

Effective Care Planning and Documentation for Skilled Nursing Facilities

InsPAC
Institute of Post-Acute Care



Welcome to Effective Care Planning and Documentation for Skilled Nursing Facilities



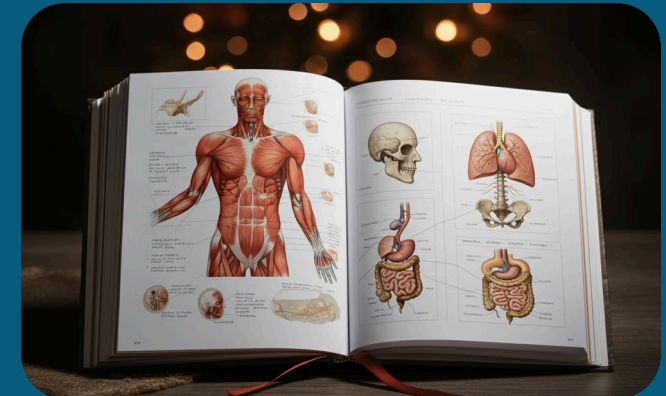
Welcome our Speaker

Our esteemed panel of healthcare leaders, includes Chief Nursing Officers, Administrators, Directors of Nursing, Infection Preventionists, Wound Care Specialists, Therapists, Nurse Aides, and Mental Health Experts.



Comprehensive Curriculum

This webinar covers the unique needs, preferences, and goals of each resident.



Holistic Assessments

You will be challenged to consider physical, mental, emotional, and social needs of your residents.

Objectives

1. Explore best practices for interdisciplinary collaboration in care planning to ensure holistic and resident-focused care.
2. Understand the key components of person-centered documentation that align with regulatory requirements.
3. Identify strategies to prevent common documentation errors that can lead to survey citations.
4. Develop actionable solutions to improve care planning workflows and enhance compliance through training and technology.

Red Flag Conditions for Admission Decision Making

Identifying critical health conditions that require careful evaluation before admission helps facilities make informed decisions about level of care needs.



Respiratory Support

Ventilator dependency or high-flow oxygen requirements may exceed facility capabilities.



Complex Wounds

Stage III/IV pressure injuries require specialized wound care expertise and resources.



IV Medication Needs

Multiple IV antibiotics may indicate infection complexity beyond facility scope.



Behavioral Health

Active suicidal ideation or aggressive behaviors require assessment for safe placement.

***Sample Admission Review Tool in Resources**



Reinforce Accurate Hospital to SNF Information

INTERACT Hospital to SNF Transfer Form

The INTERACT (Interventions to Reduce Acute Care Transfers) Hospital to SNF Transfer Form facilitates smooth transitions between care settings. It provides critical patient information that helps SNFs prepare for new admissions.

Clinical Information

Includes diagnoses, vital signs, mobility status, and mental status assessments to inform immediate care needs.

Care Instructions

Contains specific treatment protocols, medication schedules, therapy recommendations, and dietary requirements.

Risk Factors

Highlights fall risks, skin integrity concerns, infection control needs, and behavioral considerations.

Contact Information

Lists hospital providers, family contacts, and specialists involved in ongoing care coordination.

INTERACT: Improving Hospital to SNF Transfers

Key Components of INTERACT Transfer Tools

INTERACT tools create a standardized communication bridge between hospitals and nursing homes.

- Reduces medication errors during transitions
- Captures essential clinical information for continuity
- Highlights infection control and isolation needs
- Documents cognitive and functional status accurately
- Download form: <https://pathway-interact.com/>

Hospital to Post-Acute Care Transfer Form

INTERACT
Version 4.3 Tool

A. Patient Information
Name _____
DOB: ____/____/____ Gender: ☐ M ☐ F
Language: ☐ English ☐ Other _____
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other _____

B. Representative/Caregiver/Proxy Contact
Family/Caregiver Name _____
Tel: (____) _____
Healthcare Proxy/Guardian Name (if different) _____
Tel: (____) _____

C. Advance Directives/Goals of Care
☐ Full Code ☐ DNR ☐ DNR (Do Not Intubate)
☐ DNR/Do Not Hospitalize ☐ No Artificial Feeding ☐ Comfort Care
☐ Hospice Care
☐ Other (specify) _____
Were goals of care discussed during this hospitalization? ☐ No ☐ Yes (specify) _____
Patient decision making capacity? ☐ Capable of making decisions ☐ Requires proxy

D. Transferring Hospital Information
Hospital _____
Unit _____
Discharging RN _____
Tel: (____) _____
Discharging MD _____
Tel: (____) _____
Date of Admission to Hospital ____/____/____

E. Post-Acute Care Information
Transferred to _____ Tel: (____) _____
Nurse to Nurse verbal report? ☐ No ☐ Yes (specify to whom) _____

F. Hospital Physician Care Team Information
Primary Care Physician (or Hospitalist) _____ Tel: (____) _____
Specialist _____ Tel: (____) _____
Specialist _____ Tel: (____) _____

G. Key Clinical Information
Vital Signs Time Taken _____ Pain Rating _____ ☐ N/A Pain Site _____
Temp _____ BP _____ HR _____ RR _____ O2 Sat _____ Weight _____
Mental Status: ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands ☐ Not Alert
Diagnoses Primary Discharge Diagnosis _____
Other Medical Diagnoses _____
Mental/Health Diagnoses _____

H. High Risk Conditions/Treatment Information (check off that apply)
☐ Fall Risk Recurrences: ☐ New diagnosis? ☐ Exacerbation this admission? Date of last echo ____/____/____ ☐ EF ____ % Dry Weight (if known) _____
☐ Isent Failure: Reason: ☐ Atrial ☐ V-T/PE ☐ Mech. Valve ☐ Post-OP ☐ Low EF ☐ Other _____
☐ Anticoagulation: Duration: ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ Other _____
☐ On PPI: Indication(s): ☐ In-hospital prophylaxis and can be held ☐ Specific De _____
☐ On Antibiotics: Indication(s): _____ Total Treatment Course _____ days Date started ____/____/____
☐ On Scheduled Insulin _____
☐ COVID _____

I. Procedures & Key Findings (during this hospitalization) • Please Attach Reports •
List Procedures (surgeries, imaging) _____
Key Findings _____

J. Medications and Allergies
☐ Medication List Attached
Please provide a MEDICATION PRESCRIPTION FOR CONTROLLED SUBSTANCES
Allergies: ☐ None known ☐ Yes (specify) _____
Pain med: ☐ No ☐ Yes (specify) _____
Dose _____
Last Dose (am/pm) _____

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Documentation for Safe Hospital-to-SNF Transfers

Complete medical records are essential for continuity of care during this critical transition period.



Discharge Summary

Complete diagnosis list, hospital course, and current medical status to establish baseline condition.



Medication Reconciliation

Active medication list with doses, schedules, and recent changes to prevent dangerous interruptions.



Therapy Records

Recent PT/OT evaluations and treatment notes to continue appropriate mobility protocols.



Advanced Directives

Code status, healthcare proxy, and end-of-life wishes to honor resident preferences immediately.



The Interdisciplinary Team: Core Concepts

Key Components of Effective IDT Documentation

Pre-Admission Documentation Sources

Hospital discharge summaries provide key diagnostic data.

- Current medications
- Therapy evaluations
- Physician orders

Collaborative Assessment Methods

Scheduled team meetings ensure coordinated care planning.

- Cross-disciplinary assessment verification
- Joint ADL validation
- Coordinated documentation

Financial and Clinical Outcomes

Proper documentation raises reimbursement 18-22%.

- Fewer denied claims
- Appropriate case-mix grouping
- Better clinical complexity capture

New Admission Quality Checks

Ensuring comprehensive assessment and documentation during the critical admission period sets the foundation for quality care and proper reimbursement.



Verify Transfer Documentation

Confirm all hospital records are complete with medication lists and discharge instructions.

2

Initial Clinical Assessment

Document baseline vital signs, pain levels, and functional status within 24 hours.



IDT Input Collection

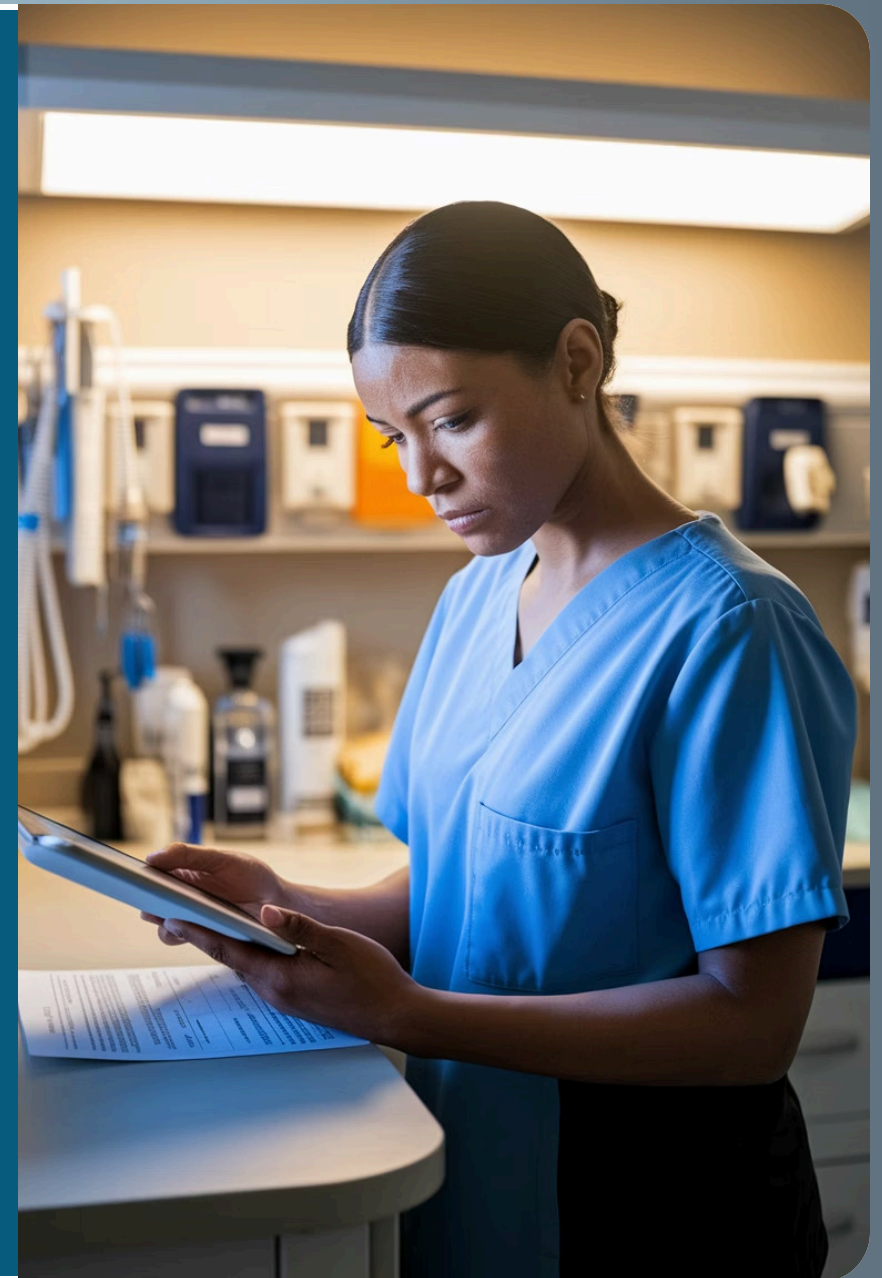
Gather observations from all disciplines for comprehensive baseline care planning.



PDPM Validation

Verify documentation supports appropriate PDPM category assignment for accurate reimbursement.

- Admission Chart Audit Resource available



Clinical and Operational Care Priorities

Balancing Clinical Excellence with Operational Efficiency

Skilled nursing facilities must prioritize both resident outcomes and operational workflows.

- Identify high-risk clinical conditions requiring immediate intervention
- Align staffing patterns with resident acuity levels
- Implement systematic documentation processes for continuity
- See [ClinicalCarePriorities.doc](#) second page
"Operations and Clinical Meeting Agenda"

Operational and Clinical Meeting Guidelines for Clinical Rounds
Following Morning Standup
Best Practice Strategies for QAPI Integrated QOC and QOL Reviews

Purpose: To provide a standardized system for tracking resident care and change in conditions
Integrate QAPI Oversight into daily, weekly, and monthly QAA

Organizing Daily Care Priorities for the DON and Nurse Leadership

1. Upon an arrival to the facility, the DON, Risk Manager, and Unit Managers check in on each unit.
2. The focus is facility and resident comfort and safety.
 - a. Identifying and responding to acute care priorities or post occurrence follow up
 - b. Identification of new or returning residents and admission completion
 - c. Identification of unplanned re hospitalizations for further review
 - d. Confirm Med availability and Reconciliation (Any residents waiting on pain meds or critical meds)
3. Staffing check; P.P.D, staff posting; Special needs; Notify Staffing coordinator as warranted.
4. Care Priorities/Needs
 - a. Pull PCC 24-hour report/incidents/new orders for discussion
 - b. Identify resident Clinical Rounds" list for the day that may include:
 - New admissions are visited daily x 7 days.
 - Residents on the PCC 24 hr. report: Select for rounding based on acute changes/new orders, ABT/infection, New psycho actives, Post occurrences, Risk factors, Advance Directives, Grievances.
 - c. The team may initially visit new admission/readmissions on Sawubona rounds, and coordinate additional visits during the shift based on priority
5. Targeted Rounds will be done at a designated time by Unit Manager, MDS for assigned unit, Nurse Leadership and others as available. Times should be consistent so floor staff can be available to give and receive information.
6. The DON/designee will run the RADAR Report through Point Right weekly and List RADAR residents on the Whiteboard or RADAR list for review during Rounds for the week. (Part of Point Right). Use any risk alert program you may have.



Daily IDT Clinical Rounds Process

How morning team meetings turn discussions into care actions

1

Morning Clinical Review

Check new patients daily for the first week. Look at changes like falls, pain, infections, important lab results, risks, and complaints. Focus on overnight issues that need quick attention.

2

Clinical Resident Assessment Rounds

Visit new patients and those with health changes. Watch them directly to check concerns, see if medicines are working, check infection recovery, and include patients in care decisions.

3

Admission Experience Evaluation

Ask new patients simple questions about their stay, comfort, how well staff explained things, and what they still need. Write down answers to find ways to improve and personalize their care.

4

Responsibility Assignment

Assign specific tasks to team members. Each department records their findings—nurses track infections and falls, pharmacy handles medications, and social services manage complaints—while meeting payment requirements.

5

Care Plan Updates

Change care plans within 24 hours after important health changes. Record assessments, antibiotic use, lab follow-ups, and investigation results. Share information between shifts for consistent care.

Staff Huddle Process After Clinical Rounds

Structured staff communication that transforms morning IDT findings into actionable care delivery for frontline staff.

IDT Round Summary

Charge nurses share priority resident needs identified during morning rounds. Focus on acute changes and new interventions.

Care Plan Updates

Review modifications from IDT rounds. Communicate new resident goals and PDPM documentation requirements to direct care staff.

Staffing Adjustments

Redistribute assignments based on resident acuity changes. Assign specialized monitoring for residents with status changes.

STOP and WATCH Early Warning Tool

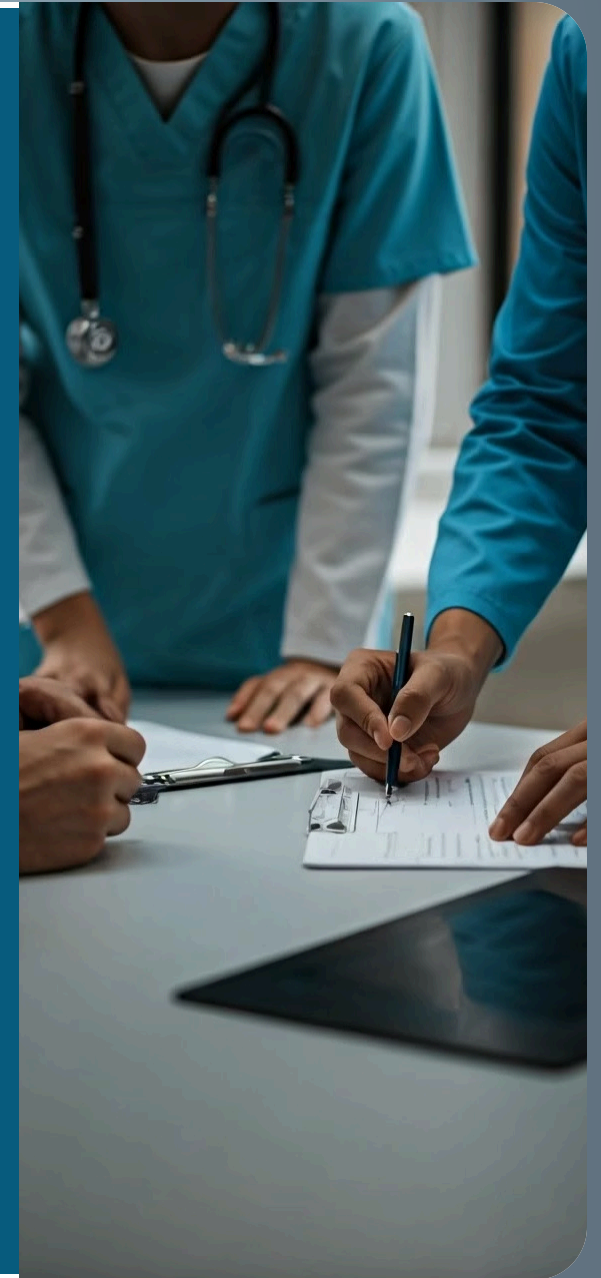
CNAs use STOP and WATCH tools to document subtle changes in resident conditions. Nurses review completed forms for early intervention opportunities.

Feedback Collection

CNAs share additional observations about resident conditions. Document clinical changes not captured by STOP and WATCH or morning rounds for follow-up.

Implementation Validation

Create accountability system to verify all new interventions are implemented. Schedule mid-shift check-in for critical resident needs.



Federal Requirements for Baseline Care Plans

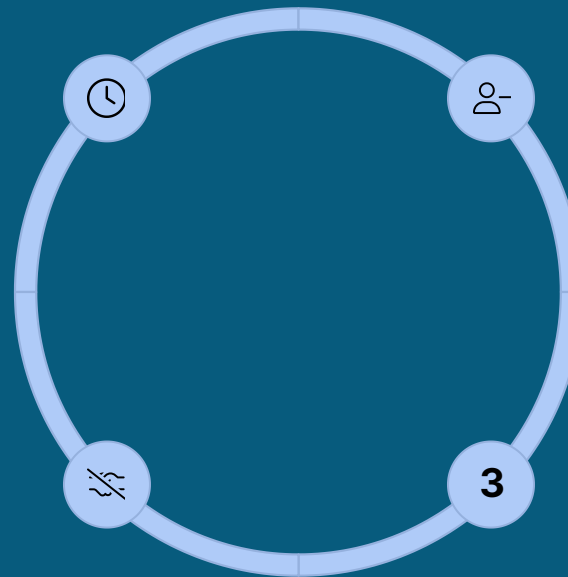
CMS mandates comprehensive baseline care plans within 48 hours of admission to ensure immediate resident safety and appropriate care delivery.

