PATHWAY HEALTH
Insight | Expertise | Knowledge

Assessment and Care Planning New Requirements for Participation

Leah Killian-Smith, BA, NHA, RHIA

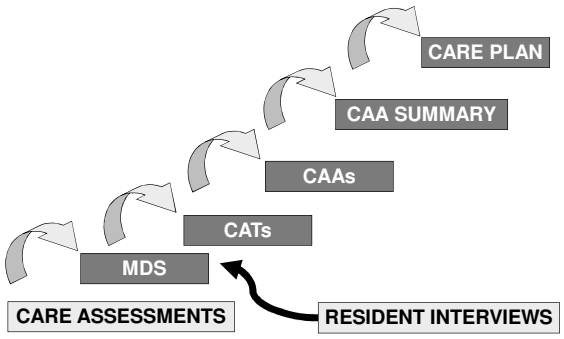
Objectives

Insight | Expertise | Knowledge

- Describe the completion of a Care Area Assessment
- Demonstrate the person-centered care planning process
- Review the Guidance to Surveyors at F250 and F272 for comprehensive assessments and medically related social work services.
- Identify the required expanded contents of a comprehensive assessment
- Recognize the medically related social work services required to be provided or arranged for residents.

RAI PROCESS

Insight | Expertise | Knowledge



Resident Assessment

Insight | Expertise | Knowledge

- **Care Area Triggers (CATs)** – Items and responses that identify potential issues that need additional assessment and review.
- **Care Area Assessments (CAAs)** – More in-depth assessment to identify contributing factors/risk factors to the possible problem as well as other areas the possible problem could affect
- **CAA Summary** - the documentation of the triggered CAA and location of the information used to support the care planning decision

Care Area Assessments

Insight | Expertise | Knowledge

- The CAA process assists staff to:
  - Consider the resident as a whole, unique individual
  - Make the critical link between the MDS and the care plan
  - Identify areas of concern for further assessment
  - Identify the interrelated nature of issues
  - Make decisions about proceeding to the care plan

Care Area Assessments

Insight | Expertise | Knowledge

The CAA process assists staff to:

- Develop a care plan that helps the resident improve, stabilize, prevent or slow decline.
- Include the resident's condition, choices and preferences in the care plan
- Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

Care Area Assessments

Insight | Expertise | Knowledge

1. Delirium
2. Cognition loss/dementia
3. Visual Function
4. Communication
5. ADL Function/ Rehabilitation Potential
6. Urinary Incontinence/Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

Why do we develop a Care Plan?

Insight | Expertise | Knowledge

- To assure consistent delivery of quality care according to acceptable standards of practice using evidence-based interventions
- To assure that the resident receives services to reach his/her highest practicable level of physical, mental, and psychosocial well being
- To give guidance and direction to staff on all shifts responsible for rendering care
- To be in compliance with federal and state regulations

Person-Centered Care Plan

Insight | Expertise | Knowledge

- An individualized, interdisciplinary plan of care specific to the resident
- Addresses problems, risks, strengths, and preferences as they impact the specific individual
- Describes goals based on the resident's desired outcomes
- Manages risks and promotes improvement or maintenance of function and conditions to reach the person's goals

Effective Care Planning

Insight | Expertise | Knowledge

- Results in care and services to assist every resident to attain and maintain the highest practicable physical, mental, and psychosocial well-being.

Care Plan Development

Insight | Expertise | Knowledge

- The assessments of the RAI process are the foundation for the care planning process in long term care
- The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs [42CFR483.20(b)]

Care Plan Development

Insight | Expertise | Knowledge

- Effective Care Plan development requires *CRITICAL THINKING*…

…the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action.

