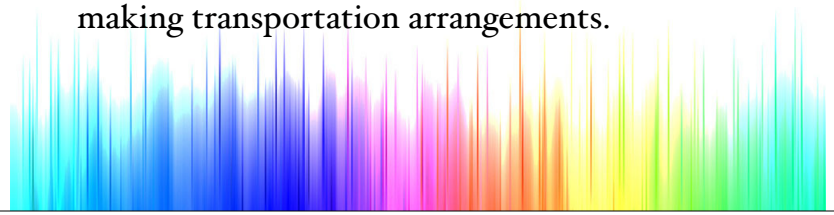
- The intent of this requirement is to ensure that each resident has the opportunity to exercise his or her autonomy regarding those things that are important in his or her life.
- This includes the residents' interests and preferences.



210

F561 §483.10(f) Self-determination.

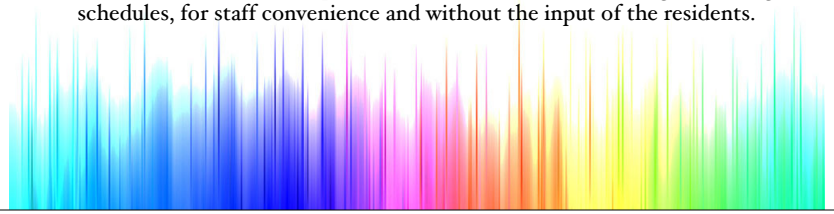
- It is important for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed.
- Additionally, a resident's needs and choices for how he or she spends time, both inside and outside the facility, should also be supported and accommodated, to the extent possible, including making transportation arrangements.



211

F561 §483.10(f) Self-determination.

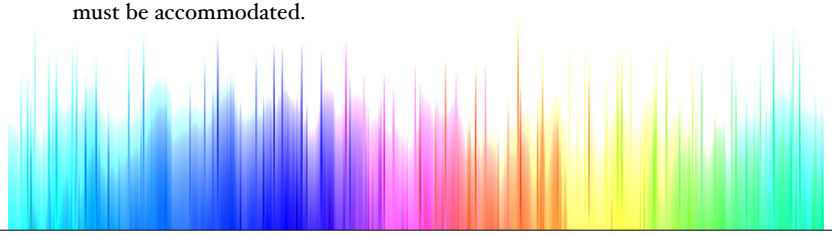
- Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans.
- This includes, but is not limited to, choices about the schedules that are important to the resident, such as waking, eating, bathing, and going to bed at night.
- Choices about schedules and ensuring that residents are able to get enough sleep is an important contributor to overall health and well-being.
- Residents also have the right to choose health care schedules consistent with their interests and preferences, and information should be gathered to proactively assist residents with the fulfillment of their choices.
- Facilities must not develop a schedule for care, such as waking or bathing schedules, for staff convenience and without the input of the residents.



212

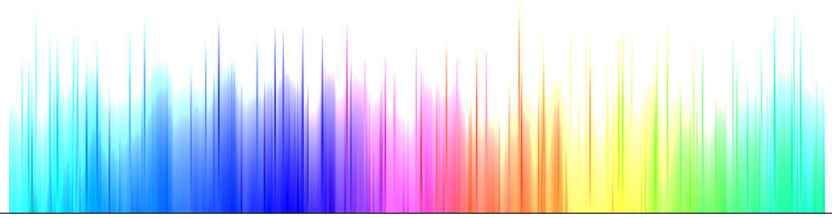
Examples of Compliance

- If a resident shares that attendance at family gatherings or external community events is of interest to them, the resident's goals of attending these events should be accommodated, to the extent possible.
- If a resident mentions that his or her therapy is scheduled at the time of a favorite television program, the resident's preference should be accommodated, to the extent possible.
- If a resident refuses a bath because he or she prefers a shower or a different bathing method, such as in-bed bathing, prefers to bathe at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the resident's preferences must be accommodated.



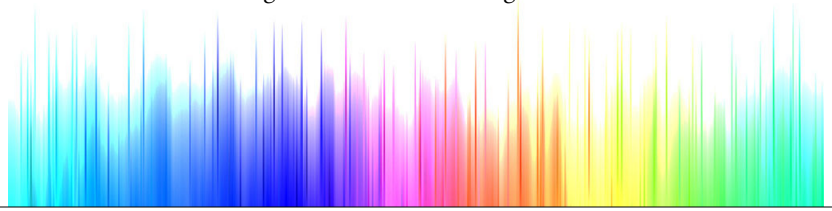
F559 - Right to Share a Room

- The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
- The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
- The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.



