# Part 4

***Part 4 will be completed for each resident in the sample.***

**Name of State Agency:** ***(please specify)***

**Team Leader:**

**Surveyors on Team:**

**Survey Date:**

**Facility Name and ID:**

**Part 4 – Dementia Care & Related Practices (See Specific Practices to Consider Below)**

**INSTRUCTIONS:**

- Please ***select*** **ONE bubble** for each "Was Practice Performed?" question, unless otherwise noted.
- If N/A is ***selected***, please explain why there is no associated observation, or why the question is not applicable, in the COMMENTS box at the end of each section.
- Dementia care should be observed not only during the cases being followed, but also while making other observations in the nursing home, throughout the survey. Interviews are used primarily to provide additional evidence for what the surveyor has observed or gleaned from the record review; but may insome cases substitute for direct observation to support a citation of deficient practice.

Specific Practices to Consider:

There are many possible situations and relationships that surveyors will want to evaluate during the Focused Dementia Care Survey. It is not possible to provide examples of all of these scenarios. However, some common practices (positive and negative) are listed below. Overall, these address the issue of meeting the resident where he/she is and entering that world, as opposed to requiring them to conform to nursing home routines. Some specific practices that surveyors may consider include:

1. Observe for language or routines that could have an impact on dignity and/or function, e.g.:
   - Use of bibs, crescent 'feeding' tables
   - High percentage of residents wearing socks/non-skid socks and institutional gowns instead of their own clothes and shoes; high percentage of residents with soiled hands or nails, unshaven or with hair not combed or brushed (a high percentage of these observations may indicate that staff does not try to re-approach residents or find ways to enable them to accept needed care/grooming; surveyors should investigate further)
   - Staff use of terms such as "feeders" "total care residents" etc. in communication versus person-centered language
   - Failure to respond to residents' communication/behavioral manifestations of distress/emotional needs versus attention to preventing escalation of distress
   - Attempts to keep residents "quiet" or prevent them from moving around versus efforts to walk or talk with residents who appear distressed

- Lack of social interaction or communication between staff and residents during direct care versus engaging residents in conversation or speaking to them even if they are unable to respond.

2. Observe for social dining atmosphere or individualized dining setting (if appropriate) with staff sharing the dining experience with residents (not standing over them). Observe for staff talking with residents, not talking only with other staff or ignoring residents. Observe for culturally appropriate meals.

3. Observe for whether or not staff assesses the environment regularly for too much or too little noise, light and stimulation. (Since this may be difficult to ascertain during observations alone, speak with staff about how they address environmental issues for individuals with dementia).
4. Observe for other basic dementia care approaches such as:
   - using soft, low voice and speaking where resident may read lips/see face clearly
   - not approaching resident from behind
   - providing adequate time during resident care and meals (not rushing)
   - encouraging maximal independence (not performing activities/care routines that resident could perform him/herself if given adequate time and task segmentation, cues)
   - encouraging time outdoors
   - encouraging physical activity
   - redirecting resident away from high stress environment
   - allowing a resident to remain in preferred location/environment (e.g., to remain in bed) if safe, and re-approaching that resident later on if they express a desire/choose to remain where they are (staff recognizing this as preference/choice, even in someone who has dementia)
   - providing stimulation (to avoid boredom); ensuring an adequate number and type of activities on all shifts, on W/E's
   - addressing loneliness/isolation
   - Appropriately limiting choices to avoid frustration/confusion.

5. Assess for adequate sleep and individualized sleep hygiene in care plan (sleep facilitators, such as reducing interruptions for continence care or pressure relief through use of appropriate continence products and mattresses); sleep log or diary if indicated. Assess for residents sleeping often during activities.

6. Evaluate for adequate pain assessment in all residents with particular attention to those with difficulty communicating about pain.

7. Assess for sensory deficits and how these deficits may impact cognition. Is there an assessment for use of adaptive equipment, and is it used appropriately and consistently?

8. Assess for issues during care transitions. For example, was there a unit or room change? What prompted this change? How was information transferred effectively among care providers ("warm handover")? Consider issues related to accepting residents back after a hospital transfer (communication with state Ombudsman Program may be helpful).

**I. Comprehensive Evaluation of Each Resident on Admission by the Interdisciplinary Team**
**(*Use this section for new admission resident/s in the sample, or those for whom admission records are available*).**

Observations in this section are to focus on staff directly involved in the admission process (e.g., admission coordinator, social worker, nurses, CNAs, therapists, etc.).

*If the condition or risks were present at the time of the required comprehensive assessment, did the nursing home comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident's behavioral and/or mental psychosocial symptoms, and needed adaptations, and the impact upon the resident's function, mood and cognition?*
*If No, cite F272. For newly admitted residents, before the 14-day assessment is complete, did the nursing home provide sufficient care planning to meet the resident's needs? If No, cite F281.*
*In addition, surveyors should consider one or more "no" responses in this section potentially indicative of non- compliance in relation to 42 CFR 483.25, F309 as well.*

| **Practices to be Assessed** | **Was Practice Performed?** |
|---|---|
| A. Is there a pre-admission or admission screening process to identify the specific care needs of residents with dementia? | ☐ YES<br>☐ NO |
| B. During admission interviews, are the resident and family asked about previous life patterns, choices, cultural patterns, preferences with respect to: daily routines such as awakening and going to bed at night, dining preferences, food choices, mobility/exercise, time outdoors, reading, hobbies or activities, bathing or use of the bathroom and any other relevant information related to the resident's comfort, well- being and rituals? (e.g., use of instrument such as Preferences for Everyday Living Tool). ** | ☐ YES<br>☐ NO<br>☐ N/A |
| C. During the admission process, did staff ask specific questions about usual cognitive patterns, mood and any behavioral distress associated with dementia?<br><br>(This should include: when behaviors have occurred, possible underlying causes; how resident typically communicates a need such as pain, discomfort, hunger or frustration; responses to triggers such as stress, anxiety or fatigue; expectations for how nursing home will work with resident to prevent and reduce any distress). | ☐ YES<br>☐ NO<br>☐ N/A |
| D. Does staff know, based on the admission process, what approaches calm or soothe a resident with dementia once resident becomes distressed (including evaluation of environmental factors that could be triggering or exacerbating behaviors)?* | ☐ YES<br>☐ NO<br>☐ N/A |
| E. Did staff document preferences and patterns (above) in the clinical record in a place easily accessible to all staff? | ☐ YES<br>☐ NO |
| F. F. Is staff able to demonstrate that they know where information is located and when/how to access it? | ☐ YES<br>☐ NO |
| G. G. Does admission staff communicate verbally and/or in writing to CNAs and other staff about these preferences and patterns in a timely manner? | ☐ YES<br>☐ NO |

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|---|---|
| H. H. Is evidence present that supports activities are implemented for the resident that are based on information gathered during the admission process (i.e., based on known hobbies, routines and life patterns)? | ☐ YES<br>☐ NO<br>☐ N/A |
| I. I. Are preferences and usual patterns related to dining integrated into meal, snack and beverage planning for the resident? | ☐ YES<br>☐ NO<br>☐ N/A |
| J. J. Has therapy staff (OT, PT and/or SLP) and/or restorative nursing staff screened the resident soon after admission to determine if services would enable resident to attain or maintain his or her highest practicable level of functioning? | ☐ YES<br>☐ NO<br>☐ N/A |
| K. Comments | |

**Note: Staff may not always know the most effective current intervention based solely on the admission process. The admission process focuses primarily on previous life patterns, approaches, preferences, etc. Some triggers and resident responses may vary based on the individual's adjustment to a new setting and environment, and staff may need to explore additional and/or alternative approaches to soothe or calm an individual, as well as those approaches that served well in the past/prior to admission.*

***Note: In any sections of this worksheet, if resident is non-interviewable and there is no family available/involved and therefore N/A is checked, note whether facility made efforts to find alternative ways of obtaining information and whether they documented those efforts. In some cases, despite efforts, minimal or no information may be available for certain residents for initial assessment and care planning. However, in those cases, the facility should indicate how social services is involved in obtaining legal representation (e.g. guardianship or other processes).*

| II. Recognition, Assessment and Cause Identification of Behavioral Manifestations of Dementia | |
|---|---|
| **Observations are to focus on staff directly involved in patient care (e.g., nurses, CNAs, therapists, etc.).** Dementia care should be observed not only during the cases being followed, but also while making other observations in the nursing home throughout the survey.<br><br>*If the condition or risks were present at the time of the required comprehensive assessment or change in condition assessment, did the nursing home comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident's behavioral and/or mental psychosocial symptoms, and needed adaptations, and the impact upon the resident's function, mood and cognition?*<br>*If No, cite F272*<br><br>*In addition, surveyors should consider one or more "no" responses in this section (B-K) potentially indicative of non- compliance in relation to 42 CFR 483.25, F309 as well.* | |
| **Practices to be Assessed** | **Was Practice Performed?** |
| A. Has the resident expressed or indicated distress or engaged in behaviors that appear to be distress-related, while residing in the nursing home?<br>(If no, skip to section III). | ☐ YES<br>☐ NO |
| B. Did staff describe the specific experience of distress (onset, duration, intensity, possible precipitating events, underlying causes or environmental triggers, etc.)? | ☐ YES<br>☐ NO<br>☐ N/A |
| C. Did staff describe related factors (appearance, alertness, environmental triggers, external events, etc.), with enough specific detail of the actual situation to permit underlying cause identification to the extent possible (including assessment of environmental factors)? | ☐ YES<br>☐ NO<br>☐ N/A |
| D. If the resident's distress represents a sudden change or worsening from baseline, did staff contact the interdisciplinary team, including the resident's family or representative to the extent possible, to discuss potential non-pharmacological approaches to care that could be attempted?<br><br>Note: If the resident is at risk of harming himself/herself or the safety of other residents is jeopardized, the attending physician's practitioner must be notified immediately for medical evaluation. | ☐ YES<br>☐ NO<br>☐ N/A |
| E. If medical causes are ruled out, did staff attempt to determine underlying causes of the distress using individualized knowledge about the person and when possible, information from the resident, previous or current family or unpaid caregivers and/or direct care staff? | ☐ YES<br>☐ NO<br>☐ N/A |
| F. As part of comprehensive assessment, did staff evaluate the resident's usual and current cognitive patterns, mood and behavior (baseline and/or with a change in condition)? | ☐ YES<br>☐ NO<br>☐ N/A |
| G. Did staff evaluate whether the cognitive patterns, mood or behavior present a risk to the resident or others? | ☐ YES<br>☐ NO<br>☐ N/A |

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|---|---|
| H. (Ruling out medical or psychiatric illness.)<br>Did staff, in collaboration with the practitioner and/or pharmacist, identify risk and underlying causes for the resident's expressed or indicated distress or behaviors that appear to be stress related, such as:<br>• Presence of co-existing medical or psychiatric conditions, or decline in cognitive function? | ☐ YES<br>☐ NO<br>☐ N/A |
| • Specifically, was delirium considered and ruled out? | ☐ YES<br>☐ NO<br>☐ N/A |
| • Were adverse consequences related to the resident's current medications considered and ruled out? | ☐ YES<br>☐ NO<br>☐ N/A |
| Comments: | |

**Note: Staff may not always know the most effective current intervention based solely on the admission process. The admission process focuses primarily on previous life patterns, approaches,preferences, etc. Some environmental triggers and resident responses may vary based on the individual's adjustment to a new setting and environment, and staff may need to explore additionaland/or alternative approaches to support the individual, as well as those approaches that served well in the past/prior to admission.*

| **III. Care Planning** | |
|---|---|
| *Did the facility develop a plan of care with measurable goals and approaches to address the care and treatment for a resident with dementia, related to the resident's expressed or indicated distress or behaviors that appear to be stress related, in accordance with the assessment, resident's wishes and current standards of practice? If no, cite F279.*<br>*In addition, surveyors should consider one or more "no" responses in this section potentially indicative of non-compliance in relation to 42 CFR 483.25, F309 as well.* | |
| **Practices to be Assessed** | **Was Practice Performed** |
| A. Was the resident and/or family/representative involved (to the extent possible and in accordance with the resident's wishes) in discussions about the potential use of any specific approaches to his/her care? | ☐ YES<br>☐ NO<br>☐ N/A |
| B. Was involvement documented in the medical record (nursing notes, care plan, CNA care plan)? | ☐ YES<br>☐ NO<br>☐ N/A |
| C. Consistent with the resident's wishes, was the person and/or family/representative involved in determining the goals of care (see also J and K)? | ☐ YES<br>☐ NO<br>☐ N/A |
| D. Does the care plan reflect an individualized approach with measurable goals, timetables and specific approaches for supporting the resident when distress is expressed or indicated? | ☐ YES<br>☐ NO<br>☐ N/A |
| E. Does the care plan include a description of potential distress triggers and nonpharmacological approaches to implement when distress is expressed or indicated? | ☐ YES<br>☐ NO<br>☐ N/A |
| F. Does the care plan include why potential triggers should be addressed (e.g., severely distressing to the individual or risk to other residents)? | ☐ YES<br>☐ NO<br>☐ N/A |
| G. Does the care plan include strategies and approaches based on information about the person's previously stated goals and preferences and knowledge about what has been helpful in supporting the resident when they have become distressed in the past? | ☐ YES<br>☐ NO<br>☐ N/A |
| H. Does the care plan include monitoring the effectiveness of any/all approaches, as well as, documentation of these efforts and revisions, as necessary? | ☐ YES<br>☐ NO |
| I. If the individual lacks decisional capacity and lacks effective family/representative support, was the facility social worker contacted to determine what type of social services or referrals are indicated? | ☐ YES<br>☐ NO<br>☐ N/A |
| J. Were these social services or referrals implemented? | ☐ YES<br>☐ NO<br>☐ N/A |

| K. Comments: |
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**IV. Individualized Approaches and Treatment: Care Plan Implementation and Staffing**

Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic dementia care principles in the care of those individuals.

*Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care? If No, cite F282*

*In addition, surveyors should consider one or more "no" responses in this section potentially indicative of non-compliance in relation to 42 CFR 483.25, F309 as well.*

| **Practices to be Assessed** | **Was Practice Performed** |
|---|---|
| A. Did staff communicate any specific triggers of distress that are of concern, as well as desired outcomes to be monitored among disciplines, across shifts and to direct caregivers? | ☐ YES<br>☐ NO<br>☐ N/A |
| B. Were individualized, person-centered approaches to care implemented with/for the resident? | ☐ YES<br>☐ NO<br>☐ N/A |
| C. Did staff document the results? | ☐ YES<br>☐ NO<br>☐ N/A |
| D. Did staff communicate and consistently implement the care plan, over time and across various shifts (D/E/N, weekday/weekend)? | ☐ YES<br>☐ NO<br>☐ N/A |
| E. If there was a sudden change in the resident's condition and medical causes of behavior or other symptoms (e.g., delirium or infection) are suspected, was the physician contacted immediately? | ☐ YES<br>☐ NO<br>☐ N/A |
| F. Were alternatives other than psychopharmacological medications discussed with staff and resident or family, with respect to the expression or indication of distress, as well as the engagement in behaviors that appear to be distress-related? | ☐ YES<br>☐ NO<br>☐ N/A |
| G. What non-pharmacological approaches were/are used for this resident with dementia (list all that are documented): | |
| H. Were individualized, approaches to care initiated in a timely manner? | ☐ YES<br>☐ NO<br>☐ N/A |
| I. Are CNAs able to describe care approaches, such as task segmentation (e.g., breaking up tasks into each step) and others that are used, as part of a comprehensive dementia care program? | ☐ YES<br>☐ NO<br>☐ N/A |

| | |
|---|---|
| J. Is there a sufficient number of staff to consistently implement the care plan? | ☐ YES<br>☐ NO<br>☐ N/A |
| K. Can staff articulate what they would do to obtain additional support/skills if they did not know how to implement care plan goals for this or other residents? | ☐ YES<br>☐ NO<br>☐ N/A |
| L. Is there evidence that unit level supervisory staff (e.g., charge nurses) have the skills to assist staff in caring for this or other residents with dementia? | ☐ YES<br>☐ NO<br>☐ N/A |
| Comments: | |

**V. Monitoring, Follow-up and Oversight**

Observations are to be made of staff identifying resident distress and making adjustments/updates to the care plan based on this monitoring function.
Did the nursing home reassess the effectiveness of the care approach and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident with dementia? If no, cite F280.
*If N/A is selected, please clarify in the comments box below why it was not applicable or not observed.*
*In addition, surveyors should consider one or more "no" responses in this section potentially indicative of non-compliance in relation to 42 CFR 483.25, F309 as well.*

| **Practices to be Assessed** | **Was Practice Performed** |
|---|---|
| A. Does staff, in collaboration with the practitioner, adjust the care plan approaches based on their effectiveness in supporting the resident when distress is expressed or indicated, as well as any adverse consequences that may occur? | ☐ YES<br>☐ NO<br>☐ N/A |
| B. When concerns related to the effectiveness or adverse consequences of a resident's plan of care and staff approaches are identified by staff, resident or family:<br><br>Does staff modify the care plan? | ☐ YES<br>☐ NO<br>☐ N/A |
| If appropriate, does staff notify the practitioner? | ☐ YES<br>☐ NO<br>☐ N/A |
| Does the practitioner respond and initiate a change to the resident's orders in a timely manner? | ☐ YES<br>☐ NO<br>☐ N/A |

Comments:

**Resident Name/Identifier or Number:**

**Facility Name or Provider Number:**

**Date:**

**Did the nursing home 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 plan of care? If No, cite F309.**

**FOR MORE INFORMATION, SEE REVISED GUIDANCE AT F309.**