KHCA CARE PLANS
SPRING JOINT PROVIDER
SURVEYOR TRAINING

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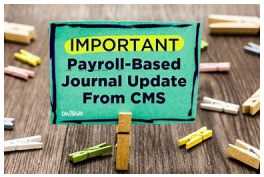
THE CONNECTIONS AND WHAT THEY MEAN TO THE COMPREHENSIVE CARE PLAN

- Timed studies from original development of the MDS



- Payroll-Based Journal

WHAT'S IMPORTANT TO THE RESIDENT?

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

TOP CARE PLAN DEFICIENCIES

- Comprehensive Care Plan not implemented as written.
- Comprehensive Care Plan not individualized/person-centered.
- Staff not knowledgeable regarding their responsibilities for implementation of the comprehensive care plan.

F656 - COMPREHENSIVE CARE PLANS

- The facility must ***develop*** and ***implement*** a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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. The comprehensive care plan must describe the following —
  - ✓ 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 §483.24, §483.25 or §483.40; and

F656 - COMPREHENSIVE CARE PLANS

- The comprehensive care plan must describe the following:
  - ✓ Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
  - ✓ 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.

F656 - COMPREHENSIVE CARE PLANS

- The comprehensive care plan must describe the following:
  - ✓ 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.

F656 - COMPREHENSIVE CARE PLANS

- The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
  - ✓ Be culturally-competent and trauma–informed.

EASING INTO CARE PLANS…

- Choose an individual from your facility. Now, ask yourself the following three questions:
  1. What am I doing with, and for, this resident
  2. Why am I doing these things?
  3. What outcome am I hoping to help the resident attain?

EASING INTO CARE PLANS…

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

CARE PLAN COMPONENTS

1. Problems/Risks/Needs/Issues/ Concerns/Preferences/ Interests/Strengths
2. Goal
3. Interventions/Approaches

CARE PLAN COMPONENTS

1. Problems/Risks/Needs/Issues/ Concerns/Preferences/Interests/ Strengths
   - ✓ Identify so specifically that it can only be interpreted ONE way – YOUR way!
   - ✓ Don't leave "open" for various interpretations

CARE PLAN COMPONENTS

2. Development of individualized, person—centered goals:
   - ✓ Goal must deal with or address the problem/need/ preference/etc. that was identified.

CARE PLAN COMPONENTS

2. Development of individualized, person—centered goals:
   - ✓ Goal should be resident-directed
   - ✓ Goal should be an observable action "task"
   - ✓ Goal should be quantifiable and measurable

CARE PLAN COMPONENTS

3. Development of specific interventions
   - ✓ Must be individualized
   - ✓ Must be specific! Consider them as specific "assignments" to a staff person.

HOW DO WE KEEP THE PLAN INDIVIDUALIZED?

Ask yourself this question:

- ✓ Could I use this same goal and/or interventions (care plan) on other residents in my care?
- ✓ If you can use the same plan on a large number of residents in your building, scrap the plan and start over!

POTENTIAL RISKS/ISSUES

- Must be a "potential" for the individual resident; not every resident in the building
- Don't address on care plan just because the MDS 3.0 triggers…further investigate utilizing the CAAs. If you determine it is not an issue for the resident, DON'T address it on the care plan.

DETERMINING "AT RISK"

- Ask yourself this question for any identified issue…
  - ✓ If my staff do not intervene with this issue, will the resident decline or deteriorate?
  - ✓ If the answer is "no," then don't address it on the care plan, but give explanation in the CAA Summary as to why it is not being addressed.
  - ✓ If the answer is "yes," then you must address the issue on the care plan.

OUTCOMES

- What is the resident outcome that you want to occur as a direct result of the care that you have provided?
- Who accomplishes the goal? Resident or staff?

SURVEYOR GUIDANCE

- **NOTE**: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more ***fluid and should be ongoing***.

SURVEYOR GUIDANCE

- The lack of ongoing clinical assessment and identification of changes in condition to meet the resident's needs between required RAI assessments should be addressed at §483.35 Nursing Services, F726 (competency and skills to identify and address a change in condition), and the relevant outcome tag, such as §483.12 Abuse, §483.24 Quality of Life, §483.25 Quality of Care, and/or §483.40 Behavioral Health.

SURVEYOR PROBES

- Use the Critical Element (CE) Pathway associated with the issue under investigation, or if there is no specific CE Pathway, use the General Critical Element Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement to develop and implement a Comprehensive Care Plan.
- If systemic concerns are identified with Comprehensive Care Plans, use the probes below to assist in your investigation.

SURVEYOR PROBES

- 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?

SURVEYOR PROBES

- 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 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))

SURVEYOR PROBES

- Is there evidence that care plan interventions were implemented consistently across all shifts?
- Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?

SURVEYOR PROBES

- 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.

