

Trauma Informed Care

Regulatory Overview and Practical Application:
A COVID-19 Perspective

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Agenda

1. Regulatory Overview
2. Trauma Defined
3. What is Trauma Informed Care?
4. How does this apply to my residents?
5. An interdisciplinary approach
6. Q&A

Regulatory

Phase 3 COP Implementation

F659

§483.21(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(iii) Be culturally-competent and trauma-informed.

[§483.21(b)(iii) will be implemented beginning November 28, 2019 (Phase 3)]

Regulatory

Phase 3 COP Implementation (Cont.)

F699

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(m) Trauma-informed care

The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

[§483.25(m) will be implemented beginning November 28, 2019 (Phase 3)]

Regulatory

Phase 3 COP Implementation (Cont.)

F741

§483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and

[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]

Regulatory

Phase 3 COP Implementation (Cont.)

F940

§483.95 Training Requirements

A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to—

[§483.95 will be implemented beginning November 28, 2019 (Phase 3)]

F949

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.95(i) Behavioral health.

A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).

[§483.95(i) will be implemented beginning November 28, 2019 (Phase 3)]

Regulatory

Existing Regulation

FACILITY ASSESSMENT:

Pursuant to §483.70(e) (F838), the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. GUIDANCE §483.40(a), (a)(1) & (a)(2)

Sufficient Staff to Provide Behavioral Health Care and Services

The facility must address in its facility assessment under §483.70(e) (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs.

Determination of Staff Competencies

As required under §483.70(e) (F838), the facility's assessment must include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. The facility must have a process for evaluating these competencies.

Regulatory

Existing Regulation (Cont.)

F742

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

§483.40(b)(1)

A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

Regulatory

Existing Regulation (Cont.)

F743

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

Survey

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Survey

Behavioral and Emotional Status Critical Element Pathway (Cont.)

Observations Across Various Shifts:

- If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- How does staff monitor the effectiveness of the resident's care plan interventions?
- How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Survey

Behavioral and Emotional Status Critical Element Pathway (Cont.)

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
 - What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rationale for each intervention?
 - How are the interventions monitored?
 - How do you ensure care is provided that is consistent with the care plan?
 - How, what, when, and to whom do you report changes in condition?
 - What types of behavioral health training have you completed?
 - Ask about any other related concerns the surveyor has identified.
 - How do you monitor for the implementation of the care plan and changes in the resident's condition?
 - How are changes in both the care plan and condition communicated to the staff?
 - How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

Survey

Behavioral and Emotional Status Critical Element Pathway (Cont.)

Record Review:

- Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- What is the time, duration, and severity of the resident's expressions or indications of distress?
- What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- What PASARR Level II services or psychosocial services are provided, as applicable?
- Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?
- Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- 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?
- Was behavioral health training provided to staff?

Trauma Defined

Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMHSA)

Trauma Defined

- According to the National Council for Community Behavioral Health Care, “Trauma occurs when a person is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness.
- Extreme stress overwhelms the person’s capacity to cope.
- There is a direct correlation between trauma and conditions such as diabetes, COPD, heart disease, cancer, and high blood pressure.
- Trauma may be experienced and expressed in numerous ways and dimensions.” Often trauma, like grief, is misunderstood or misdiagnosed and not attributed to the effects of trauma. People deal with trauma differently.
 - Biological symptoms include brain function, headaches, stomach aches, sleep changes
 - Psychological symptoms include fear, anxiety, outbursts, flashbacks, nightmares
 - Social symptoms include apathy, isolation, difficulty trusting, detachment
 - Spiritual symptoms include struggle to find meaning, anger with God

Trauma Informed

Trauma-Informed

A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices to actively resist re-traumatization. (SAMHSA)

Trauma Statistics

- Somewhere between 55% and 90% of persons have experienced at least one traumatic event.
- An estimated 6% of men and 10% of women experience Post Traumatic Stress Disorder (PTSD) within their lifetime.
- Potentially traumatic experiences include:
 - experiencing or witnessing childhood adverse events (e.g. experiencing or witnessing emotional, physical or sexual abuse or neglect, living with a parent with mental illness or substance misuse disorder, death or absence of a parent because of imprisonment)
 - domestic and sexual violence;
 - natural disasters;
 - car, train and airplane crashes;
 - combat;
 - becoming a refugee;
 - homelessness;
 - medical trauma;
 - violent crime;
 - bias and discrimination;
 - hate crimes and hate speech.

Trauma Statistics

- Motor vehicle crashes and natural disasters are associated with ~10% rates of development of PTSD,
- being in a combat zone ~18%,
- physical assault or experiencing heavy combat ~30%, and
- sexual assault and torture up to 50%.
- Medical events and procedures associated with life threat, even when they are successful, are associated with relatively high rates of PTSD development. For example, myocardial infarct / acute coronary syndrome is associated with up to 15% rate of PTSD, Major thoracic surgeries such as cardiac artery bypass graft (CABG) and open abdominal aortic aneurysm (AAA) repair, even when scheduled and expected, are also associated with ~20% rates of de novo PTSD.
- Particularly relevant to the COVID-19 pandemic, prolonged treatment in intensive care units (ICUs) such as for sepsis, and in particular, intubation, are associated with some of the highest rates of medical PTSD, with 35% of ICU survivors having clinically significant PTSD symptoms 2 years subsequent to the ICU care. Thus, in addition to “post-intubation syndrome” in survivors, once a patient is medically stabilized, it is important to assess and provide care for psychiatric responses like PTSD that are expected to be common.

Trauma Informed Approach

- **Trauma-informed Care understands...**
- **The 3-E's**
 - **Events** – what happened
 - **Experience** – The resident's unique experience
 - **Effect** – How did the experience effect the resident
- **The 4-R's**
 - **Realizes** the widespread impact of trauma and understands potential paths for recovery.
 - **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
 - Seeks to actively **resist re-traumatization**
 - **Responds** by full integrating knowledge about trauma into policies, procedures, and practices

Trauma Informed Approach

- **Trauma-informed Care understands...**
- **The 6 Key Principles**
 - **SAFETY** — all people associated with the organization feel safe. This includes the safety of the physical setting and the nature of interpersonal interactions.
 - **TRUSTWORTHINESS AND TRANSPARENCY** — your organization is run with the goal of building trust with all those involved.
 - **PEER SUPPORT** — support from other trauma survivors is a key to establishing safety and hope. Peer support may be from others in the community.
 - **COLLABORATION AND MUTUALITY** — recognition that everyone at every level can play a therapeutic role through healing and safe relationships. Your organization emphasizes the leveling of power differences and taking a partnership approach with staff.

Trauma Informed Approach

- **Trauma-informed Care understands...**
- **The 6 Key Principles (Cont.)**
 - **EMPOWERMENT, VOICE, AND CHOICE** — your organization recognizes and builds on the strengths of people — staff members and residents. You recognize the ways in which nursing home residents and staff members may have been diminished in voice and choice and have at times been subject to coercive treatment. You support and cultivate skills in self-advocacy, and seek to empower residents and staff members to function or work as well as possible with adequate organizational support.
 - **CULTURAL, HISTORICAL, AND GENDER ISSUES** — your organization actively moves past cultural biases and stereotypes (gender, region, sexual orientation, race, age, religion), leverages the healing value of cultural traditions, incorporates processes and policies that are culturally aware, and recognizes and addresses historical trauma.

Trauma Informed Care is a process not a destination

Trauma Informed Care & IDT COVID Considerations

- Consider how we will holistically address the following key elements:
 - Comprehensive Care Planning
 - Trauma Informed Care
 - Clinical Competencies

Trauma Informed Care & IDT COVID Considerations

- Evidenced Based Review of the following systems:
 - Pulmonary
 - Neurologic
 - Hematologic
 - Renal
 - Skin
 - Liver
 - Mobility Considerations

Pulmonary

- The lung damage of COVID-19 leads to an impairment of gas exchange, with potential for impaired pulmonary function.
- As a result, many patients report prolonged dyspnea and chest tightness, although the dyspnea may not be commensurate with the degree of hypoxia.
- **Pulmonary fibrosis is another factor that may affect long-term lung function**

Cardiac

- Complications can include hypotension, arrhythmia, reduced ejection fraction, and myocarditis.
- Left ventricular dysfunction in the acute phase may be attributed to markedly increased cytokine levels.
- Activation or enhanced release of inflammatory cytokines can lead to necrosis of myocardial cells and exacerbations of coronary atherosclerotic plaques, making them prone to rupture.
- An intense inflammatory response superimposed on preexisting cardiovascular disease may precipitate cardiac injury.
- **Myocardial damage might result in long-term dysfunction and must be taken into consideration for patients entering rehabilitation.**
- Although most patients develop persistent tachycardia, it has been found to be relatively benign and self-limiting.

Neurologic

- Acutely, 36% of patients with COVID-19 develop neurologic symptoms, including headaches, altered consciousness, seizures, absence of smell and taste, paresthesias, and stroke.
- Posterior reversible encephalopathy syndrome, which causes headache, confusion, seizures, and visual loss can be a complication.
- COVID-19 has been associated viral encephalitis has also been rarely reported.
- Patients are found to have very high D-dimer levels and hypercoagulability, in turn potentially increasing the risk of acute cerebrovascular events.
- As with many viral syndromes, Guillain-Barre´ syndrome, acute demyelinating encephalopathy, acute necrotizing hemorrhagic encephalopathy, and acute transverse myelitis have also been rarely reported.
- Myopathy with severe muscular symptoms is commonly observed among moderate and severe cases.

Hematologic

- Patients severely affected by COVID-19 are at high risk for a hypercoagulable state, characterized by very high D-dimer levels, thrombo-embolism, and stroke.
- In one review, thromboembolism was documented in as many as 1 in 5 patients and strokes occurred in 3%.
- Thromboembolic events occur despite prophylactic use of anticoagulants, and both venous and arterial thrombosis occurs.
- In addition, severe COVID-19 infection appears to be associated with bleeding complications, an increased risk for intracranial hemorrhage, and, in some instances, disseminated intravascular coagulation.

