Driving 5-Star & RoP Implementation Through a QAPI Approach

Final Rule:
Integrating Phase 2 New Requirements of Participation into Practice *(Part 1)*

PROACTIVE MEDICAL REVIEW

Objectives

- Recognize the key changes in the new SNF Requirements of Participation for Phase 2 Implementation
- Identify the actions necessary for compliance with the new regulations
- Acquire knowledge to implement best practices for Requirements of Participation (RoP) implementation using a QAPI approach

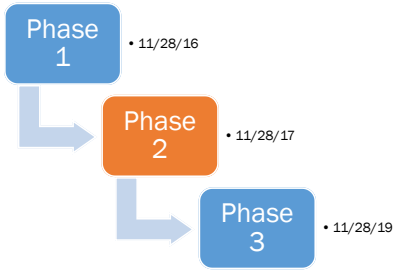
OVERVIEW OF PHASE 2 REQUIREMENTS OF PARTICIPATION

Themes, Timeframes, and Implementation Considerations

Themes of the Rule

- Person-Centered Care
- Facility Assessment, Competency-Based Approach
- Quality of Care & Quality of life
  - *New/changed evidence-based practice*
  - *Care Planning*
    - Patient goals
    - Patient as the locus of control
- Changing Patient Population
  - *Acuity*
  - *Behavioral Health*
- Alignment with HHS priorities
- Reflects dramatic cultural & technology changes over three decades

3 Phase Implementation Process



Phase 1

- Resident Rights *
- Freedom from abuse, neglect, & exploitation *
- Admission, transfer, & discharge rights *
- **Resident Assessment**
- Comprehensive person-centered care planning *
- **Quality of Life**
- Quality of Care *
- **Physician Services**
- Nursing Services *
- Behavioral Health Services *
- Pharmacy Services *
- **Laboratory, radiology, & other diagnostic services**
- Dental Services*
- Food & nutrition services *
- **Specialized rehabilitative services**
- Administration *
- Quality Assurance & Performance Improvement *
- Infection Control *
- Physical environment *
- Training requirements *

* Indicates section is partially implemented in Phase 2 or 3

Phase 2 and 3

Phase 2

- Resident rights *
- Freedom from abuse, neglect, & exploitation *
- Admission, transfer, & discharge rights*
- Comprehensive person-centered care planning*
- Behavioral health services *
- Pharmacy services *
- Dental services *
- Food & nutrition services *
- Administration*
- Infection control *
- Physical environment *

Phase 3

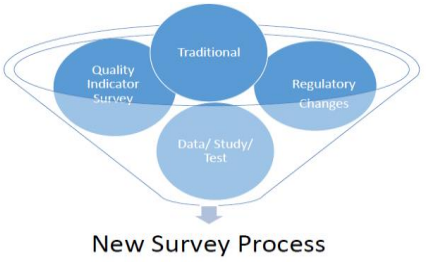
- Freedom from abuse, neglect, & exploitation *
- Comprehensive person-centered care planning*
- Quality of Care *
- Nursing services *
- Behavioral health services *
- Administration*
- Quality assurance & performance improvement *
- Infection control *
- **Compliance & ethics program**
- Physical environment *
- Training requirements*

* Indicates section partially implemented in other phases

Impact on Survey Process

- CMS is developing a new survey process
  - *Merges QIS with traditional survey*
  - *Incorporates new RoPs*
- This will change the survey focus and types of tags issued

Survey Process Changes



(CMS, 2016)

Survey Process

- New survey process starting in Phase 2 – November 28. 2017
- Incorporates new requirements
- New F-Tag Coding System – F540+

New Survey Protocol

- Computer based
- Two Parts
  - *Sample selection*
    - 70% off-site
    - 30% on-site
  - *Investigation*

Information Roll-Out Plan

- CMS intends to release information this summer relate to:
  - *New tags*
  - *New interpretive guidance*
  - *New Survey process*
- Provide tools and training
- S&C memos will be used to announce the posting or release of materials

§ 483.10 Resident Rights

- 483.10 (g)(4)(ii-v)
- The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language that he or she understands, including:
  - *(ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.);*
  - *(iii) Information regarding Medicare and Medicaid eligibility and coverage;*
  - *(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program*
  - *(v) Contact information for the Medicaid Fraud Control Unit*

§483.10 Resident Rights- Required Actions

- Update all notices, postings, and admission packet information with new required notifications & information
  - *Are notices in format and language all residents can understand?*
    - Braille
    - Alternative languages
    - Large Print
  - *How do you communicate required notices both orally and in writing?*
    - Admission process
    - Acknowledgement

§483.12 Freedom From Abuse, Neglect & Exploitation

- 483.12 (b)(5)(i-iii)
- Facility must develop and implement written P&P that:
  - *Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements*

  (see next slide)

§483.12 Freedom From Abuse, Neglect & Exploitation

- Must include following element in P&P:
- (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.
  - *(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.*
  - *(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.*

§483.12 Freedom From Abuse, Neglect & Exploitation

- A "covered individual" is defined at section 1150B(a)(3) of the Act as each individual who is an owner, operator, employee, manager, agent, or contractor of such LTC facility.

