This brochure describes symptoms, causes, and treatments for bipolar disorder with information on ways to get help and cope effectively.

- NIMH. "Post-Traumatic Stress Disorder." Accessed November 9, 2022. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd. This brochure describes symptoms, causes, and treatments for post-traumatic stress disorder with information on ways to get help and cope effectively.

- NIMH. "Anxiety Disorders." Accessed November 9, 2022.
- https://www.nimh.nih.gov/health/topics/anxiety-disorders.
  This brochure describes symptoms, causes, and treatments for anxiety disorders with information on ways to get help and cope effectively.

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

- NIMH."Generalized Anxiety Disorder (GAD): When Worry Gets Out of Control." Accessed November 9, 2022. https://www.nimh.nih.gov/health/publications/generalized-anxiety-disorder-gad.

  This brochure discusses signs and symptoms, diagnosis, and treatment options for GAD

  References to non-CMS sources are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

F741

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

§483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.7*1*. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.7*1*, and

§483.40(a)(2) Implementing non-pharmacological interventions.

INTENT §483.40(a), (a)(1) & (a)(2)

The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.7*1*. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment. Facility staff members must implement person-centered care approaches designed to meet the individual goals and needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.

NOTE: For sufficient staffing concerns that fall outside the scope of behavioral health care, review regulatory requirements at §483.35(a) (F725), Sufficient Nursing Staff and §483.35(a)(3) (F726), Competent Nursing Staff.

DEFINITIONS §483.40(a), (a)(1) & (a)(2)

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

"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.

"Trauma" results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA."SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach."July 2014. Accessed February 25, 2021.

https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf.

"Post-traumatic stress disorder" occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD.

National Institute of Mental Health. "Post-Traumatic Stress Disorder." Accessed November 9, 2022, https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd. This brochure describes symptoms, causes, and treatments for post-traumatic stress disorder with information on ways to get help and cope effectively.

"Non-pharmacological intervention" refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.

GUIDANCE §483.40(a), (a)(1) & (a)(2)

Sufficient Staff to Provide Behavioral Health Care and Services

The facility must address in its facility assessment under §483.7*1* (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs.

If a resident qualifies for specialized Level II services under PASARR, please refer to §483.20(k) (F645). 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 types of service(s) needed is clearly identified based on the individual assessment, care plan and strategies to arrange such services.

Facilities must have sufficient direct care staff (nurse aides and licensed nurses) with knowledge of behavioral health care and services in accordance with the care plans for all residents, including those with mental or psychosocial disorders, SUDs, as well as residents with a history of trauma and/or PTSD.

Facilities may be concerned about accessing sufficient professional behavioral health resources (e.g., psychiatrists) to meet these requirements due to shortages in behavioral and mental health providers in their area. A facility will not be cited for non-compliance if there are demonstrated attempts to access such services.
Facilities are not expected to provide services that are not covered by Medicare or Medicaid. They are expected to take reasonable steps to seek alternative sources (state, county or local programs) but if they are not successful, it is not the basis for a deficient practice.

Skill and Competency of Staff

The facility must identify the skills and competencies needed by staff to work effectively with residents (both with and without mental disorders, psychosocial disorders, SUDs, a history of trauma, and/or PTSD). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through the facility assessment. The facility assessment must include an evaluation of the overall number of facility staff needed to ensure that a sufficient number of qualified staff are available to meet each resident's needs. Furthermore, the assessment should include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. This also includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care identified.

Once the necessary skills and competencies are identified, staff must be aware of those disease processes and disorders (e.g. SUDs) that are relevant to each resident to enhance the resident's psychological and emotional well-being. Competency is established by observing the staff's ability to use this knowledge through the demonstration of skill and the implementation of specific, person-centered interventions identified in the care plan to meet residents' behavioral health care needs. Additionally, competency involves staff's ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements.

Under §483.152, Requirements for approval of a nurse aide training and competency evaluation program, nurse aides are required to complete and provide documentation of training that includes, but is not limited to, competencies in areas such as:

- Communication and interpersonal skills;
- Promoting residents' independence;
- Respecting residents' rights;
- Caring for the residents' environment;
- Mental health and social service needs; and
- Care of cognitively impaired residents.

All staff must have knowledge and skills sets to effectively interact with residents (communication, resident rights, meaningful activities.) Person-centered approaches to care should be implemented based upon the comprehensive assessment, in accordance with the resident's customary daily routine, life-long patterns, interests, preferences, and choices, and should involve the interdisciplinary team (IDT), the resident, resident's

family, and/or representative(s). The IDT should be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress and/or re-traumatization. Identifying the frequency, intensity, duration, and impact of a resident's expressions or indications of distress, as well as the location, surroundings or situation in which they occur, may help the IDT identify individualized interventions or approaches to care to support the resident's goals and needs. Individualized, person-centered approaches to care must be implemented to address expressions or indications of distress. Staff must also monitor the effectiveness of the interventions, changing those approaches, if needed, in accordance with current standards of practice. Additionally, they must accurately document these actions in the resident's medical record and provide ongoing assessment as to whether they are improving or stabilizing the resident's status or causing adverse consequences.

The following discussion of non-pharmacological interventions supports all residents, however, residents living with behavioral health needs may require a more formalized, documented intervention plan.

Non-pharmacological Interventions

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs of all ages may include, but are not limited to:

- Ensuring adequate hydration and nutrition (e.g., enhancing taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); exercise; and pain relief;

- Individualizing sleep and dining routines, as well as schedules to use the bathroom, to reduce the occurrence of incontinence, taking into consideration the potential need for increased dietary fiber to prevent or reduce constipation, and avoiding, where clinically inappropriate, the use of medications that may have significant adverse consequences (e.g., laxatives and stool softeners);

- Adjusting the environment to be more individually preferred and homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);

- Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment);

- Supporting the resident through meaningful activities that match his/her individual abilities (e.g., simplifying or segmenting tasks for a resident who has trouble following complex directions), interests, goals, and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns (e.g., providing an early morning activity for a farmer used to waking up early);

- Assisting the resident outdoors in the sunshine and fresh air (e.g. in a non-smoking area for a non-smoking resident);

- Providing access to pets or animals for the resident who enjoys pets (e.g. a cat for a resident who used to have a cat of their own);

- Assisting the resident to participate in activities that support their spiritual needs;

- Assisting with the opportunity for meditation and associated physical activity (e.g. chair yoga);

- Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;

- Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing;

- Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible;

- Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy; and

- Providing support with skills related to verbal de-escalation, coping skills, and stress management.

For additional guidance and examples of individualized non-pharmacological interventions, see §483.24(c) (F679), Activities.

While there may be situations where a pharmacological intervention is indicated first, these situations do not negate the obligation of the facility to also develop and implement appropriate non-pharmacological interventions.

NOTE: This guidance is not intended to exclude the use of pharmacological interventions when they are clinically necessary and appropriate. Please see the Pharmacy Services section under §483.45(d) (F757), Unnecessary Drugs and §483.45(e) (F*605*), *Chemical Restraints/Unnecessary* Psychotropic Drugs for additional guidance.

INVESTIGATIVE PROTOCOL §483.40(a), (a)(1) & (a)(2)

Determination of Sufficient Staffing

One factor used to determine sufficiency of staff (including both quantity and competency of staff) is the facility's ability to provide needed care for residents as determined by resident assessments and individual care plans. A staffing deficiency must be supported by examples of care deficits caused by insufficient quantity or competency of staff. The surveyor's investigation will include whether inadequate quantity or competency of staff prevented residents from reaching the highest practicable level of well-being.

A deficiency of insufficient staffing is determined through observations, interviews, and/or record reviews. Information gathered through these sources will help the surveyor in determining non-compliance. Concerns such as expressions or indications of distress by residents or family members, residents living with mental, psychosocial, and/or SUDs, as well as residents with a history of trauma and/or PTSD who lack care plan interventions to address their individual goals, needs, lack of resident engagement, and the incidence of elopement and resident altercations, can also offer insight into the sufficiency and competency of staff and the adequacy of training provided to them to care for residents with behavioral health needs.

Determination of Staff Competencies

As required under §483.7*1* (F838), the facility's assessment must include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. The facility must have a process for evaluating these competencies.

If sufficient and/or competent staffing concerns are present during the surveyor's investigation or while completing the Sufficient and Competent Staffing Facility Task, refer to the Behavioral and Emotional Status (CMS-20067) Critical Element Pathway.

