Staff Educational Training Program and Toolkit

Quality Measure 451

Residents Whose Ability to Move Independently Worsened in the Nursing Facility

TEXAS
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Introduction

Overview of Problem, Impact of Problem, and Those Affected

Falls are the leading cause of fatal and nonfatal injuries among adults age 65 and over ("older adults") in the United States, accounting for over 3 million emergency department visits, 962,000 hospitalizations, and approximately 30,000 deaths in 2016. Older adults who have fallen often experience decreased mobility, loss of independence, and fear of falling, which all predispose them to future falls. For example, hip fractures substantially increase the risk of death and major morbidity in the elderly. Approximately one half of individuals are unable to regain their ability to live independently after suffering hip fractures, and their ability to move independently worsened while receiving care and skilled services in the nursing facility.

A study of 2000 hip fracture cases (compared with 400 controls) showed an increased risk of death up to six years post fracture. Worse, between 2007 and 2016, death rates from falls increased by 31%, increasing from 47 to 62 per 100,000 of the population. The economic impact of falls and fall deaths is substantial, accounting for nearly $50 billion in direct medical costs each year.

In fiscal year 2015, over 90,000 people were living in Texas nursing facilities (NFs) and are the focus of this toolkit.

(Falls Among Older Adults: An Overview. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. Retrieved October 2009.)

(Burroughs,KE & Walker,KM. Hip fractures in adults. UpToDate. November 18, 2009. Available at: http://www.uptodate.com/home/index.html). (UpToDate is an evidence-based, peer-reviewed information resource.)

Source: Data includes estimates from the Medicare Current Beneficiary Survey, the National Vital Statistics System Mortality Files, the National Electronic Injury Surveillance System -- All Injury Program, and the Behavioral Risk Factor Surveillance System. Retrieved 05/16/19.

Reason for the Training Program and Toolkit

To effectively address the need to conduct an initial resident assessment during admission, a comprehensive assessment within 14 days, or an assessment after a significant change of condition, a comprehensive care plan must be developed,

implemented and revised as needed to maintain independence with activities of daily living (ADL), and/or increase range of motion and mobility. To address a resident's decline in mobility and independence while at the nursing facility, a root cause analysis and all parts of the infrastructure (different disciplines working with the resident) will need to be addressed. An infrastructure wheel was created using the systems thinking approach, that identified four specific pieces of the system that influence the care that is provided to facility residents: the prescriber, nursing, the rehabilitative therapist, and the certified nurse aide.

This training program and toolkit will provide an approach to working with these disciplines to address any educational deficit that was noted in the root cause analysis. Ensuring that these four disciplines receive comprehensive education will help eliminate deficient practices noted in each discipline as common practice. Once all these resources are put together, all Texas NFs will be able to complete the training program and toolkit in its entirety and educate their staff so they can integrate the necessary assessments, care plans, and rehabilitative therapies into the plan of care they provide for the residents.

Section 1: Orientation to the Training Program and Toolkit

Orientation to the Training Program and Toolkit

This training program and toolkit will provide NFs with regulatory requirements regarding comprehensive assessments, care plans, ADL/mobility care, and rehabilitative therapies in nursing facilities to promote resident mobility independence and to prevent a decline in mobility, and includes the following:

- What it is:
  - What is a comprehensive assessment
- Assessment of the Resident:
  - Assessing admission orders to evaluate, treat and promote mobility independence as appropriate to the resident
- Care Plan:
  - Develop a comprehensive care plan which includes ADL/mobility care to maintain and strengthen mobility to promote independence
- Staff Roles:
  - Nursing
  - Direct Care Staff (CNA, Restorative Aid)
  - Rehabilitative Therapists
  - Physician
  - Administrative Staff
- Promoting the Resident's Independent Mobility:
  - What to do to maintain and strengthen a resident's independent mobility
- Resources:
  - Evidence Based Practices from nationally known sources
    - ✓ Pioneer Network
    - ✓ Centers for Medicare and Medicaid Services (CMS)
    - ✓ American Geriatrics Society (AGS)
    - ✓ Centers for Disease Control and Prevention (CDC)
    - ✓ The Society for Post-Acute and Long-Term Care Medicine (AMDA)
    - ✓ TMF Quality Innovation Network-Quality Improvement Organization (TMF QIN-QIO)
    - ✓ National Nursing Home Quality Improvement Campaign
  - ✓ State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Instructions on Use of the Training Program and Toolkit

In order to effectively use this training program and toolkit, it is imperative that the NF staff conduct a root cause analysis[1] (RCA) related to a decline of mobility to

[1] Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs). https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

determine why residents who were independent and then became dependent, why the resident had a decline in mobility, and what changes need to be made to ensure that these residents don't continue to lose mobility and receive the highest level of care possible. An RCA can be an early step in a performance improvement project (PIP), helping to identify what needs to be changed to improve performance. Once the changes that need to be made are identified, the steps that are followed are the same as those that would be used in any type of PIP.

Seven Steps to RCA

Use the following steps to walk through an RCA to investigate problems or situations:

1. Identify the problem or situation to be investigated and gather preliminary information: Problems or situations can be the result of many different things. There should be a process in place to determine which problems or situations will undergo an RCA.
2. Charter and select team facilitators and team members: Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. The team members involved should be those with personal knowledge of the processes and systems involved in the problem or situation that is being investigated.
3. Describe what happened: Collect and organize the facts related to the problem or situation to fully understand what happened.
4. Identify the contributing factors: Determine what other situations, circumstances, or conditions increased the likelihood of the problem or situation.
5. Identify the root cause: A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the problem or situation.
6. Design and implement changes to eliminate the root causes: The team works together to determine how best to change processes and systems to reduce the likelihood of another similar problem or situation.
7. Measure the success of changes: Like all improvement projects, the success of improvement actions needs to be evaluated.

RCA Tools

There are many tools that can be used when conducting an RCA. The tool you ultimately use depends on which one works best for the current problem or situation. These tools include:

1. Five Why Analysis[2]: A tool to drill down to the root cause of a problem by asking "why" five times. The purpose of the 5 Why's is not to arrive at a single root

[2] Determine the Root Cause: 5 Whys. https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/

cause, but to uncover as many contributing why's as possible, as most complex healthcare problems are multifactorial.

2. Brainstorming[3]: Bringing together a group of people to jointly discuss the problem or situation in a facilitated manner. It is important that the individuals brainstorming have some knowledge about the problem or situation. It is important to encourage as much participation as possible. When facilitating brainstorming it is best to have a flip chart and markers, but it can be done with a white board and have someone take notes of what was recorded. Be sure to go around the room and ask each person to throw out an idea without having anyone else comment (either positively or negatively) on the idea. The faster you move, the more the participants will add ideas and be encouraged to speak up. The wilder the better, because you never know which idea may be THE ONE that is the solution. Silent brainstorming works as well to generate ideas. Give the team a pad of paper or sticky notes and ask them to write down all their ideas, one on each page. Collect all the papers and work with the team to group similar ideas and confirm meanings to anything that might not be clear.
3. Fishbone Diagram[4]: Also known as a cause and effect diagram, this tool can be used to identify the many possible causes for a problem. Using a fishbone diagram allows for ideas to be sorted into useful categories.

More information and resources related to RCA are available through the Institute for Healthcare Improvement (IHI). The Quality Improvement Essentials Toolkit[5] can be accessed here: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx. Registration is required to access the toolkit.

Once the RCA has been completed, processes must be put into place to eliminate the root cause of the problem or situation. This can best be accomplished through the use of Evidence-Based Practices (EBP).

RCA Example

In performing an RCA, all the issues should be identified to be addressed. The root cause of the resident who was independent and who worsened in mobility while at the nursing facility could be a reason such as staffing issues or turnover, an underdeveloped workforce, pre-licensure or certification requirements, or a lack of attention paid to the future workforce.

In order to affect change with the issue of a decline in resident mobility, the facility's administration and nursing should improve quality of care for NF residents, and improve quality measures (QM) data related to ADL/Mobility Care.

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[3] DADS Quality Monitoring Conference April 2014. Melody Malone-Brainstorming.
[4] Fishbone (Ishikawa) Diagram http://asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html
[5] Institute for Healthcare Quality Improvement: Quality Improvement Essentials Toolkit. http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

When performing an RCA, the issue should be taken into consideration; however much more focus must be placed on the cause rather than the effect.

How to Use the Resource Toolkit

Once you have received the training program or toolkit, you will want to read through the material as it will begin by providing you with general information related to the topics of maintaining ADL functions, mobility and independence. As you read through the information you will notice that there is specific information related to how to assess the resident, ways to decrease risk factors, steps to take towards prevention, alternate interventions that are recommended for the residents and how to care for the resident if he or she comes to the facility with mobility issues.

The roles of the different disciplines providing care for the residents are also described. As you go through the training program/toolkit you will want to note the specific role that each of your staff may have with regard to improvements in the QMs. This information may be used to create in-service educational trainings for your staff to provide them with the knowledge needed to make changes to the care provided to the residents.

Additionally you will find that there are sample assessments, sample care plans, and algorithms in this training program and toolkit that will allow your staff to have a better understanding of how best to assess resident risk factors, provide care for the residents, and how to evaluate the resident for different issues that could lead to a decrease in care based on the quality measures.

As you review the training program and toolkit, if there is information that is not available that you would like to use in coordinating training for your staff, there are resource lists at the end where additional information may be obtained.

Organizational Change

As you use the toolkits in your facility, it is important that the changes made to the processes related to the QIPP QMs are sustainable. The best way to ensure sustainability is to make the changes at the system level versus the person level. As you continue below, you will find how this can best be accomplished.

System Change vs. Person Changes

As change begins to be implemented in your facility, it is important that the change is made at a systemic level and not just the staff level. What does this mean? Well it quite simply means that it is not enough to only train the staff on the changes that are being made throughout the NF, but to put into place policies and

procedures that reflect those changes as well. When an NF experiences staff turnover, change that has been made at the staff level tends to be lost as a result.

The only effective way to ensure that the change will be maintained is to embed it throughout the NF policies and procedures that detail the way that the NF will operate. How can an NF best put practices into operation? To guide the changes that will be needed, ask the following four questions[6]:

1. How do we manage the change process at the front line? Staff will need to understand their new roles and have the knowledge and resources to carry them out. To manage the change process effectively, an Implementation Team will need to guide, coordinate, and support the implementation efforts as the new practices roll out across the NF.
2. How do we put in to place new practices? It may be helpful to begin the change process in just one area of the NF to determine if it will be effective before rolling it out facility-wide. If changes need to be made, they get made prior to NF wide roll-out. Once the change has been rolled out across the NF, observe for problems or issues that may hamper successful implementation of the change.
3. How do we get staff engaged and excited about the changes? Engaging the buy-in, commitment, and ongoing participation of staff members is particularly important for staff who are involved in hands-on care and whose involvement will be needed to achieve implementation of the change. An important aspect of engaging staff and is key to success in any change made at a systemic level is clear communication. Be sure staff know the change is coming and are familiar with the available resources and their new roles prior to the change taking place.
4. How can we help staff learn new practices? Once the initial change takes place, assess what educational needs staff have. Providing this education will enhance their knowledge. Any and all plans for new staff education related to the changes being made in the NF should be worked out in close collaboration with experts on the content.