§483.12 Freedom From Abuse, Neglect & Exploitation

- Must include following elements in P&P:
  - *(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.*
  - *(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.*

Elder Justice Act (EJA) Refresher

Purpose:

- To prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation.
- To protect elders with diminished capacity while maximizing their autonomy and help elders recognize right to be free of abuse, neglect, and exploitation

Facility Obligation for Crime Reporting :

- The owner or operator of each long-term care facility that receives at least $10,000 in federal funds for the year is obligated to comply with the crime reporting requirement to local law enforcement.
- The EJA provides that a "crime" is defined by local laws of the state in which the facility is situated.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/sletter11_30.pdf

EJA Reporting timeframes

- EJA instructs reporting must occur within two hours of the event if the resident suffers serious bodily injury
- If there is no serious bodily injury, then a report must be filed within 24 hours of the event.
- The EJA reporting timeline is based on clock time, not business hours.
- **Don't delay. Report immediately to comply with state regulation.**

The Act defines "**serious bodily injury**" as an injury with extreme physical pain; with the possibility of loss or impairment of a bodily member, mental faculty, or organ; a risk of death; or that may require surgery, hospitalization, or rehabilitation.

See State Specific EJA Resource Handout

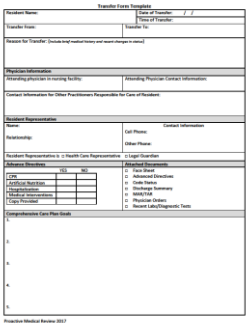
§483.12 Freedom From Abuse, Neglect & Exploitation – Required Actions

- Ensure new Phase 2 requirements are incorporated into Abuse and Elder Justice Act P&P and Abuse Training
- Educate staff on Elder Justice Act P&P
- *Notify Covered Individuals:* Annually notify each covered individual of that individual's reporting obligations described in section 1150B(b) of the Act
- *Post Conspicuous Notice:* Conspicuously post, in an appropriate location, a notice for your employees specifying the employees' rights, including the right to file a complaint under this statute. The notice must include a statement that an employee may file a complaint with the SA against a LTC facility that retaliates against an employee, as well as include information with respect to the manner of filing such a complaint
- Review Elder Justice Act requirements for compliance

§483.15 Admission, Transfer and Discharge Rights

- 483.15 (c)(2) Documentation
- When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

- See Sample Transfer Form Template



§483.15 Admission, Transfer and Discharge Rights

- (i) Documentation in the resident's medical record must include:
  - *(A) The basis for the transfer per paragraph (c)(1)(i) of this section.*
  - *(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).*

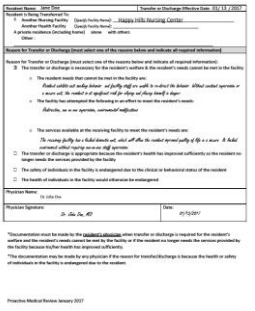
§483.15 Admission, Transfer and Discharge Rights

- The documentation required by paragraph (c)(2)(i) of this section must be made by—
  - *(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section and*
  - *(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section*

§483.15 Admission, Transfer and Discharge Rights

- (iii) Information provided to the receiving provider must include a minimum of the following:
  - *(A) Contact information of the practitioner responsible for the care of the resident*
  - *(B) Resident representative information including contact information.*
  - *(C) Advance Directive information.*
  - *(D) All special instructions or precautions for ongoing care, as appropriate.*
  - *(E) Comprehensive care plan goals,*
  - *(F) All other necessary information, including a copy of the residents discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.*

- See Sample Transfer/DC Physician Documentation Template



Physician Transfer or Discharge Documentation Template

Resident Name: Jane Doe — Transfer or Discharge Effective Date: 01/ 13 / 2017

Resident is Being Transferred To:
- Another Nursing Facility (Specify Facility Name): Happy Hills Nursing Center
- Another Health Facility (Specify Facility Name):
- A private residence (including home) alone with others:
- Other:

Reasons for Transfer or Discharge (must select one of the reasons below and indicate all required information):

Reason for Transfer or Discharge (must select one of the reasons below and indicate all required information):

☒ The transfer or discharge is necessary for the resident's welfare & the resident's needs cannot be met in the facility

- ☒ The resident needs that cannot be met in the facility are:
  Medical stability and on-going behavior and facility staff are unable to re-direct the behavior. Without constant supervision or a secure unit, the resident is at significant risk for elopement and wandering behavior.
- ☒ The facility has attempted the following in an effort to meet the resident's needs:
  Referrals, one on one supervision, environmental modification
- ☒ The services available at the receiving facility to meet the resident's needs are:
  The receiving facility has a locked dementia unit, which will allow the resident improved safety of life in a secure, & locked environment without requiring one-on-one staff supervision.

☐ The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility

☐ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident

☐ The health of individuals in the facility would otherwise be endangered

Physician Name: Dr. Julia Doc

Physician Signature: Dr. Julia Doc, MD — Date: 01/13/2017

*Documentation must be made by the resident's physician when transfer or discharge is required for the resident's welfare and the resident's needs cannot be met by the facility or if the resident no longer needs the services provided by the facility because his/her health has improved sufficiently.

*The documentation may be made by any physician if the reason for transfer/discharge is because the health or safety of individuals in the facility is endangered due to the resident.

Proactive Medical Review January 2017

§483.15 Admission, Transfer & Discharge Rights – Required Actions

- Review & modify transfer forms to ensure contains all required elements of information must provided to receiving provider
- Educate nursing staff on information they must provide to receiving providers
- Educate physicians on documentation requirements for transfers/discharges

§483.21 Comprehensive Person-Centered Care Planning

- 483.21 (a) Baseline care plans
  - *(1) 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.*

§483.21 Comprehensive Person-Centered Care Planning

- 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.

§483.21 Comprehensive Person-Centered Care Planning

- (2) 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) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21 Comprehensive Person-Centered Care Planning

- (3) 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 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.*

Sample Baseline Care Plan Summary

§483.21 Comprehensive Person-Centered Care Planning- Required Actions

- Develop P&P for baseline care plans
- Establish process for developing baseline care plans
- Establish form for documenting baseline care plans, if necessary
- Establish form/process for providing resident/representative summary of baseline care plan

§483.35 Nursing Services

- Must have sufficient nursing staff with appropriate competencies & skill sets to provide nursing and related services to assure resident safety and attain or maintain highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of facility resident population **in accordance with the facility assessment required at 483.70(e)**
- All was required in Phase 1 with exception of linking it to the facility assessment

Nursing Services Considerations

- Resident Acuity
  - *Evaluate CMI*
- Diagnoses
  - *Consider clinical complexities*
- Special Needs
  - *Dialysis*
  - *Respiratory*
  - *Diabetes*
  - *Feeding tubes*
  - *Wound care*
  - *Parenteral fluids*
  - *Behaviors*
- Special equipment
  - *Lifts*
  - *Respiratory equipment*
  - *IV equipment*
- Average admissions/discharges
  - *Short term residents*
  - *Long-term residents*

§483.35 Nursing Services – Required Actions

- Develop and implement processes to assess competencies of nursing staff.
- Develop and implement processes to determine "sufficient nursing staff" to meet requirements for nursing services, based on facility assessment.

§483.40 Behavioral Health

- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

§483.40 Behavioral Health

- (a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with § 483.70(e). These competencies and skill sets include, but are not limited to, knowledge of and appropriate training and supervision for:
  - *(2) Implementing non-pharmacological interventions*

§483.40 Behavioral Health

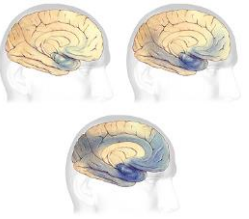
- (b) Based on the comprehensive assessment of a resident, the facility must ensure that-
  - *(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.*

§483.40 Behavioral Health

- (c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—
  - *(1) Provide the required services, including specialized rehabilitation services as required in § 483.65; or*
  - *(2) Obtain the required services from an outside resource (in accordance with § 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.*

CONSIDERATIONS FOR NON-PHARMACOLOGICAL APPROACHES TO BEHAVIOR MANAGEMENT IN PERSONS WITH DEMENTIA

Alzheimer's Disease Progression



Artwork used with permission 2008 Alzheimer's Association www.alz.org/brain/02.asp

Early stage:
Learning and memory, thinking and planning problems

Mild-Moderate stage:
More learning, memory, planning problems. Also, speaking and understanding speech and sense of where the body is in relation to objects around them (proprioception & spatial awareness) is impaired.

Advanced stage:
Most of the cortex is seriously damaged due to widespread cell death. Lose communication ability, self care skills, & ability to recognize loved ones.

How do we start?

- Define cognitive ability using an evidence based measure (stage the dementia)
- Establish reasonable care plans with functional expectations within the capabilities of the resident
- Train care partners, so that we are all "speaking the same language" regarding cognitive ability.
- Work together to build an environment that provides comfort, just right stimulation, and safety for differing levels of cognitive ability

Allen Cognitive Disabilities Model

- Focuses on functional cognition and new learning ability
- Tests provide accurate predictor of function in familiar (e.g. brushing teeth) & unfamiliar tasks (e.g. learning to use a walker)
- Remaining abilities & expected deficits have been clarified for each dementia stage & help facilitate optimal care giving and planning in areas such as best communication approaches, behavior management, activity planning and fall prevention

"An Interdisciplinary Dementia Program Model for Long Term Care," Kim Warhol, OTR/L, Topics in Geriatric Rehabilitation Vol20, No.1, pp.59-71 2005 Lippincott Williams & Wilkins, Inc.

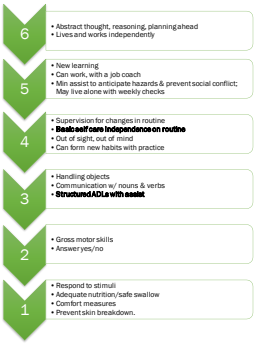
Best Ability To Function

- What residents will predictably pay attention to
- Motor control expectations
- Communication abilities

Functional Cognition Can Be Measured

- 6 levels arranged in "a continuum of clinically observable, qualitative differences in ability to perform functional activities"
- There are 26 modes of performance within the 6 categories that allow for more sensitive measurement of function
- Lower score=lower functional expectation

Resource: Brief History of the Allen Battery by Cathy Earhart March 2005
www.allen-cognitive-network.org



When is "learning" expected?

Benefit from instructions

Benefit from demo & adaptation

5-6: Can learn through language & written materials

4: Out of the ordinary recognized with striking visual cues. Imitates new methods for situation specific tasks

3: Motor drilling (practice) under constant supervision to develop new habits using routine steps

Build Caregiver Skills

Communication Approaches

- Tone
- Pace
- Body language & facial expressions
- One step at a time
- Fewer words
- Cues to task that match speech

Person Centered Interactions

- What mattered in the resident's life previously
- Usual routines
- Connecting needs to behavior

Reasons for "Behavior"

- Health conditions
- Medication
- Communication
- Environment
- The task
- Unmet needs
- Life story
- You

Purposeful Daily Activities

- Offer solutions for activities & just right challenge stimulation programs for all cognitive levels
- Individualized plans to:
  - Reduce anxiety, provide appropriate stimulation and a sense of purpose.
  - Promote a sense of comfort, structure
  - Planned management of escalating situations

http://montessorifordementia.com.au/

Sample ACL Activity Calendar

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
ACL 1	Snow globes & Carols	Scents of the Season	1:1 with Karen	Hand massage	Pet Visits	Sounds of Nature	Holiday concert Brownie Troop 316
ACL2	Music of the 40s	(AAROM) Forever Fit with Karen	Butter Making	Scarf dancing & Bean bag toss	Pet Visits and Ball Games	Clap Along Rhythm Club	Holiday concert Brownie Troop 316
ACL 3	Music of the 40s	Holiday Crafting	Bread Making	Historic Photography	Pet Visits and Winter Planter Gardening	Envelope Stuffing for United Way	Holiday Concert Brownie Troop 316
ACL 4-6	Cooking class: Apple Dumplings	Holiday Crafting	Western Movie Night	Bingo	Pet Visits and Winter Planter Gardening	Tai Chi for Balance	Holiday Concert Brownie Troop316

§483.40 Behavioral Health – Required Actions

- Review and revise Behavior/Social Service policies to reflect requirements
- Assure medically related social services provided for residents with behavioral health issues or dementia
- Develop and implement processes to determine "sufficient staff" who provide direct services to meet requirements for nursing services, based on facility assessment.
- Develop and implement a process to assess staff competencies and skills sets in implementing non-pharmacological interventions and required behavioral health needs

