Proposed Post Acute Care Requirements
Long Term Care Accreditation Program

Standard HR.01.01
The organization has the necessary staff to support the care, treatment, and services it provides.

Element of Performance for HR.01.01

21. The organization provides licensed nurses and other nursing personnel 24 hours a day, 7 days a week, in accordance with law and regulation. (See also LD.03.06.01, EP 3)

22. The organization provides the services of a registered nurse at least 8 consecutive hours a day, 7 days a week, in accordance with law and regulation.

23. If any resident(s) requires the services of a registered nurse, the organization has at least one registered nurse on duty. (See also LD.03.06.01, EP 3)

24. For post acute care: A registered nurse(s) is on duty 24 hours a day, 7 days a week.

25. For post acute care: When planning for clinical staffing the organization takes into account the following:
- resident acuity
- complexity of clinical tasks
- staff experience and expertise
- physical layout of the facility

Standard HR.01.05.03
Staff participate in education and training.

Element of Performance for HR.01.05.03

4. Staff participate in education and training whenever staff responsibilities change. Staff participation is documented.

5. Staff participate in education and training that is specific to the needs of the resident population served by the organization. Staff participation is documented. (See also PC.01.02.09, EP 3)

21. For post acute care: The organization involves staff in identifying staff learning needs relevant to post acute care services.

22. For post acute care: Staff participate in education and training that addresses how to identify early warning signs of a change in a resident's condition and how to respond to a resident's decline in condition. Participation in this education is documented.

23. Staff participate in education and training that is specific to person-centered care, according to job responsibilities and performance expectations. Staff participation is documented. (See also LD.03.01.02, EP 3 and HR.01.07.01, EP 1 and EP 6)
Standard HR.01.06.01

Staff are competent to perform their responsibilities.

Element of Performance for HR.01.06.01

1. The organization defines the competencies it requires of its staff who provide resident care, treatment, and services.
   Note: Competencies may relate to the techniques, procedures, technology, equipment, and skills required to provide the population served with care, treatment, and services. (See also NPSG.03.06.01, EP 3)

2. The organization uses assessment methods to determine the individual's competence in the skills being assessed.
   Note: Methods may include test taking, return demonstration, or the use of simulation.

3. An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence.
   Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. Alternatively, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

5. The organization conducts an initial assessment of staff competence as part of orientation. This assessment is documented.

6. Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

15. The organization takes action when a staff member's competence does not meet expectations.
   Note: Actions may include, but are not limited to, providing additional training or supervision, or modifying job responsibilities.

24. For post acute care: Staff competence is assessed and documented annually, or more frequently as required by organization policy or in accordance with law and regulation.

Standard IM.03.01.01

Knowledge-based information resources are available, current, and authoritative.

Element of Performance for IM.03.01.01

1. For post acute care: The organization provides access to knowledge-based information resources 24 hours a day, 7 days a week. (See also IM.01.01.03, EPs 2 and 6)
Standard LD.01.06.01

A medical director oversees the care, treatment, and services provided to residents.

Element of Performance for LD.01.06.01

1. The medical director is a licensed physician and is appointed by the chief executive or is designated by the medical staff.

2. The responsibilities of the medical director are defined in a written agreement with the governing body.

3. The medical director provides clinical leadership by doing the following:
   - Directing and coordinating medical care in the organization
   - Participating in the creation of policies, procedures, and guidelines for clinical care, treatment, and services and the development of emergency treatment procedures for residents
   - Participating in the provision of in-service training programs
   - Making recommendations to governance on whether or not a licensed independent practitioner can provide care, treatment, and services at the organization
   - Monitoring the performance of medical services
   - Understanding the policies and programs of public health agencies that affect resident care programs
   - Acting as the organization's medical representative in the community

4. The medical director advises the administration, the governance, and other professionals on the following:
   - The development and maintenance of the clinical record system
   - The degree to which the organization's scope of services, its medical equipment, and its professional and support staff meet residents' needs
   - Future resident care programs
   - Health and safety recommendations to resolve hazards identified in the environment
   - Methods for monitoring employee health status and the content of employee health policies
   (See also EC.04.01.03, EP 3)

5. The medical director provides physician leadership in the following ways:
   - By helping to arrange and internally communicate physician availability and coverage
   - By communicating medical staff responsibilities and medical care policies, procedures, and guidelines to all licensed independent practitioners providing or ordering care
   - By serving as a member of the organized medical staff if the organization has one
   - By collaborating with the administrator and the organized medical staff, if the organization has one, to formulate the bylaws and the rules and regulations
   - By being responsible, when there is no medical staff, for the written rules and regulations for all licensed independent practitioners who attend residents in the organization
   Note: This standard does not require the creation of a medical staff where one does not exist. The long term care organization chooses whether or not to create a medical staff.

