Psychosocial Outcome Severity Guide

Clarification of Terms

"Anger" refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

"Apathy" refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

"Anxiety" refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper- vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

"Dehumanization" refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.

"Depressed mood" (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

"Fear" *is defined as an unpleasant often strong emotion caused by anticipation or awareness of danger*[1]*.*

"Humiliation" refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

*"**Psychosocial"** refers to the combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness.*

*The **"reasonable person concept"** refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome the deficiency may have had on a reasonable person in the resident's position.*

***NOTE**: The reasonable person concept described in this Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes.*

[1] https://www.merriam-webster.com/dictionary/fear. Accessed June 17, 2021.

Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate.

Purpose

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag*, including how to determine the severity of the outcome when the impact on the resident may not be apparent or documented.* The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in*, or may result in,* a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome. The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome. For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, as demonstrated by fear, agitation, and/or *withdrawal*. *Another example is when a staff member physically assaults a resident with no resulting physical harm, but the resident only demonstrates indifference to the incident at the time of the survey; however, it is likely that this caused a greater psychosocial outcome.* In *these* case*s*, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency *as it would reflect the highest level of harm or potential for harm*.

Overview

Psychosocial outcomes (e.g., changes in mood and/or behavior) may result from a facility's noncompliance with any regulatory requirement. A resident may have experienced (or may have the potential or likelihood to experience) a negative physical outcome and/or a negative psychosocial outcome resulting from facility noncompliance.

Psychosocial and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level should reflect *the* highest level of harm/potential harm.

The presence of a given affect (i.e., behavioral manifestation of mood) does not necessarily indicate a psychosocial outcome that is the direct result of noncompliance. A resident's reactions and responses (or lack thereof) also may be affected by his/her pre-existing psychosocial issues, illnesses, medication side effects, and/or other factors. Because many
nursing home residents have sadness, anger, loss of self-esteem, etc. in reaction to normal life experiences, the survey team must determine that the negative psychosocial outcome is a result of the noncompliance and not a pre-existing condition for the resident.

Psychosocial outcomes may be the result of facility noncompliance with any regulation. This

also includes psychosocial outcomes resulting from *a* facility*'s* failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, leading to continuation or worsening of the condition.

Instructions

This Guide is designed to be used separately for each resident included in the deficiency.

NOTE: For instances of abuse, see also Appendix PP-Tag F600, Deficiency Categorization.

To determine the severity of the psychosocial outcome, the team should obtain evidence through observation, interview, and record review. For example, the team should interview the resident, and collect information regarding the resident's verbal and non-verbal responses. If a psychosocial outcome is identified, compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) and mood before and after the noncompliance, and any identified history of similar incidents. When a surveyor cannot conduct an interview with the resident for any reason, or there are no apparent or documented changes to behavior, the surveyor should attempt to interview other individuals who are familiar with the resident's routine or lifestyle, such as the resident's representative, the resident's family, Ombudsman, the resident's direct care staff, and/or medical professionals, to assess the psychosocial impact on the resident. If no such changes are apparent or documented, the surveyor should consider the response as a reasonable person in the resident's position would exhibit in light of the triggering event.

Application of the Reasonable Person Concept

There are circumstances in which the survey team should apply the "reasonable person concept" to determine *the outcome and the* severity of the deficiency, such as when a resident's psychosocial outcome may not be readily determined through the investigative process. *The following are examples of circumstances in which a resident's psychosocial outcome may not be readily determined through the investigative process and the reasonable person concept should be used:*

- When a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

- When a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person *in the resident's position* would have to the deficient practice.

To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person

in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance). The survey team should consider the following regarding the resident's position, which may include, but is not limited to:

- *The resident may consider the facility to be his/her "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.*
- *The resident trusts and relies on facility staff to meet his/her needs.*
- *The resident may be frail and vulnerable.*

The surveyor should document the resident's actual response and the perspectives of someone familiar with the resident. In addition to the evidence gathered by the surveyor, the use of the reasonable person concept should be applied and may reveal that the resident is likely to, or may potentially, suffer a greater psychosocial outcome. For example, in the case of a sexual assault, the resident did not exhibit a change in behavior as a result of the incident. In addition, the resident's relative presumed that the resident would be upset by the situation. The evidence gathered by the surveyor should still be documented, but the determination of severity would be based on how the reasonable person would experience serious psychosocial harm (immediate jeopardy) as a result of a sexual assault.

