Behavioral and Emotional Status Critical Element Pathway

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

Review the Following in Advance to Guide Observations and Interviews:

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

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

Observations across Various Shifts:
If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
Are staff implementing care planned interventions to ensure the resident’s behavioral health care and service needs are being met? If not, describe.
Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
Is there sufficient, competent staff to ensure resident safety and meet the resident’s behavioral health care needs?
What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
How does staff monitor the effectiveness of the resident’s care plan interventions?
How does staff demonstrate their knowledge of the resident’s current behavioral and emotional needs?
Does staff demonstrate competent interactions when addressing the resident’s behavioral health care needs?
Is the resident’s distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?
Behavioral and Emotional Status Critical Element Pathway  Resident, Family and/or Resident Representative Interview:

Awareness of current conditions or history of conditions or diagnoses.

How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?

How does the facility ensure approaches to care reflect your/the resident’s choices and preferences?

How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?

How are the resident’s individual needs being met through person-centered approaches to care?

What are your or the resident’s concerns, if any, regarding the resident’s mood?

Have you or the resident had a change in mood? If so, please describe.

What interventions is the resident receiving for the resident’s mood? Are the interventions effective? If not, describe.

What other non-pharmacological approaches to care are used to help with the resident’s mood? Are they effective? If not, describe.

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

What are the underlying causes of the resident’s behavioral expressions or indications of distress, specifically included in the care plan?

What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rational for each intervention?

How are the interventions monitored?

How do you ensure care is provided that is consistent with the care plan?

How, what, when, and to whom do you report changes in condition?

What types of behavioral health training have you completed?

Ask about any other related concerns the surveyor has identified.

How do you monitor for the implementation of the care plan and changes in the resident’s condition?

How are changes in both the care plan and condition communicated to the staff?

How often does the IDT meet to discuss the resident’s behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident’s condition?

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.
Behavioral and Emotional Status Critical Element Pathway

Record Review:

Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.

Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.

What is the time, duration, and severity of the resident’s expressions or indications of distress?

What are the underlying causes, risks, and potential triggers for the resident’s expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?

What non-pharmacological approaches to care are used to support the resident and lessen their distress?

What PASARR Level II services or psychosocial services are provided, as applicable?

Critical Element Decisions:

Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?

Is the care plan comprehensive? Is it consistent with the resident’s specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident’s medical record?

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

Was behavioral health training provided to staff?

1) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?

If No, cite F740

2) Does the facility have sufficient and competent direct care staff to provide nursing and related services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?

If No, cite F741
Behavioral and Emotional Status Critical Element Pathway

If No, cite F742 NA, the resident does not display or is not diagnosed with a mental or psychosocial adjustment difficulty, or does not have a history of trauma and/or PTSD.

If No, cite F743 NA, the resident’s assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

If No, cite F655 NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

If No, cite F636 NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

If No, cite F637 NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

3) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD)?

4) Did the facility ensure that the resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern is unavoidable?

5) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?

6) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident’s physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident’s function, mood, and cognition?

7) If there was a significant change in the resident’s status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

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

If No, cite F656 NA, the comprehensive assessment was not completed.

If No, cite F657 NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.
Behavioral and Emotional Status Critical Element Pathway

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

9) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet the resident’s medical, nursing, mental, and psychosocial needs and includes the resident’s goals, desired outcomes, and preferences?

10) Did the facility reassess the effectiveness of the interventions and, review and revise the resident’s care plan (with input from the resident, or resident representative, to the extent possible), if necessary to meet the resident’s needs?

Dementia Care Critical Element Pathway

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

Review the Following in Advance to Guide Observations and Interviews:

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

Physician orders. Care plan.

Observations over Various Shifts:

Are appropriate dementia care treatment and services being provided? If so, what evidence was observed?

Are staff consistently implementing a person-centered care plan that reflects the resident’s goals and maximizes the resident’s dignity, autonomy, privacy, socialization, independence, and choice?

Are staff using non-pharmacological interventions to attain or maintain the resident's well-being?

How does the facility modify the environment to accommodate the resident’s care needs?

Resident, Family, and/or Resident Representative Interview:

Can you tell me about your/the resident’s current condition or diagnosis and the history of the condition?

How did the facility involve you/the resident in the care plan and goal development process?

Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.

Does staff possess the appropriate competencies and skill sets to ensure the resident’s safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

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

How did the facility consider your/the resident’s choices and preferences?

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

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

How do you ensure care is provided that is consistent with the care plan?

Can you tell me about the resident’s care plan and his/her condition (including underlying causes)?

What are the facility’s dementia care guidelines and protocols? What types of dementia management training have you completed? How, what, when, and to whom do you report changes in condition?

Record Review:

Are the resident’s dementia care needs adequately assessed?

Is the care plan comprehensive? Does it address the resident’s specific conditions, risks, needs, preferences, interventions, and include measurable objectives and timetables? Has the care plan been revised to reflect any changes?

How do you monitor care plan implementation and changes in condition?

How are changes in the care plan and the resident’s condition communicated to staff?

Ask about any other related concerns the surveyor has identified.

Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?

Was dementia management training provided to staff?

Critical Element Decisions:

1) A.

Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:

o Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause; o If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner; o If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or o Did facility staff evaluate:

  · The resident’s usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
  
  · How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia: o Was the resident and/or family/representative involved in care plan development; o Does the care plan reflect an individualized, person-centered approach with measurable goals, timetables, and specific interventions; o Does the care plan include:

  • Monitoring of the effectiveness of any/all interventions; and/or • Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

In accordance with the resident’s care plan, did qualified staff: o Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes; o Implement
Dementia Care Critical Element Pathway

individualized, person-centered interventions and document the results; and/or Communicate and consistently implement the care plan over time and across various shifts?

Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan? If No to A, B, C, or D, cite F744

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand? If No, cite F655

NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident’s physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident’s function, mood, and cognition? If No, cite F636

NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a Significant Change in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

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

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

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

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident’s care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident’s needs? If No, cite F657

NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, QOL F550 or F675, QOC F684, Physician Services F710, Social Services F745, Unnecessary/Psychotropic Medications (CA), Sufficient and Competent Staffing (Task).
For the resident who exhibits unusual amounts of energy or walking without purpose:

- Providing a space and environmental cues that encourages physical exercise, decreases exit-seeking behavior and reduces extraneous stimulation (such as seating areas spaced along a walking path or garden; a setting in which the resident may manipulate objects; or a room with a calming atmosphere, for example, using music, light, and rocking chairs);
- Providing aroma(s)/aromatherapy that is/are pleasing and calming to the resident; and
- Validating the resident’s feelings and words; engaging the resident in conversation about who or what they are seeking; and using one-to-one activities, such as reading to the resident or looking at familiar pictures and photo albums.

For the resident who engages in behaviors not conducive with a therapeutic home-like environment:

- Providing a calm, non-rushed environment, with structured, familiar activities such as folding, sorting, and matching; using one-to-one activities or small group activities that comfort the resident, such as their preferred music, walking quietly with the staff, a family member, or a friend; eating a favorite snack; looking at familiar pictures;
- Engaging in exercise and movement activities; and
- Exchanging self-stimulatory activity for a more socially-appropriate activity that uses the hands, if in a public space.

For the resident who exhibits behavior that require a less stimulating environment to discontinue behaviors not welcomed by others sharing their social space:

- Offering activities in which the resident can succeed, that are broken into simple steps, that involve small groups or are one-to-one activities such as using the computer, that are short and repetitive, and that are stopped if the resident becomes overwhelmed (reducing excessive noise such as from the television);
- Involving in familiar occupation-related activities. (A resident, if they desire, can do paid or volunteer work and the type of work would be included in the resident’s plan of care, such as working outside the facility, sorting supplies, delivering resident mail, passing juice and snacks, refer to §483.10(e)(8) Resident Right to Work);
- Involving in physical activities such as walking, exercise or dancing, games or projects requiring strategy, planning, and concentration, such as model building, and creative programs such as music, art, dance or physically resistive activities, such as kneading clay, hammering, scrubbing, sanding, using a punching bag, using stretch bands, or lifting weights; and
  - Slow exercises (e.g., slow tapping, clapping or drumming); rocking or swinging motions (including a rocking chair).

For the resident who goes through others’ belongings:

- Using normalizing life activities such as stacking canned food onto shelves, folding laundry; offering sorting activities (e.g., sorting socks, ties or buttons); involving in organizing tasks (e.g., putting activity supplies away); providing rummage areas in plain sight, such as a dresser; and
  - Using non-entry cues, such as “Do not disturb” signs or removable sashes, at the doors of other residents’ rooms; providing locks to secure other resident’s belongings (if requested).

For the resident who has withdrawn from previous activity interests/customary routines and isolates self
in room/bed most of the day:

- Providing activities just before or after meal time and where the meal is being served (out of the room);
- Providing in-room volunteer visits, music or videos of choice;
- Encouraging volunteer-type work that begins in the room and needs to be completed outside of the room, or a small group activity in the resident’s room, if the resident agrees; working on failure-free activities, such as simple structured crafts or other activity with a friend; having the resident assist another person;
- Inviting to special events with a trusted peer or family/friend;
- Engaging in activities that give the resident a sense of value (e.g., intergenerational activities that emphasize the resident’s oral history knowledge);
- Inviting resident to participate on facility committees;
- Inviting the resident outdoors; and
- Involving in gross motor exercises (e.g., aerobics, light weight training) to increase energy and uplift mood.

For the resident who excessively seeks attention from staff and/or peers: Including in social programs, small group activities, service projects, with opportunities for leadership.

For the resident who lacks awareness of personal safety, such as putting foreign objects in her/his mouth or who is self-destructive and tries to harm self by cutting or hitting self, head banging, or causing other injuries to self:

- Observing closely during activities, taking precautions with materials (e.g., avoiding sharp objects and small items that can be put into the mouth);
- Involving in smaller groups or one-to-one activities that use the hands (e.g., folding towels, putting together PVC tubing);
- Focusing attention on activities that are emotionally soothing, such as listening to music or talking about personal strengths and skills, followed by participation in related activities; and
- Focusing attention on physical activities, such as exercise. For the resident who has delusional and hallucinatory behavior that is stressful to her/him:

- Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities and physical activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident’s experience is real to her/him.