The most important concept in organizational change is to ensure that it is sustainable. This can only happen if the change is made at the system level in the form of policies and procedures, as these will not leave the NF as turnover happens like it will if the changes are made at the staff level.

Empowerment

As you work through making changes in your facility to improve the quality of care for your residents, it is important that your staff feel empowered to assist in the implementation of the changes. As you read through the below, information will be

[6] Preventing Pressure Ulcers in Hospitals.
https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool4a.html

provided to you defining what empowerment is and the benefits that it will have on your staff.

Empowerment is a practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance. The concept of empowerment is based on the idea that giving employees skills, resources, authority, opportunity, motivations, as well as holding them responsible and accountable for outcomes of their actions will contribute to their competence and satisfaction. Empowering staff gives them a:

- Sense of meaning - the staff cares about what they are doing and ultimately, they feel as if their work is important.
- Sense of competence - staff members are confident in their abilities to do their job. They are trusted to do their job right.
- Sense of determination - they are able to choose how to do the work that they have been assigned to do and they are determined to do a good job for their residents.
- Sense of impact - the work they are doing has a positive impact on the lives of their residents as well as their own. They ultimately become comfortable taking risks to improve day-to-day operations.
- Sense of ownership, commitment, and teamwork - no one staff member works by him/herself; everyone works together to ensure the best care is given. Peers are comfortable with challenging each other to be the best they can be.
- Tolerate imperfections - understanding that as humans, mistakes are inevitable and that no one is perfect.
- Accountability - being accountable for the choices one makes, understanding that in many instances, the results of the choices made can be used as learning opportunities for the future.

Empowerment can't be delegated. It is possible to develop an empowering environment where people will take the initiative to empower themselves. Changes are seen as opportunities for growth.

Use of Standardized Assessment Tools to Determine Understanding

When looking in to any type of training, it is important to ensure that those receiving the training understand what they have been taught. The best way to do this is through the use of a standardized assessment tool. This could be a pre- and post-test on the information, questionnaire set, or case study. In the cases of comprehensive resident assessment and comprehensive care plan, there is research to support several different types of assessment tools. Two such tools will be discussed in this training program and toolkit.

Target Audiences

This training program and toolkit is designed to be used with any NF staff member, including the direct care workers (Nurse Aides, Restorative Aides, etc.), Licensed Vocational Nurses (LVNs), Registered Nurses (RNs), Rehabilitative Therapists (PT, OT, ST and RT), NF Administrators, Activities Staff, Social Workers, Housekeeping Staff, and Maintenance Staff. It is important that when changes are made in the NF that they are made at the system level and not the person level; it is possible that the changes will not be sustained if the person leaves the organization. Providing this training to all the staff in the NF and ensuring that the changes are reflected in the facility's policies and procedures is the most effective way to ensure that changes will be made and sustained going forward.

Section 2: Overview of the Population

The population residing in a NF is primarily made up of older adults. In many instances, these residents have chronic illnesses and diagnoses including Alzheimer's disease and other dementia-related conditions. These conditions may directly affect the resident's ability to move independently and may contribute to potential decline in ADL function while at the nursing facility.

Dementia is an umbrella term for a group of symptoms that describe a decline in a person's mental ability that is severe enough to interfere with their daily life, independence and even their mobility.

There are over 100 different types of dementia, with Alzheimer's disease being the most common. Some additional facts about dementia include the following:

- Over 46 million people worldwide were living with dementia in 2015, with this number almost doubling every 20 years. By the year 2050, over 131 million people are expected be affected by dementia.
- Around the world, a person develops dementia every 3 seconds.
- The total estimated cost of dementia worldwide in 2015 was $818 billion, with an anticipated rise to $2 trillion by the year 2030.
- At this time, there is no cure for dementia.

Most Common Types of Dementia

There are many different disorders and conditions that can lead to dementia. There are also many different types of dementia, with some being significantly more common than others. The three most common types of dementia are[7]:

- Alzheimer's Disease: The most common type of dementia, accounting for approximately 60-80% of cases;
- Vascular Dementia: A less common form of dementia, accounting for about 10% of the dementia cases; and
- Dementia with Lewy bodies: A far less common form of dementia, accounting for approximately only 4% of cases.

Signs and Symptoms of the Most Common Types of Dementia

Because different types of dementia affect the brain differently, the signs and symptoms may also be vastly different. The following are the signs and symptoms of the most common types of dementia[7]:

- Alzheimer's Disease: Individuals with Alzheimer's Disease often have trouble remembering things, including conversations, names, what they had for

[7] Alzheimer's Association: Types of Dementia. http://www.alz.org/dementia/types-of-dementia.asp

breakfast, familiar objects, etc. In addition, these individuals may also have impaired communication (talking, understanding, writing, and reading, for example: being unable to talk, saying the wrong words, and unable to understand what they hear), poor judgment (dressing for summer in the cold winter, inability to pay their bills, walking down the middle of a busy road), disorientation (not knowing where they are, whether it's day or night, not recognizing familiar faces), confusion, behavior changes, and difficulty speaking, walking (balance problems, shuffling of feet, spontaneous falls in late stage), and swallowing (changes in the digestive system make swallowing difficult and eventually not possible which increases the chances of choking).