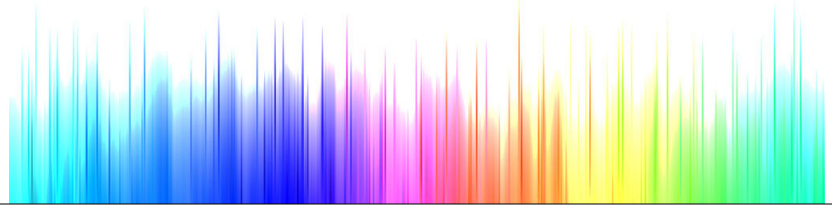
F559 - Right to Share a Room

- Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.
- There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents are not able to share a room if one of the residents has a different payment source for which the facility is not certified (if the room is in a distinct part of the facility, unless one of the residents elects to pay privately for his or her care) or one of the individuals is not eligible to reside in a nursing home.



F559 - Right to Share a Room

- Moving to a new room or changing roommates is challenging for residents.
- A resident's preferences should be taken into account when considering such changes.
- When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required.
- The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.



F559 - Right to Share a Room

- A resident receiving a new roommate should be given as much advance notice as possible.
- The resident should be supported when a roommate passes away by providing time to adjust before moving another person into the room.
- The length of time needed to adjust may differ depending upon the resident.
- Facility staff should provide necessary social services for a resident who is grieving over the death of a roommate.

F560 - The Right to Refuse to Transfer to another room in the facility, if the purpose of the transfer is:

- to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
- to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
- solely for the convenience of staff.

Resident Preferences

- "Preference" is a greater liking for one alternative over another or others.
- The MDS 3.0 serves as the basis for identifying resident preferences, and codes are usually considered when citations are received.

Resident Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes

- ☐ **A.** *how important is it to you to* ***choose what clothes to wear?***
- ☐ **B.** *how important is it to you to* ***take care of your personal belongings or things?***
- ☐ **C.** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
- ☐ **D.** *how important is it to you to* ***have snacks available between meals?***
- ☐ **E.** *how important is it to you to* ***choose your own bedtime?***
- ☐ **F.** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
- ☐ **G.** *how important is it to you to* ***be able to use the phone in private?***
- ☐ **H.** *how important is it to you to* ***have a place to lock your things to keep them safe?***

Resident Preferences

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Enter Codes in Boxes

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

☐	**A.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
☐	**B.** *how important is it to you to* ***listen to music you like?***
☐	**C.** *how important is it to you to* ***be around animals such as pets?***
☐	**D.** *how important is it to you to* ***keep up with the news?***
☐	**E.** *how important is it to you to* ***do things with groups of people?***
☐	**F.** *how important is it to you to* ***do your favorite activities?***
☐	**G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
☐	**H.** *how important is it to you to* ***participate in religious services or practices?***

221

Observing Resident Preferences

Examples:

- Resident would like to sleep in until 10:00 a.m.
- Resident wants therapy in the afternoon.
- Resident would like peanut butter sandwiches for supper every night.
- Resident would like two baths a week in the evenings.
- Resident would like a private space to make personal phone calls
- Resident wants a secure place for his/her belongings
- Resident wants their room cleaned while they are at lunch
- Resident prefers a cloth napkin instead of a clothing protector

222

Observing Resident Preferences

How do we determine resident preferences?

- Review the resident preference section of the MDS 3.0.
- Upon admission and at quarterly care conference, ask about specific preferences (especially if dealing with delivery of care)
- Report resident requests for different food, new roommate, later bed time, etc., immediately to the nurse, social worker, or supervisor
- ASK residents what they want! Don't assume they will just follow the facility schedule and routine.

223

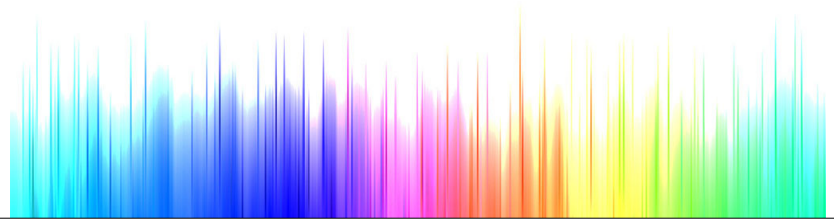
Can We Really Do That??

