Preceptor Manual

An Instructor's Training Guide

November 2005

Acknowledgment

We greatly appreciate the many individuals who contributed their time, knowledge and talents to the development of this *Manual*. Without their cooperation, updating these training materials would not have been possible.

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Introduction

The overall objective of any surveyor orientation program is to provide the newly employed surveyor, within the time frame allowed, information, resources and skills necessary to perform his/her responsibilities at an entry level of proficiency for a specific provider type. For individuals to provide effective training, they need to be not only committed to the training process but also knowledgeable of what to do and when, where, why and how to do it. Each State agency and Regional Office has a term commonly used for these individuals ("preceptor," "trainer," "mentor," "field mentor," etc.). In this *Manual* the individual will be called the "preceptor."

The role of the preceptor requires commitment and dedication to training. This individual must have relevant survey experience and the ability to communicate, observe and facilitate training of others. This person must support the organization's mission, goals and objectives and be a role model for others. Additionally, the preceptor must know the subject and available resources, develop and tailor training to meet individual needs, objectively track and document a new surveyor's progress and act as a conduit between management and the new surveyor regarding training needs, problems and progress.

What This *Manual* Is

The *Preceptor Manual* was designed as a resource of information for preceptors and newly employed surveyors. Because policies and procedures are changed and revised frequently, the *Manual* is a dynamic work in progress. For the most current information, please refer to the Survey & Certification Group's websites at:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/,
http://www.cms.hhs.gov/CertificationandComplianc/,
http://www.cms.hhs.gov/GuidanceforLawsAndRegulations/,
http://www.cms.hhs.gov/SurveyCertificationEnforcement/,
http://www.cms.hhs.gov/SurveyorTraining/ and http://www.cms.hhs.gov/OASIS/.

The expectation is that State agencies, Regional Offices and individuals will use the *Manual* as a reference guide and modify lessons to meet the surveyors' individual needs. The goal is to have a training program that is consistent, complete, effective and accountable and that meets the individualized needs of the State agency and Regional Office. The *Preceptor Manual* provides:

- *A source of basic information for preceptors to develop and use in planning training for new surveyors.*
- *Information regarding preceptors*. This includes information on the selection, work and approach of a preceptor and an outline of the agenda of a preceptor meeting to inform preceptors of their responsibilities.
- *Information to use with the general surveyor*.
- *Lesson plans, handouts, PowerPoint slides and skill assessments* for various aspects of training the new surveyor.

Portions of the *Manual* may be appropriate to the Training Administrator, whereas other portions will be more useful to the preceptor directly training new staff.

What This *Manual* Is Not

This *Manual* is not intended to meet all training needs for the new surveyor or the needs of an individual learning to survey a specific provider group. To meet the needs of his/her agency and the unique training needs of each individual, a user may selectively choose materials from the *Manual*, modify tools contained in the *Manual*, investigate other sources of information or create additional training tools.

Preceptors will ensure new surveyors understand that the Surveyor Minimum Qualifications Test (SMQT) is a tool used to evaluate a combination of activities and credentials that include State-provided orientations, web-based prerequisites, the professional's background and mentor/preceptor-supported surveying experiences or trainings. No single training or class alone prepares the new surveyor to pass the SMQT.

Suggestions for improvements to this *Manual* should be directed to the following:

Division Director Training Staff
CMS/CMSO/S&C/TS
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

Please make your suggestions for improvements as specific as possible. Written documents or similar forms of communication illustrating the specific recommendations would be appreciated.

How to Use the *Preceptor Manual*

The *Preceptor Manual* was designed for preceptors working in many different settings with various requirements. The *Manual* is not a substitute for the preceptor's own material. It is expected that trainers will use the *Manual* as a guide when creating their training packages. Therefore, it is suggested that preceptors keep an original *Manual* when customizing the materials and make changes or State-specific modifications to a copy of the *Manual*.

You may find it helpful to refer to the Table of Contents as you read the following.

Section 1 is the "Train-the-Trainer" section of the *Manual*. It explains the roles and responsibilities of a preceptor and lays out relevant skills and abilities. There is an extensive section on developing a training package, complete with information on the principles of adult learning and the outline of a training program. There are suggestions on when to use various types of presentation methods. Finally, one question often asked by training coordinators, "Is it a training issue?," can be answered using the guidelines included in *Section 1*.

Section 2 and *Section 3* contain model lesson plans for each of the tasks in the *State Operations Manual*. Lesson plans in *Section 2* are generic in the sense that they contain general surveyor

training designed for use with any of the survey specialties: long term care, hospice, home health, etc. *Section 3* contains lesson plans specific to long term care.

Each section or lesson plan format should be the same:

- First, an outline of the lesson, with learning objectives and training highlights.
- Second, a model presentation for your customization and use. With each presentation, you will find the following:
  - Talking points and "hints" to the presenter are in italics.
  - There are no references to specific page numbers or tags in the *State Operations Manua*l, as these can change over time.
- Third, a skill assessment that tracks the progress of each trainee.
- Fourth, copies of the handouts.

At the end of the *Manual* are the *Appendices*, including the *Planning the Training Session* section, which contains training aids and model lesson plans.

Section 1:
Preceptor Training

Section 1-A: Selection, Work and Approach of a Preceptor

Selection, Work and Approach of a Preceptor

A preceptor is an experienced independent surveyor who has certain unique qualities that he/she uses to improve skills of new surveyors and to train them in the practical application of survey and certification procedures. The preceptor can work individually with new surveyors or may be part of a team assigned to do this important work.

What Makes a Successful Preceptor?

The role of the preceptor requires commitment and dedication to training. First, the preceptor candidate must be enthusiastic about this role. He/she must have relevant and quality survey experience and the ability to communicate, observe and facilitate training for surveyors. The preceptor must support the organization's mission, goal and objectives and be a role model for new surveyors. Additionally, the preceptor must be well versed in the subject, keep information about available resources, be able to develop and tailor training to meet individual needs, be able to track and document a new surveyor's progress objectively and act as a conduit between management and the new surveyor regarding training needs, problems and progress. A successful preceptor will promote quality surveyors who can contribute to the survey team. See the Introduction to this *Manual* for additional information.

A preceptor can be further defined by the following:

- **Personal characteristics**
  A preceptor should have the following personal characteristics:

  - Fair.
  - Approachable.
  - Adaptable.
  - Objective.
  - Patient.
  - Self-directed.
  - Role model.
  - Tactful.
  - Consistent.
  - Organized.

- **Knowledge**
  A preceptor should know the following:

  - Principles of adult learning.
  - The survey process and regulations.
  - Organization of State and Federal governments.

- **Skills**
  The preceptor should have the following skills:

  - Survey experience.
  - Facilitation.
  - Communication.
  - Enthusiasm.
  - Observation.

- **Identification as a resource person**

Why Have a Preceptor?

A preceptor provides a personal, consistent, reliable focus for training for surveyors while promoting quality and efficiency in the survey and certification process.

A preceptor is needed for the following:

- Consistency of training.
- Expertise in skill building.
- Morale (increased job satisfaction and decreased turnover of new staff).
- Quality assurance and improvement.
- Cost savings.
- Focus for resources.
- Communication link.
- Hands-on training.
- Continued personalized training.

What Are the Minimum Functions and Responsibilities?

A preceptor has the following *minimum* functions and responsibilities:

- Train new surveyors.
- Be knowledgeable about available resources.
- Make appropriate referrals.
- Track, assess/evaluate, document and report new surveyors' progress.
- Develop or tailor training plans for individual needs.
- Support the organization's mission, goals and objectives as a role model.
- Facilitate communication between management and trainees, including progress reports.
- Serve as an ombudsman for trainees.
- Facilitate transition from the new "green" trainee to the "journeyman" surveyor.
- Act as a training resource for surveyor and supervisory staff.

As determined by the organization, a preceptor *also* may have additional functions and responsibilities. The following are examples only and are *optional*:

- Train and develop journeyman surveyors.
- Provide information to experienced surveyors.
- Train and inform providers, advocates and others.
- Reinforce training or retrain experienced surveyors.
- Identify individual training needs and those common to other surveyors.
- Identify policy and procedure issues that impact the survey and certification process.
- Promote training and program objectives.
- Maintain a resource library.
- Maintain common training records.
- Provide or arrange for in-service training or continuing education.

Where Does the Preceptor Work?

The preceptor works anywhere the trainee is learning the survey process. This may be:

- In the field.
- In the office.
- En route between office and field.

When Is the Preceptor Needed?

The preceptor is needed:

- During the new surveyor's probationary period.
- Within the surveyor's first year of employment.
- Before the surveyor attends Basic Surveyor Training.
- Before and up to the time the long term care surveyor successfully passes the Surveyor Minimum Qualifications Test (SMQT).

What Is the Relationship of the Training Coordinator and the Preceptor?

The preceptor and the training coordinator must be aware of each other's roles. The training coordinator will schedule the new surveyor after the preceptor, in conjunction with the supervisor, lets him/her know that the new surveyor is ready for the Long Term Care Basic Training and the SMQT that all surveyors must pass. The preceptor must evaluate the new surveyor's skills and knowledge base as being acceptable prior to nomination for Basic and the SMQT.

After agreement, the training coordinator will nominate the new surveyor for the Long Term Care Surveyor Basic training course. The training coordinator uses the Learning Management System (LMS) for nominating and enrolling students and tracking Federal training.

How Does the Preceptor Train?

At a minimum, the preceptor trains staff using the following:

- The principles of adult learning through application of a variety of training materials and techniques.
- The CMS *Surveyor Orientation Manual*.
- Experience, using these sources and others as a framework to outline training so objectives will be consistently accomplished.

Section 1-B:
Preceptor Orientation

Preceptor Orientation

State agency and Regional Office (RO) training administrators must provide preceptors with the knowledge and framework necessary for training new surveyors. A survey of State and RO training administrators provided the following recommendations for topics to cover during preceptor orientation:

Date completed	Topic
	General Overview (of the new surveyor orientation program) • Goals and objectives.
	Expectations and Responsibilities of the Preceptor
	Support from the State/Regional Trainer • Department/supervisory/office support. • Resources.
	Adult Learning Principles (see Planning Training) • Determining/evaluating the learning mode of the new surveyor. • Modifying training based on surveyor learning style and previous experience.
	Use of Training Materials, Equipment and Resources • Time and forms. • Visual aids and teaching techniques. • Resource library/maintenance of the resource library. • Teaching tools—developing and tailoring.
	Requirements • Conduct training following CMS protocols. • Use new surveyor skills assessment form. • Develop training plans: – Observe budget constraints. – Individualize the training plan. – Schedule surveys for skill development. – Present work in an organized manner. • Prepare and implement training plans: – Evaluate students' progress. – Assess learning and provide feedback to new surveyor. • Maintain training records/forms. • Write objective observations. • Transition after initial orientation.

Date completed	Topic
	Responsibilities of the Trainee and the Preceptor • Communication with each other and with appropriate supervisors or the training administrator. • Clarity of expectations. • Being prepared to work on the assignments. • Required records maintenance.
	Administrative Issues • Evaluating surveyor strengths/weakness and communicating this to the surveyor and the supervisor. • Preceptor-surveyor incompatibility.

Section 1-C: Orienting the New Surveyor—General Guidelines

Orienting the New Surveyor—General Guidelines

Each CMS State agency and Regional Office should have a plan in place that specifically identifies how new surveyors should be trained and evaluated. The plan should identify who does what, when, where, why and how. Awareness and coordination are key to the training of any individual. The preceptor should keep in mind the previous training and experience the new surveyor brings to the job. Additionally, both the training administrator and preceptor should be aware that training requires many resources: staff, time, budget and scheduling. In most State agencies and Regional Offices, the training of either new or experienced staff to survey a particular provider type will require negotiation regarding the availability of staff, the time allowed to train, budget constraints and scheduling alternatives to make it all work.

Suggestions to maximize the effectiveness of the training program include the following:

- State agencies and Regional Offices should adapt the orientation schedule according to the new surveyor's training needs. An evaluation of surveyor needs should precede planning the training program. The preceptor should review the program with the surveyor and his/her manager prior to implementation so that all agree to the program elements.
- Each surveyor should have an assigned preceptor to whom he/she can turn for assistance and support.
- During and upon completion of training, the newly employed surveyor should have periodic written or oral evaluations and conferences with the person who will complete his/her final assessment.
- Whenever possible, each preceptor should meet the qualifications and characteristics outlined in this manual.

Staff

Although each State agency and Regional Office has designated a person as the training administrator, the duties that individual has for the direct training of new or experienced surveyors will vary with each agency or office. The responsibility of establishing the components of a training program for staff—hiring staff, orienting and training staff, securing the supplies, assessing training and finally evaluating the competency of the trainee—may be delegated to numerous individuals: management, official preceptors, supervisors, clerical staff and surveyors, to mention some. Therefore, we suggest that each State agency and Regional Office have, in writing, a description of individual responsibilities for aspects of training discussed in this manual. Although responsibilities can be delegated to others, assignment of specific responsibilities will facilitate communication between key individuals.

If the State agency/Regional Office trainer does not train surveyors, determine who is responsible for the following:

- Writing a training program to train staff to survey a specific provider.
- Selecting a preceptor with the necessary qualifications.
- Orienting the preceptor to training responsibilities and expectations of the training program.
- Evaluating the specific needs of each trainee.
- Establishing a method of assessing the training of surveyors.
- Establishing a method through which the trainee can provide feedback regarding the training and future training needs.
- Establishing a line of communication in case the trainee has difficulties with the preceptor.
- Evaluating and updating the current training program to keep information compatible with CMS Central Office directives.
- Interviewing the trainee as well as the preceptor regarding the training experience, to identify areas for improvement.

Time

The time allocated for training will be determined by:

- The training program currently in place.
- Preceptor experience in training previous trainees with similar qualifications.
- The success or failure of trainees in functioning with reasonable independence, competence and proficiency while meeting minimum responsibilities as surveyors.
- The monetary constraints which may limit the preceptor's availability.

Changes in the training program will require a period of evaluation to determine how successfully trainees function as a result; however, the preceptor may have only a limited period of time to train new surveyors. The length of time it takes surveyors to become minimally independent, proficient and competent will vary based on the abilities of the surveyor as well as those of the preceptor.

Budget

Training budgets should reflect the usual time for training new surveyors. Each State agency and Regional Office determines a yearly training budget based on money allotted by the Central Office. This budget not only includes staff training for newly hired or experienced surveyors but may also include funds for provider and beneficiary training. The budget must include travel funds for Central Office–sponsored training as well as in-State training and supplies. The State and regional trainers must review the budgets (State and Federal) for each fiscal year to ensure that the mandatory training occurs. Trainers must also identify future training needs well in advance so that the Central Office can plan for them. In some State agencies, the training coordinator monitors the expenditures so that monies spent do not exceed the budget allocation.

Training coordinators are often involved in planning the overall training program for the year. Part of the planning includes estimating expenses related to training, such as travel costs, and maximizing training for particular audiences. Because financial resources are always limited, training coordinators must plan the most efficient and effective use of training dollars.

Training Schedule

One person should be assigned to coordinate training experiences and opportunities for both new and experienced staff. With new staff, knowing the date of hire is essential for planning. Experienced surveyors will have survey responsibilities that compete with training, so that there may be some negotiation for training time necessary with them as well as their supervisors. Individual scheduling must balance a number of other factors. The training coordinator should:

- Be aware of the training plan. For example, when will classroom training occur versus training in a facility, what will the length of training be, when will the training plan require a person with certain expertise, etc.?
- Determine who will provide what aspect of training.
- Determine the availability of a preceptor at the time needed.
- Consider holidays, vacations and other responsibilities of both the preceptor and the trainee.
- Provide adequate time for training when the preceptor will be participating as a survey team member or assisting the trainee on a survey.
- Evaluate the trainee's progress and adjust the training plan accordingly.
- Along with the preceptor, evaluate when the trainee should be exposed to other surveyors' work to enhance the learning process.

Section 1-D:
Training Modalities

Planning Training

Plan for Individual Learning Styles—Three Types of Learners

	Characteristics	Teaching Ideas
Auditory (those who do better by hearing the material)	• Talks a lot • Good storyteller • Enjoys music, singing • Asks questions about written instructions • Tells jokes, distracts the teacher • Makes up rhymes • Talks to self when working alone; moves mouth to read • Likes poems, riddles, wordplay • Likes to be in charge	• Use verbal directions • Test verbally • Give a quiet place to work • Don't talk while student is working • Reinforce verbal instructions with written ones • Encourage person to share stories
Visual (those who excel by seeing new things, who prefer to read materials or take notes)	• Tidy, does not like clutter • Finds misprints and typos • Stores materials when done • Likes books and pictures • Asks for written instructions • Notices details • Copies others' work • Remembers demonstrations • Easily distracted by noise • Good at reading maps • Likes to work puzzles	• Use demonstrations • Use audiovisual aids • Use lined paper • Use symbols to match visual to auditory • Leave room around them • Let them work in non-visual place—no windows • Give one page at a time • Review written material • Use pictures, props

	Characteristics	Teaching Ideas
Kinetic (those who must touch or be otherwise actively engaged, learning through experience)	• Touches everything • Makes things out of his/her papers • Likes sports, well coordinated • Takes things apart and rebuilds • Uses action verbs • Often likes jobs that involve physical labor or activity • Uses his/her hands to talk • Likes to draw and doodle • Enjoys projects which involve doing things	• Give individual attention • Try role play situations • Give easy-to-follow directions • Avoid visual and auditory distraction • Allow ample break times • Provide and follow an agenda • Have the person take notes as he or she listens in class • Use movement/demonstration • Use teaching aids, like models • Provide a project checklist • Alternate sitting activities with movement

How Adults Learn—Three Factors

It is important to set the physical and psychological climate to establish a learning atmosphere. Three factors define a learner's "training climate:"

	The Learner's...	Trainer's Response...
Physical	• Poor hearing/eyesight • Health • Fatigue	• Use larger visuals/microphone • Adjust time of day • Classroom atmosphere
Emotional	• Self-concept • Values and attitudes • Fear of change	• Study alone/with others • Motivation (see below)
Intellectual	• Previous learning • Expectations • Passive vs. active learners	• Refer to "Characteristics of Adult Learners" and "Learning Styles"

Characteristics of Adult Learners

Adults…	Therefore…
Are motivated by goals.	Do not assume. Tell them what their goals should be and, if necessary, what the consequences may be if the goal is not reached.
Pursue training with a sense of purpose.	Tell them why your information is important to them by creating the "big picture."
Have increasing self-reliance, autonomy, and inner-directedness.	Plan periods where individuals can work independently or with oversight rather than on a continuous basis with a trainer.
Lack confidence in their ability to learn.	Plan activities where individuals can demonstrate learning in a protected atmosphere until learning is mastered.
Are problem-oriented, and want training related to the real world.	Use real rather than hypothetical information.
Pursue accuracy rather than speed and have declines in vision, hearing, energy and reaction speed as they get older. They have a fear of failure since they do learn more slowly.	Design training packages that take these factors into account.
Need to have theory immediately applied to practice.	Plan exercises immediately after initial training.
Need to feel comfortable taking risks and experimenting with what they have learned.	Participants may need to identify a method to accomplish the work in an equally effective way.

Adults…	Therefore…
Each learns in his or her way, and at his or her own pace.	Provide different ways for the individual to learn (i.e., reading, seeing, hearing, doing, and watching others) until you identify how that individual learns best. Make sure that each person understands his/her personal responsibility for success in training.
Come to training sessions with work experience.	Plan to integrate his/her experience into the training.
Are typically verbal.	Include opportunities for trainees to contribute to discussions and share personal experiences.
Learn faster and remember longer those things which are repeated several times.	Identify methods in training to repeat the information (for example, a small group exercise or demonstration using the new information).
Learn best when they can see evidence of progress.	Examples include using prior learning to accomplish a new task, or moving from demonstrating learning under supervision to oversight to independence. Comments by the preceptor regarding their progress help trainees further realize accomplishment.

Obstacles to Successful Adult Learning

Obstacles	Remedies
Not being aware of a lack of knowledge or a specific skill.	Present a clear picture of the desired behavior, and why it is important.
Being afraid of criticism.	Plan activities that do not single out an individual, but rely on either one-to-one activities with the trainer or group activities.
Forgetting how to learn and take tests.	Train one step at a time, and try to plan an activity that will reinforce information learned at each step. Tests, for example, can be self-evaluation or a positive learning experience.
Negative memories of previous training.	This may be based on use of poor training techniques for adults. Plan to do better by using information found in this *Manual*.
Competing priorities.	Be aware of personal and other issues that may compete with the training provided. Find methods to minimize them. For example, for a new surveyor, clarify priorities (responsibilities and individuals in charge) at times through the training. For a training session, plan breaks where individuals can take care of personal business.
A bad match with the trainer/preceptor.	Be alert to this possibility and, if a resolution is not possible, consider seeking additional help from others.
Communication problems.	As discussed above, adults have different learning styles. Check with trainees to make sure your style is working.
Unrealistic expectations.	It is unlikely that a new trainee can become a competent surveyor in three hours, or that she/he can be in complete control of the new situation—both of which are outcomes preferred by adults. Preceptors must be sure to explain the training process and manage expectations.

Motivating Adult Learners

- Know the background, knowledge level, areas of expertise, and specific learning needs of your audience, and then tailor your presentations accordingly.

- Think of some of the best training you have experienced. Positive feelings and experiences in training are what you should strive to emulate by identifying the techniques that the trainer used. Remember and use these techniques when planning training.

- Formula for success = ⅓ lecture/instruction, ⅓ group/individual, ⅓ general discussion.

- Pay attention to body language for signs that you are losing your audience.

- WII-FM: explain "What's In It For Me."

- Vary presentation styles using:
  - Round table discussions for hot topics and open forums.
  - Panels for different viewpoints in a brief time period.
  - Formal speech/lecture—use for a professional speaker or significant topic with little time.
  - Small group work for team building, idea sharing, and networking.
  - Retreat for leadership skills development and strategic direction.

- Plan to include these motivators to energize your learners, and remember the old axiom: *"Tell 'em what you're going to tell 'em, tell 'em, and tell 'em what you told 'em."*

For more information, refer to appendices:

A. Training Modalities and Techniques
B. Sample Lesson Plans
C. Sample Training Objectives
D. Training Resources

Eight Ways to Energize Adult Learners

- Set the climate
- Create the need
- Involve them
- Be organized
- Create and maintain interest
- Provide recognition and encouragement
- Create friendly competition
- Get EXCITED yourself

Section 1-E: General Training Techniques

General Training Techniques

Introduction

In this section, you will find general concepts concerning effective ways for an instructor to get his/her point across. These are based on significant formal research and years of experience by those who have made adult learning a career. Pros and cons of each of the techniques and tools are very briefly outlined. Please remember that whole texts have been written to elaborate on these topics and are available from commercial bookstores in paperback. We only outline key concepts for reference.

If you want to find more detailed information about instructional techniques, there are many printed sources on the subject. One that we recommend is Mel Silberman's *Active Training: A Handbook of Techniques, Designs, Case Examples, and Tips,* 2nd ed. (Jossey-Bass/Pfeiffer). It is full of ideas on how to make lectures more interesting and effective, how to find alternatives to lectures, how to design activities and many other useful techniques.

Please note, however, that no matter how technically advanced the different tools may be, each instructor has to be sure that he/she is comfortable with the use of the tools available. We urge instructional experimentation—accomplished ahead of classroom time. Instructional technology is a rapidly evolving area which offers new and more interesting ways to be sure your students remember what was presented. That's what we're about, but we recognize that not every trainer will have access to the full array of materials and that he/she may be teaching in a remote classroom without all the required support facilities.

As with other advice offered in the *Preceptor Manual,* we suggest careful preparation ahead of the time for presentation. Eighty percent of instructional success is driven by advance preparation and practice.

In the chart on the next page, and the "Cone of Learning" by Edgar Dale, you will find help with deciding which of the tools or options is most appropriate for the learning task at hand. This section then outlines pros and cons of each of the tools with some specification concerning best times and situations to use them. When in doubt, keep it simple.

Above all, seek the most student-active solution consistent with time and technical tools available and your personal instructional "comfort zone." Have fun; teach well.

Note: Preceptors will ensure new surveyors understand that the Surveyor Minimum Qualifications Test (SMQT) is a tool used to evaluate a combination of activities and credentials that include State-provided orientations, web-based prerequisites, the professional's background, and mentor-preceptor-supported surveying experiences or trainings. No single training or class alone prepares the new surveyor to pass the SMQT.

Formats and Tools

A variety of presentation formats and techniques are available to you when planning your training session. This section provides information regarding types of presentations and techniques. The following table may help you identify the most effective methods for your presentation.

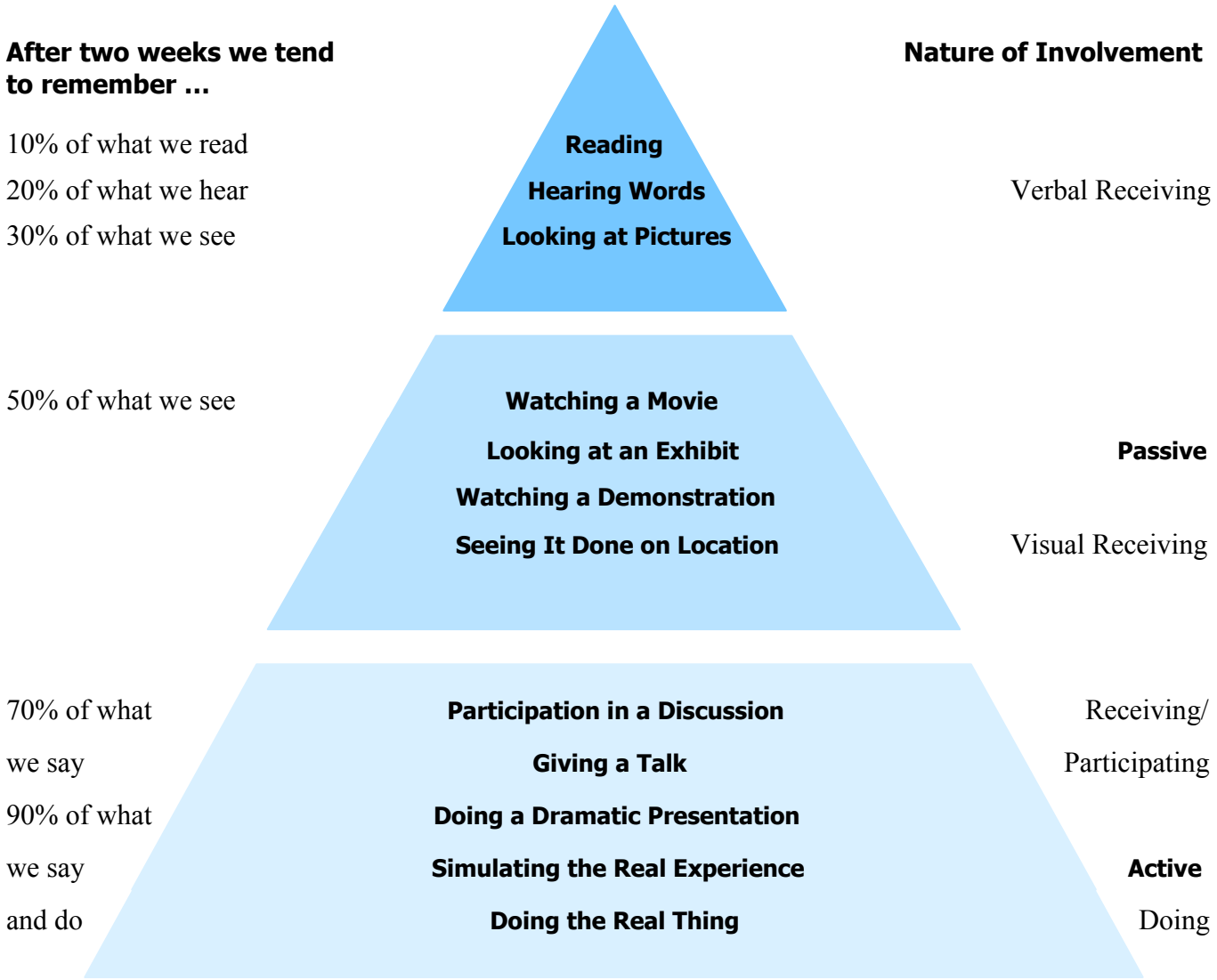
	Content Determined By:		Learner's Role:		Addresses This Type of Learning Style:		
	Trainer	Learner	Active	Passive	Hear it	Do it	See it
Presentation							
Lecture	X		X	X	X		X
Discussion/Focus Group	X	X	X	X	X	X	
Role Play/Dramatization	X		X		X	X	
Demonstration	X		X	X	X	X	X
Simulation Game	X		X		X	X	X
Buzz Session	X	X	X		X		X
Case Study/Problem Solving	X		X				X
Brainstorming	X	X	X				X
Presentation Tools							
Videos/Films	X		X	X	X		X
Handouts	X		X	X		X	
Overhead Projector	X		X	X			X
Easel Pad	X	X	X	X			X
Dry-Erase Board/Chalkboard	X	X	X	X			X
Slides	X		X	X			X
Props	X		X	X	X	X	X
Reading	X		X	X			X
Note Taking	X	X	X	X		X	X

Dale's Cone of Learning

The following is a representation of techniques to use when making presentations. Note that different visuals may be useful regardless of the size of your audience. However, studies have shown that:

- Learning improved up to 200% when visuals were used in teaching vocabulary (research by University of Wisconsin).
- Visuals improved retention by 14–38% (research by Harvard and Columbia Universities).
- The time required to present a concept can be reduced up to 40% when visuals complement a verbal presentation (research by the Wharton School of Business and the University of Minnesota).

Cone of Learning (Edgar Dale)



Source: Dale, E. (1969). *Audio-Visual Methods in Teaching* (3rd ed.). New York: Holt, Reinhart and Winston.

Lecture *(Hear it)*

Suggestions for use

- To present information not readily available elsewhere.
- To present information that is intended for short-term retention (such as introducing a subject or giving oral directions for learning tasks that will involve other techniques) rather than as a vehicle for changing attitudes, values or observable behaviors.

Techniques

- State the lecture objectives.
- Limit major points for short presentations (e.g., six within a 30-minute lecture).
- Present summaries at both the beginning and the end.
- Provide each participant with a handout of any visual aid (e.g., overhead, slide, easel pad, chalkboard).
- Try not to use a podium/lectern, but move around the room talking in a natural, conversational voice.
- Combine lecture with discussion to increase effectiveness.

Advantages

- An easy, economical and quick method of instruction to present large amounts of information to a group.
- It may be used regardless of the size of the audience.

Disadvantages

- Learner is passive and may frequently "tune out" and miss key information when the material is complex, detailed or abstract.
- Little opportunity for feedback if the purpose is to change attitudes, values or observable behavior.

Discussion/Focus Group *(Hear it and do it)*

Suggestion for use

- To present narrow or very focused topics to small groups (usually 6–20) when brainstorming or resolution is needed.

Advantages

- Peer pressure in a small group may convince the "holdout" individual.
- Stimulates thinking and often presents creative solutions to problems.
- Encourages participants to evolve from a current understanding or position to a new one set by the group and instructor.

Disadvantages

- Requires the leader to keep the discussion focused, encourage participation of all, limit arguments among participants and summarize major ideas.
- Requires more time than the lecture method.

Role Playing/Dramatization *(Hear it and do it)*

Frequently the terms "role playing" and "dramatization" are used interchangeably. However, the two techniques are different. In role playing, the leader does not know the outcome of the role playing, as the participants are free to act out their feelings. In dramatizations, the leader describes the situation and the desired outcome, but the participants are free to create the method to obtain the outcome.

Suggestions for use

- To help to change attitudes.
- To gain insight into problems.
- To stimulate discussion immediately after participation to increase meaning of exercise.

Advantages

- Provides a visual and auditory aid for learning.
- Most effective when individuals in the group feel comfortable with one another.
- Allows participants to dramatize feelings and empathy.
- Encourages personal growth.
- Allows participants to practice skills in a safe environment.

Disadvantages

- Both methods require the selection of a meaningful situation to be effective for learning.
- Individuals forced to participate do not always provide a good demonstration.
- Adults may resist role playing.
- Learning can be inconsistent.
- Requires a skilled leader to stop role playing/dramatization either when the outcome has been accomplished or when enough material has been presented for discussion (a general rule is three to seven minutes).
- Requires a skilled leader to quickly identify potential problems that develop among the participants or the audience and to be ready to stop the role playing/dramatization.

Demonstration *(Hear it, see it and do it)*

Demonstrations visually present procedures that are under discussion.

Suggestions for use

- To provide a model (behavior or skill) to replicate.
- To combine information from various sources to show a "system" approach.

Advantages
- Best adapted to teaching manual skills to a small group (not more than 10) and when it is necessary to divide the skill into steps.
- Students can demonstrate mastery of the procedure to the instructor.

Disadvantage
- Instruction is difficult if there are multiple variations of the behavior or skill.

Simulation Games *(Hear it, see it and do it)*

Suggestions for use
- To test and apply concepts.
- To develop individual and group skills and teamwork.

Advantages
- Participants have an opportunity to act/react under conditions similar to the real situation.
- Participants actively learn.
- Dynamic with low risk to participants.
- Can demonstrate many different concepts and applications.

Disadvantages
- Takes a great deal of time, both to prepare and to implement.
- The instructor must ensure that instructions are followed closely.
- Participants' actions and focus on topics must be controlled.
- Limits number of participants or requires multiple copies of instructions/directions.

Buzz Sessions *(Hear it and see it)*
This is a small cluster of learners who are temporarily grouped together for a short period of time to address a topic presented by the facilitator.

Advantages
- Most effective in small groups (three to six individuals) in answering a specific question.
- Each small group may be given the same or different questions.
- Increased involvement in course content.
- Increased participation in class discussions.

Disadvantage
- Instructions to the group(s) must be specific and may be best communicated by either writing them down (such as on an easel pad) or providing a printed handout.

Case Studies/Problem Solving *(Do it/demonstrate)*

Suggestions for use
- For management development and policy implementation.
- To combine and apply random learning.
- Problem must be carefully constructed.
- Can be used for development.
- Role play can be combined with this.

Advantages
- Stimulates and involves participants.
- Most effective for small groups.
- Stronger students help the weaker students.

Disadvantages
- Requires the leader to ensure that the problem has a solution.
- Requires the leader to conduct an effective discussion of the solutions offered when the small groups return to the larger group.
- Does not change attitudes or teach skill mastery.
- Hard to control outcomes in a group setting without a skilled leader.

Brainstorming *(Do it)*

Suggestions for use
- To elicit new or multiple ideas in a short period of time.
- To prioritize problems if the session is to focus on problem situations.
- To list all ideas, whether they are "right," "wrong," "good," or "bad," where the group can see them.
- To discuss the merits of all ideas after they have been presented.

Advantage
- Best used in small groups.

Disadvantage
- This teaching method can become a "gripe" session.

Presentation Tools

Successful trainers have an assortment of tools in their toolboxes to help get a point across. As with training techniques, these tools can "grab" different students in different ways; using a variety of tools is more effective. These tools range from easel pads to multimedia presentations. No single tool is best, but some are better suited for a particular task; for example, an easel pad is the right "tool" for a brainstorming session in which listing ideas and being able to see them is important. Trainers must remember that audiovisual aids help to develop the content of the presentation; aids supplement but do not replace other materials.

Visual Aids

While the best visual is observing the real thing, the next best would be a picture or visual description. Media aids should add to or reinforce the content, not confuse or overwhelm the audience. When developing these aids:

- Simplify:
  - Present one key point per visual.
  - Minimize words and use bullets.
- Ensure that aids are easy to read and understand.

- Be creative:
  - Use color and different-sized lettering—black-and-white typed pages are dull.
  - Add pictures or parables to visuals and handouts.
  - Translate numbers into pie charts, bar charts or graphs.
- Use variety (handouts, transparencies, audiovisuals and easel pads).
- Instructors should prepare the classroom at least 30 minutes before participants are expected to arrive. This allows time to:
  - Arrange furniture.
  - Unpack and arrange materials you brought.
  - Set up and test equipment.

Advantages

- Attract and maintain attention.
- Can underscore main ideas.
- Reinforce the written or spoken word.
- Can save time and dollars.
- Increase retention:
  - Duplicates what participants hear; they will also be able to see it.
  - When provided as a handout, students can personalize their notes against the reinforcing visual.
- Can add realism.
- Can help a participant organize his/her thoughts.
- Prevent omission of key points.
- Quick, easy and generally economical for group of any size.

Disadvantages

- If confusing, can cause misinterpretation.
- Do not change attitudes or teach skills mastery.
- Little opportunity for feedback.
- Learner is passive and may frequently tune out and miss key information.

Screen and Image

Suggestions for use

When using a screen:

- Place the bottom of the screen at least 42 inches from the floor.
- Place it in a front corner of the room, angled toward the center of the room.

When projecting an image:

- Elevate the projector and position it so the image projected on the screen is at a 90-degree angle to the screen to minimize distortion of the image.
- The image should fill the screen completely.

Seating:

- The distance from the screen to the first row of seats should equal twice the width of the screen.
- The distance from the screen to the last row of seats should equal six times the width of the screen.
- Rows should be no wider than their distance to the screen.

Videos/Films *(Hear it and see it)*

Suggestions for use
Videos/films should:

- Fit the setting.
- Support the message.
- Awaken the audience.
- Be used in moderation and be short in duration (target 10–20 minutes).

Prior to showing the video/film:

- Preview the video/film to become familiar with its format and stopping places.
- Examine any information and materials that are to be used before, during or after the video/film.
- Become familiar with the information to smoothly incorporate the video/film into training.
- Decide if you wish to use all the materials and video/film or just some of it to make the presentation more valuable to your learners; add materials pertinent or closely related to the subject.
- Prepare copies of materials that will be used with the video/film.
- Announce at the beginning if trainees will either be tested or have to demonstrate knowledge learned from the video/film to help the learner keep his/her attention focused on the information presented.
- Have all test materials available, including additional tests, pens or pencils if testing is to be conducted after the video/film.
- Arrange the time and place to allow for viewing the video/film and additional time for discussion.
- Arrange space and set up the equipment before the trainees arrive to provide optimal conditions for viewing.

Advantages
An effective video/film can:

- Grab and hold attention.
- Tap the visual sense that is vital to learning.
- Present interesting information quickly and clearly.
- Illustrate hard-to-grasp concepts.

- Present complex processes clearly.
- Realistically dramatize problematic situations.
- Portray problem-solving techniques.
- Provide role models with whom viewers can identify.
- Demonstrate correct and incorrect behaviors.
- Change attitudes.
- Provide a break from fatiguing lectures.
- Provide a break from tension-producing discussions.
- Provide standardized lessons in different locations.
- Provide exposure to "real-life" situations.

Disadvantages
Videos/films cannot:

- Tie information and behavior models directly to the viewers' work situation.
- Lead discussions and answer questions.
- Hold viewers accountable for learning.
- Replace a capable instructor.
- Offset the negative effects of a poor training program.

Handouts *(See it)*

Suggestions for use
When planning the handout:

- Use different sizes and styles of lettering, spacing, bold and underlining in text to create emphasis.
- Allow space for participants to write notes.
- If reprinting information from another source, do not use copyrighted material.
- If reprinting information from another source, mask any irrelevant or distracting information.
- Use page numbers on all handouts for easy reference.
- Have the document(s) three-hole punched, bound, stapled or arranged in packets to easily distribute, carry and store.

During the training session:

- Distribute the handout material just as it will be discussed. (If material is distributed at the beginning of the training session, participants may read the information rather than focus on the speaker.)
- Depending on the length of the information, either allow trainees to read it (and then informally check for understanding) or inform the participants that the information is for future reference.
- Do not read the handout to the trainees: silent reading occurs two or three times faster than reading aloud. If you feel it is necessary to read the handout aloud, another form of visual aid would be more effective. (If the reading is for emphasis, pause and allow

participants to read the information and then either paraphrase what it says or ask questions to ensure understanding.)

Advantages

- Provide information the trainee can refer to both during and after the training session.
- Easy to store, revise and reproduce for each subsequent session.
- Can be formatted (information arranged, stapled and three-hole punched) as desired.
- Can communicate complex or lengthy information.
- Excellent means to communicate supporting information.
- Can be used to support other visual aids.

Disadvantages

- Require periodic review to provide up-to-date information.
- Participants will attempt to read handout as soon as it is distributed to them rather than listen to the leader.