48-Hour Requirement

Initial care plan must address immediate care needs including diagnoses, medications, and treatments.

Resident Involvement

Residents and families must receive written summaries and participate in care planning process.



IDT Collaboration

Multiple disciplines must contribute expertise while documenting their specific interventions.

Comprehensive Plan

Full assessment and detailed care plan must be completed within 7 days of MDS completion.

Team Collaboration for Baseline Care Plans

Good teamwork between departments is key to creating baseline care plans within the required 48-hour window, making sure all immediate resident needs are met.



Clear Role Assignment

Define who does what during pre-admission and admission: nursing collects health data, social services gathers personal information, and dietary records food preferences to create efficient baseline plans



Quick Team Meetings with New Admits

Hold brief stand-up meetings with representatives from all departments within 24 hours of admission to share critical findings and coordinate immediate care needs



Standard Communication Methods

Use structured tools like SBAR (Situation-Background-Assessment-Recommendation) to ensure consistent record-keeping and information sharing across all departments contributing to the baseline plan



Shared Documentation

Use electronic systems where all departments can document their observations and actions at the same time, showing everyone what the resident needs for the baseline plan

Baseline Care Plans Content

1

48-Hour Documentation Requirements

Document resident goals, diagnoses, physician orders, nutritional needs, and therapy protocols within 48 hours to ensure care continuity.

2

Resident Preferences and Cultural Considerations

Record daily routine preferences, communication methods, and cultural needs during initial assessment. Share with staff.

3

Electronic and Physical Documentation Storage

Store plans in EMR under "Baseline Care Plan" tab with printed copy in resident's chart for quick access.

4

Incorporating Person-Centered Elements

Include resident's direct quotes, relevant personal history, and individualized comfort measures.

5

PDPM Documentation Requirements

Record initial functional abilities, cognitive status, and clinical complexity to establish PDPM payment categories and support care planning.



Team Collaboration for Baseline Care Plans



RN Oversight

RN oversees coordination within 48-hour timeframe



Department Responsibilities

Nursing (ADLs, clinical risks), dietary (nutritional needs), therapy (mobility, swallowing assessment), and social services (psychosocial factors and resident rights)



Implementation Verification

Daily IDT communication verifies baseline care plan implementation through STOP and WATCH tool utilization

Implementing Baseline Care Plans

48-Hour Federal Requirement (F655)

Care plans must be started within 48 hours of a new resident's arrival, as required by Medicare rules. These guide care until the full assessment is done by day 7-14.

Benefits for Residents and Payment

Helps maintain consistent care, reduces harmful events by 27%, creates a foundation for planning, and starts documentation needed for proper payment.

- 1 Initial Assessment (0-24 hours)**
Admitting nurse checks hospital records, reviews medications, and notes immediate needs like therapy, IV medications, wounds, and infection control needs.
- 2 Clinical Evaluation (24-36 hours)**
Nurse records vital signs, checks for risks, notes physical abilities, and assesses pain to determine what care is needed most and start required documentation.
- 3 Person-Centered Elements (36-40 hours)**
Social Services records personal preferences, daily routines, food needs, goals, end-of-life wishes, and personalized schedules to respect dignity.
- 4 Care Instructions (40-47 hours)**
The care team creates specific plans for high-risk areas: falls, skin care, medication monitoring, infection control, and dietary needs.
- 5 Moving to Full Care Plan (Day 7)**
MDS Coordinator adds baseline information into the assessment process, ensures proper payment documentation, and reviews how well current care is working before creating the full care plan.



Essential Elements of Baseline Care Plans

Baseline care plans provide critical information to residents and families within the first 48 hours of admission. They establish immediate care priorities while comprehensive assessments are completed.

Resident Information

Includes demographic details, emergency contacts, legal representative information, and primary physician contacts.

Medical Summary

Lists primary diagnoses, medication regimen, allergies, and immediate precautions required for resident safety.

Care Priorities

Outlines immediate needs for ADLs, mobility assistance, nutritional requirements, and specialized interventions.

Resident Preferences

Documents initial identified preferences for daily routines, communication methods, and important personal choices.

Baseline 48-Hour Care Plan: Right Hip Fracture with Complications

Addressing transition needs, pain management, functional recovery, and nutritional support

1 Facility Transition Support

Orient to facility environment q8h for first 48 hours. Review call system, safety features, and daily routine. Document adaptation to new environment and emotional adjustment at end of each shift.

3 Right Hip ORIF Site Care

Monitor surgical site q8h for redness, swelling, drainage. Maintain extremity elevation with positioning devices. Assess incision integrity with each dressing change. Document healing progression and any complications.

5 Dysphagia Management

Implement speech therapy recommendations for modified texture diet. Document swallowing difficulties during each meal. Position upright at 90° during meals and 30 minutes after. Monitor for coughing, choking, or voice changes after swallowing.

2 Acute Pain Management

Administer prescribed analgesics per order schedule with breakthrough protocol. Document pain levels q4h using 0-10 scale. Monitor effectiveness within 30-60 minutes of administration. Implement non-pharmacological measures including positioning and cold therapy.

4 ADL Support Protocol

Provide assistance with transfers and mobility with 1-2 staff. Implement limited weight-bearing precautions per physician orders. Document functional baseline for Section GG with detailed assistance levels for bed mobility, transfers, toileting, and personal hygiene.

6 Nutritional Intervention

Monitor intake at each meal (percentage consumed). Weigh resident daily at same time. Provide oral supplements between meals as ordered. Document weight trends and nutritional intake patterns for MDS and PDPM coding.

IDT Collaboration: From Baseline to Comprehensive Care Plan

The journey from baseline to comprehensive care planning requires strategic interdisciplinary collaboration focused on person-centered documentation.

Baseline Assessment (24-48 Hours)

Capture initial PDPM components across PT, OT, SLP, and nursing domains. Document functional baseline, primary diagnoses, and immediate care needs.



Person-Centered Input Gathering

Document resident preferences using PELI tools. Social services leads behavior and depression screening essential for PDPM NTA component.



Comprehensive Care Plan Development

Integrate all assessments into measurable goals. Document interventions that support both resident preferences and PDPM reimbursement categories.



Pre-Care Plan IDT Review

Team reviews baseline data, hospital records, and resident preferences. Each discipline identifies PDPM drivers and documentation priorities.



MDS Completion & CAA Process

IDT validates ADL scoring and captures clinical complexity. Document comorbidities, special treatments, and therapy needs aligned with PDPM requirements.



PDPM Categories and Documentation Requirements in the MDS and Clinical Record



Primary Diagnosis Documentation

Clearly document ICD-10 codes supporting the primary reason for SNF care. Ensure your intake tool is comprehensive.



Comorbidity Capture

Document all active diagnoses affecting treatment within the first 8 days.



Functional Status Assessment

Record detailed ADL scores including the level of assistance required.



NTA Component Support

Document all medications, treatments, and conditions impacting non-therapy ancillaries.



Cognitive/SLP Documentation

Assess cognitive status, swallowing difficulties, and communication disorders thoroughly.



PDPM Documentation: Impact on Reimbursement

5

PDPM Categories

Physical Therapy, Occupational Therapy,
SLP, Nursing, Non-Therapy Ancillary

18%

Revenue Impact

Average increase with proper clinical
documentation

48 hrs

Assessment Window

Critical period for accurate baseline
documentation

Complete, specific documentation captures all relevant clinical conditions affecting reimbursement rates.

PDPM Categories and Documentation Excellence

Accurate PDPM coding directly impacts appropriate reimbursement and quality care delivery.

Component	Key Drivers	Documentation Focus
PT/OT	Primary diagnosis, functional score, cognitive impairment	ADL assessments, therapy evaluations, cognitive status
SLP	Diagnosis, cognition, swallowing status, diet modifications	Speech evaluations, swallowing assessments, diet orders
Nursing	Depression score, restorative nursing, extensive services	Depression screening, nursing interventions, service tracking
NTA	Specific conditions, extensive services, medications	Medical diagnoses, treatment orders, medication administration

