

## General Critical Element Pathway

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Use this pathway to investigate quality of care concerns that are not otherwise covered in the remaining tags of §483.25, Quality of Care, and for which specific pathways have not been established. For investigating concerns regarding care at the end of life, use the Hospice/End of Life CE Pathway.

### Review the Following in Advance to Guide Observations and Interviews:

- The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the concern.
- Physician's orders.
- Pertinent diagnoses.
- Care plan.

### Observations Across Various Shifts:

- Does staff consistently implement the care-planned interventions? If not, describe.
- Ensure interventions adhere to professional standards of practice.
- What is the resident's response to interventions? Is the resident's response as intended?
- Do observations of the resident match the assessment? If not, describe. Are there visual cues of psychosocial distress and harm?

### Resident, Resident Representative, or Family Interview:

- Will you describe your current condition or history of the condition, or diagnosis?
- How did the facility involve you in the development of the care plan and goals?
- How effective have the interventions been? If not effective, what alternate approaches have been tried?
- What are your goals for care? Do you think the facility is meeting them? If not, why do you think that is?
- For newly admitted residents, did you receive a summary of your (or the resident's) baseline care plan? Did you understand it?

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### Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- Will you describe specific interventions for the resident, including facility-specific guidelines/protocols?
- How, what, when, and to whom do you report changes in condition?
- How does the interdisciplinary team monitor for the implementation of the care plan and changes in condition?
- How is information passed across shifts, and between all disciplines?
- How are revisions to the comprehensive care plan communicated to staff?
- How was it determined that the chosen interventions were appropriate?
- Did the resident have a change in condition that may justify additional or different interventions?
- How does staff validate the effectiveness of current interventions?

### Record Review:

- Review relevant information such as medication and treatment administration records, interdisciplinary progress notes, and any facility-required assessments that may have been completed. Does the information accurately and comprehensively reflect the resident's condition? If not, describe.
- Are federally required RAI/MDS assessments completed according to required time frames?
- For newly admitted residents, is there a baseline care plan, and does it describe the instructions necessary to meet the resident's immediate needs? Does it address the resident's clinical and safety risks?
- Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, preferences, and behaviors? Does it include goals for admission, measureable objectives, timetables, and desired outcomes? How did the resident respond to care planned interventions? Was the care plan revised if interventions weren't effective, the desired outcome was achieved, or if there was a change in condition?
- Is there evidence of resident or resident representative participation in developing resident-specific, measureable objectives, and interventions? If not, is there an explanation as to why the resident or representative did not participate?
- Is there evidence that the resident has refused any care or services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment? If so, does the care plan reflect this refusal, and how has the facility addressed this refusal?
- Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

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### Critical Element Decisions:

- 1) Did the facility ensure that the resident received treatment and care in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?  
If No, cite appropriate 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.
- 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 the 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.

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- 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:** Notification of Change F580, Admission Orders F635, Professional Standards F658, Qualified Staff F659, QOL F675, Foot Care F687, Colostomy/Urostomy/Ileostomy Care F691, Prosthesis F696, Sufficient and Competent Staffing (Task), Physician Services F710, Facility Assessment F838, Medical Director F841, Resident Records F842, QAA/QAPI (Task).