



Care Planning Best Practices

Elevating Compliance, Person-Centered Care & Staff Engagement

Questions?



↑ *Scan me!*

QR Code for Anonymous Questions

https://members.khca.org/site_page.cfm?pk_association_webpage_menu=755&pk_association_webpage=27602

QR Code for Anonymous Questions

Objectives

Participants will demonstrate understanding of the purpose of effective care plans and service plans

Participants will demonstrate understanding of the State & Federal regulatory requirements of effective care plans

Participants will demonstrate understanding examples of what should be included in specific care plans for behavior; pain management; medication management; ordered treatments; non-pharmacological interventions; new orders; psychoactive medications

Participants will demonstrate understanding of how/when & who should revise care plans & service plans

Participants will demonstrate understanding of how to effectively communicate care plan information to residents and care partners

“Care Planning isn’t a form-it’s a promise to walk beside someone on their journey”



Innovative Approaches to Care Planning

- Care planning has a “shared purpose”
- Care planning isn’t just a regulatory task
- It’s the heart of quality care



Regulatory Foundations: Person-Centered

FEDERAL

F655-Baseline Care Plan: within 48 hours

F656-Develop/Implement Comprehensive Care Plans

- Individualized
- Comprehensive
- Timely
- Person-Centered

F657-Care Plan Timing & Revision

F677 Psychosocial wellbeing as a care planning priority

F679-Activity Programming Integration

F740-F745-Behavioral Health & Trauma-informed Care; & Cultural Competence

STATE OF KANSAS

KAR 28-39-152-Quality of Care

- Highest practicable physical, mental & psychosocial wellbeing
- Based on comprehensive assessments
- Individualized, Interdisciplinary, Documentation, Resident Rights
- Specific domains
 - ADLs
 - Pressure ulcer prevention & treatment
 - Psychosocial functioning
 - Nutrition & hydration
 - Accident prevention
 - Special services

Care Planning Compliance Checklist: CMS + Kansas Integration

Domain	Kansas Reg Reference	CMS F-Tag(s)	Checklist Item	✓
Initial Assessment & Planning	K.A.R. 28-39-152	F656	Baseline care plan initiated within 48 hours of admission	☐
Comprehensive Planning	K.A.R. 28-39-152	F657	Full IDT-developed plan based on MDS, interviews, preferences	☐
Psychosocial Well-being	K.A.R. 28-39-152	F677	Psychosocial goals integrated; tracked using measurable objectives	☐
Behavior & Mental Health	K.A.R. 28-39-152	F740–F745	Trauma-informed strategies documented; care reflects emotional/behavioral needs	☐
ADLs & Mobility	K.A.R. 28-39-152	F676	Supports for independence in mobility, hygiene, toileting	☐

Pressure Injury Prevention	K.A.R. 28-39-152	F686	Risk assessment tools used; care plan includes skin integrity interventions	☐
Nutritional Support	K.A.R. 28-39-152	F692	Plan includes intake tracking, preferences, weight monitoring	☐
Hydration Monitoring	K.A.R. 28-39-152	F692	Strategies for hydration (e.g., fluid rounds, dietary prompts)	☐
Accident Prevention	K.A.R. 28-39-152	F689	Interventions reflect fall risks, supervision needs, environmental modifications	☐
Resident Participation	K.A.R. 28-39-152	F553	Resident choices & refusals respected and documented	☐

State-Licensed Only Surveyor Feedback

“A lot of the state license only have combined their negotiated service agreements in their healthcare service plans and one document which is fine. They just need to make sure that they are including interventions. A lot of them will sometimes just have a description of the service and not include the interventions so things like if they have identified the resident has impaired vision what services are they providing for that cognition is one that we frequently right because all they do is will document that they have impaired memory or are unable to make decisions for themselves, so what are you doing? Are you offering them choices of clothing to wear? Are you offering them choices for food? What are you doing to help them with their impairment?”

