F744

(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)

§483.40(b)(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.

DEFINITIONS §483.40(b)(3)

Definitions are provided to clarify terminology related to dementia and the attainment or maintenance of a resident's highest practicable well-being.

"Dementia" is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptomology and rates of progression. (Adapted from: "About Dementia." Alzheimer's Foundation of America. 30
Nov 2016. Accessed at: https://www.alzfdn.org/AboutDementia/definition.html)

"Highest practicable physical, mental, and psychosocial well-being"is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

GUIDANCE §483.40(b)(3)

Providing care for residents living with dementia is an integral part of the person-centered environment, which is necessary to support a high quality of life with meaningful relationships and engagement. Fundamental principles of care for persons living with dementia involve an interdisciplinary approach that focuses holistically on the needs of the resident living with dementia, as well as the needs of the other residents in the nursing home. Additionally, it includes qualified staff that demonstrate the competencies and skills to support residents through the implementation of individualized approaches to care (including direct care and activities) that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

If there are staffing concerns related to the provision of behavioral health services, refer to §483.40(a) (F741), Sufficient and Competent Staff.

The facility must provide dementia treatment and services which may include, but are not limited to, the following:

- Ensuring adequate medical care, diagnosis, and supports based on diagnosis;
- Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; and
- Utilizing individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address

the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being.

It is expected that a facility's approach to care for a resident living with dementia follows a systematic care process. In order to ensure that residents' individualized dementia care needs are met, the facility is expected to assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. Care plan goals must be achievable and the facility must provide those resources necessary for an individual resident to be successful in reaching those goals. Surveyors must determine whether the failure to attain or maintain the highest practicable physical, mental, and psychosocial well-being (in accordance with the comprehensive assessment and care plan) was avoidable or unavoidable. An unavoidable facility failure refers to a situation where the IDT has completed comprehensive assessments, developed and implemented individualized, person-centered approaches to care through the care-planning process, revised care plans accordingly, and residents are unable to attain or maintain their highest practicable physical, mental, and psychosocial well-being.

Residents living with dementia require specialized services and supports, (e.g., specialized activities, nutrition, and environmental modifications) that vary, based on the individual's abilities and challenges related to their condition. Dementia causes significant intellectual functioning impairments that interfere with life, including activities and relationships. People living with dementia may lose their ability to communicate, solve problems, and cope with stressors. They may also experience fear, confusion, sadness, and agitation. While memory loss is a common indication of dementia, memory loss by itself does not mean that a person has dementia.

Although it is common in very elderly individuals, dementia is not a normal part of the aging process. There are several diseases that can cause symptoms of dementia (e.g., Alzheimer's disease, vascular dementia, Lewy body dementia). Other conditions can also cause dementia or dementia-like symptoms (including, e.g., reactions to medications, metabolic problems and endocrine abnormalities, nutritional deficiencies, and heart and lung problems).

Some individuals living with dementia may have co-existing symptoms, such as paranoia, delusions or hallucinations or psychiatric conditions, such as depression or bipolar affective disorder. Progressive dementia may exacerbate these symptoms and conditions.

Behavioral or psychological expressions are occasionally related to the brain disease in dementia; however, they may also be caused or exacerbated by environmental triggers. Such expressions or indications of distress often represent a person's attempt to communicate an unmet need, discomfort, or thoughts that they can no longer articulate.

Medications may be unnecessary and are likely to cause harm when given without a clinical indication, at too high of a dose, for too long after the resident's distress has been

resolved, or if the medications are not monitored. However, medications may be effective when the underlying cause of a resident's distress has been determined and non-pharmacologic approaches to care have been ineffective or for expressions of distress that have worsened. All approaches to care, non-pharmacological and pharmacological, need to be person-centered, monitored for efficacy, risks, benefits, and harm, and revised as necessary.

If there are concerns about medication use in dementia, refer to §483.45(d) (F757), Unnecessary Drugs and §483.45(e) (F758), Psychotropic Drugs.

KEY ELEMENTS OF NONCOMPLIANCE §483.40(b)(3)
To cite deficient practice at F744, the surveyor's investigation will generally show that the facility failed to:

- Assess resident treatment and service needs through the Resident Assessment Instrument (RAI) process;
- Identify, address, and/or obtain necessary services for the dementia care needs of residents;
- Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment;
- Develop individualized interventions related to the resident's symptomology and rate of progression (e.g., providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks);
- Review and revise care plans that have not been effective and/or when the resident has a change in condition;
- Modify the environment to accommodate resident care needs; or
- Achieve expected improvements or maintain the expected stable rate of decline.

