- Residents and their representatives, if applicable, are not routinely invited to participate in care planning. While the resident did not experience an actual decline in physical, mental, or psychosocial functioning and continued to meet goals established on the care plan, the care plan goals did not show evidence of resident and if applicable, the resident representative input, having the potential for more than minimal harm.
- Direct-care staff were not made aware of revisions to the resident's care plan by the IDT for three days to assist the resident in brushing his teeth. This resulted in staff not assisting the resident with brushing his teeth for three days, and the resident did not suffer actual harm.

Examples of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, include, but are not limited to:

- Care plan was not reviewed by the IDT after the resident's quarterly assessment indicated a minor change in the resident's status.
- A required member of the IDT did not participate in development of the resident's care plan, which had no more than a minor negative impact to the resident.

F658

(Rev. 229; Issued: 04-25-25; Effective: 04-25-25; Implementation: 04-28-25)

§483.21(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality.

INTENT

To assure that *ALL* services*, as outlined by the comprehensive care plan,* being provided meet professional standards of quality.

GUIDANCE

"Professional standards of quality" means that care and *all* services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include:

- Current manuals or textbooks on nursing, social work, physical therapy, etc.
- Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.

- Current professional journal articles.

Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing. The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident's needs between required RAI assessments should be addressed at §483.35 Nursing Services, F726 (competency and skills to identify and address a change in condition), and the relevant outcome tag, such as §483.12 Abuse, §483.24 Quality of Life, §483.25 Quality of Care, and/or §483.40 Behavioral Health.

Mental Disorders are diagnosed by a practitioner, using evidence-based criteria and professional standards, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and are supported by documentation in the resident's medical record. Supporting documentation should include, but is not limited to, evaluation of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation.

Examples of insufficient documentation to support a mental health diagnosis would include:

- *A situation where schizophrenia or another diagnosis is only mentioned as an indication in medication orders without supporting documentation.*
- *The addition of, or request by the facility to a practitioner for, a diagnosis of schizophrenia or another diagnosis without documentation supporting the diagnosis.*
- *A practitioner's note or transfer summary from a previous provider stating "history of schizophrenia," "schizophrenia," or another diagnosis without supporting documentation confirming the diagnosis with a previous practitioner or family, and the facility failed to to provide evidence that a practitioner conducted a comprehensive evaluation after admission.*
- *A diagnosis list stating schizophrenia or another diagnosis without supporting documentation.*
- *A note of schizophrenia or another diagnosis in an electronic health record (EHR) without supporting documentation which populates throughout the EHR.*
- *A note of schizophrenia or another diagnosis in the medical record by a nurse without supporting documentation by the practitoner.*

Insufficient documentation for a new mental health diagnosis means that the resident's medical record does not contain the following:

- *Documentation (e.g., nurses' notes) indicating the resident has had symptoms, disturbances, or behaviors consistent with those listed in the DSM criteria, **and** for the period of time in accordance with the DSM criteria.*

- *Documentation from the diagnosing practitioner indicating that the diagnosis was given based on a comprehensive assessment, such as notes from a practitioner's visit.*

- *Documentation from the diagnosing practitioner indicating that the symptons, disturbances, or behaviors are not attributable to (i.e., ruled out) the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., UTI or high ammonia levels).*
- *Documentation regarding the effect the disturbance is having on the resident's function, such as interpersonal relationships, or self-care, in comparison to their level of function prior to the onset of disturbance.*

*The medical record must include documentation of **ALL** of these items, if not, this would constitute insufficient documentation.*

CMS is aware of situations where residents are given a diagnois of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia. For these situations, determine if non-compliance exists related to the practitioner not adhering to professional standards of *practice* for assessing and diagnosing a resident.

Surveyors should investigate this concern through record review and interviews with the practitioner(s), facility medical director, and other appropriate nursing home staff, as well as consult with the state agency medical director as needed. Surveyors are not questioning the practitioner's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.

If the facility is unable to provide practitioner documentation which supports the new psychiatric diagnosis in question, then non-compliance exists. For example, if a new diagnosis of schizophrenia is noted in the medical record, the surveyor should verify the documentation supports the use of accepted standards of practice (e.g. current DSM criteria) for the diagnosis.

Below are excerpts from the DSM (current as of the date of this publication)[1] which describe diagnostic criteria for schizophrenia, schizophreniform disorder, and schizoaffective disorder. This list is not all-inclusive and should not be used as a checklist but rather as a guide when reviewing supporting documentation.

SCHIZOPHRENIA

Diagnostic Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.

2. Hallucinations.

3. Disorganized speech (e.g., frequent derailment or incoherence).

4. Grossly disorganized or catatonic behavior.

5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less successfully treated).

SCHIZOPHRENIFORM

Schizophreniform disorder is characterized by a symptomatic presentation equivalent to that of schizophrenia except for its duration (less than 6 months) and the absence of a requirement for a decline in functioning.

