Driving 5-Star & RoP Implementation Through a QAPI Approach

Final Rule: Integrating Phase 2 New Requirements of Participation (Part 1)

Objectives

- Recognize the key changes in the new SNF Requirements of Participation for Phase 2 Implementation
- Identify the actions necessary for compliance with the new regulations
- Acquire knowledge to implement best practices for Requirements of Participation (RoP) implementation using a QAPI approach

OVERVIEW OF PHASE 2 REQUIREMENTS OF PARTICIPATION
Themes, Timeframes, and Implementation Considerations

Themes of the Rule

- Person-Centered Care
- Facility Assessment, Competency-Based Approach
- Quality of Care & Quality of life
  - New/changed evidence-based practice
  - Care Planning
  - Patient goals
  - Patient as the locus of control
- Changing Patient Population
  - Acuity
  - Behavioral Health
- Alignment with HHS priorities
- Reflects dramatic cultural & technology changes over three decades

3 Phase Implementation Process

Phase 1 • 11/28/16
- Resident Rights *
- Freedom from abuse, neglect, & exploitation *
- Admission, transfer, & discharge rights *

Phase 2 • 11/28/17
- Resident Assessment
- Comprehensive person-centered care planning *
- Quality of Life
- Quality of Care *
- Physician Services
- Nursing Services *
- Behavioral Health Services *

Phase 3 • 11/28/19
- Pharmacy Services *
- Laboratory, radiology, & other diagnostic services
- Dental Services *
- Food & nutrition services *
- Specialized rehabilitative services
- Administration *
- Quality Assurance & Performance Improvement *
- Infection Control *
- Physical environment *
- Training requirements *

* Indicates section is partially implemented in Phase 2 or 3
Phase 2 and 3

**Phase 2**
- Resident rights *
- Freedom from abuse, neglect, & exploitation *
- Admission, transfer & discharge rights *
- Comprehensive person-centered care planning *
- Behavioral health services *
- Pharmacy services *
- Dental services *
- Food & nutrition services *
- Administration *
- Infection control *
- Physical environment *

**Phase 3**
- Freedom from abuse, neglect, & exploitation *
- Comprehensive person-centered care planning *
- Quality of Care *
- Nursing services *
- Behavioral health services *
- Administration *
- Compliance & ethics program *
- Physical environment *
- Training/requirements *

* Indicates section partially implemented in other phases

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**Impact on Survey Process**
- CMS is developing a new survey process
  - Merges QIS with traditional survey
  - Incorporates new RoPs
- This will change the survey focus and types of tags issued

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**Survey Process Changes**

- New survey process starting in Phase 2 – November 28, 2017
- Incorporates new requirements
- New F-Tag Coding System – F540+

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**Survey Process**

- New survey protocol
  - Computer based
  - Two Parts
    - Sample selection
      - 70% off-site
      - 30% on-site
    - Investigation

---

**New Survey Protocol**

- Computer based
- Two Parts
  - Sample selection
    - 70% off-site
    - 30% on-site
    - Investigation

---

**Information Roll-Out Plan**

- CMS intends to release information this summer relate to:
  - New tags
  - New Interpretive guidance
  - New Survey process
- Provide tools and training
- S&C memos will be used to announce the posting or release of materials

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§ 483.10 Resident Rights

- 483.10 (g)(4)(ii-v)
  - The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language that he or she understands, including:
  - (ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000) (42 U.S.C. 15001 et seq.);
  - (iii) Information regarding Medicare and Medicaid eligibility and coverage;
  - (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program
  - (v) Contact information for the Medicaid Fraud Control Unit

§ 483.12 Freedom From Abuse, Neglect & Exploitation

- 483.12 (b)(5)(i-iii)
  - Facility must develop and implement written P&P that:
    - Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements (see next slide)

- 483.12 (d)(3)
  - A "covered individual" is defined at section 1150B(a)(3) of the Act as each individual who is an owner, operator, employee, manager, agent, or contractor of such LTC facility.

§ 483.10 Resident Rights - Required Actions

- Update all notices, postings, and admission packet information with new required notifications & information
  - Are notices in format and language all residents can understand?
    - Braille
    - Alternative languages
    - Large Print
  - How do you communicate required notices both orally and in writing?