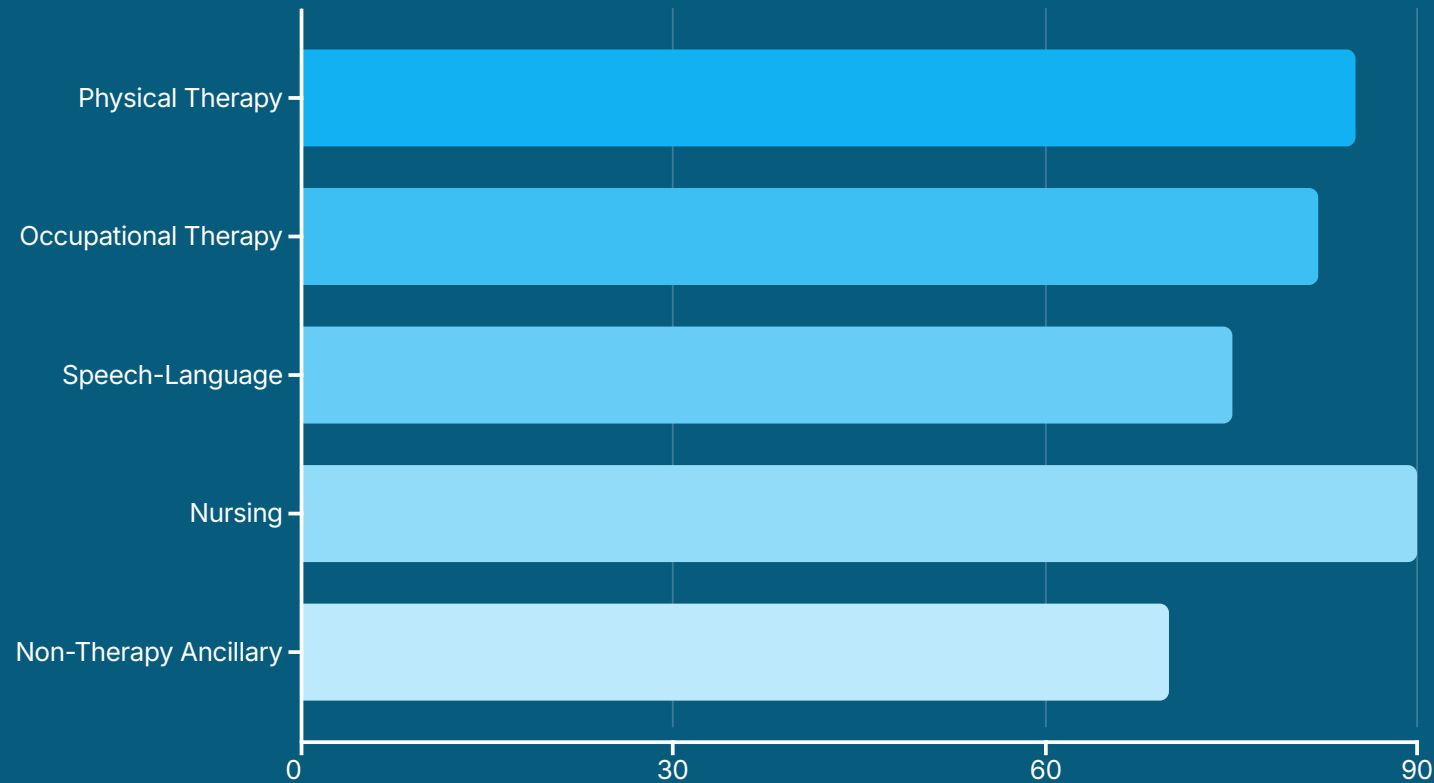
Consistent interdisciplinary documentation ensures accurate PDPM category assignment and appropriate reimbursement.

PDPM Categories Requiring MDS Assessment

Component	Key Diagnoses/Conditions	Documentation Requirements
Physical Therapy	Major joint replacement, stroke, fractures, amputation	Functional mobility scores, therapy goals, baseline status
Occupational Therapy	Neurological conditions, orthopedic disorders, cognitive impairments	ADL performance, fine motor skills, adaptive equipment needs
Speech-Language	Dysphagia, aphasia, laryngeal cancer, TBI, dementia	Swallowing assessments, cognitive communication status, diet modifications
Nursing	Diabetes with injection, wound care, IV medications, depression	Extensive services, restorative nursing interventions, clinical complexity
Non-Therapy Ancillary	HIV/AIDS, multidrug-resistant infections, IV medications	Comorbidities, special treatments, medication regimens

Each discipline must document specific PDPM elements to support appropriate reimbursement. Accurate diagnosis coding directly impacts case-mix classification and facility reimbursement.

PDPM Categories Requiring MDS Assessment



Each discipline must document specific PDPM elements to support appropriate reimbursement. Accurate diagnosis coding directly impacts case-mix classification and facility reimbursement.

Minimum Data Set (MDS) Importance

1

Accurate PDPM Coding

Document all diagnoses, services and clinical conditions within the 5-day assessment window.

2

Section GG Precision

Capture baseline functional abilities with detailed scoring that reflects true performance.

3

NTA Component Focus

Identify all comorbidities and special treatments that qualify for non-therapy ancillary points.

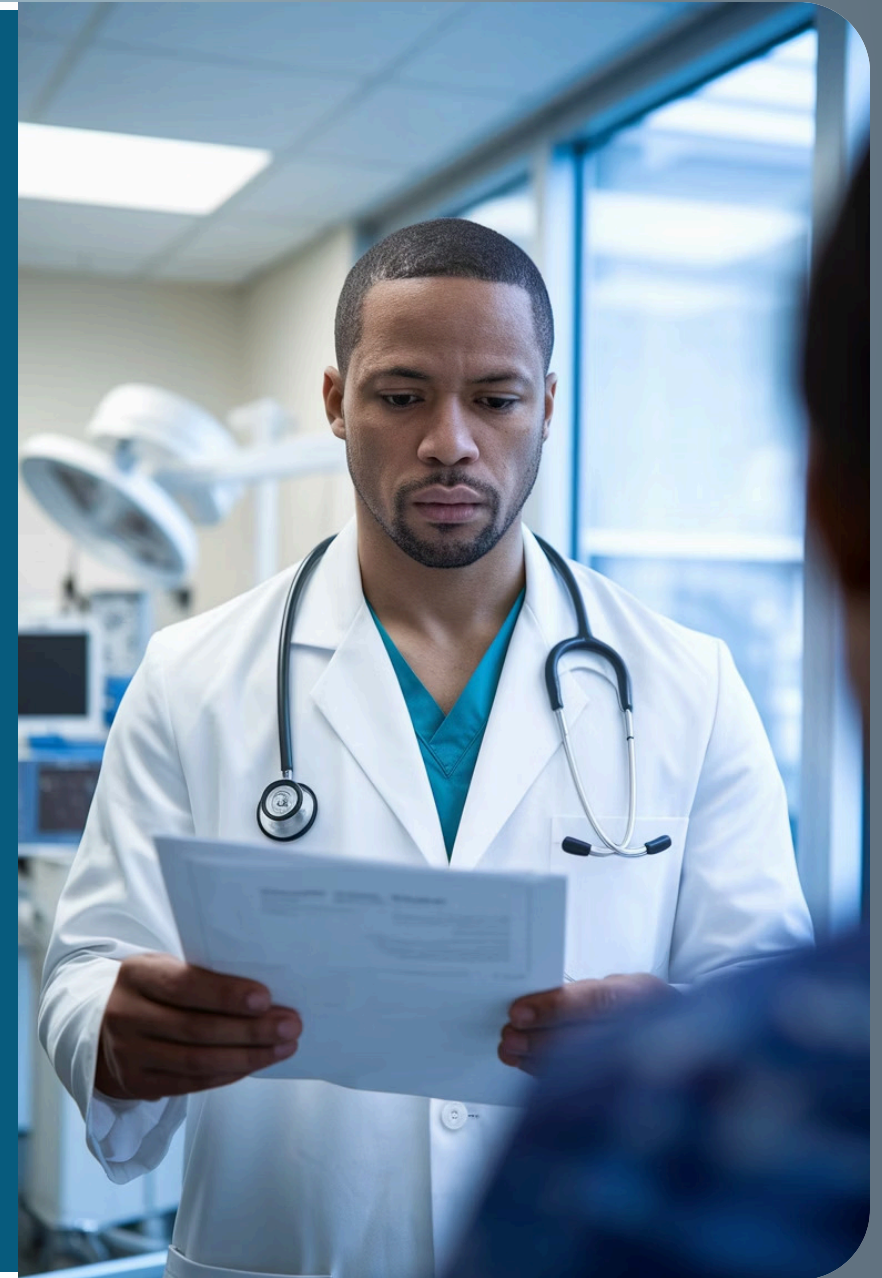
MDS nurses now serve dual clinical and financial roles. Their precise PDPM documentation directly affects care planning, reimbursement accuracy, and facility financial outcomes.

Critical MDS Documentation

Accurate MDS assessment ensures proper reimbursement while supporting individualized resident care planning.

- **PT & OT:** Section GG scores, primary diagnosis, and surgery history
- **Speech-Language:** Swallowing disorders, cognitive impairments, and dietary preferences
- **Nursing:** Depression screening, ADL assistance, and specialized treatments
- **Non-Therapy Ancillary:** Comorbidities, medications, and extensive services
- **Non-Case Mix:** Demographics, payer source, and personal preferences

Thorough documentation supports both reimbursement and resident-centered care.



Critical MDS Documentation – Part 2

Skin Condition

- Pressure injuries or wounds
- Risk assessment
- Current treatments

Nutrition

- Weight status
- Dietary needs
- Swallowing difficulties

Psychosocial

- Social engagement
- Activity preferences
- Cultural needs

Thorough documentation ensures appropriate care planning, accurate PDPM classification, and proper reimbursement.

Documentation Integration

SLP Component Documentation Requirements

- Cognitive Assessments: BIMS scores and orientation
- Swallowing Function: Diet modifications and aspiration risk
- Communication Status: Expressive/receptive disorders

Interdisciplinary Integration

- Care Planning Integration: Therapy goals in interdisciplinary plans

Dysphagia Monitoring Protocols

- Signs to Monitor: Coughing during meals and wet voice
- Safety Protocols: Upright positioning and proper meal pacing

CNA Documentation Requirements

- Documentation Needs: Record intake and choking episodes
- Early Intervention: Use STOP and WATCH tool for subtle changes

Strengthening Nursing and CNA PDPM Documentation

Nursing documentation directly impacts reimbursement across all PDPM components.



ADL Accuracy

Document assistance levels, staff numbers, and resident participation for each ADL.



Cognitive Status

Record changes in alertness, memory, and orientation responses. Clinically assess change in LOC. Rule out Infection, Delirium, Medication, Depression, etc.



Treatments & Medications

Document specialized treatments, timing, and resident responses.



Restorative Nursing

Detail intervention minutes and track progress with specific measurements.



Joint ADL Scoring Validation Strategies

Ensuring accuracy across disciplines improves resident outcomes and reimbursement integrity

Daily Observation Rounds

Nurses and CNAs jointly document functional status using standardized assessment tools during care delivery.

Cross-Discipline Verification

Therapy and nursing staff compare ADL scoring weekly to identify inconsistencies in functional assessments.

Documentation Review Sessions

Monthly IDT meetings dedicated to reviewing ADL documentation patterns and addressing scoring variability.

Real-Time Validation Technology

Mobile documentation tools allow immediate cross-checking of ADL scores between departments at point-of-care.

Consistent ADL scoring increases accuracy of PDPM classification and reduces compliance risks during audits.

Social Service: Behavior & Depression Documentation

Assessment	Frequency	Documentation	PDPM Impact
Depression Screening	Admission + Quarterly	PHQ-9 scores, mood patterns	Nursing component
Psychosocial Assessment	Admission + Changes	Mental health history, support systems	Depression validation
Behavior Planning	Initial + Monthly	Person-centered, non-pharmaceutical approaches	Nursing + care planning
Support Engagement	Monthly + PRN	Family involvement, intervention responses	Behavior intervention
Mental Health Coordination	As Needed	Consult notes, recommendations	Medical necessity

Thorough social service documentation validates depression severity, establishes behavior patterns, and supports non-pharmacological interventions—essential for accurate nursing component scoring and care justification.

Supportive Physician Documentation

Physician documentation provides essential clinical validation that strengthens PDPM scoring accuracy and ensures appropriate reimbursement.



Clinical Assessment

Document precise diagnoses with ICD-10 specificity to support PDPM primary diagnosis.



Therapy Orders

Include detailed medical necessity and functional limitations to validate therapy components.



Medication Reviews

Document clinical justification for medications affecting nursing and NTA components.



Progress Notes

Provide ongoing clinical validation of resident's condition and response to interventions.



Best Practices for Advance Directive Management



Pre-Admission and Admission Review

Request advance directive documents during pre-admission process. Conduct thorough review of all AD documents at admission and document status in EHR.



Schedule Regular Reviews

Conduct quarterly reviews during care plan meetings. Document discussions in resident's EHR.

Check face sheet accuracy.



Update at Key Transitions

Review after hospitalizations or significant health changes. Trigger automatic review when condition changes.



Family Communication

Include family/POA in directive discussions. Document all conversations with date and participants.

Great Resource: Hard Choices For Loving People by Hank Dunn



Verification Protocol

Establish standardized verification process. Confirm documentation matches current resident wishes.

Resource: [INTERACT Advance Care Planning Communication Guide](#) and [Identifying Persons who may be appropriate for Hospice or Palliative/Comfort Care Orders](#)

Hard Choices for Loving People: Resident and Family Education

Hank Dunn's guide helps families navigate difficult end-of-life medical decisions with compassion and clarity.

Core Philosophy

Balances medical intervention with quality of life when cure is unlikely.

Person-Centered Approach

Helps families honor residents' values and facilitate care preference discussions.

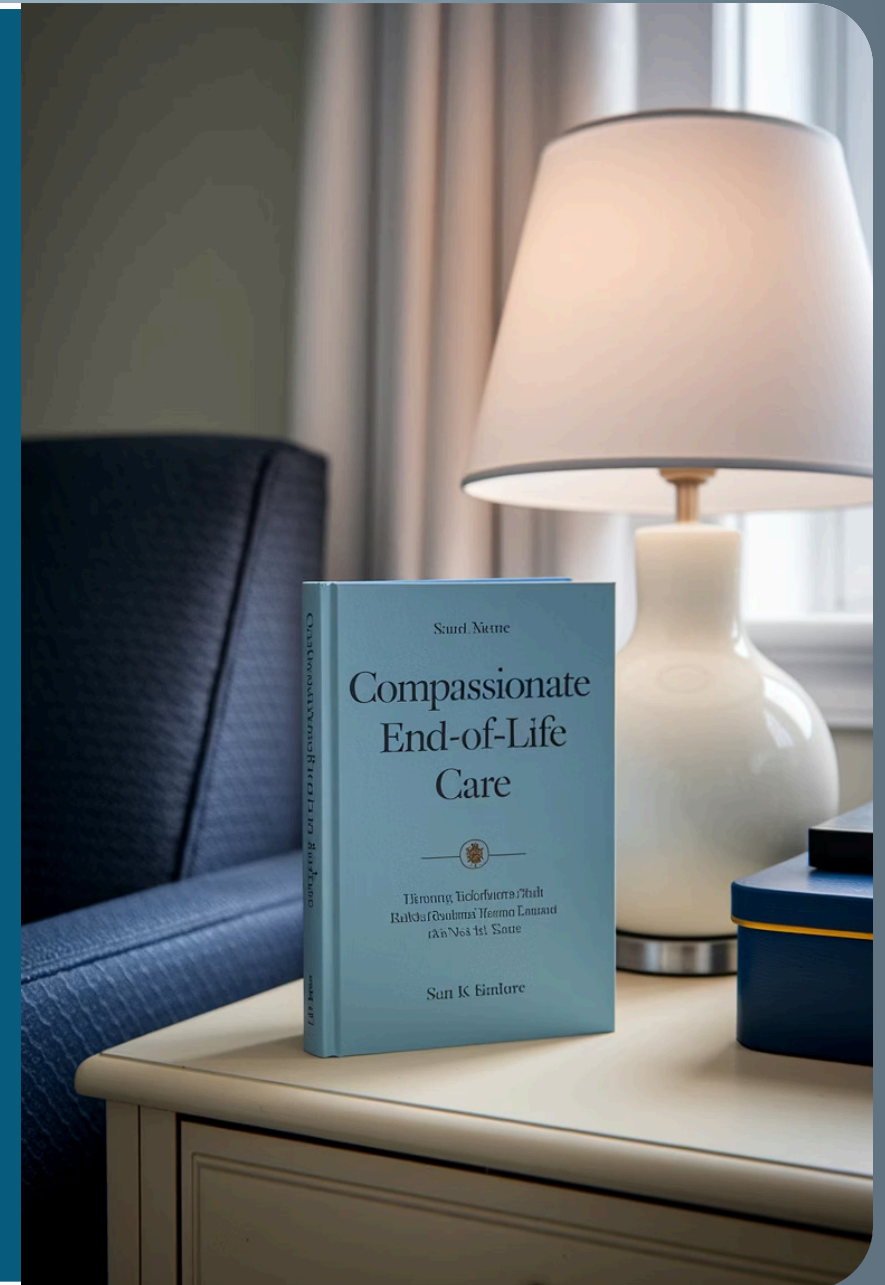
Resource: [Hard Choices for Loving People](#)

Key Topics

Addresses CPR, nutrition, hospitalization, and hospice alongside ethical considerations.

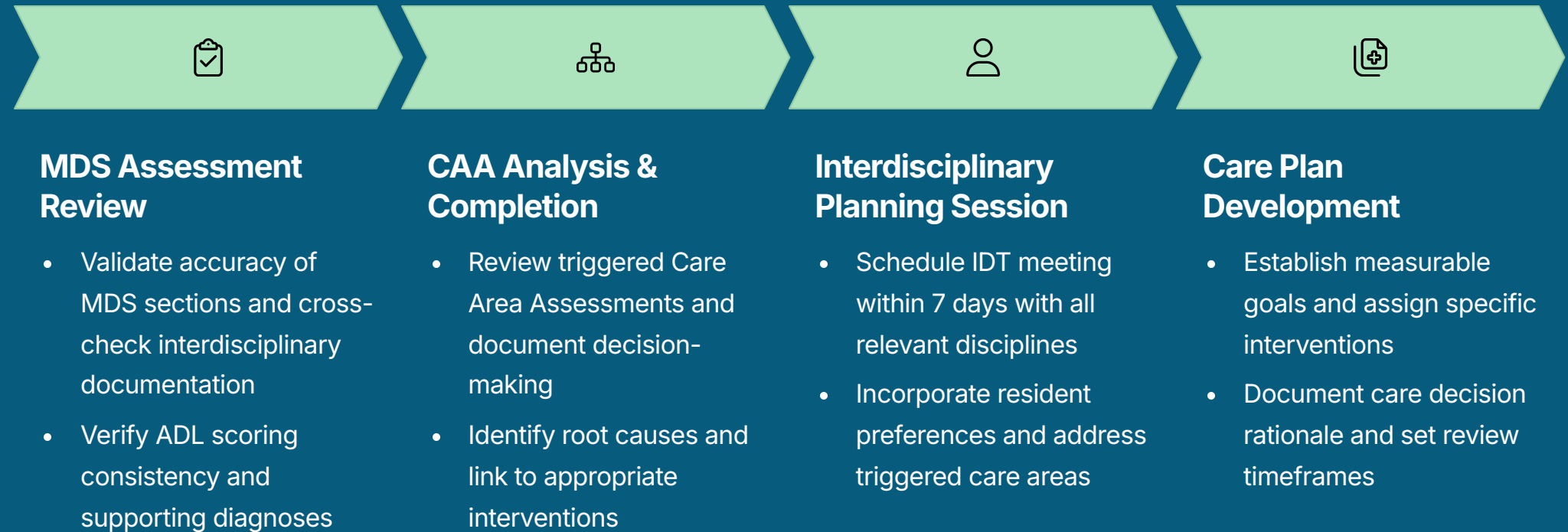
Practical Application

Provides framework for implementing directives that reflect resident wishes.



