Specialized Rehabilitative or Restorative Services Critical Element Pathway

Use this pathway for a resident to ensure the facility obtains and provides necessary rehabilitative or restorative services.

As referenced in 42 CFR §483.65 - Specialized rehabilitative services include but are not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), and are required in the resident's comprehensive plan of care.

As referenced in Section O of the MDS/RAI manual - Restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

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 Sections C - Cognitive Patterns, G – Functional Status, H – Bladder and Bowel, J – Health Conditions-Pain, and O – Special Treatment/Proc/Prog-Therapies (O0400) and Restorative Nursing Programs (O0500).
- ☐ Physician's orders (e.g., therapy which includes type of treatment, frequency and duration, restorative, ADL, and contracture needs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., ADL assistance, premedication prior to therapy, therapy interventions, or restorative approach).

Observations:

- ☐ As soon as possible, observe resident receiving therapy services as required per their assessment and plan of care:
  - Were the services provided as prescribed in the care plan and as ordered?
  - How did the therapy staff take into account the resident's risk factors when providing services (e.g., orthostatic hypotension, hip replacement precautions)?
  - How does staff encourage the resident to participate to the extent possible?
  - How are staff interacting with the resident when providing these services?
  - How much staff assistance is provided to perform tasks?
- ☐ If assistive devices are needed per the care plan and orders, are these devices used correctly and assist the resident to maximize his/her independence? How are residents encouraged to use these devices on a regular basis?
- ☐ If Passive Range of Motion (PROM) exercises are performed, are resident's joints supported and extremities moved in a smooth steady manner to the point of resistance? If not, describe.
- ☐ If a resident expressed that he/she was experiencing pain during these services, how did staff address this?
- ☐ Are therapists treating more than one resident at a time? If so, how is the resident receiving the ordered services needed to improve the resident's function (e.g., therapy is doing exercises in a group and the resident only received two minutes of devoted time)?

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Resident, Resident Representative, or Family Interview:

- ☐ How and by whom were you informed regarding the therapy services you need?
- ☐ What services are your receiving and do you understand why you are receiving these services?
- ☐ With who and how did staff discuss your treatment plan and goals with you and were you allowed to provide input or changes to this plan and the goals?
- ☐ If you refused any of these services, did someone speak with you about the consequences of not receiving these services? If so, who spoke with you?
- ☐ How often and for how long do you receive these services and do you feel you have enough time during therapy to assist you in achieving your goals?
- ☐ Do you feel these services are helping you to improve? If not, why?
- ☐ Do you experience pain during therapy services? If so, what does staff do to help you relieve your pain and is this effective?
- ☐ If staff provided you with assistive devices (e.g., reacher, mobility devices, communication devices, special eating utensils):
  - o Did someone show you how to use the device? If so, who?
  - o Do you use it? If not, why not?
  - o Do you have these devices when you need them? If not, why not?
  - o Does staff encourage you to use the device?

Staff Interviews (Nursing Aides, Nurse, Therapy, DON):

- ☐ What are the current goals and interventions for the resident?
- ☐ How were the interventions determined to ensure they were suitable for the resident's needs?
- ☐ How was the resident/representative involved in decisions regarding their goals, interventions, and treatments?
- ☐ How and by whom were you trained on the resident's therapy or restorative program needs?
- ☐ How and by whom are therapy and nursing staff supervised and monitored to ensure they are implementing care planned interventions?
- ☐ How much assistance from staff does the resident need with their therapy or restorative services?
- ☐ How do you promote and encourage the resident's participation in these services?
- ☐ How often and how is the resident assessed (e.g., quarterly therapy screen) for a change in function and where is it documented?
- ☐ Does the resident have pain or shortness of breath? If so, who do you report it to and how is it being treated?
- ☐ Does the resident ever refuse therapy or restorative services? If so, why and how is this handled?
- ☐ How do you assess if the resident's ability is maintained, improving, or getting worse?
- ☐ If a resident is declining, when did this decline begin? What might have caused this decline? To whom and when was this decline reported and did the treatment plan change?
- ☐ Were there any therapy or restorative interventions in place before the decline developed? If so, what were these interventions and why did they not prove to be effective?
- ☐ Does the resident use any assistive devices? If so, what are these devices and why are they used? How is the resident educated and encouraged to use these devices?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

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Record Review:

- ☐ How did facility staff assess the resident's therapy and restorative status and needs?
  - o Has the resident's progress including improvement or decline been assessed and documented?
  - o Were the care plan and interventions revised to reflect any changes needed?
- ☐ Were therapy or restorative services provided and implemented as ordered?
- ☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- ☐ 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?
- ☐ Does your observation of therapy or restorative services match the level of assistance described in the resident's plan of care and clinical record? If not, describe.
- ☐ Were changes in the resident's status or other risks correctly identified and communicated with the resident, staff, and the attending practitioner?

Critical Element Decisions:

1. Based on observations, interviews, and record review, did the facility provide or obtain the required specialized rehabilitative services?
   If No, cite F825
   NA, the resident does not require specialized rehabilitation services.

2. Based on observations, interviews, and record review, did the facility provide the appropriate treatment and services as outlined in the resident's plan of care to maintain, restore or improve the functional ability for the resident?
   If No, cite F676
   NA, the resident does not have a potential to maintain or improve ADL functioning.

3. 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.

4. 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.

5. 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.

6. 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

7. 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.

8. 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: Right to be Informed F552, Choices (CA), Notification of Change F580, Privacy (CA), Abuse (CA), Dignity (CA), Social Services F745, Admission Orders F635, Professional Standards F658, Community Discharge (CA), Pain (CA), Positioning/ROM (CA), ADLs (CA), Behavioral-Emotional Status (CA), Sufficient and Competent Staff (Task), Physician Delegation to Therapist F715, Qualified Rehab Person F826, Infection Control (Task), Resident Records F842, QAA/QAPI (Task).