§ 483.12 Freedom From Abuse, Neglect & Exploitation

- Must include following element in P&P:
  - (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual’s obligation to comply with the following reporting requirements.
    - (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.
    - (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.
  - (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.
  - (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
Elder Justice Act (EJA) Refresher

Purpose:
- To prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation.
- To protect elders with diminished capacity while maximizing their autonomy and help elders recognize their right to be free of abuse, neglect, and exploitation.

Facility Obligation for Crime Reporting:
- The owner or operator of each long-term care facility that receives at least $10,000 in federal funds for the year is obligated to comply with the crime reporting requirement to local law enforcement.
- The EJA provides that a "crime" is defined by local laws of the state in which the facility is situated.

EJA Reporting timeframes:
- EJA instructs reporting must occur within two hours of the event if the resident suffers serious bodily injury.
- If there is no serious bodily injury, then a report must be filed within 24 hours of the event.
- The EJA reporting timeline is based on clock time, not business hours.
- Don't delay. Report immediately to comply with state regulation.

The Act defines "serious bodily injury" as an injury with extreme physical pain; with the possibility of loss or impairment of a bodily member, mental faculty, or organ; a risk of death; or that may require surgery, hospitalization, or rehabilitation.

See State Specific EJA Resource Handout

§483.12 Freedom From Abuse, Neglect & Exploitation – Required Actions
- Ensure new Phase 2 requirements are incorporated into Abuse and Elder Justice Act P&P and Abuse Training
- Educate staff on Elder Justice Act P&P
- Notify Covered Individuals: Annually notify each covered individual of that individual’s reporting obligations described in section 1150B(b) of the Act
- Post Conspicuous Notice: Conspicuously post, in an appropriate location, a notice for your employees specifying the employees’ rights, including the right to file a complaint under this statute. The notice must include a statement that an employee may file a complaint with the SA against a LTC facility that retaliates against an employee, as well as include information with respect to the manner of filing such a complaint.
- Review Elder Justice Act requirements for compliance.

§483.15 Admission, Transfer and Discharge Rights
- 483.15(c)(2) Documentation
- When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

See Sample Transfer Form Template
§483.15 Admission, Transfer and Discharge Rights

■ (i) Documentation in the resident’s medical record must include:
  (A) The basis for the transfer per paragraph (c)(1)(i) of this section.
  (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

§483.15 Admission, Transfer and Discharge Rights

■ (iii) Information provided to the receiving provider must include a minimum of the following:
  (A) Contact information of the practitioner responsible for the care of the resident
  (B) Resident representative information including contact information.
  (C) Advance Directive information.
  (D) All special instructions or precautions for ongoing care, as appropriate.
  (E) Comprehensive care plan goals,
  (F) All other necessary information, including a copy of the residents discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

§483.15 Admission, Transfer and Discharge Rights

■ The documentation required by paragraph (c)(2)(i) of this section must be made by—
  (A) The resident’s physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section and
  (B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section

§483.15 Admission, Transfer & Discharge Rights – Required Actions

■ Review & modify transfer forms to ensure contains all required elements of information must provided to receiving provider
■ Educate nursing staff on information they must provide to receiving providers
■ Educate physicians on documentation requirements for transfers/discharges

§483.21 Comprehensive Person-Centered Care Planning

■ 483.21 (a) Baseline care plans
  (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
§483.21 Comprehensive Person-Centered Care Planning

- The baseline care plan must—
  - (i) Be developed within 48 hours of a resident’s admission.
  - (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    - (A) Initial goals based on admission orders.
    - (B) Physician orders.
    - (C) Dietary orders.
    - (D) Therapy services.
    - (E) Social services.
    - (F) PASARR recommendation, if applicable.

§483.21 Comprehensive Person-Centered Care Planning

- (2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—
  - (i) Is developed within 48 hours of the resident’s admission.
  - (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21 Comprehensive Person-Centered Care Planning

- (3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
  - (i) The initial goals of the resident.
  - (ii) A summary of the resident’s medications and dietary instructions.
  - (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
  - (iv) Any updated information based on the details of the comprehensive care plan, as necessary.