Overhead Projector or PowerPoint *(See it)*

Suggestions for use

When planning your transparency or slide:

- Use large enough type (at least 28-point font—1/2 inch-high letters or more) so that everyone in the room will be able to read the information (test by reading it 15 and 30 feet away).
- Vary the size of type by importance: "headline" the largest (40 or 44 point), subheadings 2–4 points smaller (36 point) and text 2–4 points smaller yet (32 point). Sans serif type style is typically used, with boldface for emphasis.
- Use simple typefaces and the same type style for each series of transparencies.
- Use no more than two type styles for each series of transparencies or slides.
- Use horizontal rather than vertical lettering.
- Use upper- and lowercase letters in most cases; text entirely in capital letters takes longer to read.
- Use basic words and phrases (e.g., rather than "survey or Federal regulations" use "Federal regulations"), keeping the content simple and sentences short (try to think in "bullets").
- Use a maximum of 4–5 bullets on each slide.
- Vary the length of words and provide ample spacing between letters, words and lines of type (rule of thumb is space equal to the height of an uppercase letter).
- Use check marks, bullets, arrows, boxes or other images rather than numbering for nonsequential information.
- Add a visual for impact to each slide or transparency (illustration, cartoon, graph, map, chart, etc.).
- Use no more than three colors on each slide or transparency for background tint, decoration, articulation, and emphasis—easy-to-read colors are:
  - Red for emotional response.
  - Blue for calming.

  - Yellow for excitement (never use as background).
  - Green to stimulate interaction.
- Use water-soluble markers or grease pencils to mark on transparencies so that the writing can be removed later.
- Leave space on transparencies to write if needed.
- If possible, limit information on each transparency or slide to six lines.
- Place the information on the top half of a transparency; if this is impossible, move the transparency up during the presentation so that the information under discussion is at the top half of the projected image.
  - Reveal items one by one to avoid participants' reading and writing ahead. Use a frame for each transparency:
    - Number each frame and add written key points on the frame to use as reminders during the presentation.
- Test the visibility and focus of the transparency or slide before the training session begins:
  - Place the projector squarely in front of the wall or other flat vertical surface on which the image will be projected.
  - Move the projector away from the wall/vertical surface, until writing on the transparency or slide is visible to those seated at the back of the room.
  - Focus the image.

During the presentation:

- Turn an overhead projector lamp on only when:
  - Displaying a transparency.
  - Discussing the information shown.
  - Allowing time for participants to copy the information displayed.
- Turn the projector lamp off if there is a lengthy pause.
- Face the audience with the projector between you and the audience, placing a transparency on the projector as if you were reading it. Align a transparency to be straight.
- To emphasize a particular item on a transparency, point to that item on the transparency, rather than on the screen:
  - Use a thin pointer such as a pen or pencil.
- Maintain eye contact with participants.
- Mask information not under discussion to minimize distractions.
  - Use a piece of paper or other nontransparent material.

Advantages

- Easy to enlarge material to use with large audiences.
- Easy to store, maintain and revise.
- Can be developed quickly, either before or during the training session.
- Can be organized ahead of time.
- Can use special pens and materials to create multicolored transparencies.
- Provide focus of attention on a particular page or information segment.
- Allow the presenter to face the audience at all times.

Disadvantages

- Require special equipment—a large, vertical, flat, one-colored surface on which to project the image and the ability to adjust the room's lighting to see it well.
- Exaggerate mistakes (e.g., misspelled words).
- Transparencies require special transparency materials and a machine that can produce the transparency.
- Useless without electricity or if a bulb has burned out.
- If using transparencies in place of an easel pad, it can be frustrating to students because an instructor writes illegibly, writes small or on an angle, or places too much information on one sheet.
- May require lights to be dimmed.

Easel Pad *(See it)*

Suggestions for use

- Use two-inch letters for rooms up to 30 feet deep.
- Use only the top two-thirds of page if room is large.
- Keep it simple with bar graphs, key words and pictures.
- Alternate the use of colors when writing a list to easily distinguish one idea from another.
- Develop (write on the pad) complex materials before beginning the session.
- Leave blank sheets where appropriate to make a break between concepts.
- If it's important to be able to see more than on sheet at a time, use masking tape to tape sheets to the wall (be sure the owner of the room will not object to taping).
- If writing before the training, pencil in information along the side to use as a "cheat sheet" for this portion of training.
- Place the easel pad where you can reach it easily and where it will be seen by all participants.
- Use a broad-tipped, water-based marker so the lines will be thick enough for everyone to read.
- Record key points that evolve from group discussions (e.g., problems identified and conclusions reached).
- Limit each page to one topic, key idea or concept.
- Print letters two to three inches high.
- Condense information.

Advantages

- Provides large writing surface.
- Easy to store, maintain and revise.
- Can be developed quickly, either before or during the training session.
- Can add information as you speak.
- Can employ special pens and materials to create multicolored images or emphasize key points.
- Provides focus of attention on a particular page or information segment.
- Allows for removal of individual sheets that can be posted around the room.
- Relatively inexpensive materials.
- Does not rely on electricity.
- Lights can remain on.

Disadvantages

- Mistakes are clearly visible.
- Must be stored, transported, and used carefully on flat surface to maintain appearance of paper.
- Hard to carry and not durable.
- Frustrating to viewers when the presenters write illegibly, small or on an angle or place too much information on one sheet.
- Presenter must write with his/her back to audience, thereby losing eye contact with trainees.
- Ineffective if group is too large.

Dry-Erase Board/Chalkboard *(See it)*

Suggestions for use

- To develop complex material before beginning the session.
- If using chalk, have a damp towel handy to avoid wiping your hands on your clothing.

Advantages

- Provides a large, (usually) centrally located surface area on which to write.
- Has multicolor capabilities.
- Allows for materials to be developed prior to or during the training session.
- Easy to quickly revise information.
- Allows for complex systems—relationships can be diagrammed with audience participation.

Disadvantages

- Restricts retention of information (requires immediate note taking).
- Offers a limited work surface (must continually erase data in order to reuse area).
- Information must be re-created each time (recommend designing each presentation on 8½" x 11" paper before going into the classroom).
- More difficult to read since erasers do not effectively clean the board.
- Predeveloped material can distract the audience.
- Frustrating to presenters who write illegibly, small or on an angle, have poor spelling or place too much information in an unorganized manner on one board.
- Presenter must write with his/her back to audience, thereby losing eye contact with trainees.

35-mm Slides *(See it)*

Suggestions for use

- Pretest to be sure everything is functioning normally.
- Have the right kind of extension cord available.
- Have the telephone number and name of the individual to call if the machine does not work correctly.
- Ensure slides are in proper order and not upside down or backward.

- Use a remote control slide changer.
- Adjust room lighting levels as appropriate.

Advantages
- Pictures can look professional.
- Can provide pictorial image or history in place of actual experience.
- Can be synchronized with an audiocassette.
- Allow for use of multicolored, appropriate visuals tailor-made for the training session.
- Image can be enlarged by placement of the machine for extremely large audiences.
- Can be updated by replacing with new slides.
- Easy to store, maintain and transport.
- Can be used in conjunction with other visual aids.

Disadvantages
- Can be expensive to produce and duplicate relative to PowerPoint.
- Require special equipment and bulb.
- Require time to plan, take pictures and develop clear slides that show desired image/information.
- Require a photographer and appropriate photography equipment.
- Lights must be dimmed.
- Do not allow easy conversion to handouts for student notes.

Props (*Hear it, see it or do it*)

Advantages
- Add spice.
- People remember them.

Disadvantages
- May be heavy or bulky.
- Distracting if not perfectly suited to presentation.

Further Training Techniques

- Distance learning with use of web-based training, CDs or combinations of technological tools and classroom.
- Picture telecommunication (also known as “PicTel”).
- Satellite transmissions: It is the responsibility of the preceptor and students as well as the certified surveyor to keep abreast of all broadcasts, preview them, and provide the State trainer with a certificate of completion.
- Computerized independent study courses.
- Independent study guides.
- Videotaping.

Section 1-F: Sample Skill Assessment Procedure

Sample Skill Assessment Procedure

Measurement of surveyor progress in mastery of skills necessary to perform accurate, complete and timely surveys is a key objective of the training program at each State agency and Regional Office. For this reason, the manual includes sample skill assessments to use when training the new surveyor. The criteria listed are those that new surveyors must meet to demonstrate their knowledge and understanding of information vital to their work and to new surveyor training.

The following is a sample procedure that may be used by either State agency or Regional Office staff when using the skill assessment forms. It may be modified as desired.

Instructions for Completing the Skill Assessment Form

Provide the new surveyor with a copy of the skill assessment for each lesson. Alternately, provide the new surveyor with a copy of all skill assessment forms for all lessons that will be used throughout the training. The intent is that the surveyor may use the form(s) during training to familiarize himself/herself with the criteria that will be used to assess how well he/she has learned information from the lesson(s).

For each lesson, determine who (i.e., training administrator, preceptor or supervisor) will be using the skill assessment form and the date it will be used. Provide the new surveyor with this information at least two working days before using a particular assessment form the first time and any subsequent time it will be used.

Each surveyor should have at least one opportunity to observe an experienced surveyor demonstrate the skills in question and an opportunity to actually perform the task before the skill assessment form is used.

Use only a nonerasable pen to complete the form. If a mistake is made, the person completing the form should strike it through once and initial the strike through.

The person assessing training should record the first and last name of the surveyor and his/her own name as well as the month, day and year the skill assessment is completed. If the form is used for more than one day, record all dates.

Before the skill assessment form is used, the surveyor and preceptor should review the listed skills to familiarize themselves with the listed criteria. This may be done individually or together (as mutually agreed) before the form is used.

The preceptor will directly assess the new surveyor's ability to meet the written criteria.

- Each point and subpoint should be assessed (i.e., all numbered and lettered criteria).
- The preceptor should write comments to support the assessment as required by the form. These should identify the need for continued and/or additional training that is not necessarily task-oriented.
- The preceptor should complete the written assessment of skills in a timely manner.

The preceptor should discuss the written assessment with the new surveyor in a timely manner so that the new surveyor may write any additional comments on the form by the end of the next working day.

The original completed form should be given to the new surveyor's supervisor.

A copy of the completed form should be provided to the following:

- New surveyor.
  - The new surveyor should keep the copies of the completed forms together in a folder and have them easily available for any preceptor who requests them or the surveyor's immediate supervisor.
- Preceptor who used the form.
- State training administrator (if this person was not the preceptor).

The supervisor can sign the form, indicating review. Reviews in a timely manner will encourage changes in the training plan for a new surveyor making slower-than-normal progress.

The individual who is assigned this responsibility by State agency/Regional Office procedure will review and evaluate the new surveyor's written training plan to determine whether all training needs identified on the skill assessment forms are included (i.e., training needs where the surveyor is not yet able to perform the skills for each lesson independently or with minimum supervision, and those added on each skill assessment form).

Any changes made to the individual surveyor's written training plan will be copied and provided to the individual surveyor and any preceptor for that person.

It is expected that the new surveyor's ability to meet skill assessment criteria with greater independence will improve through the training period. Therefore, if the new surveyor is assigned to more than one preceptor, each new preceptor should be made aware of the new surveyor's current ability to perform skills listed on previous skill assessments.

The original forms must be maintained as required in the State/Regional Office procedures.

Supervisory staff, rather than the preceptor or State/Regional training administrator, are responsible for counseling the new surveyor and establishing a plan for remediation. This plan is to be communicated in a timely manner to the State/Regional Training administrator/preceptor(s).

State/Regional Office procedures should address the use of the skill assessment forms in the new surveyor's written evaluation.

Section 1-G: Performance Variability

Performance Variability

Almost every individual and organization can exhibit poor or below-expected performance. Frequently, training is proposed as a method to remedy a performance problem; however, training is effective only if the primary reason for poor performance is a lack of necessary skills and knowledge. If the performance problem involves something the surveyor should already know, look for other underlying causes such as organizational barriers or lack of motivation. Even the best programs cannot resolve organizational problems, nor can they motivate surveyors who lack a desire to perform. In those cases, training will only lead to misdirected resources, frustrated employees, and an ongoing performance problem.

The following points should be considered when evaluating a performance issue.

Management's View of the Performance Discrepancy

- What is management's view of the surveyor's performance?
- When did supervisors become aware of or dissatisfied with the surveyor's performance?
- How does the supervisor's expectation compare to the surveyor's performance?

Reasons for Addressing a Performance Problem

- The impact on the program or negative outcome resulting from substandard performance.
- Underutilization of surveyor's potential.
- Cost or budget considerations when surveyors are not working effectively.
- Changing expectations of desired performance.
- Identification of better resources for improving the surveyor's work.

Assessment of the Surveyor's Knowledge/Skill Base and Potential

- What skills or knowledge does the surveyor need?
- What was the surveyor's past training or experience, including methods used?
- Does the surveyor have the mental and physical capability for the work?
- What other training method(s) would be more effective? Is further training feasible?
- What training approaches would be optimal for the surveyor: formal or informal classroom or one-to-one?

Possible Obstacles to Improving Surveyor Performance

- Unclear expectations, or expectations not consistent with the surveyor's understanding or job description.
- An overqualified surveyor.
- Surveyor stress and inability to perform.
- Conflicting demands on the surveyor's time or the need for work prioritization.

- Lack of structure to define tasks (policies and procedures).
- The need for a tool or job aid (forms, software, hardware, etc.).
- Environmental or workplace hindrances to performance.
- Lack of regular performance feedback.
- Lack of direction or support from management.
- Unclear or contradictory agency policies.
- Not enough time allotted for mastery of skills or acquiring knowledge.

Interventions other than Formal Training

- Removing obstacles that restrict performance.
- Discussing possible solutions with the surveyor.
- Changing the motivation system.
- Improving documentation of performance.
- Redesigning the job.
- Developing performance aids.
- Changing the physical environment.
- Changing hiring or assignment practices.
- Using on-the-job training.
- Calculating the average time required to attain mastery.

Performance Variability Worksheet

What is management's view of the performance discrepancy?

What is management's view of the surveyor's performance?
When did supervisors become aware of/dissatisfied with the surveyor's performance?
How does the supervisor's expectation compare to the surveyor's performance?

What are the reasons for addressing the performance problem?

Minimizing impact on the program or negative outcome from the substandard performance?
Priority 1 (low) to 5 (highest): _____ Explain:
Underutilization of surveyor's potential?
Priority 1 (low) to 5 (highest): _____ Explain:
Mitigating cost or budget impact when surveyors are not working effectively?
Priority 1 (low) to 5 (highest): _____ Explain:
Meeting changed expectations of desired performance?
Priority 1 (low) to 5 (highest): _____ Explain:
Better resources for improving the surveyor's work have been identified?
Priority 1 (low) to 5 (highest): _____ Explain:

Performance Variability Worksheet (cont.)

Assess the surveyor's knowledge/skill base and potential.

What skills or knowledge does the surveyor need?
What was the surveyor's past training or experience, including methods used?
Does the surveyor have the mental and physical capability for the work?
What other training method(s) would be more effective? Is further training feasible?
What training approaches would be optimal for the surveyor: formal or informal, classroom or one-to-one?

Performance Variability Worksheet (cont.)

What are possible obstacles to improving surveyor performance?

Unclear expectations, or expectations not consistent with the surveyor's understanding or job description? Y / N
Explain:
An overqualified surveyor? Y / N
Explain:
Surveyor stress and inability to perform? Y / N
Explain:
Conflicting demands on the surveyor's time or the need for work prioritization? Y / N
Explain:
Lack of structure to define tasks (policies and procedures)? Y / N
Explain:
The need for a tool or job aid (forms, software, hardware, etc.)? Y / N
Explain:
Environmental or workplace hindrances to performance? Y / N
Explain:
Lack of regular performance feedback? Y / N
Explain:
Lack of direction or support from management? Y / N
Explain:
Unclear or contradictory agency policies? Y / N
Explain:
Not enough time allotted for mastery of skills or acquiring knowledge? Y / N
Explain:

Performance Variability Worksheet (cont.)

To address the identified issue, formal training may not be needed. Prioritize interventions.

Removing obstacles that restrict performance.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Discussing possible solutions with the surveyor.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Changing the motivation system.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Improving documentation of performance.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Redesigning the job.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Developing performance aids.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Changing the physical environment.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Changing hiring/assignment practices.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Using on-the-job training.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:
Calculating the average time required to attain mastery.
Feasible? Y / N If Yes, assign priority: 1 (low) to 5 (highest) _____ Plan:

Performance Variability Worksheet (cont.)

Training plan:

Training subject	Resource	Target completion date

Performance Variability Worksheet (cont.)

Training plan:

Training subject	Resource	Target completion date

Section 1-H: Maintenance of Training Records

Maintenance of Training Records

Each State agency and Regional Office needs to identify, then implement and maintain, a system that tracks staff education and training. Reasons include the need to demonstrate that surveyors and other staff have received training required either by the Centers for Medicare & Medicaid Services (CMS) or by the office in which the individual is employed, as well as to justify funding needs and expenditures for staff education and training programs.

Each State agency and Regional Office may design its record-keeping system so that it best meets its operation. However, at a minimum, each office needs to track the training required by CMS for each appropriate individual in order to document the Federal budgeted monies spent in this pursuit. To the extent appropriate, each office needs to use the web-based Learning Management System, better known as LMS.

Use of the Learning Management System

In 2001, CMS implemented a tracking system that, at a minimum, tracks the training of individuals who are nominated for and attend training sponsored by CMS's Central Office. In addition, each State agency and Regional Office trainer may also use the system to track training provided by his/her office to survey and certification staff regarding Federal policies, procedures and requirements.

Each State agency and Regional Office trainer is required to use the LMS to nominate individuals to attend CMS training sponsored by the Central Office.

Yearly, CMS conducts training to familiarize trainers with the LMS. Classes are held in the Baltimore area. Each trainer and back-up trainer is expected to attend training, after which each individual is issued a unique identifier and password (which should be kept confidential) to use when accessing the system. During training, each individual will learn how to use the system. Instructors will provide this information in a manual issued to each individual during the class.

CMS mandatory training

Staff at CMS continually receive questions about the extent and depth of training provided to surveyors and certification staff regarding CMS policies, procedures and requirements. As a result, CMS has determined that certain training is required of individuals who perform certain work. For example:

- Survey and Certification Letter #02-01, Abuse and Neglect Detection and Prevention Training, requires surveyor training to detect abuse and neglect during surveys.
- Survey and Certification Letter #02-31, Mandatory Viewing of Satellite and Webcast Training Program, requires viewing of selected CMS satellite transmissions and webcasts by certain State agency and Regional Office staff as well as contractors who may be responsible for certain activities.
- Survey and Certification Letter #03-05, Fiscal Year 2003 Training Requirements for End Stage Renal Disease, Home Health Agency, Hospice and Intermediate Care Facility for the Mentally Retarded Surveyors, requires individuals who survey these types of providers and suppliers to complete required training before surveying them independently.

- Some CMS classes require the nominee to complete prerequisite training before attending training. For example, each individual must complete training about the Principles of Documentation before attending a basic surveyor class. Life Safety Code surveyors must also complete additional training provided in CD-ROM form to each State agency and Regional Office.
- *State Operations Manual (SOM)* Section 4009C, Education, Training and Experience, requires newly hired surveyors to successfully complete an orientation program approved by CMS that includes the core elements of the CMS-developed orientation program and requires that health facility surveyors, laboratory surveyors and Life Safety Code surveyors successfully complete, within the first 12 months of employment, the basic surveyor training course developed under CMS auspices, including all course prerequisites.
- *SOM* Section 4009.1, Federal Minimum Qualification Standards for Long Term Care Facility Surveyors, also requires surveyors to attend the basic long term care surveyor training and pass the Surveyor Minimum Qualifications Test before surveying long term care facilities independently for fulfillment of Federal requirements.

Tracking CMS required training

You must track, for individuals, including surveyors, certification staff and contractors (e.g., Life Safety Code surveyors, laboratory surveyors and others), all required CMS training completed. It is strongly suggested that you use the LMS to track completion of required CMS training, including satellite transmissions and webcasts.

The LMS is also programmed to prohibit the nomination of an individual to attend certain classes until the proposed nominee has completed the required prerequisites and their completion is recorded in the LMS.

The list of resources found in an Appendix of this manual includes a list of training delivered by satellite transmission or webcast that is mandatory for certain individuals. Contact your Regional Office training administrator for an up-to-date list.

Optional tracking of other training

Each State agency and Regional Office is responsible for providing continuing education to its surveyors. This education may be provided through in-service training, State, regional or national conferences, seminars and workshops and related courses as needed and appropriate within the fiscal limitations approved by CMS. Your office should have a system that tracks this training and the related expenditures.

Other tracking systems

Keeping track of each surveyor's training can be a complex task, depending on your office's mechanism for collecting these data. Included at the end of this section are samples of forms that can be used to track completed training. However, most offices now use database or spreadsheet software to track employment and training information. If you are developing a new tracking system using such software, consider first reviewing the information included in the LMS for each person and class, as well as the information listed on the forms included here.

To Be Completed by All New or Reinstated Surveyors

Please print or type.
Please submit this report with the quarterly SET report.

Surveyor ID Number:

1. **Surveyor Name** (First/MI/Last)	2. **Federal** RO	3. **State**	**State Region**	4. **Date Form Prepared** (Month/Day/Year)

5. Please indicate the number of years in the Health Care Field: _____

6. **Date of Employment**	7. **Employment** Full-time—Part-time	8. **Age Range** 20–25 ___ 25–35___ 36–45___ 46–55 ___ 55+ ___

9. Profession
(Check only one of the following which best describes the surveyor's professional discipline).

____01 Accredited Record Admin.
____02 Architect.
____03 Cytotechnologist.
____04 Doctor of Medicine.
____05 Doctor of Medicine/QMRP.
____06 Doctor of Osteopathy.
____07 Doctor of Osteopathy/QMRP.
____08 Engineer.
____09 Generalist Surveyor.
____10 Hospital/Health Care Admin.
____11 Human Services Prof/QMRP.
____12 Laboratorian/Medical Tech.
____13 Licensed Practical/Vocational Nurse.
____14 Life Safety Code Specialist.
____15 Nursing Home Administrator.
____16 Nutritionist/Dietitian.
____17 Nutritionist/Dietitian/QMRP.
____18 Occupational Therapist.
____19 Occupational Therapist/QMRP.
____20 Pathologist.
____21 Pharmacist.
____22 Physical Therapist.
____23 Physical Therapist/QMRP.
____24 Psychologist.
____25 Psychologist/QMRP.
____26 Recreational Therapist.
____27 Recreational Therapist/QMRP.
____28 Registered Nurse.
____29 Registered Nurse/QMRP.
____30 Registered Record Administrator.
____31 Sanitarian.
____32 Social Worker.
____33 Social Worker/QMRP.
____34 Speech/Audiology Therapist.
____35 Speech/Audiology Therapist/QMRP.
____36 Other (specify) _____

10. **Education Attainment:** Check all that apply:

____01 High School.
____02 Technical School Certificate.
____03 Practical Nursing School (LPN/LVN).
____04 Diploma in Nursing.
____05 Associate Degree.
____06 Baccalaureate Degree.
____07 Some Graduate Work (College).
____08 Graduate Degree (specify major) _____

11. Please provide the month and year when this surveyor attended the following CMS sponsored classes:

_____Basic Long Term Care.
_____Basic Hospital.
_____Basic Home Health Agency.
_____Basic Hospice.
_____Basic ICF/MR.
_____Basic Life Safety Code.
_____Basic Laboratory.
_____Other CMS Basic classes (specify).

12. Indicate the provider/supplier types you will be trained to survey:

____Ambulatory Surgical Centers.
____Clinical Laboratories.
____Comprehensive Outpatient Rehab Facilities.
____End State Renal Disease.
____Home Health Agencies.
____Hospices.
____Hospitals.
____Intermediate Care Facility/Mentally Retarded.
____Life Safety Code.
____Long Term Care.
____Rehabilitation Agencies.
____Other (specify).

E-Mail address:

Office address:

Office phone:

Office fax:

Signature: _____

Date: _____

Employee Continuing Education and Training Record

Employee Name **Region** **Discipline**

Current Quarter **Federal ID #**

Name of Seminar or Inservice Training Attended (include description of content)	Date Attended (month-day-year)	# Contract Hours	#CEUs	Cost	Inservice Training (Check here)

Include all workshops and inservice training (i.e., supervisors' meetings, updates on regulations or survey process, educational staff meetings, conference attendance, etc.). **Please Print Legibly**.

Section 2: General Surveyor Training

Lesson 2-A: Orientation to the Workplace

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Provide information needed for employment.
- Receive information initially needed for employment.
- Demonstrate your initial understanding of information received.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 4, Section 4009

State

(Insert State reference[s] here.)

Other

Highlights

- Provide list of information needed for the new employee
- Provide list of information the new employee initially needs
- Provide format that will enable you to determine the employee's initial understanding of information received

Training Techniques

- Individual tour
- Individual discussion

Training Aids

- Handout:
  - *Orientation to the Workplace*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Completion of *Orientation to the Workplace* handout

Development of Office Policies and Procedures

When a new staff member reports for work, he/she should receive an orientation to the workplace. This process includes securing information from the new employee to establish his/her name for payroll purposes and to initiate certain benefits. This is when State agency/Regional Office staff begin to provide the new employee with information that will be vital to his/her successful employment. The orientation process also provides the employer with an opportunity to impart to the new employee a professional attitude toward business that is conducted in the office; it also sets the standard of conduct for business outside of the office.

Each office should have a coordinated method to ensure that new employees receive the needed information, tools and resources to ensure they succeed in carrying out the duties of their position. This lesson contains a sample form that can be modified to meet your office needs. Although the trainer or preceptor may arrange for others to provide specific information (e.g., a supervisor, office manager, or clerical or other appropriate staff member), the trainer or preceptor should question the new employee to determine his/her understanding of the information. The form contains a space for the preceptor or his/her designee to initial when the information is provided to the employee (verbal, written or as required). The new surveyor/employee can also initial the appropriate space when he/she receives and understands the information. Because of the amount of information contained in the sample form, this process may take several days.

Skill Assessment

Orientation to the Workplace

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Provided information needed for employment.	
					Received information initially needed for employment.	
					Demonstrated his/her initial understanding of information received.	

Comments/Recommendations:

Orientation to the Workplace
[Name of State agency/Regional Office]
[Date of implementation or revision]

Directions for use:

- Preceptor/designee:
  - Tour the building and office, then provide required documents.
  - Discuss the information listed.
  - Initial and date each section when completed.
- New employee:
  - Initial each section when information is understood.
  - Write comments as needed (e.g., information not clearly understood or further information needed).
  - File the form as required by office policies and procedures.

Instructions	Preceptor/ Designee	New Employee	Comments
Before the Employee Arrives Prepare the work area (desk, chair, telephone, trash container, computer, printer, in-out baskets, calendar, stapler, staple remover, pens, pencils, writing paper, phone book(s), helpful telephone numbers, maps, name tag and other supplies).			
Oath of Office/Allegiance			
Tour Location and Building Parking.			
Area restaurants/cafeteria.			
Security to enter office (code/number).			

Instructions	Preceptor/ Designee	New Employee	Comments
Break room/coffee-snack area.			
Restroom.			
Emergency exits.			
Procedures for fire/bomb threat/earthquake/tornado.			
Tour Department/Office Introduce to staff.			
Procedures to report in and out.			
Mailbox.			
Telephone messages.			
Fax machine.			
Copy machine.			
Shredder.			

Instructions	Preceptor/ Designee	New Employee	Comments
Supplies. Office. Survey.			
File location.			
Resource manuals and books.			
State/Federal Orientation Manual Provide/receive copy.			
Identification Photo/identification badge.			
Assign Federal/State number.			
Assign other/position number.			
General Work Information and Completion of Forms Health plan/medical examination.			
Dental plan.			
Vision plan.			
Individuals to contact in case of illness, accident, emergency (family, physician, significant other).			

Instructions	Preceptor/ designee	New Employee	Comments
Employee assistance program.			
Retirement Information Retirement plan (and options).			
Designation of beneficiary.			
Payroll Pay period.			
Wage.			
Common deductibles.			
Optional deductibles and deferred compensation programs (e.g., life insurance, 401(k)/(a)).			
W-2.			
Direct deposit authorization/distribution of paycheck and earnings statement.			
Credit Cards Corporate credit card.			

Instructions	Preceptor/ Designee	New Employee	Comments
Telephone card.			
Responsibilities.			
Limitations.			
Expected behaviors.			
CMS Surveyor Characteristics Form (complete)			
Standard Operating Forms, Procedures, Expected Behaviors, and Professional Performance, Union Contract and Name of Union Representative(s) (if applicable)			
Working Days/Hours Legal holidays.			
Normal/alternate work hours.			
Meal and break periods.			
Working: Credit hours.			

Instructions	Preceptor/ Designee	New Employee	Comments
Overtime.			
Compensatory time.			
Weekends.			
Working at home.			
Working at other work sites (in State/out of State).			
Recording time (e.g., time sheet).			
Travel (related to official work time).			
Vacation/annual leave accrual.			
Sick leave accrual.			
Request for leave: Vacation.			
Medical/dental appointments.			

Instructions	Preceptor/ Designee	New Employee	Comments
Family illness.			
Death.			
Absences: Unplanned absence from work or delay in reporting to work (e.g., illness of self or significant other, emergency, etc.).			
Planned absence from work or during workday.			
Leave of absence.			
Family and Medical Leave Act.			
Work-related injury.			
Illness and injury prevention program.			
Security Office (keys, equipment, identification, State/Federal vehicle, cellular phone, computer, etc.).			

Instructions	Preceptor/ Designee	New Employee	Comments
Personal (e.g., parking, purse, travel, hotel).			
Conduct/Expected Behavior Changes to information provided on forms.			
Dress in office and at other work sites.			
Confidentiality.			
Report of contact with providers/others.			
Public affairs and the media.			
Speaking engagements.			
Sexual harassment.			
Political activity.			
Smoking.			

Instructions	Preceptor/ Designee	New Employee	Comments
Alcohol and substance abuse.			
Maintenance and security department records.			
Computer.			
Internet.			
Postemployment restrictions.			
Conflict of interest/ incompatible or prohibited activities (official position, outside employment, supplies, gifts, money, favors, market products, etc.).			
Telephone usage (at desk and cellular).			
Incoming mail/confidential mail.			
Emergency duty roster and call list.			
Use of Equipment Telephone procedures.			

Instructions	Preceptor/ Designee	New Employee	Comments
Significant telephone numbers.			
Copy machine.			
Fax machine.			
Computer and printer.			
Writing document.			
Internet: Office site.			
State *Operations Manual (SOM).*			
Code of Federal Regulations.			
Other commonly used software: Access/database software.			
Excel/spreadsheet software.			
PowerPoint.			

Instructions	Preceptor/ Designee	New Employee	Comments
Automated Case Tracking System (ACTS).			
Automated Survey Processing Environment (ASPEN).			
Other: Ordering supplies and additional equipment.			
Filing system.			
Routing system.			
Mail (personal and office).			
Resource individuals: Telephone numbers. E-mail addresses.			
Job Description/Duties Performance appraisal procedure (including timing and potential outcomes).			
Probationary period.			
Grievances.			
Roles and Responsibilities of the Preceptor Trainee			

Instructions	Preceptor/ Designee	New Employee	Comments
Communication with Supervisor(s)			
Survey-Related Information State/Federal vehicle. Procedure to get a vehicle.			
Gasoline use and purchase.			
Vehicle maintenance and location to have done.			
Accident procedures.			
Restrictions (use, maintenance, other).			
Use of private vehicle (e.g., reimbursement rate and accident/insurance coverage).			
Allowance/reimbursement (e.g., form to complete, what is allowed and not allowed, mileage record).			
Travel and Reservation Procedures Making reservations.			
Hotel/motel rates: in State (e.g., rural versus urban areas), out of State.			
Airline.			

Instructions	Preceptor/ Designee	New Employee	Comments
Rental vehicle.			
Cabs/shuttle/other.			
Travel advance.			
Reimbursement procedure and time frames.			
Tracking/Documenting Training Assignments and Progress Assignment sheets.			
Orientation skills checklist.			
Professional development and/or training requests for training outside the office.			
State licensing requirements.			
Receive Copies to be Used Later in Training *State Operations Manual (SOM)* with appropriate appendices.			
Long Term Care Resident Assessment Instrument User's Manual.			

Instructions	Preceptor/ Designee	New Employee	Comments
Principles of Documentation (PoD).			
ASPEN manual.			
State licensing requirements.			
List of State facilities/providers and suppliers.			
Federal survey and certification letters.			
List of Federally mandated training videos/webcasts based on employee position.			
State directives regarding survey and certification policies and procedures and other related information.			
Federal directives regarding survey and certification policies and procedures.			
Other: Personnel procedure handbook. Employee orientation manual. Electronic resources/manuals. Electronic forms.			

Sign when the entire form has been completed:

Surveyor Signature _____ **Date** _____

Preceptor Signature _____ **Date** _____

New Employee's Supervisor's Signature _____

Date _____

Lesson 2-A-1: Abbreviations, Acronyms and Common Terms

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify common abbreviations, acronyms and common terms used in both State licensing and Federal survey and certification processes.
- Apply these abbreviations, acronyms and common terms in your work.

Lesson Plan

References

Federal

- *State Operations Manual (SOM)*

State

(Insert State reference[s] here.)

Other

Highlights

- List of abbreviations, acronyms and common terms used in both State licensing and Federal surveys and certification

Training Techniques

- Self-study
- Group discussion
- Individual or small group exercise

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - *Abbreviations, Acronyms and Common Terms*
  - *Match the Common Terms with the Definitions*
  - *CMS Acronyms Word Square*

Methods of Evaluation

- Verbalization and discussion of understanding
- Completion of skill assessment

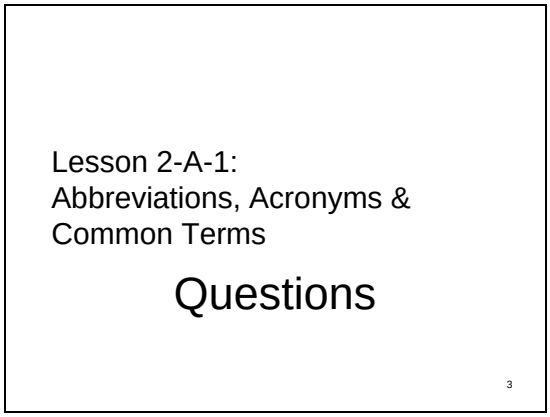
Audiovisual	Outline or text of presentation
Lesson 2-A-1: Abbreviations, Acronyms & Common Terms 1 Slide 2-A-1-1	During the survey process, you will see and hear various abbreviations, acronyms and terms.
Learning Objectives At the conclusion of this lesson, you will be able to: • Identify common abbreviations, acronyms & common terms used in both State licensing & Federal survey & certification processes. • Apply these abbreviations, acronyms & common terms in your work. 2 Slide 2-A-1-2	*(Inform the students of the objectives.)*
	(Using the handout "Abbreviations, Acronyms and Common Terms" on page 2-A-1-9 as a tool, review and discuss each section, pointing out abbreviations, acronyms and terms the surveyor will most likely hear or use when surveying. *Determine whether the students will work independently or in small groups. Refer students to the handout "Match the Common Terms with the Definitions" on page 2-A-1-23 and tell them they have 20 minutes to complete the activity.*

Audiovisual

Outline or text of presentation

Review the correct answers on page 2-A-1-25 and discuss concerns identified.

Refer students to the handout "CMS Acronyms Word Square" on page 2-A-1-27. Ask each trainee to complete it and return it to you by a specified date.)



Slide 2-A-1-3

Skill Assessment

Abbreviations, Acronyms and Common Terms

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Verbalized the meaning of the following abbreviations: • CMS. • ESRD. • IJ. • OBRA. • POC. • OSCAR.	
					Verbalized the meaning of the following medical terms: • AC. • AROM. • BID. • CVA. • QD.	
					Applied abbreviations, acronyms and common terms accurately on the job.	

Comments/Recommendations:

Abbreviations, Acronyms and Common Terms

Survey Related

ADR	adverse drug reaction
CCU	coronary care unit
CFR	*Code of Federal Regulations*
COBRA	Consolidated Ombudsman Budget Reconciliation Act
COP	Condition of Participation
CS	central supply
DME	durable medical equipment
DRG	diagnosis-related group
DUR	drug utilization review
EMTALA	Emergency Medical Treatment and Active Labor Act
FMS	Federal monitoring survey
FOSS	Federal oversight support survey
FR	*Federal Register*
FSES	Fire Safety Evaluation System
HACCP	Hazard Analysis and Critical Control Point
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HVAC	heating, ventilation and air conditioning system (of a building)
ICD	International Classification of Diseases
ICU	intensive care unit
IG	interpretive guidelines
IJ	immediate jeopardy
IOC	inspection of care
LTC	long term care
MDS	Minimum Data Set
NLTC	non–long term care
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act (usually followed by a year)
PASARR	preadmission screening and annual resident review
POC	Plan of Correction
QA	quality assurance
QAPI	quality assurance and performance improvement
QC	quality control
QI	quality improvement *or* quality indicator
QOC	quality of care
QOL	quality of life
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RTA	regional training administrator
RUG	resource utilization groups
SOD	Statement of Deficiencies (Form CMS-2567)
SRF	survey report form

S/S	scope and severity
SQC	substandard quality of care
SSA	Social Security Act *or* Social Security Administration
UC	utilization control
UO	unusual occurrence
UR	utilization review

Certification Related

ACC	automatic cancellation clause
ACD	automatic cancellation date
ACR	adjusted community rate
ADA	Americans with Disabilities Act
ADR	alternative dispute resolution
a/k/a	also known as
AO	accrediting organization
BBA	Balanced Budget Act (of 1997)
bene	beneficiary
C&T	Certification and Transmittal (Form CMS-1539)
CHOW	change of ownership
CMP	civil monetary penalty
CO	Central Office (CMS's office in Baltimore, Maryland)
CoC	Condition of Coverage
CON	certificate of need
CRIPA	Civil Rights of Institutionalized Persons Act
DAB	Department Appeals Board
d/b/a	doing business as
DP	distinct part
FFP	Federal financial participation
FI	fiscal intermediary
FOIA	Freedom of Information Act
FY	fiscal year
GAO	General Accounting Office
IDR	informal dispute resolution
LSC	Life Safety Code
MSA	Medicaid State agency *or* Medicaid single State agency
MTS	Medicare Transaction System
OCR	Office of Civil Rights
ODIE	Online Data Input and Edit System
OGC	Office of General Council
OIG	Office of Inspector General
OSCAR	Online Survey and Certification Reporting System
Part A	Provider Reimbursement - Medicare
Part B	Supplier and Physician Reimbursement - Medicare
PPS	prospective payment system
RO	Regional Office
SA	State agency *or* State survey agency

SOM	*State Operations Manual*
TANF	Temporary Assistance for Needy Families
Title V	Social Security Act - Maternal and Child Health Benefits
Title VI	Civil Rights Act
Title XVIII	Social Security Act - Medicare Program
Title XIX	Social Security Act - Medicaid Program
TLA	time-limited agreements

Medically Related

AAROM	active assistive range of motion
ABG	arterial blood gases
ac	before meals
ADLs	activities of daily living
AIDS	autoimmune deficiency syndrome
ARC	AIDS-related complex
AROM	active range of motion
ASAP	as soon as possible
ASHD	arteriosclerotic heart disease
BCG	bacille Calmette-Guérin
bid	twice a day
BIPAP	bi-level positive airway pressure
BKA	below the knee amputation
bp	blood pressure
bx	biopsy
C	celsius *or* centigrade
c (with line over it)	with
CA	cancer *or* carcinoma
CABG	coronary artery bypass graft
CAPD	continuous ambulatory peritoneal dialysis
cc	cubic centimeter
C. diff	*Clostridium difficile*
CHF	congestive heart failure
CNS	central nervous system
COLD	chronic obstructive lung disease
COPD	chronic obstructive pulmonary disease
CP	cerebral palsy
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CT	computerized tomography
CV	cardiovascular
CVA	cerebral vascular accident *or* stroke
CVD	cardiovascular disease
D&C	dilation and curettage
D&E	dilation and evacuation
DD	developmentally disabled

DJD	degenerative joint disease
DM	diabetes mellitus
DOD	date of death
DTP	diphtheria, tetanus, pertussis
DVT	deep vein thrombosis
dx	diagnosis
ECG/EKG	electrocardiogram
EEG	electroencephalogram
EENT	eye, ear, nose and throat
e.g.	for example
EMS	emergency medical services
ESRD	end stage renal disease
etc.	*et cetera*, meaning and other things *or* and so forth
F.	Fahrenheit
FSH	follicle stimulating hormone
fx	fracture
GI	gastrointestinal
gm	gram (30 grams = 1 ounce)
GYN	gynecology
HBV	hepatitis B virus
HCG	human chorionic gonadotropin
Hct	hematocrit
HCV	hepatitis C virus
HDL	high-density lipoprotein
Hgb	hemoglobin
H&P	history and physician
HIV	human immunodeficiency virus
HPV	human papilloma virus
HS	hour of sleep *or* bedtime
ht	height
hx	history
I&D	incision and drainage
I/O *or* I&O	intake and output
IDDM	insulin-dependent diabetes mellitus
i.e.	that is
IG	immune globulin
IM	intramuscularly
IV	intravenous
kcal	kilocalorie *or* calorie
kg	kilogram (2.2 pounds)
KVO	keep vein open
LDL	low-density lipoprotein
LH	luteinizing hormone
LMP	last menstrual period
MAR	medication administration record
meds	medications
mg	milligram

MH	mental health
MI	mental illness *or* myocardial infarction *or* heart attack
ml	milliliter
mm	millimeter
MR	mental retardation
MRSA	methicillin-resistant *Staphylococcus aureus*
NIDDM	non–insulin-dependent diabetes mellitus
NGT	nitroglycerin
OA	osteoarthritis
OB	obstetrics *or* obstetrician
OBS	organic brain syndrome
OPD	outpatient department
OR	operating room
Pap	Papanicolaou cervical smear
pc	after a meal
PE	physical examination
PEG	percutaneous endoscopic gastrostomy tube
PKU	phenylketonuria
PO	*per os*, meaning by mouth
PPD	purified protein derivative
ppm	parts per million
PRN	as necessary
PROM	passive range of motion
PUD	peptic ulcer disease
PVD	peripheral vascular disease
q	every
qd	every day
qh	every hour
q2h	every two hours
qid	four times a day
qod	every other day
RA	rheumatoid arthritis
RBC	red blood cells
rehab	rehabilitation
ROM	range of motion
Rx	prescription
s (with line over it)	without
SARS	severe acute respiratory syndrome
SART	sexual assault response team
SL	sublingual, meaning under the tongue
SOB	shortness of breath
SQ	subcutaneous, meaning under the skin
stat	immediately
STD	sexually transmitted disease

TB	tuberculosis *or* tubercle bacillus
TIA	transient ischemic attack
tid	three times daily
TPN	total parenteral nutrition
TSH	thyroid-stimulating hormone
tx	treatment
UA	urinalysis
URI	upper respiratory infection
UTI	urinary tract infection
VRE	vancomycin-resistant enterococcus
WBC	white blood cells
WC	wheelchair
wt	weight

Individuals

ACSW	accredited social worker
ALJ	administrative law judge
ARNP	advanced registered nurse practitioner
CEO	chief executive officer
CFO	chief financial officer
COTA	certified occupational therapy assistant
CRNA	certified registered nurse anesthetist
DCS	direct care staff
DNS	director of nursing service
DO	doctor of osteopathy
DON	director of nursing
DSD	director of staff development
GN	graduate nurse
LCSW	licensed clinical social worker
LD	licensed dietitian
LPN	licensed practical nurse
LPT	licensed physical therapist *or* licensed psychiatric technician
LVN	licensed vocational nurse (same as LPN)
MA	medical assistant
MD	doctor of medicine *or* medical director
MRA	medical record administrator
MSW	master of social work
MT	medical technologist
NHA	nursing home administrator
NP	nurse practitioner
OOT	outpatient occupational therapist
OTIP	occupational therapist in independent practice
OPT/SP	outpatient physical therapy/speech pathology services
OT	occupational therapist

PA	physician's assistant
PHN	public health nurse
PT	physical therapist
PTIP	physical therapist in independent practice
QMHP	qualified mental health professional
QMRP	qualified mental retardation professional
RA	restorative aide
RD	registered dietitian
RN	registered nurse
RNA	restorative nursing assistant
ROT	registered occupational therapist
RPS	registered professional sanitarian
RPT	registered physical therapist
RRA	registered record administrator
RRL	registered record librarian
RS	registered sanitarian
RT	recreational therapist
ST	speech therapist
SP	speech pathologist

Federally Certified Providers and Suppliers

ASC	ambulatory surgical center
CAH	critical access hospital
CLIA	Clinical Laboratory Improvement Amendments (of 1988)
CMHC	community mental health center
CORF	comprehensive outpatient rehabilitation facility
ESRD	end stage renal disease
FQHC	Federal qualified health center
HHA	home health agency
ICF/MR	intermediate care facility for the mentally retarded *or* intermediate care facility for mentally retarded individuals
LTC	long term care
NF	nursing facility
OPO	organ procurement organization
OPT	outpatient physical therapy
PRTF	psychiatric residential treatment facilities for children 21 years or under
RHC	rural health clinic
SNF	skilled nursing facility (pronounced "sniff")

Additionally, the following are certified: hospice, hospitals (acute, children's, long term care, psychiatric and rehabilitation), hospital swing-beds and portable X-rays.

