

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 pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- Physician orders.
- Pertinent diagnoses.
- Care plan (e.g., states 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 cause 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 means if the resident declines treatment).

Observations Across Various Shifts:

- If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- Are staff implementing care planned interventions 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?
- What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- How does staff monitor the effectiveness of the resident's care plan interventions?
- How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does 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 preferences (e.g., ADL care, daily routines, activities, etc.)?

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Resident, Family and/or Resident Representative Interview:

- Awareness of current conditions or history of conditions or diagnoses.
- How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?
- How does the facility ensure approaches to care reflect your/the resident's choices and preferences?
- How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- 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?
- 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.
- What other non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.

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

- What are the underlying causes 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 are the interventions monitored?
 - How do you ensure care is provided that is consistent with the care plan?
 - How, what, when, and to whom do you report changes in condition?
 - What types of behavioral health training have you completed?
 - Ask about any other related concerns the surveyor has identified.
 - 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 does 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?
- 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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Record Review:

- Review therapy 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.
- Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- 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, 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?
- Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?
- Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions 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?
- 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?

Critical Element Decisions:

- 1) 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
- 2) Does the facility have sufficient and competent direct care staff to provide nursing and related 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

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- 3) 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, or who has a history of trauma and/or post-traumatic stress disorder (PTSD)?
If No, cite F742
NA, the resident does not display or is not diagnosed with a mental or psychosocial adjustment difficulty, or does not have a history of trauma and/or PTSD.
- 4) Did the facility ensure that the resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does 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 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.
- 5) 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
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.
- 6) 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.
- 7) 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.

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- 8) 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
- 9) 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 and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.
- 10) 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), Social Services F745, Unnecessary/Psychotropic Medications (CA), Resident Records F842.