Pre-Care Plan IDT Review Process

The interdisciplinary team must systematically review assessment data before finalizing care plans to ensure comprehensive, person-centered care delivery.



Strategies for IDT MDS Collaboration

Effective MDS collaboration requires structured approaches that leverage each discipline's expertise while maintaining resident focus.



Structured Meeting Protocols

Establish weekly MDS review sessions with clear agendas. Focus discussions on assessment accuracy and care plan integration.



Cross-Disciplinary Documentation

Implement shared documentation workflows. Create discipline-specific sections that feed into comprehensive MDS reports.



Resident-Centered Validation

Verify MDS data through direct resident interaction. Cross-check observations between disciplines for comprehensive assessment accuracy.



Outcome Tracking Systems

Monitor key MDS quality measures across disciplines. Use trends to identify documentation gaps and improvement opportunities.

Preferences for Everyday Living Inventory (PELI)

The Preferences for Everyday Living Inventory (PELI) is a validated assessment tool that identifies and documents resident preferences to support person-centered care in skilled nursing facilities.



Comprehensive Assessment

Evaluates preferences across multiple domains including social interactions, activities personal care routines, and environmental considerations.



Person-Centered Foundation

Provides structured framework for understanding residents' individual choices, supporting dignity and autonomy in care delivery.



Care Planning Integration

Results directly inform the development of personalized care plans, helping staff honor preferences and improve quality of life.

When integrated into the care planning process, PELI enhances resident satisfaction, promotes regulatory compliance, and supports individualized care approaches across the interdisciplinary team.

Person Centered Resources

PELI: Preferences for Everyday Living Inventory

The PELI interview provides a systematic approach to identifying and documenting resident preferences for daily activities, routines, and care delivery.



Personal Development

Identifies preferences for growth activities, learning opportunities, and religious practices that support continued personal development.



Leisure Activities

Documents preferences for entertainment, social events, and outings that enhance quality of life and engagement.



Self-Dominion

Captures preferences related to autonomy, choice, and personal control over daily decisions.



Living Environment

Records preferences for room setup, personal belongings, and comfort measures that create a homelike atmosphere.



Social Relations

Assesses preferences for social interactions, visitors, and communication styles with staff and other residents.



Daily Routines

Documents preferences for meals, hygiene, and sleep patterns to maintain familiar and comfortable routines.

PELI results should be incorporated into care plans and daily care routines to enhance resident quality of life and satisfaction with care. The assessment covers 72 psychosocially meaningful preferences and helps fulfill regulatory requirements for person-centered care. [Link to PELI MDS Assessment](#)

Rule F636 requires complete resident assessments and care planning processes that must be done on time with proper documentation to meet requirements.

F636: Assessment & Care Planning Process

Rule F636 requires thorough resident assessments and Care Area Assessments (CAAs) that must be completed on schedule.

- Complete assessments must be done within 14 days after admission, yearly, and when a resident's condition changes significantly
- CAAs must be finished within 7 days after the MDS completion
- Records must show that assessment information was reviewed and used to create the care plan
- The facility must ensure assessments correctly show the resident's actual condition

CAA documentation should show thoughtful analysis of assessment findings and clearly explain the reasons behind care plan decisions and actions.

F636: Comprehensive Assessment & CAA Process

Care Area Assessments (CAAs) are triggered by specific MDS responses and require thorough development to inform proper care planning.



CAA Trigger Mechanism

CAAs are automatically triggered when specific MDS item responses reach established thresholds indicating potential problem areas.



Common CAA Triggers

Triggers include falls risk scores, weight loss percentages, mood scale thresholds, and cognitive performance measures.



CAA Development Process

Analyze triggered areas through resident interviews, direct observation, and review of medical records to determine root causes.



Documentation Requirements

Document decision-making rationale, supporting evidence, and whether triggered areas require care plan interventions or why they don't.



MDS Review and CAA Management

1 Standardized CAA Process

Develop consistent protocols for triggering and addressing Care Area Assessments across disciplines.

2 Root Cause Analysis

Investigate underlying factors behind triggered CAAs rather than treating surface symptoms.

3 Evidence-Based Documentation

Support CAA decisions with specific resident observations and measurable assessment data.

4 Intervention Integration

Connect CAA findings directly to care plan interventions with clear responsibility assignments.

5 Outcome Tracking

Establish metrics to evaluate if CAA-related interventions produce desired resident improvements.

Sample CAA for Dysphagia: Application in Practice

Dysphagia Assessment Process

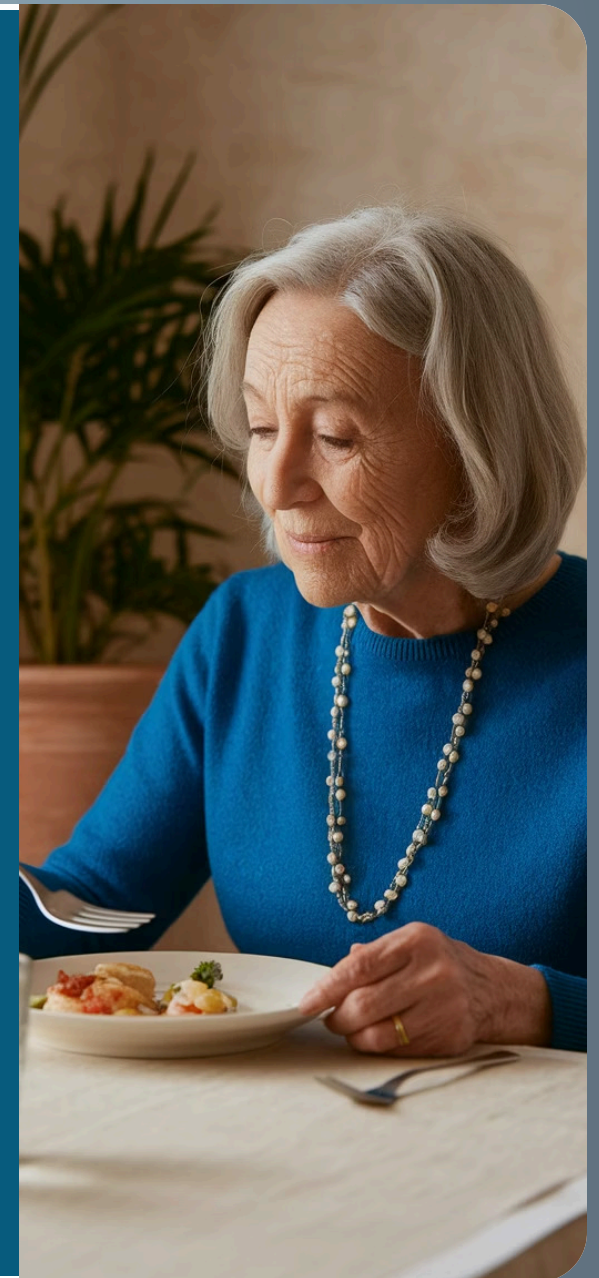
1. **Trigger Identification** MDS Section K identified significant swallowing difficulties and persistent coughing during meals. The resident specifically reported sensation of food "becoming lodged" when consuming solid foods.
2. **Root Cause Analysis** Clinical assessment revealed dysphagia symptoms intensify with specific food textures and consistencies. Evaluation identified a clinically significant delayed swallow reflex and diminished oral motor control.
3. **Evidence Documentation** Clinical record documented frequent coughing episodes during meals, extended meal completion times averaging 45 minutes, and progressive weight loss of 3% within a 30-day period.
4. **Care Plan Integration** Comprehensive SLP evaluation initiated for advanced swallowing assessment. Implemented evidence-based interventions including texture-modified diet and 90-degree upright positioning during all meals and 30 minutes post-meal.

Monitoring and Results

Structured weekly monitoring demonstrates 80% reduction in coughing episodes and aspiration risk. Twice-weekly SLP therapy has yielded measurable improvements in swallowing function and oral intake efficiency.

Clinical Significance

This clinical example illustrates how prompt identification of dysphagia symptoms, comprehensive assessment by Speech-Language Pathology, and coordinated interdisciplinary interventions generate quantifiable improvements in swallowing safety, nutritional outcomes, and overall resident quality of life.



Walking Rounds For IDT

Strategic walking rounds create opportunities for real-time interdisciplinary collaboration and direct resident observation.

Planning and Preparation

- Schedule consistent times across shifts
- Bring mobile documentation tools
- Review priority concerns beforehand

Resident Engagement

- Interact directly with residents during rounds
- Assess care plan effectiveness in real-time
- Document resident responses immediately

Team Coordination

- Ensure representation from all disciplines
- Assign clear responsibilities for follow-up
- Rotate leadership among team members

Documentation and Follow-through

- Capture observations in point-of-care systems
- Update care plans based on round findings
- Track resolution of identified issues



Critical Element Pathway: Resident Nutrition Observations

What surveyors observe during dining to evaluate nutrition care compliance and person-centered approaches.

CE Pathway Meal Observations focus on identifying care deficiencies and ensuring residents receive appropriate nutrition support.

Food Appearance

Meals match care plan specifications for texture, consistency, and portion size. Surveyors verify food temperatures, presentation, and substitutions match physician orders.

Dining Experience

Adequate time provided for meals with proper positioning and assistance. Surveyors assess dining environment, adaptive equipment use, and dignified service practices.