Sample Baseline Care Plan Summary

Sample Baseline Care Plan Summary

§483.35 Nursing Services

- Must have sufficient nursing staff with appropriate competencies & skill sets to provide nursing and related services to assure resident safety and attain or maintain highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of facility resident population. In accordance with the facility assessment required at 483.70 (a)

- All was required in Phase 1 with exception of linking it to the facility assessment
Nursing Services Considerations
■ Resident Acuity
  – Evaluate CMI
■ Diagnoses
  – Consider clinical complexities
■ Special Needs
  – Dialysis
  – Respiratory
  – Diabetes
  – Feeding tubes
  – Wound care
  – Parenteral fluids
  – Behaviors
■ Special equipment
  – Lifts
  – Respiratory equipment
  – IV equipment
■ Average admissions/discharges
  – Short term residents
  – Long-term residents

§483.35 Nursing Services – Required Actions
■ Develop and implement processes to assess competencies of nursing staff,
■ Develop and implement processes to determine “sufficient nursing staff” to meet requirements for nursing services, based on facility assessment.

§483.40 Behavioral Health
■ Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

(b) Based on the comprehensive assessment of a resident, the facility must ensure that:
  – (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.

(c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident’s comprehensive plan of care, the facility must:
  – (1) Provide the required services, including specialized rehabilitation services as required in § 483.65; or
  – (2) Obtain the required services from an outside resource (in accordance with § 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.
CONSIDERATIONS FOR NON-PHARMACOLOGICAL APPROACHES TO BEHAVIOR MANAGEMENT IN PERSONS WITH DEMENTIA

Alzheimer’s Disease Progression

Early stage:
Learning and memory, thinking and planning problems.

Mild-Moderate stage:
More learning, memory, planning problems. Also, speaking and understanding speech and sense of where the body is in relation to objects around them (proprioception & spatial awareness) is impaired.

Advanced stage:
Most of the cortex is seriously damaged due to widespread cell death. Lose communication ability, self care skills, & ability to recognize loved ones.

How do we start?

- Define cognitive ability using an evidence based measure (stage the dementia)
- Establish reasonable care plans with functional expectations within the capabilities of the resident
- Train care partners, so that we are all “speaking the same language” regarding cognitive ability.
- Work together to build an environment that provides comfort, just right stimulation, and safety for differing levels of cognitive ability

Allen Cognitive Disabilities Model

- Focuses on functional cognition and new learning ability
- Tests provide accurate predictor of function in familiar (e.g. brushing teeth) & unfamiliar tasks (e.g. learning to use a walker)
- Remaining abilities & expected deficits have been clarified for each dementia stage & help facilitate optimal care giving and planning in areas such as best communication approaches, behavior management, activity planning and fall prevention

Best Ability To Function

- What residents will predictably pay attention to
- Motor control expectations
- Communication abilities

Functional Cognition Can Be Measured

- 6 levels arranged in “a continuum of clinically observable, qualitative differences in ability to perform functional activities”
- There are 20 modes of performance within the 6 categories that allow for more sensitive measurement of function
- Lower score=lower functional expectation

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When is “learning” expected?

Benefit from instructions

5-6: Can learn through language & written materials

Benefit from demo & adaptation

4: Out of the ordinary recognized with striking visual cues. Imitates new methods for situation specific tasks

3: Motor drilling (practice) under constant supervision to develop new habits using routine steps

Build Caregiver Skills

Communication Approaches

- Tone
- Pace
- Body language & facial expressions
- One step at a time
- Fewer words
- Cues to task that match speech

Person Centered Interactions

- What mattered in the resident’s life previously
- Usual routines
- Connecting needs to behavior

Reasons for “Behavior”

- Health conditions
- Medication
- Communication
- Environment
- The task
- Unmet needs
- Life story
- You

Purposeful Daily Activities

- Offer solutions for activities & just right challenge stimulation programs for all cognitive levels
- Individualized plans to:
  - Reduce anxiety, provide appropriate stimulation and a sense of purpose.
  - Promote a sense of comfort, structure
  - Planned management of escalating situations

