

Stage II – Critical Elements for Rehabilitation and Community Discharge

Facility Name: _____ Facility ID: _____ Date: _____
Surveyor Name: _____
Resident Name: _____ Resident ID: _____
Initial Admission Date: _____ Interviewable: Yes No Resident Room: _____
Care Area(s): _____

Use

For a resident:

- Admitted for rehabilitation, received PT, OT or ST services but was not discharged back to the community (may have been discharged to another long-term care facility/skilled nursing facility); or
- Whose most recent MDS (5 and 14 day comparison) assessments indicates the resident received PT or OT but did not improve in transferring ability.

NOTE: Although this review is triggered by lack of improvement in transfer ability, all areas of functional ability should be reviewed, as pertinent to the individual. Use to determine whether the facility provided care to ensure that (a) the resident received necessary rehabilitative services and, (b) based on discharge potential, discharge planning was provided.

Procedure

- Briefly review the assessment, care plan and orders to identify facility interventions and to guide observations to be made.
- Corroborate observations by interview and record review.

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Observations

- Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care from the day of admission. During observations of interventions, note and/or follow up on deviations from the care plan, deviations from current standards of practice, as well as potential negative outcomes.

Determine whether:

- The resident received encouragement and needed assistance to perform therapy tasks (while in therapy sessions);
- Nursing staff provided restorative nursing services to foster improvement in functioning in accordance with the treatment plan such as assisting the resident to walk with a gait belt as planned assisting the resident to button rather than doing it for them, assisting the resident to use communication devices;
- The resident was provided supportive and assistive devices/equipment as assessed, received encouragement and assistance to use the device(s) on a regular basis and that devices fit properly;
- The resident exhibits signs of pain during treatment sessions, and whether staff intervene or address the pain; and
- The resident is afforded privacy during treatments that expose the body.

Notes:

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Resident/Representative Interview

Interview the resident, family or responsible party as appropriate to identify:

- The resident's/representative's involvement in the development of the care plan, defining the approaches and goals, and whether interventions reflect choice and preferences;
- The resident's/representative's awareness of the interventions in use and how to use devices or equipment;
- Whether the resident comprehends and applies information and instructions to help improve functioning;
- Whether staff allows the resident sufficient time to perform rehabilitative and restorative tasks;
- The presence of pain that affects ability to make rehabilitative progress; including location, cause, and how it is managed;
- If interventions are refused, whether alternatives were offered; and
- (If resident is due for discharge in the near future) the resident's/representative's involvement in discharge planning.

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Staff Interviews

Interview staff on various shifts to determine:

- How much assistance is needed to complete ADL tasks, including transfer and ambulation;
- Whether the resident receives therapy or restorative services and what is the schedule;
- Whether the resident is using any supportive and/or assistive devices;
- What restorative interventions staff are following, according to the care plan;
- Whether the resident displays any resistance to care, resistance to using any assistive devices, or refusal to attend therapy, and how staff respond; and
- Whether they are aware of a plan to discharge the resident to a lesser level of care or to home in the near future (if there is such a plan).

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Assessment	
<p><input type="checkbox"/> Review the MDS, physician orders, therapy notes, consultations, and other progress notes that may have information regarding the assessment of rehabilitative and discharge needs.</p> <p><input type="checkbox"/> Based on observation of the resident, interviews with staff, and interviews with the resident/responsible party (as possible), determine whether the assessment information accurately and comprehensively reflects that status of the resident.</p> <p><input type="checkbox"/> Determine whether the assessment, as appropriate:</p> <ul style="list-style-type: none">▪ Identifies causal, contributing and risk factors for decline or lack of improvement such as an unstable condition or an acute health problem, fracture, stroke, pain, neurological deficits, change in cognition, change in medications that may affect functional performance, visual/hearing problems;▪ Identifies problems and strengths related to functional and communication skills (such as gross and fine motor coordination, sensory awareness, auditory comprehension, speech production and the use of expressive language, swallow reflex function, visual-spatial awareness, body integration, and muscle strength including balance);▪ Identifies the amount and type of assistance needed to perform rehabilitative and restorative tasks;▪ Discusses the need for, proper fit and use of assistive devices to enable the resident to reach or maintain her/hers highest level of physical function;▪ Identifies history of previous refusal, resistance, or reluctance of the resident to the use of assistive devices and/or performance of exercises;▪ Includes an evaluation of overall medical, health and psychosocial status to determine appropriate expectations for rehabilitation and discharge potential; and	<p>Notes:</p>

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Assessment

- Includes a review of living arrangements prior to nursing home admission, potential for discharge, discharge needs (such as setting up home services, needed changes to the home) and possible post-discharge alternatives.