- Our job is to always try and honor the resident's preferences and choices, in the way they would like them to occur, and as soon as possible, once the request has been made.
- Our job is to OFFER choices, make sure residents know their preferences are important. Do not wait for a request, or a complaint, to meet the stated need and/or preference.

224

Surveyor Decisions

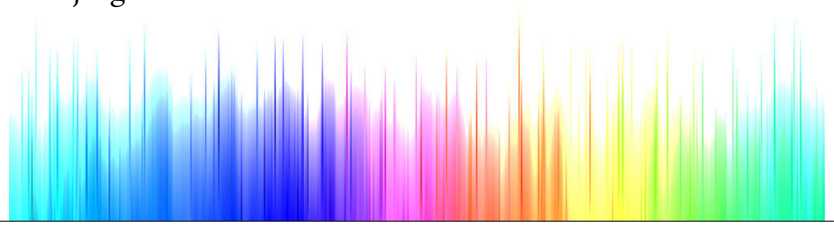
- How do staff know what a resident's preference(s) is?
- How do staff honor a resident's choice(s)?



225

Choice vs. Refusal of Care

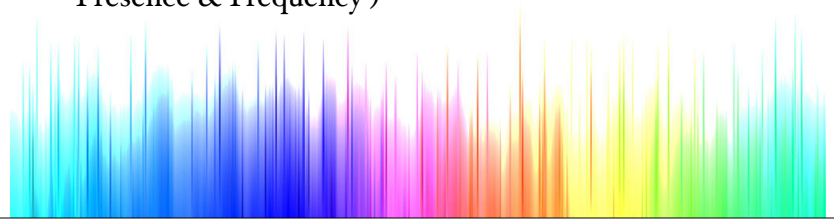
- Goals for health and well-being reflect the resident's wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.
- The resident's care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational to the clinician. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment."



226

Choice vs. Refusal of Care

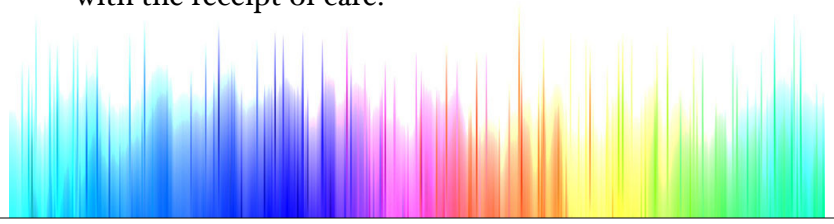
- It is really a matter of resident choice. When rejection/ decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident's choice.
- Education is provided and the resident's choices become part of the plan of care.
- On future assessments, this behavior would not be coded in this item. (E0800: Rejection of Care— Presence & Frequency)



227

Choice vs. Refusal of Care

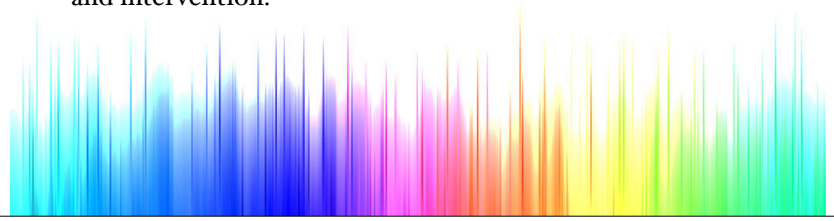
- A resident might reject/decline care because the care conflicts with his or her preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.
- Care rejection may be manifested by verbally declining, statements of refusal, or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care.



228

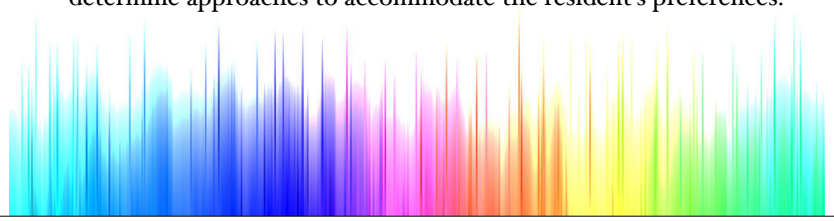
Choice vs. Refusal of Care

- This type of behavior interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.
- A resident's rejection of care might be caused by an underlying neuropsychiatric, medical, or dental problem. This can interfere with needed care that is consistent with the resident's preferences or established care goals. In such cases, care rejection behavior may be a problem that requires assessment and intervention.



