

### Stage 2 Critical Elements for Behavioral and Emotional Status

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 a sampled resident exhibiting physically or verbally abusive behaviors; socially inappropriate or disruptive behaviors, including resistance to care; psychosocial adjustment difficulties after admission; symptoms of depression; and/or presence of delirium.

#### 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.

#### Observations (if the resident is still in the facility)

Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care for residents with behavioral, mental status and/or emotional status symptoms from the day of admission. During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes, including but not limited to the following:

- The quality of staff-to-resident interactions—staff respond to residents who are exhibiting behavioral and/or mental/psychosocial symptoms in a manner that emphasizes the resident's quality of life while ensuring the safety of others; and
- Specific interventions consistently employed from one staff to another and across shifts.

#### Notes:

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Resident/Representative Interview	
<p>Interview the resident, family or responsible party to the degree possible to identify:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Resident's/Representative's involvement in the development of the care plan including providing insight into why behavioral or mood reactions might occur, defining the approaches and goals, and if interventions reflect choices and preferences;</li><li><input type="checkbox"/> Resident's/Representative's awareness of management programs to address behavioral, mental status or mood symptoms and if interventions are provided according to the care plan; and</li><li><input type="checkbox"/> If interventions are refused, whether counseling on alternatives, consequences, and/or other alternative approaches to address behavioral, mental, and/or emotional symptoms were offered.</li></ul>	<p><b>Notes:</b></p>
Staff Interviews	
<p>Interview staff on various shifts to determine:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Knowledge of behavioral management or mental/psychosocial interventions that should be carried out, and how this information is communicated between disciplines and to direct care staff;</li><li><input type="checkbox"/> The process that is in place to review behavior and/or mental/psychosocial symptoms and the roles various disciplines play in the management of behavioral and/or mental/psychosocial symptoms;</li><li><input type="checkbox"/> If nursing assistants know what, when, and to whom to report indications of behavioral, mental and/or emotional status changes; and</li><li><input type="checkbox"/> How staff monitor for the implementation of the care plan, effectiveness of interventions, and any changes in symptoms that have occurred over time.</li></ul>	<p><b>Notes:</b></p>

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Assessment	
<p>Review the MDS, physician orders, therapy notes, and other progress notes that may have information regarding the assessment of behavior symptoms, assessment of mental and/or psychosocial needs, and resident responsiveness to management programs or interventions. Determine whether the assessment information accurately and comprehensively reflects the status of the resident for:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Time, duration, and severity of behaviors and/or mental/psychosocial symptoms (depression, labile or volatile mood, adjustment reactions, delirium) exhibited;</li><li><input type="checkbox"/> Causal, risk, and contributing factors for any behavioral and/or mental/psychosocial symptom(s) that the resident is exhibiting, such as decline in cognitive functioning, confusion, or delirium; and</li><li><input type="checkbox"/> Resident participation in any behavioral management interventions or programs to address mental/psychosocial symptoms (such as symptoms of depression, labile or volatile mood, adjustment reactions).</li></ul> <p>NOTE: If a resident is resisting ADL care, it may be due to a genuine psychological symptom or may be a legitimate defensive reaction to coercive facility practices (such as forcing a resident to endure a shower even while the resident is striking out and protesting). The surveyor should determine whether the facility's practices are the causal factor for the resident's reaction. If so, these constitute deficient practices (Abuse) and not a behavioral symptom.</p> <ul style="list-style-type: none"><li><input type="checkbox"/> 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:<ol style="list-style-type: none"><li>1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting;"</li><li>2. Impacts more than one area of the resident's health status; and</li></ol></li></ul>	<p><b>Notes:</b></p>

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### Assessment

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 behavioral and/or mental/psychosocial symptoms, and needed adaptations, 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”.*

- Determine whether the facility developed a care plan that was consistent with the resident’s specific conditions, risks, needs, behaviors, and preferences and current standards of practice, and included measurable objectives and timetables, with specific interventions/services for the management and treatment of behavioral, mental and/or emotional symptoms.
- 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 the caregivers, and staff should be familiar with the protocol requirements. If care plan interventions that address aspects of the behavioral management/treatment plan are integrated within the overall care plan, the interventions do not need to be repeated.
- 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:
  - Identifies the degree of staff assistance or involvement needed to manage behavior/mental/emotional symptoms;
  - States problems with behavioral and/or mental/psychosocial symptoms in behavioral and/or functional terms as they relate specifically to the individual resident;
  - Identifies specific interventions related to managing the resident’s behavioral and/or mental/psychosocial symptoms and related risk or causal factors that reflect the resident’s medical/health condition and resident preferences and opinions;
  - Includes baseline and ongoing measurement of the behavior

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### Care Planning

and/or mental/psychosocial symptom(s) and expected response to interventions; and

- If the resident refuses or is resistant to the behavior management program or mental/psychosocial intervention, the care plan reflects efforts to find alternative means to address the behavior and/or mental/psychosocial symptoms based on causal and contributing factors determined in the assessment process.