The survey team should document on the CMS-2567 when it applies the reasonable person concept in determining the psychosocial outcome(s) for a deficiency.

Severity Levels
The following are examples of severity levels of negative psychosocial outcomes that could have developed, continued, or worsened as a result of a facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety
Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level four include, but are not limited to:

- Suicidal ideation/thoughts and preoccupation or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself, hoarding medications with the expressed intent of suicide.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., *attempting to cut oneself,* banging head against wall).

- *Anger, agitation, or distress that has caused aggression that can be*

manifested by self-directed responses or hitting, shoving, biting, scratching others, threatening, screaming, or cursing.

- *C*rying, moaning, screaming, or combative behavior *that is above the resident's baseline*.

- Expressions (verbal and/or non-verbal) of *avoidable pain that is severe, and more than transient*. *Pain is considered avoidable when there is a failure to assess, reassess, and/or take steps to manage the resident's pain;*

- *Fear/anxiety that may be manifested as panic, immobilization, screaming, and/or agitated behavior(s) (e.g., trembling, cowering); avoidance of the situation(s), person(s) or place; preoccupation with fear; resistance to care and/or social interaction; sleeplessness; fear of speaking, and/or verbal expressions of fear.*

- *Expressions of feelings of hopelessness, worthlessness or guilt (not merely self-reproach or guilt about being sick or needing care);*

- Expressions of dehumanization or humiliation in response to an identifiable situation.

- *Withdrawal from former* social patterns, such as isolation from staff, friends and family.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level three include, but are not limited to:

- *D*ecline from former social patterns that does not rise to a level of immediate jeopardy.

- *D*epressed mood that may be manifested by verbal and nonverbal symptoms such as:
    - *Decreased engagement in social activities*; apathy; tearfulness; crying; moaning;
    - *Change* of interest or ability to experience or feel pleasure *as usual*
    - Psychomotor *movements* (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects);
    - *Change in* psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering) *unrelated to medical diagnosis*;
    - Verbal *expressions* (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), *that may be* accompanied by *a* sad *tone*;
    - *D*iminished ability to think or concentrate.

- Expressions (verbal and/or non-verbal) of *moderate* pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, *or loss in interest for eating*. Pain or physical distress has become a central focus of the resident's attention, but it is not *severe* or overwhelming (as in Severity Level 4).

- *D*istress (e.g., under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something), *unrelated to medical diagnosis*.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level two include but are not limited to:

- Sadness, as reflected in facial expression and/or demeanor, or verbal/vocal *disappointment*.

- Feelings and/or complaints of discomfort *or* irritability.

- Complaints of boredom and/or reports that there is nothing to do.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm

Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the following areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome.

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

483.10 Resident Rights
F557, Respect, Dignity/Right to Have Personal Property;
F558, Reasonable Accommodation of Needs/Preferences;

483.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;

F602 Free from Misappropriation/Exploitation;
F603, Free from Involuntary Seclusion;
F604, Right to be Free from Physical Restraints;
F605, Right to be Free from Chemical Restraints;
F607, Develop/Implement Abuse/Neglect, etc. Policies;
F609, Reporting of Alleged Violations;
F610, Investigate/Prevent/Correct Alleged Violation;

483.21 Comprehensive Resident Centered Care Plans
F656, Develop/Implement Comprehensive Care Plan;
F657 Care Plan Timing and Revision;

483.24 Quality of Life
F675, Quality of Life
F679, Activities Meet Interest/Needs of Each Resident;

483.25 Quality of Care
F699, Trauma Informed Care

483.40 Behavioral Health Services
F740, Behavioral Health Services;
F741 Sufficient/Competent Staff – Behavioral Health Needs;
F742, Treatment/Services for Mental/Psychosocial Concerns;
F743, No Pattern of Behavioral Difficulties Unless Unavoidable; F745, Provision of Medically Related Social Services;

483.45 Pharmacy Services
F757, Drug Regimen is Free from Unnecessary Drugs; and
F758, Free from Unnecessary Psychotropic Medications/PRN Use.