Stage 2 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 30 day comparison) assessments indicate 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.	**Notes:**

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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).	**Notes:**

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Assessment	
☐ Review the MDS, physician orders, therapy notes, consultations, and other progress notes that may have information regarding the assessment of rehabilitative and discharge needs. ☐ 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. ☐ Determine whether there was a "significant change" in the resident's condition and whether the facility conducted a significant change comprehensive assessment within 14 days. A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting;" 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. If there was a "significant change" in the resident's condition and the facility did not conduct a significant change comprehensive assessment within 14 days, initiate **F274, Resident Assessment When Required**. If a comprehensive assessment was not conducted, also cite F272.	**Notes:**

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Assessment	
1. 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) of the resident's rehabilitation needs and potential for community discharge, and the impact upon the resident's function, mood, and cognition? ☐ Yes ☐ **No** **F272** ☐ **NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS** *NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be ongoing.* *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, Professional Standards of Quality****.*	

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Care Planning	
If the comprehensive assessment was not completed (CE#1 = No), mark CE#2 "NA, the comprehensive assessment was not completed". 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;	**Notes:**

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Care Planning	
▪ 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 ▪ 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 plan of care with measurable goals and interventions to address the resident's rehabilitative needs and other factors affecting potential for community discharge, in accordance with the assessment, resident's wishes, and current standards of practice?** ☐ Yes ☐ **No F279** ☐ **NA, the comprehensive assessment was not completed** *The comprehensive care plan does not need to be completed until 7 days after the comprehensive assessment (the assessment completed with the CAAS). Lack of sufficient care planning to meet the needs of a newly admitted resident should be addressed under **F281, Professional Standards of Quality**.*	

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Care Plan Implementation by Qualified Persons	
Observe care and interview staff over several shifts and determine whether: ☐ Care is being provided by qualified staff, and/or ☐ The care plan is adequately and/or correctly implemented. **3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?** ☐ Yes ☐ **No** **F282** ☐ **NA, no provision in the written plan of care for the concern being evaluated** *NOTE: If there is a failure to provide necessary care and services, the related care issue should also be cited when there is actual or potential outcome.*	**Notes:**

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Care Plan Revision	
If the comprehensive assessment was not completed (CE#1 = No), OR, if the care plan was not developed (CE#2 = No), mark CE#4 "NA, the comprehensive assessment was not completed OR the care plan was not developed". 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: ☐ The outcome and/or effects of goals and interventions; ☐ A decline or lack of improvement in functioning; ☐ Intervening medical events (such as acute illness or change in health status); ☐ The resident's lack of compliance with the treatment regimen; ☐ 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 ☐ 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. **4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?** ☐ Yes ☐ **No** **F280** ☐ **NA, the comprehensive assessment was not completed OR the care plan was not developed**	**Notes:**

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Provision of Care and Services	
For the resident with the potential to maintain or improve functional ability, but who has not maintained or improved:	
Determine whether the nursing staff have given the resident the appropriate treatment and services to improve functional abilities. **5. Based on observation, interviews, and record review did the facility provide the appropriate treatment and services to maintain or improve functional ability for the resident who has the potential to maintain or improve?** ☐ Yes ☐ **No** **F311**	**Notes:**
For the resident who requires specialized rehabilitative services:	
Determine whether 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. **6. Based on observation, interviews, and record review did the facility provide or obtain the required specialized rehabilitative services?** ☐ Yes ☐ **No** **F406**	**Notes:**

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Provision of Care and Services	
For residents who require medically-related social services:	
Determine whether the facility has provided adequate discharge planning based on the resident's strengths and needs, potential, and living alternatives. **7. Based on observation, interviews, and record review, did the facility provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for the resident?** ☐ Yes ☐ **No** **F250**	**Notes:**

Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements	
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): ☐ **Notification of Changes** — Determine whether staff: ▪ Consulted with the physician regarding significant changes in the resident's condition, including the need to alter treatment significantly or failure of the treatment plan; and ▪ Notified the resident's representative (if possible) of significant changes in the resident's condition. ☐ **Privacy** — Determine whether staff provide visual privacy during treatments that expose the body. ☐ **Dignity** — Determine whether staff provide treatments and assistance in a manner that preserves the resident's dignity.	**Notes:**

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements	
☐ **Choices (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. ☐ **F278, Accuracy of Assessments** — Determine whether staff that are qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline conducted an accurate assessment. ☐ **F281, Professional Standards of Quality** — Determine whether the interventions defined or care provided appear not to be consistent with recognized standards of practice. 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;	

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements	
▪ 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.). ☐ **F309, Quality of Care** — Determine whether the resident is receiving adequate pain management. ☐ **Range of Motion** — Determine whether the resident admitted with ROM limitations experienced a further decline or lack of improvement in range of motion. ☐ **Sufficient Nursing 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. ☐ **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.	

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements	
☐ **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. ☐ **F514, Clinical Records** — Determine whether the clinical records: ▪ Accurately and completely document the resident's status, the care and services provided in accordance with current professional standards and practices; and ▪ Provide a basis for determining and managing the resident's progress, including response to treatment, change in condition, and changes in treatment.	