To cite deficient practice at F732, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Ensure staffing information was posted in a prominent place readily accessible to residents, *staff,* and visitors; **or**
- Ensure staffing information was accurate and current; **or**
- Ensure staffing information was complete and was not missing information (e.g. specific units were not reflected on the posting); **or**
- Make daily staffing available to the public for review upon request: **or**

Maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

F740

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

§483.40 Behavioral health services.

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

DEFINITIONS §483.40

Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being.

"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.

"Mental disorder" is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders - Fifth edition." 2013.

"Substance use disorder" ("SUD") is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Adapted from Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Substance Use Disorders." Accessed March 2, 2021. https://www.samhsa.gov/find-help/disorders.

GUIDANCE §483.40

Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

The behavioral health care needs of those with a SUD or other serious mental disorder should be part of the facility assessment under §483.7*1* (F838) and the facility should determine if they have the capacity, services, and staff skills to meet the requirements as discussed in F741.

Surveyors should be aware that all residents are screened for possible serious mental disorders or intellectual disabilities and related conditions prior to admission to determine if specialized services under Preadmission Screening and Resident Review (PASARR) requirements are necessary. If a resident qualifies for specialized Level II services under PASARR, please refer to §483.20(k) (F645), as well as §483.20(e) (F644). If the resident does not qualify for specialized services under PASARR, but requires more intensive behavioral health services (e.g., individual counseling), the facility must demonstrate reasonable attempts to provide for and/or arrange for such services. This would include ensuring that the type(s) of service(s) needed is clearly identified based on the individual assessment, care plan and strategies to arrange such services.

Behavioral health care and services could include:

- Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;
- Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.

- Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being. Residents living with mental health and SUDs may require different activities than other nursing home residents. Facilities must ensure that activities are provided to meet the needs of their residents.

  NOTE: For concerns related to the facility's activity program, or activities which do not address the needs of the resident, refer to §483.24(c), F679, Activities Meet Interest /Needs of Each Resident.

- Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;

- Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.

Individualized Assessment and Person-Centered Planning:

In addition to the facility-wide approaches that address residents' emotional and psychosocial well-being, facilities are expected to ensure that residents' individualized behavioral health needs are met, through the Resident Assessment Instrument (RAI) Process.
All areas are to be addressed through the:

- Minimum Data Set (MDS);

- Care Area Assessment Process;

- Care Plan Development;

- Care Plan Implementation; and

- Evaluation.

Sections of the MDS related to behavioral health needs that may be helpful include, but are not limited to:

Section C. Cognitive Patterns;

- Section D. Mood;

- Section E. Behavior; and

- Section F. Activities.

Utilizing Care Areas such as Psychosocial Well-Being, Mood State, and Behavioral Symptoms will also help to ensure the assessment and care planning processes are accomplished. It is also important for the facility to use an interdisciplinary team (IDT) approach that includes the resident, their family, or resident representative.

For residents with an assessed history of a mental disorder or SUD, the care plan must address the individualized needs the resident may have related to the mental disorder or the SUD. Some facilities may use behavioral contracts as part of the individualized care plan to address behaviors which could endanger the resident, other residents and staff. Behavioral contracts may be a method for encouraging residents to follow their plan of care. However, in some circumstances, using them to impose a system of rewards and/or punishments could be construed as meeting the definition of abuse which includes the willful infliction of punishment and/or the deprivation of goods and services. Please refer to §483.5 for the definition of abuse and §483.12 for requirements pertaining to abuse, neglect, and exploitation.

Additionally, behavioral contracts are only intended to be used for residents who have the capacity to understand them. The contract cannot conflict with resident rights or other requirements of participation (i.e., requirements at §483.15 related to admission, transfer, and discharge), but may address issues such as:

- Residents with mental disorder and/or SUD may be at increased risk for leaving the facility without facility knowledge (which could be considered an elopement) at various times throughout their treatment, or if going through active withdrawal. The facility should explain the resident's right to have a leave of absence and also explain the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA). The facility cannot restrict a resident's right to leave the facility, but a contract can distinguish between a leave of absence, elopement, and leaving AMA. (For concerns related to inadequate supervision resulting in elopement, see F689 - Free of Accidents Hazards/Supervision/Devices);

- Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable;

- Steps the facility may take if substance use is suspected, which may include:

    - Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents;
    - Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff (See F563 - Right to receive/deny visitors);

- Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition;

- Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others (See F557- Respect, Dignity/Right to have Personal Property); and

- Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons (See F557- Respect, Dignity/Right to have Personal Property).

Refusal to accept or non-adherence to the terms of a behavioral contract cannot be the sole basis for a denial of admission, a transfer or discharge. A facility may only transfer or discharge a resident for one of the reasons listed in F627, §483.15(c)(1)(i)(A)-(F). Rather, non-adherence to the contract should be treated like any care plan intervention that needs attention or needs to be altered to meet the needs of the resident. The IDT should work with the resident and resident representative to revise the care plan and contract.

The following section discusses general information pertaining to conditions that are frequently seen in nursing home residents and may require facilities to provide specialized services and supports that vary, based upon residents' individual needs.

Depression

Although people experience losses, it does not necessarily mean that they will become depressed. Depression (major depressive disorder or clinical depression) is a common and serious mood disorder. Symptoms may include fatigue, sleep and appetite disturbances, agitation, and expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation. Depression is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community. Late life depression may be harder to identify due to a resident's cognitive impairment, loss of functional ability, the complexity of multiple chronic medical problems that compound the problem, and the loss of significant relationships and roles in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

Adapted from the American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders - Fifth edition." 2013.

Anxiety and Anxiety Disorders

Anxiety is a common reaction to stress that involves occasional worry about circumstantial events. Anxiety disorders, however, could include symptoms such as excessive fear, intense anxiety, significant distress, and may cause debilitating symptoms. The distinction between general anxiety and an anxiety disorder is subtle

and can be difficult to identify. Accurate diagnosis by a qualified professional is essential. Anxiety can be triggered by loss of function, changes in relationships, relocation, or medical illness. Importantly, anxiety may also be a symptom of other disorders, such as depression and dementia in older adults, and care must be taken to ensure that other disorders are not inadvertently misdiagnosed as an anxiety disorder (or vice versa). There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-traumatic Stress Disorder.

Adapted from the American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders - Fifth edition." 2013.

Schizophrenia

Schizophrenia is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40. Schizophrenia must be diagnosed by a qualified practitioner, using evidence-based criteria and professional standards, such as the Diagnostic and Statistical Manual of Mental Disorders - Fifth edition (DSM-5), and documented in the resident's medical record. Symptoms of Schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and diminished expression or initiative. Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts. Hallucinations include a person hearing voices, seeing things, or smelling things others can't perceive.

Adapted from the:

- National Alliance on Mental Illness (NAMI). "Schizophrenia." Accessed March 2, 2021. https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia.

- American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders - Fifth edition." 2013.

Bipolar Disorder

Bipolar disorder is a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly. People with bipolar experience high and low moods—known as mania and depression—which differ from the typical ups-and-downs most people experience. Symptoms and their severity can vary. A person with bipolar disorder may have distinct manic or depressed states but may also have extended periods—sometimes years—without symptoms. A person can also experience both extremes simultaneously or in rapid sequence.

Adapted from NAMI. "Bipolar Disorder." Accessed March 2, 2021. https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder.

KEY ELEMENTS OF NONCOMPLIANCE §483.40

The facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being, meets each resident's needs, and includes individualized approaches to care.

To cite deficient practice at F740, the surveyor's investigation will generally show that the facility failed to:

- Identify, address, and/or obtain necessary services for the behavioral health care needs of residents;
- Develop and implement person-centered care plans that include and support the behavioral health care needs, identified in the comprehensive assessment;
- Develop individualized interventions related to the resident's diagnosed conditions (e.g., assuring residents have access to community substance use services);
- Review and revise behavioral health care plans that have not been effective and/or when the resident has a change in condition;
- Learn the resident's history and prior level of functioning in order to identify appropriate goals and interventions;
- Identify individual resident responses to stressors and utilize person-centered interventions developed by the IDT to support each resident; or
- Achieve expected improvements or maintain the expected stable rate of decline based on the progression of the resident's diagnosed condition.

Investigating Concerns Related to Behavioral Health Services

Use the Behavioral and Emotional Status Critical Element Pathway (CMS-20067), along with guidance, when determining if the facility meets the requirements pertaining to the behavioral health care needs of their residents. The facility must provide the necessary behavioral health care and services to support the resident in attaining or maintaining the highest practicable physical, mental, and psychosocial well-being.

Review, as needed, all appropriate resident assessments, associated care planning and care plan revisions, along with physician's orders to identify initial concerns and guide the investigation. Review the Minimum Data Set (MDS) and other supporting

documentation to help determine if the facility is in compliance. Observe for evidence that behavioral health care needs are met and related services are provided. Staff are expected to assess and provide appropriate care for residents with behavioral health care needs. Interview the resident, his/her family, and/or representative and the IDT, as needed, to gather information about the behavioral health care and services in the nursing home. Corroborate the information obtained and any concerns noted during the survey, by building upon the investigation through additional observations, interviews, and record review. For additional guidance, see also the Psychosocial Severity Outcome Guide at the CMS Nursing Homes Survey Resources website that can be accessed by visiting https://www.cms.gov/files/zip/survey-resources-10262022.zip.

DEFICIENCY CATEGORIZATION §483.40

An example of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or Safety includes, but is not limited to:

- A resident was admitted to the facility one month ago with diagnoses of major depression, SUD, and a history of a suicide attempt. After admission, the resident continuously expressed wanting to die and often yelled and cursed at staff members. The attending physician ordered a psychological evaluation, an antidepressant, and 30 minute checks which were implemented by the facility. Record review showed that the psychological evaluation recommended the use of several non-pharmacological behavioral health interventions, which were not implemented. During additional record review and an interview with the nurse it was revealed that the resident was found hanging from his closet bar with a sheet tied around his neck, and no pulse. CPR was started and the resident was resuscitated.