Sample ACL Activity Calendar

<table>
<thead>
<tr>
<th>ACL 1</th>
<th>ACL 2</th>
<th>ACL 3</th>
<th>ACL 4-6</th>
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<tbody>
<tr>
<td>Jan 1</td>
<td>Music of the 40s</td>
<td>Music of the 40s</td>
<td>Coaching, Basic Apple Pancakes</td>
</tr>
<tr>
<td>Jan 2</td>
<td>1:1 with Karen</td>
<td>1:1 with Karen</td>
<td>Holiday Coat Shopping</td>
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<tr>
<td>Jan 3</td>
<td>Hand massage</td>
<td>Forever Fit with Karen</td>
<td>Holiday Crafting</td>
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<td>Jan 4</td>
<td>Pet Visits</td>
<td>Afternoon Stretching</td>
<td>Holiday Crafting</td>
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§483.40 Behavioral Health – Required Actions

- Review and revise Behavior/Social Service policies to reflect requirements
- Assure medically related social services provided for residents with behavioral health issues or dementia
- Develop and implement processes to determine “sufficient staff” who provide direct services to meet requirements for nursing services, based on facility assessment.
- Develop and implement a process to assess staff competencies and skills sets in implementing non-pharmacological interventions and required behavioral health needs

Behavioral Health Considerations

Resident Population
- Psychiatric Diagnosis
- Dementia
- Behaviors per MDS
- Behavior Monitoring Program
- PAGARN Level II

Staff Competency
- Behavior Management
  - Use of non-pharmacological interventions
- Dementia Care
- Psychotropic Drug Use procedures

Please register to attend Part 2 of this session scheduled on 01/18/2017

Session highlights:
- Operationalizing the Phase 2 Facility Assessment
- Developing an ATB Stewardship Program
- Introduction to developing the Phase 2 required facility specific QAPI plan

Questions

Thank you for joining us!

Ask questions using the options on the right of your screen to either “raise your hand” for your phone line to be unmuted OR type your question.

Please follow your state association guidance for obtaining CE credit. Inquiries related to certificates should be directed to the association with which you registered for this webinar.

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|       |         | Presentation materials\Poster Template.doc  
|       |         | - Reporting Requirements  
|       |         | Section 300ILcode.htm  
|       |         | - Reporting forms  
|       |         | https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx  
|       |         | - Information & Instruction  
|       |         | https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx  
|       |         | - Sample Policy  
|       |         | https://www.illinois.gov/aging/ProtectionAdvocacy/Pages/ombuds_reporting.aspx  
| IN    | https://secure.in.gov/isdh/25766.htm | - State Reporting Poster template  
|       |         | https://www.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/ombuds_reporting.aspx  
|       |         | - Reporting requirements  
|       |         | Elder_Justice_Act_-_Section_1150B.IN.pdf  
|       |         | - Reporting form  
|       |         | Reporting_a_Crime_Form_-_February_8_2013.IN.doc  
|       |         | - Information & Instruction  
|       |         | http://www.in.gov/isdh/25766.htm  
|       |         | - Sample Policy  
|       |         | Policy and Procedure EJA abuse reporting.doc  
| KY    | http://chfs.ky.gov | - State Specific Poster  
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|       |         | - Reporting requirements  
|       |         | AbuseNeglectViolence.KY.pdf  
|       |         | - Reporting forms  
|       |         | IncidentReportForm.KY.pdf  
|       |         | - Information & Instruction  
|       |         | APSBrochureGuidetoReportingAbuse.KY.pdf  
|       |         | - Sample Policy  
|       |         | Policy and Procedure EJA abuse reporting.doc  

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- Reporting requirements: C:\Users\HTS6810\Desktop\MO.APSreportingpolicy.doc  
- Mandated Reporter form: MandatedReporterForm.MO.pdf  
- Information & Instruction: ElderAbuseCrime.MO.pdf  
- Sample Policy: Policy and Procedure EJA abuse reporting.doc |
- Reporting Requirements: memorandumsODH.pdf  
- Reporting Forms: Complaint-Form.OH.pdf  
- Sample Policy: Policy and Procedure EJA abuse reporting.doc |
- Reporting requirements: https://tn.gov/agining/topic/elder-abuse  
- Reporting forms: https://tn.gov/agining/topic/elder-abuse  
- Information & Instruction: http://elder-abuseca.com/stateResources/tennessee.html  
- Sample Policy: Policy and Procedure EJA abuse reporting.doc |
## Transfer Form Template