- Vascular Dementia: The symptoms that may be seen in individuals with this type of dementia may include: impaired judgment, problems with planning (unable to put together a grocery shopping list, follow a recipe, complete work assignments if still working), concentrating and thinking.
- Dementia with Lewy bodies: Those who suffer from this type of dementia often have memory loss and thinking problems (ability to focus or concentrate on a topic, process and understand information). These individuals are also likely to have issues with sleep disturbances (vivid dreams that seem real; difficulty staying asleep), visual hallucinations, and muscle rigidity.

Stages of Alzheimer's Disease

Alzheimer's disease is progressive and there is no cure, so the symptoms worsen over time. The rate at which the disease progresses will vary, but the average time a person lives with Alzheimer's is four to eight years. Depending on other factors, a person can live for as long as 20 years with the disease.

The Alzheimer's Association details that Alzheimer's disease typically progresses in three general stages. Since this disease affects people in different ways, their experience with the symptoms, or progression through the disease will also be different. The three stages of Alzheimer's disease and some of the related symptoms include[8]:

- Mild Alzheimer's (the early stage): In this stage, a person may still be able to function independently; still engaging in social activities and performing complex tasks such as driving. Even though the individual is "functioning", they may struggle with memory lapses and forgetfulness which family and friends may begin to notice. Some of the common symptoms that one may notice in the individual are: problems coming up with the right word; trouble remembering someone's name; losing or misplacing a valuable object; and increasing trouble when trying to plan or organize, just to name a few.
- Moderate Alzheimer's (the middle stage): For most individuals, this is typically the longest stage and can last for many years. Individuals who are in this stage

[8] Alzheimer's Association: Stages of Alzheimer's. http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp

may begin to require more care as they become less independent. One may start to notice that the individual in this stage confuses words more frequently; gets easily frustrated or angry; or acts in ways they would not typically act, for example refusing to perform daily activities of living like bathing and dressing. You may see very specific symptoms in this stage that include: forgetfulness of events or one's own personal history; no longer participating in social activities, or withdrawn when they do; confusion to time, for example not remembering what day it is; the need for assistance with simple tasks such as choosing clothing that is suitable for the season; an increase in getting lost or wandering without a purpose; and changes to their personality and/or behavior including becoming suspicious, delusional, or compulsive.

- Severe Alzheimer's (the late stage): For individuals in the late stage of Alzheimer's, you may find that they have lost their ability to respond to the environment around them, are no longer carrying on a conversation and being unable to control their movements. They may say words or phrases that are not consistent with what is going on around them, as their cognitive skills continue to worsen. Extensive assistance with daily activities (ADLs) also becomes necessary. The following are symptoms one might see in individuals at this stage: requiring full-time, around-the-clock assistance with their daily care needs; loss of awareness of recent experiences; eventual changes in their physical abilities, being unable to walk, sit, and swallow; and become at an increased risk for infections.

As mentioned previously, the symptoms of Alzheimer's disease present differently in everyone with the disease, as does the progression. It is important to continue to allow someone with Alzheimer's disease or any other dementia-related condition to continue to function to their full capacity.

Table 1: Uncharacteristic Behaviors and Possible Causes

Behavior	Meaning
Wandering	**Boredom**
Calling out	**Loneliness**
Grabbing	**Fear of pain**
Pushing	**Desire for privacy**
Agitated	**Overstimulated**
Withdrawn	**Understimulated**
Intrusiveness	**Hunger/Thirst**

All behavior seeks to effect change. It's not enough to explain or even understand residents' out-of-character behaviors. We have to use that understanding to better meet residents' needs. In other words, residents communicate for a reason. It is

every staff members' job to figure out both what the resident wants and why. The more time that is taken getting to know the resident and the more of a relationship you have, the better you will be able to do this.

Overview of Person-Centered Care

Person-centered care[9] is a care concept that recognizes that individuals have unique values, personal histories and personalities and that each person has an equal right to dignity, respect, and to participate fully in his or her environment. In person-centered care, it is important to remember that all individuals are typically the same now as they were when they were younger, in that most often they still have the same goals for their lives of being independent, self-sufficient, active, maintaining personal relationships, and wanting to continue to have fun. The goal of person-centered care honors the importance of this by keeping the person at the center of their care and decision-making process. In this care model, caregivers must actively listen and observe to be able to adapt to each individual's changing needs, regardless of condition or disease process.

People with dementia make up a significant proportion of the older adult population. The person-centered care approach is extremely important when caring for these individuals; seeing everyone as individuals and not placing the focus on their illnesses or on their abilities or inabilities. Making sure that people are involved and central to their care is now recognized as a key component of providing for a high quality of healthcare. There are many aspects of person-centered care that should be considered, including:

- Respecting one's values and putting them at the center of care;
- Taking into account someone's preferences and expressed needs;
- Coordinating and integrating care;
- Working together to make sure there is good communication with the individual and that information and education is effectively passed along;
- Making sure people are physically comfortable and safe;
- Providing emotional support;
- Involving the individual's family and friends;
- Making sure there is continuity between and within the services that the person is receiving; and
- Making sure people have access to appropriate care when they need it.

Put simply, being person-centered is about focusing care on the needs of the person rather than the needs of the service/provider.

[9] National Nursing Home Quality Improvement Campaign
https://www.nhqualitycampaign.org/goalDetail.aspx?g=pcc

Overview of Residents Who Decline in Mobility and Independence While in the Nursing Facility

According to CMS's Resident Assessment Instrument (RAI) Manual Version 3.0, Activities of Daily Living (ADL) Assistance, almost all nursing home residents need some physical assistance. CMS emphasizes that most residents are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from resident to resident. The RAI Manual identifies additional information:

- A wide range of physical, neurological, and psychological conditions and cognitive factors can adversely affect physical function.
- Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.
- As inactivity increases, complications such as pressure ulcers, falls, contractures, depression, and muscle wasting may occur.