6. For post acute care: The responsibilities of the medical director include reviewing a sampling of records as determined by the organization for appropriateness of admission, transfer, and discharge.
Long Term Care Accreditation Program

**Standard LD.04.04.09**

<table>
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<tr>
<th>93</th>
<th>For post acute care: The organization uses clinical practice guidelines to guide the provision of post acute care.</th>
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</table>

| 95 | 1. For post acute care: The organization uses clinical practice guidelines, when available, to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms. |
| 96 | 2. For post acute care: The leaders of the organization review and approve the clinical practice guidelines that have been selected to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms. |
| 98 | 3. For post acute care: The organization manages and evaluates the implementation of clinical practice guidelines. |
| 100 | 4. For post acute care: The organization monitors and reviews clinical practice guidelines for their effectiveness and modifies them as needed. |
| 102 | 5. For post acute care: When clinical practice guidelines are not available, the organization either follows established protocols for care, treatment, or services or develops its own protocols. |

**Standard MM.03.01.01**

| 108 | The organization safely stores medications. |

| 109 | 2. The organization stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. |
| 110 | 3. The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. |
| 112 | 4. The organization has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition, and return to storage. |
| 117 | 5. The organization implements its policy addressing the control of medication between receipt by an individual health care provider and its administration. |
| 118 | 6. The organization prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. |
| 120 | 7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings. |
| 122 | 8. The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. |
| 127 | 18. The organization inspects all medication storage areas periodically, as defined by the organization, to verify that medications are stored properly. |

For post acute care: The organization keeps concentrated electrolytes present in resident care areas only when resident safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

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Standard PC.01.01.01

The organization accepts the resident for care, treatment, and services based on its ability to meet the resident’s needs.

**Element of Performance for PC.01.01.01**

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<tr>
<td>1</td>
<td>The organization has a written process for accepting a resident based on its ability to provide the care, treatment, and services required by the resident. (See also LD.01.03.01, EP 3)</td>
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<tr>
<td>7</td>
<td>The organization follows its written process for accepting a resident for care, treatment, and services.</td>
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<tr>
<td>20</td>
<td>The interdisciplinary team is consulted when necessary to determine whether a prospective resident is eligible for admission.</td>
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<tr>
<td>21</td>
<td>If a prospective resident is not accepted after referral and preadmission screening, the reasons for denying admission are documented.</td>
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<td>23</td>
<td><strong>For post acute care:</strong> When the organization cannot meet the resident’s needs, it explains its reasons to the referring organization.</td>
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<td>24</td>
<td><strong>For post acute care:</strong> The process for accepting residents that are seeking post acute services includes written screening criteria developed by the interdisciplinary team. (See also PC.02.01.05, EP 9)</td>
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<td><strong>Note:</strong> Screening criteria may address exclusionary conditions.</td>
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Standard PC.01.02.01

The organization assesses and reassesses its residents.

**Element of Performance for PC.01.02.01**

1. The organization defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. (See also RC.02.01.01, EP 2)

2. The organization defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. (See also PC.01.02.07, EP 1)

13. The organization defines, in writing, the information to be gathered during the initial assessment(s), including the following:
   - The resident's current diagnosis, pertinent history, medication history (including allergies and sensitivities), current medication, and current treatments
   - The resident's physical and neuropsychiatric status
   - The resident's communication status
   - The resident's functional status
   - The resident's rehabilitation status, potential, and needs
   - The resident's nutritional and hydration status
   - The resident's oral health status, including the condition of the oral cavity, teeth, and tooth-supporting structures; the presence or absence of natural teeth or dentures; and the ability to function with or without natural teeth or dentures
   - The resident's pain status, including recent pain history, origin, location, severity, alleviating, and exacerbating factors; current treatment for pain; and response to treatment
   - The resident's psychosocial and spiritual needs
   - The resident's cultural and ethnic factors that can influence care, treatment, and services
   - The resident's personal preferences regarding schedules, activities, and grooming
   - For the dying resident, the social, spiritual, and cultural variables that influence both the resident's and family's perceptions and experience of the process of dying

23. During assessments and reassessments of the resident, the organization gathers the defined data and information.

39. For post acute care: Information gathered in the assessment and reassessments are used to identify the resident's ability to perform self-managed tasks.

40. For post acute care: Interdisciplinary team members collaborate and share information when conducting resident assessments and reassessments.
Standard PC.01.02.03

The organization assesses and reassesses the resident and his or her condition according to defined time frames.

Element of Performance for PC.01.02.03

1. The organization defines, in writing, for each discipline the time frame(s) within which it conducts the resident’s initial assessment, in accordance with law and regulation. (See also RC.01.03.01, EP 1)

2. The organization performs the initial assessments of the resident within its defined time frame(s). (See also RC.01.03.01, EP 3)

3. Each resident is reassessed based on his or her plan of care or changes in his or her condition. Note: Reassessments may also be based on the resident's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; and/or his or her setting requirements, resident acuity and needs.

4. The attending physician or licensed independent practitioner performs the resident’s medical history and physical examination within 24 hours prior to or 72 hours (For post acute care: within 24 hours prior to or 48 hours) after the resident’s admission or readmission to the organization.
   Note: When permitted by law and regulation, a medical history and physical examination performed by the attending physician or licensed independent practitioner within 30 days prior to the resident’s admission or readmission can be used, provided it is updated with a summary of the resident’s condition and course of care during the 30-day time period.

5. When the medical history and physical examination is performed by someone other than the attending physician or licensed independent practitioner within 30 days of admission, the attending physician or licensed independent practitioner does the following within 24 hours prior to or 72 hours (For post acute care: within 24 hours prior to or 48 hours) after the resident’s admission or readmission to the organization:
   - Reviews the resident’s medical history
   - Reexamines the resident
   - Updates any findings or other information as needed and provides a summary of the resident’s physical condition and psychosocial status
   - Signs and dates the updated information and findings

17. The organization specifies, in writing, the following time frames for completion of initial assessments:
   - Each resident’s comprehensive interdisciplinary assessment is to be completed within 14 days of admission.
   - For post acute care: The organization assesses the resident within the first hour to determine immediate care needs (based on the resident’s admission diagnosis) to assist in developing the interim plan of care. (See also PC.01.03.01, EP 3)
   - For post acute care: The organization assesses the resident for pain, fall risk, skin condition, assistance needed in activities of daily living, and risk for re-hospitalization no later than eight hours after admission.
   - For post acute care: For residents with complex needs or for whom a short stay is anticipated, assessment is completed in accordance with law and regulation.

23. The organization reassesses each resident based on the following:
   - The resident’s plan of care
   - Changes in the resident’s condition
   - The scheduled evaluation of the resident’s interdisciplinary plan of care
   - For post acute care: Factors that hinder the achievement of desired outcomes
   (See also PC.01.03.01, EP 28)
Standard PC.01.02.07

The organization assesses and manages the resident's pain.

Element of Performance for PC.01.02.07

1. The organization conducts a comprehensive pain assessment of the resident that is consistent with the resident's condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8)

2. The organization uses methods to assess pain that are consistent with the resident's age, condition, and cognitive ability.

3. The organization reassesses the resident's pain, based on its reassessment criteria.

4. The organization either treats the resident’s pain or refers the resident for treatment.
   Note: Treatment of pain includes interventions for breakthrough pain.

6. For post acute care: When assessing the resident for pain, the organization documents the following:
   - Location
   - Duration
   - Type (for example: sharp, dull, throbbing)
   - Intensity (pain scale)
   - Exacerbating factors
   - Alleviating factors
   - Previous treatments and response
   - Any barriers which may prevent effective treatment

7. For post acute care: If the resident is unable to convey the presence of pain, the organization solicits input from the family in identifying and managing the resident's pain.
   This input is documented.