Staff Interactions

Staff demonstrate proper feeding techniques and encourage independent eating. Surveyors evaluate communication style, cueing effectiveness, and resident engagement during meals.

Resident Input

Residents confirm food preferences are honored and nutritional concerns addressed. Surveyors interview residents about satisfaction with meals, choices offered, and response to complaints.

Critical Element Pathway: Resident Nutrition Questions

Key questions surveyors ask residents during nutrition assessments to evaluate person-centered care.



Food Preferences

Do staff ask about your food likes and dislikes? Are your cultural food preferences honored?



Dining Experience

Are you comfortable with your dining location? Do you receive needed assistance during meals?



Meal Satisfaction

Is your food served at the right temperature? Do you have enough time to eat?



Care Involvement

Are you included in decisions about your nutrition care plan? Are concerns addressed promptly?

Critical Element Pathway: Nutrition Observations

Essential observation points for F812 compliance and dysphagia management



Intake Monitoring

Observe meal consumption percentages (0%, 25%, 50%, 75%, 100%) and document in point-of-care system. Note specific dysphagia signs: throat clearing 3+ times, coughing during/after swallows, pocketing food in cheeks >30 seconds, or audible "gurgling" vocal quality during/after meals.



Weight Tracking

Monitor weekly weights for residents with dysphagia risks. Document weight loss >5% in 30 days or >10% in 180 days as "significant change." Verify nutritional interventions within 24 hours of identified weight loss. Record BMI calculations alongside weight trends.



Dining Environment

Ensure proper positioning at 90° upright with chin tuck as indicated by Speech Therapy. Verify staff:resident ratio meets 1:2 for residents requiring extensive assistance. Confirm meal duration minimum of 30-45 minutes and socialization opportunities consistent with PELI preferences.



Nutritional Interventions

Confirm implementation of prescribed diets (mechanical soft, pureed, nectar/honey thick liquids). Validate supplement administration matches MAR timing (30 min before meals vs. with meals). Document resident acceptance/rejection of prescribed diets and alternative approaches offered.



Person-Centered Care Plan for Nutrition

Integrating nutritional care with PDPM documentation requirements while maintaining resident dignity and preferences.

Key Nutrition Documentation Components

Individual Preferences (PDPM NTA Component)

Document food likes, cultural preferences, and eating routines to support clinical categorization and reimbursement optimization.

SLP Component Documentation

Capture dysphagia severity, mechanically altered diet requirements, and feeding status to maximize appropriate SLP scoring in PDPM.

Weight Management (PDPM Nursing Component)

Track unplanned weight changes and document intervention effectiveness to support higher nursing case-mix index and reimbursement.

IDT PDPM Documentation Alignment

Ensure dietary, nursing, and therapy documentation consistently supports accurate PDPM coding across all five case-mix components.



Person-Centered Care Plan for Nutritional Deficit

Addressing weight loss and dysphagia with individualized approaches that honor resident dignity.



Assessment

Problem: "I am experiencing weight loss and have difficulty swallowing certain foods."

Goal: "I will maintain my weight within my target range and improve my ability to safely consume preferred foods."



Intervention

Problem: "I need assistance with eating due to my swallowing difficulties."

Goal: "I will participate in selecting texture modifications and positioning strategies that work best for me."



Preference Integration

Problem: "I miss the cultural foods I've enjoyed throughout my life."

Goal: "I will have my cultural food preferences and lifelong eating routines incorporated into my meal plan."



Monitoring

Problem: "I worry about my nutritional status and weight changes."

Goal: "I will review my progress with staff regularly and participate in decisions about adjustments to my nutritional care."



Critical Element Pathway: Family ADL Questions

Care Consistency

"Does staff consistently help your loved one with bathing, dressing, and grooming according to their preferences?"

Dignity Preservation

"How well do caregivers maintain your family member's dignity during personal care activities?"

Timely Assistance

"When your loved one requests help with toileting, how quickly do staff typically respond?"

Preference Incorporation

"Have staff asked about and incorporated your loved one's lifelong routines into their care?"

Best Practices for Effective Care Plan Management

Effective care plans require scheduled team reviews, measurable outcome tracking, resident participation, and timely revisions when clinical changes occur.

Ensuring comprehensive care plans remain current, properly revised, and demonstrate measurable progress while meeting regulatory requirements and supporting resident-centered outcomes.

Key Implementation Strategies



Regular Review Schedule

Establish weekly IDT review schedule with clear accountability for each care domain. Assign specific team members responsible for updating different sections and implement a sign-off system to ensure all disciplines contribute to the care plan.



Progress Tracking

Document specific, measurable outcomes with comparative baselines for each intervention. Use consistent terminology and quantifiable metrics that clearly demonstrate improvement or decline, facilitating accurate assessment of intervention effectiveness.



Resident Involvement

Include resident feedback in all care plan updates to maintain person-centered focus. Document specific preferences, concerns expressed during care conferences, and how these have been incorporated into care approaches to demonstrate meaningful resident participation.



Prompt Revisions

Implement a trigger system that initiates revisions when clinical changes occur. Define specific clinical thresholds (weight loss percentage, fall incidents, mood changes) that automatically prompt care plan review and create standardized revision protocols. Additional triggers include resident-triggered new Quality Measures, significant changes (positive or negative), and End Stage Diagnosis identification requiring palliative approach modifications.

Person-Centered Questions

Meaningful conversations that uncover resident preferences, concerns, and goals to create truly individualized care plans.



Open-Ended Approach

Ask "What matters most to you?" rather than "Do you need help?"



Active Listening

Validate concerns with phrases like "I understand this is important to you."



Cultural Sensitivity

Include questions about traditions, beliefs, and practices that influence care preferences.



Family Integration

Explore questions like "Who should be involved in care decisions?"



Key Elements of Person-Centered Care Plans

- **Personal Strengths:** Document capabilities, not just deficits
- **Preferences:** Honor individual choices and routines
- **Goals:** Establish meaningful, resident-directed outcomes
- **Interventions:** Implement individualized approaches
- **Evaluation:** Continuously assess effectiveness and adjust

Person-centered care plans move beyond clinical problems to capture the whole person, including their life history, cultural background, and individual preferences. Documentation should reflect how these personal factors influence care delivery and daily routines.

Functional ability documentation must be precise, avoiding vague terms like "maximum assistance" in favor of specific descriptions like "requires two-person physical assistance for transfers with verbal cues for safety." This precision ensures consistent care delivery across all shifts and disciplines.

Resident and Family Involvement

Partnership in Care

Residents and families offer crucial insights about preferences, history, and condition changes that clinical staff may miss.

Involving families builds trust, enhances satisfaction, and improves outcomes.

Documentation must capture resident/family input to create person-centered care plans. When residents and families understand their role, they become valuable partners in achieving positive outcomes.

Stop and Watch Early Warning Tool

- Empowers staff and family to report changes
- Uses simple, non-clinical language
- Enables early intervention
- Creates standardized communication for non-clinical observers

STOP AND WATCH Early Warning Tool

An early identification system to recognize changes in resident condition



S: Seems different than usual

Notice changes in typical behavior or appearance



T: Talks or communicates less

Reduction in verbal interaction or communication



O: Overall needs more help

Increased need for assistance with activities



P: Pain – new or worsening

Expression of new pain or increased discomfort



A: Ate less

Reduction in normal food intake



N: No bowel movement in 3 days or diarrhea

Changes in normal bowel patterns



D: Drank less

Decreased fluid intake from normal levels



W: Weight change

Noticeable gain or loss of weight



A: Agitated or nervous more than usual

Increased restlessness or anxiety



T: Tired, weak, confused, or drowsy

Changes in energy level or mental alertness



C: Change in skin color or condition

Alterations in skin appearance or integrity



H: Help with walking, transferring, or toileting more than usual

Increased need for mobility assistance

This tool empowers all staff and family members to identify and report changes in resident condition using simple, non-clinical language.

Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident/patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S T O P a n d W A T C H	Seems different than usual; Symptoms of new illness
	Talks or communicates less
	Overall needs more help
	Pain – new or worsening; Participated less in activities
	Ate less
	No bowel movement in 3 days; or diarrhea
	Drank less
	Weight change; swollen legs or feet
	Agitated or nervous more than usual
	Tired, weak, confused, or drowsy
Change in skin color or condition	
Help with walking, transferring, toileting more than usual	
☐ Check here if no change noted while monitoring high risk patient	

Patient / Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name

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Stop and Watch Early Warning Tool

The Early Warning Tool helps skilled nursing facilities identify potential issues early, enabling proactive intervention and improved resident outcomes.

By closely monitoring key indicators, the tool allows the care team to detect problems before they escalate, supporting timely decision-making and effective care planning.

Regulatory Alignment in Documentation

Survey Success

Documentation that withstands regulatory scrutiny by being thorough, accurate, and timely.

F-Tag Compliance

Meeting specific requirements of F656, F657, F658 through proper assessment and care planning.

RAI Process

Accurate MDS completion and CAA development that demonstrates resident-centered approaches.

CMS Guidelines

Following federal requirements for skilled care by documenting all required elements.



