Death Critical Element Pathway

Use this pathway for a resident who died and was not receiving end of life care, hospice, palliative care, comfort care, or terminal care to determine if facility practices were in place to identify, evaluate, and intervene as appropriate. Note: If the resident was not receiving end of life services on admission but experienced a rapid decline and subsequently received end of life services prior to their death within 30 days of admission, determine if facility practices were in place to identify, evaluate, and intervene to prevent the rapid decline. If concerns are identified, use the Death Pathway.

Record Review

You may need to return to the record to corroborate information from the observations and interviews. Potential pertinent items in the record are listed below.

- ☐ Review nursing notes, EMT records, hospital and discharge summaries, facility d/c summary, and progress notes.
- ☐ Review the most current comprehensive (i.e., admission, annual, significant change, or a significant correction to a prior comprehensive) and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAS for B - communication, C - cognitive status, E - behaviors, G - ADL status, H - bowel and bladder, I - active diagnoses, J - pain and health conditions, O - special treatments or procedures.
- ☐ Is the care plan comprehensive (e.g., specific interventions relevant to the death, measures to prevent decline in status)?
- ☐ Identify pertinent diagnosis.
- ☐ Review physician's orders (e.g., CPR status).
- ☐ Review laboratory or radiology results pertinent to the resident's death.
- ☐ The resident's change in condition or decline was assessed, monitored, and documented. Did the facility do a significant change assessment?
- ☐ Were interventions put into place to address the change or decline in condition (e.g., first aid measures, glucose monitoring, CPR, and immediate transfer)?
- ☐ Were interventions and preventive measures documented, appropriate, monitored, evaluated, and modified as necessary?
- ☐ Was pain assessed and treatment measures documented, if needed?
- ☐ Review facility policies and procedures with regard to factors that led to the resident's death.

Interview

*As part of the investigation, surveyors should attempt to initially interview **the most appropriate direct care staff member.** Your interview question should be specific to the investigation at hand and based on findings from the record review. Consider interviewing the DON, MD, CNP or PA to complete the investigation.*

Nurse:

- ☐ Are you familiar with the resident's care?
- ☐ Can you paint a picture about the resident (e.g., cognitive status, continence, ADL status) before the resident declined and prior to the resident's death?
- ☐ Did the resident have pain? If so, who did you report it to and how was it being treated? How often was the resident being assessed for pain?
- ☐ Did the resident have a change or decline in condition? If so, what interventions were in place to address the problem?
- ☐ When did the resident die and what was the cause of death?
- ☐ How often was the resident's condition assessed while experiencing a change in condition? Where is it documented? Did you report it (to whom and when) and did the treatment plan change?
- ☐ Did the resident refuse any treatments? What did you do if the resident refused?
- ☐ How did you involve the resident in decisions regarding treatment(s)?
- ☐ Were advance directives in place? If so, what was the resident's decision and were they honored?

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Make compliance decisions below by answering the four Critical Elements.

Note: *Remember if the facility failed to complete a comprehensive assessment resulting in a citation at F272, surveyors should not cite F279 as the facility could not have developed a plan of care based on a comprehensive assessment they did not complete. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.*

Critical Element

1. If the conditions or risks were present at the time of the required 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) of the resident's condition relevant to the care issues associated with the resident's death?
   If No, cite F272
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR a comprehensive assessment was not required yet.

2. Did the facility develop a plan of care with interventions and measurable goals, in accordance with the assessment, resident's wishes, and current standards of practice, to address the care and treatment related to the care issues associated with the resident's death?
   If No, cite F279
   NA, the comprehensive assessment was not completed OR a comprehensive care plan was not required yet.

3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?
   If No, cite F282
   NA, no provision in the written plan of care for the concern being evaluated.

4. Based on interviews and record review, did the facility provide care and services necessary to meet the needs of the resident in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
   If No, cite F309

Other Tags and Care Areas to consider: F155, Notification of Change (F157), Dignity (F241), Choices (F155, F242, F246), F271, F274, F278, F281, Behavioral/Emotional Status (F309, F319, F320), Nutrition (F325), Hydration (F327), Sufficient Staffing (F353, F354), F385, F501, F514, QA&A (F520).

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Notes: