



Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C-10-27-NH

**DATE:** July 30, 2010

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey & Certification Group

**SUBJECT:** Advance Copy - Description of Temporary Changes to Appendix P, State Operations Manual (SOM), Traditional Survey Process for Long Term Care Facilities (LTC) as a Result of the Minimum Data Set (MDS) 3.0 Implementation October 1, 2010

Memorandum Summary

- **Quality Measure/Quality Indicator (QM/QI) reports:** Unavailable for use October 1, 2010 in the Traditional Survey Process until further notice;
- **Temporary revisions to Traditional Survey Process Tasks 1-5C:** Revision effective October 1, 2010 and for use for all surveys in LTC Facilities in which the Traditional Survey Process is used; and will continue until further notice;
- **Permanent Revisions to Appendix P:** Revision of terminology including removing the Resident Assessment Protocols (RAPs) and replacing with Care Area Assessment (CAAs), and reports formerly identified as the OSCAR, and now known as the CASPAR are effective October 1, 2010; and
- **Training Materials:** A training document with speaker notes for Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) and State Survey Agencies (SAs) to use to train surveyors on this revision to Appendix P in the SOM is attached to this memorandum. Power point slides have been issued to ROs under a separate communication.

The purpose of this memorandum is to advise you of the temporary revision to the Traditional Survey Process in Appendix P of the State Operations Manual (SOM). The Centers for Medicare & Medicaid Services (CMS) will release the MDS 3.0 version on October 1, 2010. As a result, there will be an inability to run the QM/QI Reports which are used offsite to assist the surveyors in selecting their Phase 1 resident sample. The survey tasks have been revised so that nursing home survey teams can select the Phase 1 survey sample without the benefit of the QM/QI Reports. This temporary revision to Traditional Survey Process Tasks 1-5C will be implemented October 1, 2010 only for those nursing home surveys in which the traditional survey process is being used. An advance copy of the revised Tasks is attached.

In addition to the temporary changes to the survey tasks, we changed the title of Online Survey Certification and Reporting (OSCAR) reports, which are no longer being produced, to Certification and Survey Provider Enhanced Reporting (CASPER) reports. We are also removing any reference to the Resident Assessment Protocols (RAPs). With the implementation of the MDS 3.0, RAPs have been replaced with the Care Area Assessment (CAA) process. Revised language is presented in red and italics, and strikethroughs are used for those items that will be placed on hold until further notice. All remaining portions of Appendix P are unchanged.

Changes as a result of the implementation of MDS 3.0 will affect CMS forms CMS-672 & CMS-802, as well as Appendix PP. These changes will be identified in a future Survey & Certification memorandum, which is projected for an advance release August 13, 2010 for implementation on October 1, 2010.

Also attached are training materials for the revised traditional survey process. Use this training packet and make sure that all nursing home surveyors using the Traditional Survey Process are trained in the revised guidance by the implementation date. These materials were presented and discussed in a teleconference with the CMS Regional Offices (ROs) on July 15, 2010. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. This guidance may also be used to communicate with provider groups and other stakeholders.

RO training coordinators will document the completion for training on this new guidance for all RO and State nursing home surveyors within their region who survey under the Traditional Survey Process.

For questions on this memorandum, please contact Beverly Cullen at 410-786-6784 or via email at [Beverly.Cullen@cms.hhs.gov](mailto:Beverly.Cullen@cms.hhs.gov).

**Effective Date: October 1, 2010 and continue until further notice.**

**Training:** The information contained in this announcement should be shared with all nursing home surveyors and supervisors.

/s/

Thomas E. Hamilton

Attachments:

Temporary revision to Appendix P only for the Traditional Survey Process  
Instructor training guidance document

cc: Survey and Certification Regional Office Management (G-5)

# State Operations Manual

## Appendix P - Survey Protocol for Long Term Care Facilities

### - Part I

#### II.B. - The Traditional Survey

##### II.B.1 - Traditional Standard Survey Tasks

#### Task 1 - Offsite Survey Preparation

##### A. General Objectives

The objectives of offsite survey preparation are to analyze various sources of information available about the facility in order to:

- *Identify any potential areas of concern and any special features of the facility (such as special care units) that the team will use to focus the initial tour and information gathering tasks;*
- *Identify potential residents for the sample. Also identify potential family members or friends to consider for interviews. (On tour, surveyors will note if these residents are still at the facility and if they are good candidates for the sample. Residents who have been discharged may be selected for review as closed records);*
- Note concerns based on other sources of information listed below and note other potential residents who could be selected for the sample; and;
- Determine if the areas of potential concerns or special features of the facility require the addition to the team of any specialty surveyors.

##### B. Information Sources for Offsite Survey Preparation

The following sources of information (2-8) are used during the offsite team meeting to focus the survey:

1. *(omit this step - unavailable 10/01/2010 until further notice)* **Quality Measure/Indicator Reports**

~~QM/QIs are to be used as indicators of potential problems or concerns that warrant further investigation. They are not determinations of facility compliance with the long term care requirements. There are three QM/QI reports which should be downloaded from the State database:~~

- Facility Characteristics Report ([Exhibit 268](#))

This report provides demographic information about the resident population (in percentages) for a selected facility compared to all the facilities in the State. It includes information in the following domains: Gender, age, payment source, diagnostic characteristics, type of assessment, stability of conditions, and discharge potential.

- Facility Quality Measure/Indicator Report ([Exhibit 269](#))

This report provides facility status for each of the MDS-based QM/QIs (quality measures and quality indicators) as compared to State and national averages. Listed are the individual QM/QIs (grouped by domains). This report begins with a set of 12 domains and a total of 31 QM/QIs for the chronic (long stay) resident population, followed by three additional QM/QIs for the post-acute care (PAC) resident population. For each QM/QI, (reading across a row from left to right) are:

- The numerator—the number of residents in the facility who have the condition;
- The denominator—the number of residents in the facility who could have the condition;
- The facility observed percentage of residents who have the condition;
- The facility adjusted percentage of residents who have the condition;
- The State average percentage of residents who have the condition;
- The national average percentage of residents who have the condition; and
- The State percentile ranking of the facility on the QM/QI—a descriptor of how the facility compares (ranks) with other facilities in the state. The higher the percentile rank, the greater potential there is for a care concern in the facility.
- An asterisk is present in any row in which the facility flagged on a QM/QI, which means that the facility is at or above the 90th percentile; and any of the three sentinel event rows if any resident has the condition (see D. below for more information on sentinel events).

- Resident Level Quality Measure/Indicator Reports ([Exhibit 270](#))

The resident level reports are divided into Chronic Care and PAC samples, to correspond to the division of residents in the Facility Quality Measure/Indicator Report described above. Both reports provide resident-specific information generated

~~using current records from the CMS Minimum Data Set (MDS) data base. An X appears in a QM/QI column for a resident who has that condition. If a QM/QI is risk adjusted, this X is in either the high or low risk subcolumn, indicating whether this resident was at high or low risk to develop the condition. The Chronic Care version contains the following columns for each long-stay resident, reading from left to right:~~

- ~~• Resident identification number;~~
- ~~• Resident name in alphabetical order;~~
- ~~• MDS type of assessment (1 = admission, 2 = annual, 3 = significant change, 4 = significant correction, and 5 = quarterly);~~
- ~~• Columns for each QM/QI for the chronic care resident in the same order and under the same domains as on the Facility Quality Measure/Indicator Report; and~~
- ~~• A column that counts how many QM/QIs the resident triggered.~~

~~The PAC version contains the following columns for each PAC resident, reading from left to right:~~

- ~~• Resident identification number;~~
- ~~• Resident name in alphabetical order;~~
- ~~• Columns for the three PAC QM/QIs; and~~
- ~~• A column that counts how many QM/QIs the resident triggered.~~

~~**NOTE:** Resident specific information in the Resident Level reports must be kept confidential in accordance with the Privacy Act. These reports are only for the use of the State agency, CMS representatives, and the facility.~~

## **2. Statements of Deficiencies (CMS-2567) and Statements of Isolated Deficiencies Which Cause No Actual Harm With Only Potential For Minimal Harm (Form A)**

Statements of deficiencies from the previous survey should be reviewed, along with the sample resident identifiers list. Review the specific information under each deficiency and note any special areas of concern. For example, a deficiency was cited for comprehensive care planning last year. Share with the team the specific care planning problems that were listed as the reasons for this deficiency. For resident-centered requirements, determine if any residents identified in the deficiency might be good candidates for the sample. For example, a deficiency was cited for abuse partly based on surveyor observation of a staff member striking a resident who was combative. Identify

this resident by name and add the name to the Offsite Preparation Worksheet. During the Initial Tour, evaluate if this resident is still present for possible inclusion in the sample.

**3. *CASPER* Report 3, History Facility Profile, and *CASPER* Report 4, Full Facility Profile from CMS' *CASPER* Computer System.**

(Refer to Exhibit 96 for sample copies of Reports 3 and 4.) Report 3 contains the compliance history of the facility over the past 4 surveys. Use it to determine if the facility has patterns of repeat deficiencies in particular tags or related tags. This report also lists the dates of any complaint investigations and Federal monitoring surveys during the 4-year time period.

Report 4 contains information provided by the facility during the previous survey on the Resident Census (Form CMS-672). This report compares facility population characteristics with State, CMS region, and national averages.

**4. Results of Complaint Investigations**

Review information from both complaints investigated since the previous standard survey and complaints filed with the survey agency, but not yet investigated. Note resident and staff names related to the complaints and note patterns of problems relating to specific wings or shifts.

**5. Information about Waivers or Variances**

If the facility has, or has requested any staffing waiver or room variances, note these for onsite review. The team will determine onsite if these should be granted, continued, or revoked due to a negative effect on resident care or quality of life.

**6. Information from the State Ombudsman Office**

Note any potential areas of concern reported by the ombudsman office and note resident names reported as potential sample residents, residents for closed record review, or family members for family interviews and the reasons for their recommendation by the ombudsman.

**7. Preadmission Screening and Resident Review Reports (PASRR)**

Some States may have formal mechanisms to share with the survey agency the results of PASRR screens for residents with mental illness or mental retardation. If this information is available, evaluate if there are any potential concerns and note names of residents for possible inclusion in the sample.

## 8. Other Pertinent Information

At times, the survey agency may be aware of special potential areas of concern that were reported in the news media or through other sources. Evaluate this information to determine if there are potential areas of concern that should be investigated onsite.

### C. Team Coordinator Responsibilities

The team coordinator and/or designee is responsible for completing the following tasks:

1. **Contact the ombudsman office** in accordance with the policy developed between the State survey agency and State ombudsman agency. The purposes of this contact are to notify the ombudsman of the proposed day of entrance into the facility and to obtain any information the ombudsman wishes to share with the survey team. Ascertain whether the ombudsman will be available if residents participating in the group or individual interviews wish her/him to be present.
2. **Obtain all information sources listed in B. above** for presentation at the offsite team meeting. (See Section B. above, for descriptive information about these reports.) They are as follows:
  - *(omit - unavailable 10/01/2010 until further notice)* ~~Specified QI/QM reports:~~
    - ~~Facility Characteristics Report;~~
    - ~~Facility Quality Measure/Indicator Report; and~~
    - ~~The two resident level reports:~~
      - ~~Resident Level Quality Measure/Indicator Report: Chronic Care Sample; and~~
      - ~~Resident Level Quality Measure/Indicator Report: Post Acute Care Sample~~

**NOTE:** *(omit - unavailable 10/01/2010 until further notice)* ~~It is important that the QM/QI reports be generated as close to the date of survey as possible, preferably no more than a few days prior to the survey.~~

- Form CMS-2567 and Statement of Isolated Deficiencies Which Cause No Actual Harm With Only Potential For Minimal Harm;
- Standard *CASPER* Report 3 and 4;
- Results of complaint investigations;
- Information about waivers or variances;

- Information from the State Ombudsman office;
- Preadmission Screening and Resident Review Reports; and
- Other pertinent information.

### 3. Complete the following additional duties:

- *Obtain copies of the Roster/Sample Matrix (CMS-802(Exhibit xx/xx) for the survey team to note areas of concern for the survey and to select potential residents for the sample from the offsite information. This worksheet is also used by the facility to list all residents and check which categories apply to each resident. There are separate sets of instructions for the use of this form by the survey team and the facility. (See these instructions in Exhibit 265.)*
- Copy and distribute to the team the facility's floor plan if the team is unfamiliar with the facility's layout;
- Make extra copies of the *CASPER* Reports 3 and 4, ~~and (omit this step - unavailable 10/01/2010 until further notice - the three QM/QI reports)~~ to be given to the facility's administrator;
- Obtain an extra copy of the group interview worksheet (see Form CMS-806B, [Exhibit 94](#)) to give to the council president.

### D. Offsite Survey Preparation Team Meeting

Present copies of the information obtained to the survey team members for review at a brief team meeting offsite. The team must prepare for the survey offsite, so that they are ready to begin the Entrance Conference and Initial Tour immediately after they enter the facility. The team should:

***NOTE: OMIT ITEMS 1-3 BELOW 10/01/2010 UNTIL FURTHER NOTICE. BEGIN AT ITEM # 4***

1. ~~Review the Facility Characteristics Report to note the facility's demographics. This report can be used to identify whether the facility's population is unusual, e.g., high prevalence of young or male residents, high prevalence of residents with psychiatric diagnosis, high percentage of significant change assessments, etc.;~~
2. ~~Use a copy of the Roster/Sample Matrix (Form CMS 802, [Exhibit 90](#)) to highlight concerns the team identifies for Phase 1 of the survey, and to list residents pre-selected and the QM/QI conditions for which each was selected. Mark the offsite block on this form to distinguish it from the Phase 1 version that will be completed in [Task 4](#), "Sample Selection;"~~



The Facility Quality Measure/Indicator Report divides the QM/QIs into a set for the chronic care residents, followed by three post acute measures, which are based on MDS information for short stay residents. The three PAC QM/QI items include two that are the same topics as the chronic care residents (13.2, Short stay residents who had moderate to severe pain, and 13.3, Short stay residents with pressure ulcers) and one unique item (13.1, Short stay residents with delirium). Use this report to select concerns based on the following:

- Any sentinel health event QM/QI that is flagged. For the chronic care sample, a “sentinel health event” is a QM/QI that represents a significant occurrence that should be selected as a concern, even if it applies to only one or a few residents. The sentinel event QM/QIs are 5.4, Prevalence of fecal impaction, 7.3, Prevalence of dehydration, and 12.2, Low risk residents with pressure ulcers. This means that even if one resident has any of these conditions, this QM/QI will flag and the care area must be selected as a concern and the resident with the problem must be selected for the sample. If there are multiple residents who flag on a sentinel event QM/QI, it is not necessary to select all of them;
- Any other QM/QI that is flagged at the 90th percentile; and
- Any unflagged QM/QI in which the facility is at the 75th percentile or greater.