8. For post acute care: The organization takes measures to prevent or reduce discomfort and pain before a treatment or procedure.
   Note: Non-medication (non-pharmacological) interventions for pain can be important adjuncts to pain treatment regimens.
### Standard PC.01.02.15

The organization provides for diagnostic testing.

#### Element of Performance for PC.01.02.15

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<td>1.</td>
<td>Diagnostic testing and procedures are performed as ordered. (See also PC.02.01.03, EP 7)</td>
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<td>2.</td>
<td>Diagnostic testing and procedures are performed within time frames defined by the organization.</td>
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<td>3.</td>
<td>When a test report requires clinical interpretation, information necessary to interpret the results is provided with the request for the test.</td>
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<td>4.</td>
<td>The organization makes available radiologic and other diagnostic services, including pathology and clinical laboratory services, 24 hours a day, 7 days a week.</td>
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#### 8. For post acute care: The organization develops written procedures for managing the critical results of tests and diagnostic procedures including the following:

- The definition of critical results of tests and diagnostic procedures
- By whom and to whom critical results of tests and diagnostic procedures are reported
- The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures, including any critical results of tests and diagnostic procedures received post-discharge or transfer
- The acceptable length of time between the reporting of critical results of tests and diagnostic procedures and the response, including intervention

#### 9. For post acute care: The organization implements the procedures for managing the critical results of tests and diagnostic procedures.
Standard PC.01.03.01

The organization plans the resident’s care.

Element of Performance for PC.01.03.01

1. The organization plans the resident’s individualized care, treatment, and services based on needs identified by the resident’s assessment (including strengths and goals), reassessment, and results of diagnostic testing.

2. The resident’s written plan for care, treatment, and services is developed by an interdisciplinary team comprised of health care professionals, including the attending physician.

3. An interim plan for care, treatment, and services is developed and documented for each resident immediately after the resident is admitted.

4. The organization develops the resident’s plan for care, treatment, and services as soon as possible after admission in accordance with law and regulation, but no later than seven calendar days after the resident’s comprehensive assessments are completed.

5. The interdisciplinary team collaborates on the review and revision of the plan for care, treatment, and services.

6. The plan for care, treatment, and services identifies the following:
   - The care, treatment, and services, including interventions to facilitate the resident’s return to the community, or discharge or transfer to an appropriate level of care
   - The frequency at which care, treatment, and services will occur
   - The team members responsible for providing care, treatment, and services
   - For post acute care: Any advance directives of the resident

7. At 90-day intervals, or more frequently based on response to the resident’s condition, the interdisciplinary care team does the following:
   - Evaluates the resident’s progress toward meeting the goals of care, treatment, and services
   - Revises the plan for care, treatment, and services
   - Collaborates with the family in revising the plan for care, treatment, and services
(See also PC.01.02.03, EP 23)

46. For post acute care: The interim plan of care is updated until the comprehensive plan of care is developed.

47. For post acute care: The resident and/or family is involved in developing an individualized plan of care.

48. The resident's written plan for care, treatment, and services is based on the resident's personal preferences and freedom of choice.
Long Term Care Accreditation Program

Standard PC.02.01.05

The organization provides interdisciplinary, collaborative care, treatment, and services.

Element of Performance for PC.02.01.05

1. Care, treatment, and services are provided to the resident in an interdisciplinary, collaborative manner.

9. Information about the resident is shared among all members of the interdisciplinary team, including the physician, within the organization’s defined time frames.
   Note: Examples of this information include changes in the resident’s condition, consultation and evaluation reports, and diagnostic testing results.

13. Changes in the resident’s condition are communicated to the attending physician or other authorized health care professional(s), the resident, and the resident’s family.

14. Information from consultation and evaluation reports is communicated to the attending physician.

27. For post acute care: The interdisciplinary team has regularly scheduled team meetings to review the resident’s progress towards goal attainment.

28. For post acute care: The interdisciplinary team discusses the care, treatment, and services with the resident and/or family on an ongoing basis including the following:
   - Current status
   - Outcomes
   - Barriers to achieving goals
   - Alternative interventions to facilitate achieving goals

29. For post acute care: An attending or on-call licensed independent practitioner is available 24 hours a day, 7 days a week.

