**Person-Centered Care**

**Competency**

Suggested Implementation Checklist

**Suggested Implementation Checklist: Person-Centered Care**

| **Regulation** | **Recommended Actions:** |
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| **“F553 Right to Participate in Plan of Care**  §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:   1. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. 2. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. 3. The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.”[[1]](#footnote-1)   “§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—   1. Facilitate the inclusion of the resident and/or resident representative. 2. Include an assessment of the resident’s strengths and needs. 3. Incorporate the resident’s personal and cultural preferences in developing goals of care.”[[2]](#footnote-2) | * Review and Revise facility policy and procedure to include:   + Participation in planning   + Right to request meetings   + Right to request revisions   + How resident/resident representative will be informed of any changes   + Process to review the care plan and sign after significant changes   + Process for cultural preferences * Interdisciplinary team education on:   + Resident/resident representative involvement in care planning   + Accommodation of meeting times   + Interpersonal strategies for addressing resident or resident representative concerns   + How to provide education to the resident on risks/benefits of treatments or refusals   + Documentation and communication to the IDT regarding resident preferences and choices for care as indicated in the person-centered care plan |
| F655 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. The baseline care plan must—   1. Be developed within 48 hours of a resident’s admission. 2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—  * Initial goals based on admission orders. * Physician orders. * Dietary orders. * Therapy services. * Social services. * PASARR recommendation, if applicable.”[[3]](#footnote-3)   Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident’s life before coming to reside in the nursing home.[[4]](#footnote-4) | * Observe and Interview residents during the intake process to identify individualized goals, needs, and preferences to be included in development of the baseline care plan are determined. * Educate staff of identified choices and preferences to be followed while interacting with the resident and providing care * Provide the resident/family with a summary of the baseline care plan and review with them to make adjustments as needed to ensure preferences are included * Complete record audit: summary provided, baseline care plan within 48 hours, documentation of resident preferences in record and care directives |
| “§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are  identified in the comprehensive assessment. The comprehensive care plan must describe the following — (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. (iv)In consultation with the resident and the resident’s representative(s)— (A) The resident’s goals for admission and desired outcomes. (B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.”[[5]](#footnote-5)  Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident’s medical, physical, mental and psychosocial needs.[[6]](#footnote-6) | * Use observations, interactions with resident, and resident expressed goals and preferences in development of the comprehensive care plan * Educate staff of individualized approaches to be used while providing care and services to meet resident preferences * Identify alternative processes to be used in the case of resident refusal and inform the care team. Document * Through observation, record audit, and interviews identify effectiveness of the approaches used and involve the resident/family in updates when needed. |
| F636 Comprehensive Assessments and Timing  Resident Assessment Instrument. “A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.”[[7]](#footnote-7) | * Review the Assessment and re-evaluation * Ensure training and competency with completion of the MDS 3.0 RAI process * Ensure that the resident’s preferences are included wen completing the assessment process |
| F658: Services Provided Meet Professional Standards  “Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—  (i) Meet professional standards of quality.”[[8]](#footnote-8) | * Ensure training and competency: * Care Plan Development * Care Plan Evaluation and Revisions * Skills and Techniques to ensure that resident preferences and person-centered care practices are in place |

**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>

MDS Section Q - Transition to Community (pg. 219): [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.cms.gov_Medicare_Quality-2DInitiatives-2DPatient-2DAssessment-2DInstruments_NursingHomeQualityInits_NHQIMDS30TrainingMaterials.html&d=DwQF-g&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=e619p8B1PHn8vknwQ7KdQFaSjEZ7IPcO-ZalaVYDUqs&m=H-YyUssUyCQ56jzn63wPQNcVBosAoHSlNgzQ9ZPl9ZA&s=JRTCmYGn6eega4xFJp9_9Fhn_JijUP63ZcPBJApt3kA&e=)

Discharge Critical Element Pathway - LTC Survey Pathways (Download) <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html>

1. 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. 2,3 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-2)
3. [↑](#footnote-ref-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-4)
5. [↑](#footnote-ref-5)
6. 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-6)
7. [↑](#footnote-ref-7)
8. [↑](#footnote-ref-8)