Preventing Common Documentation Errors

Nutrition Documentation Examples

- **Ineffective Documentation:** "Resident eats poorly. Continue to monitor."
 - Lacks quantifiable intake measurements
 - Fails to specify necessary interventions
 - Omits measurable improvement goals
- **Effective Documentation:** "Consumed 30% breakfast, 45% lunch. Prefers soft, sweet foods with visual appeal."
 - Implemented fortified foods at all meals
 - Scheduled high-protein nutrition supplements between meals
 - Goal: Achieve 75% intake for at least 2 meals daily by 5/15

Dysphagia Documentation Examples

- **Ineffective Documentation:** "Resident coughs while eating. Diet downgraded."
 - Lacks detailed symptom description
 - Omits critical interdisciplinary assessment
 - Disregards resident's dietary preferences
- **Effective Documentation:** "Experiences coughing and throat clearing with thin liquids; tolerates nectar consistency without difficulty."
 - Speech therapy evaluation completed 4/3 with swallow study
 - Positions with head elevated 45° during all meals and snacks
 - Preferences incorporated: enjoys smoothies and puddings as noted in care plan

Preventing Common Documentation Errors Continued

Hip Fracture Documentation Examples

- **Ineffective Documentation:** "Needs help with ADLs after hip surgery."
 - Uses ambiguous assistance terminology
 - Lacks rehabilitation progression planning
 - Omits critical pain assessment data
- **Effective Documentation:** "Requires 2-person maximum assistance with transfers following right hip ORIF on 4/1."
 - Reports pain level 4/10 prior to therapy sessions
 - Progressing to standby assistance with walker for 10 feet
 - Goal: Achieve independent bed-to-chair transfers by 5/30

ADL Decline Documentation Examples

- **Ineffective Documentation:** "Resident refusing morning care due to pain."
 - Fails to document pain intensity scale
 - Lacks specificity about functional limitations
 - Missing comprehensive team approach
- **Effective Documentation:** "Reports 7/10 lower back pain during dressing activities, currently limiting ambulation to 5 feet."
 - Administers pain medication 30 minutes before scheduled therapy
 - OT implementing adaptive equipment and energy conservation techniques
 - Goal: Independent upper body dressing with pain maintained at $\leq 3/10$ by 6/15

Effective documentation creates clear connections between assessments, interventions, and outcomes while demonstrating regulatory compliance and supporting truly person-centered care across all disciplines.

Preventing Common Documentation Errors

Ineffective Documentation

"Resident eats poorly. Continue to monitor."

"Resident coughs while eating. Diet downgraded."

"Needs help with ADLs after hip surgery."

Effective Documentation

"Consumed 30% breakfast, 45% lunch. Prefers soft, sweet foods with visual appeal."

"Experiences coughing with thin liquids; tolerates nectar consistency without difficulty."

"Requires 2-person maximum assistance with transfers following right hip ORIF on 4/1."



Preventing Common Documentation Errors



Interdisciplinary Inconsistencies

Conflicting documentation between disciplines (e.g., nursing noting full assistance while therapy reports minimal) creates compliance risks. Implement regular IDT reviews to reconcile these disparities.



Failure to Update After Changes

Care plans must promptly reflect significant changes in resident status (falls, weight loss, new behaviors) with appropriate interventions and team notifications.



Incomplete Refusal Documentation

Document specific interventions attempted when care is declined, resident's stated reason, alternatives offered, and appropriate notifications made.



Missing Behavior Documentation

Record antecedents, specific behaviors observed, interventions implemented, and resident responses to support appropriate care planning.

Inconsistent documentation creates clinical and regulatory vulnerabilities. Standardized templates and regular cross-disciplinary audits help identify documentation gaps before impacting care or survey outcomes.

Red Flag Words and Phrases to Avoid

Red Flag Term	Why It's Problematic	Better Alternative
"Continues to..."	Suggests ongoing issue without intervention	"Resident currently exhibits..." with specific interventions
"As needed"	Too vague; lacks specific parameters	"When resident exhibits [specific behavior], staff will [specific action]"
"Monitor"	Nonspecific; doesn't indicate frequency or parameters	"Assess blood pressure every 4 hours for readings below 100/60 or above 160/90"
"Adequate," "Sufficient"	Subjective terms without measurable criteria	Specific measurements: "Consumed 75% of meal" or "Walked 100 feet with walker"
"Patient refused"	Lacking context or alternatives offered	"Resident declined morning bath, stating she felt cold. Offered alternative of evening bath, which resident accepted."

Terminology choices significantly impact documentation quality. Vague phrases like "continues to" suggest problems without resolution and imply failure to implement effective interventions. Similarly, terms like "as needed" create ambiguity about when interventions should occur.

Replacing subjective language with objective, measurable descriptions dramatically improves documentation quality. This shift supports consistent care delivery and demonstrates proactive, resident-centered approaches that satisfy regulatory requirements.

Regulatory and Legal Implications

Documentation Gaps

- Missing records of required checks or care
- No follow-up notes for reported problems
- Incomplete checks after resident falls

Legal Consequences

- Higher risk of lawsuits
- Makes care look poor or neglectful
- Can't prove care was given later

Financial Penalties

- Fines for poor documentation
- Payment denials for unrecorded services
- Higher insurance costs after claims

Protective Strategies

- Set up regular review programs
- Create clear steps to fix documentation problems
- Train staff often on proper record-keeping

The basic rule "if it wasn't written down, it wasn't done" creates major risks for facilities. In court cases, your records are the main proof that care was given. Missing or conflicting records look like missed care, even if you actually provided the service.

Streamlining Care Planning with Technology



EHR Optimization

Set up systems that make documentation easier for each role. Create simple templates that cover all needed information without extra work. Use automatic fields carefully, and always check that information is correct.



Data Integration

Use systems that connect assessment data directly to care plans to avoid duplicate work. Make sure important information moves between different parts of the system (MDS, doctor orders, notes) to keep records consistent.



Point-of-Care Solutions

Use mobile tools to record information at the resident's bedside right when it happens. This is better than writing notes on paper or waiting until the end of a shift when details might be forgotten.

Electronic records can make documentation much easier, but only when used correctly. The best systems balance automatic features with professional judgment, avoiding over-reliance on auto-filled content that might not match what each resident really needs.

Technology Integration for Better Outcomes

Advanced EHR systems now offer sophisticated dashboards that highlight care plan compliance, upcoming reviews, and potential care gaps. These visual tools allow managers to quickly identify documentation trends and address issues before they impact quality measures or survey outcomes.

Clinical decision support tools embedded within documentation systems can provide real-time alerts for potential concerns, such as significant weight changes, fall risk increases, or medication monitoring requirements. These prompts improve care plan accuracy and ensure timely intervention for changing resident needs.

[Plan of Correction 365 Pricing](#)

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Correction 365**



Ongoing Staff Training and Competency



Initial Competency Assessment

Comprehensive evaluation of documentation skills during onboarding with structured validation tools specific to facility systems and protocols.



Regular Chart Audits

Systematic review of documentation samples from each discipline using standardized audit tools to identify gaps and improvement opportunities.



Peer Mentoring

Establishing nurse-to-nurse coaching relationships where experienced staff guide newer employees in developing documentation excellence.



Performance Improvement Projects

Targeted initiatives addressing specific documentation challenges with measurable goals and structured evaluation processes.

Sustainable documentation improvement requires ongoing education rather than one-time training events. Establishing a continuous learning environment through regular competency validation, constructive feedback sessions, and peer mentoring creates documentation excellence as a cultural expectation.

Action Planning for Implementation

1 Conduct Baseline Assessment

Review your current documentation to find what needs improvement. Focus on care plans, MDS accuracy, and progress notes. Pick 3-5 key areas to work on.

Timeline: Within 2 weeks

2 Develop Improvement Strategies

Create plans to fix the problems you found. Set clear goals to measure success. Choose team leaders from each department to guide the work.

Timeline: Within 1 month

3 Implement Tools and Training

Create simple documentation tools. Train staff on how to use them. Set up a review system to make sure everyone follows the same process on all shifts.

Timeline: Within 2 months

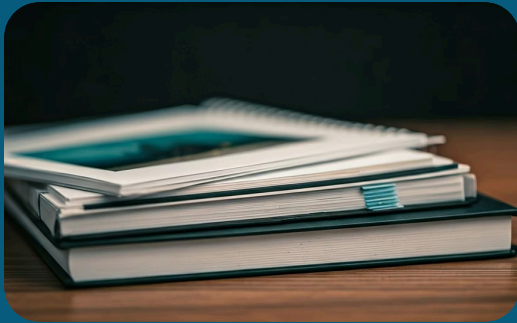
4 Evaluate Outcomes and Refine

Check if your changes are working. Ask staff about any problems they're having. Make adjustments based on what you learn.

Timeline: Within 3-4 months

Good implementation means putting knowledge into action with clear steps. By setting specific goals with deadlines and making people accountable, facilities can fix documentation problems and build lasting quality.

Key Takeaways and Resources



Documentation Toolkit

Each participant will receive our comprehensive documentation toolkit containing audit tools, competency checklists, and quick reference guides for all disciplines. This resource provides practical templates that can be immediately implemented in your daily practice.



Follow-Up Support

Today's training is just the beginning. We've scheduled monthly follow-up sessions for the next quarter to address specific documentation challenges, share success stories, and provide continuing education on advanced documentation topics.



Digital Resources

Scan the QR code to access our online learning portal containing additional training videos, sample documentation examples, and updated regulatory guidance. These resources are available 24/7 to support your ongoing documentation improvement efforts.

Exceptional documentation isn't achieved through a single training event—it requires ongoing commitment, continuous learning, and systematic process improvement. The resources provided today will support your journey toward documentation excellence that enhances resident care while meeting regulatory requirements.

Questions

Thank you for joining us today.

Remember, regulatory compliance is crucial for providing high-quality care. Don't hesitate to reach out to staff@theinspac.com for additional support.

All of the resources from this webinar can be found here:

[Effective Care Planning and Documentation for Skilled Nursing Facilities April 17 2025 | The InsPAC](#)



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