For the items that are duplicated between the chronic care and PAC residents (pain and pressure ulcers), note whether the area of concern was selected based on only chronic or PAC samples, or both. The survey team may also wish to select as concerns any other QM/QIs that are of interest to them because they are related to QM/QIs that have been selected.

3. Begin selection of potential residents for the Phase 1 survey sample with the chronic care sample residents to represent the concerns that have been selected, including selecting residents who have sentinel event QM/QI conditions; if multiple residents have a sentinel event QM/QI condition, it is not necessary to select all of them. Use [Table 1](#) in this section and the number of the total resident census to determine the sample size for the Phase 1 sample. Pre-select a few more residents (3-5) than the actual number that will be required for Phase 1 sample since some selected residents may no longer be available. Most if not all residents from the PAC sample are likely to have been discharged. The survey team may use this sample of residents from which to select potential closed records for review. (If some PAC residents that triggered a selected QM/QI are still at the facility, the team may select some of these residents in order to investigate issues of concern).
- In any facility in which the team has noted concerns with weight loss, dehydration, and/or pressure sores, select approximately one-half of the pre-selected sample as residents who have one or more of these conditions.

For the condition of hydration, select a resident who has flagged for the sentinel event QM/QI 7.3 (Prevalence of dehydration) and residents may be selected who have any of the following related QM/QI conditions: 5.4—Prevalence of fecal impaction; 6.1—Residents with a urinary tract infection; 7.1—Residents who lose too much weight; 7.2—Prevalence of tube feeding; and 9.1—Residents whose need for help with daily activities has increased. The best residents to select will be those who also have multiple care areas that have been selected as concerns. For any facility in which these concerns were not identified, the team should still select some residents who have these QM/QI conditions, if any, on the Resident Level Quality Measure/Indicator Reports, but this need not be 50% of the Phase 1 sample size.

- For the remaining half of the Phase 1 preliminary sample, select residents to represent the remaining areas of concern.

**NOTE:** If there are no other QM/QIs that have been selected as concerns, the team may select residents based on other sources of information, e.g., complaints or a report from the ombudsman, or may wait to select the remaining Phase 1 residents based on Initial Tour findings.

If the average length of stay for the facility's population is less than 14 days, there may be little information available. Pre-selection of QM/QI based concerns and/or the full sample may not be possible. Selection of some or all concerns and residents may need to be totally conducted onsite.

- The survey team should be alert to inconsistencies on the Facility Quality Measure/Indicator Report that may indicate facility error in completing and/or transmitting its Minimum Data Set (MDS) records, or a problem with State's software or CMS' database. The following are some possible indicators of data quality problems:
  - The denominator for QM/QIs that use "all residents" substantially exceeds or is substantially smaller than the facility bed size;
  - The number of residents with a QM/QI condition, i.e., the numerator, exceeds the resident population; or,
  - The numerator for a particular QM/QI is zero although other information sources indicate otherwise. For example, the QM/QI report shows zero residents in restraints, but the ombudsman notified the team that she/he verified complaints about restraints. The most common reason for this type of inconsistency is incorrect MDS coding by the facility.

If these or other potential accuracy concerns are noted, the team should add resident assessment accuracy as a concern for the survey.

**NOTE:** This review need not be done for “short stay” facilities, which will often have unusual values in the numerator and denominator due to rapid turnover of residents.

The Facility Quality Measure/Indicator Report is generated using the current MDS records in the State database at the time the report was generated. However, it excludes residents who have only an initial MDS record in the system. This was done so that the report reflects the care residents have received while residing in the facility, as opposed to the conditions of residents at the time of admission to the facility. The Resident Level reports are calculated using the most recently transmitted MDS record, e.g., annual, significant change, quarterly, or initial MDS record. Differences could be seen between the Facility Quality Measure/Indicator Report and the Resident Level reports since the former does not use the admission MDS data. For example, a Resident Level report may indicate a resident had a catheter but the Facility Quality Measure/Indicator Report might show a “0.” This is not an accuracy problem, it only reflects the use of different data to generate each report.

4. ~~(omit this portion of step - unavailable 10/01/2010 until further notice)~~

~~—Review the **CASPER** reports after the review of the QM/QI reports to add corroborative information to the QM/QI information, e.g., a pattern of repeat deficiencies in a requirement related to a flagged QM/QI, and/or to point out areas of large discrepancies between the QM/QI numerators and the **CASPER** Reports, e.g., the **CASPER** 4 report lists the facility as having triple the average number of residents in restraints, but the QM/QI for restraints shows the facility has less restraints than most facilities). The team coordinator may wish to discuss such discrepancies with the administrator on entrance to determine the reason for them.~~

~~Relate information between Reports 3 and 4 such as a pattern of repeat deficiencies in range of motion and a lower than average percentage of residents receiving rehabilitative services. Also, note any special resident characteristics not contained in the QM/QI reports.~~

**NOTE:** ~~Both the **CASPER** reports and the QM/QI reports can alert surveyors to the acuity and characteristics of the facility’s residents at the time the information for these reports was determined. This information may not represent the current condition of residents in the facility at the time of the survey. Keep in mind that the **CASPER** information is approximately 1 year old, and the QM/QI information may be from 2-6 months old. Resident characteristics that were reported by the facility during the last survey may have changed significantly and may be the source of some discrepancies between **CASPER** and QM/QI information.~~

*(Begin here)*

*Review the **CASPER** reports and relate information between Reports 3 and 4 such as a pattern of repeat deficiencies in range of motion and a lower than average percentage of*

*residents receiving rehabilitative services. Also, note any special resident characteristics.*

**NOTE:** *The CASPER reports can alert surveyors to the acuity and characteristics of the facility's residents at the time the information for these reports was determined. This information may not represent the current condition of residents in the facility at the time of the survey. Keep in mind that the CASPER information is approximately 1 year old. Resident characteristics that were reported by the facility during the last survey may have changed significantly. During the initial tour (Task3), the team will determine if the potential areas of concern discussed offsite are no longer concerns or if they are still relevant areas in which to focus the investigation.*

5. *Use a copy of the Roster/Sample Matrix (Form CMS-802, [Exhibit 90](#)) to highlight concerns the team identifies for Phase 1 of the survey, and to list any potential residents pre-selected. Mark the offsite block on this form to distinguish it from the Phase 1 version that will be completed in [Task 4](#), "Sample Selection;" Review all other sources of information and record additional information on the Offsite Preparation Worksheet (Form CMS-801, [Exhibit 89](#)), for example, residents' names for possible inclusion in the Phase 2 sample based on non-QM/QI sources of information (B. 2 through 8 above), special features of the facility, or special resident populations. Identify any outstanding complaints needing investigation. At this meeting, establish preliminary surveyor assignments and projections of which days team members will enter early and/or stay late to make observations of resident care and quality of life.*

## **Task 2 – ENTRANCE CONFERENCE/ONSITE PREPARATORY ACTIVITIES**

### **A. Entrance Conference**

1. The team coordinator informs the facility's administrator about the survey and introduces team members.
2. After the introduction to the administrator, the other team members should proceed to the initial tour ([Task 3](#)), while the team coordinator conducts the entrance conference.
3. The team coordinator should:
  - Request a copy of the actual working schedules for licensed and registered nursing staff for this time period by the end of the tour or earlier if possible.
  - Inform facility staff that the survey team will be communicating with them throughout the survey and will ask for facility assistance when needed. (See [§2713.A](#) for further information about facility staff accompanying surveyors.) Advise them that they have the opportunity to provide the team with any information that would clarify an issue brought to their attention.

- Explain the survey process and answer any questions from facility staff.
- Give the Administrator copies of *(omit this portion of step - unavailable 10/01/2010 until further notice)* ~~the QM/QI reports~~ and the **CASPER** 3 and 4 reports that are being used for the survey. Briefly explain these reports and how they were used by the survey team in Task 1. *(omit this step - unavailable 10/01/2010 until further notice)* ~~If there are discrepancies between the **CASPER** information and the QM/QI Facility Characteristics report, ask the administrator, or person designated by the administrator, to explain the discrepancies).~~
- Ask the administrator to describe any special features of the facility's care and treatment programs, organization, and resident case-mix. For example, does the facility have a special care unit for residents with dementia? Are residents with heavy care needs placed in particular units? If so, which ones?
- Ask the administrator if the facility utilizes paid feeding assistants. If yes, request further information about how and where the paid feeding assistants receive their training. Determine whether the training for the paid feeding assistant was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training.
- Request the names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks;

**NOTE:** Paid feeding assistants must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). Therefore, if a facility has a nursing waiver, that facility cannot use paid feeding assistants when a licensed nurse is not available.

- Inform the administrator that there will be interviews with individual residents, groups of residents, family members, friends, and legal representatives, and that these interviews are conducted privately, unless the interviewees request the presence of a staff member. Ask the administrator to ensure that there are times during the survey when residents can contact the survey team without facility staff present and without having to ask facility staff to leave or to allow access to the team.
- Determine through interview with the administrator if the facility has a functioning QA&A committee. Determine:
  - Which staff participate on the committee;
  - Who leads the committee;
  - How often the committee meets; and

- o With whom should the survey team discuss QA&A concerns.
- Ask the administrator to provide the following information within 1 hour of the conclusion of the entrance conference (or later at the survey team's option):
  1. List of key facility personnel and their locations, e.g., the Administrator; directors of finance, nursing services, social services, and activities; dietitian or food supervisor; rehabilitation services staff; charge nurses; pharmacy consultant; plant engineer; housekeeping supervisor; persons responsible for infection control and quality assurance; health information management professional; and the medical director;
  2. A copy of the written information that is provided to residents regarding their rights;
  3. Meal times, dining locations, copies of all menus, including therapeutic menus that will be served for the duration of the survey;
  4. Medication pass times (by unit, if variable);
  5. List of admissions during the past month, and a list of residents transferred *or discharged with destinations, or who died*, during the past 3 months;
  6. A copy of the facility's layout, indicating the location of nurses' stations, individual resident rooms, and common areas, if not obtained in Task 1;
  7. A copy of the facility admission contract(s) for all residents, i.e., Medicare, Medicaid, other payment sources;
  8. Facility policies and procedures to prohibit and investigate allegations of abuse and the name of a person the administrator designates to answer questions about what the facility does to prevent abuse. (See [Task 5G](#), Abuse Prohibition Review, for further information);
  9. Evidence that the facility, on a routine basis, monitors accidents and other incidents, records these in the clinical or other record; and has in place a system to prevent and/or minimize further accidents and incidents;

**NOTE:** At the discretion of the facility, this evidence could include or be a record of accident and incident reports.

  10. The names of any residents age 55 and under;
  11. The names of any residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominant language of the facility;

- Ask the facility to complete, to the best of their ability, the Roster/Sample Matrix (Form CMS-802), including all residents on bed-hold, by the end of the initial tour, or to provide this information in some other format, e.g., computer-generated list.

**NOTE:** This is an important source of resident information, which is crucial for the team to have for their sample selection meetings. Stress to the facility that this form should be completed first and given to the team coordinator by the end of the initial tour. After the Roster/Sample Matrix is delivered to the team, the facility may make modifications for accuracy or add additional information within 24 hours.

- Ask the facility to provide the following within 24 hours of the Entrance Conference:
  1. A completed Long Term Care Facility Application for Medicare and Medicaid (Form CMS-671), (see [Exhibit 85](#)) and a Resident Census and Conditions of Residents (Form CMS-672), (See [Exhibit 264](#)); and
  2. A list of Medicare residents who requested demand bills in the last 6 months (SNFs or dually-participating SNF/NFs only).
- Also, ask the administrator the following questions:
  1. Which, if any, rooms have less square footage than required? Do you have a variance in effect and are you prepared to continue to request a variance for any such rooms? (F458)
  2. Which, if any, rooms are occupied by more than four residents? Do you have a variance in effect and are you prepared to continue to request a variance for any such rooms? (F457)
  3. Is there at least one window to the outside in each room? (F461)
  4. Which, if any, bedrooms are not at or above ground level? (F461)
  5. Do all bedrooms have access to an exit corridor? (F459)
  6. What are the procedures to ensure water is available to essential areas when there is a loss of normal supply? (F466)

**NOTE:** If the survey is commencing at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or on a Saturday or Sunday, once onsite, announce the survey, ascertain who is in charge, ask the person to notify the administrator that a survey has begun. Modify the entrance conference in accordance with staff available and complete the task and the onsite preparatory activity as appropriate within the context of the survey.

4. For any survey conducted outside of the influenza season (October 1-March 31), obtain the name of the staff person who is responsible for coordinating and implementing the facility's immunization program to request a list of current residents who were in the facility during the previous influenza season, October 1 to March 31.

## **B. Onsite Preparatory Activities**

1. In areas easily observable by residents and visitors, post, or ask the facility to post, signs announcing that a survey is being performed and that surveyors are available to meet with residents in private.
2. The team coordinator or designee should contact the resident council president after the Entrance Conference to introduce her/himself and to announce the survey. Provide the president with a copy of the group interview questions (Exhibit 94-CMS 806B). Request the assistance of the president for arranging the group interview and to solicit any comments or concerns. Ask the council president for permission to review council minutes for the past 3 months (see [Task 5D, Section 3B](#), for further information). If there is not an active resident council, or if the council does not have officers, ask for a list of residents who attend group meetings, if any, and select a resident representative to assist in arranging the group interview. If the ombudsman has indicated interest in attending the group interview, ask the president if that is acceptable to the group; if it is, notify the ombudsman of the time/place of the meeting.
3. The team coordinator, the surveyor assigned to conduct the group interview, or a designee should arrange for date, time and private meeting space for the interview. Advise the facility staff that non-interviewable residents are not part of this meeting. (See [Task 5D](#) for further guidance.)

## **Task 3 - Initial Tour**

### **A. General Objectives**

The Initial Tour is designed to:

- Provide an initial review of the facility, the residents, and the staff;
- Obtain an initial evaluation of the environment of the facility, including the facility kitchen;
- Confirm or invalidate the ~~pre-selected~~ *pre-survey information about potential areas of concern*, if any, and add concerns discovered onsite;
- *Identify areas of concern to be investigated (Roster/Sample Matrix, CMS 802);*



- *Identify specific residents for possible inclusion in the sample using pre-survey information, if any, and observation;*
- *Identify interviewable residents who can be selected to participate in a Quality of Life Assessment Resident Interview or Group Interview (See Task 5D). This can be accomplished by talking with residents and asking questions. Examples of questions that can be asked are: What is your name? What are you planning to do today?*

**NOTE:** *Do not rely solely on the information that the facility provides concerning which residents are interviewable. The survey team should determine the residents who are able to participate in a Quality of Life Assessment interview.*

## **B. General Procedures**

The initial tour is used to gather information about concerns which have been pre-selected; new concerns discovered onsite; and whether residents pre-selected, *if any*, for the Phase 1 sample offsite are still present in the facility. In addition, *it is not necessary to meet 100% of the residents; however*, attempt to meet and talk with as many residents as possible during the tour in order to identify ~~other~~ candidates for the sample. *In addition, use the tour* to get an initial overview of facility care and services, to observe staff/resident interactions; and to evaluate the impact of the facility environment on the residents. The tour also includes a first brief look at the facility's kitchen. *During the tour:*

- Document tour information, on either the Roster/Sample Matrix (Form CMS-802 or the Surveyor Notes Worksheet (Form CMS-807).
- Document any concerns regarding the general environment on the General Observations of the Facility Worksheet, (Form CMS-803) or Surveyor Notes Worksheets, (Form CMS-807). (See [Task 5A](#) for further information.) Surveyors may also document notes on the facility's Roster/Sample Matrix or other list of residents provided by the facility.
- Document any concerns noted in the brief tour of the facility kitchen on the Kitchen/Food Service Observation worksheet (Form CMS-804, [Exhibit 92](#)). (See [Task 5B](#) for information regarding observations to make during this brief tour.)

## **C. Protocol**

Surveyors should tour individually as assigned by the team coordinator. It is desirable for team members to have a facility staff person who is familiar with the residents accompany them during the tour to answer questions and provide introductions to residents or family. However, do not delay the beginning of the Initial Tour if facility staff are not available. Begin the tour as soon as possible after entering the facility.

**NOTE:** When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the initial tour will need to be modified in recognition of the residents' activity, e.g., sleep, religious services, and types and

numbers of staff available upon entry. The tour may focus on specific care and quality of life issues, e.g., restraint use, meal service, use of foam or paper meal service products rather than regular dinnerware, adherence to the planned menu; sufficiency of staff; whether enteral/parenteral fluids are being administered as ordered; whether incontinent residents are being checked, toileted, changed; etc., as appropriate. The tour should not be delayed for lack of staff to accompany the surveyor and/or survey team.

**Phase 1-- Pre-selected Concerns and Potential Residents:** *(omit this step – QMs/QIs unavailable 10/01/2010 until further notice)*

~~During the tour, determine whether each resident pre-selected offsite for the Phase 1 sample is still there. Determine which, if any, of the pre-selected Phase 1 sample residents are interviewable residents who can be selected to participate in a Quality of Life Assessment Resident Interview or Group Interview. (See [Task 5D](#).) This can be accomplished by talking with residents and asking questions. Examples of questions that can be asked are: What is your name? What are you planning to do today?~~

~~NOTE: Do not rely solely on the information that the facility provides concerning which residents are interviewable. The survey team should determine the residents who are able to participate in a Quality of Life Assessment interview.~~

~~If possible, determine if there are family members of non-interviewable residents in the pre-selected Phase 1 sample who can be selected for a Quality of Life Assessment family interview. Also note other non-interviewable residents among the facility population whose family members could be selected for interviews;~~

### **Observations of All Residents During the Tour**

Ask staff to identify those residents who have no family or significant others. The team may include one or more of these residents in the Phase 2 sample for investigation of quality of life issues.

Have staff identify newly admitted residents, i.e., who have been admitted within the past 14 days, for possible inclusion in the sample for investigation of decline or deterioration that may have occurred before all MDS, other resident assessment information, and care planning is completed.

Have staff identify any residents for whom transfer or discharge is planned within the next 30 days.

Note residents who are interviewable or who have special factors, as listed in [Task 4](#).

When on the Initial Tour, observe and document possible quality of care and quality of life concerns in addition to those pre-selected offsite, if any. If observed concerns involve specific

residents, note the resident's name and room number on the worksheet, and the date/time when describing the observed concern. Include the details of the observation in documentation, including any effects on the residents involved.

Conduct a brief initial observation of the kitchen. (See [Task 5B](#) for further information).

While on tour, identify the licensed and registered nursing staff who are currently on duty. At the end of the tour, compare the observed staff with the duty roster the facility is to provide. If there are discrepancies between the duty roster and the staff observed onsite, ask the person in charge to explain the discrepancies. This information will be used in Task 6 to determine if the facility is compliant with the requirements for licensed and registered nursing staff at

[42 CFR 483.30\(a\)\(2\)](#), F353 and [42 CFR 483.30\(b\)\(1\)](#), F354.

*During the tour, identify residents who can be selected for the sample by focusing on the following (either through your observations or through information obtained from facility staff on tour with you):*

- Quality of Life
  1. Resident grooming and dress, including appropriate footwear;
  2. Staff - resident interaction related to residents' dignity; privacy and care needs, including staff availability and responsiveness to residents' requests for assistance;
  3. The way staff talk to residents, the nature and manner of interactions, and whether residents are spoken to when care is given; and
  4. Scheduled activities taking place and appropriateness to the residents.
- Emotional and behavioral conduct of the residents and the reactions and interventions by the staff:
  1. Resident behaviors such as crying out, disrobing, agitation, rocking, pacing; and
  2. The manner in which these behaviors are being addressed by staff, including nature and manner of staff interactions, response time, staff availability, and staff means of dealing with residents who are experiencing catastrophic reactions. (See "Abuse Prohibition Investigative Protocol" in [Task 5G](#) for a definition of catastrophic reaction.)
- Care issues, how care is provided, and prevalence of special care needs
  1. Skin conditions, e.g., excessive dryness, wetness;
  2. Skin tears, bruising, or evidence of fractures that warrant investigation;

3. Dehydration risk factors including availability of water for most residents, and other indicators or factors, e.g., the amount and color of urine in tubing and collection bags, dependence on staff, the presence of strong urinary odors, and resident complaints of dry mouth and lips;
  4. Clinical signs such as edema, emaciation and contractures;
  5. Functional risk factors such as poor positioning and use of physical restraints;
  6. Side effects of antipsychotic drug use such as tardive dyskinesia, e.g., lip, tongue or other involuntary abnormal movements;
  7. Presence or prevalence (numbers) of infections including antibiotic resistant strains of bacteria (e.g., Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium Difficile (C-Diff) or other infections: Urinary tract infections, draining wounds, eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, etc.
  8. Pressure sores, old scars from pressure sores or evidence of surgical repair of pressure sores;
  9. Amputation;
  10. Significant weight loss;
  11. Feeding tubes and/or improper positioning while feeding is infusing; and
  12. Ventilators, oxygen, or intravenous therapies.
- Impact of the facility environment and safety issues:
    1. Infection control practices, e.g., handwashing, glove use, and isolation procedures);
    2. Functional and clean equipment, including kitchen equipment;
    3. Presentation and maintenance of a homelike and clean environment; and
    4. Availability, use, and maintenance of assistive devices.

**NOTE:** If the initial tour is being conducted during a mealtime, include an initial brief observation of the dining areas. Note if there are any concerns with meal service, quality of life, positioning, sufficient space, etc.

## Task 4 - Sample Selection

### A. General Objective

The objective of this task is to select a case-mix stratified sample (see Special Factors to Consider in Sample Selection below for further information) of facility residents based on QM/QIs (*unavailable 10-01-2010 until further notice*) other offsite and onsite sources of information in order to assess compliance with the resident-centered long term care requirements.

*Residents should be selected for the sample, based on variation in case-mix, concerns that the team has selected to investigate, and based on special factors below (e.g., new admissions).*

### B. General Procedures

- *Sampling is done in two phases, after the tour and part way through the survey. Approximately 60% of the sampled residents are chosen in Phase 1, with the remaining 40% chosen in Phase 2.*
- *(This Item Is On Hold 10-01-2010 Until Further Notice – See D. Protocol For Instructions For Sample Selection)* ~~The Phase 1 sample is pre-selected during Task 1, “Offsite Survey Preparation,” based on QM/QIs and other areas of concern. The pre-selected sample is reviewed during the sample selection meeting and residents are retained for the sample unless they are discharged, or the survey team has another reason to substitute, e.g., to select interviewable residents.~~
- *In Phase 1, a selected number of residents are chosen to receive comprehensive reviews. The remaining residents in both phases are selected to receive either focused or closed record reviews.* Each team member is assigned a certain number of residents, completing all facets of review that have been selected including any quality of life assessment protocols selected for these residents.
- The Phase 2 sample is selected onsite, part way through the survey when surveyors have collected enough information to determine the focus of the remainder of the survey. The Phase 2 sample residents are selected to represent new concerns and/or to continue further investigation of Phase 1 concerns when Phase 1 reviews proved inconclusive or when necessary to determine scope of a problem.
- It is statutorily required that the sample in each facility be case-mix stratified in order to capture both interviewable and non-interviewable residents as well as residents from both heavy and light care categories, *for example residents who have various stages of impairment of physical functioning/dependency, and cognitive functioning.*

**NOTE:** If the team is conducting sample selection during meal time, delay or interrupt this task to conduct brief observations of the dining areas. Note if there are any concerns with meal service, quality of life, positioning, sufficient space, etc.

## C. Definitions

- Interviewable Resident --This is a resident who has sufficient memory and comprehension to be able to answer coherently the majority of questions contained in the Resident Interview. These residents can make day-to-day decisions in a fairly consistent and organized manner.
- Comprehensive Review -- For Task 5C, “Resident Review,” this includes observations, interviews, and record reviews for all care areas for the sampled residents, as applicable.
- Focused Review -- For Task 5C, “Resident Review,” this includes the following:
  - For Phase 1: Observations, interviews and record reviews concerning all highlighted areas of concern and all unhighlighted areas pertinent to the resident; and
  - For Phase 2: Observations, interviews and record review for all highlighted areas of concern pertinent to the resident.
- Closed Record Review -- For Task 5C, “Resident Review,” this includes a record review of residents’ care issues and transfer and discharge.
- Roster/Sample Matrix -- This worksheet, ([Exhibit 265](#), Form CMS-802), is used by the survey team during Offsite Survey Preparation, and at the Phase 1 and Phase 2 Sample Selection meetings to note areas of concern for the survey, and to select residents for the sample. *This worksheet is also used by the facility to list all residents and check which categories apply to each resident.* There are separate sets of instructions for the use of this form by the survey team and the facility. (See these instructions at [Exhibits 266 and 267](#)).

## D. Protocol

### 1. Phase 1 - Sample Selection

***NOTE: QMs/QIs ARE NOT AVAILABLE FOR SAMPLE SELECTION 10-01-2010 UNTIL FURTHER NOTICE***

~~The Phase 1 sample is pre-selected during Task 1, Offsite Survey Preparation, based on the facility’s QM/QIs of concern. (See [Task 1](#) for further information. Final~~

Phase 1 sample selection occurs after the tour is completed and the facility has provided the completed Roster/Sample Matrix (Form CMS-802, [Exhibit 265](#)), or provided this information in some other format, e.g., computer-generated list. However, do not delay Phase 1 sample

selection if the facility's Roster/Sample Matrix has not arrived. *At the sampling meeting, the team will complete the sample selection for Phase 1 by performing the following tasks:*

*Discuss information from the following sources and select areas of concern to be evaluated during Phase 1 of the survey:*

- *Potential areas of concern identified during Offsite Survey Preparation;*
- *Information from the Entrance Conference such as any rooms with variances; and*
- *Concerns identified during the Initial Tour.*

*Check "Phase 1" on the copy of the Roster/Sample Matrix that will be used to denote the resident sample for Phase 1 of the survey.*

- *Highlight the column for each identified concern for Phase 1.*
- Use Table 1 in this section and the number of the total resident census to determine the sample size for this Phase 1 sample, number of comprehensive and focused reviews, number of closed records, number of resident and family interviews, and the minimum number of residents who have conditions of weight loss, hydration risk and/or pressure sores, i.e., the WHP group. The number in the WHP column represents the minimum total of residents who must be selected for the Phase 1 sample to represent any or all of these conditions. For example, in a facility with 96 residents, out of 12 residents selected for the Phase 1 sample, a minimum of 6 will be those who have any of the conditions mentioned above, ~~if any of these 3 QM/QIs were selected as concerns.~~
- Use the unnumbered blocks to the right of Resident Name to fill in the total number of residents in each sub-sample for the entire survey as listed in Table 1. For example, in a facility with a census of 100, the total number of individual interviews is 5. Enter that number in the small block below that title.
- All residents selected for comprehensive reviews are selected by the team during the Phase 1 sample selection. Residents selected for focused reviews, closed record reviews, and individual and family interviews may be selected during Phase 1 or Phase 2 sample selection.

