**Communication**

**Competency**

Suggested Implementation Checklist

**Implementation Checklist: Communication/Sensory Deficit Competencies**

| **Regulation** | **Recommended Action** |
| --- | --- |
| **F550**  “§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.”[[1]](#footnote-1) | Provide education for all staff and volunteers on strategies for communication in a manner that shows respect and dignity to the resident, considering resident limitations |
| **F552**  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:    “§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.”[[2]](#footnote-2) | Educate staff on policy for resident communication for care planning in a language resident can understand |
| **F553**  “§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care”[[3]](#footnote-3) | Educate facility staff to observe and respond to the non-verbal communication of a resident who is unable to verbalize preference |
| **F600**  §483.12 Freedom from Abuse, Neglect, and Exploitation  The facility must have in place Structures-The nursing home’s capability and capacity to provide needed care and services such as:  “An effective communication system across all shifts for communicating necessary care and information between staff, practitioners and resident representatives”[[4]](#footnote-4) | Educate all staff on communication system across all shifts for communicating necessary care and information between staff, practitioners and resident representative |
| **F636**  §483.20 Resident Assessment  “[[5]](#footnote-5)The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity. (and must include Communication)  “Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.”[[6]](#footnote-6) | Determine process to review and evaluate accurate assessment process  Educate licensed and non-licensed staff on all shifts on resident/resident participation in assessment process |
| **F655**  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans “§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.”[[7]](#footnote-7) | Review policy and procedure for care plan, including baseline care plans  Educate the IDT on development and implementation of the care plan |
| **F660**  §483.21(c)(1) Discharge Planning Process  The discharge care plan is part of the comprehensive care plan and must:  • “Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;”[[8]](#footnote-8) | Educate the IDT on communication with the resident and/or resident representative for discharge planning |
| **F675** § 483.24 Quality of life  “Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive, and the facility must provide the  necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care”[[9]](#footnote-9). | Evaluate development and implementation of policies and procedures for person centered care;  Assess staff capability to use communication assistive devices and equipment to interact with and assist residents;  Evaluate that sensory and communication deficits are assessed, and care plan updated to direct cares and identify best methods to provide cares;  Observe that assessment, care plan, and care provided to overcome sensory deficits and interact meaningfully match.  Interview resident and staff to ensure that individual needs are met, and interactions promote the highest level of function. |
| **F676:** Activities of Daily Living – Maintain Abilities[[10]](#footnote-10)  “§483.24 (a) Based on the comprehensive assessment of a resident and consistent with the resident’s needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section …  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene –bathing, dressing, grooming, and oral care,  §483.24(b)(2) Mobility—transfer and ambulation, including walking,  §483.24(b)(3) Elimination-toileting,  §483.24(b)(4) Dining-eating, including meals and snacks,  §483.24(b)(5) Communication, including   1. Speech, 2. Language,   Other functional communication systems.”[[11]](#footnote-11) | Assess the resident’s communication abilities, related diagnoses for sensory deficits, and identify devices, equipment, or techniques used to promote interaction;  Identify staff educational needs and provide training to encourage staff/resident interactions using the most effective technique, with assistive device if ordered;  Educate and monitor staff performance of assistive device care and maintenance processes, if in use.  Observe that resident preferences and desires are followed for ADLs and assistive devices/equipment are used properly, if needed.  Observe that residents receive the assistance needed to complete ADLs and maintain abilities to perform self-care as able;  Review that staff encourage residents to communicate needs, preferences, and assist with meeting them;  Interview resident/family regarding use of assistive devices, if needed, and to ensure communication is clear and understood;  Complete assessment of vision, hearing, speech, and communication abilities to identify resident status and any deficits/ assistive device or equipment in use;  Educate and oversee staff performance to ensure that staff communication enables the resident to understand, respond, and make choices regarding cares, dining, and other activities. |
| **F684:** Quality of Care  “§ 483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices”[[12]](#footnote-12) | Review facility assessment and policies/ procedures for person centered care standards expected;  Educate all staff on communication with residents who have sensory and communication deficits;  Observe that residents with sensory deficits have a completed comprehensive plan of care which include specific assistive device/equipment use, if needed, and direct staff in communication skills needed. |
| **F685:** §483.25(a) Vision and hearing  “To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—  §483.25(a)(1) In making appointments, and  §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.”[[13]](#footnote-13) | Complete assessment of vision, hearing, speech, and communication abilities to identify resident status and any deficits/ assistive device or equipment in use;  Interview resident and observe daily interactions to determine customary routines for interaction and issues with receiving or expressing communication;  Review that assistance is provided for resident/family to locate a provider specializing in vision or hearing assistive devices and make transportation arrangements as needed.  Educate all staff on assessment for vision and hearing |
| **F726**  §483.35 Nursing Services  “Competency in skills and techniques necessary to care for residents’ needs includes but is not limited to competencies in areas such as;  • Resident Rights;  • Person centered care;  • Communication;  • Basic nursing skills;  • Basic restorative services;  • Skin and wound care; • Medication management;  • Pain management;  • Infection control;  • Identification of changes in condition;  • Cultural competency.”[[14]](#footnote-14) | Educate all staff on appropriate interpersonal communicate techniques:   * Verbal * Non-Verbal * Language Barriers * Strategies to encourage comfort with communication   Educate all staff on appropriate communication between members of the IDT:   * Verbal * Documentation * Care Plan * 24-hour report   Educate all staff on communication expectation for resident representatives  Educate nurses on communication with practitioners  Educate nurses and IDT members on communication with other healthcare entities |
| **F741**  “§483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:    §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]”[[15]](#footnote-15) | Educate all staff on communication strategies for residents with mental and psychosocial disorders, history of trauma and post-traumatic stress disorder |

**References and Resources:**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>
* Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual, Version 1.16. October 2018: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

1. 1,2,3,4 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. 6,7,8 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-5)
6. [↑](#footnote-ref-6)
7. [↑](#footnote-ref-7)
8. [↑](#footnote-ref-8)
9. 9,10 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-9)
10. [↑](#footnote-ref-10)
11. 11,12,13 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-11)
12. [↑](#footnote-ref-12)
13. [↑](#footnote-ref-13)
14. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-14)
15. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-15)