It is very important for the nursing facility IDT Team (Interdisciplinary Team) to conduct an initial assessment, gather sufficient information to establish a comprehensive assessment and to develop/implement a Person-Centered Care Plan. This Person-Centered Care Plan is very important in providing quality care to the resident and updated/revised as significant events occur.

Overview of Person-Centered Care Planning

CMS defines person-centered planning as a process, directed by the individual, with assistance as needed or desired from a representative of the individual's choosing. The process is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the individual. It may include other persons, freely chosen by the individual, who can serve as important contributors to the process. The individual or his/her representative directs the person-centered process; this means that the resident or their representative is an equal partner in the planning of their care. It means ensuring that each resident or individual acting on the resident's behalf is involved in negotiating a care plan that is specific to their individual like, dislikes, and needs. In addition to the resident, facility staff, including the CNA, must be involved in the development of the person-centered care plan.

It is important to understand that a person-centered care plan is one in which the focus is on what is important to the resident, his/her capacities, and the resident's available supports. The focus of their person-centered care plan should be the quality of the resident's life as he/she defines it. The steps in the care planning process include:

- Preparation: Understanding the resident and their situation, gathering information, encouraging others who know the person to contribute their perceptions and ideas.

- Pre-planning: Working with the person/representative to review information, set priorities, determine an agenda, and invite people to join in the planning process.
- Action Planning: Identifying the resident's needs and desires, then developing action steps to accomplish her/her goals. Action planning is often done in a team meeting, but can also be done through a series of conversations with different people.
- Quality Assurance: Making sure the documentation meets standards and requirements.
- Implementation and Monitoring: Following through on action steps, checking progress, and revising the plan as necessary.

Source: Person-Centered Care Planning/Person-Centered Thinking Course

According to CMS's RAI Version 3.0 Manual, individual care plans should address strengths and weakness, possible reversible causes such as de-conditioning, and adverse side effects of medications or other treatments. These may contribute to needless loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.

RAI emphasizes that for some residents, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.

A resident's potential for maximum function is often underestimated by family, staff, and the resident. Individualized (Patient Centered) care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.

CMS's RAI Version 3.0 also notes that many residents might require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or are given adequate time to complete the task while being provided graduated prompting and assistance. This type of supervision requires skill, time, and patience.

Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.

Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

CMS's RAI Version 3.0 Manual CH 3: MDS Items [G]

SECTION G: FUNCTIONAL STATUS

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Timely Comprehensive Assessments

CMS's MDS Version 3.0 RAI Manual emphasizes that nursing facility IDT Team talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided.

RAI 3.0 recommends when the nursing facility is reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

RAI also emphasizes, "To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well)."

Section 3: Roles and Responsibilities of Members of the Care Team

All staff members who provide care for the residents in the NF have a very important role in ensuring that residents receive the highest level of care possible. Providing important Person-Centered care in NF residents is a multi-disciplinary task; everyone in the facility plays a part in the effort. All team members are responsible for understanding their role in ensuring residents are provided the highest practical care for their physical, mental and psychosocial needs.

Certified Nurse Aide (CNA) and Restorative Aide

CNAs have a very important role in assisting residents in maintain ADLs and mobility independence in their residents. The CNA must understand that there is no a "one-size-fits-all" intervention for the residents. How CNAs provide ADL assistance is essential to the overall care provided. The CNA should stop and listen to the resident to determine what is going on and what individual needs the resident may have. The CNA would then need to ask themselves questions related to the situation: What are the physical limitations of the resident? How can I assist the resident to strengthen their ADL capabilities? What are additional considerations which may prevent ADL activities? Is sufficient time given to the resident to actively participate in the ADL care and mobility exercises? Am I asking and giving the resident sufficient choices in their care?

Ultimately, the CNA's role in the maintaining of ADL care and resident mobility is one of significant importance and should be valued. If you have information that could impact the resident's quality of care or quality of life, speak up and advocate for the resident, providing the nursing staff with that information.

According to CMS, restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. The program is very important to maintain and build the resident's ADL functional abilities, mobility strengths and independence.

CMS's (MDS) - Version 3.0. RAI O0500 Restorative Nursing Programs shows how the restorative aide program information is captured within the MDS. The facility's MDS Coordinator captures the following information:

Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days

Number of days of restorative care and the type of technique used for resident:

A. Range of motion (passive)

B. Range of motion (active)

C. Splint or brace assistance

Number of days of training and skill practice in:

D. Bed mobility

E. Transfer

F. Walking

G. Dressing and/or grooming

H. Eating and/or swallowing

I. Amputation/prostheses care

J. Communication

Nursing Staff (RNs and LVNs)

Nursing staff are responsible for ensuring that there is a timely and thorough assessment and comprehensive care plans for each one of their residents. Federal regulations require that the nursing facility must have sufficient nursing staff with the appropriate professional licensure, 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. These nursing services are determined by resident assessments and individual plans of care.

Licensed nurses are also required to have the specific competencies and skill sets necessary to care for residents' needs including assessing, evaluating nursing interventions, and implementing resident care plan as identified through resident assessments, nursing care plans and as described in the plan of care. Nursing staff are vital in the communication between the resident and the physician. Each

comprehensive assessment, care plan intervention and timely feedback to the physician's Plan of Care is another important role in the overall care of the resident.

