MDS Survey Tags

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MDS and Care Plan Related Tags

MDS

F635 Admission Physician Orders for Immediate Care
F636 Comprehensive Assessment
F637 Comprehensive Assmt after Significant
F638 Quarterly Assessment at least every 3 months
F639 Maintain 15 months of Residents Assessments
F640 Encoding/Transmitting Resident Assessment
F641 Accuracy of Assessments
F642 Coordination/Certification of Assessment
F644 Coordination of PASARR and Assessment
F645 PASARR Screening for MD&ID
F646 MD/ID Significant Change Notification

Care Plan

F655 Baseline Care Plan
F656 Development/Implementation Comprehensive Care
F657 Care Plan Timing and Revision
F658 Services Provided Meet Professional Standards
F659 Qualified Persons
F660 Discharge Planning Process
F661 Discharge Summary

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3 MDS/Care Plan Survey Tag Changes *NEW*

1. 658 Services Provided Meet Professional Standards

NOTE: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if non-compliance exists related to the practitioner not adhering to professional standards of quality for assessing and diagnosing a resident. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

2. F641 Accuracy of Assessments

Note: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing

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3 MDS/Care Plan Survey Tag Changes *NEW*

3. F656 Development/Implementation Comprehensive Care Plan
§483.21(b)(3) Be culturally-competent and trauma–informed

"Culture" is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Adapted from: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, https://store.samhsa.gov/system/files/sma14-4884.pdf

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F656 Development/Implementation Comprehensive Care Plan Continued

Culturally Competent Care Cultural competency, (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. it means being respectful and responsive to the health beliefs, practices and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious or social groups (https://www.samhsa.gov/capt/applying-strategic-prevention/culturalcompetence).

The interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity. Trauma-Informed Care Given the widespread nature and highly individualized experience of trauma, the utilization of trauma-informed approaches is an essential part of person-centered care.

Facilities must recognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions. Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others. Surveyors should refer to the following when investigating concerns related to culturally competent, trauma-informed care:

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F656 Development/Implementation Comprehensive Care Plan Continued

Probes

Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?

• For residents with a history of trauma, does the care plan describe corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident? (See §483.25(m))

Additional tags

Resident Rights, Cultural competence and trauma-informed care & Treatment/Services for mental/psychosocial concerns.

Example of IJ

The facility failed to identify a resident's cultural dietary restrictions related to eating pork. After eating her dinner, upon realization that she had eaten pork, the resident began crying inconsolably and screaming that this was explicitly forbidden in her culture and faith of Islam. The resident remained tearful and inconsolable for several days, and would not eat the food provided by the facility, which resulted in weight loss and serious psychosocial harm.

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Care Plan Tags

- F655 Baseline Care Plan
- F656 Development/Implementation Comprehensive Care
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons
- F660 Discharge Planning Process
- F661 Discharge Summary

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F655
Baseline Care Plans and Baseline Summary

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Intent

Continuity of Care

- 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.

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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.

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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.

- **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.

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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.

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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.

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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).

CMS Manual System Transmittal Pub. 100-07 State Operations Provider Certification-169- Advanced copy. Pages 254, 258, 274, 300, 340, 373, 609, 637.

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F656
Develop/Implement Comprehensive Care Plan

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

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Comprehensive Care Plan Must Describe-

1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under (Quality of life & care & behavioral health).

2) Any services that would otherwise be required under (Quality of life & care & behavioral health) but are not provided due to the resident's exercise of rights under (Resident rights), including the right to refuse treatment.

3) 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 the PASARR, it must indicate its rationale in the resident's medical record.

4) In consultation with the resident and the resident's representative(s)
   a) The resident's goals for admission and desired outcomes.
   b) 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.
   c) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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Intent

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.

Definition

"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.

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Guidance continued

Care plan should assist caregivers in understanding how the resident is communicating, verbally/non-verbally, identifying what is important to the resident with regards with daily routines and preferred activities and understanding the resident's life before coming to the nursing home.

Resident's goals set the expectation for care and services.

At a minimum, use the MDS to assess the resident's clinical condition, cognitive and functional status and services.

Care Area Assessment (CAA) is triggered- determines how the risk, weakness or need affects the residents.

CAA rationale for deciding whether or not to proceed to care plan for each triggered area and must be documented in the medical record. Even if it does not trigger on the CAA, if a risk, weakness or need is identified- it should be determined if the need is to care plan it.

The RAI assessment should be fluid and on-going not just to meet the guidelines set forth by the RAI process. Preferences and goals may change throughout their stay, facilities should have on-going discussions and update the care plan as needed.

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GUIDANCE CONTINUED

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.

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GUIDANCE CONTINUED

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.

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Guidance continued

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.