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 care and treatment related to the resident's behavioral and/or mental/psychosocial symptoms, 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**.*

### Stage 2 Critical Elements for Behavioral and Emotional Status

Care Plan Implementation by Qualified Persons	
<p>Observe care and interview staff over several shifts and determine whether:</p> <p><input type="checkbox"/> Care is being provided by qualified staff, and/or</p> <p><input type="checkbox"/> The care plan is adequately and/or correctly implemented.</p> <p><b>3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>F282</b></p> <p><input type="checkbox"/> <b>NA, no provision in the written plan of care for the concern being evaluated</b></p>	<p><b>Notes:</b></p>

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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 staff have been monitoring the resident's response to interventions for prevention and/or treatment and have evaluated and revised the care plan based on the resident's response, outcomes, and needs.
- Review the record and interview staff for information and/or evidence that:
  - If the resident experienced a decline in behavior or mental/psychosocial status or lack of improvement in behavior mental/psychosocial symptoms, the care plan was revised/updated with more appropriate goals or interventions, based on a determination of causal or contributing/risk factors (e.g., unstable condition, acute health problem or change in condition, change in ability to make decisions, change in cognition, a change in medications, sensory problems, environmental disturbances);
  - Staff evaluated outcomes of the plan (the effect of care plan goals and interventions); and
  - The resident and/or the responsible person was involved in the review and revision of the plan.

**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**

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## Stage 2 Critical Elements for Behavioral and Emotional Status

Provision of Care and Services	
For the resident who displays mental or psychosocial adjustment difficulties:	
<p>Determine whether staff have:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Recognized and assessed factors affecting the resident's behavioral and/or mental/psychosocial/emotional status;</li><li><input type="checkbox"/> Defined and implemented pertinent interventions consistent with resident condition, goals, and recognized standards of practice to try to:<ul style="list-style-type: none"><li>▪ Address factors contributing to psychosocial adjustment difficulties or symptoms such as delirium or behavioral and/or emotional symptoms unrelated to adjustment difficulties;</li><li>▪ Monitored and evaluated the resident's response to interventions; and</li><li>▪ Revised the approaches as appropriate.</li></ul></li><li><input type="checkbox"/> Determine whether there was an avoidable onset of problems or decline in behavioral or mental/psychosocial status, or lack of improvement in behavior or mental/psychosocial status.</li></ul>	<p><b>Notes:</b></p>

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Provision of Care and Services	
<p><b>5. Based on observation, interviews, and record review, did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays mental or psychosocial adjustment difficulty?</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> NA   <b>F319</b></p> <p><input type="checkbox"/> NA, the resident does not display mental or psychosocial adjustment difficulty</p>	<p><b>Notes:</b></p>
<b>For the resident whose assessment did not reveal a mental or psychosocial adjustment difficulty:</b>	
<p><b>6. Based on observation, interviews, and record review did the facility ensure that the resident whose assessment did not reveal a mental or psychosocial adjustment difficulty 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?</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> NA   <b>F320</b></p> <p><input type="checkbox"/> NA, the resident's assessment revealed a mental or psychosocial adjustment difficulty</p>	<p><b>Notes:</b></p>

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#### Provision of Care and Services

**For the resident who requires care and services to attain or maintain the highest practicable mental or psychosocial well-being:**

**7. Based on observation, interviews, and record review did the facility provide the necessary 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?**

Yes  No **F309**

**Notes:**

## Stage 2 Critical Elements for Behavioral and Emotional Status

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

During the investigation of services that address behavioral, mental and/or psychosocial needs, the surveyor may have identified concerns with related outcome, process and/or structure 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** \_\_ 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.
- Abuse** \_\_ Determine whether the facility is engaging in coercive practices to force a resident to endure ADLs or treatments against his/her will. Initiate the Abuse care area for the resident and Abuse Prohibition for the facility if concerns were identified.
- Dignity** \_\_ Determine whether staff respond to behavioral and/or emotional symptoms in a manner that promotes a sense of dignity and self-worth.
- Social Services** \_\_ Determine whether the facility is providing medically-related social services, including
  - Maintaining contact with family;
  - Providing or arranging for provision of needed counseling services;
  - Supporting preferences, customary routines, concerns, and choices;
  - Finding options that most meet the psychosocial and emotional

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

needs of the residents;

- Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;
- Teaching staff how to understand and support resident's individual needs; and
- Promoting actions by staff that maintain or enhance dignity.

- 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.
- 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** \_\_ Determine whether the services provided or arranged by the facility met professional standards of quality. Professional standards of quality is defined as services that are provided according to accepted standards of clinical practice.
- Unnecessary Medication Review** \_\_ Determine whether the facility ensures the resident is free from unnecessary medications and that antipsychotic drugs are used appropriately. An unnecessary medication is any medication when used:
  - In excessive dose (including duplicate therapy); or
  - For excessive duration; or
  - Without adequate monitoring; or

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

- Without adequate indications for its use; or
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combinations of the reasons above.

Antipsychotic medication use based on comprehensive assessment of the resident:

- The facility has ensured that residents who have not used antipsychotic medications are not given these medications unless antipsychotic medication therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
- The facility has ensured that residents who use antipsychotic medications receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these medications.

**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, to manage and/or treat the resident's behavioral, mental and/or emotional symptoms.

**F514, Clinical Records** — Determine whether the clinical records:

- Accurately and completely document the resident's status, the care and services provided (e.g., to prevent, to the extent possible, or manage the resident's pain) in accordance with current professional standards and practices and the resident's goals; and
- Provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment.