Care Planning for the Resident Who Has Dementia

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1

OUR DISCUSSION TODAY

OVERVIEW

- CMS Requirements for Dementia Care
- Comprehensive Care Plan
- Survey Focus
- Specific Care Plan Interventions

2

§483.5 Definitions

Person-Centered care

- For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

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Person-centered Care

- Care providers who truly offer a person-centered approach focus on the individual.
- They spend a great deal of time getting to know who the person is and who the person was.

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Person-centered Care

- Care-givers demonstrate a respect for each person.
- They believe each person still makes a difference in the world.
- They look at themselves not simply in a caretaker role of keeping someone safe and dry.
- They want to enable each person to use all their God-given abilities that remain.
- They believe that with proper support, people can have a relatively high level of well-being throughout the course of their illness or situation.

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What does CMS say?

F656 – Develop/Implement Comprehensive Care Plan

(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 time*frames* to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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What does CMS say?

The 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

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Care planning drives the type of care and services that a resident receives.

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What does CMS say?

- Facilities are required to develop care plans that describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences.
  - Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s).

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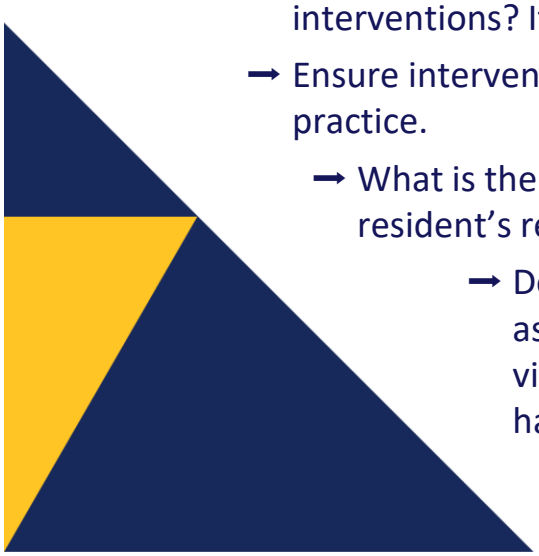
What does CMS say?

- 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?



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CMS Requirements of Participation

F744

§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

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"Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline.

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CMS Requirements of Participation

It is expected that a facility's approach to care for a resident living with dementia follows a systematic care process.

In order to ensure that residents' individualized dementia care needs are met, the facility is expected to assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible.

Care plan goals must be achievable and the facility must provide those resources necessary for an individual resident to be successful in reaching those goals.

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Nursing homes have diverse populations including, among others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences, speech/language challenges, and generational differences.

When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident.

It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to

14

14

Dementia Care

The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression.

However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse.

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Writing the care plan…

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17

Care Plan Components

1. Problems/Needs/Issues/ Concerns/Preferences/ Interests/Strengths
2. Goal
3. Interventions

18

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Care Plan Components

1. Identification of problem/need/concern/issue/preference/ strength
   - ✓ Identify so specifically that it can only be interpreted ONE way – YOUR way!
   - ✓ Don't leave "open" for various interpretations

19

19

Potential Risks/Issues

- ✓ Must be a "potential" for the individual resident; not every resident in the building
- ✓ Don't address on care plan just because the MDS 3.0 triggers…further investigate utilizing the CAAs. If you determine it is not an issue for the resident, DON'T address it on the care plan.

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Determining “at risk”…

Ask yourself this question for any identified issue…

- ✓ If my staff do not intervene with this issue, will the resident decline or deteriorate?
- ✓ If the answer is “no,” then don’t address it on the care plan, but give explanation in the CAA Summary as to why it is not being addressed.
- ✓ If the answer is “yes,” then you must address the issue on the care plan.

21

21

Care Plan Components

2. Development of goals:
   - ✓ Goal must deal with or address the problem/need/preference, etc. that was identified;
   - ✓ Goal must be resident-directed;
   - ✓ Goal must be an observable action task;
   - ✓ Goal must be quantifiable and measurable.

22

22

Care Plan Components

3. Development of interventions/approaches
   - ✓ Must be individualized
   - ✓ Must be specific; consider them specific "assignments" to a staff person

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How do I keep the plan individualized?

Ask yourself this question:

- ❖ Could I use this same goal and/or interventions (care plan) on other residents in my care?

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Outcomes…

- What is the resident outcome that you want to occur as a direct result of the care that you have provided?
- Who accomplishes the goal? Resident or staff?

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Key Elements of Noncompliance

Facility failed to…

- Assess resident treatment and service needs through the Resident Assessment Instrument (RAI) process;
- Identify, address, and/or obtain necessary services for the dementia care needs of residents;
- Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment;

26

26

Key Elements of Noncompliance

Facility failed to…

- Develop individualized interventions related to the resident's symptomology and rate of progression (e.g., providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks);
- Review and revise care plans that have not been effective and/or when the resident has a change in condition;
- Modify the environment to accommodate resident care needs; or
- Achieve expected improvements or maintain the expected stable rate of decline.