KEY ELEMENTS OF NONCOMPLIANCE §483.40(a), (a)(1) & (a)(2)
To cite deficient practice at F741, the surveyor's investigation will generally show that the facility failed to:

- Rule out underlying causes for the resident's behavioral health care needs through assessment, diagnosis, and treatment by qualified professionals, such as physicians, including psychiatrists or neurologists;

- Identify competencies and skills sets needed in the facility to work effectively with residents with mental disorders and other behavioral health needs;

- Identify the signs and symptoms of substance use in a resident with SUD;

- Provide care, in accordance with the individualized care plan, that meets the needs of residents with mental disorders, substance use disorders, a history of past trauma, and other behavioral health needs;

- Provide sufficient staff who have the knowledge, training, competencies, and skills sets to address behavioral health care needs;

- Demonstrate reasonable attempts to secure professional behavioral health services, when needed;

- Utilize and implement non-pharmacological approaches to care, based upon the comprehensive assessment and plan of care, and in accordance with the resident's abilities, customary daily routine, life-long patterns, interests, preferences, and choices;

- Monitor and provide ongoing assessment of the resident's behavioral health needs, as to whether the interventions are improving or stabilizing the resident's status or causing adverse consequences; or

- Attempt alternate approaches to care for the resident's assessed behavioral health needs, if necessary.

NOTE: In the case of a negative resident outcome, the surveyor must investigate whether or not the facility considered all relevant factors that may have contributed to the outcome. Doing so, while also using the points described in the key elements, will assist the survey team in determining if an identified concern was avoidable or unavoidable.

DEFICIENCY CATEGORIZATION §483.40(a), (a)(1) & (a)(2)

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

- The care plan of a resident, diagnosed with depression and suicidal ideation, included close supervision and one-on-one activities with staff. Based upon documentation in the resident's record, the resident was often isolated in her room and increasingly spoke of wanting to die. Additionally, the resident had recently been transported to an acute care facility for a psychiatric evaluation, when she threatened to harm herself and was deemed inconsolable by facility staff. During an interview, the Director of Nursing (DON) indicated that on many evening and weekend shifts the facility did not have enough staff to provide close supervision or one-on-one activities for the resident. No other alternative arrangements had been developed, care planned, or implemented to ensure the resident's behavioral health needs were met.

The facility lacked sufficient staff with the required skills sets to implement the resident's care planned interventions. This led to increased expressions of distress and a threat of personal harm, resulting in the deterioration of the resident's mental and psychosocial well-being.

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

- Facility staff failed to intervene when a visibly agitated and confused resident was pacing the hallways. Record review showed that these expressions of distress had occurred during the late afternoon and early evening for the past three weeks. A CNA told the surveyor that the DON said the resident had "sundowning;" however, when asked, she was unable to explain what that meant or what individualized interventions should be implemented. She was told to leave the resident alone and let him tire himself out.

The facility lacked competent staff with the knowledge and skills sets to support and assist the resident who was experiencing agitation and confusion on a daily basis. This resulted in increased distress over the course of several weeks, without the development and implementation of individualized, non-pharmacological approaches to care.

An example of Severity Level 2 Non-compliance: No Actual Harm with Likelihood for More Than Minimal Harm that is Not Immediate Jeopardy includes, but is not limited to:

- The facility failed to have sufficient numbers of staff who had the skills and competencies to monitor a resident with SUD and who had just returned from a leave of absence (LOA). The resident had a history of substance abuse when on LOA, and had care plan interventions indicating to monitor every 15 minutes for signs and symptoms of substance use, which included changes in behavior, slowed respirations and somnolence.

Upon interview of the nurse's aide assigned to monitor this resident, the aide did not know what somnolence was, and could not state what a normal respiratory rate was. The aide also stated that he or she had never been assigned to this resident before and was unaware of what the resident's baseline behaviors were. Therefore, the aide could not state if he or she had observed any changes in the resident's behaviors. This was the only aide working the unit when the resident returned from LOA.

- A surveyor heard a resident complaining to nursing home staff that he was late for his meeting again. The resident told the surveyor that he has missed his weekly Alcoholics Anonymous (AA) meeting held at the local church for the last three weeks and that this made him angry. Record review showed that attendance at these meetings was a part of his care plan. During an interview, a CNA, who helps the resident with his activities of daily living (ADL) on a consistent basis, stated that she was busy and did her best to make sure he was ready when his transportation arrived.

The facility failed to implement the resident's care planned interventions, causing him to consistently miss his AA meetings. This led to feelings of anger and had the potential to jeopardize the resident's sobriety.