Investigating Concerns Related to Dementia Care Treatment and Services
Use the Dementia Care Critical Element Pathway (CMS-20133), along with guidance, when determining if the facility meets the requirements pertaining to the treatment and services for a resident who displays or is diagnosed with dementia. Treatment and services must meet the resident's highest practicable physical, mental, and psychosocial well-being.

Review, as needed, all appropriate resident assessments, associated care planning and care plan revisions, along with physician's orders to identify initial concerns and guide the investigation. Review the Minimum Data Set (MDS) and other supporting documentation to help determine if the facility is in compliance. Observe for evidence that dementia care needs are met and related services are provided. Staff are expected to assess and provide appropriate care for residents with dementia. Interview the resident, their family, and/or representative(s) and the IDT, as needed to gather information about dementia care in the nursing home. Corroborate the information obtained and any concerns noted during the survey, by building upon the investigation through additional observations, interviews, and record review. In determining compliance, additionally refer to the Psychosocial Severity Outcome Guide.

DEFICIENCY CATEGORIZATION §483.40(b)(3)
An example of Severity Level 4: Immediate Jeopardy to Resident Health or Safety includes, but is not limited to:

- Based upon a comprehensive assessment by a qualified professional, it was identified that a resident living with dementia required close supervision to prevent injury. The resident's care plan indicated that the facility had developed individualized interventions to support him. However, documentation in the resident's record provided information about an incident that had occurred recently as a result of lack of supervision. When left alone in the bathroom, the resident sustained second degree burns to his hand from hot water, requiring treatment at the emergency room. Following the incident, no revisions were made to the resident's care plan.

The facility failed to implement individualized interventions, as well as revise the care plan accordingly, to address the resident's dementia care needs, resulting in injury, as evidenced by observation, record review, and/or interview.

An example of Severity Level 3: Actual Harm that is not Immediate Jeopardy includes, but is not limited to:

- The care plan for a resident with an identified diagnosis of dementia included the need for close supervision to prevent the resident from wandering into the rooms of other residents. However, the review of the care plan indicated that the facility had failed to develop person-centered interventions to prevent the resident from wandering. The record review also provided information about a resident-to-resident altercation that had occurred a week prior to the survey. The altercation involved a sweater that was removed from the room of another resident, who slapped and scratched the resident living with dementia, because she refused to return the garment. The resident received minor lacerations and bruising, which was cared for by the direct care staff at the nursing home. The care plan was revised to reflect the need to closely supervise.

During the survey, the resident was observed wandering in and out of resident rooms. When questioned, direct care staff were unaware that the resident required close supervision.

The facility failed to develop and implement interventions to address the resident's dementia care needs, resulting in the resident's inability to achieve her highest level of functioning.

An Example of Severity Level 2: No Actual Harm with Likelihood for More Than Minimal Harm that is Not Immediate Jeopardy

- A resident was observed standing in her doorway asking what day of the week it was. Two staff members were within hearing distance, but did not reply to the resident. The surveyor also noticed that there was no calendar in the resident's room.

Review of the resident's record showed that she had a diagnosis of dementia. The care plan noted that the resident has a tendency to forget what day of the week it is and can become anxious when not reminded. Interventions include that staff are to ensure that a current calendar is on her bedroom wall and remind the resident what day it is when she wakes up each morning and when facility staff are asked.

The facility failed to support the resident and implement care planned interventions to reduce her confusion, which had the potential to cause the resident anxiety.

Severity Level 1: No Actual Harm with Likelihood for Minimal Harm
Severity Level 1 does not apply for this regulatory requirement because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. Because more than minimal harm is likely, any deficiency for this requirement is at least a Severity Level 2. For additional guidance, see also the Psychosocial Outcome Severity Guide *at the CMS Nursing Homes Survey Resources website that can be accessed by visiting https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-Resources.zip*.

NOTE: If there are indications that a resident is in a secured/locked area without a clinical justification and/or placement is against the will of the resident, their family, and/or resident representative, review regulatory requirements at §483.12 and §483.12(a) (F603), Involuntary Seclusion. [End of Tag F744.]