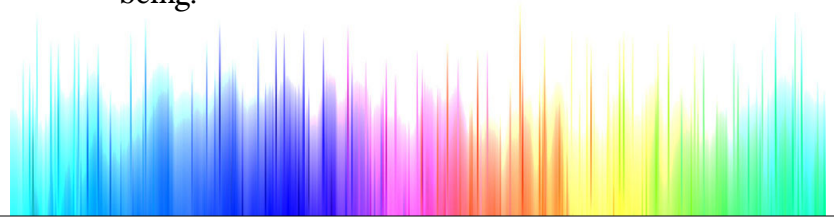
Choice vs. Refusal of Care

- Evaluation of rejection of care assists the nursing home in honoring the resident's care preferences in order to meet his or her desired health care goals.
- Follow-up assessment should consider:
  - ✓ whether established care goals clearly reflect the resident's preferences and goals and
  - ✓ whether alternative approaches could be used to achieve the resident's care goals.
- Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the resident's preferences.



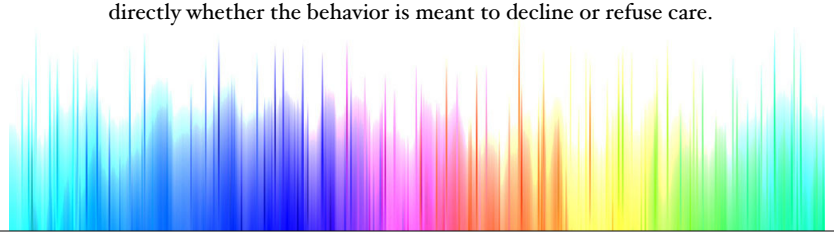
Choice vs. Refusal of Care

- Steps for assessment:
  - ✓ Review the medical record.
  - ✓ Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period.
  - ✓ Review the record and consult staff to determine whether the rejected care is needed to achieve the resident's preferences and goals for health and well-being.



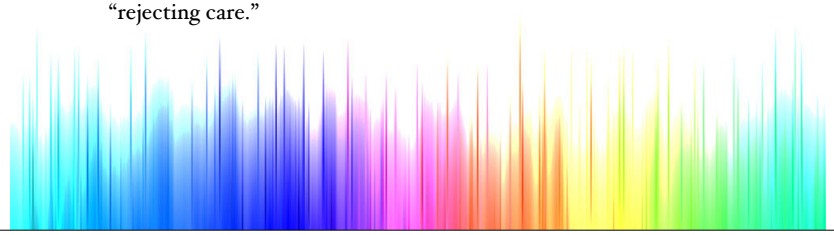
Choice vs. Refusal of Care

- Steps for assessment:
  - ✓ Review the medical record to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the resident, family, or significant other and determined to be an informed choice consistent with the resident's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.
  - ✓ If the resident exhibits behavior that appears to communicate a rejection of care (and that rejection behavior has not been previously determined to be consistent with the resident's values or goals), ask him or her directly whether the behavior is meant to decline or refuse care.



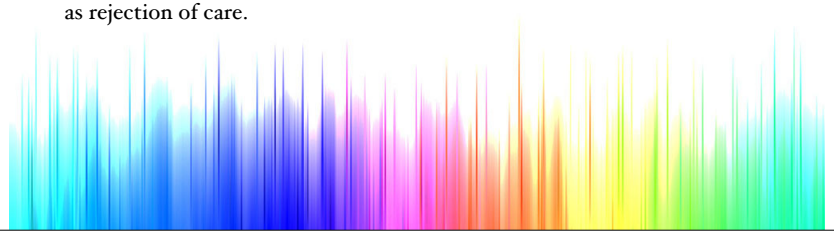
Choice vs. Refusal of Care

- Steps for assessment:
  - ✓ The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker.
  - ✓ Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and determined to be consistent with the resident's values, preferences, or goals.
  - ✓ Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."



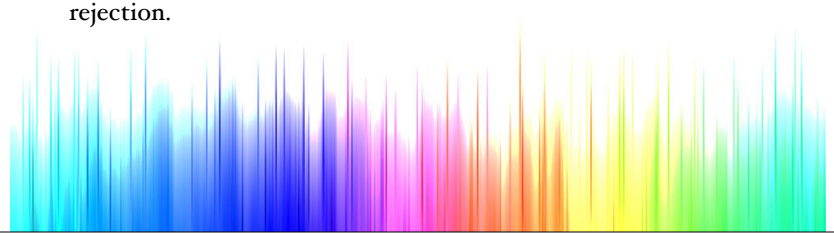
Examples...

- A resident with heart failure who recently returned to the nursing home after surgical repair of a hip fracture is offered physical therapy and declines. She says that she gets too short of breath when she tries to walk even a short distance, making physical therapy intolerable. She does not expect to walk again and does not want to try. Her physician has discussed this with her and has indicated that her prognosis for regaining ambulatory function is poor.
- Coding: E0800 would be coded "0", behavior not exhibited.
- Rationale: This resident has communicated that she considers physical therapy to be both intolerable and futile. The resident discussed this with her physician. Her choice to not accept physical therapy treatment is consistent with her values and goals for health care. Therefore, this would **not** be coded as rejection of care.



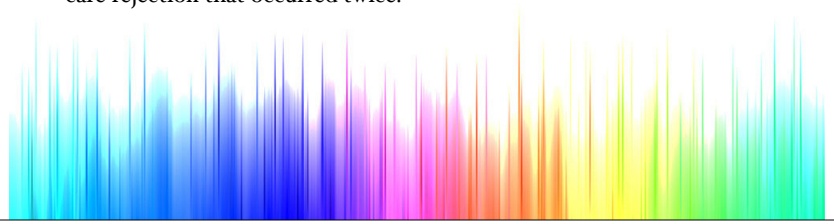
Examples...

- A resident informs the staff that he would rather receive care at home, and the next day he calls for a taxi and exits the nursing facility. When staff try to persuade him to return, he firmly states, "Leave me alone. I always swore I'd never go to a nursing home. I'll get by with my visiting nurse service at home again." He is not exhibiting signs of disorientation, confusion, or psychosis and has never been judged incompetent.
- Coding: E0800 would be coded "0", behavior not exhibited.
- Rationale: His departure is consistent with his stated preferences and goals for health care. Therefore, this is **not** coded as care rejection.



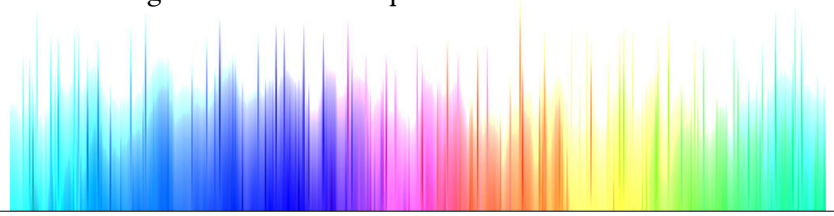
Examples...

- A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.
- Coding: E0800 would be coded "1", behavior of this type occurred 1-3 days.
- Rationale: The resident's care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.



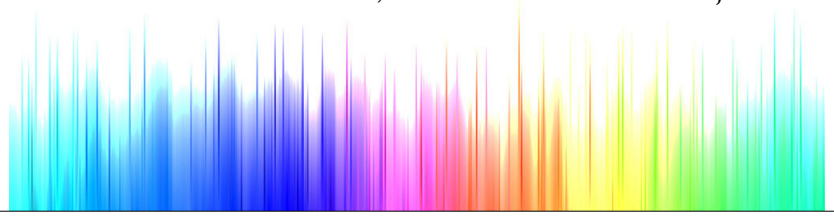
Examples...

- A resident chooses not to eat supper one day, stating that the food causes her diarrhea. She says she knows she needs to eat and does not wish to compromise her nutrition, but she is more distressed by the diarrhea than by the prospect of losing weight.
- Coding: E0800 would be coded "1," behavior of this type occurred 1-3 days.
- Rationale: Although choosing not to eat is consistent with the resident's desire to avoid diarrhea, it is also in conflict with her stated goal to maintain adequate nutrition.



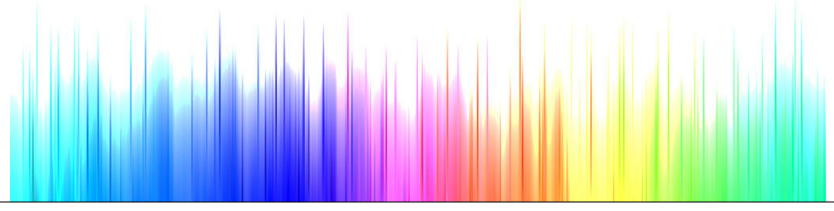
Examples...

- A resident is given his antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. This resident's assessment indicates that he does not have any swallowing problems. This happened on each of the last 4 days. The resident's advance directive indicates that he would choose to take antibiotics to treat a potentially life- threatening infection.
- Coding: E0800 would be coded "2," behavior of this type occurred 4-6 days, but less than daily.
- Rationale: The behavioral rejection of antibiotics prevents the resident from achieving his stated goals for health care listed in his advance directives. Therefore, the behavior is coded as care rejection.