30. For post acute care: The organization has a written plan to access a licensed independent practitioner should the organization be unable to communicate with the attending or on-call licensed independent practitioner regarding a change in a resident’s condition.

Standard PC.02.01.06

For post acute care: An individual(s) coordinates the provision of post acute services.

Element of Performance for PC.02.01.06

1. For post acute care: The organization designates an individual to coordinate the provision of post acute services with members of the interdisciplinary team and the resident and/or family by doing the following:
   - Making certain assessments are completed within time frames per organizational policy
   - Supporting the resident’s needs to meet self-managed care goals
   - Assisting with discharge planning from the time of admission
   - Providing educational resources to the resident and/or family in order to increase knowledge about the resident’s disease process(es)
   Note: For larger, multiple post acute care units, the organization may designate more than one individual to coordinate the provision of post acute services.

2. For post acute care: The post acute care services coordinator is a registered nurse who is educated, experienced, and skilled in the care of residents with multiple complex post acute and chronic conditions.
Standard PC.02.01.09

The organization plans for and responds to life-threatening emergencies.

Element of Performance for PC.02.01.09

1. The organization has written policies and procedures for responding to life-threatening emergencies. (See also RI.01.01.01, EP 18)

2. Policies and procedures that address life-threatening emergencies include the following:
   - Availability of first aid and Basic Life Support (CPR) services
   - Emergency transfer to another organization
   - Placement of a phone call to outside emergency assistance

3. The organization responds to life-threatening emergencies according to its policies and procedures.

9. For post acute care: Resuscitation equipment and supplies are available for staff use and are based on the needs of the population served (for example, crash cart, oxygen, automated external defibrillator, and weight-based equipment).

Standard PC.02.01.19

For post acute care: The organization recognizes and responds to changes in a resident’s condition.

Note: Organizations are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

Element of Performance for PC.02.01.19

1. For post acute care: The organization has a process for recognizing and responding to changes in a resident’s condition as soon as it appears to be worsening.

2. For post acute care: The organization develops written criteria describing early warning signs of a change or deterioration in a resident’s condition and when to seek further assistance.

3. For post acute care: Based on the organization’s early warning criteria, staff seek additional assistance when they have concerns about a resident’s condition.

4. For post acute care: The organization informs the resident and family on how to seek assistance when they have concerns about a resident’s condition.
Standard PC.04.01.01

The organization has a process that addresses transitions in the resident's care.

**Element of Performance for PC.04.01.01**

1. The organization documents the reason(s) for and conditions under which the resident is transferred or discharged.

2. The organization documents the method for transitioning the responsibility for a resident's care from one clinician, organization, program, or service to another.

3. The organization agrees with the receiving organization about each of their roles to keep the resident safe during transfer.

4. The organization includes in its transfer and discharge processes: Interdisciplinary team planning.

5. The organization includes in its transfer and discharge processes: The resident's knowledge of and demonstration of all necessary activities.

6. The organization includes in its transfer and discharge processes: Evaluation of the environment (home, hospital, other facility) to which the resident is being discharged.

Note: The evaluation may be conducted through interview, review of services offered, or other methods that provide the information needed to meet the resident's needs.

7. The organization includes in its transfer and discharge processes: Planning for providing necessary care, treatment, and services; assistance; and instruction.

8. The organization transfers or discharges a resident upon order of his or her attending licensed independent practitioner.

9. The organization follows an established process for emergency transfer or discharge resulting from medical necessity.

27. **For post acute care: A staff member(s) designated by the organization communicates the resident's discharge plan with the family and relevant practitioners across different care settings.**
Before the organization transfers or discharges a resident, it informs and educates the resident about his or her follow-up care, treatment, and services.

Element of Performance for PC.04.01.05

1. When the decision is made to transfer or discharge the resident, the organization determines the resident's transfer or discharge needs and informs the resident about the kinds of care, treatment, and services the resident will require.

Note: Residents may rely on surrogate decision-makers to participate in situations in which the resident cannot or chooses not to make a decision. Instead of stating "resident and/or surrogate decision-maker" in each occurrence where the surrogate decision-maker may need to play a role, "resident" is used with the understanding that if the resident is unable or chooses not to make decisions or participate in education, the surrogate decision-maker may do so, in accordance with law and regulation.