<table>
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<th>Resident Name:</th>
<th>Date of Transfer: / /</th>
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<tr>
<td>Time of Transfer:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transfer From:</th>
<th>Transfer To:</th>
</tr>
</thead>
</table>

### Reason for Transfer: *(Include brief medical history and recent changes in status)*

### Physician Information

- **Attending physician in nursing facility:**
- **Attending Physician Contact Information:**

### Contact Information for Other Practitioners Responsible for Care of Resident:

### Resident Representative

- **Name:**
- **Relationship:**
- **Contact Information**
  - Cell Phone:
  - Other Phone:

- Resident Representative is [ ] Health Care Representative [ ] Legal Guardian

### Advance Directives

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<tr>
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<td>CPR</td>
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<tr>
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<td>Hospitalization</td>
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<td>Medical Interventions</td>
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</tbody>
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### Attached Documents

- □ Face Sheet
- □ Advanced Directives
- □ Code Status
- □ Discharge Summary
- □ MAR/TAR
- □ Physician Orders
- □ Recent Labs/Diagnostic Tests

### Comprehensive Care Plan Goals

1. 
2. 
3. 
4. 
5. 

Proactive Medical Review 2017
**Clinical Status at Time of Transfer**

Vital Signs: BP_______ P_____ R______ T_________ Time obtained: ____________________

Pain: □Yes □ No  Rating_______ Site____________ Treatment______________________________

Other Observations:

Diagnoses:

Allergies: □ None □ Yes (list):

**Special Needs and Precautions:**
- □ Pacemaker □ Internal Defib
- **Respiratory Needs:** □ Oxygen: Device_______ Flow Rate_______ □ CPAP □ BIPAP □ Trach □ Vent
- **Isolation/Precautions:** □ None □ MRSA □ VRE □ ESBL □ C-Diff □ Other_________________
- **Diet:** □ Regular □ Mechanically Altered □ Thickened Liquids □ Tube Feed □ Other:
- **At risk alerts:** □ None □ Falls □ Pressure Ulcer □ Aspiration □ Wanders/Elopement □ Seizures
- Other Special Needs/Precautions (specify):

**Functional Status**

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Toilet</td>
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<td></td>
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<tr>
<td>Eating</td>
<td></td>
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</tr>
</tbody>
</table>

**Weight Bearing Status:** □ Full □ Limited

**Bowel:** □ Continent □ Incontinent  **Last BM:** ___________  **Bladder:** □ Continent □ Incontinent □ Catheter

**Mental Status:** □ Alert □ Forgetful □ Oriented □ Disoriented □ Unresponsive □ Depressed
- □ Other:_____________________________________________  **BIMS Score:**

**Skin Condition:**
- □ No wounds
- □ Pressure Ulcer: Site:___________ Size: _________ Stage:_________ (Attach TAR)
  - Site:___________ Size: _________ Stage:_________ (Attach TAR)
- □ Surgical Wounds (include details)
- □ Other skin conditions: (include details)

**Immunizations:**
- □ Flu Date:_______ □ Pneumo Date: _______ □ PPD Date:_______ Result:___________ Other:_____________________

**Sending Facility Contact Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Phone:</th>
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<tbody>
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<td></td>
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</tbody>
</table>

Form Completed By (print name) __________________________________________

Signature: ___________________________________ Title: ________________________ Date: ___/___/___

Proactive Medical Review 2017
## Physician Transfer or Discharge Documentation Template

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Transfer or Discharge Effective Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Is Being Transferred To:</td>
<td></td>
</tr>
<tr>
<td>□ Another Nursing Facility (Specify Facility Name): ________________________________</td>
<td></td>
</tr>
<tr>
<td>□ Another Health Facility (Specify Facility Name): ________________________________</td>
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<tr>
<td>□ A private residence (including home) □ alone □ with others</td>
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</tr>
<tr>
<td>□ Other: _____________________________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

### Reason for Transfer or Discharge (must select one of the reasons below and indicate all required information)

- □ The transfer or discharge is necessary for the resident’s welfare & the resident’s needs cannot be met in the facility
  - o The resident needs that cannot be met in the facility are:

  - o The facility has attempted the following in an effort to meet the resident’s needs:

  - o The services available at the receiving facility to meet the resident’s needs are:

- □ The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility

- □ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident

- □ The health of individuals in the facility would otherwise be endangered

### Physician Name:

<table>
<thead>
<tr>
<th>Physician Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

*Documentation must be made by the resident’s physician when transfer or discharge is required for the resident’s welfare and the resident’s needs cannot be met by the facility or if the resident no longer needs the services provided by the facility because his/her health has improved sufficiently.

