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.

F743

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

§483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

INTENT §483.40(b)(2)

The intent of this regulation is to ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder (PTSD), does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors while residing in the facility. However, after admission, if the resident is diagnosed with a condition that typically manifests a similar pattern of behaviors, documentation must validate why the pattern was unavoidable (e.g., symptoms did not initially manifest, family was unaware of previous trauma or were unavailable for interview, etc.). Development of an unavoidable pattern of behaviors refers to a situation where the interdisciplinary team, including the resident, their family, and/or resident representative, has completed comprehensive assessments, developed and implemented individualized, person-centered approaches to care through the care-planning process, revised care plans accordingly, and behavioral patterns still manifest.

GUIDANCE §483.40(b)(2)

Nursing home admission can be a stressful experience for a resident, his/her family, and/or representative. Behavioral health is an integral part of a resident's assessment process and care plan development. The assessment and care plan should include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Facility staff must:

- Monitor the resident closely for expressions or indications of distress;
- Assess and plan care for concerns identified in the resident's assessment;
- Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;
- Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;
- Ensure appropriate follow-up assessment, if needed; and

- Discuss potential modifications to the care plan.

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

KEY ELEMENTS OF NONCOMPLIANCE §483.40(b)(2)
To cite deficient practice at F743, the surveyor's investigation will generally show the facility failed to:

- Identify that a resident developed decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, and may have made verbalizations indicating these;
- Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable;
- Ensure an accurate diagnosis of a mental disorder or psychosocial adjustment difficulty, or PTSD was made by a qualified professional;
- Adequately assess and/or develop care plans for services and individualized care
- approaches that support the needs of residents who develop these patterns;
- Provide services with an individualized care approach that support the needs of residents with these indicators;
- Provide staff with training opportunities related to the person-centered care approaches that have been developed and implemented;
- Assure that staff consistently implement the approaches delineated in the care plan;
- Monitor and provide ongoing assessment as to whether the care approaches are meeting the needs of the resident; or
- Review and revise care planned interventions and accurately document the reason for revision in the resident's medical record.

INVESTIGATIVE PROTOCOL §483.40(b)(2)

Objectives
The objective of this protocol is to determine whether or not the facility meets the regulatory requirements for a resident who has displayed a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive expressions or indications of distress.

Procedures
Briefly review the comprehensive assessment and interdisciplinary care plan to guide observations.

Observations
Observe residents who appear to be isolated, withdrawn, angry, or have other expressions or indications of mental or psychosocial difficulties, a history of trauma and/or PTSD. Additionally, observations may include, but are not limited to:

- Staff and resident interactions;
- Demonstration of the staff's understanding, responsiveness, and proactive care for residents' needs; and
- Implementation of care plan interventions by staff.

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

- The level of social interaction and distress that was present upon admission;
- Whether social interaction has diminished or increased since admission;
- If withdrawal, anger, and depressive expressions or indications of distress have increased without a change in the resident's clinical condition;
- Participation in the development of a person-centered care plan; and
- Whether or not resident choices and preferences are considered.

Staff Interviews
In the case where staff members have noted changes in a resident's social interactions and behaviors after admission to the facility, and the care plan does not reflect these changes, the surveyor must:

Interview IDT member(s) as necessary to determine:

- Whether or not facility staff are aware of changes in the resident's social interactions and/or behavior;
- That staff are knowledgeable about how to support the resident when they are expressing or indicating feelings of distress;
- Whether or not facility staff, including the resident, their family, and/or resident representative have reviewed the resident's care plan and revised it as necessary, to reflect the resident's current needs and goals.

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

- Their 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 know how, what, when, and to whom to report changes in condition, including changes in a resident's social interactions and behaviors (e.g., residents who have begun to withdraw, express anger, and/or depression);
- How facility staff monitor the implementation of the care plan, and respond to changes in the resident's social interactions and behaviors; and
- How changes in both the care plan and the resident's condition are communicated to the staff.

Record Review

- Determine whether or not upon admission, the resident had a diagnosis of or displayed a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD.
- Review the resident's medical record for documentation related to a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive expressions or indications of distress. Review nursing, social service, mental health notes, or other discipline notes for description of the distress.
- Review the Resident Assessment Instrument (RAI) and identify if the Minimum Data Set (MDS) captures and was used to assess the resident's conditions. Look to see that the resident Care Area Assessments (CAA) for activities, mood state, psychosocial well- being, and psychotropic drug use trigger for any reason in the absence of related diagnoses or difficulties, or history of trauma and/or PTSD.
- Consider whether the CAA process was used to identify and assess the reason and causal factors for decline, potential for decline, or lack of improvement.
- 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?
- Review the resident's care plan to determine if interventions are in place to alleviate the assessed distress.

    - Does it thoroughly describe the distress from a person-centered perspective?
    - 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?
    - Does the record review indicate that the care and services outlined in the care plan are effective?

DEFICIENCY CATEGORIZATION §483.40(b)(2)
An example of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or Safety includes, but is not limited to:

- The facility failed to identify signs of distress exhibited by a resident who, according to the medical record, for the past month had begun rising from bed mid-morning and returning to bed immediately after dinner. This was a departure from her previous morning and night sleep patterns. Upon interview, staff communicated that as people age, they grow tired more easily and require more sleep. The staff also noted that the resident was often very tearful and seemed depressed, but again they felt that this was normal for older adults. Even though she experienced a significant weight loss and did not want to speak to a social worker when approached about these noted changes, the staff honored her wish to

be left in bed. During the resident interview, she stated that she was tired and just wanted to sleep. She informed the surveyor that the last of her friends had just died, leaving her with no other childhood contacts or meaningful social relationships other than her family. She began crying and stated that she often cried, but tried not to in front of the staff because she was too proud. She felt that by sleeping a lot, she wouldn't have to face the fact that she also would die soon.

The facility's failure to identify that the resident was in distress and needed a mental health assessment caused a delay in receiving appropriate services and a deterioration in the resident's psychosocial well-being.

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

- During the tour of the facility, the surveyor noticed a resident sitting by the front door of the facility wringing his hands and staring out the window. While engaged in conversation, he stated that he was afraid that he would miss his group again. He had to come to the nursing home after his wife's death and was having a hard time adjusting to the change. He stated that he joined a grief support group that he was finding helpful, but had not been able to attend for a few weeks. He was unable to sleep at night because of the worry about missing the group sessions.

  His care plan indicated that the only intervention to address his grief was participation in a weekly support group meeting at the senior center. His goal was to attend group sessions, so he could better cope with the multiple losses he had experienced. An interview with the facility administrator revealed that the resident had been unable to attend group sessions for six weeks because the facility's only van was in the shop. During those weeks, the facility failed to provide alternative interventions and address the distress caused by the missed meetings. The resident's medical record reflected that in the past month, he appeared more anxious, depressed, and angry and staff described him as "not his pleasant self."

  The resident suffered a decline as a direct result of being unable to attend his weekly support group meetings and the facility did not seek any alternatives when transportation was unavailable.

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

- After falling at home and fracturing her femur, a resident was admitted to the skilled nursing facility for rehabilitation services. She had no history of mental or psychosocial adjustment difficulty, trauma (other than the fall), and/or PTSD. When she was first admitted she was very involved in facility events and