To cite deficient practice at F680, the surveyor's investigation will generally show that the facility failed to ensure the activities program is directed by a qualified professional, who:

- Is licensed or registered, (if applicable); and
  - Is eligible for certification as a therapeutic recreation specialist, or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
  - Has 2 years of experience in a social or recreational program with the last 5 years, one of which was full-time in a therapeutic activities program; or
  - Is a qualified occupational therapist or occupational therapy assistant; or
  - Has completed a training course approved by the state.

NOTE: F680 is a tag that is absolute, which means the facility must have a qualified activities professional to direct the provision of activities to the residents. Thus, it is cited if the facility is non-compliant with the regulation, whether or not there have been any negative outcomes to residents. In determining the Scope and Severity, surveyors must consider the extent to which non-compliance at F679 is attributed to the lack of an activity director or the lack of qualifications of the activity director.

F684

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

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

INTENT

To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

DEFINITIONS

"Highest practicable physical, mental, and psychosocial well-being" is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

"Hospice Care" means a comprehensive set of services described in Section 1861(dd)(l) of the Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. (42 CFR §418.3)

"Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (§418.3)

"Terminally ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (§418.3)

GUIDANCE

NOTE: 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.

Use guidance at F684 for review of concerns which have caused or have a potential to cause a negative outcome to a resident's physical, mental, or psychosocial health or well-being that is not specifically addressed by any other tag at §483.25. Additionally, F684 contains guidance for end of life and hospice care.

Nursing homes must place priority on identifying what each resident's highest practicable well-being is in each of the areas of physical, mental and psychosocial health.
Each resident's care plan must reflect person-centered care, and include resident choices, preferences, goals, concerns/needs, and describe the services and care that is to be furnished to attain or maintain, or improve the resident's highest practicable physical, mental and psychosocial well-being. For concerns related to the resident's comprehensive care plan, see F656, §483.21(b) Comprehensive Care Plans.

The following sections describe some, but not all of the care needs that are not otherwise covered in the remaining tags of §483.25, Quality of Care.

I. Review of a Resident with Non Pressure-Related Skin Ulcer/Wound.

Residents may develop various types of skin ulceration. At the time of the assessment and diagnosis of a skin ulcer/wound, the clinician is expected to document the clinical basis (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the

ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one. This section differentiates some of the different types of skin ulcers/wounds that are not considered to be pressure ulcers.

NOTE: Guidance regarding pressure ulcers is found at 42 CFR 483.25 (b)(1)F686 Skin Integrity – Pressure Ulcers. Use this tag F684 for issues regarding non-pressure related skin ulcers/wounds. Kennedy Terminal Ulcers are considered to be pressure ulcers that generally occur at the end of life. For concerns related to Kennedy Terminal Ulcers, refer to F686, §483.25(b) Pressure Ulcers.

- **Arterial Ulcer:** An arterial ulcer is ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis. Inadequate blood supply to the extremity may initially present as intermittent claudication. Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders (such as arteritis), or significant vascular disease elsewhere (e.g., stroke or heart attack). The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g., top of the foot or toe, outside edge of the foot). The wound bed is frequently dry and pale with minimal or no exudate. The affected foot may exhibit: diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down (dependent) or increased pain when elevated, blanching upon elevation, delayed capillary fill time, hair loss on top of the foot and toes, toenail thickening;

- **Diabetic Neuropathic Ulcer:** A diabetic neuropathic ulcer requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot, e.g., at mid-foot, at the ball of the foot over the metatarsal heads, or on the top of toes with Charcot deformity ; and

- **Venous or Stasis Ulcer:** A venous ulcer (previously known as a stasis ulcer) is an open lesion of the skin and subcutaneous tissue of the lower leg, often occurring in the lower leg around the medial ankle. Venous ulcers are reported to be the most common vascular ulceration and may be difficult to heal, may occur off and on for several years, and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious serous drainage unless the wound is infected. The resident may experience pain that may increase when the foot is in a dependent position, such as when a resident is seated with her or his feet on the floor. Recent literature implicates venous hypertension as a causative factor. Venous hypertension may be caused by one (or a combination of) factor(s) including: loss of (or compromised) valve function in the vein, partial or complete obstruction of the vein (e.g., deep vein thrombosis, obesity, malignancy), and/or failure of the calf muscle to pump the blood (e.g., paralysis, decreased activity). Venous

insufficiency may result in edema and induration, dilated superficial veins, dry scaly crusts, dark pigmented skin in the lower third of the leg, or dermatitis. The pigmentation may appear as darkening skin, tan or purple areas in light skinned residents and dark purple, black or dark brown in dark skinned residents. Cellulitis may be present if the tissue is infected.

II. Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services

Assessment

The resident must receive a comprehensive assessment to provide direction for the development of the resident's care plan to address the choices and preferences of the resident who is nearing the end of life. In addition, in order to promote the physical, mental, and psychosocial well-being of a resident who is approaching the end of life, the facility and the resident's attending physician/practitioner, should, to the extent possible:

- Identify the resident's prognosis and the basis for that prognosis; and

- Initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preferences regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization.

Care Plan

The care plan must be based upon the resident assessment, choices and advance directives, if any. As the resident's status changes, the facility, attending practitioner and the resident representative, to the extent possible, must review and/or revise care plan goals and treatment choices. Based upon the resident's assessment, the care plan may include, but is not limited to addressing:

- Oral Care - The care plan should include the provision of ongoing, consistent oral care including interventions, as necessary to provide comfort and prevent complications associated with dry mucous membranes and compromised dentition. (For concerns related to the provision of oral hygiene, refer to F676 or F677 - Activities of Daily Living, and for concerns related to dental care, refer to F790 and F791 - Dental Services.);

- Skin Integrity – The care plan should include, for a resident who has skin integrity issues or a pressure injury or is at risk of developing a pressure injury, approaches in accordance with the resident's choices, including, to the extent possible, attempting to improve or stabilize the skin integrity/tissue breakdown and to provide treatments if a pressure injury is present. (For concerns related to pressure injuries, refer to F686.);

- Medical Treatment/Diagnostic Testing - The resident and his/her representative and the attending practitioner may, based on resident choices/directives, make decisions on whether to continue medications, treatments and/or diagnostic tests. This must be included in the resident's record. (For concerns related to choice, care planning decisions and right to discontinue treatments, refer to F552 and F553.);

- Symptom Management - Symptom management may include controlling nausea, vomiting, uncomfortable breathing, agitation, and pain. Symptom management may include both pharmacological and nonpharmacological interventions consistent with the resident's choices and goals for comfort, dignity and desired level of alertness. (For concerns related to medications, refer to F*605 Chemical Restraints/Unnecessary* Psychotropic Medications and F757 Unnecessary Medications);

- Nutrition and Hydration- The resident may experience a decline in appetite or have difficulty eating or swallowing. Care plan interventions, regarding nutrition/hydration, must be based upon the resident's assessment, disease processes, and resident choices/directives and include amount, type, texture and frequency for food and fluids. Dietary restrictions and/or weight measurements may be revised/discontinued based upon resident/representative and attending practitioner decisions, and must be included in the medical record. If the resident's condition has declined to the point where he/she may no longer swallow food or fluids, the determination of whether to use artificial nutrition/hydration, based upon resident choices/directives, is made by the resident/ representative and the attending practitioner, and consistent with applicable State law and regulation. (For concerns related to nutrition, refer to F692, for concerns related to nutrition/hydration, and for concerns related to feeding tubes, refer to F693.); and/or

- Activities/Psychosocial Needs - Care plan interventions for activities must be based on the resident's assessment and include the resident's choices, personal beliefs, interests, ethnic/cultural practices and spiritual values, as appropriate. In addition, the resident's assessment may identify psychosocial needs, such as fear, loneliness, anxiety, or depression. Interventions to address the needs must be included in the plan of care. (For concerns related to the provision of activities, refer to F679. For concerns regarding medically related social services, refer to F745.)

For concerns related to developing and implementing the care plan, refer to F656, Comprehensive Care Plans; and for revision of care plans refer to F657, Comprehensive Care Plan Revision.

Resident Care Policies

The facility in collaboration with the medical director must develop and implement resident care policies that are consistent with current professional standards of practice for not only pain management and symptom control, but for assessing residents' physical, intellectual, emotional, social, and spiritual needs as appropriate. In addition, if the facility has a written agreement with a Medicare-certified hospice, the policies must identify the ongoing collaboration and communication processes established by the nursing home and the hospice. (Refer to F841 - §483.70(*g*) Medical Director, or for the written agreement, to F849, §483.70(*n*) Hospice Services)

NOTE: If the resident has elected or is revoking the Medicare hospice benefit, a Significant Change in Status Assessment (SCSA) must be conducted as noted in the "Long Term Care Facility Resident Assessment Instrument User's Manual" (Version 3.0) Chapter 2:

- If a resident was admitted on the hospice benefit (i.e. the resident is coming into the facility having already elected the hospice benefit), the facility completes the required MDS admission assessment;

- If a terminally ill resident elects the hospice benefit after admission, a SCSA must be performed regardless of whether an MDS assessment was recently conducted on the resident. This is to ensure a coordinated care plan between the hospice and nursing home is in place; and

- A SCSA is required to be performed when a resident is receiving hospice services and decides to discontinue those services (revocation of the hospice benefit). (Refer to F637 significant change in status assessment)

Hospice Care and Services Provided by a Medicare-certified Hospice

Hospice care and services are based upon a written agreement between the nursing home and the Medicare-certified hospice (hereafter referred to as hospice or hospice services). (See F849 - Hospice Services). This section discusses the collaborative services provided by the nursing home and the hospice for a resident who is receiving hospice care and services.

A nursing home resident at the end of life may choose to elect the Medicare hospice benefit, or may choose to continue to receive the care and services provided by the nursing home. The resident considering election of the hospice benefit must meet the hospice eligibility requirements. According to 42 CFR §418.20, in order to be eligible to elect hospice care under Medicare, an individual must be –

(a) Entitled to Part A of Medicare; and

(b) Certified as being terminally ill in accordance with §418.22.

NOTE: Hospice is also an optional state plan benefit in the Medicaid program. If a resident who receives Medicaid chooses to elect the hospice benefit, the physician must provide written certification that the individual is terminally ill. (Refer to SSA Sec. 1905(o)(1)(A). [42 U.S.C. 1396d(o)(1)(A)]) If the resident is eligible for both Medicare and Medicaid, he/she must elect the hospice benefit simultaneously under both programs; and if the resident chooses to revoke the hospice benefit, he/she must revoke the benefit simultaneously under both of the programs.

There is no requirement that a nursing home offer hospice services. Although a resident may meet the eligibility requirements and may choose to elect the hospice benefit, the nursing home may or may not have an arrangement with a hospice to provide hospice care and services. If the nursing home has an agreement with a hospice, it must, consistent with F552, inform each resident before or at the time of admission, and periodically during the resident's stay, of hospice services available in the nursing home.

If a nursing home allows one or more hospice providers to provide services, there must be a written agreement between each hospice and the nursing home that describes their responsibilities prior to the hospice initiating care for the resident. (For the written agreement refer to F849 - Hospice Services.)

If the resident chooses to elect the hospice benefit, but has not chosen a hospice provider, and the nursing home does not have an agreement with a hospice provider:

- If the resident wishes, the nursing home must assist the resident with a transfer to another facility or appropriate setting where hospice services are provided; or

- The nursing home may choose to establish a written agreement with a hospice.

Coordinated Care Plan

The nursing home retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. It is the nursing home's responsibility to continue to furnish 24-hour room and board care, meeting the resident's personal care and nursing needs. The facility's services must be consistent with the care plan developed in coordination with the hospice, and the facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. Therefore, the nursing home resident should not experience any lack of services or personal care because of his or her status as a hospice patient. This includes what would normally be provided to a resident in the nursing home, including but not limited to the following: conducting the comprehensive assessments which includes the Resident Assessment Instrument (RAI), providing personal care, activities, medication administration, required physician visits, monthly medication regimen review, support for activities of daily living, social services as appropriate, nutritional support and services, and monitoring the condition of the resident. The facility

is required to develop and update the care plan in accordance with Federal, State or local laws governing the facility.