- *To select the sample:*
  - *Review information about resident characteristics gained on tour and information from the facility's Roster/Sample Matrix;*
  - *Compare the residents selected offsite for possible inclusion in the sample (if any) to the concerns selected for Phase 1 to determine if any are good candidates for the sample – either current residents or closed records; and*
  - *Select residents to be the representatives of the areas of concern and special factors (e.g., new admissions) the team wishes to investigate. (See Special Factors To Consider In Selecting Residents For The Sample (#3 below)). The team does not need to select all special factors in every survey. All residents selected for comprehensive reviews are selected during the Phase 1 sample selection. Residents selected for focused reviews, closed record reviews, individual interviews, and/or family interviews and resident observations may be selected during Phase 1 or Phase 2 sample selection.*
- Each resident the team selects is entered on the worksheet. Note the following about each resident:
  - Resident number and room number;
  - Surveyor assigned to complete the resident review and any quality of life assessment protocols (Resident Interview or Family Interview) that are selected for the resident;
    - Check any columns that pertain to this resident, whether or not they are highlighted as concerns for Phase 1. Each resident will be reviewed for each checked area, not just those that are highlighted; and
    - If there is anything about this resident that the team decides to investigate that is not one of the numbered columns on the worksheet, use a blank column at the far right to write the item that will be assessed and check that column for that resident. For example, if the team wants to assess ventilator use for a particular resident, write “ventilator” in one of the blank columns and make a check mark in that column for that resident.

**NOTE:** ~~For facilities with a population of “short-stay” residents, the team may not have been able to pre-select concerns or potential sampled residents. In that instance, Phase 1 sample selection will occur during this task.~~

- ~~First determine if any pre-selected concerns should be dropped due to the QM/QI data not representing the conditions of current residents. For example, there was a pre-selected QM/QI concern with residents with tube feedings, but the tour has verified there are no~~



~~residents in the facility who are receiving tube feedings. Note new concerns and determine if some pre-selected residents can be evaluated for the new concerns as well as those originally selected.)~~

- ~~• Review the Roster/Sample Matrix provided by the facility and compare it to the findings from the tour to determine if there is a reason to substitute another resident for any of the residents from the Offsite sample. A pre-selected resident who is no longer in the facility can be considered for the closed record review. The team may substitute other residents for those pre-selected, if necessary. They can select either from the QM/QI reports, the tour, or the facility's Roster/Sample Matrix.)~~

~~If any resident is substituted for a pre-selected resident, record a short explanation on the Offsite Roster/Sample Matrix next to that person's name, e.g., "discharged."~~

## 2. Phase 2 Sample Selection

Part way through the survey, after the team has obtained enough information to decide what concerns need further investigation, the team meets to determine the areas of concern, if any, for Phase 2 of the survey and to select the remaining sample. It is not necessary to complete all the reviews of all residents in Phase 1 before this meeting. Determine which Phase 1 concerns are ruled out as these do not need to be carried over into Phase 2 sample selection.

- Select concerns for Phase 2 based on the following:
  - Initial concerns noted during Offsite Survey Preparation or the Initial Tour that have not yet been reviewed;
  - *New concerns discovered through the Phase 1 review that have not been adequately investigated as yet;*
  - Currently un-reviewed concerns that are related to those under investigation, e.g., adding residents who have had falls based on results of the Phase 1 discovery of a problem with use of psychoactive drugs; and
  - Current concerns for which the information gathered is inconclusive.
- Select residents for the Phase 2 sample based on the following:
  - The statute requires selection of a "case mix stratified" sample (but not for each phase of the sample selection, just for the total sample). This stratification is defined by CMS as including residents who are interviewable and non-interviewable, and as including residents who require heavy and light care. It is important that at least one resident in the sample represent each of these categories. The requirements of the sample selection procedures make it necessary for survey teams to select interviewable and non-interviewable

residents in order to complete the Task 5D, Quality of Life Assessment Interviews, so those categories of case-mix stratification will be automatically filled by complying with the sample selection procedures. At the beginning of the Phase 2 sample selection meeting, the team should review the Phase 1 sample to determine if at least one heavy care and one light care resident has been selected to fulfill this portion of the case mix stratification requirement. If not, it is a priority to ensure that if either heavy or light care residents are missing from the Phase 1 sample, that at least one is selected from the missing category in Phase 2.

- Select residents who represent one or more of the areas of concern the team has selected for Phase 2 of the survey.
- If no residents have been selected for the Phase 1 sample for hydration, and if any residents are seen during Phase 1 of the survey who appear to have risk factors for dehydration, e.g., such as residents who are dependent on staff for activities of daily living, are immobile, receive tube feedings, or have dementias in which the resident no longer recognizes thirst, select at least one of these residents at risk and review the care area of dehydration.
- During Phase 2 sample selection, a clean copy of the Sample/Matrix worksheet is used as follows:
  - Check “Phase 2” on the copy of the Roster/Sample Matrix that will be used to denote the resident sample for Phase 2 of the survey;
  - Highlight the column for each identified concern for Phase 2;
  - Each resident the team selects is entered on the worksheet. Note the following about each resident:
    - Resident number and room number;
    - Surveyor assigned to complete the resident review and any quality of life assessment protocols (Resident Interview, or Family Interview) that are selected for the resident;
    - Checkmarks are made only in the highlighted columns and these residents will be reviewed for these concerns, and any other concerns that are discovered during this review;
    - Be sure that residents are selected to complete the required number of resident interviews, family interviews, and closed record reviews.

- If there are no outstanding areas of concern and the team has already selected interviewable, non-interviewable, heavy care and light care residents, then select remaining residents to represent any of the following, in no particular order:
  - An area of concern on the worksheet that has not been highlighted, but which the team has determined should be assessed;
  - Living units that are unrepresented; and
  - Special factors below that have not been reviewed.

**NOTE:** When selecting the sample in a facility in which there are no outstanding areas of concern, each resident will be reviewed for at least one area on the Roster/Sample Matrix that has not yet been reviewed.

### 3. Special Factors to Consider in Sample Selection

Residents must be selected for both the Phase 1 and Phase 2 samples as representatives of concerns to be investigated and to fulfill the case mix stratified sample requirement. If during sample selection, many more residents are identified than can be selected to represent the concerns of interest, consider the factors below in determining which residents to select:

- New admissions, especially if admitted during the previous 14 days. Even though the Resident Assessment Instrument (RAI) is not required to be completed for these residents, the facility must plan care from the first day of each resident's admission;
- Residents most at risk of neglect and abuse, i.e., residents who have dementia; no or infrequent visitors, psychosocial, interactive, and/or behavioral dysfunction; or residents who are bedfast and totally dependent on care;
- Residents in rooms in which variances have been granted for room size or number of beds in room;
- Residents receiving hospice services;
- Residents with end-stage renal disease;
- Residents under the age of 55;
- Residents with mental illness or mental retardation; and
- Residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominant language of the facility.

#### 4. Other Phase 2 Tasks

- If there are any concerns about residents' funds, check that the amount of the surety bond is at least equal to the amount of residents' funds the facility is managing as of the most recent quarter.
- If concerns have been identified in the area of infection control, review policies and procedures including a focus on what preventative infection control practices the facility has in place. For example, does the facility administer the influenza vaccine yearly to its residents, and administer pneumococcal vaccine to new residents as appropriate (does facility evaluate whether new residents have received the pneumococcal vaccine within the last 5 years)?
- Complete Task 5F Quality Assessment Assurance Review.
- If the group interview has not yet occurred, discuss what special concerns to ask of the group.
- If the facility has or has requested a nurse staffing waiver, review the requirements at [42 CFR 483.30](#).
- Review the Resident Census and Condition of Residents (Form CMS-672) that the facility has completed. Note any new areas of concern and determine if there appears to be large discrepancies between what is recorded by the facility and what the team has observed. For example, the team has noted 13 residents with pressure sores and the facility has listed 3. If there are large discrepancies, ask the facility to verify their totals. Answer questions F146 - F148 on the Resident Census.
- If the team has identified quality of care problems during Phase 1 of the survey, use the investigative protocol at Task 5C: Nursing Services, Sufficient Staffing to gather information and (at Task 6) to determine compliance with the following requirement: [42 CFR 483.30\(a\)](#), F353 Nursing services, Sufficient Staff. If problems with staffing have been discovered early in Phase 1, this protocol can begin in Phase 1.

#### 5. Substituting Residents

If the team has found it necessary during the survey to remove a resident from the sample, e.g., a resident refused to complete the interview, replace this resident with another who best fulfills the reasons the first person was selected. For example, the resident who was removed had been selected because he/she was in restraints and had a pressure sore. Attempt to select another resident who meets both of these criteria. In Phase 1, the substituted resident should be selected from the pre-selected list of residents which was determined offsite, if possible, or from other information gained during the survey. Make the substitution as early in the survey as feasible. Note on the Roster/Sample Matrix that the new resident was substituted for resident #\_\_\_, and briefly give the reason the first resident was dropped.

## 6. Supplementary Sample

If sampled residents are found not to provide enough information to make deficiency determinations concerning specific requirements under review, or to determine if there is “substandard quality of care” (see [Task 6](#) for further information), supplement the sample with residents who represent the areas of concern under investigation. Focus review for these residents only on the concern under investigation and any other concerns that are discovered during this review. Add the names of these residents to the Phase 2 Sample Matrix worksheet, checking the relevant categories. Use the Resident Review Worksheet to complete these investigations.

**Table 1 - Survey Procedures for Long Term Care Facilities - Resident Sample Selection**

### Survey Procedures for Long Term Care Facilities Resident Sample Selection

Resident Census	Phase 1/ Phase 2	Compre- hensive Reviews *	Focused Reviews *	Closed Rec. Reviews *	Res./ Family Interviews	W, H, P Group **
1 - 4	All / 0	2	2	0	1/1	All
5 - 10	3 / 2	2	2	1	1 / 1	2
11 - 20	5 / 3	2	5	1	2 / 2	3
21 - 40	6 / 4	2	7	1	3 / 2	3
41 - 44	7 / 4	2	8	1	3 / 2	4
45 - 48	7 / 5	2	9	1	3 / 2	4
49 - 52	8 / 5	3	9	1	4 / 2	4
53 - 56	8 / 6	3	9	2	4 / 2	4
57 - 75	9 / 6	4	9	2	4 / 2	5
76 / 80	10 / 6	4	9	3	4 / 2	5
81 - 85	10 / 7	4	10	3	4 / 2	5
86 - 90	11 / 7	4	11	3	4 / 2	6
91 - 95	11 / 8	4	12	3	4 / 2	6
96 - 100	12 / 8	5	12	3	5 / 2	6
101 - 105	13 / 8	5	13	3	5 / 2	7
106 - 110	13 / 9	5	14	3	5 / 2	7
111 - 115	14 / 9	5	15	3	5 / 2	7
116 - 160	14 / 10	5	16	3	5 / 2	7
161 - 166	15 / 10	5	17	3	5 / 2	8
167 - 173	16 / 10	5	18	3	5 / 2	8
174 - 180	16 / 11	5	19	3	5 / 2	8
181 - 186	17 / 11	5	20	3	5 / 2	9
187 - 193	17 / 12	5	21	3	5 / 2	9
194 - 299	18 / 12	5	22	3	5 / 2	9

Resident Census	Phase 1/ Phase 2	Comprehensive Reviews *	Focused Reviews *	Closed Rec. Reviews *	Res./ Family Interviews	W, H, P Group **
300 - 400	18 / 12	5	22	3	6 / 3	9
401 -	18 / 12	5	22	3	7 / 3	9

\* Comprehensive reviews plus focused reviews plus closed record reviews added together equals the total sample size (Phase 1 plus Phase 2).

\*\* For any survey in which there are identified concerns in the areas of (W) unintended weight loss, (H) hydration, and/or (P) pressure sores, this is the minimum total of residents who must be selected for the Phase 1 sample to represent any or all of these conditions.

## Task 5 - Information Gathering

**(Rev. 22, Issued: 12-15-06, Effective/Implementation: 12-18-06)**

Task 5 provides an organized, systematic, and consistent method of gathering information necessary to make decisions concerning whether the facility has met the requirements reviewed during the Standard Survey.

Task 5 includes the following sub-tasks:

5A General Observations of the Facility: Assessment of the environment of the facility affecting the resident's life, health and safety;

5B Kitchen/Food Service Observations: Assessment of the facility's food storage, preparation and service;

5C Resident Review: An integrated, holistic assessment of the sampled residents which includes the assessment of: drug therapies, the quality of life of the resident as affected by his/her room environment and daily interactions with staff, and assessment of those pertinent care concerns identified for each sampled resident by the survey team. Closed record reviews and dining observations are integrated into the resident review;

5D Quality of Life Assessment: Assessment of residents' quality of life through individual interviews, a group interview, family interviews, and observations of residents who are non-interviewable;

5E Medication Pass and Pharmacy Services: An assessment of the pharmaceutical services provided in the facility, including the provision of the medication pass observation; the application of the medication error detection methodology; the provision of services by a licensed pharmacist; and facility procedures and processes in place regarding the acquiring, receiving, dispensing and administering medications, use of controlled medications, and medication access and storage.

5F Quality Assessment and Assurance Review: An assessment of the facility's Quality Assessment and Assurance program to determine if the facility identifies and addresses specific care and quality issues and implements a program to resolve those issues; and

5G Abuse Prohibition Review: A determination of whether the facility has developed and operationalized policies and procedures designed to protect residents from abuse, neglect, involuntary seclusion, and misappropriation of their property. This includes policies and procedures for hiring practices, training and ongoing supervision for employees and volunteers who provide services, and the reporting and investigation of allegations and occurrences that may indicate abuse.

Use survey worksheets and Guidance to Surveyors, also known as the Interpretive Guidelines, for each of the sub-tasks and requirements reviewed in Task 5. While these sub-tasks are discrete information gathering activities, there are a number of things to take into consideration during Task 5.

#### A. General Procedures

As appropriate, use the interpretations, definitions, probes, and procedures provided in the Guidance to Surveyors to guide the investigation and to help determine whether, based on the investigation and findings, the facility has met the requirements.

Worksheet documentation should be resident-centered, as appropriate. For example, if the lack of a reading light near the resident's bedroom chair is being documented, also note that this resident has said he/she prefers to read in his/her chair, and that the light over the chair is inadequate.

Relate to the requirements and provide clear evidence, as appropriate, of the facility's failure to meet a requirement. As information is collected, keep in mind that the information written on the worksheet will be used by the team to determine if there are any deficiencies, and, if so, the degree of severity and scope. Make documentation specific enough so that these decisions can be made. Include information about how the faulty facility practice affected residents, the number of residents affected, and the number of residents at risk. This documentation will be used both to make deficiency determinations and to categorize deficiencies for severity and scope. The Guidance to Surveyors assists in gathering information in order to determine whether the facility has met the requirements. For example, the facility has care plan objectives which are measurable. If the resident does not meet her/his goals, does the documentation reflect how the lack of implementation of the care plan and/or lack of quarterly assessments prevents the resident from reaching her/his goals?

In conducting the survey, use the worksheets in conjunction with the survey procedures and Guidance to Surveyors. When investigating a concern, note the tag number listed on the worksheet for that requirement and use the Guidance to Surveyors for that tag to direct the investigation.

Devote as much time as possible during the survey to performing observations and conducting formal and informal interviews. Limit record reviews to obtaining specific information, i.e., look at what is needed, not the whole record.

The information gathering tasks are interrelated. Information acquired while doing observations and interviews will direct the record review. Likewise, information obtained while doing the record review may help direct what observations or interviews are needed. Acquire the information that is necessary to make deficiency decisions in [Task 6](#) using the survey worksheets and corresponding Guidance to Surveyors for each of the sub-tasks in Task 5.

Regardless of the task, be alert at all times to the surrounding care environment and activities. For example, while conducting the dining observations of sampled residents and the medication pass observation, observe the environment and residents, e.g., care being given, staff interactions with residents, and infection control practices.

The team should meet on a daily basis to share information, e.g., findings to date, areas of concern, any changes needed in the focus of the survey. These meetings include discussions of concerns observed, possible requirements to which those problems relate, and strategies for gathering additional information to determine whether the facility is meeting the requirements.

Throughout the survey, discuss observations, as appropriate, with team members, facility staff, residents, family members, and the ombudsman. Maintain an open and ongoing dialogue with the facility throughout the survey process. This gives the facility the opportunity to provide additional information in considering any alternative explanations before making deficiency decisions. This, however, does not mean that every negative observation is reported on a daily basis, e.g., at a nightly conference. Moreover, if the negative observation relates to a routine that needs to be monitored over time to determine whether a deficiency exists, wait until a trend has been established before notifying the facility of the problem. If it has been verified through observation and record review that a resident's condition has declined, start the investigation to determine if this decline was avoidable or unavoidable by asking a knowledgeable facility staff member, such as the nurse or other professional staff member charged with responsibility for the resident's care, to provide documentation in the resident's chart that provides the reasons for why they believe this decline occurred. Use this information to guide the investigation, but use professional judgment and team approach to determine if a deficient practice has occurred.

In conducting the tasks of the Standard Survey, situations may be identified to indicate that the facility may not be meeting a requirement not routinely reviewed in the Standard Survey.

Investigate this further. For example, residents at the council meeting say that they have not had a visit from a physician (or extender) for several months. This would lead to an investigation of facility compliance with the requirements for frequency of physician visits.

Verify information and observations in terms of credibility and reliability. If the credibility or reliability of information is doubted, validate that information or gather additional information before using it to make a compliance decision.



## B. Observations

The objectives of the observational portion of information gathering are to gather resident-specific information for the residents included in the sample, and also, to be alert to the provision of care, staff-resident interactions, and quality of life for all residents.

## C. Informal and Formal Interviews

The objectives of interviews are to:

- Collect information;
- Verify and validate information obtained from other survey procedures; and
- Provide the opportunity for all interested parties to provide what they believe is pertinent information.

Interview residents, staff, family, ombudsman, family council representatives, and other appropriate persons. Informal interviews are conducted throughout the duration of the information gathering tasks of the survey. Formal structured interviews are also done as part of the Quality of Life Assessment protocols. Use the information obtained from interviews to assist in deciding what additional observations and record review information is necessary. Avoid asking leading questions, but use the Guidance to Surveyors for specific requirements to focus questions and determine the significance of the answers.

In general, the individual who provides information during an interview will not be identified as providing that information. However, it is possible that their identity may be revealed if a deficiency is cited based in whole or part on their information, and that deficiency citation is appealed.

If residents appear reticent in providing information or express concern about retaliation:

- Verify that residents have information on whom to contact in the event they become the objects of retaliation by the facility; and
- With the resident's permission, notify the ombudsman of the resident's concerns.

## D. Record Review

The objectives of the record review are to:

- Acquire information to direct initial and/or additional observations and interviews;
- Provide a picture of the current status of the resident as assessed by the facility; and

- Evaluate assessments, plans of care, and outcomes of care interventions for residents included in the sample. Record review of RAI information, care planning, implementation of the care plan, and evaluation of care is one facet of the resident review which determines if there has been a decline, improvement, or maintenance in identified focus areas.

**NOTE:** Do not spend excessive time gathering and recording information from the record. Use the record review to obtain information necessary to validate and/or clarify information obtained through observation and interviews. Ask facility staff to assist in finding any information that has not been found or that requires validation.

#### E. Determining Citations of Past Noncompliance at the Time of the Current Survey

During information gathering, findings of past noncompliance may be identified. Before considering a citation of past noncompliance with a specific regulatory tag, surveyors must determine if current compliance with the specific regulatory tag exists. Similar to verifying correction of current noncompliance on a revisit, surveyors should use a variety of methods to determine whether correction of the past noncompliance occurred and continues. This may include, but is not limited to, the following:

- Interviews with facility staff, such as the administrator, nursing staff, social services staff, medical director, quality assessment and assurance committee members, and/or other facility staff, as indicated, to determine what procedures, systems, structures, and processes have been changed.
- Reviewing through observation, interview, and record review, how the facility identified and implemented interventions to address the noncompliance. Examples of interventions may include, but are not limited to:
  - The facility's review, revision, or development of policies and/or procedures to address the areas of concerns;
  - The provision and use of new equipment, as necessary;
  - The provision of staff training required to assure ongoing compliance for the implementation and use of new and/or revised policies, procedures, and/or equipment, especially with new and/or temporary staff;
  - The provision of additional staffing, changes in assignments or deployment of staff, as needed; and
  - The provision of a monitoring mechanism to assure that the changes made are being supervised, evaluated, and reinforced by responsible facility staff.

- Evaluating whether the facility has a functioning quality assessment and assurance committee, whose responsibilities include the identification of quality issues; providing timely response to ascertain the cause; implementing corrective action; implementing monitoring mechanisms in place to assure continued correction and revision of approaches as necessary to eliminate the potential risk of occurrence to other residents and to assure continued compliance.

A citation of past noncompliance must meet all of the criteria described in section H of Task 6 below.

## **Sub-Task 5A - General Observations of the Facility**

**(Rev. 22, Issued: 12-15-06, Effective/Implementation: 12-18-06)**

### A. General Objective

The general objective of this task is to observe physical features in the facility's environment that affect residents' quality of life, health, and safety. Use the General Observations of the Facility worksheet (Form CMS-803, [Exhibit 91](#)) to complete this task.

### B. General Procedures

During the Initial Tour, each surveyor should note and document any concerns in resident rooms and the general environment. Any concerns should be investigated and followed up either through the resident review for sampled residents or during the General Observation task. During the remainder of the survey, one surveyor is assigned to complete the General Observation of the Facility worksheet (Form CMS-803). This surveyor assures that all items on this worksheet are completed. Each surveyor who completes a medication pass observation should review medication storage on the assigned units and provide information regarding that review to the assigned surveyor responsible for the completion of Form CMS-803. All surveyors should share any additional concerns regarding the environment with the surveyor assigned to complete the worksheet. Begin observations as soon as possible after entering the facility, normally after introductions at the entrance conference.

During Task 5A, review the condition of the environment, e.g., cleanliness, sanitation, presence or absence of pests, accident hazards, functioning of equipment, and the proper and safe storage of drugs, biologicals, housekeeping compounds and equipment. (See Form CMS-803 worksheet for specific areas to review.)

### C. Making Observations

The focus in Task 5A is on quality of life and environmental health and safety indicators in areas of the facility that would be visited or used by residents. However, some non-resident areas should also be reviewed due to their potential negative effect on residents, e.g., utility rooms.

Document thoroughly at the time of observations. If additional documentation space is needed, use the Surveyor Notes Worksheet Form CMS-807.

Plan to observe the facility's environment at different times during the survey, e.g., first and second shift, common areas when in use by residents.

Share any concerns with the team coordinator and other team members to determine the possible need to gather additional information.

### **Sub-Task 5B - Kitchen/Food Service Observation**

#### **A. General Objective**

The general objective of the Kitchen/Food Service Observation is to determine if the facility is storing, preparing, distributing, and serving food according to [42 CFR 483.35\(h\)\(2\)](#) to prevent food borne illness.

#### **B. General Procedures**

One surveyor is assigned to conduct the Kitchen/Food service observation.

**NOTE:** The surveyor assigned to complete this task should begin the task with a brief visit to the kitchen as part of the initial tour, in order to observe the sanitation practices and cleanliness of the kitchen. Observe whether potentially hazardous foods have been left on counter tops or steam table and/or being prepared, the manner in which foods are being thawed, the cleanliness, sanitary practices, and appearance of kitchen staff, e.g., appropriate attire, hair restraints.

Use the Kitchen/Food Service Observation worksheet to direct observations of food storage, food preparation, and food service/sanitation. (See Kitchen/Food Service Observation worksheet (Form CMS-804, [Exhibit 92](#)) for specific areas to review).

In addition to completion of the Form CMS-804, also evaluate:

- The availability of food in relation to the number of residents; and
- Whether food being prepared is consistent with the written, planned menu.

**NOTE:** During team meetings, if surveyors, during the Dining Observation portion of the Resident Review, identified any concerns, such as the provision of meals that are not consistent in quality (such as color and texture of vegetables or meats, the preparation and presentation of mechanically altered foods); complaints regarding taste or texture of food and foods with an “off” or bad odor; or residents being at nutritional risk, including high prevalence of residents with unintended weight loss; then the surveyor assigned to Task 5(b) should review the following as appropriate.

Direct observations to the tray line and kitchen to determine:

- If recipes are available and consistent with the menu and followed by employees;
- If appropriate equipment is available and used to prepare and serve foods;
- If the food is being held for more than 30 minutes prior to food service, e.g., in the steam table, oven, refrigerator rather than freezer for frozen foods, etc.; and
- If cooked leftovers used during food preparation were stored and used within the appropriate time frames, and reheated to at least 165 degrees F.

### **Sub-Task 5C - Resident Review**

*(Rev. 42: Issued: 04-24-09; Effective/Implementation Date: 04-24-09)*

#### **A. General Objectives**

The general objectives of the Resident Review are to determine:

- How resident outcomes and the resident's quality of life are related to the provision of care by the facility;
- If the care provided by the facility has enabled residents to reach or maintain their highest practicable physical, mental, and psychosocial well-being;
- If residents are assisted to have the best quality of life that is possible. The review will include aspects of the environment, staff interactions, and provision of services that affect sampled residents in their daily lives;
- If the facility has properly assessed its residents through the completion of the Resident Assessment Instrument (RAI), including accurate coding and transmitting of the Minimum Data Set (MDS) and has properly assessed care needs, conducted proper care planning, implemented the plan and evaluated care provided to the residents; and
- If there are additional areas of concern that need to be investigated in Phase II of the survey.

#### **B. General Procedures**

The team coordinator assigns specific residents in the sample to surveyors.

One surveyor should conduct the entire Resident Review for an assigned resident. If the resident has been chosen for a Quality of Life Assessment protocol ([Task 5D](#)), this same surveyor should also complete that protocol. If a surveyor has not passed the Surveyor Minimum Qualifications Test (SMQT) or if the complexity of a resident's care requires expertise of more than one

discipline, surveyors should work jointly to complete the review. A surveyor must successfully complete the SMQT to survey independently.

To facilitate the Resident Review, ask the charge nurse for schedules of the following, as appropriate:

1. Meals;
2. Medications;
3. Activities;
4. Tube feedings and special treatments;
5. Specialized rehabilitation therapies; and
6. Physician visits or visits of other health professionals such as dentists, podiatrists, or nurse practitioners.

For all sampled residents except closed records, parts A, B, and C (Resident Room Review, Daily Life Review, and Assessment of Drug Therapies) on the Resident Review Worksheet ([Exhibit 93](#)) are completed. The difference between the two reviews is that the focus of the part D Care Review is more extensive for Comprehensive Reviews. Determine, as appropriate, if there has been a decline, maintenance or improvement of the resident in the identified focused care areas and/or Activities of Daily Living (ADL) functioning. If there has been a lack of improvement or a decline, determine if the decline or lack of improvement was avoidable or unavoidable.