3. Before the resident is transferred or discharged, the organization provides the resident with information about why he or she is being transferred or discharged.

4. The organization notifies the resident's family and encourages a family member to participate in the transfer, whenever possible.

Note: If the resident has a surrogate decision-maker, he or she will be informed of and involved with the transfer process.

5. Before the resident is transferred, the organization provides the resident with information about any alternatives to the transfer.

6. Before the resident is transferred, the organization provides the resident with information on the facility or program to which the resident is being transferred.

7. The organization educates the resident about how to obtain any continuing care, treatment, and services that he or she will need.

8. The organization provides written discharge instructions in a manner that the resident and/or the resident's family or caregiver can understand. (See also RI.01.01.03, EP 1)

15. For post acute care: The organization includes the name and contact information of the health care provider(s) responsible for the care of the resident after discharge or transfer in the discharge instructions.

16. For post acute care: Prior to discharge, the organization documents that the resident or family understands the following:
   - Medication administration and management
   - Diet and fluid intake
   - Safety considerations
   - Recommended exercises and other activities
   - Life style changes
   - Access to resources in the community
   - Follow-up appointments
   - Recognition of indications of a worsening condition and how to respond
   - Adherence to the plan of care to prevent readmission across care settings (for example, hospital, skilled nursing facility, rehabilitation facility, home care)
When a resident is transferred or discharged, the organization gives information about the care, treatment, and services provided to the resident to other service providers who will provide the resident with care, treatment, and services.

Element of Performance for PC.04.02.01

At the time of the resident's transfer or discharge, the organization informs other service providers who will provide care, treatment, and services to the resident about the following:

- The reason for the resident's transfer or discharge
- The resident's physical and psychosocial status
- A summary of care, treatment, and services it provided to the resident
- The resident's progress toward goals
- A list of community resources or referrals made or provided to the resident

(See also PC.02.02.01, EP 1)

For post acute care: Prior to transfer or discharge, the organization facilitates the transfer of important information to other service providers. (See also PC.02.02.01, EP 17)

For post acute care: When a resident is discharged, the organization communicates with the resident and/or family about the care, treatment, and services provided to the resident.

Element of Performance for PC.04.02.02

For post acute care: The organization communicates with the resident and/or family following the resident's discharge from the organization within a time frame identified by the organization.

Note: The organization may consider the clinical condition of the resident at discharge when determining the frequency.

For post acute care: The organization communicates with the resident and/or family following the resident's discharge from the organization to:

- Evaluate compliance with discharge instructions
- Inquire about the resident's current status
- Identify opportunities for improvement related to their stay (See also PI.01.01.01, EP 44)
- Inquire if equipment/services, as indicated at discharge, were provided
Element of Performance for PL.01.01.01

1. The leaders set priorities for data collection. (See also LD.04.04.01, EP 1)
2. The organization identifies the frequency for data collection.
3. The organization collects data on the following: Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)
4. The organization collects data on the following: The use of restraints. (See also LD.04.04.01, EP 2)
5. The organization collects data on the following: Behavior management and treatment. (See also LD.04.04.01, EP 2)
6. The organization collects data on the following: Quality control activities. Note: Examples of topics for quality control activities include the delivery and content of food trays and laundry services.
7. The organization collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)
8. The organization collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)
9. The organization collects data on the following: Resident (and, as needed, the family) perception of the safety and quality of care, treatment, and services. Quality of care includes the organization’s provision of person-centered care, treatment, and services.
10. The organization considers collecting data on the following:
   - Staff opinions and needs
   - Staff perceptions of risk to individuals
   - Staff suggestions for improving resident safety
   - Staff willingness to report adverse events
   Note: If the organization has not collected data on this topic, consideration can be demonstrated through methods such as interviews or meeting minutes.
11. For post acute care: The organization collects data relevant to resident readmissions from the organization to the hospital, emergency department, or other post acute setting.
12. For post acute care: The organization collects data on opportunities for improvement identified following the resident’s discharge. (See also PC.04.02.02, EP 2)