BASELINE & PERSON-CENTERED CARE PLANS

INTENT

- Promote continuity of care
- Communication among nursing home staff
- Increase resident safety
- Safeguard against adverse events that are most likely to occur right after admission
- Ensure the resident and representative (if applicable) are informed of the initial plan for delivery of care and services by written summary of the baseline care plan.
GUIDANCE

The baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.

What is Person-Centered Care?

The facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

This includes making an effort to understand:
• what each resident is communicating, verbally and nonverbally
• identifying what is important to each resident with regard to daily routines and preferred activities
• having an understanding of the resident's life before coming to reside in the nursing home.
Documentation

Goals and objectives and include interventions that address his or her current needs.

It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

Baseline Care Plans (F655)

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—

(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—
   (A) Initial goals based on admission orders.
   (B) Physician orders.
   (C) Dietary orders.
   (D) Therapy services.
   (E) Social services.
   (F) PASARR recommendation, if applicable.
The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident’s admission.

(ii) Must meet all the guidelines in the previous slide.

In this circumstance, the completion of the comprehensive care plan will not override the RAI process, and must be completed and implemented within 48 hours of admission and comply with the requirements for a comprehensive care plan with the exception of the requirement requiring the completion of the comprehensive care plan within 7 days of completion of the comprehensive assessment. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand.
Baseline Care Plans 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:

(i) The initial goals of the resident.
(ii) A summary of the resident's (current) medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

The summary must be in a language and conveyed in a manner the resident and/or representative can understand. The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.

In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.

Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes.
Surveyor Questions

- Was the baseline care plan developed and implemented within 48 hours of admission to the facility?
- Does the resident’s baseline care plan include:
  - Initial goals for care
  - The instructions needed to provide effective and person-centered care that meets professional standards of quality care
  - The resident’s immediate health and safety needs;
  - Physician and dietary orders;
  - PASARR recommendations, if applicable;
  - Therapy and social services.
- Was the baseline care plan revised and updated as needed to meet the resident’s needs until the comprehensive care plan was developed?

Surveyor Questions Continued

If the resident experienced an injury or adverse event prior to the development of the comprehensive care plan, should the baseline care plan have identified the risk for the injury/event (i.e., if risk factors were known or obvious)?

Did the facility provide the resident and his or her representative, if applicable, with a written summary of the baseline care plan that contained at least, without limitation:
- Initial goals of the resident;
- A summary of current medications and dietary instructions;
- Services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility;
- Any updated information based on details of the admission comprehensive assessment.
Impact in other areas

If the resident has been in the facility for less than 14 days (before completion of all the Resident Assessment Instrument (RAI) is required), the baseline care plan (will be reviewed) which must be completed within 48 hours to determine if the facility is providing appropriate care and services based on information available at the time of admission.

Could impact: Quality of Care (tag F684),
Vision and Hearing (tag F685),
Skin Integrity (tag F686),
Falls (tag F689),
Parenteral Fluids (F694)
Dialysis (tag F698),
Hospice (tag F849),
Infection Control (tag F880).
Comprehensive Care Plan F656

§483.21(b)

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights.

This includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.

INTENT & DEFINITIONS

Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

“Resident’s Goal”: The resident's desired outcomes and preferences for admission, which guide decision making during care planning.

“Interventions”: Actions, treatments, procedures, or activities designed to meet an objective.

“Measurable”: The ability to be evaluated or quantified.

“Objective”: A statement describing the results to be achieved to meet the resident's goals.

“Person-centered care”: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.
5 PART PERSON-CENTERED CARE PLANNING

• Resident Rights
• Care Plan Writing and Inclusion
• Discharge Care Plan Requirements
• Care Plan Meetings
• What Surveyors Want to Know

RESIDENT RIGHTS
483.10 Resident Rights

- Right to request care plan conferences
- Right to request revisions to care plan
- Right to be informed in advance of changes in care plan
- Right to sign after significant changes in care plan
- Right to have personal and cultural preferences addressed in care plan.
**483.10 Resident Rights**

- Resident has right to be informed of total health status
- Right to request, refuse, or discontinue treatment
- Right to participate in care planning including the right to identify individuals or roles to be included in the care planning. *Guardians, lawyers, friends, priests—whomever the resident requests.*
- Right to participate in family groups and have family members participate as well.

**483.10 Resident Rights**

- A resident may not be able to identify a specific person they want included in the planning process, but that should not prevent the resident from including a role, such as someone to provide spiritual, nutritional or behavioral health input.
483.10 Resident Rights

• Right to choose his/her attending physician.
• If physician chosen refuses or does not meet LTC regulations, facility may seek alternate.
• Facility must discuss alternate physician issue with resident.