The Critical Thinking Community
http://www.criticalthinking.org/pages/defining-critical-thinking/766

Care Plan Development

Insight | Expertise | Knowledge

Critical Thinking

- Sense of justice
- Self-Directed
- Disciplined
- Fair minded
- Intellectual integrity
- Humility
- Civility
- Intellectual empathy
- Curious
- Thorough
- Constant Learning
- Adherence to professional standards
- Logical thought
- Confidence in reason

Care Plan Development

Insight | Expertise | Knowledge

Critical Thinking Is Not

- Sloppy
- Artificial
- Activity for activities sake
- Incomplete reasoning
- Vague
- Inaccurate
- Illogical
- Inconsistent
- Accepting without investigating
- Simplistic
- Irrelevant

Care Planning

Insight | Expertise | Knowledge

- Is for the resident so must include the resident, family and/or significant other
- Interdisciplinary (not multidisciplinary)
- Shows evidence of the triggered CAA areas
- Shows evidence of skilled goals and care when in a skilled stay
- Includes the resident's preferences and desires
- Needs to be up to date at all times (more later)
- Reflects standards of practice
- Uses evidence-based interventions
- When goals are met or unobtainable Change them!

Care Plan Development

Insight | Expertise | Knowledge

Care Plan would reflect:

- Resident name and medical record number
- Dates of care plan entries
- Problems, needs, strengths
- Goal statements with target dates
- Interventions/approaches
- Disciplines responsible for each intervention
- Care Plan review dates
- Discontinuation dates

Minimum Care Plan Requirements

Insight | Expertise | Knowledge

- Triggered issues, risks and strengths from the RAI process
- Medically defined conditions and prior medical history that will effect the residents status in the nursing home
- Physical, cognitive and mental function needs
- Sensory and physical impairments
- Nutritional status and requirements
- Special treatments and procedures
- Discharge plan

Minimum Care Plan Requirements

Insight | Expertise | Knowledge

- Dental conditions
- Functional activities level
- Health Maintenance
- Rehabilitation potential
- Cognitive status
- Drug therapy
- Leisure preferences
- Personal preferences for daily routines

Minimum Care Plan Requirements

Insight | Expertise | Knowledge

- Section F of the MDS includes ADL preferences. If the resident indicates preferences in items 1 – 8, the facility has an obligation to care plan those preferences and to the extent possible, and appropriate, to accommodate these preferences

Types of Care Plans

Insight | Expertise | Knowledge

Short Term/Temporary Care Plans

- A method to communicate a temporary resident need that is estimated to be 30 days or less in duration
- Examples:
  - Dehydration Risk: UTI / URI / Other illness
  - Injury: fall, injury, bruise…
  - Resolve when issue is no longer active

Types of Care Plans

Insight | Expertise | Knowledge

Long Term Care Plans (Comprehensive)

- Developed no later than 7 days after the comprehensive MDS is completed.
- Reflects assessments determined during the MDS assessment period.

Evaluation/Re-assessment

Insight | Expertise | Knowledge

"Tell the Story"

"IDT met and reviewed the falls of (dates). No new risk factors were identified. Approaches were reviewed and remain current and least restrictive. Device use was discussed but because of the resident's mental status score being (XY) the resident is at higher risk for injury from the device than the actual fall. Family / resident have been updated on the continued risk for falls / injury…"

The Problem statement

Insight | Expertise | Knowledge

Also called "Focus Statement", "Strength"

- Formulated from critical analysis of the IDT assessments, including triggered CAAs
- Describes the issues specific to the resident's problem to facilitate effective goal setting and development of appropriate interventions
- Written to reflect the impact of the problem on the resident's preferred lifestyle/routines
- NOT a restatement of the medical diagnosis, but usually defines problems that arise from the medical problem
- Actual, potential, possible problems, strengths

Care Plan Problem Formats

Insight | Expertise | Knowledge

- Disease related problem statement - medical diagnosis combined with s/s exhibited by the resident:
  - CHF AEB SOB with exertion and pedal edema
  - FX right femur with pain, swelling, healing surgical incision
  - Chronic Clinical Condition/DM/Insulin Dependent with inability to administer Insulin/ clinical instability AEB frequent Hyperglycemia

Problem Formats cont.

Insight | Expertise | Knowledge

- Functional problem statement –
  - Resident is unable to dress, groom, bathe self R/T ;
  - Self Care Deficits/dressing, personal hygiene, bathing, eating R/T… AEB need for physical assistance in all areas
- CAA related problem statement -
  - Section C, BIM's: Memory Deficit

Problem Formats cont.

