

Behavioral Healthcare Survey Readiness Tool



Department of Health
Bureau of Survey & Certification
Provider Resources &
Education Program (PREP)

This tool is designed to guide providers in preparing for the annual Ohio Department of Health survey of behavioral, mental, and/or emotional healthcare and services provided to their residents. This tool is not all encompassing. The facility should use observations, interviews and record reviews to assess if care is meeting federal regulations. For more guidance, see the [CMS-20067 \(10/2023\) Behavioral and Emotional Status Critical Element Pathway](#).

Facility Assessment/Policies/Protocols	Yes	No
Based upon the facility assessment, the resident population, diagnosis, staffing, resources and staff skills/knowledge, the facility has determined it has the capability and capacity to provide the needed behavioral healthcare and services for a resident with a risk for behavioral distress development or actual behavioral distress. This includes at a minimum:		
1. Sufficient numbers of qualified professional staff who are trained and knowledgeable in behavioral healthcare, before admitting a resident that requires behavioral healthcare and services.		
2. Established resident care policies.		
Review of the facility policy and procedures for behavioral healthcare and services revealed standards of care are met regarding behavioral healthcare.		
Staff is able to verbalize facility specific guidelines/protocols.		
Staffing/Training	Yes	No
There is sufficient, competent staff to ensure resident safety and meet the resident's behavioral healthcare needs.		
Behavioral health training was provided to staff in accordance with the population and facility assessment.		
Resident	Yes	No
The facility is aware of the residents' current conditions/ history of conditions or diagnoses/emotional needs.		
Staff is able to verbalize how they identify and support individual resident needs.		
Resident has not had a change in mood and there are no concerns regarding their mood/history of trauma.		
Resident's individual needs are being met through person-centered approaches to care.		
Staff demonstrate competent interactions and apply quality-of-care principles when interacting with residents and addressing the residents' behavioral healthcare needs.		
Resident who exhibits indications of distress (e.g., anxiety, striking out, self-isolation) are addressed appropriately by staff.		
Staff is able to verbalize how they meet the resident's needs and provide emotional support to a resident who is having difficulty coping with change, loss, or stressful events.		
Trauma: Staff is able to verbalize which residents were trauma survivors, their triggers, and what to do differently for them to avoid re-traumatization.		
Choices/Cultural Preferences: Staff is able to verbalize how the facility determines cultural preferences.		
The facility ensures approaches to care reflect the resident's choices and cultural preferences by staff being respectful and providing culturally competent care (e.g., clothing or food preferences, health beliefs, and practices).		
If the resident's distress is caused by facility practices that do not accommodate resident choices, including cultural preferences (e.g., ADL care, daily routines, activities, etc.), the facility adjusts practices.		
Assessments	Yes	No
PAS ARR was accurately completed and submitted prior to admission.		
If there was a behavioral healthcare diagnosis or medication change after admission, a new PASARR was accurately completed and submitted.		
The most current comprehensive and most recent quarterly MDS/CAAs (if the comprehensive assessment is not the most current) for Sections A, C, D, E, GG, I, N, and O are accurate and reflect the resident's condition and cultural preferences.		
If there was a significant change, a significant change comprehensive assessment was conducted within 14 days.		
The facility identifies the resident's history of trauma and the effects of past trauma on the resident (based on admission assessment, history and physical, and social history/assessment).		
The facility identifies the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress that may retraumatize the resident (e.g., decline in cognitive function, result of illness/injury, or prolonged environmental factors – noise, bright lights, etc.).		

Care Plan	Yes	No
If applicable, the baseline care plan was in place within 48 hours of admission and addressed the minimum healthcare information necessary to properly care for the immediate behavioral health needs of the resident. There is proof that the resident/representative received a copy they could comprehend.		
The facility collaborates with the resident, and/or resident representative, and any other healthcare professionals (interdisciplinary team (IDT)) to develop an individualized care plan, including implementing non-pharmacological measurable goals and interventions with timelines.		
The care plan, in place seven days after MDS completion, is comprehensive and identifies the resident's specific conditions, risk, needs, triggers, expression, cultural preferences, and indications of distress.		
The care plan reflects resident specific triggers that may cause fear or re-traumatize the resident and monitoring of behavioral healthcare status.		
The care plan addresses resident specific risks for pharmacological complications.		
Care planned interventions are being implemented and monitored for effectiveness.		
Staff is able to verbalize the underlying causes (e.g., history of trauma, mental disorder) of the residents' behavioral expressions or indications of distress included in the care plan.		
Staff is able to verbalize the specific approaches to care, both non-pharmacological and pharmacological , that have been developed and implemented to support the behavioral health needs of the residents and the rationale for each intervention.		
Staff is able to verbalize how they ensure care is consistent with the care plan.		
The IDT meets timely to discuss the resident's behavioral expression or indications of distress, the effectiveness of interventions, and changes in the resident's condition.		
If interventions were not effective, the facility implemented alternative approaches.		
Staff is able to verbalize how changes in the care plan are communicated to staff.		
The care plan addresses resident refusals or resistance to staff interventions and efforts to find alternatives to address the needs identified in the assessment.		
Physician Orders	Yes	No
There are orders for non-pharmacological behavioral healthcare interventions (e.g., counseling, therapy, etc.) as indicated and if indicated based on diagnosis , there is an order for pharmacological interventions.		
The physician-ordered non-pharmacological and pharmacological interventions are evaluated for effectiveness, modified, or changed as appropriate and/or as needed.		
Medication Administration Record/Treatment Administration Record	Yes	No
The record reflects that non-pharmacological and pharmacological interventions are being provided as physician ordered and care planned.		
Counseling	Yes	No
PASARR level II services or psychosocial services are provided, as applicable.		
The facility ensures residents with mental or substance use disorders have access to counseling programs and therapies.		
Staff is able to verbalize how needed mental and psychological counseling services are provided or arranged.		
Progress Notes (Physician, Nursing, Therapy, Social Services)	Yes	No
The record did not reflect any complications, or the record did reflect behavioral health complications with the appropriate staff response, notification of physician/representative and change to resident's care plan.		
The resident's expressions or indications of distress are thoroughly documented based on time, duration, and severity, guiding staff on what interventions are effective and not effective.		
The record reflects how the resident responds to care-planned interventions.		
The resident's medical record accurately reflects their behavioral health status.		
Change of Condition	Yes	No
Staff is able to verbalize how, what, when and to whom they report changes in condition, including reporting to other frontline staff providing direct care.		
Additional Record Reviews	Yes	No
Outside records (e.g. hospital records, therapy records etc.) revealed no documentation of concern regarding the behavioral healthcare the facility provided.		