

Stage 2 Critical Elements for Hospitalization or Death

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

Use

Use this protocol for:

- ☐ Hospitalization of a resident for other than a planned elective surgery.
- ☐ Death of a resident not receiving terminal or hospice care.

NOTE: All pertinent conditions must be addressed during the Stage 2 review.

Assessment

- ☐ Review the MDS or initial admission (or readmission) information, physician orders, progress notes, history and physical, hospital and discharge summaries, EMT records, facility discharge summary, and other information to determine relevant care issues associated with the resident's hospitalization or death. Determine whether staff:
- Identified risk and contributing factors related to the relevant condition for which the resident was hospitalized or to the resident's death;
 - Conducted ongoing assessments and monitored the resident's condition while the resident was experiencing a change in condition; and
 - If the resident resisted services and treatment, identified the reasons for the refusal and revised interventions to address resident needs.

Notes:

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Assessment

- ☐ Interview staff and the resident/responsible party, as appropriate, to determine whether the assessment information accurately and sufficiently reflected the 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.
- 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 condition relevant to the care issues associated with the resident's hospitalization or death, 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

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Assessment

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".

- ☐ Review the plan of care for specific interventions relevant to the care issues associated with the hospitalization or death. Determine whether the care plan:
- Was oriented towards recognizing and preventing decline in status; and
 - Reflected decisions or written instructions identified in advance directives or made explicitly by a resident with capacity to make health care decisions.
- ☐ As needed, interview staff responsible for care planning as to the rationale for the plan of care.

2. Did the facility develop a plan care with measurable goals and interventions to address the care and treatment related to the care issues associated with the hospitalization and/or death, 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 RAPS). Lack of sufficient care planning to meet the needs of a newly admitted resident should be addressed under **F281, Professional Standards of Quality**.*

Notes:

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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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Provision of Care and Services

Determine whether staff have:

- ☐ Recognized and assessed factors placing the resident at risk for specific conditions, causes and/or problems;
- ☐ Defined and implemented interventions in accordance with resident needs, goals, and recognized standards of practice;
- ☐ Monitored and evaluated the resident's response to preventive efforts and treatment; and
- ☐ Revised the approaches as appropriate.

4. Based on observation, interviews, and record review, did the facility provide care and services necessary to meet the needs of the resident in order to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care?

☐ Yes ☐ No **F309**

Notes:

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

During the investigation of care and services provided to meet the needs of the resident, the surveyor may have identified concerns with related structure, process and/or outcome requirements, such as the examples listed below. If an additional concern has been identified, the surveyor should initiate the appropriate care area or F tag and investigate the identified concern. Do not cite any related or associated requirements before first conducting an investigation to determine compliance.

- ☐ **Notification of Changes** __ Review documentation, and interview staff and resident/representative (if possible), to determine whether staff consulted with the physician and the resident and/or representative to ensure prompt care and treatment, based on resident/representative desires. Determine whether staff:
- Consulted with the physician in a timely manner according to resident condition;
 - Obtained diagnostic tests (lab work, X-rays) as ordered by the physician with prompt notification of the diagnostic results to the physician;
 - Updated the physician regarding the resident's condition when there were changes or when expected outcomes did not occur and there was a need to alter treatment; and
 - Promptly notified and consulted with the resident, family, or representative regarding changes in resident status.
- ☐ **Dignity** __ Determine whether the facility provided care in a manner that enhances the resident's dignity and respect with full recognition for his/her individuality.
- ☐ **F271, Admission Orders** __ Determine whether the facility received physician orders for provision of immediate care before conducting the comprehensive assessment and developing an interdisciplinary care plan.

Notes:

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

- ☐ **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 facility, beginning from the time of admission, provided care and services related to the identified concern that meet professional standards of quality.
 - Review the record and determine whether staff immediately:
 - Identified and responded to an acute status change;
 - Documented signs and symptoms reported by the resident, family/significant others, or other members of the interdisciplinary team (such as behavioral changes, mental status changes, physical function changes, evidence of delayed response to resident needs and/or mistreatment or abuse, and signs/symptoms of acute pain);
 - Evaluated vital signs, assessed acute pain, and reviewed body system[s];
 - Informed the physician of the change and implemented orders;
 - Informed the family/responsible party of the change in condition;
 - Identified potential contributing or causal factors such as medications, current medical diagnoses and potential for exacerbation, falls or other recent events, recent abnormal lab values; and
 - Interventions were consistent with established standards of clinical practice such as immediate first aid measures and other acute care procedures including (according to advance directives) glucose monitoring, oxygen evaluation and

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

delivery, wound care, CPR and Immediate transfer in a life-threatening situation.

- Interview the resident/responsible party, as possible and appropriate, to gain additional information about staff response to condition.

☐ **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.

☐ **Sufficient Nursing Staff** __ Determine whether the facility had qualified staff in sufficient numbers to assure the resident was provided necessary care and services.

☐ **F385, Physician Supervision** __ Determine whether the physician has assessed and developed a treatment regimen relevant to acute changes or end of life care and responded appropriately to the notice of changes in condition.

☐ **F501, Medical Director** __ Determine whether the medical director:

- Assisted the facility in the development and implementation of policies and procedures for care related to acute changes and provision of care related to end of life, and that these are based on current standards of practice; 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.