*The documentation may be made by any physician if the reason for transfer/discharge is because the health or safety of individuals in the facility is endangered due to the resident.
Policy and Procedure: Baseline Care Plan

Policy Statement
It is the policy of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident’s admission.

Policy Interpretation and Implementation
1. To ensure that the resident’s immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of a resident’s admission.
2. The Interdisciplinary Team will review the Attending Physician’s orders and implement a baseline care plan to meet the resident’s immediate care needs.
3. The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
   a. Initial goals based on admission orders
   b. Physician orders
   c. Dietary orders
   d. Therapy services
   e. Social services
   f. PASARR recommendation, if applicable
4. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan.
5. The facility will provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
   a. The initial goals of the resident
   b. A summary of the resident’s medications and dietary instructions
   c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
   d. Any updated information based on the details of the comprehensive care plan, as necessary

Source Documents & References

<table>
<thead>
<tr>
<th>Federal Regulations</th>
<th>483.21 (a)(1-3) F279</th>
</tr>
</thead>
</table>

Related Documents

Policy Review and Updates
This policy will be reviewed annually by the QAPI committee.

Date of Review/Update
By:

Proactive Medical Review Sample Baseline Care Plan Policy and Procedure 01/2017
<table>
<thead>
<tr>
<th>Cognitive Colors</th>
<th>Caregiver &amp; Elder Focus</th>
<th>Pays Attention To</th>
<th>ADL Assistance</th>
<th>Strengths</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RED</strong></td>
<td>Caregiver Focus: “STOP” Check diet, positioning, skin and pain Elder Focus: <strong>Survival</strong></td>
<td>Sensory Cues Objects placed 8” from their face</td>
<td>Total Assist (often bed bound)</td>
<td>• Some active movement • Responds to stimuli • Intact senses • Facial expressions (non-verbal)</td>
<td>Range of Motion Positioning Splinting Feeding/Swallowing Sensory Stimulation</td>
</tr>
<tr>
<td><strong>ORANGE</strong></td>
<td>Caregiver Focus: “Safety” Ensure a safe area for mobility (fear of falling) and provide a comfortable calm environment Elder Focus: <strong>Comfort/Safety</strong></td>
<td>Proprioceptive and Tactile Cues Objects placed 8” from their face (does not attend to things below the knee: trashcans, wet floor signs, potted plants, shoes left on floor)</td>
<td>Extensive Assist (can grasp objects but may have difficulty releasing grasp)</td>
<td>• Follows count to 3 to start movement • Answers “yes or no” • 1 word communication • Mobility by walking or w/c • Feeds self – often not hungry • May use grab bar with cue during transfers</td>
<td>Walking Rhythmic Movement (dancing, rocking, marching) Prevent Falls (remove bedside table, provide seat to rest, adequate lighting, secure area) Singing Activities Hydration Initiation Feeding</td>
</tr>
<tr>
<td><strong>YELLOW</strong></td>
<td>Caregiver Focus: “Caution” Don’t leave unattended Elder Focus: <strong>Using hands to touch and fidget with things</strong></td>
<td>Tactile (touch) and Picture Cues Objects placed 14” in front on them (tunnel vision) – no peripheral vision</td>
<td>Limited to Extensive Assist</td>
<td>• Uses hands purposefully • Does not initiate communication, but can speak in sentences • May find own room • Can name objects • Will learn new routine after a few weeks • Places objects in a row</td>
<td>Set-up ADL supplies in a row and give cues to keep going Enjoys Repetitive Activity (sorting, sanding, polishing) Communication Program (memory books, reminiscing, prevent isolation)</td>
</tr>
<tr>
<td><strong>GREEN</strong></td>
<td>Caregiver Focus: “GO” Help someone else and come back to check results Elder Focus: <strong>Completing a familiar/routine task</strong></td>
<td>Striking Visual Cues Objects 3-4 feet in front and to either the left or right side Higher level 4’s will scan environment</td>
<td>Independent to Supervision (may need set-up or to check results for accuracy)</td>
<td>• Able to sequence self through steps • Responds to written cues • Conversational speech; may have word finding difficulty • May live alone • Likes supplies in same place consistently</td>
<td>Adaptive Equipment Use Checklists Jobs An unfamiliar task may become upsetting if there is no guidance – difficulty problem solving</td>
</tr>
<tr>
<td><strong>BLUE</strong></td>
<td>Caregiver Focus: “Guide” social interactions. Lack empathy and think the world revolves around them. Difficulty with abstract thinking and anticipating hazards. Elder Focus: <strong>Independent Learning</strong></td>
<td>Written Cues Scans environment, refers to sample, can see 3 dimensions and diagonals</td>
<td>Independent (impulsive, talks while completing tasks, easily frustrated)</td>
<td>• New learning • Simple problem solving • Uses memory aids • Fine motor adjustments • Able to read • Conversational speech; without regard of time constraints of the listener • Will search for needed supplies</td>
<td>Time Management Social Interactions Use of Memory Aids Organizational Skills Medication Management Safety Awareness Reading Comprehension</td>
</tr>
</tbody>
</table>
### Activities Ideas for Dementia Care

