

Death Critical Element Pathway

Use this pathway to 1) investigate circumstances surrounding the death of a resident who was **not** receiving end of life care, hospice, or palliative care, to determine if the facility identified and assessed any change in condition, and intervened as appropriate, or 2) determine if facility practices were in place to identify, assess, and intervene to prevent the rapid decline if the resident died within 30 days of admission and was not receiving end of life services on admission.

Record Review:

- ☐ Review nursing notes, EMT records, hospital and discharge summaries, facility d/c summary, death certificate (noting cause of death), and progress notes/vital signs.
- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections B – Hearing, Speech, and Vision, C - Cognitive Patterns, E - Behavior, G – Functional Status, H - Bowel and Bladder, I - Active Diagnoses, J - Health Conditions, and O - Special Treatments, Procedures, and Programs.
- ☐ Does the comprehensive care plan identify interventions for the risks and conditions related to the resident's death? If not, describe.
- ☐ If the resident expired before the development of the comprehensive care plan, determine what baseline care plan interventions were related to the resident's death, and if they were carried out.
- ☐ Identify pertinent diagnoses.
- ☐ Review physician's orders (e.g., code status).
- ☐ Review laboratory or radiology results pertinent to the resident's death.
- ☐ Was the resident's change in condition or decline assessed, monitored, and documented? Did the facility do a significant change assessment?
- ☐ Review progress notes to determine what interventions were put into place to address the change or decline in condition (e.g., first aid measures, glucose monitoring, cardiopulmonary resuscitation [CPR], and immediate transfer)?
- ☐ Were interventions and preventive measures documented, appropriate, monitored, evaluated, and modified as necessary?
- ☐ Was pain assessed and treatment measures documented, if needed?
- ☐ Was care consistent with the resident's advance directives or goals for care?
- ☐ If concerns are identified, review facility policies and procedures with regard to factors that led to the resident's death.

Family or Resident Representative Interview:

- ☐ Were you made aware of the resident's change in condition? If so, when, and what was the facility going to do to address it?
- ☐ When was the last time you saw the resident? Did the resident appear to be at their baseline, or did you notice a difference? If you noticed a difference, did you notify staff? If so, whom did you notify and when?
- ☐ Were advance directives in place? If so, what were the resident's decisions and were they honored?

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Nurse and DON Interviews:

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| <input type="checkbox"/> Are you familiar with the resident's care? | <input type="checkbox"/> When did the resident die and what was the cause of death? |
| <input type="checkbox"/> Can you describe the resident's cognitive, functional, and health status before the resident declined and prior to the resident's death? | <input type="checkbox"/> How often was the resident's condition assessed while experiencing a change in condition? Where is it documented? Did you report it (to whom and when) and did the treatment plan change? |
| <input type="checkbox"/> Did the resident have pain? If so, who did you report it to and how was it being treated? How often was the resident being assessed for pain? | <input type="checkbox"/> Did the resident refuse any treatments? What did you do if the resident refused? |
| <input type="checkbox"/> Did the resident have a change or decline in condition? If so, what interventions were in place to address the problem? | <input type="checkbox"/> How did you involve the resident in decisions regarding treatment(s)? |
| <input type="checkbox"/> When was the practitioner notified? When was the resident's representative notified? | <input type="checkbox"/> Were advance directives in place? If so, what were the resident's decisions and were they honored? |

Critical Element Decisions:

- 1) Did the facility ensure that the resident received treatment and care that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
If No, cite the relevant outcome tag or F684
- 2) For newly admitted residents, and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
- 3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

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- 4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.
- 5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status) ?
If No, cite F641
- 6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.
- 7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed F552, Advance Directives (CA), Notification of Change F580, Dignity (CA), Choices (CA), Admission Orders F635, Professional Standards F658, QOL F675, CPR F678, Behavioral-Emotional Status (CA), Advance Directives (CA), Hospice/End of Life (CA), Nutrition (CA), Hydration (CA), Pain (CA), Sufficient and Competent Staffing (Task), Physician Supervision F710, Medical Director F841, Resident Records F842, QAA/QAPI (Task).