§483.25 Quality of Care (Ftag 309)
States that "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

The stated Intent of section: §483.25 is that the "facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process."

Definitions: §483.25
"Highest practicable physical, mental, and psychosocial well-being" is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

Interpretive Guidelines §483.25
In any instance in which there has been a lack of improvement or a decline, one must determine if the occurrence was "unavoidable or avoidable". A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:
• An accurate and complete assessment (see §483.20);
• A care plan that is implemented consistently and based on information from the assessment; and
• Evaluation of the results of the interventions and revising the interventions as necessary.

Compliance with F309, Quality of Care - The facility is in compliance with this requirement if staff:
• Recognized and assessed factors placing the resident at risk for specific conditions, causes, and/or problems;
• Defined and implemented interventions in accordance with resident needs, goals, and recognized standards of practice;
• Monitored and evaluated the resident's response to preventive efforts and treatment; and
• Revised the approaches as appropriate.

Full Text of
42CFR483.25 Quality of care
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

© Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that—

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty 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 such a pattern was unavoidable.

(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents. The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(l) Unnecessary drugs--(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors. The facility must ensure that—

(1) It is free of medication error rates of five percent or greater; and

(2) Residents are free of any significant medication errors.

Associated Regulations:
Some examples include, but are not limited to, the following:

• 42 CFR 483.10(b)(11), F157, Notification of Changes
Determine whether staff notified the resident and consulted the physician regarding significant changes in the resident's condition or a need to alter treatment significantly or notified the representative of a significant condition change.

• 42 CFR 483.(20)(b), F272, Comprehensive Assessments
Determine whether the facility assessed the resident's condition, including existing status, and resident-specific risk factors (including potential causative factors) in relation to the identified concern under review.

• 42 CFR 483.20(k), F279, Comprehensive Care Plan
Determine whether the facility established a care plan with timetables and resident specific goals and interventions to address the care needs and treatment related to the clinical diagnosis and/or the identified concern.

• 42 CFR 483.20(k)(2)(iii), 483.10(d)(3), F280, Care Plan Revision
Determine whether the staff reviewed and revised the care plan as indicated based upon the resident's response to the care plan interventions, and obtained input from the resident or representative to the extent possible.

• 42 CFR 483.20(k)3)(i), F281, Services Provided Meets Professional Standards of Quality
Determine whether the facility, beginning from the time of admission, provided care and services related to the identified concern that meet professional standards of quality.

• 42 CFR 483.20(k)(3)(ii), F282,Care Provided by Qualified Persons in Accordance with Plan of Care
Determine whether care was provided by qualified staff and whether staff implemented the care plan correctly and adequately.

• 42 CFR 483.30(a), F353, Sufficient Staff
Determine whether the facility had qualified nursing staff in sufficient numbers to assure the resident was provided necessary care and services 24 hours a day, based upon the comprehensive assessment and care plan.

• 42 CFR 483.40(a)(1)&(2), F385, Physician Supervision
Determine whether the physician has assessed and developed a relevant treatment regimen and responded appropriately to the notice of changes in condition.

• 42 CFR 483.75(f), F498, Proficiency of Nurse Aides

Determine whether nurse aides demonstrate competency in the delivery of care and services related to the concern being investigated.

• 42 CFR 483.75(i)(2), F501, Medical Director

Determine whether the medical director:

- Assisted the facility in the development and implementation of policies and procedures and that these are based on current standards of practice; and
- Interacts with the physician supervising the care of the resident if requested by the facility to intervene on behalf of the residents.

• 42 CFR 483.75(l), F514, Clinical Records

Determine whether the clinical records:

- Accurately and completely document the resident's status, the care and services provided in accordance with current professional standards and practices; and
- Provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment.