F656

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§483.21(b) Comprehensive Care Plans

§483.21(b)(1) 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 —

(i) 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

(ii) 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).

(iii) 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.

(iv)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.

§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(iii) Be culturally-competent and trauma–informed.

INTENT

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

DEFINITIONS

"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. Adopted from Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. https://store.samhsa.gov/system/files/sma14-4849.pdf.

"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.
US Department of Health and Human Services publication: A Blueprint for Advancing and Sustaining CLAS Policy and Practice at: https://www.thinkculturalhealth.hhs.gov/clas/blueprint.

"Resident's Goal" refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning.

"Interventions" are actions, treatments, procedures, or activities designed to meet an objective.

"Measurable" is the ability to be evaluated or quantified.

"Objective" is 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.

"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.

GUIDANCE

Through the care planning process, facility staff must work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. If care planning is not complete, or is inadequate, the consequences may negatively impact the resident's quality of life, as well as the quality of care and services received.

Facilities are required to develop care plans that describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences. Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s).

Care plans must be person-centered and reflect the resident's goals for admission and desired outcomes. Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

Residents' goals set the expectations for the care and services he or she wishes to receive. For example, a resident admitted for rehabilitation may have the following goal – "Receive the necessary care and services so that I may return to independent living." Another resident may have a goal of receiving the necessary care and services to meet needs they cannot independently achieve, while maintaining as much independence as possible. And yet another resident or his or her representative, if applicable, may have a goal of receiving the necessary care and services to keep the resident comfortable and pain-free at the end of their life. Each of these examples would

be supported by measurable objectives, interventions and timeframes designed to meet each specific resident goal.

Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified. For example, "Mrs. Jones, who underwent hip replacement, will report adequate pain control (as evidenced by pain at 1-3, on a scale of 1-10) throughout her SNF stay." Facility staff will use this objective to monitor the resident's progress.

The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Interventions for the example above, related to pain, may include, but are not limited to:

- Evaluate pain level using pain scale (0-10) 45 minutes after administering pain medication;
- Administer pain medication 45-60 minutes prior to physical therapy.

When developing the comprehensive care plan, facility staff must, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.

There may be times when a resident risk, weakness or need is identified within the context of the MDS assessment, but may not cause a CAA to trigger. The facility is responsible for addressing these areas and must document the assessment of these risks, weaknesses or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area. If the decision to proceed to care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident's representative, if applicable (§483.21(b)(2)(ii)), must develop and implement the comprehensive care plan and describe how the facility will address the resident's goals, preferences, strengths, weaknesses, and needs.

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. 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.

In some cases, a resident may wish to refuse certain services or treatments that professional staff believes may be indicated to assist the resident in reaching his or her highest practicable level of well-being or to keep the resident safe. 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. See guidelines at §483.10(c)(6) (F578) for additional guidance concerning the resident's decision to refuse treatment. Additionally, a resident's decision-making ability may decline over time. The facility should determine how the resident's decisions may increase risks to health and safety, evaluate the resident's decision making capacity, and involve the interdisciplinary team and the resident's representative, if applicable, in the care planning process.

In addition to addressing preferences and needs assessed by the MDS, the comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations. If the IDT disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. The rationale should include an explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations and how the resident would benefit from alternative interventions. The facility should also document a resident's the resident's preference for a different approach to achieve goals or refusal of recommended services.

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

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.

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/cultural-competence). 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:

- F656: For concerns related to development or implementation of culturally competent and/or trauma-informed care plan interventions;
- F699: For concerns related to outcomes or potential outcomes to the resident related to culturally-competent and/or trauma-informed care;
- F726: For concerns related to the knowledge, competencies, or skill sets of nursing staff to provide care or services that are culturally competent and trauma-informed.
- F742: For concerns related to treatment and services for resident with history of trauma and/or history of post-traumatic stress disorder (PTSD)

INVESTIGATIVE PROCEDURES

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

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?
- 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?
- 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))
- 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?
- 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.

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

- F658: for concerns regarding the delivery of care within professional standards of practice.

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

- Resident Rights, §483.10
- Resident assessment, §483.20
- Activities, §483.24(c)
- Nursing services, §483.35
- Food and nutrition services, §483.60
- Facility assessment, §483.71
- Cultural competence and trauma-informed care, §483.25(m)
- Treatment/Services for mental/psychosocial concerns §483.40(b)(1)

KEY ELEMENTS OF NON-COMPLIANCE

To cite deficient practice at F656, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Develop and implement a care plan that:
    - Is comprehensive and individualized;
    - Is consistent with the resident's goals and right to be informed and participate in his/her treatment;
    - Meets each of the medical, nursing, mental and psychosocial needs identified on the resident's comprehensive assessment;
    - Includes measurable objectives, interventions and timeframes for how staff will meet the resident's needs.

- Develop and implement a care plan that describes all of the following:
    - Resident goals and desired outcomes;
    - The care/services that will be furnished so that the resident can attain or maintain his/her highest practicable physical, mental and psychosocial well-being;

- The specialized services to be provided as a result of the PASARR evaluation and/or the comprehensive assessment;
- The resident's discharge plan and any referrals to the local contact agency;
- Refusals of care and action taken by facility staff to educate the resident and resident representative, if applicable, regarding alternatives and consequences;
- Care and services which are culturally competent and trauma-informed.

DEFICIENCY CATEGORIZATION

Examples of Level 4, immediate jeopardy to resident health and safety, include, but are not limited to:

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

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

- 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.

Examples of Level 3, actual harm that is not immediate jeopardy include, but are not limited to:

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

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

Examples of Level 2, no actual harm, with potential for than more than minimal harm, that is not immediate jeopardy, include, but are not limited to:

- During the comprehensive assessment, a resident indicated a desire to participate in particular activities, but the comprehensive care plan did not address the resident's preferences for activities, which resulted in the resident complaining of being bored, and

sometimes feeling sad about not participating in activities he/she expressed interest in attending.

- An inaccurate or incomplete care plan resulted in facility staff providing one staff to assist the resident, when the resident required the assistance of two staff, which had the potential to cause more than minimal harm.

An example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, includes, but is not limited to:

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