483.10 Resident Rights

• Right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with interests, assessments, and plan of care.
• Right to make choices about aspects of life in facility that are significant to resident.
CARE PLAN WRITING AND INCLUSION

Nursing Care Plans

COMPREHENSIVE CARE PLANS, BY CMS

• All services furnished to attain, maintain highest practicable well-being
• Any services required but not provided due to resident’s exercise of rights
• Any specialized services (PASSAR) or specialized rehab
• Resident goal for admission and desired outcome
• Resident preference for discharge
• Discharge plans
**Comprehensive Care Plans, by CMS**

- The resident and/or representative **MUST** participate in the interdisciplinary team that develops the resident's care plan.
- Physician orders **MUST** be documented in a care plan. What's Your Policy?
- Facilities are required to provide written advance directive information to the resident and representative.

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**Comprehensive Care Plans, by CMS**

- Reviewed and revised after each assessment
- Meet professional standards of quality
- Be provided by qualified persons
- Be culturally-competent and trauma informed
**Comprehensive Care Plans, by CMS**

- Resident has the right to see the care plan along with the right to sign it after significant changes.
- Encourage the facility to provide a copy of the comprehensive care plan upon request. Residents have right to review and obtain copy of their medical record, the care plan is a part of their medical record.

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**F550 (formerly F242)**

**F242**
The resident has the right to –
(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

…the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life.

This includes actively seeking information from the resident regarding significant interests and preferences in order to provide necessary assistance to help residents fulfill their choices over aspects of their lives in the facility.
Residents shall not have their personal lives regulated or controlled beyond reasonable adherence to meal schedules and other written policies which may be necessary for the orderly management of the facility and the personal safety of the residents.

19 CSR 30-88.010 (41)
F550 (formerly 242)


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### Care Plan Meeting Summary

<table>
<thead>
<tr>
<th>Resident's Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for meeting: (circle one)</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Nursing notes</td>
<td></td>
</tr>
<tr>
<td>Dietary notes: Weight from previous quarter</td>
<td>Current weight</td>
</tr>
<tr>
<td>Dietary changes: (circle one) Y/N</td>
<td>Date of change</td>
</tr>
<tr>
<td>Resident's preferences</td>
<td></td>
</tr>
<tr>
<td>Social services notes</td>
<td></td>
</tr>
<tr>
<td>Therapy notes: (circle one) PT/OT/ST/Restorative</td>
<td></td>
</tr>
<tr>
<td>Resident/Family requests/complaints:</td>
<td></td>
</tr>
<tr>
<td>Signatures of attendance</td>
<td>Date</td>
</tr>
<tr>
<td>Resident/family requests a copy of careplan</td>
<td>Y/N</td>
</tr>
</tbody>
</table>
**Care Plan Writing and Inclusion**

- Person-centered, individual care plans are the key!!
  - Cultural preference
  - Spiritual preferences
  - Dietary preferences (see New Dining Standards at Pioneer Network Coalition for evidence-based practices)
  - Sleep/natural wakening routine practices
  - Activity preferences
  - Clinical practices (pain management)

**CARE PLAN**

**Traditional Example:**
Problem: Resident has a hx of falling d/t weakness and unsteady gate.
Goal: Resident will remain free from falls for the next 90 days

**Person-centered Example:**
“Jim has a history of falling late in the afternoon. He walks all throughout the day with his walker. Jim has early stages of dementia and gets restless. Walking helps him relieve anxiety; however, by the end of the day he is tired. Staff will be available to walk with Jim and engage him, particularly as he tires, using the poetry gait rhythm method that encourages rest stops. Jim's goal will be to reduce the number of episodes and risk of injury from falling, while improving his quality of life through meaningful engagement.”
**Care Plan Writing and Inclusion**

- **Assessment**
  - Try interviewing over coffee instead of a clipboard.
  - What was your normal routine?
    - Break it down—morning, noon, night
    - Relationships—who helps calm them down??
    - Pleasures (church groups, clubs, veteran’s networks, etc.)...CMS says we have to provide opportunities to continue these social networks.
    - Preferences on medication administration, lighting, noise

**What if They Can’t Tell You What They Want?**

- Discuss with families what they think the person’s goals would be now.

- If residents are unable and family is unavailable, then staff can step in and determine as best as they can from really knowing the person, what the person’s goals might be.

REMINDER—on the MDS, if they can’t tell you, then we should know that from section B. Lots of times these don’t match.