Insight | Expertise | Knowledge

I-Care Plan Problem Statement - "Resident driven" instead of "Resident focused"

- Written in "FIRST" person
  - E.g.. "Last year I fell and broke my hip. The doctors tried to repair my hip, but it is still causing me a lot of pain. I still have trouble walking and transferring by myself. Because of this, sometimes I don't make it to the bathroom in time. When this happens I get really frustrated with myself. I will put my call light on when I need help to go to the toilet…

Care Plan Problems

Insight | Expertise | Knowledge

Regardless of the format or wording, the problem statement must contain enough information to ensure that goals and interventions selected are related to the true problem as it affects the specific resident.

Simplify the language to make the care plan useful to all care givers

Problem, Strength Suggestions

Insight | Expertise | Knowledge

- Arrange the problem and strength areas in the same order as the MDS
- Combine related problems if they have the same rationale or are closely related:
  - Communication and problem behaviors for a resident with Dementia
  - Cardiac and pulmonary medical conditions
  - Risk for bruises or skin tears
  - Mobility, incontinence for pressure ulcer risks

Problem, Strength Suggestions

Insight | Expertise | Knowledge

- Several ADL areas might be grouped for a resident with a new CVA/hemiplegia
  - Mobility / Bed mobility, transfers, walking, and locomotion
  - ADLs/ Dressing, Eating, Personal Hygiene, Bathing
  - Toileting, continence, elimination, risk for recurrent UTIs
- Nutrition and Hydration may be grouped due to the similar risk factors

Problem, Strength Suggestions

Insight | Expertise | Knowledge

- Identify high profile areas as separate problems to increase ease of evaluation and revision:
  - fall risk
  - pressure ulcer risk
  - significant clinical conditions such as DM (insulin dependent), COPD with O2 dependence and significant S/S

Goals

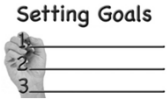
Insight | Expertise | Knowledge

- **The reasonable expected outcome for a specific resident problem(s)**
- Should lead to the residents highest level of functioning as defined by the resident and professional standards
- Action oriented, reasonable, realistic, goal for the resident not staff,
- Measurable, time-limited, and individualized for each resident
- Resident focused; "Resident will…"

Goals

Insight | Expertise | Knowledge

- Each problem has at least 1 goal
- Related areas may share the same goal
- Areas that are grouped together may have multiple goals (1 for each separate area)
- For residents in skilled rehab ensure the ADL goals parallel the rehab goals, and are the resident goals



Types of Goals

Insight | Expertise | Knowledge

Rehabilitation goals: *encourage a higher level of physical, social, or psychosocial functioning*

- Transfers - Resident will progress from extensive assist of 1 to limited assist of 1 within 30 days.
- Urinary Incontinence - Resident will improve daytime continence evidenced by less than 1 episode of incontinence daily within 2 weeks
- Walking - Resident will increase walking frequency to 3 times daily within 2 weeks

Types of Goals

Insight | Expertise | Knowledge

Maintenance goals: *aimed at keeping the resident at his/her highest level of health and functioning and or retard the severity and/or rate of deterioration*

•Resident will maintain the ability to walk with supervision and rolling walker through next review date.

•Resident will maintain weight of 130 ± 5 lbs. in the next 30d.

Types of Goals

Insight | Expertise | Knowledge

Preventive goals: *directed at preventing complications from occurring*

- Resident will not demonstrate any fall related major injuries within the next week
- Resident will not demonstrate a significant weight loss within the next 30 days
- Resident will remain free from pressure ulcers through the next review.