### C. Comprehensive Care Review

A Comprehensive Review includes observations, interviews, and a record review. After observing and talking with the resident, the surveyor conducts a comprehensive review, which includes the following:

- ~~*(omit this step – QM/QIs unavailable 10/1/2010 until further notice)*~~ A check of specific items on the MDS for accurate coding of the resident's condition. ~~The specific items to be checked will be based on QM/QIs identified for the resident on the Resident Level Summary. At least 2 of the QM/QIs identified for the resident must be matched against the QM/QI definitions (see [Exhibit 270](#)) and against evidence other than the MDS to verify that the resident's condition is accurately recorded in the MDS. What is being verified is~~
- That the resident's condition was accurately assessed at the time the MDS was completed;
- An overall review of the facility's completion of the RAI process including their:

- o Use of the *Care Area Assessment (CAA) Process*;
- o Evaluation of assessment information not covered by the *CAAs*;
- o Identification of risks and causes of resident conditions;
- o Completion of the *CAA* Summary;
- o Development of a care plan that meets the identified needs of the resident;

*NOTE: For information on the CAAs, see Chapter 4 of the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website*

*([http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage))*

- A review of the implementation of the care plan and resident response;
- A review of the relationship of the resident's drug regimen to the resident's condition (see the description of procedures for completing part C below);
- A thorough review of any of the following conditions that apply to the resident: weight loss, dehydration, pressure sores. This review is completed using the investigative protocols. (*omit this – QM/QIs unavailable 10/1/2010 until further notice* - ~~NOTE: All the residents selected for comprehensive reviews should have one or more of these concerns checked on the QM/QI reports [unless there are no residents with these concerns in the facility];~~ and
- An evaluation of the resident's dining experience (see Dining Observation Protocol below).

#### D. Focused Care Review Phase 1

This focused review includes observations, interviews, and a record review. This review focuses on care areas that were checked for the resident on the Resident Level Summary and any additional care items checked by the team as pertinent to the resident, e.g., all areas that are checked on the Roster/Sample Matrix by the team for the resident are reviewed, whether or not they have been highlighted as concerns for the survey. The dining observation is done for a resident if the resident has any checkmarks related to dining or the investigating team member has any concerns about the resident related to dining, e.g., such as weight loss.

The Phase 1 focused care review includes all care areas the team has checked for the resident: a review of the MDS, the facility's use of the *CAA process*, care planning, implementation of the care plan, and the resident's response to the care provided.

#### E. Focused Care Review Phase 2

This focused review includes observations, interviews and a record review, which concentrates only on those areas of concern for which the team requires additional information. For example, if the team needs additional information concerning facility compliance with the requirements for tube feeding, review only those RAI areas related to tube feeding; make observations of nutritional status, complications, and techniques of tube feeding, and interview residents, family and staff concerning related areas.

#### F. Closed Record Review

This includes a record review of the resident's care issues, *including* transfer and discharge requirements *as applicable*. ~~It may be possible to select some or all of the closed records from the preselected list of residents for the Phase 1 sample, if any of these preselected residents were noted onsite to be discharged or deceased.~~

Assess quality of care and quality of life requirements that relate to the identified care areas for the sampled resident. While assessing these, note and investigate concerns with any other requirements.

#### G. Conducting the Resident Review

The Resident Review consists of 4 main sections: Resident Room Review, Daily Life Review, Assessment of Drug Therapies, and Care Review. See Resident Review Worksheet and instructions (Form CMS-805, [Exhibit 93](#)) for specific areas to review.

1. Section A - The Resident Room Review assesses aspects of accommodation of needs, environmental quality, and quality of life in the resident's room. Through observations and interviews, evaluate how the resident's environment affects his/her quality of life.
2. Section B - The Daily Life Review is a review of the resident's daily quality of life, especially in the areas of staff responsiveness to resident grooming and other needs, staff interactions, choices, and activities. Through ongoing observations and interviews, evaluate the resident's daily life routines and interactions with staff.
3. Section C - The Assessment of Drug Therapies is a review of the medications the resident is receiving to evaluate whether the effectiveness of the therapeutic regimen, including all drugs that may play a significant role in the resident's everyday life, is being monitored and assessed. Record the information on the Resident Review Worksheet, Form CMS-805. Review and record, as pertinent, all non-prescription and prescription medications taken by the resident during the past 7 days. In addition follow the guidance in Appendix PP, Tag F329 for the determination of unnecessary medications.
4. Section D -- The care review is an assessment of those quality of care areas (see [42 CFR 483.25](#)) that are pertinent to the sampled resident. The survey team, through use of the Roster/Sample Matrix, determines what care areas will be reviewed for each sampled resident. Additional areas for evaluation may be identified during the review.



There are a designated number of comprehensive, focused and closed record care reviews completed, depending on the size of the sample.

H. Care Observations and Interviews -- Make resident observations and conduct interviews, which include those factors or care areas as determined by the Roster/Sample Matrix. For example, if the resident was chosen because he/she is receiving tube feedings, observe the care and the outcomes of the interventions, facility monitoring and assessment, and nutritional needs/adequacy related to tube feeding.

Complete the following tasks:

- Observe the resident and caregivers during care and treatments, at meals, and various times of the day, including early morning and evening, over the entire survey period. Observe residents in both informal and structured settings, e.g., receiving specialized rehabilitation services, participating in formal and informal activities. Also, observe staff-resident interactions;
- Gather resident-specific information, including information on the resident's functional ability, potential for increasing ability, and any complications concerning special care needs;
- Evaluate implementation of the care plan. Determine if the care plan is consistently implemented by all personnel at all times of the day, and if the care plan is working for the resident. If the care plan is not working, look for evidence that the facility has identified this and acted on it even if the care plan has not formally been revised;
- Determine if there is a significant difference between the facility's assessment of the resident and observations; and
- Evaluate the adequacy of care provided to the resident using the Guidance to Surveyors.

Do not continue to follow residents once enough information has been accrued to determine whether the resident has received care in accordance with the regulatory requirements.

If there are indicators to suggest the presence of a quality of care problem that is not readily observable, e.g., a leg ulcer covered with a dressing, or a sacral pressure sore, ask facility staff to assist in making observations by removing, for example, a dressing or bedclothes.

Resident care observations should be made by those persons who have the clinical knowledge and skills to evaluate compliance.

When observing residents, respect their right to privacy, including the privacy of their bodies. If the resident's genital or rectal area or female breast area must be observed in order to document and confirm suspicions of a care problem, a member of the nursing staff must be present at this observation, and the resident must give clear consent.

If the resident is unable to give consent, e.g., is unresponsive, incompetent, and a legal surrogate (family member who can act on the resident's behalf or legal representative as provided by State law) is present, ask this individual to give consent.

An observation of a resident's rectal or genital area (and for females, the breast area) may be made without a resident's or legal surrogate's consent, under the following conditions:

1. It is determined that there is a strong possibility that the resident is receiving less than adequate care, which can only be confirmed by direct observation;
2. The resident is unable to give clear consent; and
3. A legal surrogate is not present in the facility.

Only a surveyor who is a licensed nurse, a physician's assistant or a physician may make an observation of a resident's genitals, rectal area, or, for females, the breast area.

## I. Record Review

Conduct a record review to provide a picture of the current status of the resident as assessed by the facility; information on changes in the resident's status over the last 12 months for those areas identified for review; and information on planned care, resident goals, and expected outcomes.

Use the record review to help determine whether the assessments accurately reflect the resident's status and are internally consistent. An example of inconsistency may be that the facility assessed the resident's ADLs as being independently performed yet had indicated that the resident requires task segmentation for performing ADLs.

For sampled residents selected for either a comprehensive or a focused review, conduct a review of the RAI information including:

- To assist in assessing the quality of life of the resident, *review the appropriate sections of the MDS for background information including customary routines and demographic information to provide an understanding of the resident prior to admission. For the location of the specific sections of the MDS 3.0, see Chapter 3 of the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website ([http://www.cms.gov/NursingHomeQualityInits/45\\_NHOIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHOIMDS30TrainingMaterials.asp#TopOfPage)).*
- The latest MDS to determine which *CAAs* were triggered. For a sampled resident receiving a comprehensive review, note all triggered areas. Also, review the facility's assessment of the resident's level of functioning and note particularly drug therapy and cognitive, behavior, and ADL function. For a resident receiving a focused review in Phase I

of the survey, review both the areas of concern specific to the resident and the other care areas that have been identified with the Roster/Sample Matrix. For Phase 2 residents, review only those areas that have been identified by the team as areas of concern.

If the RAI is less than 9 months old, review and compare with the previous RAI and the most recent quarterly review. If the RAI is 9 months or older, compare the current RAI with the most recent quarterly review. Review the following:

- The *CAA* summary sheet to see where the assessment documentation is located for any *CAA* triggered;
- The information summarizing the assessments (*CAAs*) and decision to proceed or not to proceed to care planning. Determine if the assessments indicate that the facility used the *CAA process* and considered the nature of the problem, the causal and risk factors, the need for referrals, complications, and decisions for care planning. If this is a reassessment, review whether the facility determined if the care plan required revision or was effective in moving the resident toward his/her goals;
- The care plan to identify whether the facility used the RAI to make sound care planning decisions. Determine whether the facility identified resident strengths, needs, and problems which needed to be addressed to assist the resident to maintain or improve his/her current functional status. Determine whether the facility identified resident-centered, measurable goals and specific interventions to achieve those goals. With observations, interviews, and record review, determine if the facility implemented the interventions defined; and
- Determine whether the facility documentation and resident status as observed indicate the decision to proceed or not to proceed to care planning was appropriate. This information will assist in determining whether a resident's decline or failure to improve was avoidable or unavoidable.
- It is not necessary to review the entire resident record. Review only those sections that are necessary to verify and clarify the information necessary to make compliance decisions. These sections may include, for example, laboratory reports, progress notes, and drug regimen review reports.
- In any care area in which it is determined that there has been a lack of improvement, a decline, or failure to reach highest practicable well being, assess if the change for the resident was avoidable or unavoidable. Note both the faulty facility practice and its effect on resident(s). Determine if a reassessment based on significant change should have been conducted, and if the absence of reassessment contributed to the resident's decline or lack of improvement.
- Verify that the information needed has been obtained to determine if the facility fulfilled its obligation to provide care that allowed the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

**NOTE:** When conducting either a focused or comprehensive review, if there are areas of concern which fall outside the care areas identified, investigate these, as necessary.

The following are special investigative protocols which should be used in Task 5C to gather information and in Task 6, to determine facility compliance in the care areas of pressure sore/ulcer(s), hydration, unintended weight loss, sufficient nursing staffing, and dining and food services.

**NOTE:** “Although the RAI assessments [discussed in the following investigative protocols] must occur at specific times, by Federal regulation, a facility’s obligation to meet each resident’s needs through ongoing assessment is not neatly confined to these mandated time frames. Likewise, completion of the RAI in the prescribed time frame does not necessarily fulfill a facility’s obligation to perform a comprehensive assessment. Facility’s are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI.” (“CMS Long-Term Care Facility Resident Assessment Instrument User’s Manual,” Version 3.0.)

## Investigative Protocol

### Hydration

#### Objectives:

- To determine if the facility identified risk factors which lead to dehydration and developed an appropriate preventative care plan; and
- To determine if the facility provided the resident with sufficient fluid intake to maintain proper hydration and health.

#### Task 5C: Use:

Use this protocol for the following situations:

- A sampled resident *who has been identified with concerns related to* ~~flagged for the sentinel event of~~ dehydration (QM/QI 7.3);
- A sampled resident who has *been identified with concerns related to* one or more of the following QM/QI conditions:
  - ~~5.4— Prevalence of~~ *F*ecal impaction;
  - ~~6.1—~~ Residents with a urinary tract infection;
  - ~~7.1—~~ Residents who lose too much weight;

- o ~~7.2— Prevalence of~~ *Residents receiving a* tube feeding;
  - o ~~9.1—~~ Residents whose need for help with daily activities has increased; and
  - o *Residents who are at risk for, or have, a* ~~Any of the three~~ pressure ulcer QM/QIs: ~~12.1, 12.2, or 13.3.~~
- A sampled resident who was discovered to have any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious processes, dependence on staff for the provision of fluid intake, use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphagia, a history of refusing fluids, limited fluid intake or lacking the sensation of thirst.

Procedures:

- Observations/interviews conducted as part of this procedure should be recorded on the Forms CMS-805 and/or the Form CMS-807.
- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and whether there were abnormal laboratory test values which may be an indicator of dehydration.

**NOTE:** A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires. If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?
- Observe the care delivery to determine if the interventions identified in the care plan have been implemented as described.
  - o What is the resident's response to the interventions? Does staff provide the necessary fluids as described in the plan? Do the fluids provided contribute to dehydration, e.g., caffeinated beverages, alcohol? Was the correct type of fluid provided with a resident with dysphagia?
  - o Is the resident able to reach, pour and drink fluids without assistance and is the resident consuming sufficient fluids? If not, are staff providing the fluids according to the care plan?

- o Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?
  - o If the resident refuses water, are alternative fluids offered that are tolerable to the resident?
  - o Are the resident's beverage preferences identified and honored at meals?
  - o Does staff encourage the resident to drink? Are they aware of the resident's fluid needs? Are staff providing fluids during and between meals?
  - o Determine how the facility monitors to assure that the resident maintains fluid parameters as planned. If the facility is monitoring the intake and output of the resident, review the record to determine if the fluid goals or calculated fluid needs were met consistently.
- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident, should know of, or be able to provide information about the causes of a resident's condition or problem.

**NOTE:** If a resident is at an end of life stage and has an advance directive, according to State law, (or a decision has been made by the resident's surrogate or representative, in accordance with State law) or the resident has reached an end of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute noncompliance with the requirement for hydration. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with [42 CFR 483.25](#), F309, Quality of Care.

- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

#### **Task 6: Determination of Compliance:**

- Compliance with [42 CFR 483.25\(j\)](#), F327, Hydration:
  - o For this resident, the facility is compliant with this requirement to maintain proper hydration if they properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, cite at F327.