- Talk to your CNAs and floor nurses!! They know this person’s routine and what works and what doesn’t better than you do!!
## Care Plan Writing and Inclusion

### Typical Care Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dental Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
<th>Preferences</th>
<th>Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Care</td>
<td>Susan will maintain healthy teeth and gums.</td>
<td>Susan prefers to brush her teeth before breakfast and after supper. She likes mint toothpaste and she has a difficult time flossing on her own because of the arthritis in her fingers.</td>
<td>Staff will assist Susan with her dental care by following her routine and preparing her toothbrush if needed. Staff will assist her with flossing after supper at her discretion, and will offer professional dental services bi-annually or as needed.</td>
</tr>
</tbody>
</table>
**CARE PLAN WRITING AND INCLUSION**

**Narrative “I” Care Plan**

**COMMUNICATION/MEMORY:** I have a little bit of trouble with my memory. I have been diagnosed with early Alzheimer’s dementia. I am aware of my situation, my caregivers and my family.

Occasionally I am a little forgetful and confused. Be sure to orient me as part of our conversation while you are providing care. Remind me what is going to happen next. Introduce yourself every time you meet me until I am able to remember you. If I should be more confused than you normally see me, or I don’t remember details about my day, notify the nurse. Often times this means that I am having health complications, which my nurse will be able to assess. I enjoy conversation about your family and your children. I have had a lot of experience raising kids. If you would like some advice on beauty, I love to share my opinion. Especially on how you should do your hair or what clothes look good on you. Being a model all those years has paid off.

**GOAL:** I want to remain oriented to my family and my caregivers. I want to be able to remember special events and holidays with your reminders.

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**CARE PLAN WRITING AND INCLUSION**

Possible “person-centered” categories for a care plan…

- Dental Care
- Bladder Management
- Skin Care
- Nutrition
- Fluid Maintenance
- Pain Management and Comfort
- Activities
- Discharge Plan
CARE PLAN WRITING AND INCLUSION

Possible “person-centered” categories for a care plan…

- Social History
- Memory Enhancement & Communication
- Mental Wellness
- Mobility Enhancement
- Safety
- Visual function
GUIDANCE for DISCHARGE

The comprehensive care plan must address a resident's preference for future discharge, as early as upon admission, to ensure that each resident is given every opportunity to attain his/her highest quality of life.

This encourages facilities to operate in a person-centered fashion that addresses resident choice and preferences.
Discharge Planning (In Care Plans)

- § 483.21(c) Facilities must develop and implement an effective discharge planning process.
  - Identify discharge goals and needs
  - Develop a discharge plan, including referrals to local agencies, etc. for returning to the community.

Discharge Planning (In Care Plans)

Information provided to receiving provider (another home, resident's home, etc):

- Contact information of the practitioner who was responsible for the care of the resident;
- Resident representative information, including contact information;
- Advance directive information;
- Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:
  - Treatments and devices (oxygen, implants, IVs, tubes/catheters);
  - Precautions such as isolation or contact;
  - Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;
Discharge Planning (in Care Plans), cont’d

• The resident’s comprehensive care plan goals; and
• All information necessary to meet the resident’s needs, which includes, but may not be limited to:
  • Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;
  • Diagnoses and allergies;
  • Medications (including when last received); and
  • Most recent relevant labs, other diagnostic tests, and recent immunizations.

Discharge Planning (in Care Plans)

• …require regular re-evaluation of residents to identify changes that require modification of the discharge plan and update the care plan to reflect these changes. MAKE SURE YOU DATE AND INITIAL ANY CHANGES.
• And, they want the MDS (or care plan coordinator) involved in the discharge planning process.
GUIDANCE FOR REFUSAL OF CARE

In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate.

The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.

Additionally, a resident's decision-making ability may decline over time. The facility must determine how the resident's decisions may increase risks to health and safety, evaluate the resident's decision making capacity, and involve the interdisciplinary team and the resident's representative, if applicable, in the care planning process.

See guidelines at §483.10(c)(6) (F578) (Request/Refuse/Discontinue Treatment/Formulate Adv Directives) for additional guidance concerning the resident's decision to refuse treatment.

GUIDANCE FOR PASARR

In addition to addressing preferences and needs assessed by the MDS, the comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations.

If the IDT disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. The rationale should include an explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations and how the resident would benefit from alternative interventions. The facility should also document the resident's preference for a different approach to achieve goals or refusal of recommended services.

Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

REMEMBER the RULES—Residents retain the right for basic living choices and considerations.
GUIDANCE FOR CARE AREA ASSESSMENT (CAA)

If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident.

Documentation regarding these assessments and the facility’s rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.

There may be times when a resident risk, weakness or need is identified within the context of the MDS assessment, but may not cause a CAA to trigger. The facility is responsible for addressing these areas and must document the assessment of these risks, weaknesses or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area. If the decision to proceed to care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident’s representative, if applicable, must develop and implement the comprehensive care plan and describe how the facility will address the resident’s goals, preferences, strengths, weaknesses, and needs.

CARE AREA ASSESSMENT (CAA) DOCUMENTATION

ANALYSIS OF FINDINGS- this is where MDS Coordinators need to summarize their CAA findings.