1. Did the facility assess adequately to identify rehabilitative needs and potential for community discharge? Yes No **F272**

*The comprehensive assessment is not required to be completed until 14 days after admission. For newly admitted residents, before the 14-day assessment is complete, the lack of sufficient assessment and care planning to meet the resident's needs should be addressed under **F281** (see the Care and Services Meet Professional Standards section).*

NOTE: The facility may have completed a 5-day assessment for the Medicare beneficiary. Use the 5-day assessment as the comprehensive review only if it was completed with the RAPS.

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Care Planning

If the care plan refers to a specific facility treatment protocol that contains details of the treatment regimen, the care plan should refer to that protocol and should clarify any deviations from or revisions to the protocol for this resident. The treatment protocol must be available to care givers, and staff should be familiar with the protocol requirements.

- Review the care plan to determine whether the plan is based upon the goals, needs, and strengths specific to the resident and reflects the comprehensive assessment. Determine whether the plan, as applicable:
- Utilizes assessment information in the development of the care plan and addresses relevant risk, contributing and causal factors;
 - Identifies staff/departments responsible for services (i.e., therapy, restorative, or nursing staff); interventions to be provided by staff other than therapists (for example nursing or restorative staff) reflective of therapy goals and interventions;
 - Uses interventions designed to increase resident performance and decrease the amount of staff assistance needed to perform a task;
 - Includes interventions that reflect the resident's medical/health condition;
 - (If rehabilitative therapy was discontinued), a maintenance program (provided by nursing or restorative services staff) was initiated to maintain functional and physical status, according to resident's medical/health condition;
 - Identifies supportive and assistive devices/equipment that is needed to meet physical and ADL needs;
 - Reflects (for the resident who refused or is resistant to services) efforts to find alternative means to address the needs identified in the assessment process;
 - Reflects resident preferences and opinions; and

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Care Planning

- Includes (for a resident who is getting ready for discharge) interventions that specifically address discharge planning such as pre-discharge self-care and health education, review of community options, assisting with arrangements for home or community visits, arranging for post-discharge services.

If care plan concerns are noted, Interview staff responsible for care planning as to the rationale for the current plan of care.

2. Did the facility develop a care plan to address rehabilitative needs and other factors affecting potential for community discharge?

Yes No **F279**

*The comprehensive care plan does not need to be completed until 7 days after the comprehensive assessment (the assessment completed with the RAPS). Lack of sufficient care planning to meet the needs of a newly admitted resident should be addressed under **F281** (see the Care and Services Meet Professional Standards section).*

*Additionally, lack of physician orders for immediate care (until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan) should be addressed under **F271**.*

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Care and Services Meet Professional Standards

Interviews with Health Care Practitioners and Professionals: If the interventions defined or care provided appear not to be consistent with recognized standards of practice, interview one or more health care practitioners and professionals as necessary (e.g., therapist, physician, charge nurse, director of nursing, social worker) who, by virtue of training and knowledge of the resident, should be able to provide information about the causes, treatment and evaluation of the resident's condition or problem. If the attending physician is unavailable, interview the medical director, as appropriate.

Depending on the issue, ask about:

- The causal and/or contributing factors to the problems related to functional and communication skills;
- How the resident's overall medical, health, and psychosocial status has affected the progress of rehabilitation, ADL improvement, and readiness for discharge;
- What specific services were received during therapy sessions (e.g., services to increase activity tolerance, decrease amount of staff assistance needed, improve strength and balance, improve speech; instruction on use of assistive devices);
- What contributed to a lack of expected improvement in functioning;
- The nature of the discharge plan including timeframes, plans to obtain community services, family instruction in assisting the resident when at home, etc.; and
- What preparations the facility made for the resident's expected post-discharge needs (such as contacts with community service providers, evaluation of the prospective living setting to determine what changes were needed to support the resident's discharge, etc.).

3. Did the facility implement practices that meet professional standards of quality? Yes No **F281**

NOTE: If the care plan addressed the risks and identified needs of the resident, but the care plan was not implemented as written, consider F282 for failure to implement the care plan.

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Care Plan Revision	
<p>Determine whether the resident's condition and effectiveness of the care plan interventions have been monitored and care plan revisions (and discharge plan revisions, as appropriate) were made based upon the following:</p> <ul style="list-style-type: none"><input type="checkbox"/> The outcome and/or effects of goals and interventions;<input type="checkbox"/> A decline or lack of improvement in functioning;<input type="checkbox"/> Intervening medical events (such as acute illness or change in health status);<input type="checkbox"/> The resident's lack of compliance with the treatment regimen;<input type="checkbox"/> Alternatives and/or treatment revision for refusal, resistance, or reluctance of the resident to the use of assistive devices and/or performance of exercises; and<input type="checkbox"/> Changes in the appropriateness of the discharge setting and services such as changes in availability of primary care giver, long waiting list for needed post-discharge health services.	<p>Notes:</p>
<p>4. Did the facility revise the care plan as needed? <input type="checkbox"/> Yes <input type="checkbox"/> No F280</p>	

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Provision of Care and Services

Criteria for Compliance:

- F250, Social Services** — The facility is in compliance with F250 if the facility has provided adequate discharge planning based on the resident's strengths and needs, potential, and living alternatives.
- F311, Activities of Daily Living** — The facility is in compliance with F311 for the provision of restorative services by nursing staff if they have given the resident the appropriate treatment and services to improve functional abilities.
- F406, Specialized Rehabilitative Services** — The facility is in compliance with F406 if professional therapy staff and qualified therapy assistants have provided adequate rehabilitative services, based on the resident's assessed needs and strengths, according to the care plan.

5. Based on observation, interviews, and record review did the facility ensure that (a) the resident received necessary rehabilitative services and, (b) based on discharge potential, discharge planning was provided? Yes No

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Concerns with Structure, Process, and/or Outcome Requirements Related to Process of Care

During the investigation, the surveyor may have identified concerns with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present. Some examples of requirements that should be considered include the following (not all inclusive):

- F157, Notification of Changes** — Determine whether staff notified the physician of significant changes in the resident's condition or refusal or lack of progress in the treatment plan.
- F164, Privacy and Confidentiality** — Determine whether staff provide visual privacy during treatments that expose the body.
- F241, Dignity** — Determine whether staff provide treatments and assistance in a manner that preserves the resident's dignity.
- F242, Self-determination and Participation** — Determine whether the facility has provided the resident with choices about aspects of his or her life in the facility that are significant to the resident.
- F246, Accommodation of Needs** — Determine whether the facility has adapted the resident's physical environment (room, bathroom, furniture, temperature, lighting, sound levels) to accommodate the resident's individual needs.
- F309, Quality of Care** — Determine whether the resident is receiving adequate pain management.
- F318, Range of Motion** — Determine whether the resident admitted with ROM limitations experienced a further decline or lack of improvement in range of motion.
- F353, Sufficient Staff** — Determine whether the facility had qualified staff in sufficient numbers to provide necessary care and services, based upon the comprehensive assessment and care plan.

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Concerns with Structure, Process, and/or Outcome Requirements Related to Process of Care

- F385, Physician Supervision** — Determine whether the physician has assessed, evaluated, ordered and revised orders as appropriate.
- F498, Proficiency of Nurse Aides** — Determine whether nurse aides demonstrate competency in the provision of restorative nursing.
- F501, Medical Director** — Determine whether the medical director
 - Assisted the facility in the development and implementation of policies and procedures for rehabilitative and restorative services based on current standards of practice and policies on discharge planning; and
 - Interacts with the physician supervising the care of the resident if requested by the facility to intervene on behalf of the resident.

If the surveyor determines that the facility is not in compliance with any of these related requirements, the appropriate F tag should be surveyor initiated.