Diagnostic Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.

2. Hallucinations.

3. Disorganized speech (e.g., frequent derailment or incoherence).

4. Grossly disorganized or catatonic behavior.

5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional."

C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

SCHIZOAFFECTIVE DISORDER

Diagnostic Criteria

A. An ninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.

Note: The major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

When residents are admitted to the facility with a mental health diagnosis, *supporting documentation should include, but is not limited to:*

- *The PASARR evaluation and determination report from the State Mental Health Authority;*

- *Facility attempts to obtain documentation regarding the mental health diagnosis from the previous provider(s);*

- *Validation of the resident's mental health diagnosis by the practitioner in accordance with professional standards of practice, such as reviewing information available in the medical record, including information from the previous provider(s), discussions about the diagnosis and history with the resident or resident representative, conducting a comprehensive evaluation, the need for a psychiatric or other consultations if necessary, and their determination of the resident's diagnosis.*

INVESTIGATIVE PROCEDURES

There is no requirement for the surveyor to cite a reference or source (e.g., current textbooks, professional organizations or clinical practice guidelines) for the standard of practice that has not been followed related to care and services provided within professional scopes of practice, such as failure of nursing staff to assess a change in the resident's condition. However, in cases where the facility provides a reference supporting a particular standard of practice for which the surveyor has concerns, the surveyor must provide evidence that the standard of practice the facility is using is not up-to-date, widely accepted, or supported by recent clinical literature. Such evidence should include a citation for the reference or source (e.g., current textbooks, professional organizations or clinical practice guidelines) for the current standard of practice from which facility deviated.

If a negative or potentially negative resident outcome is determined to be related to the facility's failure to meet professional standards and the team determines a deficiency has occurred, it should also be cited under the appropriate quality of care or other relevant requirement. For example, if a resident develops a pressure injury because the facility's nursing staff failed to provide care in accordance with professional standards of quality, the team should cite the deficiency at both F658 and F686 (Skin Integrity).

PROBES

- Do the services provided or arranged by the facility, as outlined in the comprehensive care plan, reflect accepted standards of practice?

- Are the references for standards of practice, used by the facility *and/or physician*, up to date, and accurate for the service being delivered?

- *Does the documentation show how the physician arrived at the diagnosis based on the DSM criteria? For example, for a new diagnosis of schizophrenia, does the medical record contain notes (e.g., from nursing or medical providers) of symptoms or behaviors consistent with the symptoms from criterion A, and for the period of time in criterion C as listed in the DSM?*

- *Is there documentation of a physician's visit assessing the resident and concluding a diagnosis of schizophrenia?*

The following questions may be used to assist the surveyor in discussing a resident's diagnosis with a physician:

- *Who established the mental health diagnosis?*

- *How did you arrive at the diagnosis according to standards of practice (DSM), and where is this documented? (Documentation should include information on the DSM criteria specified above such as symptoms and behaviors and their duration.)*

- *Were other underlying conditions excluded, such as medical or psychiatric conditions, progression of an existing condition such as dementia, medication side effects, delirium, etc., prior to diagnosing the resident with schizophrenia?*

DEFICIENCY CATEGORIZATION

If the surveyor identifies a pattern (e.g., three or more) of residents who have a new diagnosis which lacks sufficient supporting documentation, the surveyor should cite the scope of the non-compliance at a minimum scope of pattern (e.g., level 2 = "E," Level 3 = "H," or Level 4 = "K"), Additionally, the surveyor should discuss the findings with their state agency to consider referringl a physician, nurse practitioner, clinical nurse specialist, or physician assistant to their respective state board (e.g., state medical board, state nursing board, etc.).

A medical record which lacks sufficient documentation, such as a comprehensive evaluation and behavioral documentation, to support a new diagnosis of schizophrenia by a practitioner would represent non-compliance at F658. If the resident is receiving an antipsychotic medication and experienced negative side effects, evaluate compliance with other requirements such as F605. For example:

- *While receiving the antipsychotic medication, the resident withdrew from social activities because of difficulty concentrating and carrying on conversations and spends their day isolated in their room, or engages minimally with staff and their family since starting the antipsychotic medication. A lack of documentation to support a practitioner's diagnosis of schizoaffective disorder **and** the use of an antipsychotic medication without an adequate clinical indication represents Immediate Jeopardy at F658 and F605.*

- *Because of a practitioner diagnosed schizophrenia in a resident (without supporting documentation), the facility did not attempt a gradual dose reduction (GDR) or demonstrate the GDR was contraindicated. There was no indication of a change in the resident's behavior or function,but the potential for more than minimal harm exists. Therefore, use of the antipsychotic medication without a gradual dose reduction unless contraindicated an adequate clinical indication and lack of documentation to support the diagnosis would be Level 2 at F658 and F605.*

- *A resident was diagnosed with schizophrenia after admission to the nursing home and an antipsychotic medication was initiated for agitation and aggressive behaviors. The*