Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care Critical Element (CE) Pathway to determine if the facility is providing the necessary care and services for residents living with dementia. Refer to the Communication/Sensory CE Pathway for concerns regarding communication with residents who are non-English speaking.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A, C, D, E, G*G*, I, N, and O.
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., identifies concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident; potential causes or risk factors for the resident's behavior or mood; person-centered non-pharmacological, and pharmacological interventions to support the resident and lessen distress; if pharmacological interventions are in place, how staff track, monitor, and assess the interventions; and alternative approaches if the resident declines treatment; cultural preferences and/or interventions to address a history of trauma, as appropriate).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how did staff address these indications?
- ☐ Are staff implementing interventions in accordance with the care plan to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ Are staff being respectful and responsive to the resident's cultural preferences, health beliefs and practices?
- ☐ Do staff provide culturally competent care (e.g., clothing or food preferences, cultural etiquette, or materials in their preferred language)?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art, massage, essential oils, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment, and access to counseling and therapies) did staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How did staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How did staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Did staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident choices, including cultural preferences (e.g., ADL care, daily routines, activities, etc.)?

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Resident, Family and/or Resident Representative Interview:

- ☐ Is the facility aware of your/the resident's current conditions or history of conditions or diagnoses?
- ☐ How did the facility involve you/the resident in developing the care plan, including implementing non-pharmacological interventions and goals and identifying triggers that may cause fear or re-traumatize the resident?
- ☐ What non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.
- ☐ How did the facility ensure approaches to care reflect your/the resident's choices and cultural preferences?
- ☐ How are the resident's individual needs being met through person-centered approaches to care?
- ☐ What are your or the resident's concerns, if any, regarding the resident's mood or history of trauma?
- ☐ Have you or the resident had a change in mood? If so, please describe.
- ☐ What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?

Staff Interviews (Interdisciplinary team (IDT) members including social services) across Various Shifts:

- ☐ What are the underlying causes (e.g., history of trauma, mental disorder) of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rationale for each intervention?
- ☐ How do you meet the resident's needs and provide emotional support to a resident who is having difficulty coping with change, loss or coping with stressful events?
- ☐ How do you provide or arrange for needed mental and psychological counseling services?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you know a resident is a trauma survivor and what do you need to do differently for that resident?
- ☐ How did the facility determine cultural preferences which should be honored while the resident is in the facility?
- ☐ What types of behavioral health training have you completed?
- ☐ How do you identify and support individual resident's needs?
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often did the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- ☐ Ask about any other related concerns the surveyor has identified.

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

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- ☐ How do you know what triggers to avoid for a resident with a history of trauma?

Record Review:

- ☐ Review therapy notes, social service notes, and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- ☐ Review the admission assessment, History & Physical, and social history/assessment to determine whether the facility identified the resident's history of trauma and the effects of past trauma on the resident.
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident and cultural preferences, as appropriate.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress which may re-traumatize the resident, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ What PASARR Level II services or psychosocial services are provided, as applicable?
- ☐ Did the facility ensure residents with mental or substance use disorders have access to counseling programs or therapies (e.g., 12 step groups)?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions, cultural preferences, or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- ☐ Did the facility collaborate with the resident, and/or resident representative, and any other health care professionals to develop an individualized care plan that addresses resident specific triggers.
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Was behavioral health training provided to staff in accordance with the facility assessment?

Critical Element Decisions:

1) Did the facility ensure trauma survivors received culturally-competent and/or trauma-informed care which accounted for the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization?

   If No, cite F699

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NA, the comprehensive assessment did not reveal the resident had a history of trauma, PTSD, and/or cultural preferences.

2) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
If No, cite F740

3) Did the facility have sufficient staff who provide direct services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?
If No, cite F741

4) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty?
If No, cite F742
NA, *the comprehensive assessment did not reveal* the resident *displayed or was* diagnosed with a mental or psychosocial adjustment difficulty.

5) Did the facility ensure that the resident whose comprehensive assessment did not reveal or who did not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD did not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable?
If No, cite F743
NA, the resident's comprehensive assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

6) Did the facility provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for this resident?
If No, cite F745

7) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655

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NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

8) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?

   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

9) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

10) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
    If No, cite F641

11) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs (including trauma-informed care) and includes the resident's goals, desired outcomes, and preferences (including cultural preferences)?

    If No, cite F656
    NA, the comprehensive assessment was not completed.

12) Did the facility reassess the effectiveness of the interventions and, review and revise the resident's care plan (with input from the resident, or resident representative, to the extent possible), if necessary, to meet the resident's needs?

    If No, cite F657
    NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Unnecessary/Psychotropic Medications (CA), Resident Records F842, Qualifications of Social Worker >120 Beds F850.