27

27

Surveyor Focus

- Behaviors (abuse & neglect)
  - ✓ Documented evidence of thorough investigation
  - ✓ Consistent plan across all shifts
  - ✓ Awareness of documentation from all relevant disciplines
  - ✓ Implementation of plan & effectiveness (or lack thereof)
  - ✓ Resident upon resident aggression & altercations

28

28

Surveyor Focus

- Falls
  - ✓ Falls risk assessment
  - ✓ Cognition assessment
  - ✓ Independent/Need for assistance
  - ✓ Bathroom patterns
  - ✓ Care plans NEED to have more interventions than toilet every 2 hours and bed alarms
  - ✓ Bed alarms? (They don't work!!)

29

29

Surveyor Focus

- Wandering/Elopement
  - ✓ Cognition assessment
  - ✓ Safety/Risk assessment
  - ✓ Independent/Need for assistance
  - ✓ Supervision/Monitoring

30

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Specific Interventions

- Cognitive Support
  - ✓ **Provide structured routines:** Keep daily schedules consistent to reduce confusion and anxiety.
  - ✓ **Use memory aids:** Label drawers/doors, use clocks with date/time, memory boards, or photo albums.
  - ✓ **Offer orientation cues:** Gently reorient residents to time, place, and person without arguing or correcting harshly.

31

Specific Interventions

- Cognitive Support
  - ✓ **Simplify communication:** Use clear, simple instructions and ask one question at a time.
  - ✓ **Engage in cognitive stimulation activities:** Use puzzles, music, reminiscence therapy, or life story work.

32

Specific Interventions

- Behavioral and Psychological Symptoms of Dementia (BPSD)
  - ✓ **Identify triggers for agitation or aggression:** Modify the environment to reduce overstimulation (noise, clutter).
  - ✓ **Use de-escalation techniques:** Speak in a calm voice, give space, and validate emotions.
  - ✓ **Provide meaningful activities:** Tailored to past interests to reduce boredom and restlessness.

33

33

Specific Interventions

- Behavioral and Psychological Symptoms of Dementia (BPSD)
  - ✓ **Monitor for pain or unmet needs:** Address underlying causes (e.g., hunger, toileting, discomfort).
  - ✓ **Avoid confrontation or correcting false beliefs:** Redirect gently instead of arguing.

34

34

Specific Interventions

❖ **Safety Interventions**

- ✓ **Fall prevention measures:** Use non-slip footwear, adequate lighting, grab bars, and call bells within reach.
- ✓ **Wander management:** Use GPS bracelets, wander alarms, or locked but supervised areas.
- ✓ **Monitor for swallowing difficulties (dysphagia):** Modify food textures and ensure upright positioning during meals.
- ✓ **Elopement prevention:** Secure exits and conduct regular checks.

35

35

Specific Interventions

❖ **Personal Care & ADLs**

- ✓ **Encourage independence with assistance:** Use cueing and hand-over-hand techniques.
- ✓ **Break tasks into small steps:** Allow extra time and avoid rushing the resident.
- ✓ **Use familiar routines:** Promote comfort by maintaining familiar grooming or dressing rituals.
- ✓ **Maintain dignity in care:** Explain each step, provide privacy, and respect preferences.

36

36

Specific Interventions

- **Emotional & Social Support**
  - ✓ **Promote social engagement:** Small group activities, pet therapy, music therapy, or spiritual visits.
  - ✓ **Use validation therapy:** Acknowledge feelings rather than challenge reality.
  - ✓ **Family involvement:** Encourage regular visits and participation in care planning.
  - ✓ **Offer reassurance frequently:** Use calming language and comforting touch if appropriate.

37

37

Specific Interventions

- **Nutrition & Hydration**
  - ✓ **Monitor food/fluid intake:** Keep records and intervene if intake is poor.
  - ✓ **Offer finger foods:** Useful for residents who wander or cannot use utensils well.
  - ✓ **Supervise meals as needed:** Provide encouragement or assistance without rushing.

38

38

Specific Interventions

- **Sleep and Rest**
  - ✓ **Promote good sleep hygiene:** Reduce naps during the day, limit caffeine, and establish bedtime routines.
  - ✓ **Monitor for sundowning:** Use calming activities in late afternoon/evening and reduce stimuli.

39

39

Specific Interventions

- **Medication Management**
  - ✓ **Review medications regularly:** Minimize use of antipsychotics; monitor for side effects.
  - ✓ **Use non-pharmacologic strategies first:** Address behaviors with environment or activity changes before medication.

40

40

Tips that work…

→ Staff assistance and coordination of care
Staff training
With dementia, “not my job, not my department” is a moot point!
Communication among and between departments.
Utilize activities, but ALL staff have to be involved with this - not just the Activity Director

41

41

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42

42