

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being. *If a resident is prescribed psychotropic medications, review the Unnecessary Medication, Psychotropic Medications, and Medication Regimen Review Critical Element (CE) Pathway.*

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Most current comprehensive *or the* most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, E – Behavior and N – Medications.
- ☐ Physician orders.
- ☐ *Pertinent diagnoses.*
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided *to meet the resident's individual needs*? If so, what evidence was observed?
 - ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice (*e.g., daily routines, dining preferences, mobility, activities, bathing, or use of the bathroom*)?
 - ☐ Are staff using *individualized*, non-pharmacological interventions to attain or maintain the resident's well-being? *If so, provide examples.*
 - ☐ *How does staff monitor the effectiveness of the resident's care planned interventions?*
 - ☐ How does the facility modify the environment *or facility practices (e.g., ADL care, daily routines, activities)* to accommodate the resident's care needs?
 - ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
 - ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.
- Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741 *using the Behavior-Emotional Status CE pathway.*

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
 - ☐ How did the facility involve you/the resident in the care plan and goal development process, *including the implementation of non-pharmacological approaches to care*?
 - ☐ *How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?*
 - ☐ How did the facility consider your/the resident's choices and preferences?
- Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to

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- ☐ *How were you informed of the risks and benefits of all interventions in your/the resident's care plan?*
- ☐ *How were you informed of the intended benefits and potential side effects of your/the resident's medication regimen?*

determine what type of social services or referrals have been implemented, *also determine compliance with F745.*

Staff Interviews (Interdisciplinary team (IDT) members) Across Various Shifts:

- ☐ *Can you tell me about the resident's care plan and his/her condition (including underlying causes)?*
- ☐ How do you ensure care is consistent with the care plan?
- ☐ *How do you use non-pharmacological interventions to attain or maintain the resident's well-being?*
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ *How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?*
- ☐ *What process is used to inform the resident and/or resident representative of the risks and benefits of all interventions in the resident's care plan?*
- ☐ *What process is used to inform the resident and/or resident representative of the intended benefits and potential side effects of the resident's medication regimen?*
- ☐ *How do you ensure that pharmaceutical interventions are used only when clinically indicated, at the lowest dose, shortest duration, and closely monitored?*
- ☐ *What are the facility's dementia care guidelines and protocols?*
- ☐ *What types of dementia management training have you completed?*
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
 - ☐ *Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.*
 - ☐ *What is the time, duration, and severity of the resident's expressions or indications of distress?*
 - ☐ *What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?*
 - ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and
 - ☐ *What non-pharmacological approaches to care are used to support the resident and lessen their distress?*
 - ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
 - ☐ *Determine what documentation identifies, in advance of the care to be furnished, the explanation of the risks and benefits of proposed interventions.*
 - ☐ Was dementia management training provided to staff?
- Note: *How does the facility inform residents and/or resident representatives, in advance of care, of the risks and benefits and*

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include measurable objectives and timetables? Has the care plan been revised to reflect any changes?

possible alternatives of treatment (e.g., non-pharmacological approaches to care and treatment other than medications)? Is this process in compliance with requirements at F552?

Critical Element Decisions:

- 1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
 - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
 - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
 - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
 - Did facility staff evaluate:
 - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
 - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?
 - B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
 - Was the resident and/or family/representative involved in care plan development;
 - Does the care plan reflect an individualized, person-centered approach with measurable goals, timetables, and specific interventions;
 - Does the care plan include:
 - Monitoring of the effectiveness of any/all interventions; and/or
 - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?
 - C. In accordance with the resident's care plan, did qualified staff:
 - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
 - Implement individualized, person-centered interventions and document the results; and/or
 - Communicate and consistently implement the care plan over time and across various shifts?
 - D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?
- If No to A, B, C, or D, cite F744

- 2) *Did the facility inform the resident and/or resident representative, in advance of care, of the risks and benefits and possible alternatives of treatment?*
If No, cite F552

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- 3) 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 services was not necessary to be included in a baseline care plan.
- 4) 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 in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.
- 5) 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.
- 6) 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
- 7) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable 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.
- 8) 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.

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Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, *Resident Rights* F550, *Choices (CA)*, *QOL* F675, Physician Services F710, Social Services F745, Sufficient and Competent Staffing (Task), *Activities (CA)*.