Behavioral Health Considerations

Resident Population

- Psychiatric Diagnosis
- Dementia
- Behaviors per MDS
- Behavior Monitoring Program
- PASARR Level II

Staff Competency

- Behavior Management
  - *Use of non-pharmacological interventions*
- Dementia Care
- Psychotropic Drug Use procedures

Please register to attend Part 2 of this session scheduled on 01/18/2017

Session highlights:

- Operationalizing the Phase 2 Facility Assessment
- Developing an ATB Stewardship Program
- Introduction to developing the Phase 2 required facility specific QAPI plan

Questions

PROACTIVE MEDICAL REVIEW

Thank you for joining us !

Ask questions using the options on the right of your screen to either "raise your hand" for your phone line to be unmuted OR type your question

Please follow your state association guidance for obtaining CE credit. Inquiries related to certificates should be directed to the association with which you registered for this webinar.

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ELDER JUSTICE ACT RESOURCES

	Website	Information Available
IL	https://www.illinois.gov	• State Specific Poster template Presentation materials\Poster Template.doc • Reporting Requirements Section 300ILcode.htm • Reporting forms https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx • Information & Instruction https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx • Sample Policy • https://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse_reporting.aspx
IN	https://secure.in.gov/isdh/25766.htm	• State Reporting Poster template https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx • Reporting requirements Elder_Justice_Act_-_Section_1150B.IN.pdf • Reporting form Reporting_a_Crime_Form_-_February_8_2013.IN.doc • Information & Instruction http://www.in.gov/isdh/25766.htm • Sample Policy Policy and Procedure EJA abuse reporting.doc
KY	http://chfs.ky.gov	• State Specific Poster Presentation materials\kentucky_ea_poster.jpg • Reporting requirements AbuseNeglectViolence.KY.pdf • Reporting forms IncidentReportForm.KY.pdf • Information & Instruction APSBrochureGuidetoReportingAbuse.KY.pdf • Sample Policy Policy and Procedure EJA abuse reporting.doc

ELDER JUSTICE ACT RESOURCES

MO	http://health.mo.gov	• State Specific Poster C:\Users\HTS6810\Desktop\ShouldYouReport.MO.pdf • Reporting requirements C:\Users\HTS6810\Desktop\MO.APSreportingpolicy.doc MO.RevisedStatutes.docx • Mandated Reporter form MandatedReporterForm.MO.pdf • Information & Instruction ElderAbuseCrime.MO.pdf • Sample Policy • Policy and Procedure EJA abuse reporting.doc
OH	http://www.odh.ohio.gov	• State Specific Poster template https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx • Reporting Requirements memorandumsODH.pdf • Reporting Forms Complaint-Form.OH.pdf • Information & Instruction http://www.odh.ohio.gov/odhprograms/dspc/complnt/complnt1.aspx • Sample Policy Policy and Procedure EJA abuse reporting.doc
TN	https://tn.gov	• State Specific Poster template https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx • Reporting requirements https://tn.gov/aging/topic/elder-abuse • Reporting forms https://tn.gov/aging/topic/elder-abuse • Information & Instruction http://elder-abuseca.com/stateResources/tennessee.html • Sample Policy Policy and Procedure EJA abuse reporting.doc

Transfer Form Template

Resident Name:	Date of Transfer: / /
	Time of Transfer:
Transfer From:	Transfer To:
Reason for Transfer: (*Include brief medical history and recent changes in status*)	

Physician Information

Attending physician in nursing facility:	Attending Physician Contact Information:
Contact Information for Other Practitioners Responsible for Care of Resident:	

Resident Representative

Name: Relationship:	Contact Information Cell Phone: Other Phone:
Resident Representative is □ Health Care Representative □ Legal Guardian	

Advance Directives

	YES	NO
CPR		
Artificial Nutrition		
Hospitalization		
Medical Interventions		
Copy Provided		

Attached Documents

- □ Face Sheet
- □ Advanced Directives
- □ Code Status
- □ Discharge Summary
- □ MAR/TAR
- □ Physician Orders
- □ Recent Labs/Diagnostic Tests

Comprehensive Care Plan Goals

1.

2.

3.

4.

5.

Transfer Form Template

Clinical Status at Time of Transfer

Vital Signs: BP_____ P_____ R_____ T_____ Time obtained: _____

Pain: □Yes □ No Rating_____ Site_____ Treatment_____

Other Observations:

Diagnoses:

Allergies: □ None □ Yes (list):

Special Needs and Precautions:
□ Pacemaker □ Internal Defib
Respiratory Needs: □ Oxygen: Device_____ Flow Rate_____ □ CPAP □ BIPAP □ Trach □ Vent
Isolation/Precautions: □ None □ MRSA □ VRE □ ESBL □ C-Diff □ Other_____
Diet: □ Regular □ Mechanically Altered □ Thickened Liquids □ Tube Feed □ Other:
At risk alerts: □ None □ Falls □ Pressure Ulcer □ Aspiration □ Wanders/Elopement □ Seizures
Other Special Needs/Precautions (specify):

Functional Status

	Self	With Assist	Not Able
Ambulation			
Transfer			
Toilet			
Eating			

Vision: □ Good □ Poor □ Blind □ Glasses
Hearing: □ Good □ Poor □ Deaf □ Hearing Aide __L __R
Speech: □ Clear □ Difficult □ Aphasia

Weight Bearing Status: □ Full □ Limited
Bowel: □ Continent □ Incontinent Last BM: _____ **Bladder:** □ Continent □ Incontinent □ Catheter

Mental Status: □ Alert □ Forgetful □ Oriented □ Disoriented □ Unresponsive □ Depressed
□ Other:_____ BIMS Score:

Skin Condition:
□ No wounds
□ Pressure Ulcer: Site:_____ Size: _____ Stage:_____ (Attach TAR)
Site:_____ Size: _____ Stage:_____ (Attach TAR)
□ Surgical Wounds (*Include details*)
□ Other skin conditions: (*Include details*)

Immunizations:
□ Flu Date:_____ □ Pneumo Date: _____ □ PPD Date:_____ Result:_____ Other: _____

Sending Facility Contact Information

Name:	Title:	Phone:
Name:	Title:	Phone:

Form Completed By (*print name*) _____
Signature: _____Title: _____ Date: ____/___/___

Physician Transfer or Discharge Documentation Template

Resident Name:	Transfer or Discharge Effective Date: / /

Resident Is Being Transferred To:

- ☐ Another Nursing Facility (*Specify Facility Name*): _____
- ☐ Another Health Facility (*Specify Facility Name*): _____
- ☐ A private residence (including home) ☐ alone ☐ with others
- ☐ Other : _____

Reason for Transfer or Discharge (must select one of the reasons below and indicate all required information)

- ☐ The transfer or discharge is necessary for the resident's welfare & the resident's needs cannot be met in the facility
  - The resident needs that cannot be met in the facility are:
  - The facility has attempted the following in an effort to meet the resident's needs:
  - The services available at the receiving facility to meet the resident's needs are:
- ☐ The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility
- ☐ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident
- ☐ The health of individuals in the facility would otherwise be endangered

Physician Name:	
Physician Signature:	Date:

*Documentation must be made by the resident's physician when transfer or discharge is required for the resident's welfare and the resident's needs cannot be met by the facility or if the resident no longer needs the services provided by the facility because his/her health has improved sufficiently.

*The documentation may be made by any physician if the reason for transfer/discharge is because the health or safety of individuals in the facility is endangered due to the resident.

Policy and Procedure: Baseline Care Plan

Policy Statement

It is the policy of this facility to 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 within 48 hours of a resident's admission.

Policy Interpretation and Implementation

1. To ensure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of a resident's admission.

2. The Interdisciplinary Team will review the Attending Physician's orders and implement a baseline care plan to meet the resident's immediate care needs.

3. The baseline care plan will 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

4. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan.

5. The facility will provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

    a. The initial goals of the resident
    b. A summary of the resident's medications and dietary instructions
    c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
    d. Any updated information based on the details of the comprehensive care plan, as necessary

Source Documents & References	
Federal Regulations	483.21 (a)(1-3) F279
Related Documents	1. State Operations Manual – Appendix PP – Guidance to Surveyors for Long Term Care Facilities https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Policy Review and Updates This policy will be reviewed annually by the QAPI committee.	
Date of Review/Update	By:

Cognitive Colors	Caregiver & Elder Focus	Pays Attention To	ADL Assistance	Strengths	Approach
RED  **Allen Cognitive Level 1**	**Caregiver Focus:** **"STOP"** Check diet, positioning, skin and pain **Elder Focus:** **Survival**	Sensory Cues Objects placed 8" from their face	Total Assist (often bed bound)	• Some active movement • Responds to stimuli • Intact senses • Facial expressions (non- verbal)	Range of Motion Positioning Splinting Feeding/Swallowing Sensory Stimulation
ORANGE  **Allen Cognitive Level 2**	**Caregiver Focus:** **"Safety"** Ensure a safe area for mobility (fear of falling) and provide a comfortable calm environment **Elder Focus:** **Comfort/Safety**	Proprioceptive and Tactile Cues Objects placed 8" from their face (does not attend to things below the knee: trashcans, wet floor signs, potted plants, shoes left on floor)	Extensive Assist (can grasp objects but may have difficulty releasing grasp)	• Follows count to 3 to start movement • Answers "yes or no" • 1 word communication • Mobility by walking or w/c • Feeds self – often not hungry • May use grab bar with cue during transfers	Walking Rhythmic Movement (dancing, rocking, marching) Prevent Falls (remove bedside table, provide seat to rest, adequate lighting, secure area) Singing Activities Hydration Initiation Feeding
YELLOW  **Allen Cognitive Level 3**	**Caregiver Focus:** **"Caution"** Don't leave unattended **Elder Focus:** **Using hands to touch and fidget with things**	Tactile (touch) and Picture Cues Objects placed 14" in front on them (tunnel vision) – no peripheral vision	Limited to Extensive Assist	• Uses hands purposefully • Does not initiate communication, but can speak in sentences • May find own room • Can name objects • Will learn new routine after a few weeks • Places objects in a row	Set-up ADL supplies in a row and give cues to keep going Enjoys Repetitive Activity (sorting, sanding, polishing) Communication Program (memory books, reminiscing, prevent isolation)
GREEN  **Allen Cognitive Level 4**	**Caregiver Focus:** **"GO"** Help someone else and come back to check results **Elder Focus:** **Completing a familiar/routine task**	Striking Visual Cues Objects 3-4 feet in front and to either the left or right side Higher level 4's will scan environment	Independent to Supervision (may need set-up or to check results for accuracy)	• Able to sequence self through steps • Responds to written cues • Conversational speech; may have word finding difficulty • May live alone • Likes supplies in same place consistently	Adaptive Equipment Use Checklists Jobs An unfamiliar task may become upsetting if there is no guidance –difficulty problem solving
BLUE  **Allen Cognitive Level 5**	**Caregiver Focus:** **"Guide"** social interactions. Lack empathy and think the world revolves around them. Difficulty with abstract thinking and anticipating hazards. **Elder Focus:** **Independent Learning**	Written Cues Scans environment, refers to sample, can see 3 dimensions and diagonals	Independent (impulsive, talks while completing tasks, easily frustrated)	• New learning • Simple problem solving • Uses memory aids • Fine motor adjustments • Able to read • Conversational speech; without regard of time constraints of the listener • Will search for needed supplies	Time Management Social Interactions Use of Memory Aids Organizational Skills Medication Management Safety Awareness Reading Comprehension

PROACTIVE MEDICAL REVIEW

Activities Ideas for Dementia Care

Activity Considerations Based on Cognitive Stage

General Tips: • Make supplies visible • Assist for solving problems • Maintain a routine • Break down steps • Use familiar objects • Use verbal, visual and tactile cues to gain attention and process directions

Early Stage 4.0–4.6	Middle/Moderate Stage 3.2–3.8	Late Stage 3.0–2.2	End Stage 2.0–1.0
• Follows activity calendar • Remembers goal of simple, familiar games (cards, dice, bingo) • Duplicates sample craft • Follows 2-3 step directions **Tips:** Offer activities with a goal/sample and purpose; make supplies visible; can assist with leading the group and planning the calendar, maintain a routine	**High 3:** • Follow 1-step direction with cues to sequence simple game or craft • Simple sorting **Low 3:** • May need more cues or hands on cues to sequence simple familiar game or craft • Holds and uses familiar objects (crayon) for a brief period **Tips:** Benefits from small groups of 30 mins or less sitting close to leader, avoid excessively "verbal activities" (multi-sensory activities best); Wait for a response after direction, provide meaningful stimuli to promote vocalization, movement and interaction; place items directly in front of them to gain attention	• Can say at least one word • Can make large body movements like kicking a ball, dancing **Tips:** May need to come and go during activity, sensory stimulation for 15-30 mins. May need hand over hand assist to hold, touch, use or throw objects	• Needs 1:1 sensory stimulation in a quiet environment around a familiar, meaningful theme • Can promote movement and awareness

Sample Activity Ideas for Men

	Early Stage 4.0–4.6	Middle/Moderate Stage 3.2–3.8	Late Stage 3.0–2.2
Sports Related Activities	Sporting events (tv games, corn hole horseshoe/washer tournaments) Wii Hunting/Target Games Bowling, Putting green	Sorting baseball cards, Team/city match Gross motor ball games Sports reminiscing groups Cleaning golf clubs, Oiling baseball glove	Hands-on sports memorabilia Large Ball Games
Games with Wagers	Horse races with racing cards (large print) Poker night with chips	Poker hand match Sorting cards	Placing cards
Household/Repair Activities	Wheelchair maintenance Measuring windows Hang picture Habitat Humanity projects Assist to change light bulbs	Small appliance disassembly (cord removed) Sorting tools in toolbox, nuts/bolts Flash light repair Pipe tree, Simple non-toxic painting 1:1 with maintenance, Pad lock key sorting Shoe polishing	Matching bottles and lids Dusting, Window wash Sanding, Polishing Simple Montessori template matching tools
Outdoor Activities	Camp fire cook out, Gardening, Spray/sweep level walkways Fishing, Bird watching	Tackle box sorting, Matching lures Sorting seed packets, Sorting fish cards Watering plants with assist Filling bird feeders	Patio time, Bird song book, Pet therapy, Sensory: smelling flowers, cut grass, rain
Military Activities	Local VFW/Legion meetings on site Flag raising/lowering Military care package drive (packing boxes, writing postcards) Military strategy e-games	Sort military insignia Military reminiscing Historic battle diorama with assist	Marching Folding flag with assist
Motor Interest Activities	Classic car visits/exhibition Model car/airplane kits Train set, Pine car derby partner	Automobile interest print media Matchbox car sorting by color Automobile reminiscing	Matchbox car sorting by color

General Group Activity Considerations:
10 residents or less with frequent small groups throughout the day and individual activities for each resident to complement groups;
Focus on failure-free activities in supportive social and physical environment (limit distractions, stimulus that supports theme, praising efforts)
Grade and adapt activities to the cognitive and physical abilities, access long term memories with props that provide sensory cues.

Large groups of 11 residents or more – Appropriate for activities with little sequencing involved (sing along, church, parties)
Up to 1 hour Early Stage / 45 minutes Middle Stage / 30 minutes Late Stage

Small Group Activities to Grade for Various Levels	
	Food Related: Bread baking and butter churning, Fruit salad prep, Churning ice cream/sundae bar, Chili cook-off, Grill out, Pie of the month club, Men's breakfast, coffee/donuts and news, Party planning & set up
	Reminiscing: Wedding, Farming, Travel, Music, Movie stars, Holidays, School days, Photos, Historic events
	Motor: Sittercise, Tai chi, Dance, Ball toss games, Gardening, Large piece puzzles, Object sort/grasp-release

Baseline Care Plan Summary

Initial Goals of the Resident:

1. Will perform ADLs (transfers, bed mobility, toileting, ambulation, eating) independently by 02/15/17.
2. Will tolerate regular diet and maintain current weight by 02/15/17.
3. Will participate in PT/OT daily.
4. Pneumonia will resolve by 01/20/17.
5. Pain level will remain below 3 on a scale of 1-10.
6. Blood sugar will remain between 70-110.

Summary of Medications and Dietary Instructions:

Medication	Reason for Use	Dose/Frequency
Azithromycin	Antibiotic to treat pneumonia	500 mg orally for 3 days
Metformin	To control blood sugar levels r/t diabetes	500mg twice a day
Tylenol	To control pain	500 mg as needed

Diet Ordered: Regular consistency with no concentrated sweets

Services and Treatments to be administered by facility:

Physical therapy daily
Occupational therapy daily
Oxygen 2L per nasal cannula
Blood sugars monitoring daily

Additional Information:

To use walker for ambulation

☒ **Copy Provided to Resident** ☒ **Copy Provided to Resident Representative**
Date: 01/12/17 **Date:** 01/12/17

Signature of Staff Completing Form: S.Maffia, A.Martin, J. Doe, M. White

Jane Doe	100	Dr. Adams	1234
Resident Name	Room #	Physician	Med Rec #

Baseline Care Plan Summary

Initial Goals of the Resident:

Summary of Medications and Dietary Instructions:

Medication	Reason for Use	Dose/Frequency

Diet Ordered:

Services and Treatments to be administered by facility:

Additional Information:

□ **Copy Provided to Resident** □ **Copy Provided to Resident Representative**
Date: **Date:**

Signature of Staff Completing Form:

Resident Name	Room #	Physician	Med Rec #