

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive MDS/CAAs for Sections B – Hearing, Speech, and Vision, C – Cognitive Patterns, E – Behavior, G – Functional Status, I – Active Diagnoses, J – Health Conditions-Pain, Falls, N – Medications, and O – Special Treatments, Procedures, and Programs.
- Physician’s orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).
- Pertinent diagnoses.
- Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident’s hospitalization.
- Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident’s needs, goals, preferences, and assessment).

Observations:

- Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
 - Physical distress;
 - Mental status changes;
 - A change in condition; and/or
 - Pain?
- If symptoms are exhibited, what does staff do?
- Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

- Why were you sent to the hospital? Has your condition improved? If not, do you know why it’s not getting better?
- When did you start to feel different, sick, or have a change in condition?
- Do you feel staff responded as quickly as they could have when you had a change in condition?
- Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?
- Do you have pain? If so, what does staff do for your pain?
- Has your health declined since you were in the hospital? If so, what has staff done?
- What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).

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- Were you notified immediately about your change in condition and need for potential hospitalization?
- Were you involved in the development of the care plan and goals regarding your care before and after you got back from the hospital?
- Do the interventions reflect your choices and preferences?
- Did you refuse care related to the symptoms which led to your hospitalization? If so, what was your reason for refusing care? Did the staff provide you with other options for treatment or provide you with education on what might happen if you did not follow the treatment plan?
- Has your hospitalization caused you to be less involved in activities you enjoy?
- Since your hospitalization, have you had a change in your mood or ability to function? If so, what has staff done?
- Did you receive a notice of transfer or discharge from the facility?
- Did the facility give you information about holding your bed for you while you were at the hospital?
- Were you allowed to return to the facility and to your previous room? If not, do you know why not?

Staff Interviews (Nursing Aides, Nurses, DON, Practitioner):

- Are you familiar with the resident's care?
- When did the hospitalization occur? What was the cause (e.g., pain, infection, mental status change, or fall)?
- Do you have a structured process for identifying and addressing a resident's change in condition (e.g., facility developed tool, Interventions to Reduce Acute Care Transfers [INTERACT])?
- Prior to the hospitalization, did the resident have a change or decline in condition? If so, when? How often did you assess the resident? Where is it documented?
- If the resident had a change in condition, who did you notify (e.g., practitioner or representative) and when?
- Prior to or after the hospitalization, did the resident refuse any treatment? What do you do if the resident refuses?
- Is the resident at risk for additional hospitalizations?
- Since the resident returned from the hospital, has the resident had a change or decline in condition? If so, what interventions are in place to address the problem(s)?
- How do you monitor staff to ensure they are implementing care-planned interventions?
- How did you involve the resident/representative in decisions regarding treatments?
- If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current care plan.
- Ask about identified concerns.

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Record Review:

- Was the cause of the hospitalization assessed, monitored, and documented timely (e.g., nursing notes, EMT records, hospital discharge summaries, H&P, progress notes/vital signs)?
- Did the facility adequately identify and address the resident's change in condition?
- Were changes in the resident's status or other risks associated with the hospitalization identified as soon as possible?
- Were changes in the resident's status related to the hospitalization communicated to staff, practitioner, resident and representative immediately after they were identified?
- Was the transfer to the hospital necessary (e.g., the resident's needs couldn't be met after facility attempts to address the needs, or the health or safety of individuals in the facility would be endangered if the resident stayed in the facility)?
- If the transfer to the hospital is necessary for the resident's welfare and the resident's needs cannot be met in the facility, did the facility document the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)?
- Did the facility send all necessary clinical information to the hospital (i.e., practitioner and representative's contact info, advance directive, special instructions or precautions for ongoing care, care plan goals, and all other information needed to care for the resident). Refer to 483.15(c)(2)(iii) for additional guidance on what must be conveyed.
- Did the appropriate practitioner document the basis for the transfer? [F622, 483.15(c)(2)(ii)]
- Was the resident/representative provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand?
- Did the notice meet all the notice requirements at 483.15(c)(3)?
- Did the resident/representative receive the notice of Bed Hold per 483.15(d)?
- Did the facility assess and monitor the resident's response to interventions?
- Did the facility identify necessary changes in interventions to prevent further hospitalizations?
- Does the resident have a medical condition or receive medications that require monitoring? If so, did the monitoring take place and was it documented (e.g., blood glucose monitored and treated appropriately)?
- Were there any medication changes that were pertinent to the hospitalization?
- Were any laboratory results pertinent to the hospitalization?
- Review facility policies and procedures relevant to the resident's hospitalization (e.g., policy on changes in condition).
- Review the facility's admission information provided during the Entrance Conference regarding bed holds and transfers.
- Ensure the resident was provided the policy on returning to the facility in the same room, if possible, and bed holds.
- Could the transfer to the hospital have been avoided (e.g., had the change in condition been identified and addressed earlier, the condition would not have declined to the point where the resident required a transfer)?
- Residents not permitted to return to facility after hospitalization (Discharge):** When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is considered to be a facility-initiated discharge – ensure the facility is in compliance with all discharge requirements at 483.15(c)(1) through (6).

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- For any resident whose **transfer to the hospital resulted in a discharge**, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave: [Refer to 483.15(c), (d), and (e) for additional guidance.]
- What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]
 - Did the resident/representative receive all appropriate notification (Notice of Transfer, containing the basis for transfer; and Notice of Bed Hold); Was a copy of the notice sent to the ombudsman? [Refer to F623 and F625]
 - Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624]
 - When the transfer became a discharge, did the facility issue another notice of discharge? If so, what was the basis for the discharge? For residents discharged after a transfer to the hospital because the health or safety of individuals would be endangered, is there evidence that residents with similar health needs, conditions, or symptoms currently reside in the facility, or were admitted after the resident was discharged? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to F623 and F626]
 - Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to F626]
 - Was the decision to not allow the resident to return based on the resident's care needs at the time of transfer to the hospital/acute care setting or at the time the resident sought return to the facility? Do the resident's records from the nursing home and the acute care facility support this decision (Surveyors may need to review hospital records in this situation)? [Refer to F626]
 - Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to F622]

Critical Element Decisions:

- 1) Did the facility ensure that the resident received treatment and care to prevent the hospitalization, 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 in Quality of Life, Quality of Care, or if no specific outcome tag, cite F684
- 2) Was the basis for the resident's transfer/discharge consistent with the requirements at 483.15(c)(1)? Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements at 483.15(c)(2)(i)-(ii)? Is there evidence that the information conveyed to the receiving provider met the requirements at 483.15(c)(2)(iii)? Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
If No to any of these questions, cite F622

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N/A, resident was permitted to return and not discharged.

- 3) Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?
If No, cite F623
- 4) For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?
If No, cite F623
N/A, resident was permitted to return and not discharged.
- 5) Was the resident sufficiently prepared and oriented for their transfer to the hospital?
If No, cite F624
- 6) Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
If No, cite F625
- 7) Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
If No, cite F626
N/A, resident was permitted to return and not discharged.
- 8) 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.
- 9) 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.
- 10) 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?

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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 status.

- 11) 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

- 12) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable 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.

- 13) 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: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAPI/QAA (Task).