- Compliance with [42 CFR 483.20\(b\)\(1\) & \(2\)](#), F272, Comprehensive Assessments:
  - For this resident in the area of hydration, the facility is compliant with this requirement if they assessed factors that put the resident at risk for dehydration, whether chronic or acute. If not, cite at F272.
  
- Compliance with [42 CFR 483.20\(k\)\(1\)](#), F279, Comprehensive Care Plans:
  - For this resident in the area of hydration, the facility is compliant with this requirement if they developed a care plan that includes measurable objectives and timetables to meet the resident's needs as identified in the resident's assessment. If not, cite at F279.
  
- Compliance with [42 CFR 483.20\(k\)\(3\)\(ii\)](#), F 282, Provision of care in accordance with the care plan:
  - For this resident in the area of hydration, the facility is compliant with this requirement if qualified persons implemented the resident's care plan. If not, cite at F282.

## **Slide 1**

**Title:** CMS SOM - Appendix P

Revised Tasks 1-5

Traditional Survey Process

Effective 10-1-2010

### **Instructor Notes:**

N/A

## **Slide 2**

**Title:** Text Changes to Appendix P

- These training materials will highlight only the temporary changes.
- Strikethrough in Appendix P is used to denote those items that are no longer applicable related to MDS 2.0
- Red font and italics used to denote new temporary processes or steps
- Temporary changes occur in Task 1 through Task 5

### **Instructor Notes:**

On October 1, 2010, implementation for the MDS 3.0 will begin in nursing homes.

The traditional survey requires the offsite selection of the survey sample based upon the QM/QI reports. Beginning on October 1, these reports will not be produced until the MDS 3.0 data base has enough information and quarters in place to provide the reports.

As a result, CMS is providing a temporary revision for the traditional survey process in Appendix P in Tasks 1-5. This revision will remain in effect until the QM/QI reports are developed based upon the MDS 3.0 data that has been transmitted from nursing homes.

As the changes to the survey process in Appendix P are temporary, CMS will provide the notification of the changes via a Survey and Certification Memo.



As you review the changes to the Appendix P, you will note that there is strikethrough in Tasks 1-5 in areas that were applicable for MDS 2.0. The temporary revisions are identified with red font and italics.

The purpose of these training materials is to bring to your attention only those areas in Appendix P in which revisions to the sample selection or areas that were applicable to MDS 2.0 have been identified.

### **Slide 3**

**Title:** Changes to Traditional Survey

- Implementation of MDS 3.0 scheduled for October 1, 2010. This will temporarily result in:
  - Inability to run Quality Measure-Quality Indicator (QM/QI) reports
  - Inability to select offsite sample based on MDS data
- Identification of residents and/or concerns during onsite tour

### **Instructor Notes:**

As previously mentioned, we will no longer have the ability to run the QM/QI reports. Due to completion and submission requirements, you may see that some facilities may still be submitting completed MDS 2.0 reports past October 1<sup>st</sup>. However, for any resident admitted on and after October 1, 2010, or who has an assessment scheduled on or after October 1, the MDS 3.0 must be conducted and transmitted according to the regulations.

### **Slide 4**

**Title:** Transition to MDS 3.0

- Implementation – October 1, 2010
- Assessment timing based upon:
  - Type of assessment;
  - Last assessment completion; and
  - Assessment Reference Dates (ARD):

- MDS 2.0 or MDS 3.0
- Comprehensive or Non-comprehensive
- Assessment Transmission – Within 14 days of completion to the CMS system

**Instructor Notes:**

The MDS, Version 3.0, will be implemented October 1, 2010 across the nation. What this means is that facilities must complete MDS 3.0 assessments on residents for any assessment scheduled with an Assessment Reference Date (ARD) of October 1, or later. If the ARD is on or before September 30, then an MDS 2.0 assessment must be completed. CMS promulgated new rules for the implementation of MDS 3.0. We will be covering these regulatory changes later in the training.

I would like to describe some of the changes in relation to the timing and scheduling of the assessments. Let's start with the timing changes. As you know, the timing of assessment scheduling for the MDS 2.0 is based on completion dates that the RN certifies that the assessment was completed. These dates are located at Vb2 for the comprehensive assessments and at R2b for the quarterly assessments.

Now, let me describe the timing changes for the MDS 3.0. The regulation at 483.20(b)(2)(iii) located at F275, requires that a comprehensive assessment must be conducted at least every 12 months. This is unchanged. What has changed is that the timing of assessment scheduling for the MDS 3.0 is based upon Assessment Reference Dates, called ARDs. The ARD is the end of the observation or look back period of the assessment. For transition purposes, if the most recent prior comprehensive assessment is a MDS 2.0, then the ARD of the next annual comprehensive assessment, using the MDS 3.0, must be within 366 days of the date located on the MDS 2.0 at Vb2.

Now for the quarterly assessments, 483.20(c) F276, requires the quarterly assessment to be conducted at least every 3 months. This is unchanged. What has changed is that for transition purposes, if the most recent annual or quarterly assessment is a MDS 2.0, then the ARD of the next quarterly assessment, using the MDS 3.0, must be within 92 days of the date located on the MDS 2.0 at R2b.

Now, let's talk about the changes for the transmission of the MDS 3.0. The current regulation at 483.20(f)(3) F287, requires the transmission of the MDS data to the State for all assessments conducted within the previous month. This regulation language has been changed to reflect the requirement for transmission of the MDS data within 14 days, rather than 30 days, after completion to the CMS system, rather than to the State Agency. This will go into effect October 1, 2010.

## **Slide 5**

### **Title:** Task 1 – Offsite Survey Preparation

A resident may be selected based on offsite information such as:

- Results of Complaint investigations
- Statement of Deficiencies -CMS-2567
- CASPAR Reports 3 and 4
- Information on Waivers/Variances
- Information from the State Ombudsman Office
- Preadmission Screening and Resident Review Reports (PASRR) or

Other Pertinent Information

### **Instructor Notes:**

Now that you have background information on the MDS 3.0 implementation, let's talk about how it will affect the traditional survey process.

For those surveyors who surveyed prior to 1998, this change will seem familiar as it will echo the 1995 non-QM/QI based survey process.

The team coordinator will review offsite information as listed on the slide and present the information to the team. After reviewing the offsite information sources, the team may choose to add a resident identified from these sources for the onsite sample selection. For example, this could include a resident identified for follow up for a complaint or from concerns identified from the State Ombudsman. This is not a change from the current traditional process.

The major change for the offsite sample selection is that there are no QM/QI reports to run and an offsite sample selection for the Phase 1 sample cannot occur.

## **Slide 6**

### **Title:** Task 1 – Offsite Preparation

Team Coordinator will provide:

- Information from offsite sources and will record concerns, if any, on a Roster/Sample Matrix (CMS 802)

- Blank copies of the Roster/Sample Matrix (CMS 802) for surveyors to use during the initial tour to record any concerns and to identify potential residents

**Instructor Notes:**

The team coordinator will pull a blank Roster/Sample Matrix (CMS 802) and label this as offsite sample selection. The coordinator will highlight any columns of potential concerns and will enter the names of any potential residents identified from the sources that we previously described.

The team coordinator will meet with the team at a brief meeting prior to entering the facility and provide them with any identified offsite areas of concern and the names of potential residents for the phase 1 sample.

The team coordinator will provide blank copies of the Roster Sample Matrix (CMS 802) for the surveyors to use during the initial tour.

**Slide 7**

**Title:** Roster/Sample Matrix (CMS 802)

- Revisions to 802 form
  - Falls/Fractures is now a separate field from Abrasions/Bruises
  - Behavioral Symptoms is now a separate field from Depression
  - Resident Characteristics renumbered

**Instructor Notes:**

So let's talk about what happens to the Roster/Sample Matrix, CMS 802, as a result of implementation of the MDS 3.0.

For this training, we provided you with a draft copy of the CMS 802, the 802P, the provider instructions and the 802S which are the surveyor instructions. Note that these documents are being revised by our graphics department and will be released as an advanced copy attached to an S&C Memo in the next month.

We have already mentioned that the QM/QIs, and QM/QI reports will be unavailable beginning 10/1/2010. The current 802S contains references to specific MDS 2.0 coding. Because of the changes on the MDS 3.0, we made revisions to the 802 form itself, as well as to the 802P - provider instructions and the 802S - surveyor instructions, to accommodate the changes.

Please pull out the 802 form and I will point out the areas with revisions. First, due to the changes in the MDS 3.0 coding, the resident characteristic field titled

Falls/Fractures/Abrasions/Bruises has been separated into 2 fields, one titled Falls/Fractures and the other titled Abrasions/Bruises.

The second change is located at the resident characteristic field titled “Behavioral Symptoms/Depression”. This field has been separated into 2 fields, one titled “Behavioral Symptoms” and the other titled “Depression”.

These changes have resulted in the renumbering of the resident characteristic fields on the form itself.

When the QM/QIs and the QM/QI reports are available again, this form may be revised to accommodate future changes.

### **Slide 8**

**Title:** Roster/Sample Matrix (CMS 802P) Provider Instructions

- Revisions to 802P (provider instructions)
  - MDS 3.0 coding or manual coding instructions
  - Resident Characteristic fields renumbered

### **Instructor Notes:**

Now, let’s talk about the changes to the Roster/Sample Matrix for the provider instructions, CMS 802P.

As you can see, these changes are reflected on the form in red italicized font.

As a result of the changes to the MDS 3.0 instrument, as well as the renumbering of the resident characteristic fields on the 802 itself, we have revised the provider instructions for completing the 802 form.

These revisions include the renumbering of the resident characteristic fields accordingly, as well as changes to MDS item & coding references.

It is important to note that some providers have previously automated the 802, and all of the fields were filled in based on the MDS 2.0 instrument. However, some fields are not reflected in the MDS 3.0, such as the section on “Fecal Impaction” and the form now contains instructions for the provider to code the information manually. Facilities must complete the 802 with the information they have in their clinical records, regardless of the availability of MDS information.

### **Slide 9**

**Title:** Roster/Sample Matrix (CMS 802S) Surveyor Instructions

- Revisions to 802S (surveyor instructions)
  - References to QM/QIs removed
  - Resident Characteristic fields renumbered

**Instructor Notes:**

Ok, let's move on to the changes to the Roster/Sample Matrix for the surveyor instructions, CMS 802S. As you can see, these changes are also reflected on the form in red italicized font.

As a result of the changes to the MDS 3.0 instrument and the unavailability of the QM/QI reports, as well as the renumbering of the resident characteristic fields on the 802 itself, we have revised the surveyor instructions. These revisions include the renumbering of the resident characteristic fields as well as removing any references to the QM/QIs.

As soon as the QM/QIs and the QM/QI reports are available for use, these instructions will be revised accordingly.

**Slide 10**

**Title:** Resident Census & Conditions of Residents (CMS 672)

- Revisions to 672 form
  - None
- Revisions to 672 instructions
  - MDS 3.0 coding replaces MDS 2.0 coding references
  - Manual coding instructions for some fields
- The use of the form has NOT changed

**Instructor Notes:**

The team coordinator may need to explain to the administrator, how the CMS 672 form, the Resident Census & Conditions of Residents, has changed. So let's talk about what happens to the CMS 672 form as a result of implementation of the MDS 3.0.

For this training, we provided you with a draft copy of the Resident Census and Condition of Residents, the CMS 672 and the instructions for its completion. Note that these documents are being revised by our graphics department and will be released as an advanced copy attached to an S&C Memo in the next month. As you can see, these changes are reflected on the form in red italicized font.

The revisions include the removal of all items reflected on the MDS 2.0 and now only address those items found on the MDS 3.0.

It is important to note that some providers have previously automated the 672 and all of the fields were filled in based on the MDS 2.0 instrument. However, some fields are not reflected in the MDS 3.0, such as the item on “Bedfast Residents”. At that section, the form now contains instructions for the provider to code the information manually. Facilities must complete the 672 with the information they have in their clinical records, regardless of the availability of MDS information.

We do not expect that these instructions will need to be revised when the QM/QI reports become available again.

It is worth noting that how this form is used NOT changed.

### **Slide 11**

#### **Title: Task 2 – ENTRANCE CONFERENCE ONSITE PREPARATORY ACTIVITIES**

- QM/QI reports are not provided
- Provide knowledgeable staff to accompany the surveyors during the tour
- Request the completion of the Roster/Sample Matrix by the end of the tour.
  - Include each resident (including residents on bed-hold)
  - Check off each area of concern for that particular resident.

#### **Instructor Notes:**

Upon entrance the team coordinator will announce the survey and introduce the team. The team will leave the room and immediately begin the initial tour. The team coordinator will need to explain that the offsite QM/QI reports will not be run until further notice, and that there is no offsite sample selection generated from the MDS data. The team coordinator will explain the process for the initial tour and that the surveyors will be identifying potential residents and areas of concern during the tour.

The coordinator will also request that the administrator provide knowledgeable staff to accompany the surveyors as they conduct the initial tour. The surveyors will be interviewing residents, families and staff members during the tour in order to identify concerns and residents for the sample selection. It is important that the staff persons accompanying the surveyors are knowledgeable about the resident’s clinical condition and familiar with the resident in order to be able to answer the surveyors questions.

The surveyors will each use a Roster/Sample Matrix during the tour, recording the resident's name, location and identifying those areas that are applicable to the individual resident, and add other concerns, if any to the Roster/Sample Matrix. For example, if a resident was observed to have an indwelling urinary catheter, this would be checked on the form. In addition, if during interviews with staff it was noted that the resident had a urinary tract infection, this would also be checked on the matrix. Any area that is on the matrix that applies to each particular resident will be checked and recorded by the surveyor. If there is a concern that is not on the Roster/Sample Matrix, the surveyor will record this on the document.

### **Slide 12**

**Title:** Task 3 - Initial Tour

- Provide an initial review of the facility, residents, and staff
- Obtain an initial evaluation of the environment of the facility, including the facility kitchen
- Confirm or invalidate the pre-survey information about potential areas of concern, if any, and add concerns discovered onsite
- Identify potential residents and areas of concern to be investigated (Roster/Sample Matrix, CMS 802)

### **Instructor Notes:**

Remember to refer to the Appendix P guidance for observations of residents during the tour noting issues or concerns related to quality of life, such as grooming and dress, activities, emotional and behavioral conduct of the residents and interactions with staff, care issues, such as skin tears, skin conditions, contractures, restraints, isolation and infection control practices, presence of ventilators, oxygen or IV therapy, cleanliness and maintenance of a homelike and clean environment.

### **Slide 13**

**Title:** Task 3 - Initial Tour

- Attempt to meet as many residents as possible

in order to identify residents for the sample using pre-survey information, if any, and observation. It is not necessary to meet 100% of the residents



- Identify interviewable residents to participate in Quality

of Life (QOL)Assessment Resident Interview or Group

Interview

**Instructor Notes:**

The phase 1 sample selection is based upon off-site information, if any, and the results of the initial tour. It is important for the surveyors to attempt to meet as many of the residents as possible although it may not be possible to meet all the residents due to scheduling of appointments or activities. In addition, during the tour, the surveyors will observe whether any potential resident selected based upon offsite information is still in the facility.

When identifying interviewable residents, it is important to remember that the team should not rely solely on facility staff interviews concerning which residents are interviewable. The survey team should determine the residents who are able to participate in a QOL Assessment interview.

The requirements for observing and documenting concerns for the General Observations of the Facility and the Kitchen/Food Service observations have not changed.

**Slide 14**

**Title:** Task 4 – Sample Selection

Statutorily required sample - case-mix stratified to capture:

- Both interviewable and non-interviewable residents
- Residents from both heavy and light care categories,

Includes various stages of impairment of physical functioning/dependency, and cognitive functioning.

**Instructor Notes:**

The team must select a case mix stratified sample. This is why it is important for the team, during the tour, to identify not only interviewable and non-interviewable residents but residents that require heavy and/or light care on the Roster/Sample matrix.

**Slide 15**

**Title:** Task 4 - Sample Selection

**Sample based on:**

- Variation in case-mix,
- Concerns that the team has selected to investigate, and
- Special factors
- **Sampling in two phases:**
  - Phase 1 - after the tour, approximately 60% of the sampled residents are chosen,
  - Phase 2 - Part way through the survey, the remaining 40% chosen
- **In Phase 1** - selected number of residents receive comprehensive reviews. Remaining residents in both phases receive either focused or closed record reviews.

**Instructor Notes:**

The team coordinator should use Table 1 in Appendix P titled “Survey Procedures For Long Term Care Facilities – Resident Sample Selection” for determining the sample sizes. The use of this table has not changed. The table provides, based upon the resident census, the number of Phase 1 and 2 samples, the number of comprehensive reviews, focused reviews, closed record and resident/family interviews. In addition the weight loss, hydration and pressure ulcer group also applies to this sampling process. We will describe how the WHP sample is selected later in this training.

**Slide 16**

**Title:** Task 4 - Sample Selection

**Phase 1 - Sample Selection**

- Check “Phase 1” on a copy of the Roster/Sample Matrix
- Highlight the column for each identified concern

**Residents/Areas of Concern:**

- Potential residents/concerns identified during Offsite Survey Preparation;
- Information from the Entrance Conference such as any rooms with variances; and
- Residents/concerns identified during the Initial Tour.

**Instructor Notes:**

The team coordinator will obtain a blank Roster/Sample Matrix, label it as Phase 1 and convene a team meeting. The coordinator should obtain the facility’s completed Roster/Sample Matrix

for this meeting, but should not delay the meeting if the facility has not completed the form. The team can review the facility's form at a later time if not available in time for the team meeting.

The surveyors will review their recommended residents and potential concerns with the team. The team will determine the areas of concerns based on consensus and the team coordinator will highlight those areas on the Roster/Sample matrix. The surveyors should review their resident list and make recommendations for those residents that have highlighted concerns. They should attempt to select a resident that has multiple areas of concern identified for the comprehensive resident review. However, this does not preclude a resident from being selected with few areas of concerns as the case mix must contain at least 1 resident in the light care category.

In addition, the team coordinator should identify any offsite concerns or residents for possible inclusion in the sample. If a potential resident selected offsite is no longer in the facility, they may be considered for a closed record review of care needs.

Remember, that the selection of the resident sample and concerns is a team decision.

### **Slide 17**

**Title:** Task 4 - WHP Sample Selection

For the weight loss, hydration risk and/or pressure ulcers

(WHP) sample, use Table 1 and the total resident census in

order to:

- Determine the minimum number of residents required for the WHP sample.
- The number in the WHP column represents the minimum total of residents who must be selected for the Phase 1 sample to represent any or all of these conditions.
- These residents will be may be identified through offsite information (i.e. – complaints) or during the initial tour.

### **Instructor Notes:**

During the tour, the surveyors should identify, through their observations and interviews the presence of a resident who potentially has had a weight loss, dehydration issues and/or has pressure ulcers.

This does not mean that the surveyors should conduct an observation of skin condition, but should interview the resident, their families or responsible party if present, or staff regarding the presence of a potential ulcer.

## **Slide 18**

### **Title:** Task 4 - Sample Selection

Sample selection:

- Review information about resident characteristics gained on tour and information from the facility's Roster/Sample Matrix;
- Compare the residents selected offsite, if any, to the concerns selected for Phase 1 to determine if any are good candidates for the sample – either current residents or closed records;
- Select residents to be the representatives of the areas of concern and special factors (e.g., new admissions)
- The team does not need to select all special factors.

### **Instructor Notes:**

These sample selection rules have not changed from the traditional process.

Although the team is not required to select a resident representing each of the special factors, we would encourage the team to select a resident, if any, who:

- Is receiving ESRD services;
- Is receiving services from a certified hospice; or
- Is on a ventilator.

The intent is to assure that the needs of the resident requiring these services are being met and that there is coordination of care provided if an arrangement with an outside provider is being used. See the guidance in Appendix PP, 483.25, F309 – Quality of Care, Guidance to Surveyors, for more information on surveying for services provided under arrangement.

## **Slide 19**

### **Title:** Task 4 - Sample Selection

- All residents selected for comprehensive reviews are selected during the Phase 1 sample selection.
- Residents selected for focused reviews, closed record reviews, individual interviews, and/or family interviews and resident observations may be selected during Phase 1 or Phase 2 sample selection.

**Instructor Notes:**

Again, the sample selection guidance has not changed for the types of reviews required to be conducted.

**Slide 20****Title:** Task 4 - Sample Selection

Select concerns for Phase 2 based on the following:

- Initial concerns noted during Offsite Survey Preparation or the Initial Tour that have not yet been reviewed;
- New concerns discovered through the Phase 1 review that have not been adequately investigated as yet;
- Currently un-reviewed concerns that are related to those under investigation, e.g., adding residents who have had falls based on results of the Phase 1 discovery of a problem with use of psychoactive drugs; and
- Current concerns for which the information gathered is inconclusive.

**Instructor Notes:**

The timing of the team meeting and criteria for the selection of the phase 2 sample remains unchanged.

**Slide 21****Title:** Task 5 - Information Gathering

Comprehensive Care Review –

- Removal of Resident Assessment Protocols
- Use of the Care Area Assessment (CAA) Process:
  - Identification of potential resident conditions/issues;
  - Identification of risks and causes of resident conditions;

**Instructor Notes:**

You will notice that the guidance in Appendix P of the SOM, was changed to remove Resident Assessment Protocols (RAPs). We have replaced that terminology with the Care Area

Assessments, or CAAs. We will be making these changes to the Guidance to Surveyors in Appendix PP at 483.20 which will be effective October 1, 2010.

So what are CAAs? The CAAs, just like the RAPs, reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. The CAAs remain a mechanism, as were the RAPs, for the identification of risks & causes of potential resident conditions/issues, and therefore remain as a 'bridge' to the development of a care plan that meets the identified needs of the resident.

There were 18 RAPS associated with the MDS 2.0. These remain intact as CAAs, and CMS added 2 CAAs, one for the assessment of pain and one for the return to community referral.

You should note that the use of the CAAs are only required to be used for completion of a comprehensive MDS assessment. Each triggered item **must** be assessed further through the use of the CAA process to facilitate care plan decision making, but it **may or may not** represent a condition that should or will be addressed in the care plan.

## **Slide 22**

**Title:** Task 5 - Information Gathering

- Use of the Care Area Assessment (CAA) Process:
  - Completion of the CAA Summary;
  - Development of a care plan that meets the identified needs of the resident.
- For information on the CAAs, see Chapter 4 and

Appendix C of the Long-Term Care Facility Resident

Assessment Instrument User's Manual, Version 3.0, effective

10/1/2010, which is located on the CMS MDS 3.0 website at:

[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage)

### **Instructor Notes:**

So what does this mean in terms of the documentation surveyors will see at the facilities? Chapter 4 of the MDS 3.0 manual instructs facilities to ensure that CAA documentation indicates:

- 1) the nature of the resident's condition/issue,
- 2) related underlying causes, contributing factors, and risk factors,

- 3) complications,
- 4) factors that must be considered in developing individualized care plan interventions,
- 5) the decision to care plan or not,
- 6) the need for additional evaluation, and
- 7) the resource(s) or assessment tool(s) used for decision-making, including conclusions.

The CAA process, like the RAP process, requires the completion of the CAA Summary, which continues to be Section V of the MDS. Specifically, V0200A on the MDS provides information regarding whether a CAA has been triggered, whether that triggered care area has been addressed in the care plan, and the location and date of any CAA process documentation.

Also, the facility is required to document the comprehensive assessment of each triggered item in the resident's clinical record. Regardless of the CAA tool utilized, facilities must document what tool they have used either in the resident's clinical record or as part of the facility's operating procedures.

Appendix C of the MDS 3.0 manual provides a list of resources and an assessment tool for each CAA and corresponding directions for its use similar to the RAPs. Although it is not mandatory, facilities may choose to use these assessment tools for the completion of the CAA process. It is important to note that references to non-CMS sources or sites on the internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or the U. S. Department of Health and Human Services. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of the publication of the manual. Remember these resources are not mandatory or all-inclusive.

In addition, the language regarding the MDS 2.0 care area triggers was changed. On the MDS 3.0, triggered care areas are referred to as Care Area Triggers, or CATs. We have included the location of the Resident Assessment Instrument Manual for the MDS 3.0, which may be found on the CMS website as noted in the slide.

### **Slide 23**

**Title:** Task 5 - Information Gathering

#### **Record Review:**

- Review the appropriate sections of the MDS for background information including customary routines and demographic information to provide an understanding of the resident prior to admission.

- For the location of the specific sections of the MDS 3.0, see Chapter 3 of the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website:

[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage)

**Instructor Notes:**

As you are reviewing the resident's record, you may have questions on particular MDS items, such as the background information. There is not a crosswalk of MDS 2.0 items to MDS 3.0 items. For information regarding what is included in each of the sections of the MDS 3.0., refer to Chapter 3 of the manual whose location is noted on the slide.

Also included on this site, either via download or as a link, are the remainder of the MDS 3.0 manual, technical specifications for MDS data, and MDS 3.0 training presentations and instructor's guides.

The information on this site includes valuable resources about every aspect of the MDS 3.0. Surveyors should familiarize themselves with the location of the information and refer providers to this site for questions on coding or completion of the MDS 3.0.

**Slide 24**

**Title:** Hydration Investigative Protocol

Use this protocol for a resident with concerns

related to hydration, such as:

- A fecal impaction;
- The presence of a urinary tract infection;
- Weight loss; or
- The presence of a pressure ulcer.

**Instructor Notes:**

So this concludes the changes to the survey process for selecting the resident sample.

However, we did make changes to the directions for completion of the Hydration Investigative Protocol, located in Appendix P, so that there are no longer references to the QM/QI triggers. Instead, a resident would be identified with hydration concerns based on observation and/or interviews during the tour.



The use of this protocol will be based on concerns regarding hydration as identified by the team.

## **Slide 25**

### **Title:** Appendix PP

- Revisions to Regulations
  - 483.20(b)(1)(xvii) (F272) - replaces RAPs with CAAs
  - 483.20(f)(3) (F287):
    - Replaces transmission to the State with transmission to the CMS/MDS System
    - Replaces transmission monthly with transmission within 14 days
- Formatting and editorial revisions throughout the Guidance to Surveyors
  - References to MDS items & coding
  - References to CAAs, ARDs, timing, & definitions
  - Changes in guidance for staging pressure ulcers

### **Instructor Notes:**

Now that we have finished with our discussion of changes in Appendix P, we would like to bring to your attention, revisions to the regulations and to Appendix PP regarding the MDS 3.0.

The regulatory language at several sections of 483.20 have been changed. These revisions will be released in a transmittal. These changes include:

- The use of CAAs instead of the use of RAPs; and
- The transmission of the assessment within 14 days, instead of monthly, to the CMS/MDS system instead of transmitting to the State Agency.

Also as a result of the MDS 3.0 requirements and implementation on October 1, references throughout the Guidance to Surveyors regarding the MDS 2.0, including specific items and coding responses, RAPs, submission timing, and assessment scheduling based on completion dates, have been revised. For the most part, references to specific MDS 2.0 items, sections, and coding responses have been replaced with general references to the MDS. The references to Activities of Daily Living (ADL) are an exception to this in order to maintain the integrity of the interpretive guidance.

Other changes include revisions to pressure ulcer and ADL definitions in accordance with the MDS 3.0.

The revised Appendix PP, CMS-672, & CMS-802, including the provider and surveyor instructions will be released as an advanced copy with an associated S&C memo with an effective date of October 1, 2010.