Describe the problem, what are the causes and contributing factors and what are risk factors related to the area.
CARE PLAN MEETINGS

• Must-have participants
  – CNA who provides care
  – Dietary staff
• No members of the IDT are required to participate in person.
• Facilities have the flexibility to determine how to hold IDT meetings whether in person or by conference call.
• The facility may determine that participation by the nursing assistant or any member, may be best met through email participation or written notes. We believe that this added flexibility will help to alleviate concerns of shortage and availability.
**Care Plan Meetings...§ 483.21(b)**

- § 483.21(b)(2)(ii)(F), to provide that to the extent practicable, the IDT must include the participation of the resident and the resident representatives.
- An explanation must be included in a resident’s medical record if the IDT decides not to include the resident and/or their resident representative in the development of the resident's care plan or if a resident or their representative chooses not to participate.

**Care Plan Meetings**

- CMS encourages facilities to explore ways to allow residents, families and representatives to access care plan on a routine basis using technology solutions that enable real time access for authorized users.
- Face-time, Skype
- **Beware** of HIPPA violations! No careplan meetings in Wal-Mart 😊
PERSON-CENTERED CARE PLAN MEETINGS

1. Ask yourself: Are you having a conversation about someone’s care in their home or are you coming to a meeting because you have to, holding a clipboard, and checking off a list?

2. Are the various disciplines rattling off their speels then walking out of the room?

3. What is the ratio of staff to resident and family? Remind you of a firing squad? Think about who REALLY needs to be present.

4. Is it too cold, too hot, distracting, private, comfortable for the resident and family?

WHAT SURVEYORS WANT TO KNOW

SURVEY SAYS...
SURVEYOR QUESTIONS

Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?

• Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?

• Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?

• Does the care plan describe specialized services and interventions to address PASARR recommendations, as appropriate?

SURVEYOR QUESTIONS

• Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?

• Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.

• Evaluate whether the care plan reflects the facility’s efforts to find alternative means to address care of the resident if he or she has refused treatment.

• Is there evidence that the care plan interventions were implemented consistently across all shifts?
IMPACT IN OTHER AREAS

If the surveyor identifies concerns about the resident's care plan being individualized and person-centered, the surveyor should also review requirements at:

- Resident assessment, §483.20
- Activities, §483.24(c)
- Nursing services, §483.35
- Food and nutrition services, §483.60
- Facility assessment, §483.70(e)

DEFICIENCY CATEGORIZATION

Examples of Level 4, immediate jeopardy to resident health and safety,

- A resident has a known history of inappropriate sexual behaviors and aggression, but the comprehensive care plan did not address the resident’s inappropriate sexual behaviors or aggression which placed the resident and other residents in the facility at risk for serious physical and/or psychosocial injury, harm, impairment, or death.

- The facility failed to implement care plan interventions to monitor a resident with a known history of elopement attempts, which resulted in the resident leaving the building unsupervised, putting the resident at risk for serious injury or death.
DEFICIENCY CATEGORIZATION (Cont)

Examples of Level 3, actual harm that is not immediate jeopardy

• The CAA Summary for a resident indicates the need for a care plan to be developed to address nutritional risks in a resident who had poor nutritional intake. A care plan was not developed, or the care plan interventions did not address the problems/risks identified. The lack of interventions caused the resident to experience weight loss.

• Lack of care plan interventions to address a resident’s anxiety, depression, and hallucinations resulted in psychosocial harm to the resident

DEFICIENCY CATEGORIZATION (Cont)

Examples of Level 2, no actual harm, with potential for than more than minimal harm, that is not immediate jeopardy

• During the comprehensive assessment, a resident indicated a desire to participate in particular activities, but the comprehensive care plan did not address the resident’s preferences for activities, which resulted in the resident complaining of being bored, and sometimes feeling sad about not participating in activities he/she expressed interest in attending.

• An inaccurate or incomplete care plan resulted in facility staff providing one staff to assist the resident, when the resident required the assistance of two staff, which had the potential to cause more than minimal harm.
An example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident

• For one or more care plans, the staff did not include a measurable objective, which resulted in no more than a minor negative impact on the involved residents.

Phase 3

• Care that addresses unique needs of Holocaust survivors, war survivors, disasters, and other profound trauma are important aspect of person-centered care.

• MORE INFORMATION TO COME…
• Carmen Bowman, Edu-catering, *Individualized Care Planning*

• Centers for Medicare & Medicaid Services, 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489, [CMS-3260-F], Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, [https://federalregister.gov/d/2016-23503](https://federalregister.gov/d/2016-23503)

• Missouri State Code of Regulations, [https://www.sos.mo.gov/cmsimages/adrules/CSR/CURRENT/19CSR/19CSR-88.pdf](https://www.sos.mo.gov/cmsimages/adrules/CSR/CURRENT/19CSR/19CSR-88.pdf)