CLINICAL MONOGRAPH

Change of Condition in Skilled Nursing Facilities: Clinical Recognition, Assessment, SBAR Communication, and Regulatory Follow-Up

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Abstract and Learning Context

Changes in a nursing facility resident's condition may begin with subtle departures from baseline function, cognition, appetite, mobility, or vital signs. Early recognition requires comparison with individualized baseline information, focused assessment, appropriate prioritization, and timely communication. This clinical monograph examines the licensed nurse's role in recognizing acute and non-urgent deterioration; applying the federal notification framework associated with F580; communicating assessment findings through Situation, Background, Assessment, and Recommendation (SBAR); and documenting interventions, reassessment, and response. It also distinguishes immediate clinical notification from the separate Minimum Data Set significant-change assessment process. Practical workflows and examples emphasize resident-centered decision-making, interdisciplinary collaboration, and continuity across shifts. This supplemental reading reinforces the accompanying video while functioning as an independent clinical resource. Learners should apply its principles in conjunction with practitioner orders, local emergency response procedures, organizational policy, and applicable federal and state regulations.

Behavioral Learning Objectives

1. Identify a clinically meaningful departure from an individual resident's established baseline and distinguish urgent from non-urgent findings.
2. Identify circumstances triggering notification and consultation under CMS F580 and 42 C.F.R. § 483.10(g)(14).
3. Organize and communicate clinically pertinent findings using the four components of SBAR.
4. Document assessment, notifications, practitioner instructions, interventions, response, and reassessment.
5. Apply a structured change-of-condition workflow to a realistic skilled-nursing resident scenario.

Clinical Content

Introduction: Clinical Recognition Is the Starting Point

Changes in a resident's condition are among the most important clinical observations made in skilled nursing and long-term care. A resident may develop new symptoms abruptly, or a decline may become apparent through subtle changes in behavior, function, intake, cognition, or tolerance of routine activities. Effective management requires more than identifying an abnormal measurement. It requires comparing current findings

with the resident's established baseline, determining clinical urgency, completing a focused assessment, communicating the findings, and evaluating the response to interventions.

The resident's baseline provides the context for interpreting observations. For example, a resident who routinely walks to meals but suddenly needs extensive assistance to transfer has experienced a meaningful functional change, even if vital signs appear acceptable. Similarly, a normally conversational resident who becomes unusually drowsy or confused requires assessment rather than an assumption that the behavior reflects aging or a chronic diagnosis. A new refusal of food and fluids, altered sleep patterns, worsening pain, or reduced participation in usual activities can also signal deterioration.

Recognition should be supported by observations from the entire care team. Certified nursing assistants, restorative nursing assistants, dietary personnel, therapists, and family members may notice changes before a formal nursing assessment occurs. Their reports should be taken seriously, clarified, and evaluated by the licensed nurse. The goal is to identify what changed, when it changed, how the resident differs from usual, and what immediate action is needed.

Evidence and practice context: (AHRQ, n.d.; CMS, 2024)

Determining Urgency and Responding to Deterioration

Not every change in condition is an emergency, but every clinically meaningful change deserves an appropriate response. Immediate or urgent changes may involve sudden or marked deterioration, severe symptoms, an acute alteration in mental status, or symptoms that remain uncontrolled despite prescribed treatment. Examples include significant difficulty breathing, unresponsiveness, new stroke-like symptoms, or rapidly worsening clinical status. Emergency response procedures take priority when such findings occur.

Non-immediate changes may still require prompt nursing assessment, practitioner communication, ongoing monitoring, and revision of the care plan. A stable resident with new reduced appetite, a change in mobility, or a developing symptom should not simply be left for the next shift without evaluation. The nurse must consider the nature of the change, resident-specific risk factors, available orders, and facility escalation procedures.

The first clinical priority is resident safety. When emergency conditions are suspected, staff should activate the appropriate response and obtain assistance. Completion of an SBAR form or progress note must not delay needed emergency care. Communication and documentation remain essential, but they occur in coordination with—not in place of—clinical intervention.

Clinical judgment also requires avoiding premature diagnostic assumptions. Confusion, weakness, or altered intake can have multiple causes. Nursing assessment should describe the observable findings and relevant trends rather than presenting an unsupported diagnosis. The practitioner can then evaluate the clinical picture and determine additional orders or treatment.

Evidence and practice context: (AHRQ, n.d.; CMS, 2024)

CLINICAL PEARL | Treat sudden unresponsiveness, stroke-like symptoms, or severe respiratory distress as emergencies; complete documentation without delaying immediate care.

Focused Nursing Assessment

A focused change-of-condition assessment begins with the resident's presenting concern and the time course of the change. The nurse should establish what was first observed, who identified it, when it began, and whether the problem is improving, worsening, or fluctuating. The resident's usual mental status, functional ability, respiratory status, pain pattern, and other relevant baseline characteristics should be compared with current findings.

Assessment findings may include vital signs, oxygen saturation when indicated, level of consciousness, respiratory effort, skin appearance, pain characteristics, mobility, intake, output, and other system-specific observations. Relevant medication administration, recent treatment changes, diagnoses, allergies, advance directives, and previous episodes may help place the change in context. The depth and type of assessment should match the symptoms and the licensed nurse's scope of practice.

Objective descriptions are especially valuable. A statement such as "resident not acting right" does not communicate the same information as "resident is newly disoriented to place, usually oriented to person and place, and requires repeated prompting to answer questions." Similarly, a report of "shortness of breath" is strengthened by findings describing respiratory rate, work of breathing, oxygen saturation, positioning, and response to immediate measures.

Reassessment is part of the assessment process. A single set of findings documents one point in time; a change-of-condition record should show whether the resident stabilized, improved, or deteriorated after the intervention. A repeat examination may also identify the need for further escalation.

Evidence and practice context: (AHRQ, n.d.; CMS, 2024)

Federal Notification Responsibilities: CMS F580

In Medicare- and Medicaid-certified nursing facilities, CMS State Operations Manual Appendix PP addresses notification of changes under F580, associated with 42 CFR § 483.10(g)(14). The regulation identifies circumstances in which the facility must immediately inform the resident, consult with the physician, and notify the resident representative consistent with applicable requirements. These include an accident involving injury with the potential to require physician intervention; significant changes in physical, mental, or psychosocial status; a need to significantly alter treatment; and certain transfer or discharge decisions.

The regulatory notification threshold should not be confused with the broader clinical obligation to respond to meaningful changes. A symptom may warrant nursing assessment and practitioner contact even when it does not meet a particular F580 notification category. Conversely, when the regulation's qualifying circumstances are present, the facility must complete the required notification process rather than relying solely on an internal note.

A practical approach is to organize the response around four actions: inform, consult, notify, and document. The resident should be informed as appropriate to the resident's condition and ability to participate. The physician or other appropriate practitioner should receive relevant assessment information. The resident representative should be notified as required, considering the representative's authority and applicable policies. The medical record should reflect the events, contacts, instructions, interventions, and resident response.

Timely notification is not satisfied merely by recording that a message was left when the clinical situation requires an active response. Staff should follow the facility's escalation process when the contacted practitioner is unavailable or when the resident's condition worsens. Emergency care must not be delayed while attempting to complete routine notification steps.

Evidence and practice context: (CMS, 2024; Electronic Code of Federal Regulations, n.d.)

Distinguishing Clinical Change from MDS Significant Change

The phrase "significant change" is used in different clinical and regulatory contexts. A change-of-condition assessment and F580 notification are not interchangeable with the MDS Significant Change in Status Assessment process. The clinical response addresses what is happening to the resident now: recognition, assessment, communication, intervention, and follow-up. The MDS process has separate assessment criteria and scheduling requirements.

A resident may experience an acute change requiring immediate evaluation without necessarily meeting the criteria for an MDS Significant Change in Status Assessment. Conversely, an enduring decline may require interdisciplinary review and MDS consideration under the applicable Resident Assessment Instrument guidance. Nurses should avoid using one process as a substitute for the other. Appropriate clinical care and notification should proceed without waiting for an MDS determination.

Evidence and practice context: (CMS, 2025)

Using SBAR for Clear Practitioner Communication

SBAR—Situation, Background, Assessment, and Recommendation—is a structured approach to communicating clinical information. It helps the nurse organize a concise report while ensuring that the practitioner receives enough context to make a decision. SBAR is a communication tool, not a replacement for clinical judgment, assessment, or regulatory notification.

Situation identifies the resident, the immediate concern, the onset or discovery of the change, and the reason for contacting the practitioner. Background supplies pertinent diagnoses, baseline function or cognition, relevant medications, recent events, and other information that influences the current concern. Assessment describes the nurse's findings, including vital signs, symptoms, examination observations, trends, and response to measures already taken. Recommendation states the action being requested, such as further evaluation, clarification of orders, treatment guidance, or transfer consideration.

An effective SBAR is specific and actionable. Rather than saying "the resident is worse," the nurse might report that a resident who normally transfers with one-person assistance now cannot stand, has new weakness, and has a documented change in vital signs. Relevant findings should be communicated without overwhelming the practitioner with unrelated historical information. The nurse should clarify orders, repeat back information when required by policy, and document the practitioner's response.