Types of Goals

Insight | Expertise | Knowledge

Palliative goals: *directed at making the resident more comfortable*

- Resident will demonstrate decreased episodes of chemo related nausea as evidenced by c/o same less than ___day, within 1 week

Coping goals: *directed at helping a resident understand, accept/compensate for losses*

- Resident will verbalize acceptance of stroke related functional changes within next 90d days

Approaches/Interventions

Insight | Expertise | Knowledge

- **Instructions/directions to the care team**
- Must include concise, focused action statements of direction regarding the resident's care:
  - Action - such as walk
  - Amount, distance, quantity such as to the dining room
  - Method - with physical aid of 1 and RW
  - Frequency - all meals
  - Additional clarifying information or direction , such as observe for SOB and c/o pain

Approaches/Interventions

Insight | Expertise | Knowledge

- Vary in focus dependent upon desired outcome
  - Facilitate improvement
  - Prevent avoidable decline
  - Provide palliative care
- Categories to consider
  - Assessments
  - Observation and monitoring
  - Specific clinical approaches designed to achieve specific outcomes
  - Teaching activities

Approaches/Interventions

Insight | Expertise | Knowledge

- Use only approaches specific to the resident
- Can use actual physician orders or refer to the physician orders
  - Pressure ulcer treatment, refer to TAR for specifics
  - Cardiac Medication as ordered, refer to MAR
  - Labs as ordered, refer to Physician orders for specifics
- Do not have too many approaches under one problem

When to Update the Care Plan

Insight | Expertise | Knowledge

- With any change in condition
- When the goal has changed, but the problem and approaches are the same
- With a new problem
- With new MD orders not yet reflected
- With any deletions to the care plan
- Remember to initial and date any additions, deletions if care plan is on paper

About Electronic Care Plans

Insight | Expertise | Knowledge

- Software has a care plan library
  - May be organized by CAA, Medical condition, Major categories of deficits
- Choose appropriate items for the individual resident's Problem/Goal/Interventions
- Edit as needed to reflect individual resident
- Use custom options to write from scratch

Well Designed Care Plans

Insight | Expertise | Knowledge

- A central source of information
- Direction for person-centered care
- A mechanism for continuity
- A tool for providing quality care
- Reimbursement data
- Documentation for legal issues
- Implications for staffing needs
- A basis for evaluating team functioning

Check for Compliance

Insight | Expertise | Knowledge

- Is all of the "regulatory jargon" on the care plan?
- Does the care plan reflect current standards of practice?
- Is reimbursement jargon on the care plan?
- Are facility specific protocols present?

Ineffective Care plans

Insight | Expertise | Knowledge

- Incomplete or inaccurate assessments leading to incomplete or inaccurate data
- Failure to tailor the plan to meet the individual needs of the resident
- Omission of significant resident needs or problems
- Lack of objective, time limited, measurable goals
- Being too vague or too complex to be implemented easily

Ineffective Care Plans

Insight | Expertise | Knowledge

- Lack of periodic evaluation resulting in outdated information
- Inadequate time devoted to care plan development
- Lack of resources/training for accurate care
- Failure to clearly designate responsibilities the care plan should not force the caregiver to make a decision about care

In a Nut Shell

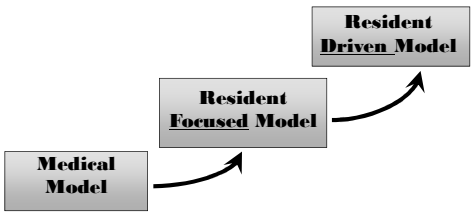
Insight | Expertise | Knowledge

- What is the issue, risk, concern, or strength (Problem), specific to the resident
- What is the result you, the resident, the family have agreed upon (Goal)
- What are you going to do to assist the resident to achieve the result (Interventions)

I-Care Plans

Insight | Expertise | Knowledge

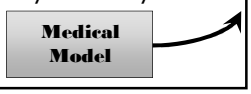
Care Planning "Transformation"



Medical Care Plan Model

Insight | Expertise | Knowledge

- Institutional "routine" is the focus
- CP Difficult to read for direct care staff
- Language is complicated
- Not personal, staff determines content
- Diagnosis driven
- Focused on knowing resident by "problems" and "Diagnosis"
- Interventions determined by clinically desired outcomes



Medical Care Plan Model

Insight | Expertise | Knowledge

- Written in "THIRD" person
  - E.g.. "Resident incontinent of bowel and bladder R/T immobility AEB unable to transfer to toilet independently"
- IDT does not include nursing assistants and is often not "truly" interdisciplinary.

