

Stage 2 General Critical Element Pathway

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 General Investigative Protocol to investigate quality of care concerns that are not otherwise covered in the remaining tags of §483.25, Quality of Care, or for which specific investigative protocols have not been established. For investigating concerns regarding management of pain, use the pain recognition and management CE Pathway. Surveyors should consider any quality of care issue that is not covered in a specific quality of care tag to be covered under F309.

Procedure

- ☐ Briefly review the assessment, care plan, and orders to identify whether the facility has recognized and addressed the concerns or resident care needs being investigated. Also use this review to identify facility interventions and to guide observations to be made.
- ☐ Corroborate observations by interview and record review.

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Observations (if the resident is still in the facility)	
<div><input type="checkbox"/> Observe whether staff consistently implement the care plan over time and across various shifts.</div> <div><input type="checkbox"/> During observations of the interventions, note and/or follow up on deviations from the care plan, deviations from current standards of practice, and potential negative outcomes.</div>	<div>Notes:</div>

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Resident/Representative Interview

Interview the resident or representative to the degree possible to determine the resident's or representative's:

- ☐ Awareness of the current condition(s) or history of the condition(s) or diagnosis/diagnoses;
- ☐ Involvement in the development of the care plan, goals, and if interventions reflect choices and preferences; and
- ☐ How effective the interventions have been and if not effective, whether alternate approaches have been tried by the facility.

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Nursing Staff Interviews	
<p>Interview nursing staff on various shifts to determine:</p> <ul style="list-style-type: none"><input type="checkbox"/> Their knowledge of the specific interventions for the resident, including facility-specific guidelines/protocols;<input type="checkbox"/> Whether nursing assistants know what, when, and to whom to report changes in condition; and<input type="checkbox"/> How the charge nurse monitors for the implementation of the care plan, and changes in condition.	<p>Notes:</p>

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Assessment

- ☐ Review information such as orders, medication administration records, multi-disciplinary progress notes, the RAI/MDS, and any specific assessments that may have been completed. Determine whether the information accurately and comprehensively reflects the resident's condition. In considering the appropriateness of a facility's response to the presence or progression of a condition/diagnosis, take into account the time needed to determine the effectiveness of treatment, and the facility's efforts, where possible, to remove, modify, or stabilize the risk factors and underlying causal factors.
- ☐ 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.

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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 condition 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, preferences, and current standards of practice, and included measurable objectives and timetables with specific interventions. 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 major 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.

NOTE: A specific care plan intervention is not needed if other components of the care plan address related risks adequately. For example, the risk of nutritional compromise for a resident with diabetes mellitus might be addressed in that part of the care plan that deals with nutritional management.

- 2. Did the facility develop a plan of care with measurable goals and interventions to address the care and treatment related to the clinical diagnosis and/or the identified condition, 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.

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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 staff have monitored the resident's condition and effectiveness of the care plan interventions and revised the care plan with input by the resident and/or the responsible person, to the extent possible (or justified the continuation of the existing plan), based upon the following:

- ☐ Achieving the desired outcome;
- ☐ Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; and/or
- ☐ Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms, or visual problems.

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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INTERVIEWS TO CONDUCT ONLY IF PROBLEMS HAVE BEEN IDENTIFIED

Health Care Practitioners and Professionals

If the care provided has not been consistent with the care plan or 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., physician, charge nurse, director of nursing, therapist) 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 there is a medical question, contact the physician if he/she is the most appropriate person to interview. If the attending physician is unavailable, interview the medical director, as appropriate. Depending on the issue, ask about:

- ☐ How it was determined that chosen interventions were appropriate;
- ☐ Risks identified for which there were no interventions;
- ☐ Changes in condition that may justify additional or different interventions; or
- ☐ How staff validated the effectiveness of current interventions.

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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.

5. 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**

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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 Change** — 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.

☐ **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 of Quality** — 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.

☐ **Sufficient Nursing Staff** — Determine whether the facility had qualified nursing staff in sufficient numbers to assure the resident was provided necessary care and services 24 hours a day, based upon the comprehensive assessment and care plan.

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

- ☐ **F498, Proficiency of Nurse Aides** -- Determine whether nurse aides demonstrate competency in the delivery of care and services related to the concern being investigated and in the reporting of changes of condition, as indicated.
- ☐ **F385, Physician Supervision** — Determine whether the physician has assessed and developed a relevant treatment regimen 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 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 residents.
- ☐ **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.