Prescribers (Physicians, PA-Cs, APRNs)

Practitioners with prescribing privileges have a key role as a member of the interdisciplinary team, prescribers should:

- Evaluate each resident to determine the continued appropriateness of the resident's current medical plan of care.
- Review prescribed treatments, therapies and closely monitor all needs based on validated diagnoses for active and new problems.
- Update diagnoses, conditions and prognoses to help residents attain the highest possible level of functioning in the least restrictive environment possible.
- Document relevant conditions that affect quality of care and quality of life, especially in residents with dementia.
- Inquire about care plans with specific and individualized interventions and approaches.

Rehabilitative Therapists (Physical and Occupational)

Federal regulations require that facility must provide or arrange for the provision of specialized rehabilitative services to all residents that require these services for the appropriate length of time as assessed in their comprehensive plan of care. These services are considered a facility service provided to all residents who need them based on their comprehensive plan of care and are included within the scope of facility services.

Care provided by all facility staff must be coordinated and consistent with the specialized rehabilitative services provided by qualified personnel.

CMS states that "Specialized Rehabilitative Services" includes but is not limited to physical therapy, speech-language pathology, occupational therapy, or respiratory therapy and are provided or arranged for by the nursing home. They are "specialized" in that they are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel. These therapies are important to the needs of the resident and may be instrumental in assisting the resident to maintain their ADL functions and mobility independence in the nursing facility.

According to the CMS State Operations Manual Appendix PP, physical and occupational therapists should be evaluating and providing rehabilitative services while answering the following questions:

• How did these services maintain, improve, or restore the individual's muscle strength, balance, range of motion, functional mobility or prevent or slow decline or deterioration in the individual's muscle strength?

• How are these services maintaining, improving or restoring the amount of activity the individual could do to maintain, improve or restore their independence?

• Do these services assist an individual in minimizing pain to enhance function and independence?

• How are these services maintaining, increasing or decreasing the amount of assistance needed by the individual to perform a task?

• How are these services maintaining, improving or restoring gross and fine motor coordination, including sensory awareness, visual-spatial awareness, and body integration?

• Do these services assist to maintain, improve or restore memory, problem solving, attention span, and the ability to recognize safety hazards?

Family and Others

The resident's family members or other loved ones play an important role of promoting the resident's quality of care/quality of life and individual psychosocial well-being. These include:

If the resident requires minimum, moderate, or extensive assistance with ADLs, the family member can ask:

- What can we do to promote mobility and ADL independence while encouraging person centered thinking?
- How can we improve the resident's environment to promote mobility throughout the nursing facility in a safe manner?
- How has the care team tried to help with the resident's ADLs, Mobility and Independence on a daily basis using person centered thinking?
- What is the plan to establish, implement and evaluate measurable short and long-term mobility and ADL goals?

The NF staff will never know all that the family knows. Family members and loved ones can help by providing answers to questions such as:

- How does your family member express themselves when they are scared, angry, anxious, and hungry?
- What, in the past, has comforted them?
- What is their typical daily routine?
- Are there any behaviors that you have found more difficult to respond to than others?
- What have you tried to prevent them?
- Stay involved in your loved ones care and attend care plan meetings.

- Get to know staff – their names and duties
- Attend care plan or service plan meetings
- Talk to staff about concerns you have with the care being provided to the resident.
- Join or organize a resident or family council

Section 4: Interventions by Care Team Members

The interventions discussed in this section can be provided by the majority of the NF staff and in most cases do not require a significant amount of financial resource to accomplish.

Non-Pharmacological Approaches to Antipsychotic Medication Use[10]

Unlike pharmacological therapies, non-pharmacological therapies have not been shown to alter the course of Alzheimer's disease. Non-pharmacological therapies are used instead with the goal of maintaining a resident's cognitive function, as well as improve the quality of life or reduce out-of-character behavioral symptoms such as depression, apathy, wandering, sleep disturbances, agitation and aggression.

The nurse should use the following guidelines, as outlined by the National Partnership to Improve Dementia Care in Nursing Homes, when intervening on the use of antipsychotic medications:

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.
- Provide consistent caregivers.
- Screen for depression and possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

Once the nurse has obtained this information, it is important document it in the resident's medical record so that it can be used in the care planning process when

[10] Alzheimer's Association: Success for Less – Reducing the use of antipsychotic medications in nursing homes. http://www.alz.org/sewi/documents/Psych_Meds_Rept_(2).pdf

working to determine which interventions would be best suited for this resident, most especially those that help to decrease the out-of-character behaviors.

There are additional practices that all NF staff can implement that will help to decrease the use of medications, including:

- Changing their own behavior:
  - Staff have the power to escalate or de-escalate most situations. De-escalation is usually possible, and it's a very valuable skill to practice. Monitoring our body language and our own fear response can help avoid triggering a fear response in a resident.
  - Look at environmental ways to make sure basic needs are met.
  - Take time to get to learn about the residents' lives before they entered the nursing facility. This happens spontaneously all the time with residents who have pleasant and outgoing personalities and can talk about their interests and show an interest in the staff. The staff's job is to make sure they make the same effort with residents with dementia who may not be able to initiate conversation, but who have the same basic need for affection, inclusion and identity.
- Changing their practices:
  - Look at the person with dementia rather than at the symptoms of dementia.
  - Use the paradigm of behaviors as communication of unmet needs.
  - Anticipating and meeting core psychological needs to prevent behaviors.
  - Addressing the risks of boredom, helplessness and loneliness that continue to plague many nursing homes.
  - Creating individualized care plans that reflect a person's wishes and emphasize strengths and choice.
  - Addressing stress in caregivers.

Facility staff, along with the resident, benefit greatly from this project in the following ways:

- Increase in participation by the resident in their care
- Decrease in the number of falls
- Decrease in the use of psychotropic medications
- Decrease in the signs of anxiety and depression in the residents
- Increase in staff job satisfaction

Section 5: Resources, Tools, and Trainings

Resources from HHSC

HHSC LTC Regulatory Joint Provider Training Course Website
https://apps.hhs.texas.gov/providers/training/jointtraining.cfm

Resources from Other Organizations

CMS Measures Inventory Tool

Functional Change: Change in Mobility Score for Skilled Nursing Facilities

https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5924

Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

The National Nursing Home Quality Improvement (NNHQI) Campaign exists to provide long term care providers, consumers and their advocates, and quality improvement professionals with free, easy access to evidence-based and model-practice resources to support continuous quality improvement.

https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob#tab2

CMS's RAI Version 3.0 Manual CH 3: MDS Items

SECTION G: FUNCTIONAL STATUS

G0110: Activities of Daily Living (ADL) Assistance

https://www.ahcancal.org/facility_operations/Documents/UpdatedFilesOct2010/Chapter%203%20-%20Section%20G%20V1.04%20Sept%202010.pdf

American Occupational Therapy Association

https://www.aota.org/~/media/Corporate/Files/Practice/Manage/Documentation/Self-Care-Mobility-Section-GG-Items-Assessment-Template.pdf

The Pioneer Network "Pioneers in Culture Change and Person-Directed Care"

https://www.pioneernetwork.net/

Tools

Many tools are available for use in determining the preferences of individuals with Alzheimer's disease or other dementia-related conditions. These conditions may directly affect the nursing facility's ability to develop and implement appropriate lans of care for the resident's ADLs, mobility and independence. That information is then used to care plan the appropriate person-centered thinking interventions for them. These tools include:

- Preferences for Everyday Living (PELI)[11]: The PELI is a scientifically validated tool that is used to assess individual preferences for social contact, personal development, leisure activities, living environment, and daily routines. NFs can access either the full length PELI or a mid-level version. Both versions are designed to spark conversations about the resident's preferences, lay the foundation for building trusting relationships between the resident, family, and NF staff, and promote person-centered care plans and service, honoring the resident's preferences as the highest priority. Both versions of this tool can be found at https://preferencebasedliving.com/peli-tools.
- "This is Me"[12]: The Alzheimer's Society's booklet "This is Me", will help support a person who is being cared for in an unfamiliar place. The use of this tool will enable NF staff to see the person as an individual and deliver person-centered care that is tailored specifically to the resident's needs. That information can help reduce distress for residents with dementia, and help prevent issues with out-of-character behaviors. "This is Me" can be downloaded at https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/this_is_me.pdf.
- "A Passport Into My Life: Understanding My Journey Will Help You Understand Me"[13]: The Behavior Management Task Force created the Passport to provide information about the resident, painting a picture of who the person really is. Passport information includes interests, accomplishments, daily routines, familiar names, traumatic life events, and a number of expressions of needs. A sample of this tool can be found in the LVN Educator/New LVN toolkit on the QMP website, in Module 3 at: https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/AssessmentModule.pdf.

[11] Preference Based Living. PELI Tools. https://preferencebasedliving.com/peli-tools
[12] Alzheimer's Society. "This is Me". https://www.alzheimers.org.uk/thisisme
[13] A Passport to Better Care. http://www.providermagazine.com/archives/2014_Archives/Pages/0814/A-Passport-To-Better-Care.aspx

Trainings

There are many training opportunities available to NF staff **free of charge** that will provide education related to dementia care and person-centered thinking. The QMP provides training opportunities such as:

- Alzheimer's Disease and Dementia Care Training (ADDCT);
- Texas OASIS: Dementia Training Academy;
- Virtual Dementia Tour (VDT); and
- Person Centered Thinking Training (PCT).

You can obtain more information about these trainings by visiting https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based-best-practices-qmp/alzheimers-disease-dementia-care. To schedule one of these trainings for your staff, please email the request to QMP@hhsc.state.tx.us.

Additional free trainings are available through the UT Center for Excellence in Aging Services and Long-Term Care. Information about these can be found at http://www.utlongtermcarenurse.com/.

Section 6: Evaluation of the Training Program/Toolkit

Training program evaluation is a continual and systematic process of assessing the value or potential value of a training program. Results of the evaluation are used to guide decision-making around various components of the training (e.g. instructional design, delivery, results) and its overall continuation, modification, or elimination.

In order to determine if this training program is helpful in providing NF staff with information related to initial resident assessments, assessments after a significant change, developing and implementing comprehensive care plans and care plans after a significant change, an evaluation can be done in several ways:

- Measuring a change in knowledge, skill, or attitudes. This can be done both before and after the training in the form of a pre- and post-test.
- Measuring a change in behavior. This evaluation technique may take more time; however, it may show a more consistent change in what the participant did with what they learned. Did the participant put any of the information to use? Is the participant able to teach their new knowledge, skills, and attitudes to others? Is the participant aware that their behavior has changed? Evaluating for this information would be done by conducting observations and interviews of the participants, over the course of time. It would be helpful to have a baseline of their behavior(s) prior to their receipt of the training to compare to their behavior(s) after the training.
- Measuring results. This evaluation may be the most time consuming, as results cannot be measured right away. In the case of antipsychotic medications, the result that would be measured is the CMS long-stay antipsychotic medication usage QM on both the State level and the NF level. This data has a 3-month lag time from when it is collected to when it is released by CMS. Also, it takes time for the data in a QM to adjust to show positive or negative change. An NF could conduct the training one month and begin making changes, however, the data may not show significant positive change for several months due to the number of assessments being performed for the data that relates to the QM. This method of evaluating the training program, however, is probably the most significant in terms of the actual changes that are taking place to the care being provided to NF residents.