The hospice retains primary responsibility for the provision of hospice care and services, based upon the resident's assessments, including but not limited to the following: providing medical direction and management of the resident; nursing,(including assigning a hospice aide as needed to support the resident's ongoing care); counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. See 42 C.F.R. §418.112(c)(6).

NOTE: If there is an issue related to the provision of care by the hospice, the survey team may request the written agreement and review to see the steps the nursing home has taken to resolve the resident care issues. The written agreement should include how differences are resolved between the nursing home and the hospice, and the nursing home and hospice liaisons may need to be interviewed regarding the identified concerns. If there are concerns related to the provision of care based upon the failure of the implementation of the written agreement or the lack of a written agreement, refer to F849.

The resident/representative must be included in the development of the care plan, which must reflect the resident's choices to the extent possible. In order to address communication regarding the resident's care between the nursing home and the hospice, the nursing home must designate a staff person to participate in the ongoing communication and include the resident representative in decision-making. The nursing home should provide the name of the designated staff member/or designee to the resident/representative for ongoing communication regarding care or concerns. (Refer to F849 - Designated member of Interdisciplinary Group (IDG))

In order to provide continuity of care, the hospice, nursing home, and resident/representative must collaborate in the development of a coordinated care plan which includes, but is not limited to, the following:

- Resident/representative choices regarding care;
- The hospice philosophy of care and all services necessary for the palliation and management of the terminal illness and related conditions;
- Measurable goals and interventions based on comprehensive and ongoing assessments;
- Interventions that address, as appropriate, the identification of timely, pertinent non-pharmacologic and pharmacological interventions to manage pain and other symptoms of discomfort;

- The hospice portion that governs the actions of the hospice and describes the services that are needed to care for the resident;

- Identification of the services the nursing home will continue to provide; and

- The identification of the provider responsible for performing specific services/functions that have been agreed upon.

The structure of the care plan is established by the nursing home and the hospice. The care plan may be divided into two portions, one maintained by the nursing home and the other maintained by the hospice. The nursing home and the hospice must be aware of the location and content of the coordinated care plan (which includes the nursing home portion and the hospice portion) and the plan must be current and internally consistent in order to assure that the needs of the resident for both hospice care and nursing home care are met at all times. Any changes to the plan(s) must be discussed and approved by the nursing home, hospice staff and, to the extent possible, the resident and/or representative.

As the condition of the resident declines, the hospice and nursing home must continue a joint collaborative effort, which includes ongoing communication with and input from the resident/ representative, to assure that the care provided addresses concerns as identified in the ongoing assessments.

Physician Services

When a hospice patient is a resident of a nursing home, that resident's hospice care plan must be established and maintained in consultation with the resident's attending physician/practitioner, representatives of the nursing home and the resident/representative, to the extent possible. (See F710 – Physician supervision of care) In a nursing home, a physician's assistant may not act as the hospice attending physician, however, the resident's attending physician at the nursing home may delegate tasks to a physician's assistant. See F714 – physician delegation of tasks.

NOTE: For informational purposes, the definition of an attending physician as identified in the hospice federal regulations is provided below. This clarifies that a doctor of medicine, osteopathy or nurse practitioner, if meeting the listed requirements, may function as the "attending physician" in a hospice. The hospice regulations do not provide for a physician assistant to function in this category.

> §418.3 Definitions. For the purposes of this part — "Attending physician" means a —
> (1)(i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or
> (ii) Nurse practitioner who meets the training, education, and experience requirements as described in §410.75 (b) of this chapter.

(2) Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

Communication

Nursing home staff must immediately contact and communicate with the hospice staff regarding any significant changes in the resident's status, clinical complications or emergent situations. These situations may include but are not limited to changes in cognition or sudden unexpected decline in condition, a fall with a suspected fracture or adverse consequences to a medication or therapy, or other situations requiring a review or revision to the care plan. The immediate notification to hospice does not change the requirement that a nursing home also immediately notify the resident's attending physician/practitioner and the family resident representative of significant changes in condition or a need to change the care plan. (Refer to F580 - Notification of Changes) Prior to care plan or order changes, the hospice and the resident's attending physician/practitioner may need to collaborate to address this change and to assure the resident's immediate needs and treatment decisions are met, including situations which could require a potential transfer to an acute care setting. This decision making must be consistent with the resident's wishes. (Refer to F849 - Hospice Services.) Additionally, the communication of necessary information to the receiving provider must include those items required at§483.15(c)(2)(iii), *F628.*

If there is a conflict between the hospice and the resident's attending physician/practitioner regarding the care plan, there must be communication between the hospice and the nursing home regarding the issue. This communication should be timely and include the hospice medical director and the nursing home medical director as well as other pertinent hospice and facility staff, as needed.

The care of the resident receiving hospice services must reflect ongoing communication and collaboration between the nursing home and the hospice staff. It is essential that a communication process be established between the nursing home and the hospice to be used 24-hours a day and that it include how the communication will be documented to reflect concerns and responses. (Refer to F849 - which requires that the written agreement specify the process for hospice and nursing home communication of necessary information regarding the resident's care.)

Review of Facility Practices/Written Agreement for Hospice Services

Any concerns identified by the survey team related to end of life and/or care provided by a hospice should trigger a review of the facility's policies and procedures on end of life and hospice care and/or related policies (e.g., advance directives). In addition, the survey team should request a copy of the written agreement between the nursing home and the hospice. If there is a failure to develop and or implement portions of the written agreement with a hospice, refer to F849 - Hospice Services.

NOTE: Surveyors should refer the following concerns, as a complaint, to the State agency responsible for oversight of hospice for residents receiving Medicare-certified hospice services;

- Hospice failure to address and resolve concerns made known to them by the nursing facility which are related to coordination of care or implementation of appropriate services; and/or

- Hospice failure to provide services in accordance with the coordinated plan of care regardless of notice from the facility.

  In addition, if the hospice was advised of the concerns, and failed to resolve issues related to the management of a resident's care, coordination of care, or implementation of appropriate services, review the nursing home/hospice written agreement to determine whether there is a failure by the nursing home related to the implementation of the agreement at F849.

The survey team must refer the complaint to the State agency responsible for oversight of hospice, identifying the specific resident(s) involved and the concerns identified. If the hospice was advised of the concerns, and failed to resolve issues related to the management of a resident's care, coordination of care, or implementation of appropriate services, review the appropriate portions of F849 regarding the written agreement and determine whether there is a failure by the nursing home related to the implementation of the agreement.

INVESTIGATIVE PROTOCOL for F684 – Quality of Care Use

Use the General Critical Element (CE) Pathway, or if applicable, the Hospice and End of Life Care and Services CE Pathway, along with the above interpretive guidelines, or applicable professional standards of practice for investigating concerns related to the facility's requirement to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices – for which there is no other Quality of Care tag that would address the issue.

Summary of Investigative Procedure

Briefly review the most recent comprehensive assessments, comprehensive care plan and orders to identify whether the facility has recognized and assessed concerns or resident care needs under investigation. If the resident has been in the facility for less than 14 days (before completion of all the Resident Assessment Instrument (RAI) is required), review the baseline care plan which must be completed within 48 hours to determine if the facility is providing appropriate care and services based on information available at the time of admission.

This information will guide observations and interviews to be made in order to corroborate concerns identified. Make note of whether the comprehensive care plan is

evaluated and revised based on the resident's response to interventions. Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).

NOTE: *In addition to actual or potential physical harm,* always observe for visual cues of psychosocial distress and harm *and consider whether psychosocial harm has occurred when determining severity level* (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide *located in the Survey Resources zip file located at* https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes).

During the investigation, identify the extent to which the facility has developed and implemented interventions in accordance with the resident's needs, goals for care and professional standards of practice for the specific condition or concern being investigated. In any instance in which the surveyor has identified a lack of improvement or a decline, it must be determined whether this was unavoidable or avoidable. In order to make a determination of unavoidable decline or failure to reach highest practicable well-being, the facility must have:

- Conducted an accurate and comprehensive assessment (see §483.20 Resident Assessment) including evaluating the resident's clinical condition and risk factors for the concern being investigated;

- Based on information gathered through resident assessments, with resident/representative input, developed a person centered care plan, defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice;

- Implemented the care plan, and monitored resident responses to the interventions; and

- Provided ongoing review and revision of the care plan and interventions as necessary.