Person-Centered Planning in Action

Care Plans reflect:

- Resident voice
- Resident choice
- Resident's story

Domains:

- Physical
- Emotional
- Spiritual
- Cultural

Sample Tools:

- Life Story
- Honoring Preferences
- Trauma-Informed Assessment including Transition Trauma
- Social History
- Previous preferences and routines
- All clinical assessments
- All nutritional assessments

The Interdisciplinary Team: Care Plans are a “Team Sport”

RESIDENT AND FAMILY MEMBER(S) including assigned Representative if applicable

MDS/Care Plan Coordinator

RN/LPN

CNA

Social Services/Activity Director

Therapy Staff

Dietary Staff

Physician

Consulting Pharmacist if applicable

Care Plan Conference:

- Identify “focus”/”problems”/”situation”
- Identify resident & family stated goals
- Identify feasibility of resident/family stated goals
- Goals must be measurable, reasonable with timetable
- Identify interventions through collaboration
- Use IDT huddles and care conferences to build accountability
- Assign ownership for care plan interventions

Uncomfortable Care Plan Situations: Be Prepared!

Resident or family isn't aware of issues identified in care plan	Resident or family don't agree with issues identified in the care plan	At time of review, staff is unaware of interventions in the care plan	Direct care partners disagree with issues identified in the care plan
Resident's refusals of care or treatment	Behavioral challenges identified in the care plan	Non-adherence to care plans	Sensitive personal preferences (cultural, religious, sexual identify)
	Dysfunctional family dynamics or family disagreements	End-of-life decisions	

Innovations in Care Planning

Digital dashboards for plan visibility: implies everyone with a “need-to-know” has access at all times

QR-coded resident video profiles for new staff/agency staff

- Short video introductions of residents linked to a QR code: when scanned by staff using a mobile device, the QR code opens a video that shares key information about the resident such as:
 - Preferred name & pronunciation
 - Personal interests & hobbies
 - Communication preferences
 - Daily routines & care needs
 - Family background or life story highlights
 - Behavioral tips or emotional triggers (especially helpful in memory care)
- Technology Integration
 - Platforms like TSOLife ([Staff App - Resident Directory and Profile – TSOLife](#)) and LifeLoop (<https://lifeloopapp.com>) offer mobile apps that include resident directories, video profiles, and QR code access. These tools integrate with care plans and engagement programming to support holistic wellness

Voice-to-text tools for documenting preferences

AI-prompted care goals from assessments

Monitoring & Adjusting Care Plans

Weekly review checklist based on MDS triggers

Reassessment after hospitalization or change in condition

- ICD-10 code reviews require extra attention

REMEMBER: a great care plan isn't written once-it's lived and revisited

Use audit feedback to improve care planning quality

- Evidence of IDT collaboration & timely updates
- Evidence of resident/family input
- Are goals being met? If not, is there documentation of reassessment & plan adjustment?
- Evidence of progress notes aligning with care plan goals
- Documentation quality
 - Clear, legible & complete entries
 - Consistent across disciplines
 - Use of standardized terminology
- Health equity & psychosocial considerations
 - Cultural preferences, language needs, health literacy addressed
 - Behavioral health & trauma-informed care integrated
 - Social determinants of health considered in planning
- Audit summary & action plan for QAPI

Behavioral Health Integration

Incorporate trauma-informed care and mental health needs

Use calming supports, de-escalation strategies, therapy referrals

Document psychosocial interventions alongside clinical interventions

Staff Training & Engagement

Microlearning modules on care planning essentials

- Huddles with shift team
- Huddles with between-shift teams
- Have direct care partners teach each other on knowing, understanding, & modifying care plans

Peer mentoring & role-playing training

Gamified training with progress badges

Let's Pretend

You have just been admitted as a resident to your center.
What do you want the staff to know about you to take care of you, & to meet your expectations?



Questions...Challenges |

Thank you

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