Figure 1: Evaluation of Staff Educational Training Program/Toolkit

Measure	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content is relevant to the stated objectives	1	2	3	4	5
The content is well organized into clearly labeled sections	1	2	3	4	5
The resources and links provided in the sections are evidence based and credible organizations/resources	1	2	3	4	5
The content is appropriate and free from bias, stereotypes or insensitivity	1	2	3	4	5
The links to the CMS and HHSC provide useful information relevant to the misuse of Antipsychotics with those who have a diagnosis of Alzheimer's disease or a dementia-related condition and reside in a nursing facility	1	2	3	4	5
The content of the Education/Resource Tool Kit addressed prescribing patterns	1	2	3	4	5
The content of the Education/Resource tool kit addressed alternate interventions that can be used prior to introducing or prescribing an antipsychotic	1	2	2	4	5
I will make/implement change based on what I have learned from this Education/Resource Tool Kit	1	2	3	4	5
Overall, I am satisfied with the content of this Education/Resource Tool Kit	1	2	3	4	5
Comments:					

Federal Regulations[14]

F710 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.

Physician Supervision
The facility must ensure that:

- The medical care of each resident is supervised by a physician; and
- Another physician supervises the medical care of residents when their attending physician is unavailable.

F711 Physician Visits

The physician must:

- Review the resident's total program of care, including medications and treatments, at each visit required as per frequency of physician visits;
- Write, sign and date progress notes at each visit; and
- Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

F712 Frequency of Physician Visits

The residents must be seen by a physician at least once every30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

All required physician visits must be made by the physician personally. There are exceptions. At the option of the physician, required visits in skilled nursing facilities (SNFs), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist.

F636 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

[14] CMS State Operations Manual, Appendix PP Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R173SOMA.pdf

The intent is to ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.

F637 Comprehensive Assessment After Significant Change

The facility must conduct a comprehensive assessment after a significant change within 14 days after the facility determines, or should have determined, that there was a significant change in the resident's physical or mental condition.

F655 Comprehensive Person-Centered Care Planning

The facility must ensure that its residents are free of any significant medication errors.

Baseline Care Plans:
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; and
- PASARR recommendation, if applicable.

Replacement Baseline Care Plan:
The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan:

- Is developed within 48 hours of the resident's admission; and
- Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

Baseline Care Plan Summary:
The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

- The initial goals of the resident;

- A summary of the resident's medications and dietary instructions;
- Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and
- Any updated information based on the details of the comprehensive care plan, as necessary.

F656 Comprehensive Care Plans

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Comprehensive Care Plan contents: The comprehensive care plan must describe the following:

- Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;
- Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment;
- Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of PASARR, it must indicate its rationale in the resident's medical record; and
- In consultation with the resident and the resident's representative(s):
    - The resident's goals for admission and desired outcomes;
    - The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose; and
    - Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements.

F657 Care Plan Timing and Revision

A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. Prepared by an interdisciplinary team including:

- The Attending physician
- A registered nurse with responsibility for the resident
- A nurse aide with responsibility for the resident
- A member of food and nutrition services staff

- To the extent practicable, the participation of the resident and the resident's representative(s)

F676 Activities of Daily Living (ADLs)/Maintain Abilities

Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. Activities of Daily Living include the following:

- Hygiene-bathing, dressing, grooming, and oral care
- Mobility-transfer and ambulation, including walking
- Elimination-toileting
- Dining-eating including meals and snacks
- Communication including speech, language and other functional communication systems

F677 ADL Care Provided for Dependent Residents

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

The existence of a clinical diagnosis shall not justify a decline in a resident's ability to perform ADLs unless the resident's clinical picture reflects the normal progression of the disease/ condition has resulted in an unavoidable decline in the resident's ability to perform ADLs. Conditions which may demonstrate an unavoidable decline in the resident's ability to perform ADLs include but are not limited to the following:

• The natural progression of a debilitating disease with known functional decline;

• The onset of an acute episode causing physical or mental disability while the resident is receiving care to restore or maintain functional abilities; and

• The resident's or his/her representative's decision to refuse care and treatment to restore or maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative.

F688 Increase/Prevent Decrease in ROM/Mobility

The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

F825 Provide/Obtain Specialized Rehabilitative Services

The intent of this regulation is to ensure that every resident receives specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional and psycho-social well-being. The intent is also to ensure that residents with a Mental Disorder (MD), Intellectual Disability (ID) or a related condition receive services as determined by their Preadmission Screening and Resident Review (PASARR).

"Specialized Rehabilitative Services" includes but is not limited to physical therapy, speech-language pathology, occupational therapy, or respiratory therapy and are provided or arranged for by the nursing home. They are "specialized" in that they are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel.

The facility must provide or arrange for the provision of specialized rehabilitative services to all residents that require these services for the appropriate length of time as assessed in their comprehensive plan of care. These services are considered a facility service provided to all residents who need them based on their comprehensive plan of care and are included within the scope of facility services.

F835 Administration

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Resources include but are not limited to a facility's operating budget, staff, supplies, or other services necessary to provide for the needs of residents.

F841 Responsibilities of Medical Director

The facility must designate a physician to serve as medical director.

"Medical director" means a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

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