The facility failed to adequately meet a resident's mental health needs when it did not address non-pharmacological approaches to care.

An example of Severity Level 3 Non-compliance: Actual Harm that is not Immediate Jeopardy includes, but is not limited to:

- A resident was admitted to the facility with a diagnosis of post-traumatic stress disorder, from war related trauma. The resident assessment identified that certain environmental triggers such as loud noises and being startled caused the resident distress and provoked screaming. The resident's care plan identified that his environment should not have loud noises and that staff should speak softly to the resident. Observations in the home revealed that the entry and exit doors had alarms that sounded with a loud horn each time they were opened. Additionally, staff were observed approaching the resident from behind and shaking his shoulder to get his attention. The resident was startled and screamed for fifteen minutes. The director of nursing (DON) stated that they hoped he would eventually get used to living in the home.

The facility identified triggers that were known to cause the resident distress and developed a care plan to support the resident's behavioral health care needs. However, the facility failed to implement the care planned approaches to care.

Examples of Severity Level 2: No Actual Harm with Likelihood for More Than Minimal Harm that is Not Immediate Jeopardy, include:

- A resident with a diagnosed anxiety disorder preferred staff to announce themselves before entering his room. His care plan identified the non-pharmacological approach of staff knocking on his door and requesting permission before entering. This had proved effective in reducing his anxiety.

  When interviewed, the resident indicated that facility staff usually followed this direction. He feels anxious on weekends when the workers from a temporary staffing agency provide care, because they frequently enter his room without asking permission. Although this increases his anxiety, he tries to live with it, but wished the nursing home would do something about it. During an interview, the DON mentioned that he was not aware of the resident's concern and that it was difficult to control all staff interactions with the resident. However, the DON agreed to investigate the situation and work to find a resolution.

  The facility failed to ensure that all staff members, both those employed by the nursing home and those from the staffing agency, respected the privacy of each resident by announcing themselves prior to entering resident rooms. This led to increased anxiety for the resident.

Severity Level 1: No Actual Harm with Likelihood for Minimal Harm

Severity Level 1 does not apply for this regulatory requirement because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. Because more than minimal harm is likely, any deficiency for this requirement is at least a Severity Level 2. For additional guidance, see also the Psychosocial Outcome Severity Guide at the CMS Nursing Homes Survey Resources website that can be accessed by visiting https://www.cms.gov/files/zip/survey-resources-10262022.zip.

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION:

If there are concerns regarding the provision of dementia care treatment and services, review regulatory requirements at §483.40(b)(3) (F744).

If there are indications that a resident is in a secured/locked area without a clinical justification and/or placement is against the will of the resident, their family, and/or resident representative, review regulatory requirements at §483.12 and §483.12(a) (F603), Involuntary Seclusion.

If there are concerns about the resident assessment process to review for mood and psychosocial well-being see §483.20 (F636, F637, or F641), Resident Assessment.

Some resources pertaining to behavioral health care and services can be found by visiting:

- SAMHSA. Accessed March 2, 2021. http://www.samhsa.gov/.
  This website provides numerous resources with the mission to reduce the impact of substance abuse and mental illness on America's communities.

- NAMI. Accessed March 2, 2021. https://www.nami.org/.
  This website provides resources dedicated to building better lives for the millions of Americans affected by mental illness.

- National Institute of Mental Health (NIMH). Accessed November 9, 2022.https://www.nimh.nih.gov/.
  This website provides resources for the understanding and treatment of mental illnesses.

- National Long-term Care Ombudsman Resource Center. Accessed March 2, 2021. https://ltcombudsman.org/.
  This website is filled with information, resources, and news from Ombudsman programs to support and inform programs across the country.

- MentalHealth.gov. Accessed March 2, 2021. https://www.mentalhealth.gov/.
  This website provides one-stop access to U.S. government mental health and mental health problems information.

- SAMSHA. "Anger Management for Substance Use Disorder and Mental Health Clients: Participant Workbook." Accessed March 2, 2021. https://store.samhsa.gov/sites/default/files/d7/priv/anger_management_workbook_508_compliant.pdf.

  This workbook is designed for people living with a mental illness and/or substance use disorder who participate in group cognitive behavioral therapy sessions pertaining to anger management. It summarizes core concepts for each session, and includes worksheets and homework assignments.

- NIMH. "Schizophrenia." Accessed November 9, 2022. https://www.nimh.nih.gov/health/topics/schizophrenia.
  This brochure describes symptoms, causes, and treatments for schizophrenia with information on ways to get help and cope effectively.
- NIMH. "Bipolar Disorder." Accessed November 9, 2022. https://www.nimh.nih.gov/health/topics/bipolar-disorder.