If the facility has not done one or more of the above bulleted items, and a decline or failure to reach his/her highest practicable well-being occurred, this would be considered an avoidable decline.

NOTE: During the investigation of services provided to a resident from a Medicare-certified hospice determine whether:

- The hospice was advised of concerns by the nursing home and failed to address and resolve issues related to coordination of care or implementation of appropriate services; and/or

- The hospice failed to provide services in accordance with the coordinated care plan, regardless of notice from the facility.

The survey team must refer the above concerns as complaints to the State agency responsible for oversight of hospice, identifying the specific resident(s) involved and the concerns identified. If the hospice was advised of the concerns, and failed to resolve issues related to the management of a resident's care, coordination of care, or implementation of appropriate services, review the appropriate portions of F849 regarding the written agreement and determine whether there is a failure by the nursing home related to the implementation of the agreement.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F684, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Provide needed care or services resulting in an actual or potential decline in one or more residents' physical, mental, and/or psychosocial well-being;

- Provide needed care or services (i.e., manage symptoms) resulting in one or more residents' failure to improve and/or attain their highest practicable physical, mental, and/or psychosocial well-being;

- Recognize and/or assess risk factors placing the resident at risk for specific conditions and/or problems;

- Implement resident-directed care and treatment consistent with the resident's comprehensive assessment and care plan, preferences, choices, rights, advance directives (if any, and if applicable, according to State law), goals, physician orders, and professional standards of practice, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems.;

- Monitor, evaluate the resident's response to interventions, and/or revise the interventions as appropriate, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems; and

- Inform and educate the resident who decides to decline care about risks/benefits of such declination; and offer alternative care options and take steps to minimize further decline, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems.

NOTE: Most noncompliance related to the failure to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being can also be cited at other regulations (e.g., assessment, care planning, accommodation of needs, and physician supervision). Surveyors should

evaluate compliance with these regulations and cite deficiencies at F684 only when other regulations do not address the deficient practice**.** Refer to F697 for pain management, and if there is a failure to develop and or implement portions of the written agreement with a hospice, refer to F849 - Hospice Services.

DEFICIENCY CATEGORIZATION

Examples of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety include but are not limited to:

- The facility failed to promptly identify and intervene for an acute change in a resident's condition related to congestive heart failure (CHF), resulting in the family calling 911 to transport the resident to the hospital. The resident was admitted to the hospital with respiratory distress, pulmonary edema, and complications of CHF.(Also cross-referenced and cited at F580, Notification of Changes.)

- As a result of the facility's continuous or repeated failure to implement comfort measures in accordance with the care plan, the resident experienced serious harm related to uncontrolled vomiting and nausea.

Examples of Severity Level 3 Noncompliance Actual Harm that is Not Immediate Jeopardy include, but are not limited to:

- The facility failed to provide care for a resident with a stasis ulcer as identified on the resident's care plan and physician's orders, resulting in worsening of the stasis ulcer, as evidenced by a large area of the skin surrounding the ulcer being reddened, swollen and, according to the nurse, warm to touch. There was exudate and slough on the wound bed, and according to measurements, the wound had increased in size.

- The facility failed to implement a resident's hospice/nursing home coordinated care plan that specified the resident not being transferred to the hospital for treatment. The facility transferred the resident to the hospital for treatment related to a urinary tract infection even though the resident and the coordinated care plan indicated the resident did not wish to be hospitalized and preferred treatment at the facility. The facility did not contact the hospice prior to initiating the transfer to the hospital. The resident experienced increased pain during the transfer to the hospital and continued to express emotional distress (tearful/crying) over the transfer.

- The resident had requested and the care plan included a symptom management plan with the use of medication to reduce the resident's symptoms but not to the point that the resident was symptom free so that the resident could be alert and able to participate in visits with family/friends. However, the facility failed to administer the medications as indicated in the plan of care. The resident