Renal

- Patients severely affected by COVID-19 are more likely to have acute kidney injury.
- Studies have shown that among those with normal creatinine levels on admission, most will recover from an acute kidney injury. However, proteinuria and hematuria can be prolonged.
- **It is recommended that patients with acute kidney injury be regularly assessed for 3-6 months after discharge.**

Skin

- COVID-19 has been associated skin lesions include (from most common to least common) maculopapular eruptions, urticarial, acral erythema with vesicles or pustules (pseudo-chilblains), vesicular eruptions, and livedo reticularis.
- Frank necrosis, secondary to vasculopathy, can also occur and may result in limb loss.
- Because of prone positioning, facial wounds may occur among survivors and could be problematic because of secondary infections and necrosis.

Liver

- COVID-19 related liver dysfunction with abnormal liver enzymes (mainly elevated serum prominences in those patients who spend significant amounts of time in prone position).
- Frequent changes in position and the use of supports to float the bony prominences are required.
- **Interdisciplinary collaboration between the rehabilitation team, nursing, and respiratory therapy is crucial to provide frequent pressure relief. Prone teams that include physical or occupational therapists and are available 24 hours per day 7 days per week may be helpful in reinforcing proper technique to minimize injuries.**
- For noncritically ill inpatients, daily out-of-bed mobility and participation in activities of daily living (ADL) helps to promote functional recovery and improve delirium.
- Interdisciplinary collaboration between the rehabilitation team, nursing team, and physicians to bundle care and promote mobility activities is recommended to reduce immobility-related harm while ensuring efficient use of resources.
- Rehabilitation team members play a crucial role in educating nursing and other team members on the safe progression of patient mobility. Education about engaging patients in daily therapeutic exercises, ADLs, and cognitive stimulation tasks is recommended for carry over from therapy sessions to amplify functional recovery.

Mobility and the IDT

- **Interdisciplinary collaboration between the rehabilitation team, nursing, and respiratory therapy is crucial to provide frequent pressure relief. Prone teams that include physical or occupational therapists and are available 24 hours per day 7 days per week may be helpful in reinforcing proper technique to minimize injuries.**
- For noncritically ill inpatients, daily out-of-bed mobility and participation in activities of daily living (ADL) helps to promote functional recovery and improve delirium.
- Interdisciplinary collaboration between the rehabilitation team, nursing team, and physicians to bundle care and promote mobility activities is recommended to reduce immobility-related harm while ensuring efficient use of resources.
- Rehabilitation team members play a crucial role in educating nursing and other team members on the safe progression of patient mobility. Education about engaging patients in daily therapeutic exercises, ADLs, and cognitive stimulation tasks is recommended for carry over from therapy sessions to amplify functional recovery.

Chronic Condition and Ventilation

- Survivors of acute respiratory distress syndrome with mechanical ventilation are reported to have complications such as laryngeal injury, tracheal stenosis, heterotopic ossification, contractures, adhesive capsulitis, decubitus ulcers, dysphonia, dysphagia, sensorineural hearing loss, brachial plexus injuries, and peripheral neuropathies (peroneal and ulnar).

Chronic Condition and ICU Weakness

- Weakness and decreased exercise capacity are the most common symptoms after prolonged ICU stay and immobility.
- Critical illness polyneuropathy (CIP), critical illness myopathy (CIM), and muscle atrophy are major causes of functional impairment related to COVID-19. CIP and CIM are characterized by generalized and symmetrical weakness, atrophy, and decreased or absent deep tendon reflexes and can cause difficulty weaning from mechanical ventilation because of associated respiratory muscle weakness.
- CIP and/or CIM co-occur with other symptoms or complications, including pain, reduced range of motion, fatigue, incontinence, and dysphagia.
- **Many of these secondary complications are preventable if appropriate rehabilitation is provided early in the disease course**

Chronic Condition and Cognition

- COVID-19 can produce prolonged hypoxia that may lead to both acute and long-term neuropsychological dysfunction.
- The further elements of prolonged ventilation, use of sedatives, prone positioning, human isolation, and extended time away from social contacts may contribute to severe delirium.
- All components of cognition can be affected, including attention, visual-spatial abilities, memory, and higher order executive functions.
- Common adverse psychological effects include posttraumatic stress disorder, insomnia, depression, and general anxiety, and they can be exacerbated by fear, stigma, and isolation.

The 6 “M’s” Managing COVID Long Term

- **In particular, the 5 M’s approach may be helpful for COVID-19 survivors:**
 - **Mind (Cognition),**
 - **Mobility (Function),**
 - **Medications (Optimizing simplifying Medications),**
 - **Multicomplexity (managing the complex medical/social issues of a given patient),**
 - **and Matters Most (what patients value most for their care).^{75,76}**
- **For geriatric rehabilitation and also in our COVID-19 survivors, it is also important to consider Motivation (factors affecting behavior change and/or health) as being critical factors in our rehabilitative care.**

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