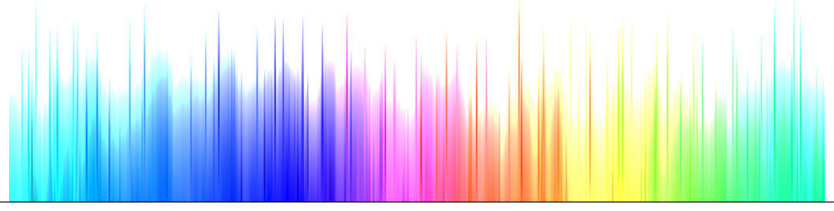
Examples...

- A resident who recently returned to the nursing home after surgery for a hip fracture is offered physical therapy and declines. She states that she wants to walk again but is afraid of falling. This occurred on 4 days during the look-back period.
- Coding: E0800 would be coded "2," behavior of this type occurred 4-6 days, but less than daily.
- Rationale: Even though the resident's health care goal is to regain her ambulatory status, her fear of falling results in rejection of physical therapy and interferes with her rehabilitation. This would be coded as rejection of care.



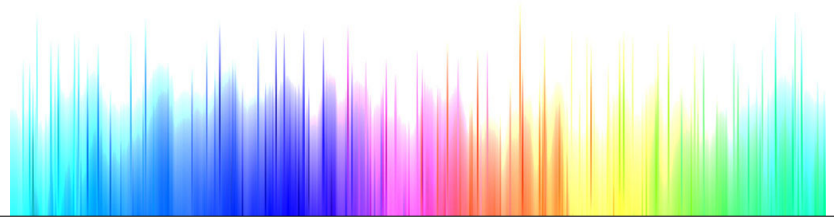
Examples...

- A resident who previously ate well and prided herself on following a healthy diet has been refusing to eat every day for the past 2 weeks. She complains that the food is boring and that she feels full after just a few bites. She says she wants to eat to maintain her weight and avoid getting sick, but she cannot push herself to eat anymore.
- Coding: E0800 would be coded "3," behavior of type occurred daily.
- Rationale: The resident's choice not to eat is not consistent with her goal of weight maintenance and health. Choosing not to eat may be related to a medical condition such as a disturbance of taste sensation, gastrointestinal illness, endocrine condition, depressive disorder, or medication side effects.



Something to consider…

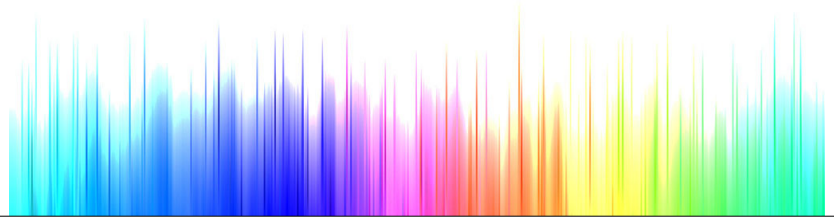
- Cognition, ability to understand, and decision-making play a huge role in determining a "choice" as opposed to a "refusal of care."
- Be mindful of Section F!



241

How to do it…

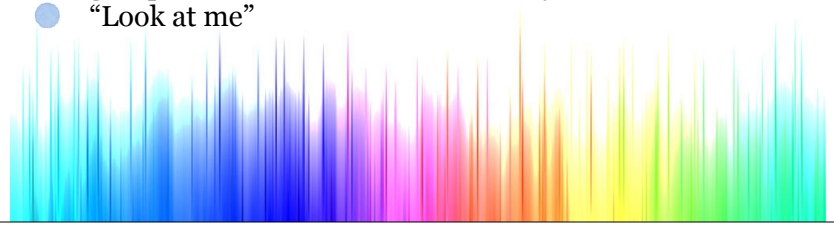
- Person-centered care is a recognition that resident choice and autonomy should be the primary aim of resident care in nursing homes.
- Staff should build a relationship with the resident and the resident's family.
- Forming a personal attachment results in fewer complaints from the residents.
- It also helps to reduce staff turnover.



242

How to do it…

- Listening is probably not only the greatest gift that we can give to older adults but is one of the most important skills in understanding their life and needs. An older adult said, "I stopped talking when people stopped listening."
- Recognize their view of their age
- Relate to older adults as a 2-way communication bridge
- Treat older adults as individuals not as part of a larger group labeled 'seniors' or 'the elderly'
- "Look at me"



243