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Potential Tags for Additional Investigation

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
- Activities
- Nursing services
- Food and nutrition services
- Facility assessment

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F657
Care Plan Timing and Revision

A comprehensive care plan must be—

1) **Developed within 7 days after completion of the comprehensive assessment.**
2) **Prepared by an interdisciplinary team**, that includes but is not limited to--
   a) The attending physician.
   b) A registered nurse with responsibility for the resident.
   c) A nurse aide with responsibility for the resident.
   d) A member of food and nutrition services staff.
   e) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
   f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
3) **Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.**

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Intent

To ensure the **timeliness** of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is **reviewed and revised by an interdisciplinary team composed** of individuals who have knowledge of the resident and his/her needs, and that **each resident and resident representative**, if applicable, **is involved in** developing the care plan and making **decisions about his or her care.**

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Guidance

- **Complete** comprehensive care plan **by day 21.**
- The IDT can meet its responsibility in development of the interdisciplinary care plan by face-to-face meetings, teleconference, written communication etc… it is at the discretion of the facility.
- In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.
- Provide advanced notice of the care plan meeting. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing. *If they cannot attend or do not respond, make sure you document how you tried to reach them.*

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Guidance continued

Care plan meeting participants should include:

- attending physician,
- RN,
- nurses aide responsible for the resident,
- a member of the food and nutritional service staff,
- resident and resident representative to the extent as possible.

Other professionals should participate based on the physical, mental and psychosocial condition of the resident.

If the attending physician is unable to participate in the development of the care plan, he/she may delegate participation to an NPP who is involved in the resident's care, to the extent permitted by state law, or arrange alternative methods of providing input in the development and revision of the care plan, such as one-on-one discussions, videoconferencing and conference calls with the IDT.

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F658
Services Provided Meet Professional Standards

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

(i) Meet professional standards of quality

Intent

The intent of this regulation is to assure that services being provided meet professional standards of quality.

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Guidance

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

There is no requirement for the surveyor to cite a reference or source (e.g., current textbooks, professional organizations or clinical practice guidelines) for the standard of practice. However, in cases where the facility provides a reference supporting a particular standard of practice for which the surveyor has concerns, the surveyor must provide evidence that the standard of practice the facility is using is not up-to-date, widely accepted, or supported by recent clinical literature.

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F659 Qualified Person

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

Be provided by qualified persons in accordance with each resident's written plan of care.

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Guidance

The facility must ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required.

Procedures and Probes

NOTE: Provision of services by qualified individuals would be cited here, but implementation of the care plan would be cited in F656.

- Are the services identified in the comprehensive care plan being provided by qualified persons?
- Do staff assigned to the resident have the skills, experience?

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F636
Comprehensive Assessment and Timing

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

Completed through the MDS, conversation, observation, and documentation.

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Comprehensive Assessment

A facility must conduct a comprehensive assessment of a resident in accordance with the timeframes, **within 14 calendar days after admission**, excluding readmissions in which there is no significant change in the resident's physical or mental condition.

(For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)

AND not less than once every 12 months.

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Intent

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 on-going 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**.

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F637
Comprehensive Assessment After a Significant Change

Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.

(For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

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Definitions of Significant Change

"Significant Change" is a major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered "self-limiting"

A Significant Change in Status MDS is required when:

- A resident enrolls in a hospice program; or
- A resident changes hospice providers and remains in the facility; or
- A resident receiving hospice services discontinues those services; or
- A resident experiences a consistent pattern of changes, with either **two or more** areas of decline or **two or more** areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS).

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Significant Change Decline Examples

- Resident's decision-making ability has changed;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E Behavior;
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment;
- Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days).
- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type, when it was not used before;
- Emergence of a condition/disease in which a resident is judged to be unstable.

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Significant Change Improvement Examples

- Any improvement in ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision-making ability improves;
- Resident's incontinence pattern improves;

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Examples of Significant Change NOT NEEDED

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

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F638
Quarterly Assessment at Least Every 3 Months

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months via on OBRA review at least every 92 days to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all Minimum Data Set (MDS) items appear on the Quarterly assessment.

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F639 Maintain 15 Months of Resident Assessments

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

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Guidance

- Can be electronic or paper.
- If paper, ensure that hard copies of the MDS assessment signature pages are maintained for every MDS assessment conducted in the resident's active clinical record for 15 months. (This includes enough information to identify the resident and type and date of assessment linked with the particular assessment's signature pages),
- Kept in a centralized location and must be readily and easily accessible. This information must be available to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. (This information must also be made readily and easily accessible for review by the State Survey agency and CMS.) Resident-specific information must also be available to the individual resident also.

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F641 Accuracy of Assessments

"Accuracy of Assessment" means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).

Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.

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Guidance Continued

The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.

When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.

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F642 Coordination/Certification of Assessment

- A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
- Certification: A registered nurse must sign and certify that the assessment is completed.
- Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- Penalty for Falsification. Under Medicare and Medicaid, an individual who willfully and knowingly—
  i. Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
  ii. Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.

