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 the CMS Nursing Homes Survey Resources website that can be accessed by visiting https://www.cms.gov/files/zip/survey-resources-10262022.zip.

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F742

(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

§483.40(b)(1)
A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

DEFINITIONS §483.40(b) & §483.40(b)(1)
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 and psychosocial adjustment difficulty" refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms. (Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.).

INTENT §483.40(b) & §483.40(b)(1)
The intent of this regulation is to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being. Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a

history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.

GUIDANCE §483.40(b) & §483.40(b)(1)
Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (PTSD) require specialized care and services to meet their individual needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.

For additional information regarding non-pharmacological interventions, see §483.40(a)(2) (F741), Implementing non-pharmacological interventions.

What is appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being?

The facility must provide the "appropriate treatment and services" to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. The determination of what is "appropriate" is person-centered and would be based on the individualized assessment and comprehensive care plan. To the extent that the care plan identifies particular treatment and services, the facility must make reasonable attempts to provide these services directly or assist residents with accessing such services.

A facility must determine through its facility assessment what types of behavioral health services it may be able to provide. Some examples of treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for autonomy; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. The coping skills of a person with a history of trauma or PTSD will vary, so assessment of symptoms and implementation of care strategies should be highly individualized. Facilities should use evidence-based interventions, if possible.

Background on Trauma and PTSD
A close relationship exists between mental and psychosocial adjustment difficulties, histories of trauma, and PTSD.

- Adjustment difficulties:
    - Occur within 3 months of the onset of a stressor and last no longer than 6 months after the stressor or its consequences have ended;
    - Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural

factors, and/or a significant impairment in social, occupational, or other important areas of functioning;
    - May be related to a single event or involve multiple stressors and may be recurrent or continuous;
    - May cause a depressed mood, anxiety, and/or aggression;
    - May be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief exceeds what normally might be expected; and
    - Can occur for individuals with or without PTSD or a history of trauma.

- History of trauma:

    - Involves psychological distress, following a traumatic or stressful event, that is often variable;
    - May be connected to feelings of anxiety and/or fear;
    - Often involves expressions of anger or aggressiveness; and
    - Some individuals who experience trauma will develop PTSD.

- PTSD:

    - Involves the development of symptoms following exposure to one or more traumatic, life-threatening events;
    - Usually develops within the first 3 months after the trauma occurs, although there may be a delay in months or even years;
    - Symptoms may include, but are not limited to, the re-experiencing or re-living of the
      stressful event (e.g., flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g., outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g., detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g., increased startle response or difficulty sleeping); and
    - May be severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture or sexual violence).

(Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013.)

Although PTSD is commonly viewed as a disorder experienced only by military veterans, it is not exclusively a consequence of combat or war zone exposure. Individuals who have been physically or sexually assaulted or who experienced a terrorist attack or natural disaster, among other things may also be affected by PTSD. Additionally, some older nursing home residents may have lived through a time of genocide and witnessed or been subjected to the intentional and systematic destruction of a racial, political, or cultural group such as that which occurred during the Holocaust in World War II.

Moving from the community into a long-term care facility, for an individual with a history of trauma or PTSD, can be a very difficult transition and cause worsening or reemergence of symptoms. Additionally, the structured environment of the nursing home can trigger memories of traumatic events and coping with these memories may be more difficult for older adults.

KEY ELEMENTS OF NONCOMPLIANCE §483.40(b) & §483.40(b)(1)
To cite deficient practice at F742, the surveyor's investigation will generally show that the facility failed to:

- Assess the resident's expressions or indications of distress to determine if services were needed;
- Provide services and individualized care approaches that address the assessed needs of the resident and are within the scope of the resources in the facility assessment;
- Develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident;
- Assure that staff consistently implement the care approaches delineated in the care plan;
- Monitor and provide ongoing assessment as to whether the care approaches are meeting the emotional and psychosocial needs of the resident; or
- Review and revise care plans that have not been effective and/or when the resident has a change in condition and accurately document all of these actions in the resident's medical record.

NOTE: For behavioral health care concerns that do not pertain to residents who display or are diagnosed with a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder, review regulatory requirements at §483.40 (F740), Behavioral Health Services.

INVESTIGATIVE PROTOCOL §483.40(b) & §483.40(b)(1)

Objectives
The objectives of this protocol are to determine, based on the comprehensive assessment of a resident, that the facility ensured that the resident who displays or is diagnosed with a mental or psychosocial adjustment difficulty, or who has a history of trauma and/or PTSD receives the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning.

Procedures
In order to guide observations, briefly review the comprehensive assessment and interdisciplinary care plan.

Observations

Observe for manifestations related to mental and psychosocial adjustment difficulties, a history of trauma and/or PTSD which may, over a period of time, include:

- Impaired verbal communication without physiological cause;
- Social isolation and withdrawal inconsistent with the resident's usual demeanor;
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Deviation from past spiritual beliefs or rituals (alterations in one's belief system);
- Inability to control behavior, anger, and the potential for physical harm to oneself or others; and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

NOTE: Observe staff interactions with the resident in formal and informal situations and determine whether or not they implement interventions in accordance with the care plan.

Interviews
Resident/Resident Representative
Interview the resident, resident's family, or representative(s), to the degree possible, to determine:

- Awareness of the current condition(s) or history of the condition(s) or diagnosis/diagnoses;
- Participation in the development of a person-centered care plan;
- Whether or not resident choices and preferences are considered; and
- Validity of observations and data collection.