Organizations

AAA	Administration on Aging
AAHSA	American Association of Homes and Services for the Aging
AARP	American Association of Retired Persons
ABR	American Board of Radiology
ACDD	Accreditation Council for Services to Persons with Developmental Disabilities
ACHCA	American College of Health Care Administrators
ACP	American College of Physicians
ACS	American College of Surgeons
ACT-UP	AIDS activist group
ADA	American Dental Association *or* American Dietetic Association *or* American Diabetes Association
AFHHA	American Federation of Home Health Agencies
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
AHA	American Heart Association *or* American Hospital Association
AHCA	American Health Care Association
AHFSA	Association of Health Facility Survey Agencies
AMA	American Medical Association
AMT	American Medical Technologists
ANA	American Nurses Association
ANSI	American National Standards Institute
ANHA	American Nursing Home Association
AOA	American Osteopathic Association
APA	American Psychiatric Association
APHA	American Pharmaceutical Association
ARC	Aid to Retarded Citizens *or* Association for Retarded Citizens
ASCP	American Society of Clinical Pathologists
ASHA	American Speech and Hearing Association
ASTD	American Society for Training & Development
BC	Blue Cross
BLUES	Blue Cross and Blue Shield
BS	Blue Shield
CAP	College of American Pathologists
CDC	Centers for Disease Control
CMS	Centers for Medicare & Medicaid Services
CHAP	Community Health Accreditation Program
DHHS	Department of Health and Human Services
DMA	Dietary Managers Association
FDA	Food and Drug Administration
HMO	Health Maintenance Organization
IACET	International Association for Continuing Education and Training
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NCCNHR	National Citizens Coalition for Nursing Home Reform

NCSC	National Council for Senior Citizens
NEHA	National Environmental Health Association *or* National Executive Housekeepers Association
NFPA	National Fire Protection Association
NHO	National Hospice Organization
NIH	National Institutes of Health
NIMH	National Institutes of Mental Health
NRC	National Research Council
NSCLC	National Senior Citizens Law Center
NSF	National Sanitation Foundation
OSHA	Occupational Safety & Health Administration
PHS	Public Health Service
PHTN	Public Health Training Network
PRO	Peer Review Organization
SGMP	Society of Government Meeting Professionals
VA	Veterans Administration

Common Terms

Acceptable Plan of Correction: A plan of action(s) designed to correct Medicare and/or Medicaid deficiencies within a period of time acceptable to the authority that determines compliance with program requirements. For Medicaid-only certified facilities, the State agency (SA) determines compliance. For Medicare certified facilities, the Federal Regional Office determines compliance.

Active Treatment: The aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimum functional status.

Administrative Law Judge: One of a group of specifically designated individuals from the Office of Hearings and Appeals, Social Security Administration, responsible for conducting evidentiary hearings under the Medicare and Medicaid administrative appeals process.

Adverse Actions: Procedures applied by the Centers for Medicare & Medicaid Services (CMS) or the Medicaid SA when a provider or supplier is found not to meet one or more of the Conditions of Participation or Coverage.

Adverse Drug Reaction: A secondary effect of a drug that is usually undesirable and different from the therapeutic and helpful effects of the drug. The term “side effect” is often used interchangeably with adverse drug reaction.

Agreement (1864): Under section 1864 of the Social Security Act (the Act), CMS contracts with each State to perform various survey and certification functions with respect to providers and suppliers participating in Medicare. Under this agreement (1864), States consent to perform survey and certification functions, while the Secretary consents to pay the States for reasonable costs related to the performance of these functions. (Under section 1902 of the Act, the States must utilize the same SA to perform survey and certification functions for Medicaid.)

Appeals Process (Medicaid): This process provides for an evidentiary hearing by the State before the effective date of the denial, termination or nonrenewal or within 120 days after the effective date of the adverse action initiated by the State. (An informal reconsideration must be provided prior to the adverse action if the State elects to provide a full evidentiary hearing after the effective date of the adverse action.)

Appeals Process (Medicare): Process provides for a hearing before an administrative law judge (ALJ) after the effective date of denial, termination or nonrenewal. For denials and nonrenewals, the hearing is preceded by a reconsideration by the CMS Regional Office (RO). If the provider is dissatisfied with the decision of the ALJ, an appeal may be made to the Appeals Council, and the provider may appeal to the United States District Court.

Automatic Cancellation Clause: A time-limited agreement may contain an automatic cancellation clause. The clause provides that if corrections of deficiencies are not made by the 60th day following the last date by which all corrections are to have been made or if substantial effort and progress have not been achieved and an acceptable revised Plan of Correction submitted, the agreement will be automatically canceled on that 60th day. This applies only to intermediate care facilities for mentally retarded individuals (ICF/MR).

Beneficiary: An individual entitled to receive Medicare or Medicaid services.

Carrier: Organization, contracted by the Federal government, to pay bills submitted by certified suppliers for care given to Medicare-eligible beneficiaries and to make Medicare Part B payments (e.g., Blue Shield).

Certification: Federal process that describes when a provider requests to be “certified” to receive Medicare or Medicaid monies for providing care and services to eligible beneficiaries. It is also a recommendation made by the State survey agency on the compliance of providers or suppliers with Conditions of Participation, requirements [for skilled nursing facilities (SNFs) and nursing facilities (NFs)] and Conditions of Coverage. Certification is *voluntary*.

Comparative Survey: A Federal survey conducted by Federal Regional Office surveyors or CMS surveyor contractors within 60 days of the State’s survey to assess SA performance in the interpretation, application and enforcement of Federal requirements. Whenever possible, comparative surveys are conducted within 30 days of the State survey. This is also known as a Federal Monitoring Survey or a “look behind” survey.

Complaint Survey: Onsite inspection conducted by Federal RO staff or SA surveyors to investigate an allegation against Medicare or Medicaid providers or suppliers.

Condition of Coverage or Condition of Participation: Federal requirements which must be met if certain types of providers or suppliers desire to participate in the Medicare or Medicaid programs.

Consultation: Surveyor's explanation of deficiencies and how each deficiency relates to a particular regulatory requirement. This type of consultation precludes professional technical advice on how to correct a deficiency.

Credible Allegation of Compliance: A statement made by a provider or supplier that deficiencies have been corrected. The allegation of compliance must be realistic in terms of the provider's or supplier's ability to correct the deficiencies between the survey date and the date of the allegation. If the allegation of compliance is found credible by the SA or RO, the SA will conduct a revisit. A credible allegation of compliance may be an acceptable Plan of Correction.

Deemed Status: Providers are "deemed" to meet Federal regulations when inspected by organizations whose survey process and regulations are "deemed" to be equivalent to the Federal survey process and regulations (e.g., Joint Commission on Accreditation of Healthcare Organizations). This organization is known as the accrediting organization.

Deficiency: A provider's or supplier's violation of an applicable program requirement.

Direct or Federal Jurisdictional Survey: A Federal survey by RO surveyors to assess provider performance and to determine whether a provider or supplier meets all applicable program requirements. It is used as the basis for approving a provider where the SA lacks jurisdiction [e.g., Federal RO surveyors conduct surveys of health facilities of the Indian Health Services, Commonwealth of the Virgin Islands and participating end stage renal disease (ESRD) facilities in Veterans Administration hospitals].

Distinct Part: A component within a facility which furnishes a different level or type of covered services. A distinct part component must be recognizable or distinguishable as separate.

Dual Certification: Simultaneous participation of a facility in both the Medicare and Medicaid programs.

Due Process: Those rights of appeal afforded providers and suppliers who are the subjects of adverse action taken by the State or CMS.

Entity: A generic term used to describe providers and suppliers under the Social Security Act or laboratories that participate in the Clinical Laboratory Improvement Amendments (of 1988) program.

Federal Financial Participation (FFP): The Federal government's share of the money paid to the State for services furnished to State Medicaid recipients as well as for administrative costs in relation to the operation of the Medicaid program in the State. The FFP share is determined by a formula based on the State's per capita income.

Federal Monitoring Survey: Surveys of Medicare and/or Medicaid participating facilities performed by a Federal team or CMS surveyor consultants to assess SA performance in certifying providers and suppliers. A monitoring survey is generally conducted within 60 days of a State survey. They are selected on a sample or focused basis.

Federal Oversight Support Survey: An onsite SNF/NF survey in which the Federal surveyor(s) accompanies the State survey team during an initial, recertification, revisit or complaint survey to observe and assess the State surveyor team's performance. The RO surveyors may provide training and/or technical assistance to address identified performance needs as a result of the evaluation of outcomes. The RO team also evaluates Form CMS-2567, Statement of Deficiencies, to identify whether deficient practices identified onsite are reflected in the document.

Fiscal Intermediary: An organization contracted by the Federal government to pay for care given to Medicare-eligible beneficiaries by certified providers and to make Medicare Part A payments (e.g., Blue Cross).

Freedom of Information Act: Establishes the right of the public to have access to numerous types of Federal and/or State documents.

Health Maintenance Organization: A legal entity which provides or arranges for the provision of prepaid basic and supplemental health services to its members in the manner prescribed by and operated in accordance with section 1301 of the Public Health Services Act.

Institute of Medicine (IOM): Chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the public. The Institute is an advisor to the Federal government and, on its own initiative, identifies issues of medical care, research and education. In 1986, the IOM submitted a report to CMS on the regulation of nursing homes.

Levels of Care: The range of services provided within a specific type of health care facility and/or the range of services needed by an individual receiving health care.

Licensure/Licensing: Each State has determined the individuals and entities that have to be licensed to operate as a business in the State. State licensure is *mandatory*.

Life Safety Code (LSC): A set of fire protection requirements written by the National Fire Protection Association designed to establish minimum requirements that will provide a reasonable degree of safety from fire, smoke and panic. These requirements cover construction, exiting, protection from hazards and requirements for operational features. The requirements are designed to provide an appropriate level of safety for individuals in health

care facilities. LSC surveys are conducted by individuals employed either directly by the SA or under contract.

Look Behind: CMS's authority to validate and, if appropriate, cancel a State's provider agreement with any Medicaid provider.

Nosocomial Infection: An infection that is acquired while in a health care facility.

Outcome-Oriented Survey Process: A person-centered process in which the surveyor, while onsite, makes observations, conducts interviews and reviews documents to determine whether the care and services provided resulted in an actual negative outcome to the individual or whether the lack of a system may potentially result in a negative outcome.

Plan of Correction (POC): Provider's or supplier's written plan on the Statement of Deficiencies and Plan of Correction form (CMS-2567), stating how corrective actions will be made and the completion date for corrections. A provider will ordinarily be expected to achieve compliance within 30 to 60 days of the survey.

Prospective Payment System: A system under which Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a set of specific diagnostic-related groups.

Provider: Individual, institution or organization that *provides* care for patients awaiting, receiving or recuperating from treatment by intervening practitioners (i.e., hospitals, SNFs/NFs, home health agencies, hospices and comprehensive outpatient rehabilitation facilities).

Quality Indicators (QIs): In long term care facilities, used as indicators of potential problems or concerns that warrant further investigation.

Sentinel Health Event: In long term care facilities, a QI that represents a significant occurrence that should be selected as a survey concern, even if it applies to only one or a few residents.

Single State Agency: The State office which administers Medicaid, also known as the Medicaid State agency.

Spell of Illness: A Medicare beneficiary is limited to a specific maximum number of days of covered inpatient hospital care and of covered posthospital extended care in a SNF within a period of time known as spell of illness or benefit period. Once these benefit days have been used, additional benefit days are not available until the spell of illness ends and a new benefit period begins.

Supplier: Individual or organization that supplies goods and services used in care and treatment of the patient (i.e., rural health clinics, ESRD facilities, ambulatory surgical centers, independent therapists, pharmacies and DME suppliers).

Title XVIII (Title 18): Pertaining to the Medicare program.

Title XIX (Title 19): Pertaining to the Medicaid program.

Validation Survey of Accredited Facilities: Hospitals, home health agencies, hospice entities and ambulatory surgical centers may be accredited by various organizations which have been "deemed" by CMS to have a survey process and regulations similar to Federal requirements. The CMS Central Office staff determines which accredited hospital or other certified accredited entity will receive a survey by the SA to validate the findings of the accrediting organization.

Match the Common Terms with the Definitions

_____ 1. Status of a facility that participates in Title XVIII or Title XIX by virtue of accreditation by a national organization such as the Joint Commission on Accreditation of Healthcare Organizations.

_____ 2. Component within a facility which provides a different level or type of covered services.

_____ 3. Written statement by provider stating how corrective actions will be made and date of completion.

_____ 4. CMS's authority to validate and/or cancel a State provider's agreement with an ICF/MR or disallow FFP to a State for care provided in a particular ICF/MR.

_____ 5. Pertaining to the Medicaid program.

_____ 6. Federal government share of money paid to the State for services provided to State Medicaid recipients.

_____ 7. System under which Medicare payment is made at a predetermined, specific rate.

_____ 8. Pertaining to the Medicare program.

_____ 9. CMS's surveys of SNFs and NFs in each State to assess the adequacy of SA surveys.

_____ 10. A resident-centered inspection for outcome of care during an onsite survey. Includes interviews with residents and staff to determine whether appropriate care and services are being provided.

_____ 11. Federal agency designated to administer the Medicare and Medicare programs.

_____ 12. Federal law which authorizes and regulates participation in the Medicare and Medicaid programs.

a. Prospective Payment System.

b. Omnibus Budget Reconciliation Act.

c. Deemed status.

d. Title XIX.

e. Title XVIII.

f. Look behind.

g. Federal financial participation (FFP).

h. Distinct part.

i. Centers for Medicare & Medicaid Services.

j. Outcome-oriented survey process.

k. Plan of Correction (POC).

l. Federal monitoring survey.

Match the Common Terms with the Definitions

Answers:

1. c
2. h
3. k
4. f
5. d
6. g
7. a
8. e
9. l
10. j
11. i
12. b

CMS Acronyms Word Square

Directions: Find the CMS acronyms in the word square below. The letters will be directly next to each other horizontally, vertically or diagonally. Circle all letters to make each acronym.

W	I	R	R	I	C	M	J	M	V	V	I	G	K	E
A	W	J	C	A	H	O	L	T	C	U	N	K	X	C
E	H	F	H	I	C	S	A	S	O	N	H	C	D	M
S	M	Z	O	L	F	S	I	D	P	F	G	P	A	S
R	K	F	W	C	A	H	O	A	V	F	L	X	I	I
D	F	N	N	Q	M	H	F	B	R	Q	Y	S	R	Y
P	M	C	G	S	E	D	H	O	R	O	S	I	Z	D
G	S	V	D	A	R	S	S	F	Q	A	M	S	C	X
L	D	P	V	J	G	R	H	Q	N	A	Y	Z	Y	G

ALJ	Administrative Law Judge
ASC	Ambulatory Surgical Center
CFR	*Code of Federal Regulations*
CHOW	Change of Ownership
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
DAB	Departmental Appeals Board
DHHS	Department of Health and Human Services
DP	Distinct Part
ESRD	End Stage Renal Disease
FFP	Federal Financial Participation
FMS	Federal Monitoring Survey
FOIA	Freedom of Information Act
HHA	Home Health Agency
ICF-MR	Intermediate Care Facility for the Mentally Retarded
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LSC	Life Safety Code
LTC	Long Term Care
MDS	Minimum Data Set
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OSCAR	Online Survey and Certification Reporting System
POC	Plan of Correction
QA	Quality Assurance
RAI	Resident Assessment Instrument
RO	Regional Office
SA	State Agency
SMA	State Medicaid Agency
SNF	Skilled Nursing Facility
SOM	*State Operations Manual*
SSA	Social Security Act

CMS Acronyms Word Square

Answers:

W	I	R	R	I	C	M	J	M	V	V	I	G	K	E
A	W	I	C	A	H	O	L	T	C	U	N	K	X	C
E	H	F	H	I	C	S	A	S	O	N	H	C	D	M
S	M	Z	O	L	F	S	I	D	P	F	G	P	A	S
R	K	F	W	C	A	H	O	A	V	F	L	X	I	I
D	F	N	N	Q	M	H	F	B	R	Q	Y	S	R	Y
P	M	C	G	S	E	D	H	O	R	O	S	I	Z	D
G	S	V	D	A	R	S	S	F	Q	A	M	S	C	X
L	D	P	V	J	G	R	H	Q	N	A	Y	Z	Y	G

Lesson 2-A-2: Tables of Organization

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the location of the Centers for Medicare & Medicaid Services' Regional Office to which your State agency reports.
- Discuss the general structure of the State agency or the State Regional Office in which you work.
- Identify whom to consult regarding issues of employment.

Lesson Plan

References

Federal

None

State

(Insert State reference[s] here.)

Other

Highlights

- Presentation of the general table of organization of CMS Regional Offices
- Presentation of the table of organization for the State agency where the individual is employed
- Presentation of the table of organization for the region within the State or Regional Office in which the individual works

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Satellite transmission video, *Orientation for Newly Employed Surveyors*, transmitted on May 7, 2004 (required viewing for all new survey and certification staff)
- Handouts:
  - *State agency table of organization for [insert name of State]*
  - *State agency table of organization for region in which the surveyor works*
  - *List of whom to contact for specific reasons*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-A-2:
Tables of Organization

1

Slide 2-A-2-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the location of the Centers for Medicare & Medicaid Services' Regional Office to which your State agency reports.
- Discuss the general structure of the State agency or the State Regional Office in which you work.
- Identify whom to consult regarding issues of employment.

2

Slide 2-A-2-2

(Inform the students of the objectives.)

CMS Regional Offices

- The Centers for Medicare & Medicaid Services (CMS) divides country into 10 regions, each with its own Regional Office:

Region 1–Boston	Region 6–Dallas
Region 2–New York City	Region 7–Kansas City
Region 3–Philadelphia	Region 8–Denver
Region 4–Atlanta	Region 9–San Francisco
Region 5–Chicago	Region 10–Seattle

3

Slide 2-A-2-3

CMS Regional Offices

The Centers for Medicare & Medicaid Services (CMS) divides the country into 10 regions, each with its own Regional Office:

- Region 1–Boston.
- Region 2–New York City.
- Region 3–Philadelphia.
- Region 4–Atlanta.
- Region 5–Chicago.
- Region 6–Dallas.
- Region 7–Kansas City.
- Region 8–Denver.

Audiovisual

Outline or text of presentation

- Region 9–San Francisco.
- Region 10–Seattle.

CMS Consortia

- Northeastern
- Southern
- Midwestern
- Western

4

Slide 2-A-2-4

CMS Consortia

The Regional Offices are further combined into the following consortia:

- Northeastern.
- Southern.
- Midwestern.
- Western.

(Ask the students what consortium and region their State is in and in which city their Regional Office is located.)

Services in Regional Offices

- Medicare
- Medicaid
- Beneficiary Services
- Office of Quality Improvement
- Office of Financial Management
- Survey & Certification

5

Slide 2-A-2-5

Services in Regional Offices

Each Regional Office has departments or divisions that include:

- Medicare:
  - Staff in this division work with fiscal intermediaries. When a Medicare-eligible individual receives services covered by Medicare, the hospital, rehabilitation agency or other entity sends a bill to the fiscal intermediary, which pays the bill for Medicare services.
- Medicaid:
  - Staff in this division work with the State Medicaid agency (in this State it is [*name of state agency*]).
- Beneficiary Services:
  - Staff in this division work with Medicare- and Medicaid-eligible individuals regarding any concerns those individuals bring to the attention of the Regional Office. They also work with the public regarding benefits available to

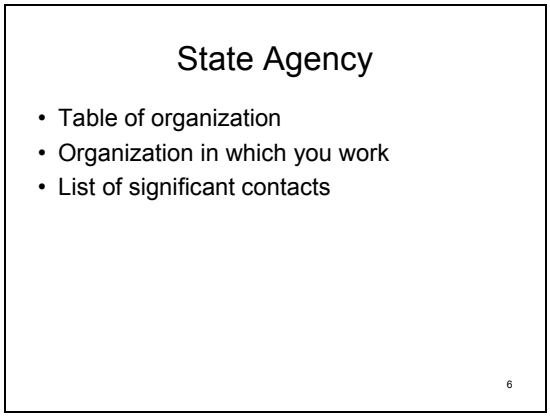
Audiovisual	Outline or text of presentation
	Medicare- and Medicaid-eligible individuals. Two such initiatives have been to make people aware that Medicare will pay for flu and pneumonia vaccines. • Office of Quality Improvement: – Staff in this office work with quality improvement organizations to improve health care provided to individuals receiving Medicare and Medicaid; however, their work has an impact on all individuals who receive care. One example is a project working with hospitals to reduce the time between a stroke and the administration of clot-dissolving medication to minimize the effects of the stroke. • Office of Financial Management: – Staff in this office identify and investigate fraudulent activity in the Medicare and Medicaid programs. • Survey and Certification: – State agency staff work most closely with the staff in this office, whose responsibilities include working with the State and providers who want to be certified to administer care to Medicare- and Medicaid-eligible individuals. Each year Regional Office surveyors are required by Congress either to observe State surveyors of long term care providers while they conduct a survey or follow a State survey team's survey within 30 days to compare their findings with those of the State survey. For other types of providers (e.g., hospitals or home health agencies) regional surveyors may either accompany State surveyors on surveys or, again, follow a State survey within 30 days.

Audiovisual

Outline or text of presentation

(Provide handouts of the tables of organization for the following to make the new employees aware of the chain of authority/command:

- *State government.*
- *State survey and certification agency.*
- *State regional, district or other office in which the new employees work.)*



Slide 2-A-2-6

State Agency

- Table of organization.
- Organization in which you work.
- List of significant contacts.

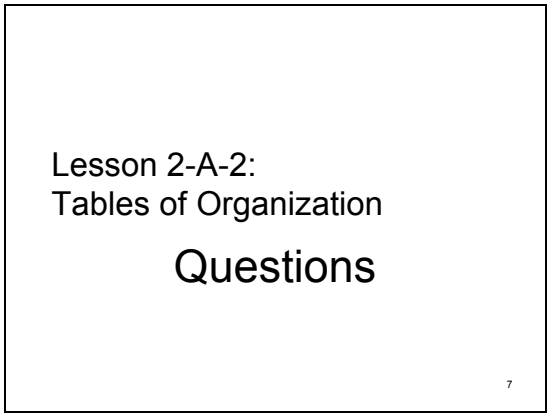
(Provide a handout that lists at least the following contacts:

- *Ombudsman.*
- *Licensing agencies for various professionals.*
- *State department for communicable diseases.*
- *Human services.*

Staff and surveyors with whom the surveyor will work closely.)

Audiovisual

Outline or text of presentation



Slide 2-A-2-7

Skill Assessment

Tables of Organization

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified the city and State of the CMS Regional Office to which the State reports.	
					Described the general structure of the State agency and the section or region in which the surveyor works.	
					Identified whom the employee consults regarding employment issues.	

Comments/Recommendations:

Lesson 2-A-3: Office Policies and Procedures

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe office policies and procedures important to your employment and your job responsibilities.
- Identify the individual who can answer your policy and procedure questions.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 4, section 4009C

State

(Insert State reference[s] here.)

Other

Highlights

- Provide the new employee with office policies and procedures significant to the individual's work

Training Techniques

- Lecture
- Individual or group discussion

Training Aids

- PowerPoint slides and handouts

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-A-3:
Office Policies & Procedures

1

Slide 2-A-3-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe office policies and procedures important to your employment and your job responsibilities.
- Identify the individual who can answer your policy and procedure questions.

2

Slide 2-A-3-2

(Inform the students of the objectives.)

Office Policies & Procedures

Discuss following policies & determine individual you should consult for each:

- Health & benefits
- Retirement information
- Payroll
- Credit cards
- Work
- Security

3

Slide 2-A-3-3

(Provide examples of office policy and procedure documents to students.

Use the "Orientation to the Workplace" form found in Appendix G to evaluate those that may be appropriate.)

Office Policies and Procedures

Discuss the following policies and determine the individual you should consult for each:

- Health and benefits.
- Retirement information.

Audiovisual

Office Policies & Procedures (cont.)

- Conduct & expected behavior
- Use of equipment
- Supplies
- Job description
- Communication with supervisor
- Travel
- Training period
- Documents

4

Slide 2-A-3-4

Outline or text of presentation

- Payroll.
- Credit cards.
- Work.
- Security.

- Conduct and expected behavior.
- Use of equipment.
- Supplies.
- Job description.
- Communication with supervisor.
- Travel.
- Training period.
- Documents.

Lesson 2-A-3:
Office Policies & Procedures

Questions

5

Slide 2-A-3-5

Skill Assessment

Office Policies and Procedures

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed office policies and procedures, including at least the following: • Health and benefits. • Retirement information. • Payroll. • Credit cards. • Work. • Security. • Conduct and expected behavior. • Use of equipment. • Supplies. • Job description. • Communication with supervisor. • Travel. • Training period. • Documents.	
					For the topics listed above, verbalized to whom he or she should go with questions.	

Comments/Recommendations:

Lesson 2-B: Licensure, Certification and Surveys

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Distinguish between licensure and certification.
- Describe the relationship between CMS and the State survey agency.
- Explain the certification and survey differences between Medicare and Medicaid.

Lesson Plan

References

Federal

- Social Security Act:
  - Section 1864 (for Medicare)
  - Section 1902 (for Medicaid)
  - Sections 1861(e and j), sentence following section 1861(s)(13)
  - Section 1902(a)(9) (for CLIA)
- *Code of Federal Regulations:*
  - Various sections of Title 42, Public Health
- *State Operations Manual (SOM):*
  - Chapter 1

State

(Insert State reference[s] here.)

Other

Highlights

- Comparison of State licensure and Federal certification, including:
  - The source of the regulations
  - The entities affected
  - The who, when, where and why of surveys
- The relationship between CMS and the State survey agency
- The differences between Medicare and Medicaid

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Handout:
  - *Licensure, Certification and Surveys*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-B:
Licensure, Certification & Surveys

1

Slide 2-B-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Distinguish between licensure & certification.
- Describe the relationship between CMS & the State survey agency.
- Explain the certification & survey differences between Medicare & Medicaid.

2

Slide 2-B-2

(Inform the students of the objectives.)

(Review and discuss the "Licensure, Certification and Surveys" handout.)

CMS Primary Mission

- Administration of Medicare
  - Regulates quality of care
  - Promotes beneficiary awareness of benefits
  - Promotes health care system efficiency & quality
- Joint oversight (with State) of Medicaid

3

Slide 2-B-3

CMS Mission

The primary mission of CMS is to administer the Medicare program defined by Federal requirements in the regulations (42 CFR) and certain related provisions of the Social Security Act in a manner that:

- Promotes timely and economic delivery of appropriate quality of care to eligible beneficiaries.
- Promotes beneficiary awareness of the services for which they are eligible.

Audiovisual

Outline or text of presentation

- Promotes efficiency and quality within the total health care delivery system.

CMS also works with the State to provide joint oversight of the Medicaid program.

CMS Central Office

- Baltimore, Maryland
- Coordinates overall policymaking
- Determines & communicates:
  - Operational policies
  - Instructions
  - Official interpretations of policy

4

Slide 2-B-4

CMS Central Office

Overall policymaking responsibility is centralized in CMS headquarters, where all aspects of the Medicare program and oversight of the State Medicaid programs are coordinated. CMS headquarters, located in Baltimore, Maryland, is known as the CMS Central Office. It is responsible for:

- Monitoring the surveillance and overall administrative control of the certification process, including its financial aspects.
- Establishing operational policy for the certification process.
- Conveying operational policies, instructions and official interpretations of policy to the Regional Offices and State survey agencies.

Overview of Survey & Certification Programs

- Medicare
- Medicaid
- Clinical Laboratory Improvement Amendments (CLIA)
- Relationship between CMS & State survey agencies
- General provisions of State agreements

5

Slide 2-B-5

Overview of Survey and Certification Programs

- Medicare
- Medicaid
- Clinical Laboratory Improvement Amendments (CLIA)
- Relationship between CMS and State survey agencies
- General provisions of State agreements

Audiovisual

Medicare

- Federal health insurance program
- Wide range of benefits for aged & disabled
- Providers must be certified & suppliers approved to receive reimbursement

6

Slide 2-B-6

Medicaid

- State program funded with State & Federal monies
- Provides:
  - Core services to eligible needy
  - Optional services
- Providers *voluntarily* participate
- Agreement is between provider, Medicaid State agency & Secretary of Health & Human Services

7

Slide 2-B-7

Outline or text of presentation

Medicare

- Is a Federal health insurance program.
- Offers a wide range of benefits for the aged and disabled.
- Allows providers to request certification, since Medicare is a program in which they *voluntarily* participate.
- Allows suppliers to request approval and voluntarily participate.
  - The general distinction between providers and suppliers is that providers are parties that care for patients awaiting, receiving or recuperating from treatment; suppliers include those who furnish goods and services used in care and treatment.
- Requires that providers are certified and suppliers approved to receive reimbursement for caring for Medicare-eligible beneficiaries.

Medicaid

- Is a State program funded with State and Federal monies.
- Provides core services to eligible needy, as well as optional services.
- Provider participation is voluntary.
- The agreement to provide services is between the provider, the Medicaid State agency, and the Secretary of Health and Human Services.

Audiovisual

CLIA

- CLIA laboratories:
  - Examine materials derived from human body for purpose of providing information for diagnosis, prevention or treatment of any disease or impairment
  - Assess health of human beings
- Participation is *mandatory* for almost all laboratories

8

Slide 2-B-8

Outline or text of presentation

Clinical Laboratory Improvement Amendments

CLIA laboratories are facilities for:

- Examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment.
- Assessment of the health of human beings.
  - Biological.
  - Microbiological.
  - Serological.
  - Chemical.
  - Immunohematological.
  - Biophysical.
  - Cytological.
  - Pathological.
- Participation is *mandatory* for almost all laboratories.

Relationship Between CMS & State Survey Agency

- Secretary of HHS makes agreement with State
  - Governor designates State agency
  - Contract is known as "1864 agreement"
- CMS evaluates performance of State agency using protocols in State Performance Standards

9

Slide 2-B-9

Relationship between CMS and the State survey agencies

Agreements between the Secretary of Health and Human Services and the various States, territories, and the District of Columbia stipulate that:

- A State agency designated by the governor is responsible for performing certification functions created by section 1864 of the Social Security Act.
  - The CMS contract with the State agency is known as the "1864 agreement."
  - The designated agency keeps necessary and appropriate records to be furnished as required by delegates of the Secretary.

Audiovisual

Outline or text of presentation

- The agency employs management methods, personnel procedures, equal opportunity policies, and merit system procedures in accordance with agreed-upon or established practices.

- CMS evaluates the performance of each State agency using protocols currently called the State Performance Standards.

General Provisions of State Agreements

- Secretary:
  - Agrees to provide funds for reasonable & necessary costs
  - Defines workload annually
- Lifetime is unlimited

10

Slide 2-B-10

General provisions of State agreements

- The Secretary:
  - Agrees to provide funds for the reasonable and necessary costs to the States to perform the functions authorized in the agreements.
  - Defines the agency's workload annually in the budget call letter.
- The lifetime of State agreements is unlimited, but an agreement may be terminated under specific conditions by action of either of the parties.

General Provisions of State Agreements (cont.)

- Governor can propose modification of agreement
- State agency may not redelegate responsibility for evaluation & certification

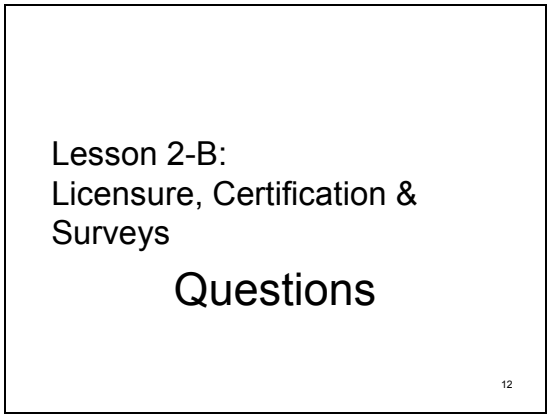
11

Slide 2-B-11

- The governor has the prerogative to propose modification of the agreement to allow for variations in organizational location of responsibilities.
- The State agency's responsibility for evaluation and certification may not be redelegated; however, the State agency subcontracts some of the survey responsibilities to other State agencies. In this State subcontractors are *[list any subcontractors, such as for Life Safety Code and CLIA surveys]*.

Audiovisual

Outline or text of presentation



Slide 2-B-12

Skill Assessment

Licensure, Certification and Surveys

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Verbally defined licensure and certification.	
					For licensure and certification, explained: • The source of regulations. • How the survey frequency is determined. • The reason each were surveyed: license, certification or both.	
					Described understanding of the relationship between CMS and the State survey agency.	
					Explained the differences between Medicare and Medicaid.	

Comments/Recommendations:

Licensure, Certification and Surveys

	State/Licensure	Federal/Certification
Who makes the regulations for health care facilities and providers?	State legislature.	Congress.
How do the regulations come into being?	Regulations are: • Proposed. • Considered by committee. • Voted by the legislature.	• Legislator proposes a law. • Law considered by committee. • Law voted on by Congress (usually as part of the Social Security Act or another, such as the Omnibus Budget Reconciliation Act). • When authority is given to the Department of Health and Human Services, it is delegated to the Centers for Medicare & Medicaid Services (CMS) to formulate regulation to implement the law. After law is enacted: • Notice of Proposed Rule Making (NPRM) is published in the *Federal Register* (where the law and associated regulations will be better defined). • Period of comment (minimum 60 days) is open to anyone. • CMS reviews comments and final rules proposed. • Rules are cleared by the Office of Management and Budget. • Rules are signed by the Secretary of Health and Human Services. • Regulations are published as final rule in the *Federal Register*, effective on a given date.

	State/Licensure	Federal/Certification
		The rules are placed into the *Code of Federal Regulations (CFR)*. From there, the *SOM* interprets the regulations and provides policy and process guidance to determine compliance with Federal requirements. Both the State agency (SA) and the CMS Regional Office (RO) staff use the *SOM* in certification and survey activities.
What is this process called?	Licensure.	Certification.
Who has to have a license or certification?	The State legislature determines the individuals and entities that must be licensed in order to operate as a business or provide specific services in the State. State licensure is mandatory for all affected individuals or entities.	Certification is voluntary. Entities who wish to receive money for treating Medicare- and Medicaid-eligible individuals must contact the SA, request an application packet, complete the application process, and then receive an initial survey. If the entity meets all applicable regulations or provides an acceptable plan for correcting deficiencies, the entity is certified.
Who investigates whether the individuals and providers are following the regulations?	When authorized by the State, the State survey agency conducts surveys.	The governor in the State determines which agency within State government will do Federal survey and certification work. CMS formally contracts with that agency to do this work.
How frequently are the individuals and providers inspected (or surveyed)?	State licensing regulations and the money provided in the State budget determine the survey frequency.	Yearly, CMS sends the SA a budget call letter that includes the frequency for surveying each type of provider/supplier. The Federal government matches Medicaid funding, but Medicare surveys and certification work (for hospitals, skilled nursing facilities, etc.) is paid for entirely from Medicare money. Congress determines the size of this funding each year. Medicare monies fund not only surveys, but also certification, training, equipment

	State/Licensure	Federal/Certification
		and State agency overhead expenses. State surveyors conduct Federal surveys in long term care facilities every 9 to 15 months (required by law). For other providers, survey frequency depends on the budget call letter. Yearly, Federal surveyors have to conduct a survey of 5% of the long term care facilities in the State, and 1% of other providers. Federal surveyors can either survey within 30 days after State surveyors conduct their survey (sometimes called a "look behind" survey) or accompany State surveyors on their surveys. The purpose of this is to monitor the State agency and assess the training of its surveyors.
Why are surveys needed?	To ensure that licensed entities provide quality health care and services to people who receive them.	To ensure that licensed entities meet mandated requirements in the provision of quality health care and services to people who receive them.
Where do we survey?	State policies and procedures determine whether you survey at all locations included in the license.	Unless directed otherwise, you survey at all locations included in the certification.

Lesson 2-B-1: Review of the *State Operations Manual*

Learning Objective

At the conclusion of this lesson, you will be able to:

- Find information in the *State Operations Manual* pertinent to your position.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):* http://new.cms.hhs.gov/manuals/downloads/som107c08.pdf
- Social Security Act:
  - http://www.ssa.gov/OP_Home/ssact/comp-toc.htm
  - Title 18
  - Title 19

State

(Insert State reference[s] here.)

