

Case-Based Activity Resident Eleven
Long-Term Care Learning Activity

Item	Description
Objective:	Given a scenario, the surveyor will identify areas of concern, potential citations, related regulatory requirements, and write the deficient practice statement.
Prior to Class:	Print copies of the scenario. Have the long-term care regulations available. Have flip charts and markers available. Provide copies of the Severity and Scope grid to each new surveyor.
Total Time for Activity:	60 minutes (The time given is approximate.)
Set-Up:	Set class up for small groups as needed.*

Step:	Preceptor Instructions:	Activity Time:
1.	Divide the class into small groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario.	25 min.
4.	As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	
5.	Debrief the scenario by discussing key points.	25 min.

*For individual assignment, provide direction and support where appropriate during the completion of the scenario. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.

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Directions: Read the two scenario components (*Document Review* and *Interview*) and answer the questions at the end using the resources provided by your preceptor. When completed, turn in your answer sheet to your preceptor to discuss and review.

Resident Eleven—Noah

Document Review

Noah's physician's diagnoses consisted of the following:

- Intellectual disability
- Atypical psychosis with agitated features
- Adjustment disorders with depressed mood
- Schizophrenia
- Diabetes mellitus

Noah's quarterly Minimum Data Set (MDS), dated 03/22/2012, identified that he was cognitively impaired and had moods of feeling bad about himself nearly every day during the assessment period.

A document review identified that Noah (R11) was under the care of a psychiatrist for behavior management for paranoid feelings.

R11's plan of care, undated, instructed staff that R11 was to see the psychologist PRN (as needed).

A psychiatrist note, dated 07/1/2012, instructed R11 to continue on the Clozapine 700 mg and to follow up with the psychiatrist in "11 months, sooner as needed" regarding current medications. Psychology notes indicated R11 had been seen by a psychologist who came to the facility every two weeks. The last note from the psychologist, dated 07/21/2011, indicated, "Will help him more accurately process stimuli in his environment and not always insist that people are against him. Follow up was recommended for two to four weeks." There was no further documentation regarding appointments with the psychologist after 07/21/2011, which was nearly nine months ago.

Interview

During an interview on 04/05/2012 at 11:25 AM, the clinical manager (CM-A) stated the household coordinator (social worker) takes care of the follow-up psychology appointments and was unsure why R11 had not seen a psychologist again. CM-A stated that in July 2011, the facility started working with a different psychologist. CM-A also stated R11 had refused care in

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the past, although the CM-A was unable to provide any documentation regarding any appointments that R11 had refused.

During interview on 04/05/2012 at 12:05 PM, a social worker (SW-A) stated the psychologist recommended follow-up in two to four weeks and was unsure why these recommendations were not followed.

A facility policy titled "Physician visits" dated 06/11 instructs, "Appointments needed for other physicians or medical specialties will be scheduled by the health unit coordinator as directed."

No further information was provided.

Survey Scenario Questions:

1. What areas of concern do you have? (Document on the flip chart provided.)
2. If you noticed any areas, would you stop the nurse and point these out? (Document on the flip chart provided.)
3. How would you continue to investigate your concerns? (Document on the flip chart provided.)
4. Do you think there will be deficiencies cited? Defend your answer. (Document on the flip chart provided.)
5. Based on the information given, what do you think the possible severity would be for this case?
6. Write a deficient practice statement for this situation.

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Preceptor Answer Sheet

Directions: Preceptor, document your answers in the spaces below prior to completing this activity. Use this information during your debrief.

1. What areas of concern do you have? (Document on the flip chart provided.)
 - The facility failed to follow-up as recommended by the psychologist
 - Potential for deterioration in mental status and medical status
 - Possible failure to monitor medication
 - Potential impact of Clozapine on Diabetes Mellitus
 - Care Plan interventions not followed regarding seeing psychologist PRN
 - Lack of care plan updates regarding residents refusal of treatment

2. If you noticed any areas, would you stop the nurse and point these out? (Document on the flip chart provided.)
 - No, there is not an indication that care should be stopped at this point.

3. How would you continue to investigate your concerns? (Document on the flip chart provided.)
 - Observe the resident for behaviors and response to medications.
 - Review documentation for resident's behaviors and response to medications.
 - Review the care plan to determine goals, interventions, and any evaluations that have been completed.
 - Interview resident and/or significant others (if appropriate) regarding behaviors, medications, and notifications of changes (in behaviors, medication, physician appointments, refusal of treatment). Has resident and/or family had input on plan of care and treatment options?
 - Interview direct care staff (including nurse and nursing assistants) regarding any possible behavior changes, ask direct care staff to describe R11's plan of care, and care measures related to his multiple diagnosis.
 - Interview activity and/or recreation therapy staff to determine what assessments was completed and what activities are in place, and R11's participation level.
 - Review physician orders for medication and monitoring lab work (leukopenia, glucose monitoring).
 - Interview the pharmacist and review pharmacy record reviews.

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4. Do you think there will be deficiencies cited? Please list the specific tags and your rationale. (Document on the flip chart provided.)
 - Yes, based on the information provided the following should be considered for deficient practice:
 - F250, SW failure to follow up
 - F319, facility failed to provide services
 - F282, implement care plan related
 - F280, failed to revise the care plan related to the resident's refusals
 - F329, due to lack of medication monitoring

5. Based on the information given, what do you think the possible severity would be for this case?
 - The new surveyor should be able to identify this as a level 2.

6. Optional: Write a deficient practice statement for this situation. If there are multiple tags, refer to your preceptor for guidance regarding which deficient practice statement to complete.

To the Preceptor: You may use this learning activity to help the new surveyor become more proficient with Principles of Documentation. To do this, be sure to give the new surveyor the information needed to complete a deficient practice statement.