F657 - COMPREHENSIVE CARE PLANS

- A comprehensive care plan must be —
  - ➡ Developed within 7 days after completion of the comprehensive assessment.
  - ➡ Prepared by an interdisciplinary team, that includes but is not limited to—
    - ✓ 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). 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.
    - ✓ Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
  - ➡ Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

F657 - CARE PLAN REVISIONS

- A comprehensive care plan must be revised —
  - ➡ When condition or status of resident changes
  - ➡ Upon significant change as defined by MDS 3.0 RAI Manual
  - ➡ Achieving the desired outcome;

F657 - CARE PLAN REVISIONS

- A comprehensive care plan must be revised —
  - ➡ Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; and/or

F657 - CARE PLAN REVISIONS

- A comprehensive care plan must be revised —
  - ➡ Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems.
  - ➡ When plan/interventions are not working or effective

KANSAS SURVEYOR FOCUS - F656

- Failure to develop person-centered care plan…
  - ✓ Catheter use/presence (communication/staff guidance)
  - ✓ Staff unaware of skin issues/worsened (communication)
  - ✓ Safe use of side rails (communication)
  - ✓ Wound care (communication)

KANSAS SURVEYOR FOCUS - F656

- Failure to develop person-centered care plan…
  - ✓ Did not address anticoagulant
  - ✓ Did not address antidepressant med usage/ side effect monitoring; no instructions for staff
  - ✓ Risk for miscommunication among staff

KANSAS SURVEYOR FOCUS - F656

- Failure to develop comprehensive care plan…
  - ✓ Use of oxygen with no orders
  - ✓ No interventions for nebulizer use
  - ✓ Risk items noted on MDS not care planned, especially ADLs
  - ✓ No interventions for splint/brace care

KANSAS SURVEYOR FOCUS - F656

- Failure to develop comprehensive care plan…
  - ✓ Communication between facility & dialysis center
  - ✓ No interventions for specific risk issues regarding certain diagnoses
  - ✓ Behavioral issues - risk for inappropriate care and uncommunicated care needs

KANSAS SURVEYOR FOCUS - F656

- Failure to develop comprehensive care plan…
  - ✓ Lack of documentation to support CPAP equipment
  - ✓ PTSD; interventions to prevent traumatization triggers
  - ✓ Worsening contractures - uncommunicated care needs

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ Staff assistance needed for transfer
  - ✓ No staff interventions of resident's frequent documented refusals for bathing
  - ✓ Frequent falls; no interventions for increased behaviors

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ Staff assistance needed for transfer
  - ✓ No staff interventions of resident's frequent documented refusals for bathing
  - ✓ **Frequent falls**; no interventions for **increased behaviors**

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ No instructions for preferences; nail care
  - ✓ No instructions for non-pharmacological interventions
  - ✓ Revision/update of medication changes

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ No interventions to prevent pressure ulcers
  - ✓ Change adding use of bedrails
  - ✓ Updated orders for skin care protection
  - ✓ No interventions for restorative services and nutritional needs after surgical wound debridement

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ Resident refusals to be transferred to bed or recliner to prevent bruising
  - ✓ Multiple falls - no root cause analysis to determine causative factors

KANSAS SURVEYOR FOCUS - F657

- Failure to revise comprehensive care plan…
  - ✓ Resident preference/use of dignity bag for catheter
  - ✓ No instructions/revision for fluid intake/fluid restrictions
  - ✓ Decline in eating

KANSAS SURVEYOR FOCUS - F656 & F657

"Placed resident at risk for inadequate care due to uncommunicated care needs…"

SUPPORTING DOCUMENTATION

Begin with the MDS 3.0

- Pay close attention to the codes on each resident.
- Make certain that any "risks," preferences, strengths, problematic areas identified on the MDS are first addressed on the comprehensive care plan.
- Make certain any documentation (progress notes, updates, reviews, etc.) reflects and supports the code that has been designated for a particular item or section.
- Make certain the documentation is interdisciplinary if appropriate or needed.

SUPPORTING DOCUMENTATION

Next stop is the Comprehensive Care Plan

- Documentation should indicate the implementation, monitoring, and review of this plan.
- Progress notes, reviews, updates, etc. should address specific issues noted on the care plan.
- Progress notes, reviews, updates, etc. should indicate that specific interventions identified on the care plan have been carried out, or if not, why?
- Progress notes, reviews, updates, etc. should indicate the resident's response to identified interventions.

SUPPORTING DOCUMENTATION

Next stop is the Comprehensive Care Plan

- Progress notes, reviews, updates should indicate who actually carried out the intervention.
- Progress notes, reviews, updates should indicate "follow-up" and "monitoring"
  - ✓ Why?
  - ✓ What?
  - ✓ How?
  - ✓ When?
  - ✓ By Whom?
  - ✓ Require any action?

SUPPORTING DOCUMENTATION

Next stop is the Comprehensive Care Plan

- Progress notes/documentation should reflect behavior issues:
  - ✓ Thorough investigation
  - ✓ Tracking document
  - ✓ Implementation of interventions
  - ✓ Resident outcomes
  - ✓ Education of staff

SUPPORTING DOCUMENTATION

- Progress reports/reviews/updates:
  - ✓ Carry out the interventions that were identified on the Comprehensive Care Plan.
  - ✓ Note the resident's response to each intervention. If evidence cannot be found to support that the plan was actually implemented, it appears to surveyors that the plan was ***not*** implemented.

SUPPORTING DOCUMENTATION

Progress reports/reviews/updates:

- Update information regarding identified problems/needs/strengths/ preferences and goals:
  - ✓ If the problem/need has been resolved or met, and the goals have been attained, state as such.
  - ✓ If the problem/need has not been resolved and you would like to continue the present goal and "plan of action," state as such.

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

SUPPORTING DOCUMENTATION

Progress reports/reviews/updates:

- Update information regarding identified problems/needs/ strengths/preferences and goals:
  - ✓ If the problem has not been resolved, or the need not met, and the goal is not feasible, state this and develop a new plan of action.
  - ✓ If there is a new problem or need, identify those issues. Develop an appropriate plan of action to be incorporated into the Comprehensive Care Plan.

SUPPORTING DOCUMENTATION

Progress reports/reviews/updates:

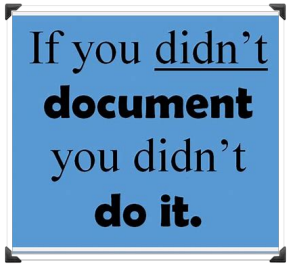
- Comment on problems/needs as they arise and note the outcome or resolution.
- Note referrals and follow-ups.
- Note resident's mental, physical, emotional, and psychosocial well-being during the past time period that you are reflecting in the progress note.
- Pay special attention to cognition deficits, behavioral symptoms and symptoms of depression.

SUPPORTING DOCUMENTATION

Progress reports/reviews/updates:

- Document deliverance of services or care. While it is virtually impossible to document every little service that you provide to each individual resident, it is important to document the services that reflect implementation of the care plan.
- Note any changes in the resident's condition (improvement or decline/deterioration) and hospital stays.

"IF IT WASN'T DOCUMENTED, IT DIDN'T HAPPEN...."



Priority reasons to document:

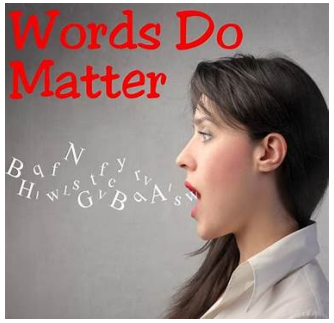
- Written support of the care and services that is actually provided to the resident.
- A means of communication among the professionals who are providing services and care to the resident.

WHEN DOCUMENTING...

Ask yourself these questions:

- Do I know what is required to meet the intensity level
- Have I supported services in my notes?
- Are all relevant disciplines consistent in their documentation, or is there contradiction?

AMBIGUOUS WORDS/PHRASES



- Will monitor.
- Will observe.
- Will follow-up.
- Notified physician.
- Physician called.
- 7-3 or 3-11 will call MD/DR.

AMBIGUOUS WORDS/PHRASES

- Appears
- Routine, Same, Common
- Good. Poor. Fair. Well.
- More. Less.
- Increase. Decrease.

AMBIGUOUS WORDS/PHRASES

- Adequate, Inadequate
- Appropriate, Inappropriate
- Wandered
- Abusive
- Combative

CARE PLAN "SELF-CHECKS"

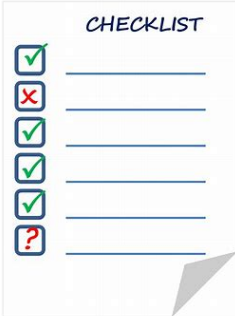
- Is the plan interdisciplinary?
- Is your content based on your findings/conclusions from the MDS 3.0 and other discipline-specific assessments?

CARE PLAN "SELF-CHECKS"

- Does the plan contain the necessary components?
  - ✓ Specific/detailed identification of problem, need, concern, issue, interest, preference, choice, strength. Could this be interpreted more than one way?

CARE PLAN "SELF-CHECKS"

- Does the plan contain the necessary components?
  - ✓ Resident goal (related to what has been identified/ described). Addresses issues? Resident-directed? Observable action task? Measurable and quantifiable?
  - ✓ Specific staff interventions. (Specific assignments? Assigned responsibility? Understandable? Communicated? Measurable?)



CARE PLAN "SELF-CHECKS"

- Is it realistic and "doable?" Can your staff TRULY carry out the assigned interventions?
- Could you use this plan on other residents in your building? How many?

CONTACT INFORMATION

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