#### Activity Considerations Based on Cognitive Stage

**General Tips:**
- Make supplies visible
- Assist for solving problems
- Maintain a routine
- Break down steps
- Use familiar objects
- Use verbal, visual and tactile cues to gain attention and process directions

<table>
<thead>
<tr>
<th>Early Stage 4.0–4.6</th>
<th>Middle/Moderate Stage 3.2–3.8</th>
<th>Late Stage 3.0–2.2</th>
<th>End Stage 2.0–1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows activity calendar</td>
<td>High 3: Following 1-step direction with cues to sequence simple game or craft</td>
<td>Can say at least one word</td>
<td>Needs 1:1 sensory stimulation in a quiet environment around a familiar, meaningful theme</td>
</tr>
<tr>
<td>Remembers goal of simple, familiar games (cards, dice, bingo)</td>
<td>Low 3: May need more cues or hands on cues to sequence simple familiar game or craft</td>
<td>Can make large body movements like kicking a ball, dancing</td>
<td>Can promote movement and awareness</td>
</tr>
<tr>
<td>Duplicates sample craft</td>
<td>Holds and uses familiar objects (crayon) for a brief period</td>
<td>Tips: May need to come and go during activity, sensory stimulation for 15–30 mins. May need hand over hand assist to hold, touch, use or throw objects</td>
<td></td>
</tr>
<tr>
<td>Follows 2–3 step directions</td>
<td>Tips: Benefits from small groups of 30 mins or less sitting close to leader, avoid excessively “verbal activities” (multi-sensory activities best); Wait for a response after direction, provide meaningful stimuli to promote vocalization, movement and interaction; place items directly in front of them to gain attention</td>
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<tr>
<td><strong>Tips:</strong> Offer activities with a goal/sample and purpose, make supplies visible; can assist with leading the group and planning the calendar, maintain a routine</td>
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</tbody>
</table>

### Sample Activity Ideas for Men

<table>
<thead>
<tr>
<th>Early Stage 4.0–4.6</th>
<th>Middle/Moderate Stage 3.2–3.8</th>
<th>Late Stage 3.0–2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sports Related Activities</td>
<td></td>
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</tr>
<tr>
<td>Sporting events (tv games, corn hole horseshoe/washer tournaments)</td>
<td>Sorting baseball cards, Team/city match Gross motor ball games Sports reminiscing groups Cleaning golf clubs, Oiling baseball glove</td>
<td></td>
</tr>
<tr>
<td>Wii Hunting/Target Games</td>
<td>Bowling, Putting green</td>
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<tr>
<td>Games with Wagers</td>
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<tr>
<td>Horse races with racing cards (large print)</td>
<td>Poker hand match Sorting cards</td>
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<tr>
<td>Poker night with chips</td>
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<tr>
<td>Household/Repair Activities</td>
<td></td>
<td></td>
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<tr>
<td>Wheelchair maintenance Measuring windows Hang picture Habitat Humanity projects Assist to change light bulbs</td>
<td></td>
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<tr>
<td>Small appliance disassembly (cord removed) Sorting tools in toolbox, nuts/bolts Flash light repair Pipe tree, Simple non-toxic painting 1:1 with maintenance, Pad lock key sorting Shoe polishing</td>
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<tr>
<td>Outdoor Activities</td>
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<tr>
<td>Camp fire cook out, Gardening, Spray/sweep level walkways Fishing, Bird watching</td>
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<tr>
<td>Tackle box sorting, Matching lures Sorting seed packets, Sorting fish cards Watering plants with assist Filling bird feeders</td>
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<tr>
<td>Military Activities</td>
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<tr>
<td>Local VFW/Legion meetings on site Flag raising/lowering Military care package drive (packing boxes, writing postcards) Military strategy e-games</td>
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<tr>
<td>Sort military insignia Military reminiscing Historic battle diorama with assist</td>
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<td></td>
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<tr>
<td>Motor Interest Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classic car visits/exhibition Model car/airplane kits Train set, Pine car derby partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automobile interest print media Matchbox car sorting by color Automobile reminiscing</td>
<td></td>
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</tbody>
</table>
| **General Group Activity Considerations:**
10 residents or less with frequent small groups throughout the day and individual activities for each resident to complement groups;
Focus on failure-free activities in supportive social and physical environment (limit distractions, stimuli that supports theme, praising efforts)
Grade and adapt activities to the cognitive and physical abilities, access long term memories with props that provide sensory cues.

Large groups of 11 residents or more – Appropriate for activities with little sequencing involved (sing along, church, parties)
Up to 1 hour Early Stage / 45 minutes Middle Stage / 30 minutes Late Stage

**Small Group Activities to Grade for Various Levels**

- **Food Related:** Bread baking and butter churning, Fruit salad prep, Churning ice cream/sundae bar, Chili cook-off, Grill out, Pie of the month club, Men’s breakfast, coffee/donuts and news, Party planning & set up
- **Reminiscing:** Wedding, Farming, Travel, Music, Movie stars, Holidays, School days, Photos, Historic events
- **Motor:** Sittercise, Tai chi, Dance, Ball toss games, Gardening, Large piece puzzles, Object sort/grasp-release
## Baseline Care Plan Summary

### Initial Goals of the Resident:
1. Will perform ADLs (transfers, bed mobility, toileting, ambulation, eating) independently by 02/15/17.
2. Will tolerate regular diet and maintain current weight by 02/15/17.
3. Will participate in PT/OT daily.
4. Pneumonia will resolve by 01/20/17.
5. Pain level will remain below 3 on a scale of 1-10.
6. Blood sugar will remain between 70-110.

### Summary of Medications and Dietary Instructions:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for Use</th>
<th>Dose/Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>Antibiotic to treat pneumonia</td>
<td>500 mg orally for 3 days</td>
</tr>
<tr>
<td>Metformin</td>
<td>To control blood sugar levels r/t diabetes</td>
<td>500mg twice a day</td>
</tr>
<tr>
<td>Tylenol</td>
<td>To control pain</td>
<td>500 mg as needed</td>
</tr>
</tbody>
</table>

Diet Ordered: Regular consistency with no concentrated sweets

### Services and Treatments to be administered by facility:
- Physical therapy daily
- Occupational therapy daily
- Oxygen 2L per nasal cannula
- Blood sugars monitoring daily

### Additional Information:
To use walker for ambulation

- Copy Provided to Resident
- Copy Provided to Resident Representative

| Date: 01/12/17 | Date: 01/12/17 |

**Signature of Staff Completing Form:**

<table>
<thead>
<tr>
<th>Use</th>
<th>Dr. Adams</th>
<th>1234</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td></td>
<td></td>
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</tbody>
</table>

**Resident Name**: Jane Doe

**Room #**: 100

**Physician**: Dr. Adams

**Med Rec #**: 1234
Baseline Care Plan Summary

Initial Goals of the Resident:

<table>
<thead>
<tr>
<th>Medication</th>
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</table>

Diet Ordered:

Services and Treatments to be administered by facility:

Additional Information:

☐ Copy Provided to Resident  ☐ Copy Provided to Resident Representative

Date:                  Date:

Signature of Staff Completing Form:

Resident Name          Room #          Physician          Med Rec #