Other

Highlights

- Sources of information contained in the *SOM*
- Information in the *SOM* pertinent to the student's responsibilities

Training Techniques

- Lecture
- Individual or group discussion
- Small group exercise (optional)

Training Aids

- PowerPoint slides and handouts
- Handout:
  - *Centers for Medicare & Medicaid Services State Operations Manual*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-B-1:
Review of the
State Operations Manual

1

Slide 2-B-1-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Find information in the *State Operations Manual* pertinent to your position.

2

Slide 2-B-1-2

(Inform the students of the objectives.)

Background

State Operations Manual (*SOM):*

- Implements Federal regulations for survey & certification of health care providers & suppliers
- Derives authority from:
  - Social Security Act
  - Code of Federal Regulations

3

Slide 2-B-1-3

Background

The Centers for Medicare & Medicaid Services (CMS) *State Operations Manual (SOM)* implements Federal regulations for the survey and certification of health care providers and suppliers.

The Social Security Act (referred to in the *SOM* as "the Act") and the *Code of Federal Regulations* are the statutory and regulatory references for certification, regulation and surveys. These documents

Audiovisual

Internet Resources

- Social Security Act
  http://www.ssa.gov/OP_Home/ssact/comp-ssa.htm
- *Code of Federal Regulations*
  http://www.gpoaccess.gov/cfr/index.html

4

Slide 2-B-1-4

Internet Resources (cont.)

- *Federal Register*
  http://www.gpoaccess.gov/fr/index.html
- *State Operations Manual*
  http://new.cms.hhs.gov/manuals/downloads/som107c08.pdf

5

Slide 2-B-1-5

Certification

- Health care entity applies to the State agency
- Process is: application, initial survey & initial certification
- Entity may be certified for Medicare, Medicaid or CLIA
- If in substantial compliance, is "certified"
- Entity decertified when no longer in substantial compliance

6

Slide 2-B-1-6

Outline or text of presentation

have given authority to the U.S. Department of Health and Human Services. In turn, it has assigned the authority and responsibility for survey and certification to CMS. New regulations are published in the *Federal Register*.

Survey and Certification

"Survey" and "certification" are two terms you hear frequently.

"Certification" is the process that follows after a health care entity applies to its State agency for approval to provide Medicare, Clinical Laboratory Improvement Amendments (CLIA) or Medicaid services. After it submits the application and if it meets the requirements, the entity receives an initial visit (a survey). If this survey determines that it is in substantial compliance with the applicable

Audiovisual

Outline or text of presentation

regulations, it is "certified," or approved to care for Medicare and Medicaid-eligible individuals and to be paid accordingly.

Decertification can occur when an entity is no longer in substantial compliance with applicable regulations.

Survey

- Determines whether entity initially:
  - Meets applicable requirements
  - Substantially conforms with applicable regulations
- Confirms that entity continues to be in substantial compliance

7

Slide 2-B-1-7

"Survey" is the process used to determine whether an entity initially meets the requirements for the type of health care it provides and is in substantial compliance with regulations. Subsequent surveys determine whether it continues to meet requirements and remains in compliance with regulations.

Contents

SOM
- Chapters
- Exhibits
- Appendices
- Policies & procedures implementing:
  - Social Security Act
  - *Code of Federal Regulations*

8

Slide 2-B-1-8

Contents

The *SOM* includes various chapters, exhibits and appendices. It contains the policies and procedures that implement the Social Security Act and the *Code of Federal Regulations.*

(Use the handout "Centers for Medicare & Medicaid Services State Operations Manual" to review the content of each chapter, the exhibits and the appendices. Point out information important to the provider or supplier type that the student is most likely to survey or certify. Include at least:

- *Sections 3010 and 3012.*
- *Chapter 8, State Performance Standards.*
- *Appropriate appendices.)*

Audiovisual

Outline or text of presentation

The *SOM* does not address every issue and nuance. State agency staff, CMS Regional Office staff and CMS Central Office staff must follow *SOM* directives; however, staff can make further decisions regarding policies and procedures not addressed in the *SOM*.

SOM on Internet

- Website
  - http://new.cms.hhs.gov/manuals/downloads/som107c08.pdf

9

Slide 2-B-1-9

The *SOM* is available on the CMS website http://new.cms.hhs.gov/manuals/downloads/som107c08.pdf.

(Suggestions for learning activities:

For the provider/supplier the student is most likely to survey, make a list of chapters, sections and appendices and a list of the general topics the individual will most likely need to know.

Either:

- *Provide the list of the general topics in writing and ask the student to list the exact location of each item, then compare your list of locations and his/hers.*

Or:

- *After going through the handout, break the students into at least two groups, then have a contest: when you call out a general topic, see which group can find the reference most quickly.)*

Audiovisual

Lesson 2-B-1:
Review of the
State Operations Manual

Questions

10

Slide 2-B-1-10

Outline or text of presentation

Skill Assessment

Review of the *State Operations Manual*

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					For the entity he/she is to most commonly survey, the trainee found references in the *State Operations Manual (SOM)* pertinent to his/her position: • Relevant appendices. • Certification information. • Complaint investigation information. • Enforcement action information.	

Comments/Recommendations:

Centers for Medicare & Medicaid Services
State Operations Manual
April 2005

Chapter 1: Program Background and Responsibilities—establishes the minimum health and safety and Clinical Laboratory Improvement Amendment (CLIA) standards that must be met by providers and suppliers participating in Medicare and Medicaid programs.

1000 Medicare and Medicaid—Background.
1002 Basis for State Agency (SA) Activities under Title XVIII and Title XIX of the Act.
1004 Title XVIII Agreements with States.
1006 CMS's Role.
1008 Adjudication Authority.
1010 Certification Related Functions of SA.
1012 Explanation of Certification and Survey.
1014 Relationship of Survey Date to Date of Initial Medicare Approval.
1016 Approval and Correction of Deficiencies.
1018 Exceptions to SA Certification.
1020 Effect of Accreditation, Licensure and Other Approval Programs on Medicare.

Chapter 2: The Certification Process—establishes the framework within which State agencies, under agreements between the State and HHS Secretary, carry out the Medicare/Medicaid certification process. Process involves surveys that are conducted to ascertain whether a provider/supplier meets applicable requirements for participation in Medicare and/or Medicaid programs and to evaluate performance effectiveness in rendering safe and acceptable quality of care.

2000–2018 Identification of Providers and Suppliers and Related Presurvey Activities.
2020–2054 Hospitals.
2080–2087 Hospices.
2130–2141 Intermediate Care Facilities.
2160–2168 Spell of Illness Certifications.
2180–2202 Home Health Agencies (HHAs).
2210 Ambulatory Surgical Centers (ASCs).
2240–2249 Rural Health Clinics (RHCs).
2250–2252 Community Mental Health Centers (CMHCs).
2254–2262 Clinical Access Hospitals (CAHs).
2270–2287 End Stage Renal Disease (ESRD) Facilities.
2290–2306 Providers of Outpatient Physical Therapy or Outpatient Speech Pathology (OPT/OSP) Services.
2360–2366 Comprehensive Outpatient Rehabilitation Facilities (CORFs).
2420–2424 Suppliers of Portable X-Ray Services.
2450–2454 Certification of Chiropractors to Furnish Specified Services.
2460 Screening Mammography.
2470–2490 Life Safety Code (LSC).

2496 Utilization Review.
2700–2800 The Survey Process.
2810–2819 Organ Procurement Organizations (OPOs).
2825–2826 Federally Qualified Health Centers (FQHCs).

Chapter 3: Additional Program Activities—outlines procedures and processes for implementing things outside the normal scope of practice, including adverse actions, hearings and changes in provider/supplier status.

3000–3049 Adverse Actions—The Regional Office (RO) and State survey agency (SA) follow the procedures outlined in this part if an adverse action is likely to be initiated against Medicare and Medicaid participating providers and suppliers.
3050–3060 Reconsideration, Hearings and Appeals.
3100–3112 Prospective Payment System (PPS).
3200–3210 Changes in Provider Status or Services.
3220–3224 Expansion of Services.
3240–3257 Validation Surveys of Accredited Providers and Suppliers.
3300–3320 Handling Public Inquiries.
3330 Additional SA Responsibilities.
3350–3356 Response to Subpoenas Served on and Suits against the SA.

Chapter 4: Program Administration and Fiscal Management—outlines the functional role of State survey agencies in the Medicare/Medicaid program and provides for the establishment of an administrative relationship based upon a formal agreement negotiated between the governor of the state and the Secretary of Health and Human Services.

4000–4055 Administration.
4060–4062 Office of Management and Budget (OMB) Approval of Information Collected from the Public.
4100–4146 Survey and Certification Related Activities.
4149–4160 SA Analysis Activity.
4200–4225 Provider Certification Files and Program Reporting.
4500–4544 Necessary SA Expenses.
4600–4642 The Budgetary Process.
4700–4767 Financial Accounts and Reporting.
4780–4796 Section 1864/Section 1903(a) Fiscal Audits.
4800–4806 Disposition of Medicare and Medicaid Records.

Chapter 5: Complaint Procedures—provides direction and guidance in the management of complaints and reported incidents for nursing homes, home health agencies, end-stage renal disease facilities, hospitals, suppliers of portable x-ray services, providers of outpatient physical therapy or speech pathology services, rural health clinics and comprehensive outpatient rehabilitation facilities.

5000 Management of Complaints and Incidents.
5010 Intake Process.

5020 Triage and Priority Assignment.
5030 Priority Definitions.
5040 Investigation Findings and Reports.
5050 CMS RO Responsibility for Monitoring SA Management of Complaints and Incidents.
5060 ASPEN Complaints/Incidents Tracking System (ACTS).
- 5100 Investigation of Complaints Against Accredited/Deemed Providers and Suppliers.
- 5110 Basics for Investigation of Complaints Against Accredited/Deemed Providers and Suppliers.
- 5120 RO Direction of Accredited Hospital Complaint Investigation.
- 5130 Conducting an Accredited Hospital Complaint Validation Survey.
- 5140 Forwarding Investigation Report to RO.
- 5150 Accredited Hospital Found in Compliance Following Complaint Validation Survey.
- 5160 Accredited Hospital Found Not in Compliance Following Complaint Validation Survey.
- 5170 Reinstatement to Accreditation Organization Jurisdiction.
- 5180 Termination of Accredited Hospital.
- 5190 Investigating Complaints Involving ESRD Services Provided by Accredited Hospitals.

5200 Investigation of Complaints Against Other Than Accredited/Deemed Providers and Suppliers.
- 5210 SA Processing of General, Certification-Related Complaints.
- 5220 RO Processing General, Certification-Related Complaints.
- 5230 RO Complaint Management.
- 5240 Hospital Restraints/Seclusion Death Reporting and Investigation.
- 5250 Complaints Involving HIV-Infected Individuals.

5300 Investigations Involving Alleged EMTALA Violations.
- 5310 Basis for Investigation.
- 5320 RO Direction of Investigation.
- 5330 Conducting an Investigation.
- 5340 Forwarding Report of Investigation to the RO.
- 5350 RO Review of Investigation.
- 5355 RO Procedures for Coordinating Statutorily Mandated QIO (5-day) Review of Alleged Violations of 42 CFR 489.24.
- 5360 Termination Procedures for Violations of 42 CFR 489.24 and/or the Related Requirements at 42 CFR 489.20(l), (m), (q) and (r).
- 5370 RO Procedures for Coordinating Statutorily Mandated QIO Review of Confirmed Dumping Cases.

5400 Additional Provisions for the Investigation of Complaints in Nursing Homes.
- 5410 Task 1: Offsite Survey Preparation.
- 5420 Task 2: Entrance Conference/Onsite Preparatory Activities.
- 5430 Task 5: Information Gathering.
- 5440 Task 6: Information Analysis.
- 5450 Task 7: Exit Conference.

5460 Action on Complaints of Resident Neglect and Abuse and Misappropriation of Resident Property.
5500 Complaints Involving Unaccredited Laboratories.
5510 CLIA-Exempt Laboratory Complaint Investigations—General.
5520 Review of CLIA-Exempt Laboratory Complaints.
5530 Conducting Complaint Survey for CLIA-Exempt Laboratories.
5540 Complaint Investigations and Surveys of Accredited Laboratories Under CLIA.
5550 RO Direction of Complaint Investigation of an Accredited Laboratory.
5560 Conducting Complaint Survey of an Accredited Laboratory.
5570 Forwarding Investigation Report to RO.
5580 Accredited laboratory Found in Compliance Following a Complaint Survey.
5590 Accredited Laboratory Found Not in Compliance Following a Complaint Survey.
Attachment 1 Guidance to Distinguish Between the Priorities of Immediate Jeopardy and Non-Immediate Jeopardy-High in Nursing Home Allegations.
Attachment 2 ACTS Required Fields.

Chapter 6: Special Procedures for Laboratories—outlines regulatory guidelines for all laboratories that test human specimens for the purpose of providing information for diagnosis, prevention or treatment of any disease or impairment of or the assessment of the health of human beings. The Clinical Laboratory Improvement Amendments (CLIA) mandate that virtually all laboratories, including physician's office laboratories, meet the applicable Federal requirements and have CLIA certification in order to operate.

Chapter 7: Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities—implements the nursing home survey, certification and enforcement regulations of 42 CFR 488. Included are the following expectations: that providers remain in substantial compliance with Medicare/Medicaid programs as well as State law, that all deficiencies will be addressed promptly and that residents will receive the care and services they need to meet their highest practicable level of functioning.

7000 Introduction.
7001 Definitions and Acronyms.
7002 Change in Certification Status for Medicaid Nursing Facilities.
7003 Skilled Nursing Facility (SNF)—Citations and Description.
7006 Nursing Facility (NF)—Citations and Description.
7008 Types of Facilities That May Qualify as SNFs and NFs.
7010 SNFs Providing Outpatient Physical Therapy, Speech Pathology or Occupational Services.
7014 Special Waivers Applicable to SNFs and NFs Survey Process.

Survey Process.
7200 Emphasis, Components and Applicability.
7201 Survey Team Size and Composition—Length of Survey.
7202 Conflicts of Interest for Federal and State Employees.
7203 Survey Protocol.
7205 Survey Frequency.

7207 Unannounced Surveys.
7210 Substandard Quality of Care and Extended and Partial Extended Surveys.
7212 Informal Dispute Resolution.
7300 Certification of Compliance and Noncompliance for SNFs and NFs.
7301 Action When Facility Is Not in Substantial Compliance.
7303 Appeal of Certification of Noncompliance.
7304 Certification-Related Terms.
7305 Notice Requirements.
7306 Timing of Civil Money Penalties.
7307 Immediate Jeopardy (IJ) Exists.
7308 Enforcement Action When IJ Exists.
7309 Key Dates When IJ Exists.
7310 IJ Does Not Exist.
7311 Enforcement Action When IJ Does Not Exist.
7312 Considerations Affecting Enforcement Recommendation to Impose Remedies When IJ Does Not Exist.
7313 Procedures for Recommending Enforcement Remedies When IJ Does Not Exist.
7314 Special Procedures for Recommending and Providing Notice of Category 1 Remedies and Denial of Payment for New Admissions Remedy.
7315 Disagreements About Remedies When IJ Does Not Exist.
7316 Key Dates When IJ Does Not Exist.
7317 Response to the Plan of Correction.
7319 Procedures for Certifying Compliance.
7320 Action When There is Substandard Quality of Care.
7321 SNF or Dually Participating Facility Readmission to Medicare or Medicaid Program After Termination (Excludes Medicaid-only NFs).

Enforcement Process.
7400 Enforcement Remedies for SNFs and NFs.
7401 Life Safety Code Enforcement Guidelines for SNFs and NFs.

Remedies.
7500 Directed Plan of Correction.
7502 Directed In-Service Training.
7504 State Monitoring.
7506 Denial of Payment for All New Medicare and Medicaid Admissions for SNFs and NFs.
7508 Secretarial Authority to Deny All Payment for All Medicare and Medicaid Residents.

Civil Money Penalties.
7510 Basis for Imposing Civil Money Penalties.
7511 Per Instance Civil Money Penalty and No Opportunity to Correct.
7512 Compliance with Section 1128A of the Social Security Act.
7514 Special Procedures Regarding Compliance Decision and Overlap of Remedies.
7516 Determining Amount of Civil Money Penalty.
7518 Effective Date of Civil Money Penalty.

7520 Notice of Imposition of Civil Money Penalty.
7522 Duration of Civil Money Penalty.
7524 Settlement of Civil Money Penalty.
7526 Appeal of Noncompliance That Led to Imposition of Civil Money Penalty.
7528 When Penalty Is Due and Payable.
7530 Notice of Amount Due and Collectible.
7534 Disposition of Collected Civil Money Penalty.
7536 Loss of Nurse Aide Training and Competency Evaluation Program or Competency Evaluation Program as a Result of Civil Money Penalty.
7550 Temporary Management.
7552 Transfer of Residents and Transfer of Residents with Closure of Facility.
7556 Termination Procedures for SNFs and NFs When Facility Is Not In Substantial Compliance with Participation Requirements.
7600 Continuation of Payments During Correction.
7700 Nurse Aide Registry and Findings of Abuse, Neglect or Misappropriation of Property.
7701 Reporting Abuse to Law Enforcement and the Medicaid Fraud Control Unit.

Program Management.
7800 Consistency of Survey Results.
7801 Sanctions for Inadequate State Survey Performance.
7803 Educational Programs.
7805 Criteria for Reviewing State Plan Amendments for Specified and Alternative Enforcement Remedies.
7807 State/Federal Disagreements About Timing and Choice of Remedies.
7809 Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Program Disapprovals.

Disclosure.
7900 Information Disclosed to Public.
7901 Requesting Public Information.
7902 Charges for Information.
7903 Time Periods for Disclosing SNF/NF Information.
7904 Information Furnished to State's Long Term Care Ombudsman.
7905 Information Furnished to State by Facility with Substandard Quality of Care.
7906 Information Furnished to Attending Physician and State Board.
7907 Access to Information by State Medicaid Fraud Control Unit.

Chapter 8: Standards and Certification—provides the regulatory authority for the State Performance Standards and protocols. Outlines the definition of inadequate survey performance, lists the performance standards and explains CMS's evaluation process to determine if performance standards have been met. Sets out the sanctions available and the State's appeal rights, both formal and informal, when CMS has imposed sanctions.

8000 State Performance Standards.

Exhibits—contains forms with model language for correspondence and notices; reporting formats and worksheets and supplemental guides for instruction in the *SOM* Chapters and Appendices.

Appendices:

A	Hospitals.
AA	Psychiatric Hospitals.
B	Home Health Agencies.
C	Laboratories and Laboratory Services.
D	Portable X-Ray Services.
E	Outpatient Physical Therapy or Speech Pathology Services—Interpretive Guidelines.
F	Physical Therapists in Independent Practice. (Deleted)
G	Rural Health Clinics (RHCs).
H	End-Stage Renal Disease Facilities.
I	Life Safety Code.
J	Intermediate Care Facilities for Persons with Mental Retardation.
K	Comprehensive Outpatient Rehabilitation Facilities.
L	Ambulatory Surgical Services Interpretive Guidelines
M	Hospice.
N	Pharmaceutical Service Requirements in Long-Term Care Facilities. (Deleted)
P	Survey Protocol for Long-Term Care Facilities.
PP	Interpretive Guidelines for Long-Term Care Facilities.
Q	Determining Immediate Jeopardy.
R	Resident Assessment Instrument for Long-Term Care Facilities.
S	Mammography Suppliers. (Deleted)
T	Swing-Beds.
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions.
V	Responsibilities of Medicare Participating Hospitals in Emergency Cases.
W	Critical Access Hospitals (CAHs).

Lesson 2-B-2: The Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify and discuss the appropriate process for surveying specific providers and suppliers.

- Describe the core tasks included in different types of surveys for providers and suppliers that have no written survey process, including:
  - Initial.
  - Recertification.
  - Revisit.
  - Complaint.
  - Validation of accredited provider.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Sections 1012–1016, 2700–2800, 3240–3257, 5330 and 5400
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix AA, Psychiatric Hospitals—Interpretive Guidelines and Survey Procedures
  - Appendix B, Guidance to Surveyors: Home Health Agencies
  - Appendix C, Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services
  - Appendix D, Guidance to Surveyors: Portable X-Ray Services
  - Appendix E, Guidance to Surveyors: Outpatient Physical Therapy or Speech Pathology Services
  - Appendix G, Guidance to Surveyors: Rural Health Clinics (RHCs)
  - Appendix H, Guidance to Surveyors: End-Stage Renal Disease Facilities
  - Appendix I, Survey Procedures and Interpretive Guidelines for Life Safety Code Surveys
  - Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Persons with Mental Retardation
  - Appendix L, Guidance to Surveyors: Ambulatory Surgical Services
  - Appendix M, Guidance to Surveyors: Hospice
  - Appendix T, Regulations and Interpretive Guidelines for Swing Beds in Hospitals
  - Appendix U, Survey Procedures and Interpretive Guidelines for Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
  - Appendix V, Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

State

(Insert State reference[s] here.)

Other

See Section 3 of this Manual for a description of the survey process for nursing facilities and skilled nursing facilities.

Highlights

- Identify and be able to discuss the process for surveying specific providers and suppliers that have a written survey process
- Optionally, describe the core tasks common to any survey process that does not have a written survey protocol and those tasks most likely to be included in the following types of surveys:
  - Initial
  - Recertification
  - Revisit
  - Complaint
  - Validation of accredited provider

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Handout:
  - *Core Tasks of a Survey Process*
- Appendices appropriate to students' survey responsibilities:
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix AA, Psychiatric Hospitals—Interpretive Guidelines and Survey Procedures
  - Appendix B, Guidance to Surveyors: Home Health Agencies
  - Appendix C, Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services
  - Appendix D, Guidance to Surveyors: Portable X-Ray Services
  - Appendix E, Guidance to Surveyors: Outpatient Physical Therapy or Speech Pathology Services
  - Appendix G, Guidance to Surveyors: Rural Health Clinics (RHCs)
  - Appendix H, Guidance to Surveyors: End-Stage Renal Disease Facilities
  - Appendix I, Survey Procedures and Interpretive Guidelines for Life Safety Code Surveys
  - Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Persons with Mental Retardation
  - Appendix L, Guidance to Surveyors: Ambulatory Surgical Services
  - Appendix M, Guidance to Surveyors: Hospice
  - Appendix T, Regulations and Interpretive Guidelines for Swing Beds in Hospitals
  - Appendix U, Survey Procedures and Interpretive Guidelines for Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
  - Appendix V, Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

- CMS forms appropriate for the students' survey responsibilities:
  - Sample OSCAR Report 3

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-B-2: The Survey Process 1	
Slide 2-B-2-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Identify & discuss the process for surveying specific providers & suppliers. 2	*(Inform the students of the objectives.)*
Slide 2-B-2-2	
Learning Objectives (cont.) • Describe the core tasks included in different types of surveys for providers & suppliers that have no written survey process, including: – Initial. – Recertification. – Revisit. – Complaint. – Validation of accredited provider. 3	
Slide 2-B-2-3	

Audiovisual

Purpose of Survey

- Determine compliance of entity with all applicable Federal regulations:
  - Health
  - Life Safety Code (most likely occurs with health survey)
    - Ambulatory surgical centers (ASCs)
    - Hospitals
    - Critical access hospitals (CAHs)

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Slide 2-B-2-4

Purpose of Survey (cont.)

- Intermediate care facilities for persons with mental retardation (ICF/MR)
- Nursing facilities/skilled nursing facilities (NFs/SNFs)
- Some hospices
- End stage renal disease (ESRD) facilities (proposed to begin in 2005)

5

Slide 2-B-2-5

Purpose of Survey (cont.)

- Results determine further actions:
  - Certification
  - Enforcement for long term care providers
  - Decertification

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Slide 2-B-2-6

Outline or text of presentation

Purpose of a Survey

Determine compliance of the entity with all applicable Federal regulations:

- Health.
- Life Safety Code:
  - LSC surveys will most likely occur with health surveys.
  - Includes survey of:
    - Ambulatory surgical centers (ASCs).
    - Hospitals.
    - Critical access hospitals (CAHs).
    - Intermediate care facilities for persons with mental retardation (ICFs/MR).
    - Nursing facilities/skilled nursing facilities (NFs/SNFs).
    - Hospices that directly provide inpatient services.
    - End stage renal disease (ESRD) facilities (proposed to begin in 2005).

Results determine further actions:

- Certification.
- Enforcement for long term care providers.
- Decertification.

For non–long term care providers and suppliers, either the entity is certified or the Regional Office has initiated decertification if the entity does not meet all Conditions of Participation or Conditions of Coverage.

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Outline or text of presentation

Outcome-Oriented Survey

- Outcome-oriented survey protocol:
  - Actual & potential outcomes
- Use in:
  - SNFs/NFs
  - Home health agencies (HHAs)
  - ICFs/MR
  - Rewritten interpretive guidelines for hospitals & CAHs

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Slide 2-B-2-7

Outcome-Oriented Survey

The outcome-oriented survey protocol involves investigation to identify actual and potential outcomes.

(Based on the provider the students are most likely to survey, provide examples of potential and actual outcomes.)

Some regulations have been written to reflect the outcome-oriented survey process. They include ones for:

- SNFs/NFs.
- Home health agencies (HHAs).
- ICFs/MR.

The hospital and CAH regulations have not changed, but the interpretive guidelines used by surveyors were rewritten in 2004 to help surveyors look for outcomes as well as investigate the systems in place to ensure appropriate care and services in a safe environment.

Written Survey Process

Appendices:

- A (Hospitals)
- AA (Psychiatric hospitals)
- C (Labs & lab services)
- H (ESRD facilities)
- I (Life Safety Code)
- J (ICFs/MR)
- M (Hospices)
- U (Medicare participating religious nonmedical healthcare institutions)
- V (Medicare participating hospitals in emergency cases)
- W (CAHs)

8

Slide 2-B-2-8

Written Survey Process

There is a written survey process for each of the following types of Federally certified providers and suppliers:

- Hospitals (Appendix A of *State Operations Manual [SOM]*).
- Psychiatric hospitals (Appendix AA).
- Laboratories and laboratory services (Appendix C).
- ESRD facilities (Appendix H).
- Life Safety Code (Appendix I).
- ICFs/MR (Appendix J).
- Hospices (Appendix M).
- Medicare participating religious nonmedical healthcare institutions (Appendix U).

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Outline or text of presentation

- Medicare participating hospitals in emergency cases (Appendix V), also known as "EMTALA" (Emergency Medical Treatment and Labor Act).
- CAHs (Appendix W).

If you survey any of these entities, you are required to use the written process and carefully follow it.

Common Tasks

- Offsite survey preparation
- Entrance conference & activities
- Sample selection
- Investigation
- Analysis of findings & decision making
- Exit conference
- Postsurvey activities

9

Slide 2-B-2-9

Common Tasks

Although each certified provider and supplier does not have a written survey protocol, the *SOM* and the written survey protocols identify tasks common to most surveys:

- Offsite survey preparation.
- Entrance conference and activities.
- Sample selection.
- Investigation.
- Analysis of findings and decision making.
- Exit conference.
- Postsurvey activities.

We are going to discuss each core task.

(Refer students to the handout "Core Tasks of a Survey Process" on page 2-B-2-27.)

Offsite Survey Preparation

- Check schedule
- Gather information:
  - Provider or supplier
  - Type of survey(s)
  - Location(s) of certified entity
  - Current certification status
  - History of compliance

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Slide 2-B-2-10

Offsite Survey Preparation

- Check schedule:
  - Frequency of survey is based on the budget call letter.
  - SNFs/NFs and HHAs are on a flexible cycle to reduce the "predictability" of the survey.
- Gather information:
  - Provider or supplier: What is the name of the entity you are going to

Audiovisual	Outline or text of presentation
	survey? Does the entity do business using another name? – Type of survey(s): initial, recertification, complaint, revisit, licensure or validation are the most common. However, you may have a combination of surveys (e.g., a recertification and a complaint, or a revisit and a complaint). You may also survey because of any of the following: o Complaint of deteriorating standards of care or report in the media. o Loss of accreditation. o Employee strike. o Change of ownership. o Significant change in the type of treatment provided. – Location(s) of certified entity: street address and city. Potentially you have to survey most or all locations included in the certification. – Current certification status. – History of compliance: review provider file and OSCAR Report 3, History Facility Profile. *(Distribute the appropriate State-specific OSCAR Report 3 and discuss sections of the form as well as the information listed.)*

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Offsite Survey Preparation (cont.)

– Publicly available information
– Floor plan or layout, if available
– Waivers appropriate to provider
• Determine team size & composition:
– Coordinate with team members
– Estimate time needed for travel & onsite survey

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Slide 2-B-2-11

Outline or text of presentation

- Publicly available information (e.g., a website or telephone directory).
- Floor plan or layout, if available.
- Waivers appropriate to the provider.

- Determine team size and composition:
  - Coordinate with team members.
  - Estimate time needed for travel and onsite survey.

Offsite Survey Preparation (cont.)

• Make travel arrangements:
– Hotel
– Airline &/or car
• Gather resources:
– Required appendix
– Appendix Q
– References (e.g., State licensure regulations, etc.)

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Slide 2-B-2-12

- Make travel arrangements:
  - Hotel.
  - Airline and/or car.
- Gather resources:
  - Required appendix.
  - Appendix Q.
  - References (e.g., State licensure regulations, etc.).

Offsite Survey Preparation (cont.)

– Supplies
– Forms
– Request to establish eligibility

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Slide 2-B-2-13

- Supplies.
- Forms.
- Request to establish eligibility.

Audiovisual

Offsite Survey Preparation (cont.)

- Conduct offsite team meeting:
  - Follow office procedure
  - Provide documents

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Slide 2-B-2-14

Outline or text of presentation

- Conduct offsite team meeting:
  - Follow office procedure.
  - Provide documents.

Offsite Survey Preparation (cont.)

- Do not announce survey. However, exceptions include laboratories, & 1-day notice is provided if:
  - Facility is inaccessible
  - Special travel arrangements are necessary
  - High probability that:
    - Staff will be absent
    - Entity will be closed
- $2,000 civil money penalty for any individual that notifies SNF/NF or HHA that it is going to be surveyed

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Slide 2-B-2-15

- Do not announce survey. However, exceptions include laboratories, and a one-day notice is provided if:
  - Facility is inaccessible or special travel arrangements are necessary.
  - The probability is high that essential staff will be absent or the entity will be closed.
- There is a $2,000 civil money penalty for any individual that notifies an SNF/NF or HHA that it is about to be surveyed.

Entrance Conference/ Activities

- Meet administrator or designee
- Introduce yourself (& others)
- Explain reason for visit
- Explain survey process
- Request information/documents

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Slide 2-B-2-16

Entrance Conference

- Meet administrator or designee.
- Introduce yourself (and others).
- Explain reason for visit.
- Explain survey process.
- Request information/documents.

Audiovisual

Entrance Conference/ Activities (cont.)

- If entity is going to tape record exit conference, request that copy be made available at conclusion
  - Do not accept promise that copy of tape will be mailed later
  - Videotaping is at discretion of survey team & office
- Ask with whom to discuss concerns

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Slide 2-B-2-17

Outline or text of presentation

- If the entity is going to tape record the exit conference, request that a copy be made available to the survey team at the conclusion of the conference:
  - Do not accept a promise that a copy will be mailed at a later date.
  - Videotaping the exit conference is at the discretion of the survey team and office. Call and discuss it with your supervisor.
- Ask with whom to discuss concerns.

During the survey, surveyors may allow or refuse to allow facility personnel to accompany them. Each case is at the State agency's and the surveyor's discretion and is to be worked out with facility management. Facility personnel may be helpful but may also hinder the surveyor, argue about observed problems and make the survey more difficult. If any of these problems occur, call your supervisor.

Sample Selection

- Select clients of entity to investigate compliance with regulations
- Regulations apply to all individuals treated by entity regardless of payment source, unless stated otherwise in regulations

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Slide 2-B-2-18

Sample Selection

Select clients of the entity to investigate compliance with regulations.

Regulations apply to all individuals treated by the entity regardless of the payment source unless stated otherwise in the regulations.

Audiovisual

Investigation

- Observe
- Interview
- Review documents

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Slide 2-B-2-19

Outline or text of presentation

Investigation

- For all regulations appropriate to visit:
  - Observe.
  - Interview.
  - Review documents.

Investigation (cont.)

- Throughout the day, observe:
  - Patients/clients
  - Activities
  - Treatments
  - Medication administration
  - Privacy during treatment & care giving
- Do not touch or examine patient yourself
- Share concerns timely so team can investigate further

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Slide 2-B-2-20

- Throughout the day, observe:
  - Patients/clients.
  - Activities.
  - Treatments.
  - Medication administration.
  - Privacy during treatment and care giving.
- Do not touch or examine a patient yourself, but obtain the patient's or representative's permission and request that a staff member interact with the individual as necessary. *(See SOM, Section 2713B.)*
- Share concerns timely so team can investigate further.

Investigation (cont.)

- Environment:
  - Safety (pharmaceuticals, infection control, fire & maintenance):
    - Confirm that what is there should be
    - Look: Is something not here that should be?
    - Confirm: Is it safe to use?
  - Maintenance
  - Cleanliness:
    - Not white glove inspection
  - Confidentiality of information/medical records

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Slide 2-B-2-21

- Environment:
  - Safety (pharmaceuticals, infection control, fire and maintenance):
    - Confirm that what is there should be.
    - Look: Is something not here that should be?
    - Confirm: Is it safe to use?
  - Maintenance.
  - Cleanliness:
    - Not a white-glove inspection.
  - Confidentiality of information/ medical records.

Audiovisual

Investigation (cont.)

- Interview:
  - Patients/clients:
    - In strict confidence
    - With permission
  - Staff:
    - Direct questions to appropriate staff
  - Management

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Slide 2-B-2-22

Investigation (cont.)

- Review documents:
  - Medical records:
    - Patient/client—include all care & services
    - Current treatment
    - Measurable goals set & reached

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Slide 2-B-2-23

Outline or text of presentation

- Interview:
  - Patients/clients.
    - Conduct interviews with patients/clients in strict privacy and with prior permission of the individual.
  - Staff: Direct questions to appropriate staff. For example, begin with those who work most closely with the individual.
  - Management: Interview to clarify information.

For all interviews, if the individual wishes another person there, you must respect his/her wishes. However, this may be a problem when patients/clients or staff are fearful of retaliation. If you suspect such fears on the part of patients/clients or staff, contact your supervisor.

- Review documents:
  - Medical records:
    - Patient/client—include all care and services.
    - Current treatment.
    - Check that staff set and reach measurable goals.

Audiovisual

Investigation (cont.)

– Policies & procedures
– Quality assurance if appropriate
– Staff:
  • Licensing
  • Inservice education

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Slide 2-B-2-24

Outline or text of presentation

- Policies and procedures required by regulation or to investigate identified concerns.
- Quality assurance (if appropriate to the survey).
- Staff:
  - Licensing.
  - Inservice education.

Investigation (cont.)

• Communicate with team members throughout investigation
• Communicate concerns timely
• Investigate concerns or inconsistencies further regarding regulations

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Slide 2-B-2-25

- For many surveys you may be the only surveyor. However, if you are a member of a team, communicate with team members throughout the investigation.
- Communicate concerns timely.
- Investigate concerns or inconsistencies further regarding regulations. Use observations, interviews or review of documents as appropriate.
- Use the regulations and the interpretive guidelines to help direct your investigation.

The interpretive guidelines clarify regulations for specific types of entities. They contain authoritative interpretations and clarifications of statutory and regulatory requirements and are to be used to make determinations about an entity's compliance with requirements.

The interpretive guidelines define or explain the relevant statutes and regulations and do not impose any requirements that are not otherwise set forth in the statutes or regulations. However, the guidelines do not provide an exhaustive, all-inclusive listing of

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Outline or text of presentation

circumstances that might indicate violations of the requirements.

Analysis of Findings

- Do not wait until end of survey
- Review all:
  - Documents
  - Applicable regulations & interpretive guidelines
- Determine whether further investigation is needed
- Conduct investigation:
  - Determine extent & significance or outcome

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Slide 2-B-2-26

Analysis of Findings

- Do not wait until the end of the survey to analyze your findings. If you identify something that may indicate that the requirements of a regulation are not met, share the finding with other team members in a timely manner.
- Review all documents.
- Review all regulations and interpretive guidelines that apply to the entity you are surveying.
- Determine whether further investigation is needed.
- Conduct an investigation to determine the extent and significance or outcome.
- If a concern is identified regarding the care or services provided to an individual, determine whether there is also a breakdown in the entity's system to provide appropriate care and services.

Decision Making

- Determines compliance with regulations
- Determines extent & significance or outcome of regulation
- Determines whether system is not in place or absent

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Slide 2-B-2-27

Decision Making

If a team of surveyors conducted the survey, decisions are team decisions and not just the decision of an individual. Always listen to how each surveyor made appropriate observations, interviewed appropriate people and reviewed all appropriate documents to support any decision. The team:

- Determines compliance with regulations.
- Determines the extent and significance or outcome of the regulation.
- Determines whether a system is not in place or is absent.

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Outline or text of presentation

Communicate with your supervisor before the exit conference.

Exit Conference

- Thank:
  - Staff
  - Patients/clients
  - Others
- Clarify:
  - Meeting is informal
  - Present preliminary findings
  - Explain postsurvey process

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Slide 2-B-2-28

Exit Conference

- Thank staff, patients/clients, and others for their cooperation.
- Make it clear that the exit conference is an informal meeting to present preliminary findings.
- Explain the postsurvey process.

Postsurvey Activities

- Complete:
  - Form CMS-2567, *Statement of Deficiencies & Plan of Correction*
  - Form CMS-670, *Survey Team Composition & Workload Report*
  - Any other documents required
- Compile packet as required
- Review & approve Plan of Correction

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Slide 2-B-2-29

Postsurvey Activities

- Complete:
  - Form CMS-2567, *Statement of Deficiencies and Plan of Correction.*
  - Form CMS-670, *Survey Team Composition and Workload Report.*
  - Any other documents required.
- Compile packet as required.
- Review and approve Plan of Correction *(as appropriate to your agency)*.

Types of Surveys: Initial

- Before survey, entity:
  - Applies for certification (Form CMS-855)
  - Is licensed, if needed
  - Meets other requirements
- During survey, entity:
  - Demonstrates compliance with all regulations
    - Adequate number of patients/clients to demonstrate compliance

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Slide 2-B-2-30

Types of Surveys

Initial

- Before survey, entity:
  - Applies for certification (Form CMS-855).
  - Is licensed, if needed.
  - Meets other requirements:
    - Location.
    - CAH: application with State rural health entity.

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Outline or text of presentation

- During survey, entity:
  - Demonstrates compliance with all regulations.
    - Adequate number of patients/clients to demonstrate compliance.

Types of Surveys: Initial (cont.)

- During survey, survey team:
  - Determines compliance with all regulations
  - Conducts all core tasks

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Slide 2-B-2-31

- During survey, survey team:
  - Determines compliance with all regulations.
  - Conducts all core tasks of survey.

Types of Surveys: Recertification

- Survey team conducts all core tasks:
  - Offsite survey preparation
  - Entrance conference & activities
  - Sample selection
  - Investigation
  - Analysis of findings & decision making
  - Exit conference
  - Postsurvey activities

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Slide 2-B-2-32

Recertification

- Survey team conducts all core tasks:
  - Offsite survey preparation.
  - Entrance conference and activities.
  - Sample selection.
  - Investigation.
  - Analysis of findings and decision making.
  - Exit conference.
  - Postsurvey activities.

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Types of Surveys: Revisit

- Survey team conducts tasks appropriate to determine whether entity has corrected previously cited deficiencies but includes at least:
  - Offsite survey preparation
  - Entrance conference & activities
  - Investigation
  - Analysis of findings & decision making
  - Exit conference
  - Postsurvey activities

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Slide 2-B-2-33

Outline or text of presentation

Revisit

Survey team conducts tasks appropriate to determine whether the entity has corrected previously cited deficiencies but includes at least:

- Offsite survey preparation.
- Entrance conference and activities.
- Investigation.
- Analysis of findings and decision making.
- Exit conference.
- Postsurvey activities.

Types of Surveys: Revisit (cont.)

- Sample selection will depend on deficiencies previously cited

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Slide 2-B-2-34

- Sample selection will depend on the deficiencies previously cited.

Types of Surveys: Complaint

- Investigate Condition of Participation (CoP) or Coverage (CoC) throughout entity:
  - Triage—determine how soon complaint will be investigated
  - SNF/NF—investigate requirement
  - Non-LTC—investigate entire CoP or CoC throughout certified entity
- If deemed, Regional Office determines investigation

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Slide 2-B-2-35

Complaint

- Investigate Condition of Participation (CoP) or Coverage (CoC) throughout entity:
  - Triage—determine how soon the complaint will be investigated.
  - SNF/NF—investigate the requirement.
  - Non-LTC—investigate the entire CoP or CoC throughout the certified entity.
- If deemed, Regional Office determines investigation.

Audiovisual

Types of Surveys: Complaint (cont.)

- Conduct tasks appropriate to provider & complaint. At minimum:
  - Modified offsite survey preparation
  - Entrance conference & activities
  - Investigation
  - Analysis of findings & decision making
  - Exit conference
  - Postsurvey activities
- Sample selection will depend on allegations within complaint & regulations included in CoP or CoC

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Slide 2-B-2-36

Outline or text of presentation

- Conduct tasks appropriate to the provider and the complaint. Tasks will include at least:
  - Modified offsite survey preparation (modified to gather information needed for complaint investigation).
  - Entrance conference and activities.
  - Investigation.
  - Analysis of findings and decision making.
  - Exit conference.
  - Postsurvey activities.

Sample selection will depend on the allegations within the complaint as well as all regulations included in the COP/COC.

Types of Surveys: Validation

- Entity is accredited by an organization that CMS has "deemed" to have regulations & survey process similar to Federal regulations & survey process
- Team validates results of accrediting organization
- Provider is selected at random by CMS Central Office staff

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Slide 2-B-2-37

Validation

- Entity is accredited by an organization that CMS has "deemed" to have regulations and a survey process similar to the Federal regulations and survey process.
- Team validates results of accrediting organization.
- Provider is selected at random by CMS Central Office staff.

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Types of Surveys: Validation (cont.)

- Team uses Federal survey process & regulations
  - You will not be informed of accrediting organization's survey results

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Slide 2-B-2-38

Lesson 2-B-2:
The Survey Process

Questions

39

Slide 2-B-2-39

Outline or text of presentation

- Team uses Federal survey process and regulations:
  - You will not be informed of the accrediting organization's survey results.

(Provide a copy of the appendix appropriate to the students' survey responsibilities. If the students are to survey any Federally certified providers or suppliers, provide a copy of the survey protocol and discuss it.

Provide any office worksheets or CMS forms included in the written process.)

Skill Assessment

The Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified and discussed the process to use when surveying *(name of provider or supplier entity).*	
					Described the core tasks included in the following types of surveys: • Initial. • Recertification. • Revisit. • Complaint. • Validation.	

Comments/Recommendations:

Core Tasks of a Survey Process

Core task	Activities
Offsite survey preparation	• Check schedule. • Gather information: – Provider/supplier. – Type of survey(s). – Location(s) of certified entity. – Current certification status. – History of compliance. – Publicly available information. – Floor plan or layout, if available. – Waiver in effect (LSC, nursing or other). • Determine team size and composition: – Coordinate team members. • Make travel arrangements: – Estimate time needed for travel and onsite survey. – Make hotel reservations. – Arrange transportation: airline and/or car. • Gather resources: – Required appendix. – Appendix Q. – References. – Supplies. – Forms: o Request to establish eligibility. • Conduct offsite team meeting. – Follow office procedure. – Provide documents. • Do not announce survey except for laboratories, and one-day notice is provided if: o Facility is inaccessible, or special travel arrangements are necessary. o Probability is high that essential staff will be absent or the entity will be closed.
Entrance conference and activities	• Meet administrator or designee. • Introduce self (and others). • Explain reason for visit. • Explain survey process. • Request information/documents. • If the entity is going to record the exit conference, request that it provide a copy to the team at the conclusion. • Ask with whom to discuss concerns.

Sample selection	• Identify individuals to investigate for entity's compliance with regulations: – Regulations apply to all individuals treated by the entity regardless of payment source unless stated otherwise in the regulations.
Investigation	• Observe: – Patients/clients throughout the day: o Activities. o Treatments. o Medication administration. o Privacy during treatment and care giving. ▪ Do not touch or examine a patient alone. Secure permission of patient and staff assistance. – Environment: o Safety (pharmaceuticals, infection control, fire, preventive maintenance): ▪ Confirm that what is there should be. ▪ Is something not there that should be? ▪ Is it safe to use? o Maintenance. o Cleanliness. o Information/medical records kept confidential. • Interview: – Patients/clients: Conduct with prior permission of the individual and in strict privacy. – Staff: Direct questions to appropriate staff. – Management. • Review documents: – Medical records: o Patient/client condition and progress (outcome of care and services), current treatment, establishment and attainment of measurable goals. – Policies and procedures. – Quality assurance (if appropriate to survey). – Staff licensing and in-service education. • Communicate with team members throughout investigation in a timely manner. • Identify concerns or inconsistencies regarding regulations and investigate further if necessary. • Use regulations and interpretive guidelines.

Analysis of findings and decision making	• Analysis of findings: – Do not wait until the end of the survey. – Review all of your documents. – Based on type of survey, review regulations and interpretive guidelines. – Determine whether further investigation is needed. – Conduct the investigation to determine the extent and significance or outcome of the practice and whether an entity system is out of place. • Decision making: – Determines compliance with regulations based on observation, interview and review of documents. – Determines extent and significance or outcome/lack of system. – Communicate decisions with supervisor before exit conference.
Exit conference	• Thank staff, patients/residents and others for cooperation. • Conduct informal meeting. • Communicate preliminary findings. • Explain postsurvey process.
Postsurvey activities	• Complete: – Form CMS-2567, *Statement of Deficiencies and Plan of Correction.* – Form CMS-670, *Survey Team Composition and Workload Report.* – Any other document required. • Compile packet as required. • Review and approve Plan of Correction.

Lesson 2-C: Surveyor Dress and Approach

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe appropriate general surveyor conduct and demeanor.
- Verbalize what to bring and not bring on a survey.
- Define conflict of interest and a balanced attitude.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Sections 4008 and 7202

State

(Insert State reference[s] here.)

Other

Highlights

- Dress and appearance
- Documents and articles to bring into the facility
- Guidance for speaking to people in the facility
- General rules of conduct and demeanor
- Preparing for and working with survey team members
- Conflict of interest
- Maintaining an objective attitude

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handout

Methods of Evaluation

- Completion of skill assessment

Audiovisual

Lesson 2-C:
Surveyor Dress & Approach

1

Slide 2-C-1

Outline or text of presentation

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe appropriate general surveyor conduct & demeanor.
- Verbalize what to bring & not bring on a survey.
- Define conflict of interest & a balanced attitude.

2

Slide 2-C-2

(Inform the students of the objectives.)

Basic Expectations

- General appearance & demeanor
- Be prepared:
  - Wear your name tag or badge
  - Bring your business card
  - Wear clean, comfortable, easily laundered clothing
  - Wear comfortable shoes
  - Special attire in facility's kitchen
  - Follow facility's dress code, if any

3

Slide 2-C-3

Basic Expectations for Your Role as Surveyor

When we meet new people, we create a perception of our competence and professionalism by our appearance. Clothing, grooming and the smell of one's body create a lasting impression.

While surveying, you will meet a wide variety of people on whom it is important to make a positive impression. Contacts you will make during the survey include:

Audiovisual

Outline or text of presentation

- Administrator of the facility.
- Facility staff.
- Patients/residents/clients and their families.

In a small community, any individual with whom you come in contact, such as a waitress at a restaurant, may be aware that you are conducting a survey. It is also possible that you may be recognized by your vehicle's license plate. Therefore, it is very important to be appropriately groomed and dressed at work and in public. Furthermore, it is important to present a friendly, professional image and demeanor.

Always remember that you are representing your office.

Be prepared

- Wear your name tag or badge while surveying any provider or supplier location.
- Bring your business card with you to give to facility staff.
- Wear clean, comfortable clothing that is appropriate for the weather. Keep in mind that many facilities are not air conditioned.
- Wear easily laundered clothing.
- Wear comfortable shoes, as you will be on your feet a lot. (Sport shoes, however, are not acceptable.)
- Wear hair covers (such as surgical caps, hair nets or other special garments) when in the kitchen, surgical areas or other areas requiring special attire.

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Basic Expectations (cont.)

- Chewing gum
- Smoking

4

Slide 2-C-4

Outline or text of presentation

- Chewing gum: Use good etiquette.
- Smoking breaks: Observe facility policies.

(Review your office policies and procedures regarding the following with the students before presenting the remaining information in this lesson:

- *Dress code, including garments, shoes and jewelry.*
- *General grooming.*
- *Name tag or badge.*
- *Business cards.*
- *Chewing gum.*
- *Smoking.*

Address both office and work-site policies.)

What to Bring to Facility

- Federal & State regulations
- Other references
- Required forms or worksheets
- Clipboard or similar tool
- Office supplies
- Measuring tape
- Thermometer
- Computer & printer

5

Slide 2-C-5

What to bring to the facility

- A copy of the Federal and State regulations for the entity.
- Other references, as appropriate (e.g., a drug reference, Appendix Q, etc.).
- Required forms or worksheets.
- Clipboard or similar tool.
- Office supplies (e.g., pens, markers, Post-it notes, clips, stapler).
- Measuring tape.
- Thermometer.
- Computer and printer.

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What Not to Bring to Facility

- Schedule of surveys
- Confidential information
- Valuable personal items

6

Slide 2-C-6

Outline or text of presentation

What not to bring to the facility

- A schedule of surveys.
- Confidential information (if you must bring it with you, keep it with you at all times).
- Personal items you do not want to lose.

Food & Beverages

- Food
- Beverages
- Clean up

7

Slide 2-C-7

Food and beverages

- You are not to request beverages or food items except water.
- If the facility staff offers you coffee, tea or other beverages, however, you may accept.
- You must never accept a meal.
- If you bring food into a facility, be sure to clean up any mess and dispose of trash properly.

(Review your office policies and procedures regarding the following with the students before presenting the remaining information in this lesson:

- *Food and beverages.*
- *Meal and other breaks.)*

Conflict of Interest

- Worked within the past 2 years as employee, officer, consultant or agent
- Have financial interest or ownership interest
- Have immediate family member who is a patient/resident/client or works at facility

8

Slide 2-C-8

Conflict of Interest

According to Federal directives, you may not survey a facility if you have:

- Worked in the facility within the past two years as employee, officer, consultant or agent. If you worked for an entity and will likely survey that entity, discuss this with your supervisor.
- A financial interest or ownership interest in the facility.

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Outline or text of presentation

- An immediate family member (i.e., spouse, child, sibling, parent, step-relative) who either is a patient/resident/client in the facility or works there.

Objective Attitude

- Should not be "gotcha" or that entity must follow "letter of the law" but should identify how facility meets regulations
- Do not impose preferences—look for ways facility has implemented regulations

9

Slide 2-C-9

Objective Attitude (cont.)

- Balanced attitude: assessing regulation to outcome of care & services or system actually in place vs. way you would meet regulations
  - Maintain open mind
  - Use approach necessary to accomplish improvement
  - Recognize reality & what is reasonable versus ideal

10

Slide 2-C-10

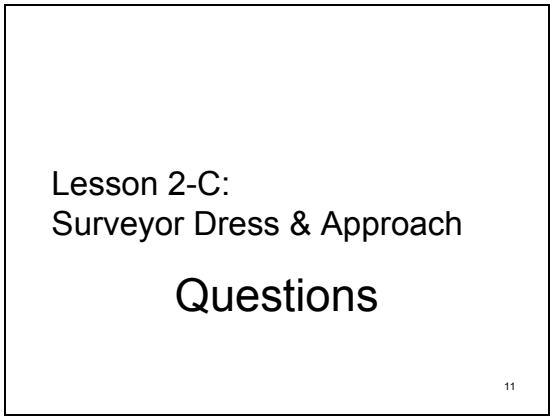
Objective Attitude

Survey findings are the bridge between regulations and license and/or certification action. Use your authority responsibly:

- Your attitude should not be "gotcha" or that the entity must follow the "letter of the law" but should be to identify how the facility meets the regulations.
- Do not impose your preferences but look for the unique ways that facility has implemented the regulations.
- Use a balanced attitude: assessing the regulation to any outcome of care and services or the system actually in place versus the way that you would meet the regulations.
  - Maintain an open mind.
  - Recognize reality and what is reasonable versus ideal.

Audiovisual

Outline or text of presentation



Slide 2-C-11

Skill Assessment

Surveyor Dress and Approach

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described appropriate general surveyor conduct and demeanor.	
					Verbalized: • Items to bring on a survey. • Items to bring into facility. • Items not to bring into facility.	
					Defined conflict of interest and a balanced attitude.	

Comments/Recommendations:

Lesson 2-C-1: Surveyor Conduct and Etiquette

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Interact appropriately with team members, patients/residents and facility staff.
- Demonstrate appropriate surveyor conduct and etiquette.

Lesson Plan

References

Federal

- *State Operations Manual (SOM),* Chapter 2:
  - Sections 2713A, 2713B, 2715 and 2727
- *Health Insurance Portability and Accountability Act of 1996*
- U.S. Department of Health and Human Services, Office for Civil Rights. (2004, September 16). *Medical Privacy—National Standards to Protect the Privacy of Personal Health Information* [On-line]. Available: http://www.hhs.gov/ocr/hipaa/

State

(Insert State reference[s] here.)

Other

Highlights

- Interactions with facility staff and patients or residents
- Talking with staff, but not consulting
- General responsibilities during the survey and working with other surveyors
- Confidentiality

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts

Methods of Evaluation

- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-C-1:
Surveyor Conduct & Etiquette

1

Slide 2-C-1-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Interact appropriately with team members, patients/residents & facility staff.
- Demonstrate appropriate surveyor conduct & etiquette.

2

Slide 2-C-1-2

(Inform the students of the objectives.)

Interaction with Facility Staff

As a surveyor, you will be interacting with all levels of facility staff and potentially in all departments:

- Administrator.
- Administrative staff.
- Nursing staff.
- Department heads.
- Facility staff.
- Consultants to the facility.

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Limitation on Consulting

- Don't consult
- Share information attributable to regulations
- Accurately represent rationale for regulations
- Don't impose or substitute personal preferences

3

Slide 2-C-1-3

Outline or text of presentation

As you survey, you may find that the facility is not in compliance with one or more regulations. Discuss this with your team members and determine the appropriate time to share with facility staff information learned during the survey.

Limitation on Consulting

It is important to keep in mind that you are a surveyor and not a consultant. Federal directives limit the amount of consultation you may do [*State Operations Manual (SOM), section 2727*]. The *SOM* permits you to discuss the regulations and the survey process, which can result in a better understanding by all parties involved.

You may explain any regulation to facility staff as well as the observations, results of interviews and review of documents that have led to your determination that the facility is not following that regulation. You are not, however, to present your solution to the problem or offer ideas about how to fix and/or address the problem, as this may have serious repercussions for you.

(Discuss with students examples of appropriate and inappropriate communication with facility staff, based on the above paragraph.)

If you make a determination of noncompliance with one or more regulations, it is the facility's responsibility to identify the reasons why it is not in compliance with the regulation(s) and decide how to best address the issue. A professional consultant may be an option for some facilities.

Audiovisual

Outline or text of presentation

Discussion with the Facility

- When you interview facility staff, share information related to the regulations:
  - If you encounter what you suspect is an instance of facility noncompliance but you don't yet know the regulation or guidance that is applicable to the situation, tell the facility that you would like to discuss it later.
  - Review the information yourself and if needed, ask assistance from another surveyor or the team coordinator.
- Accurately represent the rationale for or the principles underlying the regulations.
- Never impose your personal or professional preferences for achieving compliance with regulations.

Your Responsibilities

- Before survey, know following:
  - Where you are going
  - Who is on your team
  - Who the team coordinator is
  - How to contact team coordinator
  - Day, time & location
  - Where to meet
- Complete required work prior to offsite team meeting

4

Slide 2-C-1-4

Your Responsibilities

- Before the survey, know the following:
  - Where you are going.
  - Who is on your team.
  - Who the team coordinator is.
  - How to contact the team coordinator.
  - The day, time and location of the survey and where to meet.
- Complete required work prior to the offsite team meeting.

Audiovisual

Your Responsibilities (cont.)

- Bring:
  - Federal & State regulations
  - Sufficient forms for all aspects of survey
  - References
- Complete tasks assigned to you
- Keep team members informed of progress

5

Slide 2-C-1-5

Outline or text of presentation

- Bring the following to the survey:
  - Federal and State regulations.
  - Sufficient forms for all aspects of the survey.
  - References.

(*Based on the provider or supplier the student will survey, list the Federal and State regulations and references needed.)*

- Complete tasks assigned to you.
- Keep team members informed of your progress. If you anticipate problems completing assigned tasks, inform the team coordinator and team promptly so adjustments can be made to individual assignments.
- Adjust your speed as needed to complete assignments timely and to help team complete the survey within the allotted time. At times you will have to complete work more quickly than you may prefer. Your team coordinator and supervisor may have ideas to assist you.
- Be prepared and organized for team meetings.
- Gather information related to the regulations.

Your Responsibilities (cont.)

- Adjust your speed as needed to complete assignments timely & to complete survey within allotted time
- Be prepared & organized for team meetings
- Gather information related to regulations

6

Slide 2-C-1-6

Working with Facility Staff

- Respect role of provider
- Be aware that provider may be nervous
- Try not to intimidate
- Be sensitive, but remain objective
- Be aware of your body language

7

Slide 2-C-1-7

Working with the Facility Staff

- Respect the role of the provider; he/she has a difficult job to do.
- Be aware that the provider may be very nervous because of your presence in the facility. Because you're a surveyor, your presence will be an intimidating factor to the staff, who may be unaccustomed to someone looking over their shoulders.

Audiovisual

Outline or text of presentation

- Try not to intimidate the staff. Smile and greet staff members in a friendly manner.
- Be sensitive to the body language and the feelings of the provider's staff regarding their efforts and problems, but remain objective while determining compliance with regulations.
- Be aware of your body language:
  - Guard your facial expression.
  - Be aware of how close you stand to the staff.
  - Be conscious of your posture (e.g., do not place your hands on your hips or cross your arms).
  - Be sensitive to the volume and tone of your voice.

Working with Facility Staff (cont.)

- Do not let provider intimidate you
- Maintain open & ongoing dialogue with facility staff
- Provide information to appropriate staff at proper time using suitable method
- Don't consult, share opinions or tell stories or jokes

8

Slide 2-C-1-8

- Do not let the provider intimidate you.
- Maintain an open and ongoing dialogue with the facility staff throughout the survey. This gives the facility an opportunity to provide you with additional information before you make deficiency decisions.
- This does not mean that you report every finding on a daily basis or before you have completed as much of the investigation as possible first. As agreed upon by the team, provide information to the appropriate staff after the team has investigated the issue.
- Don't consult, share opinions or tell stories or jokes.

Audiovisual

Working with Facility Staff (cont.)

- Respect role & time of staff
  - Don't interrupt care & services
- Remain gracious & polite
- Never argue with staff
  - Present information & concerns clearly & concisely
- Request information & documents

9

Slide 2-C-1-9

Outline or text of presentation

- Respect the role and time of staff; don't interrupt care and services.
- Remain gracious and polite.
- Never argue with staff, but rather present information and concerns clearly and concisely. Remember, the person that loses his/her temper is the one that has lost control of the situation.
- Ask staff to present additional information and documents that they may have to help resolve your concerns.

Working with Facility Staff (cont.)

- Never ask personal favors
- Never engage in social activities with provider staff during survey
- Notify supervisor as soon as possible if you have:
  - Relative, friend or neighbor that is patient/resident at facility you are scheduled to survey

10

Slide 2-C-1-10

- Never ask personal favors. For example, it is unacceptable to request to observe a treatment at a certain time so that you would be able to leave early.
- Never engage in social activities with provider staff during the survey.
- Notify your supervisor as soon as possible if you have:
  - A relative, friend or neighbor that is a patient/resident at a facility you are scheduled to survey.

Working with Facility Staff (cont.)

  - Any affiliations or investments that might cause conflict of interest
- Never allow personal feelings or knowledge about provider to interfere with compliance decisions

11

Slide 2-C-1-11

  - Any affiliations or investments that might cause a conflict of interest.
- Never allow your personal feelings or knowledge about a provider to interfere with compliance decisions.

Audiovisual

Etiquette in Regard to Patients/Residents

- Always knock & wait for response
- Introduce yourself & explain your work at facility
- Never treat, care for or otherwise handle patient/resident

12

Slide 2-C-1-12

Etiquette in Regard to Patients/Residents (cont.)

- Respect patient's/resident's privacy
  - Always obtain patient's/resident's permission before observing care or interviewing
  - Conduct interview in private unless individual requests presence of another

13

Slide 2-C-1-13

Outline or text of presentation

Etiquette in Regard to Patients/Residents

- Always knock and wait for a response before entering the patient's or resident's room. Some patients/residents may not be able to provide a response. Always use the reasonable-person approach (i.e., wait for a response, if no response knock and wait again, if again no response carefully open the door).
- Introduce yourself and explain your work at the facility.

(See SOM, Section 2713B, regarding the following points.)

- Never treat, care for or otherwise handle a patient/resident. Be a "gofer" and go for facility staff to assist the patient. Direct staff who touch and manipulate the resident as necessary.
- Respect the patient's/resident's privacy.
  - Always obtain the patient's/resident's permission before observing care and/or treatments or conducting interviews.
  - Conduct interviews in private unless the individual being interviewed requests the presence of another.

Audiovisual

Etiquette in Regard to Patients/Residents (cont.)

- Include patient/resident in conversation if present
- Ask permission before going through any personal belongings

14

Slide 2-C-1-14

Outline or text of presentation

- Discuss issues regarding a patient/resident who is present only when the patient/resident is included in the conversation, even if the individual is cognitively impaired.
- Always ask for the patient's/resident's permission before going through any personal belongings. An example might include looking in the individual's bedside table for dentures or glasses.

Risk of Harm or Injury to Patient/Resident

- Intervene if patient/resident is at risk for injury or harm:
  - Nurse is about to administer wrong medication
  - Patient/resident is about to slip on water
  - Patient/resident is trying to get out of bed over bed rails

15

Slide 2-C-1-15

Risk of Harm or Injury to the Patient/Resident

If a facility practice puts a patient/resident at risk of injury or harm, intervene promptly. Examples:

- The nurse is about to administer the wrong medication.
- A patient/resident is about to slip on water on the floor that facility staff have failed to clean up.
- A patient/resident is trying to get out of bed over the bed rails.

HIPAA

- Ensures patient/resident's right to privacy with respect to personal health records
- Sets rules & limits regarding who can look at & receive information
- Requires that providers & health insurers:
  - Teach employees to use information properly
  - Take appropriate & reasonable steps to secure patient/resident information

16

Slide 2-C-1-16

Health Insurance Portability and Accountability Act

Privacy is important to all of us. Under Federal law individuals have privacy rights. Health care providers, health care professionals, health insurance companies and certain government programs that pay for health care, including Medicare and Medicaid, must follow the law.

Providers are required to adhere to the Health Insurance Portability and

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Outline or text of presentation

Accountability Act (HIPAA) and ensure an individual's rights to:

- Ask to see and get a copy of his/her personal health record.
- Have corrections made to the health information contained in his/her record.
- Receive a notice that informs him/her how his/her health information is used and shared.
- Determine and give permission before information is shared for certain purposes, such as information given to an employer or given for things like sales calls and advertising.

HIPAA sets rules and limits regarding who can look at and receive an individual's information.

By law, providers and health insurers must keep individual information private through the following steps:

- Teach employees how to use information properly.
- Take appropriate and reasonable steps to keep an individual's health information secure.

For further information, please visit http://www.hhs.gov/ocr/hipaa/.

Confidentiality for Surveyors

- Keep confidential information confidential
- Share with facility staff names of patients/residents about whom information is obtained through record review
- Share patient/resident interview information with facility staff only if patient/resident gives permission

17

Slide 2-C-1-17

Confidentiality for Surveyors

As a surveyor, you must:

- Keep confidential information confidential.
- Share with facility staff the names of patients/residents about whom information is obtained through record review.
- Share patient/resident interview information with facility staff only if the patient/resident gives you permission.

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Working with Other Surveyors

- Do not ask for special treatment or favors
- Provide team members with information timely
- When information is shared with you, follow up in timely manner

18

Slide 2-C-1-18

Working with Other Surveyors (cont.)

- Contribute productively to team discussion
- Notify team immediately if you identify immediate jeopardy
- Adapt to team

19

Slide 2-C-1-19

Lesson 2-C-1:
Surveyor Conduct & Etiquette

Questions

20

Slide 2-C-1-20

Outline or text of presentation

Working with Other Surveyors

- Do not ask for special treatment or favors from other surveyors. A coworker may offer to do a favor, but do not treat this as something you have a right to expect.
- Provide team members with information timely to assist the team in conducting the survey.
- When another surveyor shares information with you, follow up in a timely fashion when it is appropriate to do so.

- Contribute productively to team discussions.
- Notify the team immediately if you identify the potential for immediate jeopardy.

Each team will be different based on the individuals who are part of the team. As a team member, you must adapt accordingly. If you are experiencing any difficulties working with a team, notify your supervisor.

Skill Assessment

Surveyor Conduct and Etiquette

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Demonstrated appropriate interactions: • Shared information appropriately with facility staff. • Shared information appropriately with team members.	
					Demonstrated appropriate body language and behaviors.	
					Demonstrated appropriate behaviors with patients/residents, including respecting privacy, not handling patient/resident and securing permission before observing care and conducting interviews.	
					Intervened appropriately when patient/resident was at risk of harm.	
					Maintained confidentiality of interview and records, when appropriate.	

Comments/Recommendations:

Lesson 2-C-2: Teamwork—Working Together as a Team

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the teamwork concept, team member roles and potential team difficulties.
- Identify benefits of working together as a team.
- Demonstrate ability to work as an effective, fully contributing and functioning team member.

References

Federal

- *State Operations Manual (SOM):*
  - Section 2706
  - Section 4009
  - Section 7201

State

(Insert State reference[s] here.)

Other

- Tuckman, B. W. (1965). Developmental sequences in small groups. *Psychological Bulletin,* 63, 384–399.

Highlights

- The qualified surveyor
- Team development and effective relationships
- Team composition and size
- Preparation for the survey and the roles of team members
- Benefits and difficulties of team work

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handout

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

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Lesson 2-C-2:
Teamwork—Working
Together as a Team

1

Slide 2-C-2-1

Outline or text of presentation

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the teamwork concept, team member roles & potential team difficulties.
- Identify benefits of working together as a team.
- Demonstrate ability to work as an effective, fully contributing & functioning team member.

2

Slide 2-C-2-2

(Inform the students of the objectives.)

Qualified Surveyor

- Appropriate background in health profession or administration
- Skills to investigate, evaluate, determine whether regulations are met & write official reports
- Completion of orientation & training program
- For long term care, passing SMQT

3

Slide 2-C-2-3

Qualified Surveyor

[See the State Operations Manual (SOM), Section 4009.]

Each of you has the appropriate background, training and experience to qualify as a surveyor. That is why you are here.

A surveyor is an individual who has successfully completed training to:

- Investigate, evaluate and make official reports of situations and conditions in a health care facility.

Audiovisual

Outline or text of presentation

- Determine the degree to which the facility meets specific criteria set forth in Federal and State regulations.

During this training and orientation period, you will learn the Federal and State regulations that are applicable to surveying specific providers and suppliers.

As a long term care facility surveyor, you will be required to take and pass the Surveyor Minimum Qualifications Test (SMQT). Individuals who survey other providers and suppliers are not required by Federal directives to take the SMQT.

In your work as a surveyor, you will often work in teams with other surveyors.

Teamwork

Team:
- More than group of people
- Group of people who depend on each other to attain shared goal

Teamwork:
- Process through which group of people *work together* to reach common goal

4

Slide 2-C-2-4

Teamwork

A group of people may form a team, but "teamwork" involves more than simply being grouped with other people. It is the process through which a group of people *work together* to reach a common goal, to solve a particular problem or to achieve specified results. Many times a team will work together but often will divide tasks among members based on each individual's relative skills.

Audiovisual

Team Development

- Teams move through sequence of developmental stages
  - Form
  - Storm
  - Norm
  - Perform
  - "Team think"

5

Slide 2-C-2-5

Outline or text of presentation

Team Development

Teams move through a sequence of developmental stages:

- Form/infancy—You do not know each other and have never worked together before. Everything is new.
- Storm/teenage—You know some things about each other, but not enough to get along well. Conflict is likely to occur.
- Norm/adult—You have made friends and know how each thinks and reacts to situations. Conflict is less likely to occur.
- Perform/mature—You know and are considerate of each other's feelings and beliefs. Conflict rarely occurs.
- "Team think"—You know each other so well that minimum communication is needed to transmit information and conduct a thorough survey.

"Harvest" of Effective Relationships

- Prepare ground with self-disclosure
- Plant in climate of trust
- Fertilize communication skills
- Cultivate constructive confrontation
- Grow healthy feelings
- Harvest characteristics of acceptance
- Maintain commitment to harvest shared goals

6

Slide 2-C-2-6

"Harvest" of Effective Relationships

Effective team relationships don't just happen. Team members must all contribute to making the team effective.

- Prepare the ground with self-disclosure.
- Plant in a climate of trust.
- Fertilize your communication skills.
- Cultivate with constructive confrontation.
- Grow with healthy feelings.
- Harvest the characteristics of acceptance.
- Maintain a commitment to harvest shared goals.

Audiovisual

Team Composition & Size

- Type of provider & supplier, size & history of entity determine team size & composition (disciplines & experience)
- Long term care teams must include:
  - 1 SMQT-qualified person
  - 1 nurse
- Teams may include surveyors of mixed disciplines & experience to enrich application of regulations & perspectives

7

Slide 2-C-2-7

Outline or text of presentation

Team Composition and Size

(See SOM, Sections 2706 and 7201.)

- The type of provider and supplier, size and history of the entity being surveyed determine the team size and composition (disciplines and experience).
- Long term care teams must include:
  - One SMQT-qualified person.
  - One nurse.
- Teams may include surveyors of mixed disciplines and experience to enrich the application of regulations and perspectives.

Prepare for a Survey

- Address team organization
  - Who is team coordinator?
  - Who is on team?
  - Who is riding with whom?
  - When & where will team meet?
  - Where is team staying?
  - Are there unique needs of team or individuals?

8

Slide 2-C-2-8

Prepare for a Survey

- Address team organization:
  - Who is the team coordinator?
  - Who is on the team?
  - Who is riding with whom?
  - When and where will the team meet?
  - Where is the team staying?
  - Are there unique needs of either the team or individuals?

Prepare for a Survey (cont.)

- Finish any work needed in preparation for survey & offsite team meeting
- Bring needed regulations, supplies & forms

9

Slide 2-C-2-9

- Finish any work needed in preparation for the survey and the offsite team meeting.
- Bring needed regulations, supplies and forms.

Audiovisual

Effective Teamwork

- Team meetings
  - Come prepared
  - Contribute productively
- Roles
  - Team coordinator
  - Scribe
  - Devil's advocate

10

Slide 2-C-2-10

Outline or text of presentation

Effective Teamwork

To do the best job the team has to work together effectively and efficiently and make it a pleasant experience for all. This is key to the survey process.

Team meetings
Team meetings usually occur at set intervals throughout the survey and at the end before the exit conference. Before the exit conference, the team meets and analyzes its findings and makes decisions about the facility's compliance with regulations.

Team meetings are an opportunity to discuss findings, share concerns and obtain insight, feedback, guidance and suggestions from other team members. Each member should come prepared to contribute productively.

Roles of Survey Team Members

Survey team members can play various roles, including team coordinator, scribe and devil's advocate.

Team Coordinator

- Organizes information packets & forms
- Gathers supplies
- Makes travel arrangements
- Reviews documents before offsite team meeting

11

Slide 2-C-2-11

Team coordinator
The team coordinator (also referred to as team leader) usually:

- Organizes information packets and forms.
- Gathers supplies.
- Makes travel arrangements.
- Reviews documents before the offsite team meeting.
- Determines team member assignments for the survey.

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Team Coordinator (cont.)

- Determines team member assignments for survey
- Communicates with facility, facility consultants, ombudsman (for long term care surveys), State agency or Regional Office supervisor & team
- Sets tone for team dynamics

12

Slide 2-C-2-12

Outline or text of presentation

- Communicates with the facility, facility consultants, the ombudsman (for long term care surveys), the State agency or Regional Office supervisor and the team.
- Sets the tone for team dynamics.

Scribe

- Takes notes
- May be team coordinator

13

Slide 2-C-2-13

Scribe
The scribe takes notes at team meetings. This person may also be the team coordinator.

Devil's Advocate

- Asks tough questions
- Makes suggestions about additional information needed to support deficiency

14

Slide 2-C-2-14

Devil's advocate
The devil's advocate helps the team determine any deficiency by asking tough questions and making suggestions about additional information needed to support a deficiency.

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Team Member Responsibilities

- Be team player
- Complete assignments
- Communicate concerns promptly
- Be prepared for team meetings
- Be on time for team meetings

15

Slide 2-C-2-15

Team Member Responsibilities (cont.)

- Contribute productively
- Be prepared for:
  - Analysis of findings
  - Team decision making
- Promptly write up survey findings
- Support & assist team & individual team members

16

Slide 2-C-2-16

Effective Teamwork

- Appreciate team member differences
- Recognize you are in this together
  - Be reasonable with each other
  - Support each other

17

Slide 2-C-2-17

Outline or text of presentation

Team Member Responsibilities

- Be a team player.
- Complete your assignments. If you are experiencing difficulties, make your team coordinator aware as soon as possible.
- Promptly communicate any additional concerns you might have to your team coordinator. These might include:
  - The need to talk with a consultant.
  - Difficulties you might be experiencing with the facility.
- Be prepared for team meetings.
- Be on time for team meetings.
- Contribute productively.
- Be prepared for the analysis of findings and team decision making.
- Promptly write up survey findings.
- Support and assist the team and individual team members.

Effective Teamwork

Members of an effective team must recognize, understand and appreciate individual team member differences.

Survey teams must always be aware of their common goal to protect the health and safety of patients/residents in any facility they survey and to improve the quality of health care provided in that facility.

All team members have a responsibility to enhance team functioning. Ideally, they

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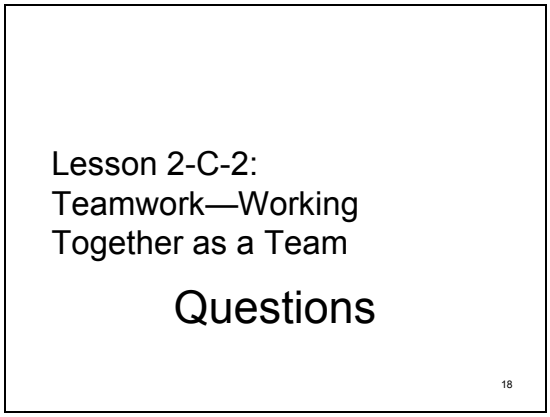
Outline or text of presentation

should always focus on their shared goal. This can happen through creation of a cohesive, supportive environment. Certainly, a team's effectiveness depends on the abilities of its members to interact effectively with one another.

All team members have a responsibility to identify ways to build upon individual strengths and improve group activities, such as time management, conflict resolution and problem solving.

Team interaction is influenced by individual personalities within the team. Team members should keep in mind that disagreement can be a normal part of team work. However, being too emotional and taking interactions too personally can reduce a team's effectiveness and a team member's credibility.

The ability to effectively interact with other team members plays a large role in team success.



Slide 2-C-2-18

Skill Assessment

Teamwork—Working Together as a Team

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Verbalized the concept of teamwork.	
					Described team coordinator roles and responsibilities.	
					Described team member roles and responsibilities.	
					Verbalized benefits of teamwork and potential team difficulties.	
					Demonstrated an ability to work as an effective, fully contributing and functioning team member.	

Comments/Recommendations:

Lesson 2-D: Investigative Skills

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify at least three pieces of evidence in each observation.
- Identify at least one "red flag" (critical decision point) on each observation activity and one critical decision point during the interview activity.
- Document observations and findings appropriately of at least one observation during an activity (i.e., painting a picture with words).
- Discuss the levels of evidence and the strength of different types of evidence.
- Discuss how evidence needs to be objectively weighed when there is conflicting evidence.
- Identify the components of the interview.
- Identify the process of reviewing the medical record and documents and key elements of the review.
- Discuss the use of facility records.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Section 2712, Use of Survey Protocol in the Survey Process
  - Section 2713B, Physical Contact With Patients/Residents
  - Section 2714, Interviewing Key Personnel
  - Section 2715, Interviewing Residents Using the LTC Survey Process
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Persons With Mental Retardation
  - Appendix M, Guidance to Surveyors: Hospice
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs
- *Satellite* transmissions:
  - *Investigative Techniques,* transmitted on October 24, 2003
  - Interviewing *Technique,* transmitted on May 21, 2004
  - Communicating *Skills,* transmitted on April 29, 2005

State

(Insert State reference[s] here.)

Other

Gordon, Nathan J., & Fleisher, William L. (2001). *Effective Interviewing and Interrogation Techniques* (C. Donald Weinberg, Ed.). San Diego, CA: Academic Press.

Highlights

- The purpose of the lesson is to assist surveyors in the development of skills to gather data and understand the critical elements of evidence
- Observations, interviews, record review and documentation are addressed in depth with activities

Training Techniques

- Lecture
- Group discussion
- Video
- Small group and individual exercise

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - *Critical Decision-Making Elements within the Survey Process*
  - *Aspects of Surveyor Expertise Associated with the Skills of Investigative Work*
  - *The Beauty Shop*
  - *Inference Exercise*
  - *Elements of Communication Styles*
  - *Effective Communication Self-Evaluation*
  - *Effective Communication Self-Evaluation Scoring*
  - *Interview versus Interrogation 1*
  - *Guidelines for Reducing Resistance*
  - *Interview versus Interrogation 2*
  - *Interviewing Difficult People*
  - *Cultural Differences and Interviewing with an Interpreter*
- Videos
  - *Investigative Techniques,* transmitted on October 24, 2003 (optional)
  - *Interviewing Technique,* transmitted on May 21, 2004 (optional)
  - *Communicating Skills,* transmitted on April 29, 2005 (optional)

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-D: Investigative Skills 1	
Slide 2-D-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Identify at least 3 pieces of evidence in each observation. • Identify at least 1 “red flag” (critical decision point) on each observation activity & 1 critical decision point during the interview activity. 2	*(Inform the students of the objectives.)*
Slide 2-D-2	
Learning Objectives (cont.) • Document observations & findings appropriately of at least 1 observation during an activity (i.e., painting a picture with words). • Discuss the levels of evidence & the strength of different types of evidence. • Discuss how evidence needs to be objectively weighed when there is conflicting evidence. 3	
Slide 2-D-3	

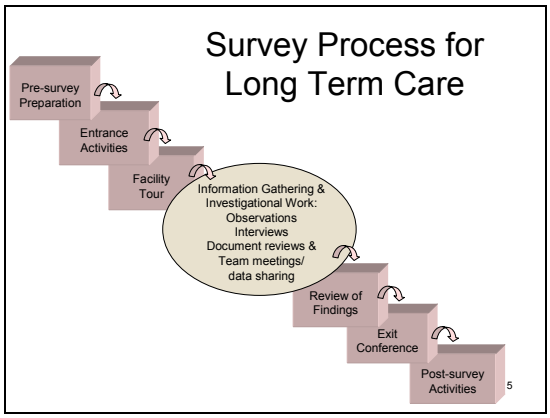
Audiovisual

Learning Objectives (cont.)

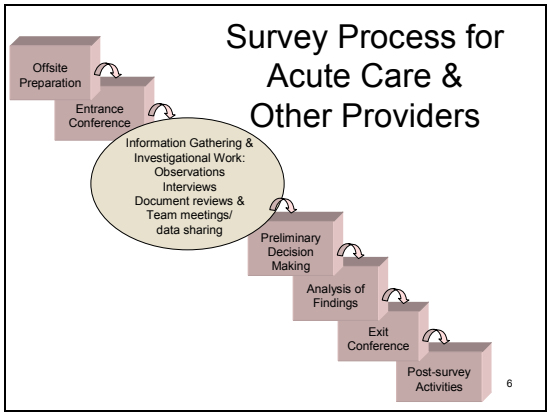
- Identify the components of the interview.
- Identify the process of reviewing the medical record & documents & key elements of the review.
- Discuss the use of facility records.

4

Slide 2-D-4



Slide 2-D-5



Slide 2-D-6

Outline or text of presentation

Decision Making—Not Just at the End of Survey

There are key cognitive areas of decision making that guide or impact data gathering during any type of survey.

These key cognitive areas are vital in guiding the direction of the investigatory work and directing the surveyor to investigate an issue further.

The first slide is the survey process for long term care facilities.

The second slide is the survey process for acute care and other providers.

Although there are specific tasks areas within each survey process that include data collection/fact finding/information gathering (all of the different processes call it a different thing), a critical point within each task, from the entrance to the exit, is when the surveyor decides what information is important and what is not.