Structured communication is especially important during handoffs and transitions. The receiving clinician needs to know what changed, what was done, which instructions remain pending, and which observations require continued monitoring. A complete handoff reduces the risk that important follow-up tasks will be lost between shifts.

Evidence and practice context: (AHRQ, n.d.; Florida Atlantic University, n.d.)

SBAR WORKFLOW

- Situation — state the immediate concern and change from baseline.
- Background — summarize diagnoses, relevant history, current treatments, and prior observations.
- Assessment — communicate objective findings, vital signs, focused examination, and trend.
- Recommendation — state the requested evaluation, clarification, or orders; read back and document instructions.

Implementing Orders, Monitoring, and Follow-Up

Communication is not the endpoint of change-of-condition management. Once instructions or orders are received, the nurse must ensure that interventions are carried out within the appropriate timeframe and scope of practice. The plan may involve additional assessment, medication or treatment administration, diagnostic testing, increased monitoring, a higher level of care, or other resident-specific measures.

The resident's response must then be evaluated. For example, after an intervention for pain or respiratory symptoms, reassessment should address whether the presenting concern improved, persisted, or worsened. The appropriate interval depends on the condition, treatment, and facility policy. Unresolved or worsening

findings require additional communication and escalation rather than a passive assumption that the original order was sufficient.

The interdisciplinary team may need to review the resident's care plan, monitoring instructions, assistance requirements, safety precautions, and related risks. Staff who provide direct care should receive clear direction about what to observe and report. Where the change affects transfers, mobility, swallowing, behavior, or other functional areas, the relevant discipline may need to participate in reassessment and care planning.

Evidence and practice context: (CMS, 2024; Electronic Code of Federal Regulations, n.d.)

Documenting the Complete Clinical Story

A defensible nursing record describes the full sequence of events. Documentation should establish the resident's baseline and new findings, the date and time the change was recognized, the nursing assessment, the urgency determination, and actions taken. It should also identify who was contacted, when communication occurred, what information was provided, what instructions or orders were received, and how the resident responded.

Records should distinguish direct observations from information reported by others. The time of the event, the time the nurse learned of it, and the time of documentation may differ; these should not be presented as interchangeable. Objective, timely entries are more useful than generalized statements such as "MD aware," "resident stable," or "continue to monitor" without supporting detail.

When monitoring is ordered or clinically indicated, follow-up entries should show the actual reassessment findings and whether escalation was needed. A note that records the first call but never addresses the resident's subsequent status leaves the clinical narrative incomplete. The same principle applies when a resident is transferred: relevant clinical findings, notifications, and transfer information should be documented in accordance with facility procedures.

Evidence and practice context: (CMS, 2024; Electronic Code of Federal Regulations, n.d.)

DOCUMENTATION CHECKPOINT

- Time and nature of observed change
- Baseline comparison and nursing assessment
- Practitioner and representative contacts, with times and responses
- Orders and interventions implemented
- Reassessment, response, and escalation or shift handoff

Practical Clinical Application

Consider a resident who is usually alert, converses with staff, and walks short distances with assistance. During the morning shift, the resident is newly confused, eats very little breakfast, and needs substantially more help to transfer. The change should not be dismissed because one vital sign falls within a reference range. The nurse should compare the findings with baseline, complete a focused assessment, determine urgency, and communicate pertinent information to the practitioner.

An SBAR report would identify the new confusion and functional decline, provide relevant medical background, describe objective assessment findings, and request appropriate clinical direction. Subsequent documentation would record the contact, orders, interventions, and reassessment. If the resident deteriorates, emergency response and further escalation are indicated according to the clinical situation and facility policy.

A second example involves a resident who develops severe respiratory distress. In this situation, immediate safety measures and emergency response take priority. The nurse should not wait to finish an SBAR form before

initiating necessary care. Practitioner and representative notifications, communication with emergency personnel, and documentation should be completed as appropriate while the clinical response proceeds.

These examples demonstrate a consistent clinical sequence: recognize a difference from baseline; assess; determine urgency; communicate; intervene; reassess; and document. Consistency across these steps supports resident safety, continuity of care, and a clearer clinical record.

Evidence and practice context: (AHRQ, n.d.; CMS, 2024)

Conclusion

Effective change-of-condition management is a continuous process rather than a single telephone call or documentation entry. Licensed nurses are responsible for connecting early recognition with clinical assessment, appropriate escalation, clear communication, timely intervention, and meaningful follow-up. CMS F580 supplies important notification obligations for qualifying circumstances, while SBAR provides a practical structure for communicating the clinical findings.

The central clinical question remains straightforward: What is different from this resident's usual condition, and what must be done about that difference? A reliable response is grounded in resident-specific assessment, sound clinical judgment, the applicable requirements, and clear documentation of what happened next.

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References

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