Medical Model

Resident Focused CP Model

Insight | Expertise | Knowledge

- Second generation of care planning
- Care plan emphasizes staff understanding of resident's individualized needs, preferences
- Takes clinical conditions and focuses them on "best case" resident outcomes.

Resident Focused Model

Resident Focused Model

Insight | Expertise | Knowledge

- Usually driven by writer's perception of what's best for resident
- "easier" than Medical Model to create
- May or may not include direct care staff
- e.g. *Problem: "Resident fell trying to get to bathroom. Goal: Will not fall this quarter. Intervention: Tab alarm in chair.*

Resident Focused Model

Resident Driven Model

Insight | Expertise | Knowledge

- Uses input from Resident, Family and Direct Care Staff
- Process draws out resident's life patterns, interests, unique personhood
- Process not focused solely on medical needs but holistically includes Resident's soul, mind, and body

Resident Driven Model

Insight | Expertise | Knowledge

- This model uses more time spent with resident.
- The positive "side effect" of this process is increased socialization and satisfaction for both resident and staff.
- Tells staff not just the "how", but also the "why" of resident care instructions

Resident Driven Model

Insight | Expertise | Knowledge

- Can be time consuming in the beginning
- Can be hard to coordinate and be confusing in the initial stages
- Team can lose focus and get off track
- Stay committed and don't give up!!!
- Try this format for some or all of the care plan problem areas

"Unavoidable"

Insight | Expertise | Knowledge

- **Highest Practicable function** is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline
- Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental, and psychosocial needs of the individual

"Unavoidable"

Insight | Expertise | Knowledge

- The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process
- *In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable*

"Unavoidable"

Insight | Expertise | Knowledge

A determination of unavoidable decline or failure to reach the highest practicable well-being may be made only if all of the following are present.

- An Accurate and complete assessment
- A care plan which is implemented consistently and based on information from the assessment
- Evaluation of the results of the interventions and revision of the interventions as necessary

OVERVIEW

Insight | Expertise | Knowledge

§483.20 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, **strengths**, **goals, life history and preferences**, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

OVERVIEW

Insight | Expertise | Knowledge

§ 483.40 Behavioral health services.

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

DEFINITIONS

Insight | Expertise | Knowledge

"The accuracy of the assessment"

"Medically-related social services"

"Psychosocial well-being"

"Resident Assessment Instrument"

"Total health status"

Comprehensive Assessment

Insight | Expertise | Knowledge

A facility must make a comprehensive assessment of a **resident's needs, strengths, goals, life history and preferences**, using the resident assessment instrument (RAI) specified by CMS.

Each area of the assessment should collect relevant information about the resident's;

Needs: Actual problems, functional, and cognitive deficits, psychosocial issues and risk areas to address to reach and maintain the resident's highest practicable level of function

Strengths: the characteristics of the resident that allow them to succeed or persevere in the face of adversity. Strengths may include knowledge, wisdom, experience, beliefs, physical characteristics, mental outlook, coping skills, financial or physical assets, or emotional supports.

Comprehensive Assessment

Insight | Expertise | Knowledge

Each area of the assessment should collect relevant information about the resident's;

Goals: The resident's desired outcomes both short term and long term. This may include specific functional objectives and overall life goals.

Life History: The information about the resident's experiences, relationships, occupation. History applies to each area of the assessment period. The resident's history helps define who they are now.

Preferences: Each person has their own likes and dislikes and daily living patterns. Use this information to help the resident to live they way they want to live in the facility. Knowing the person's preferences shows we honor and respect who they are.

Examples

Insight | Expertise | Knowledge

Cognitive patterns

Needs:
- What is the cognitive functioning of the resident? Use standardized assessment tools - BIMS

Strengths:
- What is the resident capable of? What cognitive function have they retained?

Goals:
- What practical objectives does the resident and their representative have for their cognitive function?

History:
- What has been the time frame and pattern of the resident's cognitive loss? Is there a family history?

Preferences:
- How would the resident like to be engaged? Do they prefer physical contact or not? What personal items help them remember who they are and feel comfortable?

Examples

Insight | Expertise | Knowledge

Mood

Needs:
Does the resident have mood symptoms?

Strengths:
Can the resident express their feelings? What are their effective coping skills?

Goals:
How would the resident like to manage mood or behavior issues? What level of symptoms is acceptable to resident?

Life history:
How long has the resident experienced mood symptoms? Have they received treatment in the past? What treatment, interventions or coping mechanisms have been effective?

Preferences:
Does the resident prefer to talk about their feelings with specific staff? How would they like to receive feedback about mood symptoms?

Behavior Patterns

Insight | Expertise | Knowledge

Needs:
Does the resident have problem behaviors?

Strengths:
Can the resident express some feelings or needs? DO they have some insight into the cause of their problem behavior? Can they accept distraction or redirection?

Goals:
How would the resident and/or representative like to manage problem behaviors? What level of symptoms is acceptable to resident and their representative?

Life history:
How long has the resident experienced behavior problems? What has provided relief and comfort to the resident in the past; both before the behavior problems developed and since?

Preferences:
Does the resident and/or their representative prefer to have the environment modified to minimize behaviors? Do they prefer being near others or a quiet environment?

Examples

Insight | Expertise | Knowledge

Psychosocial well-being

Needs:
Does the resident have psychosocial or relationship difficulties? Does the resident have a sense of personal well-being?

Strengths:
Does the resident have connections to their prior living community? Is the resident a member of an organization or social group?

Goals:
Does the resident wish to stay connected with prior supports? What is important to help them retain their sense of self?

Life History:
Can the resident identify important relationships in their life? Have they had personal losses?

Preferences:
Does the resident get satisfaction from helping others? From reminiscing?

Examples

Insight | Expertise | Knowledge

Physical functioning

Needs:
What level of assistance does the resident need to maintain their health and well-being?
Strengths:
What can the resident do for themselves?
Goals:
What level of independence does the resident think they can realistically achieve?
Life history:
How long has the resident had the functional deficit? How long have they been working on improving function?
Preferences:
Does the resident prefer to receive most treatment in the morning? Do they like to go to the gym for therapy?

Example

Insight | Expertise | Knowledge

Activities

Needs:
- to support of physical, mental and psychosocial well-being

Strengths:
- Interests, community connections, abilities

Goals:
- Things the resident want to continue to do

Life history:
- Interests and activities prior to entry

Preferences:
- What activities, independent or group, facility sponsored or independent,

Examples

Insight | Expertise | Knowledge

Disease, diagnosis and health concerns

Needs:
- Does the resident have an unstable or chronic medical condition?

Strength:
- Has the resident been successful in managing their illness? Do they have knowledge about their condition?

Goals:
- What level of symptom management would the resident like to achieve? What would they like to do without symptoms?

Life history:
- How long has the resident had the illness or condition? Is there a family history that impacts the resident's expectation for managing the condition?

Preferences:
- What are the resident's treatment preferences?

Medically Related Social Services

Insight | Expertise | Knowledge

- Maintaining contact with facility (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;
- Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications;

Medically Related Social Services

Insight | Expertise | Knowledge

- Making arrangements to obtain adaptive equipment, clothing and personal items.
- Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);

Medically Related Social Services

Insight | Expertise | Knowledge

- Providing or arranging provision of needed counseling services;
- 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;
- Meeting the needs of residents who are grieving; and

Medically Related Social Services

Insight | Expertise | Knowledge

- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
- Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);

Medically Related Social Services

Insight | Expertise | Knowledge

- Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs;
- Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;
- Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications;

Conclusion

Insight | Expertise | Knowledge

Expand the information gathered in the comprehensive assessment process to encompass the whole person of the resident:

- Needs
- Strengths
- Goals
- Life History
- Preferences

References

Insight | Expertise | Knowledge

References

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 10/04/16:
https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities, 06/10/16:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM), Appendix PP- Revised Regulations and Tags, 11/09/16:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf

Insight | Expertise | Knowledge

Questions?

Insight | Expertise | Knowledge

Thank You!

Leah Killian-Smith, Director
Pathway Health, Inc.
Leah.smith@pathwayhealth.com
651-407-8699