Throughout the survey, you are making decisions about the information you have obtained from your observations and what

Audiovisual	Outline or text of presentation
	you believe you should or are expected to observe. 1. If you decide through your initial decision making that data/findings/information are important, the issue may be investigated further. However, if you determine that the data are not important, you may not investigate further, or the data may be ignored and a possible issue dropped. 2. The second type of decision is based on what is "not seen" or what is "not happening" that triggers or does not trigger further investigation. *(Direct students to handouts "Critical Decision-Making Elements within the Survey Process" and "Aspects of Surveyor Expertise Associated with the Skills of Investigative Work" on page 2-D-75.)* Within each survey process there are underlying, critical decision-making elements. Some of these are: 1. Identifying a representative beneficiary sample to investigate the issues so the scope of the problem can be determined. 2. Determining an accurate set of problems and issues to investigate. 3. Determining and focusing on what to look for and where to find it. 4. Noticing "red flags" (detecting indicators of potential problems). 5. Uncovering the root cause of the problem—what specifically did the facility fail to do? 6. Documenting the findings—painting a picture with words. 7. Determining extent or scope and severity of the problems. 8. Interpreting rules and regulations. 9. Determining what to cite at what tag or regulation.

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Outline or text of presentation

(Use these handouts and critical elements to evaluate your progress in developing your investigative skills and understanding and learning the survey process.)

We are going to focus on the basic set of skills in data gathering/information gathering/fact finding as a prerequisite to decision making.

If data-gathering/information-gathering/fact-finding skills are not developed, the critical elements outlined in the decision-making process above cannot be performed, and decision making may be faulty.

Elements of Investigation

- Observations
- Interviews
- Record or document reviews

7

Slide 2-D-7

Elements of Investigation

- Observations.
- Interviews.
- Record or document reviews.

All three elements of investigation impact the investigative work and decision making during the survey process.

The first element is observations which are:

- Essential components of the investigation that help surveyors put together pieces of the puzzle and identify areas that may need further investigation.
- More complex than just looking to see what is there; they also involve looking to see "what is not there."

As one surveyor noted, "The expertise of this job lies in seeing what isn't happening."

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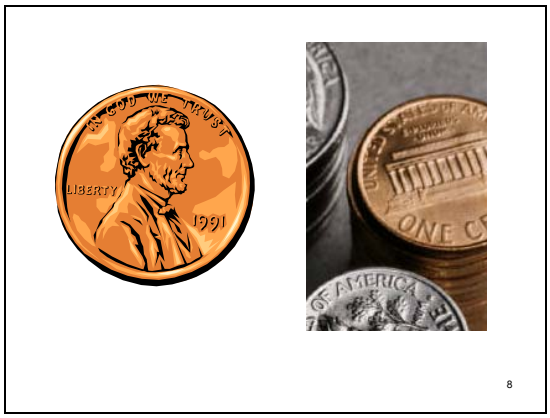

Slide 2-D-8

Outline or text of presentation

Observation skills also have to do with focusing all parts of your attention: your senses, your hearing, your smell.

(Activity: For the following activity, do not show Slide 2-D-8 until you ask the students to take out a piece of paper and draw both sides of a penny.

Tell the students: Take out a piece of paper and, without pulling out a penny, draw both sides of the penny on your paper. Look up at me when you are done.

After giving the students time to try to draw the penny, change the slide to show the pictures of both sides of the penny.

The purpose of the activity is to point out that everyone frequently observes a penny but really doesn't "see" the penny or its details.)

Did you know that, according to the US Treasury Department, the average person handles a penny 1,000 times a year?

How much do you pay attention to what is going on around you?

- What building is on the twenty-dollar bill? *(The White House)*
- What is the smallest division on a ruler? *(1/32 inch)*
- In a pack of playing cards, which king is in profile? *(spades)*
- If quotation marks are commas, is the first pair upside down or right side up? *(first pair is upside down)*
- On the telephone, the letters "JKL" are on what number? *(5)*

There are some aspects associated with observation skills that will help you measure your progress in the next few

Audiovisual	Outline or text of presentation
	months. Use the handout to review after each survey. *(Refer students to the handouts "Critical Decision-Making Elements within the Survey Process" and "Aspects of Surveyor Expertise Associated with the Skills of Investigative Work" on page 2-D-75.)* **Aspects of surveyor expertise associated with the skills of investigative work** • Awareness of singular cues that should alert you to investigate something further. • Understanding combinations or patterns of cues that should alert you and then applying your knowledge to know what may be suggested by those cues and the corresponding regulation(s). • Awareness of what cues to watch for within each of the general problem areas or regulations (e.g., what things should alert you to pressure sores? What things should alert you to potential problems with safety or infection control or residents' rights?). • An understanding of what is typical or normal so that you can more easily identify abnormality ("red flags"). • Awareness that other members of the team, trained in other professions, notice different things.

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Elements of Investigation (cont.)

- Assess:
  - Whether specific care & services provided are appropriate
  - Integration of care & services provided by various individuals or departments to each resident
  - Environment
- Validate using interview & record review

9

Slide 2-D-9

Outline or text of presentation

The Intent of Observations

Within the context of the regulations, assess:

- Whether the specific care and services provided are appropriate.
- The integration of care and services provided by individuals or departments to each resident.
- The environment in which care and services are provided.

Observations give surveyors first-hand knowledge.

Remember observations are the most powerful evidence when validated by interviews and record review.

When they are documented factually, they help decision making to be more clear-cut and based on fact.

Elements of Investigation (cont.)

- Techniques
  - Position yourself
  - Observe throughout day
  - Share findings with others—follow up

10

Slide 2-D-10

General Observations

Observations begin in the parking lot and end after you have driven away from the facility.

- Although you should not impede staff caring for residents, make observations by stationing yourself as physically close to resident care as possible. Interrupt staff only when necessary.
  - While completing a chart review, for instance, it may be possible to also observe the environment and the residents, staff interactions with residents, safety hazards and other practices that are impacting the care and services of the residents or have the potential to do so.
- Observe at different times during the day and throughout the survey until you have made decisions regarding

Audiovisual	Outline or text of presentation
	facility compliance. A good rule of thumb is to observe and record observations of each sample resident every 30 minutes during the survey. • Share any concerns with team members and the team coordinator and discuss what other possible information or observations are needed to make a determination. Follow up on your concerns as well as those of your teammates. • Always discuss concerns with the team as soon as possible, so each member of the team can add the concern to his/her investigation. • In the team meetings, each surveyor should address findings and areas of concern, and the team should coordinate efforts to obtain additional information. • One of the unique features of working with a team on survey is the need to use observations about one specific issue from each team member. One way of thinking about data and using the team is that one surveyor is like a note in a song. By itself a note has little context, but, with the other notes, it develops into a song. The “notes” of each surveyor develop into a context of a “song” or a larger perspective of the practice of the facility.

Audiovisual

Elements of Investigation (cont.)

- Resident areas
  - Resident condition, care & services
  - Staff activities & interactions with residents
  - Beneficiary rights
  - Participation in & knowledge of care

11

Slide 2-D-11

Elements of Investigation (cont.)

- Abuse & neglect
- Medications & biologicals
- Infection control
- General environmental & safety
- Medical records
- Confidentiality

12

Slide 2-D-12

Outline or text of presentation

Resident Areas

Observe the actual provision of care and services. This will require visiting resident care settings, including inpatient care units, outpatient care units, anesthetizing locations, emergency department, imaging and rehabilitation, remote locations, etc.

Observe the activities taking place. Focus on the complexity of care services at each location as well as regulations that apply to all areas. For example:

- Resident care, including treatments and therapies in all resident care settings.
- Staff activities and interactions with residents.
- Beneficiary rights.
- Participation in and knowledge of care.
- Abuse and neglect.
- Medications and biologicals.
- Infection control.
- General environmental and safety.
- Medical records.
- Confidentiality.

Audiovisual

Elements of Investigation (cont.)

- Non-resident areas
  - In acute care setting, observe all areas
  - In long term care, observe all areas
    - In hospital-based long term care units, observe all areas on long term care unit, other areas visited or used by residents (e.g., rehabilitation, smoking area) as well as significant support areas (e.g., kitchen, laundry, medical record storage, boiler room)

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Slide 2-D-13

Outline or text of presentation

Non-Resident Areas

- In acute care settings, observe all areas.
- In long term care settings, observe all areas.
  - In hospital-based long term care units, observe all areas on the long term care unit, other areas visited or used by residents (e.g., rehabilitation, smoking area) as well as significant support areas (e.g., kitchen, laundry, medical record storage, boiler room).
- Observe for integration of all services, indicative of the facility's functioning as a whole. The facility's systems should be integrated to provide care.
- Observe for systems of care for specific parts or portions of the systems that are not present or are not of the quality required by regulations.

Elements of Investigation (cont.)

- Documentation
  - Date
  - Time
  - Location of observation
  - When appropriate, name & title of staff individual with you
  - Resident name(s)
  - Name, title & job description of each staff person providing care
  - Factual description of observations

14

Slide 2-D-14

Documentation

Each surveyor should make notes about general observations. Remember, different surveyors will focus on different concerns. Pretend you are a data "sponge" and write down everything you see. Document on worksheet:

- Date.
- Time.
- Location of the observation.
- When appropriate, the name and title of the staff individual with you.
- Resident name(s).
- Name, title and job description of each staff person providing care.
- Factual description of the observations.

Remember that your documentation and worksheets are considered legal evidence. Exercise care in documentation.

Audiovisual

Slide 2-D-15

Outline or text of presentation

Document your observations as soon as possible. Consider what you were doing yesterday. Can you remember every key element that was said? What about six months from now if you have to testify at a hearing? You will have to develop your own system of note taking; however, each survey process has specific forms to help you keep organized.

(Activity: For the following activity, do not show Slide 2-D-15 until the questions have been answered and you are ready to begin the discussion.

Direct students to the handout "The Beauty Shop" on page 2-D-77 and tell them to put it face down. Ask them to not turn the picture over until you tell them.

Tell them to turn it over, study the picture and take notes if desired. They will have 30 seconds to study the picture.

Tell them to turn it back over, and then ask them the following questions:

1. *How much is a haircut? ($6)*
2. *A shampoo costs how much? ($2)*
3. *You can buy a wig for how much? ($20)*
4. *How many people are getting haircuts? (1)*
5. *What time of day is it? (6:20)*
6. *What day of the week is it? (Saturday)*
7. *What is the name of the shop?(MDS Beauty Salon)*
8. *True or False? There are two cats hiding in the picture. (True)*
9. *How many customers are in the shop? (Possibly six; the woman using the phone could be an employee or a customer.)*
10. *How many licensed beauticians are there? (You can't tell.)*

Audiovisual

Outline or text of presentation

11. How many have a license displayed? (None)
12. True or False? There are a total of five chairs in the picture. (False)
13. How many cars are in the accident? (2)
14. How many cars are visible through the window? (3)

Discuss the following:

- *Memory and the need to write things down as soon as possible.*
- *The need to develop a note-taking system.*
- *Writing down general observations.*
- *The necessity for surveyors to share their observations.)*

While you are observing, you may not know what is important. However, when added to other observations and interviews (yours or those of another surveyor), the observations may contribute to your identification of issues and concerns.

Evidence

- Information relevant to decision making in determining compliance

16

Slide 2-D-16

What Is Evidence?

Evidence is information that is reasonably relevant to proving or disproving a fact that is relevant to proving the event at issue.

Although this is a good definition for complaint investigation, in relation to surveys, evidence is information that is reasonably relevant to decision making in determining whether the provider or facility is or is not in compliance with the regulations.

Documentation of observations
(Discuss how the observations should be resident-centered.)

Audiovisual	Outline or text of presentation
	(Activity: Example 1: Observation finds residents eating in their rooms with the food tray on the overbed table. In some rooms, the overbed table is at the height of the resident's nose. In other rooms, you observe the overbed table either to the right or the left of where the resident is seated at the side of the bed. The resident is leaning to one side to reach the food on the tray. • *What do you document?* • *What other things would you observe?* • *What would you ask the resident?* • *Who else would you interview?* • *What documents may you review?* *The surveyor should note any food or beverages out of reach of the individual, the quantity of foods and beverages that remained on the tray, whether the individual had a choice about eating elsewhere, the frequency the resident eats in the room and any cognitive limitation or range of motion that may limit consumption. In addition, the surveyor should note whether the individual liked what was served or would have preferred something different, any substitutions offered by staff and any evidence of a nutritional problem (e.g., concentrated urine in a catheter bag, recent surgery, dentures that clacked—indicating difficulty with chewing, etc.).* *Example 2: The resident tells you he prefers to read in his chair and that the light over the chair is inadequate. He states he has told the nurses a number of times that he needs more light to read.* • *What do you observe?* • *What would you document?* • *What would you ask?* • *Who would you interview?*

Audiovisual	Outline or text of presentation
	• *What other issues besides the issue of inadequate light could you identify from your observations and interviews?* *The surveyor should have noted in the example that the room lacks a reading light near the chair or perhaps that the reading light has or doesn't have a bulb or place to connect to electricity. It might be important to note how far the light is from the chair in the room. It might be important to note whether the resident has cataracts or wears glasses and how old the prescription is. The surveyor should also interview the nurse or social worker about the light and his/her knowledge that this resident likes to read in his chair. The surveyor might also consider requesting information about how grievances are handled.)* It is evident that, through decision making, one observation and an informal interview could lead the surveyor in a number of different directions. In summary, for the team or surveyor to make decisions regarding compliance with the regulations, the surveyor needs to make multiple factual observations that are documented clearly. *(Activity: Visualization Exercise.* *Tell the students you are going to read a statement and you want them to write down what they see in their minds.* *Say, "Close your eyes for just a minute and listen as I read the following sentence. When a picture comes to your mind, write down what you see in your mind's eye."* *"The bear was very close."*

Audiovisual	Outline or text of presentation
	Have students tell you what they wrote, and ask them the following questions: *1. What is "close"?* *2. What color is the bear?* *3. How big was the bear?* *4. Where was the bear?* *5. Were you in the picture?)* • The concept is that we all have different pictures in our minds. As surveyors we have to write and document in such a way as to "paint a picture" based on the facts so others can see what we saw. • As a team this can be easier, because we can gather our observations together or we can make observations together with staff or another surveyor. Then our observation has been validated. • One technique that can be used in survey when you want to look at a specific item in a room is to perform some of the observation with a facility staff member. Ask the staff member to describe something. While observing care, have a staff member with you. Record your observation, and then record the staff member's description. What did he/she see? What does he/she hear? What does he/she know? **Facts versus Opinion** Let the facts speak for themselves.

Audiovisual

Activity

- Ashes & cigarette butts in ashtray showed that someone had been smoking in room

17

Slide 2-D-17

Outline or text of presentation

What does the observation on the slide tell you?

(The students should say that the only thing you really know from the observation is that there are ashes and cigarette butts in the ashtray. Some students may say that someone has been smoking in the room.

Point out to the students that the conclusion that someone has been smoking in the room is an inference or a conclusion not based on fact.)

Activity (cont.)

- Five people were waiting for bus at 5th Street bus stop
  - Note: Do not change slide

18

Slide 2-D-18

What do you know about the observation on this slide?

(Say, "All that is really known is that five people are at the bus stop at 5th Street. You don't know if anyone is waiting for the bus unless you ask each person.")

Other information that should be included in survey observations:

- How the facility practice affected the residents.
- The number of residents affected.
- The number of residents at risk.

Devote as much time as possible to performing observations and conducting formal and informal interviews.

Limit record reviews to obtaining specific information; look at what you need, not the whole record. Information gathering is intertwined.

(Distribute the handout "Inference Exercise" on page 2-D-79 and have each student read and complete it. Review the answers on page 2-D-81.)

Audiovisual	Outline or text of presentation
	What do we mean when we say document "factual observations"? Factual observations are the words that are used to provide a clear description, an unambiguous picture, for someone else. The following words are ambiguous and require clarification: • Close—Is the person close enough to brush against you? Close could be two feet away. • Small—How small is it? Is it three micrograms or three pounds? • Big—How big is it? Is it two inches or two feet? • Horrible—How bad is it? Observations and interviews may lead to a specific portion of record review, and specific information in the record may lead the surveyor to other necessary observations and interviews. Remember, observations are the most powerful evidence and are even more powerful when validated by interviews and record review. Be alert to the environment and activities around you, not only with the sample residents but also with all residents and staff. *(Activity: Have students pair up.* *Have them face each other for 30 seconds without talking. Then have them move their chairs so that they are back to back and answer the following questions:* *1. What color is his/her shirt?* *2. What color is his/her hair?* *3. What color are his/her eyes?* *4. What color are his/her pants and shoes?* *Then ask:* *What other details do you remember?*

Audiovisual

Outline or text of presentation

What time did the person eat lunch yesterday? What did he/she eat and drink?

What did you eat and drink for breakfast the Saturday before last?

Do you think you could remember these details next week? Next month? Next year?

Activity: One way to sharpen skills is to practice them.

Say, "I know a girl whose uncle used to play a game with her when she was a child. He would open a magazine for 15 seconds, close it and then ask her what she saw. After she told him her descriptions, he would open the magazine and discuss what she had observed. We are going to use that technique today to start to sharpen your skills.

The first couple of pictures are general and then we will go on to actual facility pictures.

You may document your observations on a sheet of paper."

Slide 2-D-19

Do not advance the slide until you are ready. Do not give any more instructions than what you presented above.) Tell students, "Okay, 15 seconds. Go!"

Uncover the picture and watch the time for 15 seconds. When 15 seconds are up, cover the picture and ask the following questions of one or two students:

- *What day did this event take place?*
- *What time of day did this event take place?*
- *How many people were involved?*
- *Can you describe the picture for me?*

Audiovisual

Outline or text of presentation

Ask the students to review any notes they made regarding the picture and then ask them, "If in one year I asked you to again describe the event in the picture you just saw, could you? How useful would your written documentation be? In a dispute with the facility? In a court of law?"

Go through each picture, letting the students review their documentation and observation skills.)

Slide 2-D-20

Slide 2-D-21

Audiovisual

Outline or text of presentation

Slide 2-D-22

Slide 2-D-23

The four objectives of survey observations are to:

- Gather resident-specific information.
- Observe the provision of care.
- Observe staff-to-resident interactions.
- Observe quality of life for all residents.

(Ask the students, "What do your observations of the following slides tell you about the residents in the rooms? What possible safety issues do you see?")

Slide 2-D-24

Audiovisual

Outline or text of presentation

Slide 2-D-25

Slide 2-D-26

Slide 2-D-27

Audiovisual

Observations

Things that change or influence our observations:

- Personal bias
- Experience
- Interests
- Perceptions
- Focus
- Gender
- Complacence

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Slide 2-D-28

Outline or text of presentation

There are things that change or influence our observations.

(Read the slide.)

- Personal bias.
  - May produce unreasoned distortion of what you see.
- Experience.
  - Education, family experiences or events in our lives.
- Interests.
  - A nurse might notice the smell of a wound, whereas a social worker might notice a despondent resident.
- Perceptions.
  - What you believe you saw without validation from interviews or other surveyor observations.
- Focus.
  - Again, a nurse might notice care issues and miss issues with depression or mental health, whereas a social worker might notice a despondent resident before identifying medical care as an issue.
- Gender.
  - For some men it is not important to have their personal things around them, but for some women it produces a feeling of security.
- Complacence.
  - The acceptance by some residents, staff and surveyors that nothing can be changed to individualize care, because the reality is that these are facilities and, therefore, the needs of the many outweigh the needs of an individual. The fact that residents have to accept what is provided in an institutional setting.

Audiovisual

Perceptions Get in the Way

- Auto accident
  - Doctor
  - Lawyer
  - Engineer
  - Thief
  - Preacher

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Slide 2-D-29

Interviewing

- Art of questioning & listening

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Slide 2-D-30

Outline or text of presentation

Perceptions

Suppose there is a fatal auto accident which is observed by a doctor, a lawyer, an engineer, a thief and a preacher.

What is the first thought in each of their minds?

- The doctor thinks about first aid.
- The lawyer thinks about who was wrong.
- The engineer thinks about what went wrong.
- The thief thinks about how much the car is worth or whether there are valuables inside.
- The preacher hopes everyone was saved.

Interviews

Humans communicate in different ways, such as:

- Drumbeats.
- Electrical codes, such as Morse code.
- Physical actions, such as sign language.
- Nonverbally—facial expression, body posture and arm position.
- Sounds and spoken words.

We communicate, and the facilities communicate to us, through observations, demonstrating care and interviews with residents and staff and in writing through Statements of Deficiency, resident records and facility policy and procedures.

It is estimated that 80 to 90 percent of our time as surveyors is spent in interviewing, either formally or informally. It goes to show how important good observation skills and communication skills are in the positions we hold.

Audiovisual

Outline or text of presentation

Communication, questioning, interviewing and listening are huge topics. Because we have a limited amount of time, and many of you have attended various presentations and workshops on these subjects, we are going to discuss highlights of the skill of questioning and listening.

Today, we are going to review aspects of communication that focus on skills needed for the work we do.

Our objectives are to discuss and participate in activities that:

- Help each of us recognize actions and words that we use that support communication and enable us to have successful interviews.
- Review some of the skills we already have.
- Help us understand and recognize the barriers that may prohibit successful communication and stronger interviews with residents and providers.

Outline of the Discussion on Interviewing

Today we are going to:

- Start with developing self-awareness of our communication style.
- Discuss other communication styles that the resident or provider may use.
- Look at and discuss tips on how to "read" nonverbal communication.
- Spend some time on activities related to verbal communication: asking the "right" questions and using appropriate words.
- View role-plays and try out some activities.
- End with a short discussion about communicating with difficult people, noninterviewable residents, people

Audiovisual

Outline or text of presentation

who are resistant and those working with an interpreter. This discussion will focus on developing awareness and techniques to successfully interview people from different backgrounds and cultures.

Open Communication

- Self-awareness
- Self-responsibility
- Intention
- Authentic

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Slide 2-D-31

Open Communication

There are some basic concepts that support communication and increase our chances of having successful interviews:

- Self-awareness of our style, our words and our bodies.
- Self-responsibility for our part in the communication process. We cannot control how others communicate with us; we can only control how we communicate with and respond to them.
- Intention—communication should have a purpose other than satisfying yourself or your own needs, a purpose of finding the truth of the situation; a win-win attitude and behaviors that support, enhance and encourage communication.
- Authentic—our nonverbal and verbal communication is congruent, consistent and truth-seeking.

Barriers to Communication

- Unconscious communication
- Unintentional communication
- Incongruent communication
- Fear

32

Slide 2-D-32

Barriers to Communication

There are also some basic barriers to communication that impact our success in interviewing.

1. Unconscious communication:
    - Not planning communication or not thinking about the impact of the communication.
    - Not accounting for differences in style of the person being interviewed.
    - Not continually assessing our nonverbal and verbal style and techniques.

Audiovisual	Outline or text of presentation
	2. Unintentional communication: • Focusing on win-lose position. • Using a competitive pattern of communication rather than focusing on understanding and being understood. 3. Incongruent communication: • Nonverbal communication does not match verbal communication. 4. Fear: • Fear of others and what they will think or do. • Fear of the result of the communication. Good interviewers have the following character traits in common: 1. The ability to understand their communication style and how they communicate verbally and nonverbally. 2. The ability to "read" the nonverbal communication of others, allowing them to establish rapport and allowing verbal communication to begin or continue. 3. The ability to allow the interview to "flow" naturally but also knowledge of when to direct or redirect to clarify or obtain more information. 4. The understanding that interviewing is an art as well as a technique that matures and is refined only with practice. 5. The ability to close the interview in a manner that allows communication. **Basic Truths About Interviewing** • Interviewing is not the same across all provider settings. • Residents have different physical capacities and different cognitive levels that may impact their understanding of issues and ability to communicate with others.

Audiovisual	Outline or text of presentation
	• Providers have different educational backgrounds and experience levels. • Surveyors have different experience and background skill levels in interviewing. • In each communication we have with others we have a choice about how we perform and our responses: – Are they competitive? – Do we avoid doing interviews? – Do we accommodate when someone is in conflict and is attempting to avoid an interview? – Are we collaborative in our techniques, allowing for flexibility of the person being interviewed and our need for information? Although we have no control over how providers communicate with us, we can influence their communication style. **Communication Style** There are three basic communication styles: • Aggressive. • Passive. • Assertive. *(Distribute the handout "Elements of Communication Styles" on page 2-D-83.)* Clearly, the assertive style is the one to strive for. Try to keep in mind that very few people use only one style. In fact, the aggressive style is essential at certain times, such as: • When a decision has to be made quickly. • In the event of fire. • During emergencies. • When you know you're right, and the fact is crucial.

Audiovisual	Outline or text of presentation
	• Stimulating creativity—designing competitions destined for use in training or to increase productivity. Passiveness also has its critical application, such as: • When an issue is minor. • When the problems caused by the conflict are greater than the conflict itself. • When emotions are running high, and it makes sense to take a break to calm down and regain perspective. • When your power is much less than that of the other parties. • When the other person's position is impossible to change for all practical purposes (i.e., policies or regulations). Remaining aware of your own communication style and fine-tuning it gives you the best chance of success in the interview and in communication with the provider and residents. *(Activity: Distribute the handouts "Effective Communication Self-Evaluation" on page 2-D-87 and "Effective Communication Self-Evaluation Scoring" on page 2-D-89 and have students self-evaluate during a break.* *Discuss some of the findings.* • *What did students find out about themselves that was new?* • *What did they find that they might need to work on when dealing with others?)*

Audiovisual

Interviewing

- Interviewing is a nonsuggestive process of attempting to objectively determine facts
  - Dialogue
  - Information gathering
  - Conversation between 2 people

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Slide 2-D-33

Outline or text of presentation

Definition of Interviewing

Interviewing is a nonsuggestive process of attempting to objectively determine facts. It can be described as a dialogue, information gathering and a conversation between two people.

Most of us do not take what others tell us as "real" unless we can validate it in some way. One way to validate the facts obtained by observation is to interview residents and staff. One way to validate the answers obtained by interview is to observe.

Another way is to compare one person's statement to another person's. When validating facts obtained from interviewing, there are two areas to weigh: the verbal facts or information and the nonverbal communication of the person being interviewed. Reading and taking clues from nonverbal communication can help reveal the person's true perception of an issue.

Learning to Read Physical Communication

- Nonverbal communication
  - Demeanor & posture
  - People communicate with body language
  - Nonverbal communication—message is difficult to mask
    - Difficult for people to be deceptive with body language

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Slide 2-D-34

Nonverbal Communication

Learning to read the physical communication of the person being interviewed

Nonverbal communication is sometimes called demeanor or posture.

- If the nonverbal matches the truth of the verbal, the communication is congruent.
- If the nonverbal does not match the truth of the verbal, the communication is incongruent or inconsistent.

Audiovisual	Outline or text of presentation
	Some facts about nonverbal communication are: • People communicate with nonverbal behavior. • Most nonverbal responses are universally based in the psychobiological character of all humans. • Nonverbal communication is difficult to mask and is therefore more "truthful" about how the person is feeling. Why learn it? There are two reasons to learn this new language. One is to be aware of how we communicate nonverbally with others, and the other is to identify when the person being interviewed is uncomfortable with what he/she is verbally stating. • By being aware of our own body language as a communication tool we may encourage open responses from the person being interviewed. We may also prevent barriers to open, honest communication. • By being aware of other people's body language and "reading" their communication, we will be more consciously aware of why someone's verbal responses disturb us or don't have credibility. We may also be able to read the communication throughout the interview to determine where changes occur and when the person being interviewed is uncomfortable or deceptive with his/her answer. **Our body language** • The interviewer must maintain a truthful, open body position. The goal is not to demonstrate negative nonverbal behavior.

Audiovisual

Outline or text of presentation

- When they are not conscious of their own behavior, people tend to mimic or parallel each other's behavior. This is called modeling.
- If the interviewer models defensive or deceptive behavior, the modeling will negatively affect the interview by the nonverbal message it sends. Remember, nonverbal messages speak louder than verbal messages.
- If the interviewer is verbally truthful but exhibits defensive or deceptive behavior, his/her behavior is incongruent and inconsistent and will hamper the communication and therefore hamper the success of the interview. The person being interviewed will have an innate sense that something is wrong. Consistency between body language and verbal statements is crucial.
- On the other hand, if the interviewer is modeling open and truthful nonverbal behavior with a verbally open and truthful communication, he/she will send a subconscious message to others, which will create openness. This will help establish and maintain rapport.
- If the person being interviewed mimics the interviewer's behavior, the nonverbal message to his/her brain will be to tell the truth and not hide or mislead.

Body Language

- Emblems
- Illustrators
- Adapters

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Slide 2-D-35

Body language of the person being interviewed

There are three general categories of nonverbal behaviors:

- Emblems.
- Illustrators.
- Adapters.

Emblems are nonverbal behaviors that express the entire communication. For example, you are driving down the highway and notice a man standing

Audiovisual

Outline or text of presentation

alongside the road with his thumb out. You know he wants a ride.

Illustrators are nonverbal behaviors that help the listener better understand the verbal communication. They indicate consistency between verbal and nonverbal communication.

Examples include a speaker who uses his hand to demonstrate his words or the distasteful facial expression that tells you that someone's food is not very good.

The speaker is attempting to assist the listener in understanding what is being said. As the illustrator increases the behavior, the likelihood of truthfulness increases. As the behavior decreases or suddenly stops, the likelihood of deception increases.

Adapters are subconscious nonverbal behaviors that serve no purpose in communicating and frequently detract from it. They are often indicators of deception. These include rubbing, stroking, picking, massaging or touching the body or face.

Body Language (cont.)

- Reflected in:
  - General posture
  - Head & face
  - Arms & hands
  - Sense arousal gestures
  - Legs & feet

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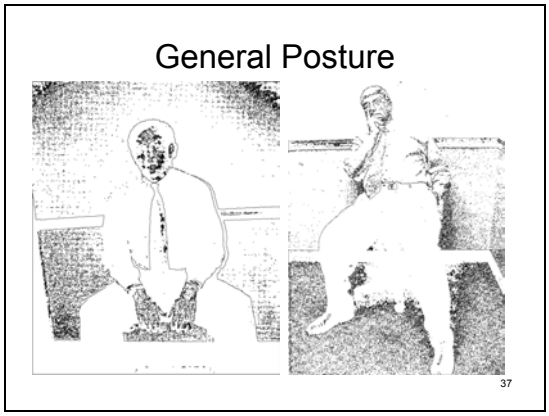
Slide 2-D-36

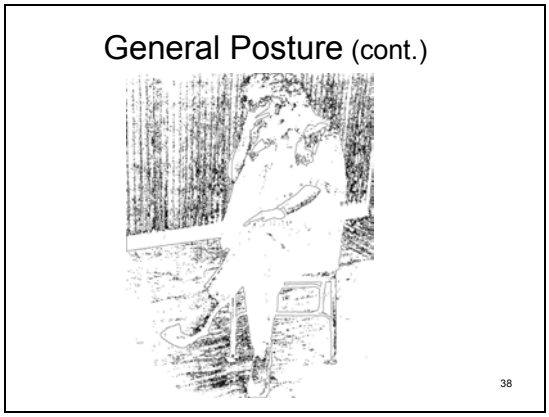
Let's look at some pictures of these characteristics as they are reflected in:

- General posture.
- Head and face.
- Arms and hands.
- Sense arousal gestures.
- Legs and feet.

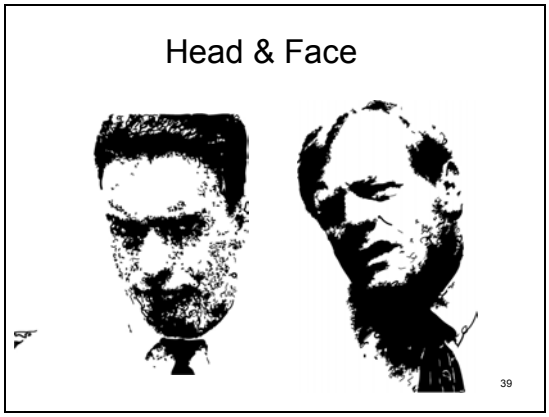
Audiovisual



Slide 2-D-37



Slide 2-D-38



Slide 2-D-39

Outline or text of presentation

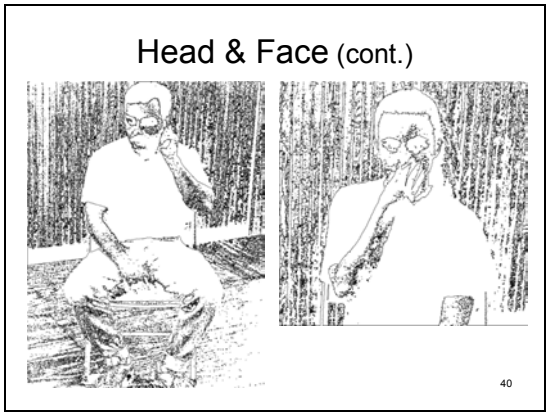
General posture

- Truthful people usually use body position as an illustrator and have an open, settled upright position.
  - They will lean slightly forward, indicating interest in what is being said.
  - Shoulders tend to remain squared and the body aligned with the interviewer's.
  - They have a natural or settled foot and leg position and open facial expression.
- Deceptive people are often closed and show defensive positions, such as crossed arms or legs.
  - They often lean back or stretch out their legs to increase the distance between the interviewer and themselves.
  - They may assume a position of defeat, with their shoulders forward and their chin on their chest.
  - They are often tense and restless; they face away from the interviewer and groom or touch their face or arms in a rubbing motion.
  - They also show a closed position because of fear or as a defense against disclosing.

Head and face

- Tilting of the head to the side, as with the man on the right, is an illustrator and generally suggests cooperation, interest and belief in what is being said.
- Tilting the head forward, as with the man on the left, is considered an aggressive behavior.
- With eyes and eyebrows, a relaxed look about the eyes may indicate truthful communication, and a widened

Audiovisual

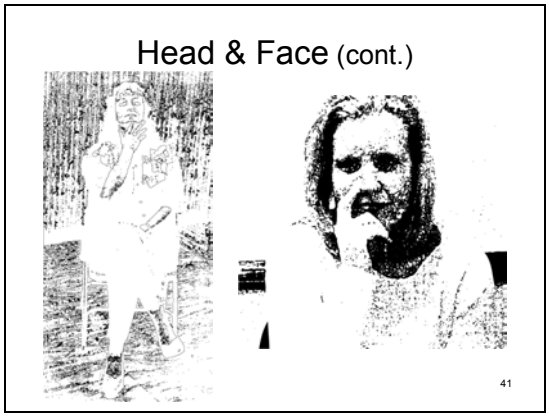


Slide 2-D-40

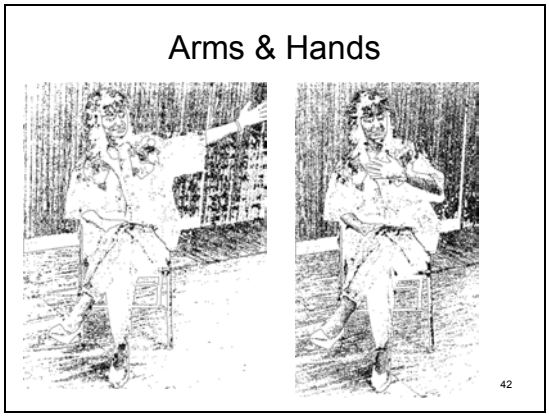
Outline or text of presentation

eye and raised eyebrows may indicate aggressive or deceptive behavior.

- Tense lips or biting of the lips may indicate an attempt not to talk or may indicate anger.
- Behaviors such as grooming or touching of the face are generally considered soothing behaviors and indicators of someone hiding something or being afraid of what is being asked. The person is using these mechanisms to soothe his/her anxiety.



Slide 2-D-41



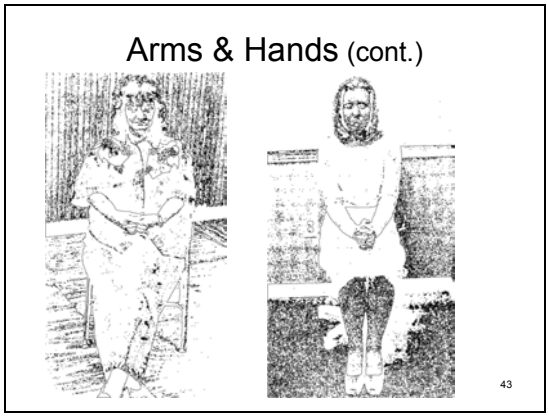
Slide 2-D-42

Arms and hands

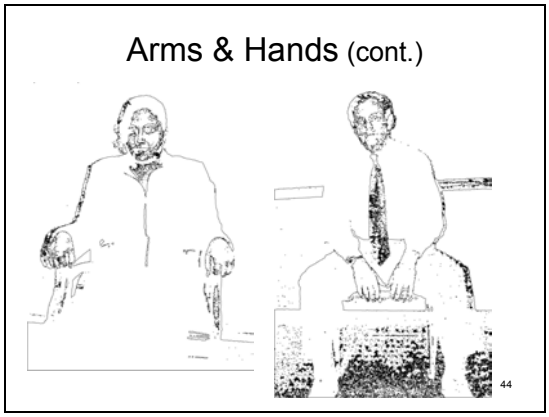
Using the arms away from the body is generally intended to deflect the question or line of questioning. It is a move to divert the attention of the interviewer from the person being interviewed to something else.

Audiovisual

Outline or text of presentation



Slide 2-D-43



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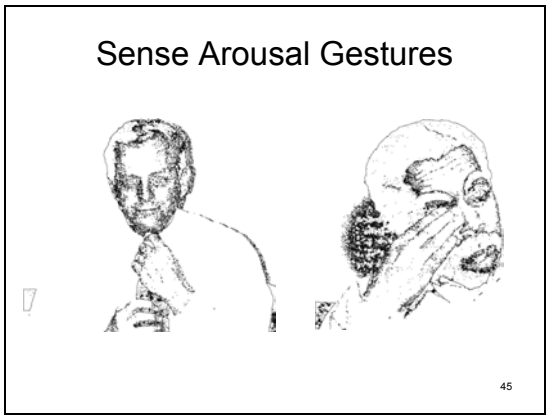

Slide 2-D-45

Sense arousal gestures

- Sense arousal gestures include smelling, hearing, seeing and touching.
- These increase noticeably when a critical or uncomfortable question is asked.
- Young children, when they are afraid, run to their parents for comfort. Parents generally hold them, stroke them, pat them and rock them. Adults subconsciously repeat these gestures to calm themselves.

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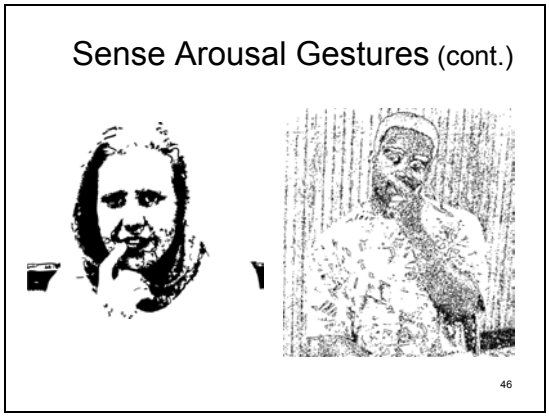

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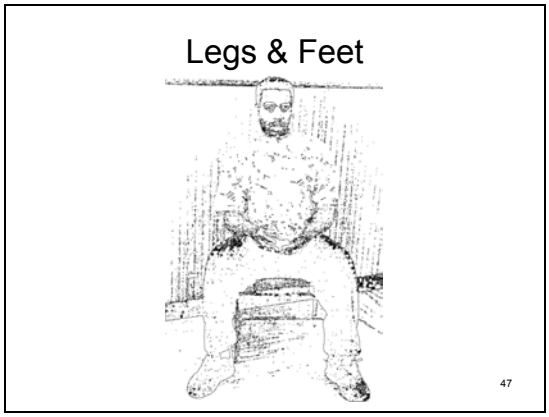
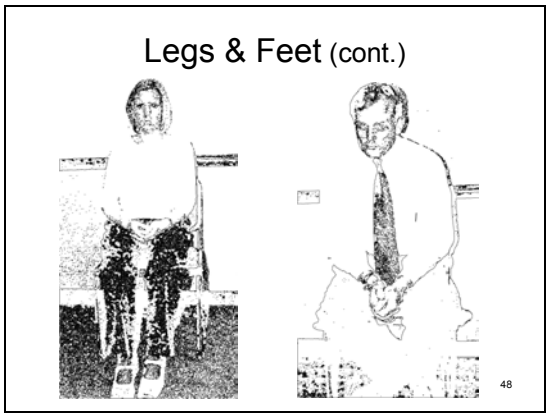


Slide 2-D-47

Legs and feet
Legs suddenly pulled under the chair or in a runner's position indicate a defensive posture and relate to the fight-or-flight position.



Slide 2-D-48

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Outline or text of presentation

Technique example
One basic technique for deciphering adapters is to ask a question that the interviewer would answer truthfully in 99 percent of the cases.

By starting out in the rapport-building phase and asking a few personal questions that would not normally be masked, the interviewer can "read" the behaviors that are "real" or "true." Behavioral changes are noted when the questions change.

Proxemics

- Intimate distance—actual physical contact to as far away as 18 inches
- Personal distance—18 inches to 4 feet
- Social distance—4 to 12 feet
- Public distance—12 to 25 feet or greater

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Slide 2-D-49

Now that we have discussed nonverbal communication let's review proxemics, or the use of personal space.

Proxemics

- The use of personal space is called proxemics.
- According to Dr. Edward T. Hall, a professor of anthropology at Northwestern University who conducted research into this phenomenon, distance relationships among people of varying intimacy have a direct effect on a person's manner of relating.
- Humans are territorial and have territorial zones that imply different degrees of acceptance and comfort with particular people acting in those zones.
- When zones are violated or when a less welcome individual intrudes beyond a psychological zone barrier, there are certain predictable responses.
- When zones are not intimate enough, people do not communicate information that may be stressful.
- Zones vary from culture to culture.

Audiovisual	Outline or text of presentation

	In Western culture there are generally four spatial zones:
	• Intimate distance—ranges from actual physical contact to 18 inches, still within touching distance.
	  – When circumstances require our personal zone to be invaded to the limit of the intimate zone, we psychologically isolate ourselves and tighten our muscles.
	  – This zone causes the greatest anxiety and involves the strongest responses.
	  – Invasion of this zone by anyone other than our most intimate associates is anxiety-producing, with anxiety increasing as distance is reduced.
	  – As emotions become stronger, anxiety increases and communication decreases.
	  – If we attempt to interview someone and continually invade his/her intimate zone, our interview may be unproductive.
	• Personal distance—ranges from 18 inches to 4 feet.
	  – This is just outside the touching zone. An interview may be most productive when conducted within the personal distance zone.
	• Social distance—ranges from 4 to 12 feet.
	  – Four to seven feet is the distance in which we conduct most of our informal transactions. Seven to 12 feet is the distance in which more formal social and business relationships take place.
	• Public distance—ranges from 12 to 25 feet or greater.
	  – This is the furthest limit of our territorial zones.
	  – These are teaching or public speaking distances.

Audiovisual	Outline or text of presentation
	In interviewing • Interviews should take place at the outer limits of the personal zone, approximately four feet away. • The key element is to account for the comfortable distance of the interviewee. Not accommodating the person being interviewed will discourage communication. • Respecting the personal zone will ensure that spatial discomfort does not cause the interviewee to display unnatural defensive behavior, which could be then mistaken as deceptive behavior or attacking behaviors. • Disrespecting the personal zone will yield less than satisfactory results. The information you were trying to obtain may not be obtained, possibly resulting in a disgruntled provider or intimidated resident or staff member. • The easier it is for the person being interviewed to relax, the easier it is for the interviewer to make an accurate assessment. • In other cultures the proxemics are different. • Residents may want more intimate distance, or they may need more personal distance. • If the interviewer is too close, the provider, staff or residents may feel invaded and placed on the defensive without the interviewer intending to invade or intimidate. They may also feel "disconnected" if the interviewer is too far away. Can you remember an instance when your boundaries were "invaded"? How did you feel? To test this phenomenon yourself, during a meal start encroaching on a fellow

Audiovisual	Outline or text of presentation
	diner's territory by moving your silverware, condiments, ashtray, etc. to his/her side of the table. *(Ask the students to try it with one of the students sitting next to them.)* How does it make you feel? **Environmental** If we are truly seeking the truth or the reality about a concern, taking the time to manage the environment is one of the first steps toward conducting a good interview. • The environment should not be so comfortable as to distract but should be supportive and nonthreatening. The room should be as free as possible from audio distractions and interruptions. • Height also gives a psychological perception of superiority. Sitting at eye level facing the individual being interviewed in an open stance can enhance the relaxation of the interviewee and also enhance his/her perception of openness and honesty on your part. Let's review some of things we have discussed in the context of interview versus interrogation, dialogue versus debate, open communication versus closed communication. *(Distribute the handout "Interview versus Interrogation 1" on page 2-D-91.)* The chart sometimes helps us recognize when we may, by our behaviors or questions, move from interview to interrogation, which places the resident, facility staff or others on the defensive.

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Outline or text of presentation

Any sudden change in writing behavior of the interviewer whether he/she stops writing or suddenly begins writing, will alert the interviewee that there has been a change in thought or importance of what was said. It may have a positive or negative impact on the verbal and nonverbal behavior of the person being interviewed.

Now we are going to move on to verbal communication and the interview process.

Verbal Communication

Verbal communication is a matter of questioning and clarifying:

- Asking a few questions in the right manner and attitude can enable you to obtain a great deal of information.
- Asking questions in some ways can close communication.
- It is good to remember that the person being interviewed knows the answers; you only have to ask the right questions with the right attitude and the right words.

Art of Questioning:
Open versus Closed

- Closed
  - Can you tell me what happened to Harold Jones?
  - Were you assigned to Harold yesterday?

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Slide 2-D-50

Open-ended versus closed-ended questions

If you are seeking more information, ask questions that get others involved in their answers rather than questions that can be answered yes or no. Remember, your attitude about the person or provider will show through your questioning and may become a barrier to communication.

Closed-ended questions can be answered with a yes or no.

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Art of Questioning:
Open versus Closed (cont.)

- Open
  - I understand you were working 3–11 shift yesterday. Describe, starting from when you entered facility, who you took care of & tasks that were assigned to you.
  - Describe your usual work day here.

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Slide 2-D-51

Outline or text of presentation

Open-ended questions require the resident to describe something.

Art of Questioning:
Open versus Leading

- Leading
  - Do you have any problems with Harold?
  - Do you think Harold is asking for help when he can do things himself?
- Open
  - What can you tell me about care that Harold needs?
  - Can you tell me what you do when you need help? How could you get more assistance if you needed it?

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Slide 2-D-52

Open versus leading questions
If you are trying to search for an answer or uncover undisclosed information, ask an open-ended question rather than a leading question.

The fewer words in the question and the less you say, the smaller the possibility of the question becoming a leading question. It allows the interviewee to insert what is important to him/her or to focus on his/her greatest concern at the moment.

The fewer descriptions and the less information used within the question, the smaller the possibility that the question will become a leading question. Simply ask the resident to describe what happened.

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Art of Questioning

- Why
  - Why did you say that?
  - Why did they do that?
  - Why didn't you provide more assistance?
  - Why did you think that providing care that way was good?

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Slide 2-D-53

Art of Questioning (cont.)

- What
  - What caused you to be concerned about Harold?
  - Can you tell me how you felt when that happened?
  - I am not clear about all of incident. Can you tell me more about it?

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Slide 2-D-54

Interviewing

- To gather information
- Nonaccusatory, open to whatever is said
- Free-flowing
- Person asking questions speaks 5% of time & person answering questions speaks 95% of time

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Slide 2-D-55

Outline or text of presentation

Choose Your Words Wisely

Reasons not to use "why"
The other question words, such as "who," "what," "where," "when," "which" and "how," relate to the actual experience of the person being interviewed, and they do not produce a defensive stance.

"What" versus "why" questions:

- Using "what" or clarifying the person's statement lets the interviewee know you heard him/her. You can then ask a question that more accurately reflects what you wanted to know. For example:
  - "You said the aide comes when she can. What happens when the aide is busy with another resident?"
  - "What kinds of things were going on, or what were you doing before this happened? What happened then? What else happened?"

Summary

(Read the slides.)

In summary, interviewing is:

- Used to gather information.
- Nonaccusatory, open to whatever is said.
- Free-flowing.
- The person asking the questions speaks 5 percent of the time, and the person answering the questions speaks 95 percent of the time.

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Interviewing (cont.)

- Interviewer demonstrates open, truthful, nondeceptive attitude & nonverbal behavior
- Behaviors demonstrate decision making has not been completed & new information is welcomed

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Slide 2-D-56

Outline or text of presentation

- The interviewer demonstrates open, truthful, nondeceptive attitude and nonverbal behavior.
- Behaviors demonstrate that decision making has not been completed and new information is welcome.

Additional Information on Questions

Questions to get additional information

- What more can you tell me?
- What other concerns do you have about your life here?
- What other types of activities would you like to have here?

Psychology of interviewing residents, staff and providers

In all of us there is a strong mechanism of internalized guilt and the need for acceptance.

- Guilt is an internalized state that begins when we perceive the message from our parents that when we do wrong, the act renders us unlovable.
- As people get older, when they know they do something wrong, they psychologically punish themselves: this is guilt.
- Society reinforces the guilt mechanism by declaring certain public and private behaviors socially unacceptable and avoiding those who practice that behavior.
- For many people the need to relieve the guilt is so strong that they will confess or attempt to say what they believe the surveyor wants to hear.

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Outline or text of presentation

- The need to be accepted and "say or do the right thing" (the "thing" they believe you want) is just as strong. People want to please.
- When people are not accepted or are placed in a position where they feel guilty, communication will stop or become defensive.
- When we use techniques that focus on debate or interrogation, we close communication.

When You
Encounter Resistance

- Paraphrase
- Request clarification

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Slide 2-D-57

(Distribute the handout "Guidelines for Reducing Resistance" on page 2-D-93 and review the questions.)

Questions for when you encounter resistance

- What reservations (concerns) do you have?
- What potential problems do you foresee?
- What might happen if you tell me what happened?
- What significant problems have other residents had associated with this issue? (Helps to deflect some anxiety and focus from self to others.)
- What would you like to see happen?
- What would you expect to happen in this situation?

Paraphrase and clarification

Two more techniques to verify or encourage communication are paraphrasing and clarifying.

Examples:

- I didn't understand what you said; would you tell me again?
- I didn't quite catch that; can you give me an example of when that happened?
- Your question isn't clear to me yet; would you describe your situation?

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Outline or text of presentation

Other general interviewing techniques

1. Completely explore one issue before going on to the next. Residents generally list one of the most important issues first; it may not be the issue you think should be first, but it is at the top of the resident's list.
2. Finish in the order the resident lists to build rapport and get him/her to provide more information about what you wanted to talk about later. Additionally, the issues may end up being related. The resident may not tie the issues together, so it is up to you to tie evidence together and determine facility practice.
3. Use the same words the resident uses to tell the resident you are listening. If you describe the resident's complaint or concern in different words, you communicate that you are not listening to him/her.
4. Eliminate as many verbal barriers as you can. Remember:
   - Physical barriers—an average talker talks at 200 words per minute, a listener can process at 300 to 500 words per minute.
   - Semantic barriers—the dictionary contains thousands of words and yet the average adult uses 500. Each word can have up to 20–25 meanings, which means that two people using 500 words can have possibly 12,500 meanings.

Ask the right question the right way

Asking the right question the right way is an essential element in interviewing. One effective questioning technique is to change the wording of your questions.

(Do not show Slide 2-D-58 to the students until after asking them to close their eyes

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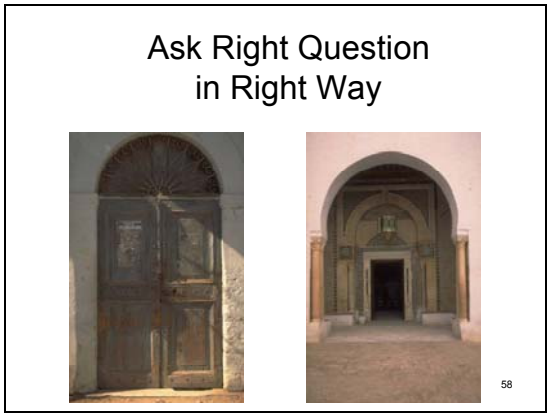


Slide 2-D-58

Outline or text of presentation

and reading the questions below. Ask students to close their eyes and verbalize the first thing that they "see" when you read each of the following statements.)

- "What type of door should I use to connect these rooms?" versus,
- "What sort of passageway should I put here?"

The change in the question pushes your mind into thinking in a different context. This helps during interviews when the person you are interviewing is going in a different direction than the question you thought you asked.

(Activity: Read the following story to the students. This creates word pictures and makes the point of the "right" question.

Story: A deadly plague appeared in a village. What was curious about this disease was its grip on its victim. As soon as a person contracted it, he/she would go into a deep, almost deathlike, coma. Most died within a day, but occasionally a hardy soul would make it back to the full bloom of health. The problem was that since eighteenth-century medical technology wasn't very advanced, the people who were not afflicted had quite a difficult time telling whether a victim was dead or alive.

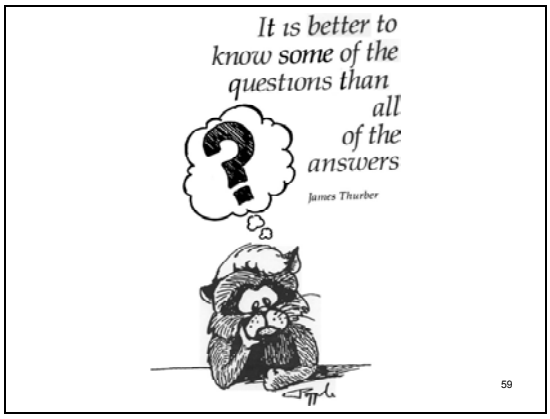
One day it was discovered that someone had been buried alive. This alarmed the townspeople, so they called a town meeting to decide what should be done to prevent such a situation from happening again. After much discussion, most people agreed on a solution. They decided to put food and water into the casket next to the body and create an air hole from the casket up to the earth's surface through which would hang

Audiovisual

Outline or text of presentation

a string attached to a bell. The person could then pull on the string and let those above ground know that he/she was still alive. These procedures would be expensive, but they would be more than worthwhile if they saved lives. Another group came up with a second, less expensive "right answer." They proposed implanting a twelve-inch stake in every coffin lid directly above where the victim's heart would be. Then any doubts about whether the person was dead or alive would be eliminated as soon as the coffin lid was closed.

What differentiated the two solutions? Answer: The questions used to find the answer were different. Whereas the first group asked, "What should we do if we bury somebody alive?" the second group wondered, "How can we make sure everyone we bury is dead?")



Slide 2-D-59

Key concept

The moral of the story above for interview questions is:

- "You don't have to know all the answers; you only have to know how to ask the right questions."

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Putting It All Together: Interviewing

- Building rapport
- Planning interview
- Setting environment
- Conducting interview
- Closing

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Slide 2-D-60

Outline or text of presentation

Putting It All Together

The elements of interviewing include:
- Building rapport.
- Planning the interview.
- Setting the environment.
- Conducting the interview.
- Closing.

Building rapport
In general, people want to be treated fairly and feel that they have been understood and respected. You want to appear neutral, nonjudgmental and impartial. People stop talking when they perceive disapproval.

Establishing rapport includes:
- Verbal introduction of who you are, why you are here and what you are going to be doing.

Think about the following questions before interviewing a resident or provider:
- Who am I?
- What am I doing here?
- Why should he/she tell me anything?
- What is he/she gaining or risking by talking or discussing the issues with me?

Then consider:
- Eye contact.
- Body language.
- Word choice.
- Identifying whether the resident has any special care needs. Check on the resident's eyeglasses and hearing aids and his/her schedule of activities or appointments.
- Do homework on resident and provider, if possible.

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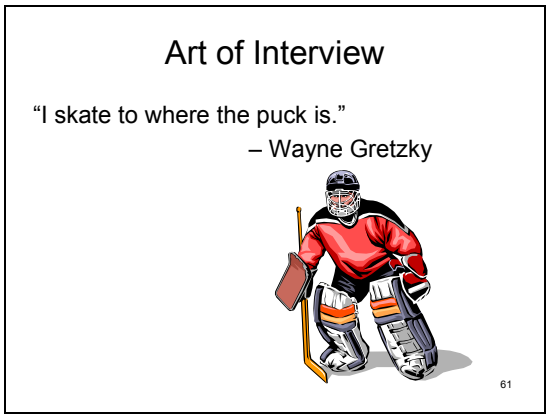

Slide 2-D-61

Outline or text of presentation

Key concept
Effective interviewers try to mirror the communication style of the person being interviewed.

Planning
(*Ask, "How many of you know who Wayne Gretzky is?" Answer: He is a famous hockey player.)*

When Wayne Gretzky was asked how he knows where the puck is going, he answered, "I skate to where the puck is."

He went on to explain that he thinks about where it might go and where he wants it to go and then he just goes to where it is.

The strategy in interviewing is to have a plan and anticipate where the interview may go, but to be flexible. Always focus on where the interview is going, how the interviewee is at that moment and what of importance is being communicated.

Preparing
- Know what information you are looking for.
- Is it a general interview on care and services, or are there concerns about specific care and services that you are trying to find out about?
- Get as much background information as you can before conducting the interview.
- Plan the interview process. Know how you are going to open, where you want to go and how you are going to end the interview.

Audiovisual	Outline or text of presentation
	The plan Ask the most critical questions first. The following questions will help you focus or plan the interview: • What do I want to know before I end the interview? What are the top issues that I must have information about? • What information do I need? • What can I control in the interview? What can I not control? *(This is very different depending on provider types.)* • What is my goal? Questions about the resident: • What concerns do I need to explore with the resident? • How does the resident feel about the care, services and staff, and how do the provider's practices affect the way the resident feels? Nonverbal elements: • Distance of three to six feet. • Light on your face. Verbal elements: • Short sentences. • Don't rush. • Leave ample pauses—someone will break the silence, allowing the other person to break the silence. • Ask one question at a time, on one topic at a time. • Avoid yes or no questions. Questions for the provider: • How does the system work? • What are the provider's expectations of the care it is giving?

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Outline or text of presentation

Set the environment by:

- Eliminating distractions—noise, and other residents or staff interrupting.
- Making sure you and the resident are comfortable, sitting level with each other and facing each other.
- Taking the time to listen. Choose a time to start the main portion of the interview when you will have time to listen and when the resident is not tired or eager to go to an activity.
- Stopping talking. If you are talking more than the person you are interviewing, you are not interviewing. You have moved from interviewing to interrogation. The use of interrogation moves the focus from fact-finding to "I know what you did, now confess." The person being interviewed will unconsciously feel the difference, and a barrier to communication will result.
- Concentrating not only on what is being said but also how it is being said.
- Using verbal and nonverbal cues to encourage the interviewee to speak.

Conducting and Focusing the Interview

Opening/warm up

For staff interviews:

- Ask some general questions about the interviewee's background and what he/she does at the facility.
- Ask how he/she feels about the residents and his/her jobs.
- Organize the questions in a logical sequence to help you get to the point and to get what you need.

Audiovisual	Outline or text of presentation

	For administrator and management staff:
	• Tell him/her that you and the team will be asking a lot of questions.
	  – Questions help surveyors understand what is happening every day in the facility.
	  – Be aware that the perspective of some facility staff is that when questions are asked or notes are taken, something is wrong or incorrect or they are being set up. Assure them that the team spends most of the survey gathering data.
	• Surveyors are looking for the whole picture. Information that is written down and what is observed, said or read allows the team to review and verify the whole picture.
	• Ask "if" questions: "If this were to happen, what would the staff do?" Follow up with questions about policies and procedures.
	• Ask open-ended questions. "Describe when or give me an example of" encourages staff to talk about a situation or symptom.
	• Focus the discussion on the key elements of the message. Clarify describing words so that you have a clear picture of the perspective of the person you are talking to.
	• Rephrase his/her statements or repeat your questions. Speak clearly and distinctly, and don't make snap judgments. People can sense when interviewers have already made up their minds and then they close down.
	• Be okay with pauses. Some people need to organize their thoughts or diffuse their emotions.
	• Listen for verbal clues. Look for visual clues.
	• Remain mentally flexible.

Audiovisual	Outline or text of presentation
	• Listen reflectively and affirm what you have heard. – "I see. Go on." – "What do you mean by. . .?" – "It appears that. . ." – "It sounds like. . ." – "What you seem to be saying is. . ." For clarification: • Generally let the resident lead the interview. However, there may be times where you will have to ask a series of questions about portions of what the resident has said. Remember to go back to all of the issues which were brought out by the resident. • Collect information and verify and validate information obtained from other methods of data gathering. • The interview process should focus on the resident and his/her life. • Interview as a conversation: not every question needs to be asked, but they may serve as probes. You do not necessarily need to follow the order of the questions on the worksheets. Probes allow the surveyor the opportunity to get at what's really important to a resident. • Let the resident guide the process (e.g., follow up on resident comments such as, "I like the food fine, but I'm supposed to get my medication before I eat and usually don't."). This leads to questions about the medical care. • Avoid asking leading questions, but plan the interview ahead of time when possible, and determine what information you hope to gain or verify from the interview. Then review the Guidance to Surveyors for probing questions and focus.

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Remember the following points to help ensure you have a successful interview with an administrator or management staff.

- Record or paraphrase in writing and discuss findings with your team members or field manager.
- Relax, breathe deeply.
- Take your time.
- Allow for silence and pauses.
- Don't talk, just listen.
- Allow for free-flowing conversation, but use clarifying and paraphrasing or rephrase the question when the interview is going in an unproductive direction.
- Ask clarifying questions and paraphrase the ideas and feelings of the person being interviewed.
- Ask whether you accurately understood what the interviewee meant.
- Keep questions open-ended and concentrate on one issue at a time.

To determine compliance, we need to focus on the reality of what the experience is for residents living in the facilities we are surveying. If we make others feel guilty or disrespected, we construct barriers, which will impact our ability to be successful in our mission.

Closing Interview

- Do *not* close with decision
- Say you may have to talk with individual again for more information or clarification

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Closing the Interview

Thank the individual for his/her time and assistance.

- Mutual respect and graciousness go a long way toward establishing a positive ongoing relationship.
- Summarize what the information will be used for, if appropriate.
- Ask whether you may return if you need to clarify something or other questions come up.

Audiovisual	Outline or text of presentation
	• Know when you have obtained what you need or what you can realistically get. • Clearly let the interviewee know that the interview is concluded and what will follow the interview. **What to avoid** • Rushing to judgments. • Giving unwanted advice. • Jumping to conclusions. • Moving prematurely to another topic or problem solving. *(Distribute the handout "Interview versus Interrogation 2" on page 2-D-95.)* **Interviewing versus Interrogation** In the context of interview versus interrogation, dialogue versus debate and opening communication versus closing communication: • An interview may be structured, focusing on the issue or concern the interviewer might have. It still should remain free-flowing, nondirective and open-ended. The purpose remains to gather information. • The less the interviewer talks, the more pure and abundant the information he/she gathers. By refraining from talking, leading questions are avoided. The interviewer learns to ask questions based on the information the interviewee reveals. • In interrogation the interrogator is only seeking confirmation of the information he already knows. All the interrogator or debater wants the person to do is say "yes" or concede the point. • The interview is a nonsuggestive process, because the interviewer is

Audiovisual	Outline or text of presentation
	there to make an objective determination of facts and whether the interviewee is credible. • The interviewer must not contaminate the information with excessive and direct input. He/she must display an unbiased professional attitude. • The tone of the interview must be objective and nonjudgmental. The interviewer must remain focused and determine what information or interviewee is the most credible. • Providers and licensees have commented that leading questions made them feel that they were only being asked to confirm that they had somehow "failed" in caring for the resident. • In interviews with facility staff and licensees, it is good to check yourself: are you interviewing with a focus of obtaining information, or are you interviewing with a focus of confirming what you already know? Your attitude is crucial and will show in your questions. One of the key elements in learning new skills or improving the skills you already have is practice, practice, practice. . . Now we are going to increase the skills we already have and identify the skills that we need to work on. Remember, practicing, planning and analyzing increase our skills. *(Activity: Interviewing.* *Direct each person to pick a card. Tell students they have 10 minutes to progress through the steps of an "interview."* *Determine and discuss what they felt the hardest steps were. Staff generally say that focusing the interview is one of the hardest steps.)*

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(Activity: Open and Close.
Have cards made up with subjects or questions on them for each student to pick or draw.

1. *Have additional cards for each pair made up with the word "open" on one side and "closed" on the other in large capital letters.*
2. *Split up the group into pairs.*
3. *Have each student choose a card with a question or subject on the card.*
4. *He/she is to interview the other person about the question or subject on the card.*
5. *When the interviewee feels that communication is closing (the physical nonverbal cues, a closed question was used, a statement of judgment was made, etc.), he/she will turn his/her card around to cue the interviewer that something has happened to close communication.*
6. *After 15 minutes the pairs are to switch roles.*

After each person has had an opportunity to participate in both roles, have him/her discuss the specific things that closed the communication.)

Interviewing Difficult People

- What was difficult for you?
- What behavior or communication style exhibited or used was difficult or upsetting or challenging to you?

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Communicating With and Interviewing Difficult People

One of the best ways to improve your skills is to complete an analysis after something goes wrong. Here is a handout with questions to review after you have done some of your interviews in the field.

Audiovisual

Interviewing Difficult People (cont.)

- Does person exhibit nonverbal behaviors that say different things than his/her verbal communication? Does he/she exhibit nonverbal behavior that is distracting to you?
- What can you do about situation?

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Outline or text of presentation

(Distribute the handout "Interviewing Difficult People" on page 2-D-97.

- *Assess the situation and discuss the questions with the students.*
- *Ask whether their communication was supportive.*
- *Discuss communicating a criticism supportively.)*

Cultural Differences and Interviewing with an Interpreter

The interview:

- The surveyor will have to establish rapport with the interpreter and then allow the interpreter to establish rapport with the resident.
- Go over your plan with the interpreter. Just because he/she communicates in the other language extensively, he/she is not necessarily good at interviewing or using open-ended questions. Closed-ended questions are "easier" to deal with.
- Remind the interpreter to allow the resident to lead and to give a complete description or explanation.
- If the interpreter and the resident talk for an extended amount of time and then the interpreter answers "yes" to one of your questions, remind the interpreter that it is very important that you receive exactly what the resident said.
- Watch closely the body language of both the resident and the interpreter for "open communication."
- Even though you may feel like a third wheel on a bike, remind yourself to remain engaged and keep your

Audiovisual	Outline or text of presentation

	nonverbal communication open. Remember, nonverbal communication speaks loudly.
	
	(Play the CMS video, "Interviewing Technique."
	
	Distribute the handout "Cultural Differences and Interviewing with an Interpreter" on page 2-D-99.)
	
	Interviewing Summary
	
	General interpretation of interviews
	(Post the following three components on a flipchart:)
	
	1. Be aware of nonverbal indicators.
	  • Actions, facial expressions and manner of speech.
	2. Evaluate the interview as it progresses.
	  • Body language may indicate truthfulness or dishonesty.
	3. Check for internal consistency.
	  • If the story were true, what else would you expect to be true or false? How can you verify it?
	  • Ask for other information so you can check for consistency.
	  – For example, a Director of Nursing (DON) tells you that he/she makes every effort not to be understaffed; however, you have conducted interviews with other staff and residents who say the facility is consistently understaffed. The DON should be able to produce appropriate policies and give concrete and specific examples of how the facility has handled staffing problems on the night shift. Who makes the decision about whether the facility is understaffed and who to call in?

Audiovisual	Outline or text of presentation
	Noninterviewable resident Noninterviewable residents require more observations, and, with a family interview, the key element is to interview the family member who visits most often and is knowledgeable about the resident. **Group interview process** Surveyors might do group interviews for some provider types. Preparation: • Make notes of possible issues to ask team members about, such as observing residents wearing bibs during meals and the use of pet names. • Review minutes of previous Resident Council Meetings to be able to follow up on issues that may have been raised. • Identify and chat with residents prior to the interview. • Ensure the timing of the group interview is not too early or too late in the inspection or survey process. • Some teams use two licensors or surveyors, one to record and the other to facilitate the meeting. • Licensors or surveyors should try to select the members of the group; however, don't turn residents away. • Allow the group to focus on issues that impact all residents. • Identify confidentiality issues. • Identify whether there are individual issues and ask whether you may follow up on those specific items with the individual. • Discuss the results with the team.

Audiovisual

Record Review

- Record or document review is another way to validate & clarify observations or interviews
- Ultimate goal—use information contained in records, in combination with observations & interviews, to determine whether there are deficiencies

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Outline or text of presentation

Record Review

Records can:

- Provide you with a picture of the resident as he/she was assessed by the facility.
- Assist you in evaluation of the assessment, Plan of Care and outcomes of care interviews for the sample residents.
- Help you acquire information to direct further observations or interviews.
- Prevent your spending excessive time gathering and recording information from the record.
- Validate or clarify information you have obtained through observations and interviews.

This stage of investigation entails examining records of the resident. Although surveyors review standard items in the records during every survey, they also direct their attention based on the particular issues of concern by the team currently under investigation.

Key concepts

- Records reflect the provider or facility viewpoint. Know how to determine the significance of unrecorded information. Know that they contain historical and current information on care expected to be provided.
- It is not necessary or efficient to review every piece of documentation or every record you encounter.
- Record review should focus only on the documents that provide information on the care and services being provided or investigated or on concerns and issues that require follow up.

Audiovisual	Outline or text of presentation
	Ask facility staff to help you find any information that you have been unable to find on your own. Be open to potential issues. Sometimes while looking for one thing, you will spot something else that alerts you to a potential problem. Records and documents can be another way of validating or clarifying observations and interviews. The ultimate goal is to use the information contained in the records, in combination with observations and interviews, to determine whether there are deficiencies. **Putting it all together** • Knowing where to *find* certain information can be challenging for surveyors. Sometimes the information that you need is in a record or chart. Getting this information can be tricky for surveyors who do not have a background in medical language and systems or for inexperienced surveyors who do not know what is contained in particular records. • Experienced surveyors note that sometimes you can find the information you need only by speaking with a nurse, nurse's aide, another resident or a family member. Talking to the staff is one of the best ways to get information. The staff can usually tell you more than what is written down. • One can learn a lot, for example, by asking the staff, "What does Jane or Joe need?" By asking questions like this, surveyors learn a lot about what the staff knows, or, more importantly, what the staff doesn't know. If they don't know a particular resident is

Audiovisual

Outline or text of presentation

dependent and needs assistance with turning or eating, for example, this is a serious lack of knowledge. Knowing who is likely to have what information, however, is not always obvious.

Summary of record review

- Documentation and records are written from the viewpoint of the provider.
- We live in a regulatory world. It would be beneficial to survey a facility and discuss the issues with the provider and have the provider correct the issues. However, the expectation is that the provider will be in continual compliance, and for us to make clear-cut decisions in determining that the facility is in or out of compliance, evidence must be obtained and clearly and concisely documented on working papers and within the citation.
- To make clear-cut decisions, strong facts must be collected and observations, interviews, and document and record review must be completed.

Weighing Facts

- Test thoughts
  - Have you verified findings by some other means (other interviews, observations of another resident's care, etc.)?
  - Have you tested conclusions for assumptions? What other information would either validate or change assumption?

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Weighing the Facts

The final stage of the survey process involves weighing the information and then assembling the supporting findings and forming them into a cohesive citation. Evaluate the findings during data collection.

- Have you verified findings by some other means (other interviews, observations of another resident's care, etc.)?
- Have you tested your conclusions for assumptions? When assumptions have been made, what other information would either validate or change the assumption?

Audiovisual

Weighing Facts (cont.)

- Do facts or information give clear-cut direction in decision of compliance?
  - If not, what other facts or information could make decision more clear-cut?
    - More observations?
    - Another interview?
    - Interview specific person?

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Weighing Facts (cont.)

- Measure information or data against Interpretive Guidelines & Guidance to Surveyors
- Discuss findings during team meeting

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Outline or text of presentation

- Do your facts or information provide clear-cut direction in the decision of compliance?
  - If not, what other facts or information could make the decision more clear-cut?
    - More observations?
    - Another interview?
    - A specific person to be interviewed?

Some surveyors rely on their education and experience to determine deficient practice. Some surveyors "know" that the resident isn't getting the care or service that he/she needs.

- When surveyors decide there is deficient practice before the evidence or data are gathered, decision making regarding compliance can be faulty. Essentially the surveyor has relied on his/her assumptions rather than the facts of the case to make a decision.
- If the evidence (observations, interviews or record reviews) has not been obtained and the surveyor is relying on assumptions or vague information, clear-cut decision making is impossible.

When surveyors fail to gather the factual data that lead to the decision of deficient practice, they fail in their primary role and in the intent of their positions.

In conclusion:

- The goal of our information or data and fact finding is to provide irrefutable evidence regarding the provider's compliance with the regulations.
- Devote as much time as possible to performing observations and conducting formal and informal interviews.

Audiovisual

Outline or text of presentation

- Limit record reviews to obtaining specific information; look at what you need, not the whole record.
- Information gathering is intertwined with decision making at each survey task, within each survey. Observations and interviews may lead to a specific portion of record review, and a specific piece of information in the record may direct the surveyor to additional observations and interviews.
- The quality of the information gathered is the basis of decision making regarding compliance.

Writing Citation Requires Data Collection

- Have you gathered information & documented finding on working papers so "facts speak for themselves"?
- Do descriptions assist recalling event?

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Writing

If the surveyor has gathered the information and documented the finding on working papers in such a way that the "facts speak for themselves" and the descriptions assist in recalling the event, then writing a citation is not difficult.

One surveyor explained this stage as "trying to paint a picture with words." The intent is to write in such a way that anyone reading the citation can picture in his/her mind what you pictured in yours.

Gathering information, documenting and writing all take practice.

(Optional Activity: Putting it all together. The trainer may create some scenarios for providers or suppliers the students are most likely to survey. Include situations in which the surveyor is likely to investigate using observation, interview and document review. Examples may include the following issues:

- *Fire in surgery.*
- *Development of pressure sores.*
- *Inadequate hydration.*

Audiovisual

Outline or text of presentation

- *No physician orders for care provided.*
- *Unlocked or outdated medications available for use.*
- *Plan of care and treatment not reflective of beneficiary abilities and needs.)*

Lesson 2-D:
Investigative Skills

Questions

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Slide 2-D-70

Skill Assessment

Investigative Skills

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified at least three pieces of evidence in each observation.	
					Identified at least one "red flag" (critical decision point) on each facility observation activity and one critical decision point during the interview activity.	
					Discussed the levels and strengths of different types of evidence.	
					Discussed how conflicting evidence needs to be objectively weighed.	
					Identified the components of the interview.	
					Identified the process of reviewing the medical record and documents and key elements of the review.	
					Discussed the use of facility records.	

Comments/Recommendations:

Critical Decision-Making Elements within the Survey Process

Use this handout to evaluate your progress.

Within each decision-making process are underlying critical elements. Some of these are:

- Identifying a representative beneficiary sample to investigate the issues so that the extent and scope of the problem can be determined.
- Determining an accurate set of problems and issues to investigate.
- Determining and focusing on what to look for and where to find it.
- Noticing "red flags" (detecting indicators of potential problems).
- Uncovering the root cause of the problem—the specific practice the facility failed to do.
- Determining extent and severity of the problems.
- Interpreting rules and regulations.
- Determining what to cite and what tags to assign.
- Documenting the findings—painting a picture with words.

Aspects of Surveyor Expertise Associated with the Skills of Investigative Work

- Awareness of single cues that should alert a surveyor to investigate something further.
- Perceiving a combination or pattern of cues that may suggest a need for further investigation.
- Awareness of cues to watch for within each of the general problem areas (e.g., what information should alert you to pressure sores or what things should alert you to potential problems with security, etc.).
- Understanding what is typical or normal to more easily identify abnormality ("red flags").
- Awareness that the different professional training of a team member may add expertise in other areas.

The Beauty Shop

Inference Exercise

On August 15, 2002, at 10:45 a.m. Resident #8 was observed sitting in her wheelchair in the activity room. She had no positioning device to support her upper torso, which was leaning to the left. Her left elbow was observed pressed into the left side of her waist. The Director of Nurses (DON) observed the resident and stated she required a positioning device to support her left elbow and to realign her sitting position.

On August 20, 2002, at 12:00 noon, Resident #8 was again observed sitting in a wheelchair in the activity room. A certified nurse's aide was observed assisting her to eat. Resident #8 was observed with a positioning device placed below her right elbow only. She was again observed leaning toward her left side, with her elbow pressing into her waist.

A review of the resident's Care Plan, dated November 14, 2002, disclosed a problem of impaired joint mobility, with a severely contracted left elbow, left and right hands and fingers and minimum contractures of the left wrist and right elbow. For management of this problem, the facility identified the need to use a positioning pillow. However, the facility did not specify when, where and how staff must use the positioning pillow.

Please indicate whether the following statements are true, false or based on the information provided you cannot be certain.

	True	**False**	**Unknown**
1. Resident #8 was sitting in a wheelchair in the activity room on August 15, 2002, and August 20, 2002.			
2. Resident #8 needs a positioning device to support her left elbow.			
3. Resident #8 needs a positioning pillow for management of contractures.			
4. Resident #8 sits in a wheelchair until after the noon meal.			
5. Resident #8 cannot feed herself because of contractures of both hands.			
6. The Care Plan did not identify the need for a positioning device.			
7. Resident #8 required a positioning device and a positioning pillow.			
8. The Care Plan was not updated.			
9. The DON stated that Resident #8 required a positioning device to support her left elbow.			

Inference Exercise—Answers

1. T.
2. T.
3. F.
4. F/not known.
5. F.
6. F.
7. F. Pillow/device, same difference.
8. Not known.
9. F.

Elements of Communication Styles

	Aggressive Style
Mottos and Beliefs	Everyone should be like me. I am never wrong. I've got rights, but you don't.
Communication Style	Closed-minded. Poor listener. Has difficulty seeing the other person's point of view. Interrupts. Monopolizes.
Characteristics	Achieves goals, often at expense of others. Domineering, bullying. Patronizing. Condescending, sarcastic.
Behavior	Puts others down. Doesn't ever think they are wrong. Bossy. Moves into other people's space, overpowers. Jumps on others, pushes people around. Know-it-all attitude. Doesn't show appreciation.
Nonverbal Cues	Points and shakes fingers. Frowns and squints critically. Glares and stares. Rigid posture. Critical, loud tone of voice. Fast, clipped speech.
Verbal Cues	"You should, must, ought to." "Don't ask why—just do it." Verbally abusive.
Confrontation and Problem Solving	Must win arguments, threatens, attacks. Operates from a win-lose position.
Feelings	Anger. Hostility. Frustration. Impatience.
Effects	Provokes counteraggression. Alienation from others. Ill health. Wastes time and energy supervising others. Pays high price in human relationships. Fosters resistance. Defiance, sabotaging, striking back. Forming alliances. Lying and covering up. Forces resentful compliance.

	Passive Style
Mottos and Beliefs	Don't express true feelings. Don't make waves. Don't disagree. Others have more rights than I do.
Communication Style	Indirect. Always agrees. Doesn't speak up or is hesitant.
Characteristics	Apologetic, self-conscious, trusts others but not self. Doesn't express own wants and feelings—allows others to make decisions for self. Doesn't get what he/she wants.
Behavior	Sighs a lot. Tries to sit on both sides of the fence to avoid conflict. Clams up when feeling treated unfairly. Asks permission unnecessarily and complains instead of taking action. Lets others make choices. Has difficulty implementing plans. Self-effacing.
Nonverbal Cues	Fidgets. Nods head often—comes across as pleading. Lack of facial animation. Smiles and nods in agreement but with downcast eyes and slumped posture. Low volume, meek. Talks fast when anxious. Slow, hesitant when doubtful.
Verbal Cues	"You should do it." "You have more experience than I do." "I can't." "This is probably wrong, but. . .I'll try." Monotone, low energy.
Confrontation and Problem Solving	Avoids, ignores, leaves, postpones. Withdraws, is sullen and silent. Agrees externally while disagreeing internally. Expends energy to avoid conflicts that are anxiety-provoking. Spends too much time asking for advice. As a supervisor, agrees too often.
Feelings	Powerlessness. Wonders why doesn't receive credit for good work. Chalks lack of recognition up to others' inabilities.
Effects	Gives up being himself/herself. Builds dependent relationships. Doesn't know where he/she stands. Slowly loses self-esteem. Promotes others' causes. Is not well liked.