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Electronic Signatures

FYI, if you're using electronic signatures… the facility must have written policies in place to ensure proper security measures are in place to protect use of an electronic signature by anyone other than the person to which the electronic signature belongs. The policy must also ensure access to a hard copy of clinical records is made available to surveyors and others who are authorized access to clinical records by law, including the resident and/or resident representative.

Facilities that are not capable of maintaining the MDS signatures electronically must adhere to the current federal requirements at §483.20(d) addressing the need for either a hand-written copy or a computer-generated form.

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F644 Coordination of PASARR and Assessments

Appendix PP page 191-195

F645 PASARR Screening for MD & ID

Appendix PP page 195-201

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F646 MD/ID Significant Change Notification

A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

Intent

To ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs.

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Definition

"Preadmission Screening and Resident Review (PASARR)" is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care. PASARR requires that:

1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability;
2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.

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GUIDANCE

Referral to the SMH/ID authority should be made as soon as the criteria indicative of a significant change are evident — the facility should not wait until the SCSA is complete.

Referral for Level II resident review evaluation is required for individuals previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change. Examples of such changes include, but are not limited to:

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the residents' plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but has behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASARR Level II evaluation and determination.

(**NOTE** that a referral for a possible new Level II PASARR evaluation is required whenever such a disparity is discovered, whether or not associated with a SCSA.)

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F660 DISCHARGE PLANNING PROCESS

Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the **resident's discharge goals**, the preparation of residents to **be active partners** and **effectively transition them to post-discharge care**, and the reduction of factors leading to preventable readmissions.

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Appendix PP page 218-224

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F660 Discharge Planning Process

- Create a discharge plan. Update as needed.
- Involve the interdisciplinary team.
- Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
- Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
- Address the resident's goals of care and treatment preferences.

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F660 Discharge Planning Process continued

- Document that a resident has been asked about their interest in receiving information regarding returning to the community.
  a) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
  b) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
  c) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
- If going to another healthcare facility, assist resident and representative in finding a suitable place based on relevant measures for that person's care.
- Document in a timely manner so as to avoid unnecessary delays in the resident's discharge or transfer.

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F660 Discharge Planning Process continued

<u>If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe</u>, the facility must treat this situation similarly to refusal of care, and must:

- Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;
- Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;
- Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;
- Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.

Use the Discharge Critical Element Pathway as well as Appendix PP

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F661 Discharge Summary

Must include:

1. Summary of resident's stay, including diagnosis, treatment, therapy, lab/diagnostic, consultations.
2. Residents status, including All special instructions or precautions for ongoing care, as appropriate.
3. Medication reconciliation.
4. Discharge plan stating where resident will resident, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
5. Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident;
6. Resident representative information, if applicable, including contact information;
7. Advance directive information;
8. Comprehensive care plan goals; and

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F661 Discharge Summary

Timing of the Discharge Summary

The discharge summary contains necessary medical information that the facility must furnish **at the time the resident leaves the facility**, to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary **may be furnished in either hard copy or electronic format**, if the provider assuming responsibility for the resident's care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident. The medical record must contain the discharge summary information and identify the recipient of the summary.

NOTE: In situations where there is no continuing care provider (e.g., resident has no primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider.

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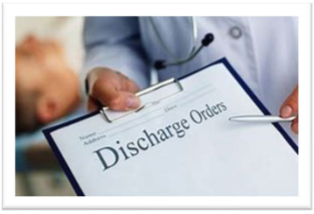
F661 Discharge Summary

Instructions to residents discharged to home

For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. These instructions must be discussed with the resident and resident representative and conveyed in a language and manner they will understand.



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IMPORTANT – CEU INFORMATION

TODAY'S WEBINAR HAS BEEN APPROVED FOR CEU HOUR(S)

IN ORDER FOR MO LNHAS TO GET CREDIT:

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  - ✓ A pop-up at the end of the webinar, or
  - ✓ An automated email from GoToWebinar that will be sent to attendees
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This follow-up email was sent to 129 attendees.

We hope you enjoyed our webinar.

Please send your questions, comments and feedback to: musonqipmo@missouri.edu.

Please take the following survey:

QIPMO Webinar Survey

Your certificate is available here:

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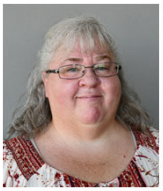

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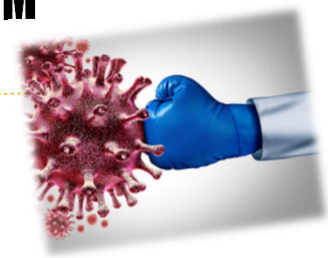

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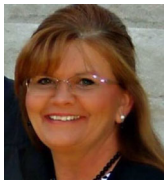

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