Staff Interviews

Interview IDT member(s) as necessary to determine:

- Whether or not care provided is consistent with the care plan; and
- That staff are knowledgeable about how to support the resident when they are expressing or indicating feelings of distress;

Additionally, speaking to staff on various shifts can help to determine:

- Staff knowledge of facility-specific guidelines and protocols related to the treatment of mental disorders and psychosocial adjustment difficulties, history of trauma, and PTSD;
- Whether certified nurse aides (CNA) know how, what, when, and to whom to report changes in condition;
- How facility staff monitor care plan implementation, and changes in condition; and
- How changes in both the care plan and the resident's condition are communicated to the staff.

Record Review

- Identify if the resident triggers Care Area Assessments (CAA) for activities, mood state, psychosocial well-being, and psychotropic drug use.
  - Consider whether the CAA process was used to assess the causal factors for decline, potential for decline, or lack of improvement.
- Review the resident's care plan for interventions to address the assessed problem.
- How are mental and psychosocial adjustment difficulties, a history of trauma, and/or PTSD addressed in the care plan?
  - Does it describe the expressions or indications of distress that the resident has experienced because of the assessed problem?
  - Does it describe the programs and activities that have been implemented to assist the resident in reaching and maintaining the highest level of mental and psychosocial functioning?
  - Is the care plan written in measurable language that allows assessment of its effectiveness?
- Are the data to be collected to evaluate the effectiveness of the care plan identified?
- Are the data collection done according to the care plan?
- Is there an assessment of the resident's usual and customary routines and preferences?
  - Are accommodations made by the facility to support the resident by incorporating these routines and preferences in the care plan?
- Does record review indicate that the care and services outlined in the care plan are effective in decreasing the resident's expressions or indications of distress?
- If the data collected indicate that expressions or indications of distress are unchanged in frequency or severity over two or more assessment periods, is the plan reassessed and intervention approaches revised to support the resident in attaining the highest practicable mental and psychosocial well-being?

NOTE: Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty may include, but are not limited to:

- Metabolic or endocrine disorders (e.g., Cushing's disease, diabetes/hypoglycemia, hypothyroidism);
- Central nervous system disorders (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease);
- Miscellaneous conditions (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure, hypotension, dehydration, circadian rhythm disruption);
- Over-medication for treatment of other conditions; and
- Use of restraints.

DEFICIENCY CATEGORIZATION §483.40(b) & §483.40(b)(1)

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

- A surveyor observed a resident, who was crying and exhibiting signs of distress, lying in bed in her room. During an interview, the resident told the surveyor that she had lost all hope, felt betrayed by her family and her faith, and was ready to die. The resident shared that her children sold her house before she came to the nursing home, but that she had planned to go back there to live once her health improved. The resident added that she had lived in that house for 55 years, raising her children and enjoying life. Record review showed that upon admission, the resident indicated her goal was to return home, but also that her house had been sold by her family.

  Facility progress notes documented increased anxiety and depressive mood, as well as isolation from activities she had previously enjoyed, including attendance at religious services. Additionally, the resident had stopped eating or drinking. She was receiving IV fluids and the insertion of a feeding tube was being considered.

  An interview with the Care Plan Coordinator confirmed that the facility failed to develop an individualized care plan that addressed the assessed emotional and psychosocial needs of the resident. During an interview with the social worker, she indicated that she had been aware the house sold, but did not realize the resident was so distraught about it.

  The facility failed to acknowledge and assess the underlying causes of the resident's expressions of distress or develop and implement a care plan that addressed this distress. This resulted in the deterioration of the resident's physical, 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:

- The facility determined that a resident's resistance to receiving staff assistance in the shower was a result of a traumatic event that occurred at home years ago when a home health aide left her in the shower unattended and she fell, fracturing her hip. The resident has never been able to return home since the event and is distrustful of the nursing home staff. Interventions listed on the care plan specified that she is to be assisted by two staff members in the shower. The resident is to be approached in an unhurried manner, with calm voices and soft lighting.

  The surveyor observed the resident in the shower with only one certified nurse aide (CNA) in attendance and harsh lighting. During the shower the resident demonstrated anxiety and fear. She was yelling, crying, restless, and tried to get out of the shower chair many times during care. When observed 30 minutes

after her shower, the resident was no longer yelling, however she still appeared fearful and her crying was just beginning to resolve.

An interview with the CNA and director of nursing confirmed that the care plan interventions had not been followed.

The facility failed to ensure that a resident, who has a history of trauma, received the appropriate treatment and services to reduce her anxiety and fear in the shower. Care planned interventions were not implemented, leading to increased expressions of distress by the resident and a decline in her mental and psychosocial well-being.

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:

- A surveyor heard a resident yelling for help. Facility staff and the surveyor followed the sound to the resident's room where they found her lying in bed in a darkened room, clinging tightly to her wallet and blanket. The staff turned on the lights to assist in calming her down.

  During an interview later that day, the resident shared that she had been robbed at knife point in her own home prior to being admitted to the nursing home last year. She also mentioned that, although she felt secure in the nursing home, she still had nightmares sometimes and the nurses are supposed to leave her bathroom light on at night. The resident also asked to be moved to a room closer to the nursing station, but that had not happened yet.

  Record review of the resident's assessment and care plan documented that the resident did have care planned interventions regarding her increased need for reassurance, due to the robbery prior to admission. Interventions included leaving the resident's bathroom light on at night.

  Interviews with facility staff confirmed that they sometimes forget to leave the bathroom light on at night for the resident. Additionally, the social worker confirmed that the possibility of a room closer to the nursing station had not yet been investigated.

  The facility failed to implement person-centered, non-pharmacological approaches to care for a resident, with a history of trauma, causing the resident increased distress and fear.

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