	Assertive Style
Mottos and Beliefs	Believes self and others are valuable, knowing that assertiveness does not always mean you win but that you handled the situation as effectively as possible. "I have rights and so do others."
Communication Style	Effective, active listener. States limits, expectations. States observations——no labels or judgments. Expresses self directly, honestly and as soon as possible about feelings and wants. Checks on feelings of others.
Characteristics	Nonjudgmental. Observes behavior rather than labeling it. Trusts self and others—confident. Self-aware, open, flexible, versatile. Playful sense of humor. Decisive. Proactive initiating.
Behavior	Operates from choice. Knows what is needed and develops a plan to get it. Action-oriented, firm, realistic in expectations. Fair and just, consistent. Takes appropriate action toward getting what he/she wants without denying rights of others.
Nonverbal Cues	Open, natural gestures. Attentive, interested facial expression. Direct eye contact, confident or relaxed posture. Appropriate vocal volume. Expressive, varied rate of speech.
Verbal Cues	"I choose to." "What are my options?" "What alternatives do we have?"
Confrontation and Problem Solving	Negotiates, bargains, trades off, compromises. Confronts problems at the time they happen. Doesn't let negative feelings build up.
Feelings	Enthusiasm. Well-being. Even tempered.
Effects	Increased self-esteem and self-confidence. Increased self-esteem of others. Feels motivated and understood. Others know where they stand.

Effective Communication Self-Evaluation

To help you become more aware of your listening habits, complete the following listening self-evaluation. Place an "x" in the most appropriate column to reflect your usual style.

Communicating	Most of the Time	Frequently	Occasionally	Almost Never
How often do you: 1. Tune out people who say something you don't agree with or don't want to hear?				
2. Concentrate on what is being said even if you are not really interested?				
3. Assume you know what the talker is going to say and stop listening?				
4. Repeat in your own words what the talker has just said?				
5. Listen to the other person's viewpoint even if it differs from yours?				
6. Learn something from each person you meet, even if it is ever so slight?				
7. Find out what words mean when they are used in ways not familiar to you?				
8. Form a rebuttal in your head while the speaker is talking?				
9. Give the appearance of listening when you aren't?				
10. Daydream while the speaker is talking?				
11. Listen to the whole message—what the talker is saying verbally and nonverbally?				
12. Recognize that words don't mean exactly the same thing to different people?				
13. Listen to only what you want to hear, blotting out the speaker's whole message?				
14. Look at the person who is talking?				
15. Concentrate on the speaker's meaning rather than how he/she looks?				
16. Know which words and phrases you respond to emotionally?				
17. Think about what you want to accomplish with your communication?				
18. Plan the best time to say what you want to say?				

19. Think about how the other person might react to what you say?				
20. Consider the best way to make your communication (written, spoken, phone, bulletin board, memo, etc.) work?				
21. Think about what kind of person you're talking to (worried, hostile, disinterested, rushed, shy, stubborn, impatient, etc.)?				
22. Interrupt the speaker while he/she is still talking?				
23. Think "I assumed he/she would know that"?				
24. Allow the speaker to vent negative feelings toward you without becoming defensive?				
25. Practice regularly to increase your listening efficiency?				
26. Take notes when necessary to help you remember?				
27. Hear noises without being distracted by them?				
28. Listen to the speaker without judging or criticizing?				
29. Restate instructions and messages to be sure you understand correctly?				
30. Paraphrase what you believe the speaker is feeling?				

Effective Communication Self-Evaluation Scoring

1. Circle the number that matches the time frame that you checked on each of the self-evaluation items.
2. Total the circled items in each column.
3. Which is the column with the highest score?

1	1	2	3	4
2	4	3	2	1
3	1	2	3	4
4	4	3	2	1
5	4	3	2	1
6	4	3	2	1
7	4	3	2	1
8	1	2	3	4
9	1	2	3	4
10	1	2	2	4
11	4	3	2	1
12	4	3	3	1
13	1	3	2	4
14	4	3	2	1
15	4	3	2	1
16	1	3	2	1
17	4	3	2	1
18	4	3	2	1
19	4	3	2	1
20	4	3	2	1
21	4	3	2	1
22	1	2	3	4
23	1	2	3	4
24	4	3	2	1
25	4	3	2	1
26	4	3	2	1
27	4	3	2	1
28	4	3	2	1
29	4	3	2	1
30	4	3	2	1
Total				

Interview versus Interrogation 1

Interview/Dialogue/Opening Communication	Interrogation/Debate/Closing Communication
Purpose is to gather information. This requires listening and clarifying.	Purpose is to get a confession. The interviewer is focused on rebutting the statements of the person being interviewed.
Nonaccusatory—hear their position.	Accusatory—defend your position.
Free-flowing.	Structured.
Interviewer speaks 5% of the time. Explore information.	Interviewer speaks 95% of the time. In a debate the information is known, and the interviewer gives information and answers questions.
Person being interviewed speaks 95% of the time. Observe and describe others' behavior without evaluation.	Person being interrogated speaks 5% of the time. Interpret, judge others' behavior as right or wrong.
State what you hear—check it.	Assume you know what he/she means.
Think more or less without evaluating.	Think "either/or" and find one best way.
Share information. Accept and disclose views.	Give advice on what's best. Evaluate each other's views.
Respect differences.	Overcome objections.
Ask "What happened, and how can we?" questions.	Ask "Why don't you?" questions.
Strive for mutual gain.	Strive to win.
Build relationships to create ongoing benefits.	Make points now to build your track record.

Guidelines for Reducing Resistance

1. Ask for clarification or additional information to support what the person said instead of abruptly disapproving or contradicting what was said.
2. Find a point of agreement to build on, rather than disagreeing. If you aren't able to find something in the content of the discussion, agree with the person's feelings (e.g., "I can understand your feelings of frustration when you aren't able to find a solution that works.").
3. Control your own natural ego-building desire to get the upper hand by pointing things out in the other's point of view. Question the points that are not supported by examples or facts when you notice them, but do so in way that keeps the other person's ego and self-esteem intact.
4. Use every opportunity to positively reinforce the other person's behavior, ideas or actions.
5. To get your instructions carried out and reach goals that involve others, remember that people want positive attention paid to what they say and do. They want understanding and clarity on what is expected of them, along with acceptance of themselves and their ideas whenever possible.
6. Very rarely will anyone change his or her mind by being asked, told or directed to do so. If you want to influence the listener to see things differently, avoid using threatening language, both verbal and nonverbal. By so doing, you can decrease the need for the listener to defend himself/herself.
7. Anticipate the things that would influence the listener to resist—take them into account, empathize and know the other person.
   You can get to know others by being aware of:
   - Their beliefs—how do they look at the world?
   - What makes them feel comfortable, confident?
   - What throws them off balance?
   - What kind of phrases will help you get through to them?
   - What things do they do that are effective or ineffective?
8. People resist others less and listen to them more because of credibility. Whenever possible, build your credibility through the following means:
   - Competence—How much do you know, how much experience do you have and how well trained are you?
   - Knowledge—Do you keep abreast of what is going on and pass the information on to others?
   - Dependability and trustworthiness—How much can you be trusted to do what's in other people's interest? Are you sincere and honest? Do you keep your word and not make promises you can't keep? If in a position of authority, do you back your people, remain empathetic and see things as others see them?
   - Energy and drive—Do you have the drive to see things through and do what you say you will? Do you get the job done?
   - Effective communication—Do you stay in an attitude of "okay-okay"? Do you listen actively as much as possible? Do you communicate with a positive, engaging, committed style?

Interview versus Interrogation 2

	Interview/Dialogue/Opening Communication	**Interrogation/Debate/ Closing Communication**
Environmental	The environment is varied and is more under the control of the person being interviewed—more comfortable settings.	Interviewer is in control of the environment and location and time of the sessions.
Proxemics	Distance between chairs is personal or social zone.	Distance between chairs starts at personal and goes to intimate zone.
Verbal/Nonverbal Consistency	Writing is okay if consistent and if it accurately reflects what the person being interviewed means.	Generally there is no writing, because the focus is not information gathering.
Nonverbal	Body language is open, relaxed and calm. Mannerisms and movement are consistent.	Body language is tense; hands are held tightly and position may reflect fight or flight rather than open and relaxed. Sudden changes in mannerisms.

Interviewing Difficult People

Assess the situation:

- What was difficult for you?
- What behavior or communication style used did you find difficult, upsetting or challenging?
- Did the person exhibit nonverbal behaviors that say different things than his/her verbal communication? Did he/she exhibit nonverbal behavior that is distracting to you?
- Next time, what can you do about the answers to the above?
- Did you recognize incongruent communication when it happened?
- Were you hoping that the person would change? The person is not going to be different.
- Do we have control over what we say and do? For what do we have responsibility? It is important for each of us to accept what we can change and understand what we have no control over.
- How well planned was your interview? Did you leave with information about the critical issues? Was it the words you used? Was it the individual you interviewed? Was it the questions you asked? Could you have used different words or questions? Formulate a plan (e.g., continue to focus on what the resident needs and what is best for that person.).
  - Practice and discuss your struggles with your coach. Ask if you can watch one of his/her interviews.
  - Plan to do it differently next time.
  - Implement your plan.
  - Reassess your successes.

Supportive Communication		
Defensive	versus	Supportive
Judgmental		Descriptive
Controlling		Problem Solving
Strategizing		Spontaneous
Neutral		Empathic
Superior		Equal
Rigid		Flexible

Communicating a criticism supportively:

- Describe the situation objectively.
- Describe the result or outcome as objectively as possible.
- Describe the options you see.
- Give the other person time to do the thinking you have already done, ask for a time to discuss or offer to discuss after he/she has considered what you have said.
- Be aware of red button words:
  - Always.
  - Never.
  - Should.
  - Too.
  - But.

Cultural Differences and Interviewing with an Interpreter

The interview:

- The surveyor will have to establish rapport with the interpreter, and then allow the interpreter to establish rapport with the resident.
- Go over your plan with the interpreter. Just because the interpreter communicates extensively in another language does not mean he/she is necessarily good at interviewing or using open-ended questions. Closed-ended questions are "easier" to deal with.
- Remind the interpreter to allow the resident to lead and to give a complete description or explanation.
- If the interpreter and the resident talk for an extended amount of time and then the interpreter answers "yes" to one of your questions, remind the interpreter that it is very important that you receive exactly what the resident said in the resident's own words.
- Observe body language closely between the resident and the interpreter for "open communication."
- Even though you are feeling like a third wheel on a bike, remain engaged and keep your nonverbal communication open. Remember, nonverbal communication speaks loudly.

Lesson 2-D-1: Complaint Investigation

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify specific issues in different types of complaints.
- Read a complaint intake and routing form.
- Plan a complaint investigation.
- Explain the elements of a complaint report.
- Identify the elements of a complaint Statement of Deficiencies.
- Calculate complaint time.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 5, Complaint Procedures
  - Appendix PP, Section VII, Abbreviated Standard Surveys
- CMS letter: Guidelines for Complaint Investigation (June 10, 1997).
- CMS letter: Guiding Principles for Complaint Investigation (October 13, 1999).
- S&C letter 03-04: Interim Guidance to Support the National Pilot of the ASPEN Complaints/Incidents Tracking System (ACTS) (November 14, 2002). Available online: http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
- S&C letter 04-09: Guidelines to Support the Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (November 13, 2003). Available online: http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

State

(Insert State reference[s] here.)

Other

Highlights

- Investigating complaints
- Preparing reports of investigation
- Entering complaint information into ASPEN Automated Complaint Tracking System

Training Techniques

- Lecture
- Group discussion
- Activities

Training Aids

- PowerPoint slides and handouts
- Blank copies of Form CMS-562, *Medicare/Medicaid/CLIA Complaint Form* (one per student)
- Blank copies of Form 670, available electronically from ASPEN (one per student)
- Copies of *SOM* Chapter 5 (one per student)

- Two actual initial complaints of varying priorities, one with multiple issues (State-supplied)
- Completed investigation reports, one for each actual initial complaint used in this lesson (State-supplied)
- Chart pad paper and easel, and tape to tape up multiple sheets (if necessary)
- Handouts:
  - *Planning a Complaint Investigation*
  - *Basic - NH Complaint/Incident Investigation Protocol*
  - *Elements of Complaint Reports and Packets*
  - *Entering a Complaint into ASPEN*

Methods of Evaluation

- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-D-1: Complaint Investigation 1	
Slide 2-D-1-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Identify specific issues in different types of complaints. • Read a complaint intake & routing form. • Plan a complaint investigation. 2	*(Inform the students of the objectives.)*
Slide 2-D-1-2	
Learning Objectives (cont.) • Explain the elements of a complaint report. • Identify the elements of a complaint Statement of Deficiency. • Calculate complaint time. 3	
Slide 2-D-1-3	

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Goals of Learning to Investigate

- Timely complaint resolution
- Consistent investigation
- Thorough investigation

4

Slide 2-D-1-4

Outline or text of presentation

The goal of learning to investigate complaints is to ensure that:

- Complaint resolution takes place in a timely manner.
- Investigation is consistent.
- Issues are thoroughly investigated to prevent more harm from occurring to beneficiaries.

Some background: guidelines for complaint investigation were promulgated in a CMS letter in 1997. They were revised in a CMS letter in 1999 and further revised to address the ASPEN Automated Complaint Tracking System in 2002 and 2003. In 2004, a revision to the *SOM* incorporated a chapter (Chapter 5) on complaint investigation.

Definitions

- Complainant: person who reports complaint
- Complaint: report of situation, problem or concern that may pose health or safety threat or has potential to cause harm
  - Called "incident" if referred by provider or agency representing provider
- Beneficiary: any person receiving care, treatment or services from provider or supplier

5

Slide 2-D-1-5

Some definitions:

- **Complainant:** the person who reports or files a complaint by calling or writing with information about a situation, concern or problem.
- **Complaint:** report of a situation, problem or concern that may pose a health or safety threat or has the potential to cause harm. The complaint can be general or specific and can involve staff, beneficiaries, volunteers and the physical environment of a facility or its administration.
  - Called an "incident" if reported by a provider or supplier or by an agency representing a provider or supplier.
- **Beneficiary:** any person receiving care, treatment or services from a provider or supplier.

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Complaint Investigation

- Determines whether:
  - Beneficiary is safe, has been harmed or may be harmed
  - Alleged situation occurred or was likely to occur
  - Deficient practice was or is present
  - Condition of Participation or Coverage not met
  - Situation resolved, corrected or ongoing

6

Slide 2-D-1-6

Steps in Complaint Investigation

- Presurvey preparation
- Entrance conference & onsite preparatory activities
- Information gathering
- Information analysis & decision making
- Documentation
- Exit conference
- Followup
- Response to complainant & beneficiary
- Referral of complaint to other agencies

7

Slide 2-D-1-7

Outline or text of presentation

Complaint investigation means gathering information to determine whether:

- A beneficiary is safe.
- A beneficiary has been harmed or may be harmed.
- The situation described in the complaint occurred or is likely to occur.
- Deficient practice was or is present.
- A Condition of Participation or Coverage was not met.
- The situation described in the complaint has been resolved or corrected or is still going on.

Steps in Complaint Investigation

Steps in a complaint investigation are:

- Presurvey preparation.
- Entrance conference and onsite preparatory activities.
- Information gathering.
- Information analysis and decision making.
- Documentation.
- Exit conference.
- Followup.
- Response to complainant and beneficiary.
- Referral of the complaint to other agencies.

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Presurvey Preparation

- Gather information from:
  - Intake form (Form CMS-562)
  - Complainant
- Note information needed for ASPEN Automated Complaint Tracking System
  - Form 670

8

Slide 2-D-1-8

Outline or text of presentation

Presurvey Preparation

In this step, gather information about the complaint from the intake report or from the complainant.

Form CMS-562, *Medicare/Medicaid/CLIA Complaint Form*, provides a framework and overview of the complaint investigation process. Form 670 will also be completed as part of the reporting process for the ASPEN Automated Complaint Tracking System (ACTS).

(Review blank copies of Form CMS-562 and Form 670 with the students.)

Identification of Issues & Allegations

- Who complaint is about
- What facts are
- Whether complaint concerns isolated occurrence or ongoing situation

9

Slide 2-D-1-9

Review the intake report and identify the issues and allegations. Identify:

- Who the complaint is about.
- What the facts are.
- The time frame: Is the complaint about an isolated occurrence or an ongoing situation?

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Identification of Issues & Allegations (cont.)

- Where & how incident(s) took place
- Who witnesses were
- Whether staff were involved & who they were
- Whether other beneficiaries, families or volunteers were involved

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Slide 2-D-1-10

Outline or text of presentation

- Where and how the incident(s) took place.
- Who the witnesses were.
- Whether staff were involved and who they were.
- Whether other beneficiaries, families or volunteers were involved.

Complaint Classification

- Category (e.g., abuse & neglect, rights, care & services)
- Priority level
- Status: initiated or not initiated
- Regulatory requirements or standards that may be involved

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Slide 2-D-1-11

Then preliminarily classify the complaint:

- Category (e.g., abuse and neglect, rights, care and services).
- Priority level.
- Status: initiated or not initiated.
- Regulatory requirements or standards that may be involved.

Priority level and status will be discussed in a moment.

Complaint Initiation

- Initiation—contacting complainant & clarifying issues
  - Contact is by telephone
  - Unsuccessful attempts are to be documented
  - At least 3 attempts are to be made

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Slide 2-D-1-12

A complaint is “initiated” when an investigator contacts the complainant and obtains clarification on the issues. The investigator should contact the complainant by telephone. Whenever telephone contact is not successful, the investigator is to document the times and dates of the attempts in the complaint report. It is expected that the investigator will make three attempts at different times and on different days.

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Outline or text of presentation

Questions for Complainant

- Who were individuals involved or affected?
- Who were witnesses & accusers?
- What were specifics of allegation or incident?
- Is complaint about isolated event or systemic problem?

13

Slide 2-D-1-13

Interviewing the complainant prior to the onsite visit is an advantage. You may be able to clarify the issues and focus by asking:

- Who were the individuals involved or affected?
- Who were the witnesses and accusers?
- What were the specifics of the allegation or incident?
- Is the complaint about an isolated event or a systemic problem?

Questions for Complainant (cont.)

- Why did incident occur?
- Was facility notified of complainant's concerns or issues?
- What was done to resolve issues or mitigate consequences of incident?

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Slide 2-D-1-14

- Why did the incident occur?
- Was the facility notified of the complainant's concerns or issues?
- What was done to resolve the issues or mitigate the consequences of the incident?

Information for Complainant

- Policies & procedures regarding complaints
- Scope of State agency regulatory authority
- Considerations pertaining to confidentiality
- State agency's planned course of action

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Slide 2-D-1-15

During the interview, inform the complainant of:

- Policies and procedures regarding complaints.
- The scope of State agency regulatory authority.
- Considerations pertaining to confidentiality.
- The State agency's planned course of action.

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Information for Complainant (cont.)

- Time investigation is expected to take
- Information about other agencies that could investigate complaint, with contact information
- Name & number of State agency contact for complainant followup

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Slide 2-D-1-16

Outline or text of presentation

- The amount of time the investigation is expected to take. This depends on the priority assigned after triage.
- Information about other agencies that could investigate the complaint, with contact information.
- Name and number of State agency contact for complainant followup.

Triage Categories

- Immediate Jeopardy
  - Investigation within 2 working days
  - Exceptions:
    - Accredited/deemed providers: 2 working days after receipt of Form CMS-2802
    - Hospital EMTALA: 5 working days after RO authorization to investigate
    - Restraint or seclusion death reports: 5 working days after RO telephone authorization to investigate

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Slide 2-D-1-17

Triage categories

The priority of the investigation is assigned by triage. Triage focuses on the impact on the resident and special requirements for some providers:

- Immediate Jeopardy. Investigation will take place within two working days of receipt of the information if the jeopardy is not removed, except for special cases:
  - Accredited/deemed providers (two working days of the receipt of Form CMS-2802).
  - Hospital Emergency Medical Treatment and Active Labor Act (EMTALA) (five working days after Regional Office (RO) authorization to investigate).
  - Restraint or seclusion death reports (five working days after RO telephone authorization to investigate).

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Triage Categories (cont.)

- Non-Immediate Jeopardy—High
  - Investigation initiated within 10 working days
- Non-Immediate Jeopardy—Medium
  - Onsite survey scheduled
  - For non-EMTALA providers or suppliers with deemed status, onsite survey scheduled within 45 days of authorization by RO
- Non-Immediate Jeopardy—Low
  - Allegation reviewed at next scheduled onsite survey

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Slide 2-D-1-18

Outline or text of presentation

- Non-Immediate Jeopardy—High. Investigation will be initiated within 10 working days.
- Non-Immediate Jeopardy—Medium. An onsite survey will be scheduled. For non-EMTALA providers or suppliers with deemed status, an onsite survey is scheduled within 45 days of authorization by the RO.
- Non-Immediate Jeopardy—Low. The allegation will be reviewed at the next scheduled onsite survey.

Triage Categories (cont.)

- Administrative review/offsite investigation
  - Information collected but onsite investigation not needed
  - SA may review allegation at next onsite survey

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Slide 2-D-1-19

- Administrative review/offsite investigation. Information is collected, but an onsite investigation is not needed. The SA may review the allegation at the next onsite survey.

Triage Categories (cont.)

- Referral—Immediate
  - Circumstances warrant referral to another agency, board or network without delay
- Referral—Other
  - Complaints referred for investigation or for informational purposes

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Slide 2-D-1-20

- Referral—Immediate. Circumstances warrant referral to another agency, board or network without delay.
- Referral—Other. Complaints referred for investigation or for informational purposes.

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Review of Facility File

Look for:
- Similar complaints
- Recent changes in staff or ownership
- Unique beneficiary characteristics
- Beneficiary acuity level
- Facility age

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Slide 2-D-1-21

Outline or text of presentation

Another part of the presurvey preparation is reviewing the facility file. Look for:
- Other complaints of the same nature.
- Recent changes in staff or ownership.
- Unique beneficiary characteristics.
- Beneficiary acuity level.
- Facility age.

Review of OSCAR Data

- Report 3 for 4-year survey history
- Report 4 for 1-year survey history
- Report 40 for last 4 complaint surveys

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Slide 2-D-1-22

- Also review Online Survey and Certification Reporting System (OSCAR) Reports for the facility:
  - Report 3 for a four-year survey history.
  - Report 4 for a one-year survey history.
  - Report 40 for the last four complaint surveys of the facility.

Planning Investigation

Plan enables you to:
- Systematically find truth to better protect beneficiary
- Systematically review allegations
- Clear allegations or determine culpability

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Slide 2-D-1-23

At this point, it is necessary to plan your investigation. Why plan? A plan enables you to systematically find the truth to better protect the beneficiary. It also enables you to systematically review allegations and clear the allegations or determine culpability.

(Refer students to the handout "Planning a Complaint Investigation" on page 2-D-1-31. Briefly review the handout to prepare the students for a complaint investigation planning activity to be done later. Also briefly review the guidance on planning investigations in SOM, Chapter 5 and the

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Outline or text of presentation

handout "Basic - NH Complaint/Incident Investigation Protocol on page 2-D-1-33.)

Entrance Conference

- Note:
  - Complaint investigations are always unannounced
  - Complaint report & complaint intake form are highly confidential
- Advise administrator only of general purpose of visit

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Slide 2-D-1-24

Entrance Conference

Complaint investigations should always be unannounced. The complaint report (or copy) and complaint intake form should never be taken into the facility, because they are highly confidential.

At the entrance conference, advise the administrator what the purpose of the visit is (e.g., to investigate concerns about the "quality of care" or "meeting the nutritional needs of beneficiaries"). Be general: the providers know that you will not reveal the complainant or the issue the complaint is about.

Information Gathering

- Consider order & manner in which you gather information
- Prioritize & strive for efficiency
- Maintain confidentiality

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Slide 2-D-1-25

Information Gathering

Consider the order and manner in which you gather information. Prioritize: you may have a limited amount of time and a number of complaints to investigate. Developing efficiency takes time and experience, but strive for it.

On the other hand, confidentiality is important. If the complaint is about one person, plan to look at a cross section of staff and beneficiary records. Perform observations so that individuals are not singled out.

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Information Gathering (cont.)

- Interview beneficiary involved & surrogate if appropriate
  - If not done, document reason
- Determine:
  - Whether alleged events happened
  - What facility practice led to complaint situation
  - Whether there is failed practice

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Slide 2-D-1-26

Outline or text of presentation

Interview the beneficiary involved and the surrogate if appropriate, unless there are compelling reasons not to do so. Those reasons must be documented in the report.

It is not enough to determine whether the alleged events happened. Sometimes bad things happen, but facility practice may not be to blame. You must determine what facility practice led to the complaint situation and whether there is a failed practice.

Suggestions for Information Gathering

- Obtain most critical information first
- Emphasize observations
- Verify each piece of information
- Know how to request information or obtain access to information at other facilities

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Slide 2-D-1-27

Obtain the most critical information first. Observations, interview and record review can be done in any order; however, observations yield the most powerful evidence. Each piece of information should be verified by interview, record review or observation.

You may need to go to more than one health-care entity to gather information. Have references on procedures for requesting information or obtaining access to information ready in case you need them.

Maintaining Focus

Key information:
- Sequence of events
- Injury that occurred
- Who was involved
- How facility responded
- Facility practices & procedures relevant to:
  - Incident
  - Staff assignments
  - Safety of beneficiaries
  - Compliance

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Slide 2-D-1-28

Key pieces of information are:
- The sequence of events.
- The injury that occurred.
- Who was involved.
- How the facility responded.
- Facility practices and procedures relevant to:
  - The incident.
  - Staff assignments.
  - Safety of beneficiaries.
  - Facility compliance.

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Outline or text of presentation

Remember to remain focused. There may be many things that are not according to best practices of beneficiary care; you are there only to investigate the complaint. If you find yourself with *many* care issues, or a lot of abuse or neglect issues, consult your field manager. You may need additional help.

Guidelines for Observations

Note:
- General circumstances:
  - Physical environment
  - Procedures
  - Patterns of care
  - Delivery of services
- Specific care & services
- Indications of systemic issues

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Slide 2-D-1-29

Observations

Observe general circumstances of the complaint:
- Physical environment.
- Procedures.
- Patterns of care.
- Delivery of services.

Observe specific care and services (e.g., dressing changes, infection control techniques, infection control program, nutrition, etc.) Observe a dining experience.

Observe things that will help you determine whether the complaint is due to a systemic issue.

Example 1: If a family member of a beneficiary complains that a facility is not assisting with transportation to therapy or for treatments, ask other beneficiaries whether they go out to visit their physician. If they do, then ask how they get there.

Example 2: If there are complaints about wound care for a specific beneficiary, observe not only wound care for that beneficiary, but also review the admission log and see if there are other beneficiaries with wounds who were admitted with surgical wounds from the hospital. Reviewing the quality indicators may give you the identities of other beneficiaries with pressure ulcers and wound care needs that you could observe.

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Guidelines for Interviews

- Interview complainant & principals
  - Maintain confidentiality of witnesses
  - Interview in person or by telephone
- Prepare outlines of topics for interviews
- Reinterview to validate findings, if necessary

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Slide 2-D-1-30

Outline or text of presentation

Interviews

Interview the complainant and principals, while maintaining the confidentiality of your witnesses. You may do interviews over the telephone, although it is preferable to interview in person.

Prepare outlines of topics to be covered in interviews. Reinterview specific staff and beneficiaries to validate findings, if necessary.

Guidelines for Interviews (cont.)

- Record:
  - Identity of interviewee
  - Time
  - Date
  - Location
  - Direct quotes whenever relevant, if at all possible

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Slide 2-D-1-31

Follow the principles of survey documentation: record to whom you spoke, the time, the date and the location, and whenever possible, record direct quotes.

Guidelines for Record Review

- Identify condition of beneficiary prior to & after incident
- Determine whether facility assessed, planned, implemented & reevaluated
- Determine what individuals were involved in care
  - Review staff schedules or logs
- Look for trends, facility practice or process

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Slide 2-D-1-32

Record review

Identify the condition of the beneficiary prior to and after the incident. If the issue is care, identify whether assessment, planning, implementation and reevaluation have been done.

Identify who you need to interview. Determine what individuals were involved in care (review staff schedules or logs to identify a particular shift or time frame). Find out who would know about the issue being investigated.

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Outline or text of presentation

Review records and logs for trends or facility practice or process.

Example: Suppose the issue is food service. Interviewing nursing services about the food a beneficiary is receiving will probably not get you as much information as observing dining or interviewing beneficiaries, direct care staff who assist the beneficiaries and whoever monitors what is provided on the tray line (kitchen staff or dietitian).

Don't forget to record all evidence and facts in your working papers.

Evaluating Evidence

Evidence must be:
- Relevant
- Reliable
- Credible

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Slide 2-D-1-33

Criteria for evaluating evidence

Evidence must be:
- Relevant: logically related to the issue.
- Reliable: obtained from a documented, reliable source or through a reliable means.
- Credible: accurate and believable.

Analysis of Evidence

Ask if evidence is:
- Based on opinion or fact, objective or subjective information?
- Relevant, reliable, credible?
- Sufficient for decision?
  - Feasible to obtain additional evidence?

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Slide 2-D-1-34

Analysis of evidence

As you go, evaluate all evidence and facts in your notes. Ask yourself:
- Is evidence based on opinion or fact, objective or subjective information?
- Does the evidence meet the criteria for evaluating evidence?
- Is more evidence needed before a decision can be made?
- Is it feasible to obtain the additional evidence?

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Referral to Other Agencies

If:	Then:
Circumstances warrant referral	Check initial complaint for prior notification
Relevant referral has not yet been made	Make referral & note on intake form

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Slide 2-D-1-35

Outline or text of presentation

Referral of the Complaint to Other Agencies

In the course of the investigation, you may decide that other agencies should be notified about the complaint. First, review the initial complaint; other agencies may already have been notified.

If you believe other agencies should be notified (and have not been), notify your supervisor or the appropriate contact of your findings. If another agency is notified of the situation, the notification should be recorded on the complaint intake form.

Complaints Received During Survey

- Ask your supervisor for guidance
- Options for investigation:
  - During survey
  - Separately

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Slide 2-D-1-36

Complaints Received During Survey

In the case of complaints identified during survey, ask your supervisor for guidance. The supervisor will determine whether the complaint is to be investigated during the survey or separately.

Information Analysis

Check for:

- Gaps in evidence
- Immediate Jeopardy:
  - Potential or actual abuse, neglect or harm
  - Potential harm that is or was severe & could not be reversed
- Inconsistencies or contradictions
  - Collect additional data to verify or corroborate

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Slide 2-D-1-37

Information Analysis and Decision Making

Information analysis

Before you start making decisions about what action to take, review all of your information. Is there any other information you need to obtain?

Remember that with the following situations you must consider Immediate Jeopardy:

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Outline or text of presentation

- Potential or actual abuse, neglect or harm.
- Potential harm that is or was severe and could not be reversed.

Identify any inconsistencies or contradictions among interviews, observations and record reviews.

Collect additional data to verify or corroborate information related to inconsistencies.

Decision Making

Classify complaint:
- Substantiated
- Unsubstantiated
- Not supported by sufficient evidence

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Slide 2-D-1-38

Decision making

Using relevant, reliable and credible evidence, classify the complaint as one of the following:
- Substantiated: enough facts exist to show that the incident occurred, how it happened and who did it. Note whether the situation is still present.
- Unsubstantiated: enough facts exist to show the incident did *not* occur, or the facts do not show how it happened or who did it.
- Insufficient evidence: evidence is missing, cannot be obtained, is unreliable or is inconclusive.

Substantiated Complaints

For these, consider:
- Facility compliance with pertinent regulation
- Contribution of facility practice or procedure to incident
  - Has it been corrected?
- What facility should have known or done, given knowledge about needs & assessment of beneficiary

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Slide 2-D-1-39

If the complaint is substantiated, ask:
- Is the facility out of compliance with the regulation that pertains to the issues within the complaint?
- Has a facility practice or procedure contributed to the incident? Has it been corrected?
- What should the facility have known or done, given the knowledge they had about the needs and assessment of the beneficiary?

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General Documentation Guidelines

- Note:
  - Time
  - Date
  - Location
  - Identification of person from whom information was obtained

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Slide 2-D-1-40

Outline or text of presentation

Documentation

In general, documentation is integral to good practice and risk prevention for health-care providers. Without good documentation, even the best practice may be challenged and questioned.

Similarly, good documentation is important to complaint investigation. All information you need should be carefully documented. Note the time, date, location and person from whom the information was obtained.

General Documentation Guidelines (cont.)

- Document all contacts made
- Mention all interviews & records reviewed
  - Copies of records may be made to verify noncompliance
- Record objective facts & observations, along with statements from client, witnesses & perpetrator
- Document elements of facility practice

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Slide 2-D-1-41

Also:

- Document contacts made during the investigation, including phone contacts, collateral contacts and observations made during the visit.
- Include interviews with other individuals and documented records that were reviewed. Copies of records may be made to verify noncompliance.
- Record objective facts and observations, along with statements from the client, witnesses and perpetrator and any reference documents.
- Document the elements of facility practice.

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General Documentation Guidelines

- Document rationale for decision, investigation plan & final determination
  - As soon after contact or event as possible
- Follow up on problems seen & document action taken
- Ensure that records do not require interpretation or explanation
- Remember that working papers are disclosable

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Slide 2-D-1-42

Outline or text of presentation

- Document the rationale for your decision, including your investigation plan and final determination.
- Document every contact, the date, the party involved and the content of the information received.
- Document as soon after the time of contact or event as possible; don't delay for weeks and rely on your memory.
- Follow up on problems seen during client contacts and document the action you took. Write for the future: ensure that your records stand on their own and do not require a lot of interpretation or explanation.

Remember that your working papers are disclosable. They are important records of the evidence.

Exit Conference

- Advise administrator of general investigation findings & any deficiencies present
- Do not disclose confidential information
- Do not express personal concerns about any specific issues

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Slide 2-D-1-43

Exit Conference

At the exit conference, advise the administrator of the general investigation findings and any deficiencies present without disclosing confidential information. You protect the confidentiality of the individual complainants by not expressing your concerns about any specific issues.

Examples:

- "The issue concerns thorough investigations of possible abuse and neglect."
- "The issue concerns reporting incidents to the State."
- "The issue concerns the ability of the staff to serve food while it is hot."

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Outline or text of presentation

Substantiated Complaint

- Statement of Deficiencies following policies & procedures for abbreviated survey
- Plan of Correction
- Revisit (optional: will depend on revisit policy)

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Slide 2-D-1-44

Followup to the Complaint Investigation

Followup depends on the classification of the complaint.

If the complaint was substantiated and the facility failed in practice, write a Statement of Deficiencies following the policies and procedures for abbreviated survey. The facility will then write a Plan of Correction. There may or may not be a revisit (this will depend on the revisit policy).

Substantiated, But Corrected Complaint

- Complainant may be notified that situation is corrected
- Followup will depend on:
  - How information gained relates to definition of neglect
  - What facility should have known or did know

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Slide 2-D-1-45

If the complaint is substantiated but corrected (the issue was resolved), discuss the findings with your field manager. It may be that the complainant will be notified that the situation is corrected. The followup will depend on how the information gained relates to the definition of neglect and what the facility should have known or did know.

Unsubstantiated Complaint

If:	Then:
Without failed practice	Prepare complaint memorandum
With failed practice in areas other than those identified in complaint	Write Statement of Deficiencies

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Slide 2-D-1-46

If the complaint is classified as unsubstantiated without failed practice, a complaint memorandum is prepared.

If the complaint is classified as unsubstantiated without failed practice, but the investigation reveals failed practice in areas other than those identified in the complaint, a Statement of Deficiencies will be written.

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Response to Complainant

- Acknowledge complainant's concerns
- Identify SA's regulatory authority to investigate & any statutory or regulatory limits
- Provide summary of investigation methods
- Provide date(s) of investigation

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Slide 2-D-1-47

Response to Complainant (cont.)

- Provide explanation of decision-making process, including definition of terms
- Provide summary of findings
  - Note: summary should preserve anonymity when appropriate
- Identify followup actions to be taken by SA, if any
- Identify appropriate referral information (i.e., other agencies involved)

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Slide 2-D-1-48

Outline or text of presentation

Response to the Complainant and Beneficiary

Check with the field manager about sending out documentation and a response to the complainant.

According to the *SOM*, Section 5040, the report to the complainant should:

- Acknowledge the complainant's concerns.
- Identify the SA's regulatory authority to investigate and any statutory or regulatory limits on that authority.
- Provide a summary of investigation methods.
- Provide date(s) of investigation.
- Provide an explanation of the decision-making process, including a definition of terms used (e.g., substantiated, unsubstantiated, etc.).
- Provide a summary of the findings. Note: the summary should preserve anonymity when anonymity has been requested or is appropriate in the judgment of the SA.
- Identify followup actions to be taken by the SA, if any.
- Identify appropriate referral information (i.e., other agencies that may be involved).

Now let's review two actual complaints.

[Distribute a copy of two sample complaints to each student (hold onto the resulting reports for now).

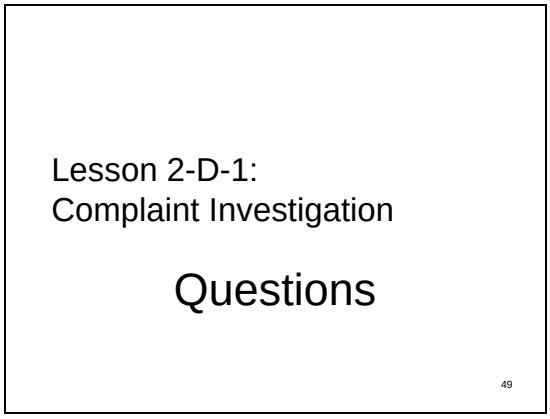
Each participant is to identify the issues and, using the SOM, Chapter 5, and the other resources provided in the lesson, write out a plan for investigating each complaint and complaint issue.

Audiovisual	Outline or text of presentation
	Have the group discuss the issues identified and plans made: begin by having the person closest to a classroom landmark (the podium, the overhead projector, the door) read a complaint and their plan. Ask the group to consider the plan and decide whether the plan: • *Was focused.* • *Called for enough information to make a decision about the complaint.* *Ask participants to silently brainstorm and make notes on what other areas of observations, interviews or facility record reviews might assist this participant in investigating the incident.* *Then ask the students to share all their issues while you make a consolidated list of issues on chart pad paper. If the list requires multiple sheets, tape them up on the wall.* *Review the actual complaint reports, including Statements of Deficiencies and Plans of Correction, to see what the original complaint investigator identified as issues and found after investigation.* *Compare the students' list of issues on the chart pad paper with the list in the reports.* *Ask the students if there was other information that might have been obtained by the investigator, might have assisted in determining whether the complaint was substantiated and might have helped with a determination of the scope of the situation.* *Finally, have the students consider the format of the reports. Review the handouts "Elements of Complaint Reports and*

Audiovisual	Outline or text of presentation
	Packets" on page 2-D-1-47 and "Entering a Complaint into ASPEN" on page 2-D-1-49. Then have the students analyze the packet (noting its organization relative to that suggested in the handout) and ASPEN material (noting the entries made).]
	Summary
	• Document the facts and findings relevant to each allegation. • Record relevant interview comments as direct quotes when possible. • Record exactly what you see, hear, smell, taste or feel in observations. • Weigh the evidence. • Obtain enough evidence to substantiate the allegations, so the preponderance of evidence is clear. • Adjust your plan as you proceed: be flexible.
	A thorough investigation: • Is timely. • Is cost-effective. • Saves time. • Preserves the evidence. • Helps prevent the incident from happening again. • Keeps beneficiaries from harm or the continuation of harm.

Audiovisual

Outline or text of presentation



Slide 2-D-1-49

Skill Assessment

Complaint Investigation

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified specific issues in different types of complaints.	
					Read a complaint intake and routing form.	
					Planned a complaint investigation.	
					Explained the elements of a complaint report.	
					Identified the elements of a complaint Statement of Deficiencies.	
					Calculated complaint time.	

Comments/Recommendations:

Planning a Complaint Investigation

Things to consider:

1. What information do you need to obtain during the complaint investigation?
2. What methods can you use to obtain the information?
3. Identify who you should talk to and why.
   - Who should you talk to first and why?
   - What should you ask each person?
     - Some staff say you should begin with friendly witnesses.
     - Identify elements of potential bias, yours and theirs.
     - What would make his/her statement credible or questionable?
   - What staff might you need to interview, not only for primary information but to validate information from other sources?
4. What regulatory information might you need during the investigation?
5. Prepare a list. Review the protocol in *SOM* Chapter 5.
   - Determine what resources you need.
   - Make a checklist of what evidence you need to gather.
6. Plan interviews, observations and record reviews needed.
7. Write down some questions to help organize your thoughts and direct you to other questions that are important to ask.
   - Consider asking questions in several different ways with several different words to validate the information.
   - How are you going to protect the identity and confidentiality of each beneficiary involved?
8. If a complaint appears to be from a delusional or incompetent beneficiary, make no predeterminations about the beneficiary's credibility as a witness.
   - Be as thorough as possible: the situation may not be part of the delusional perception but related to an actual incident.
   - Interview staff that work with the beneficiary on a regular basis.

Note: The following document is a sample of a State-developed protocol.

BASIC - NH COMPLAINT/INCIDENT INVESTIGATION PROTOCOL

Draft #15a 6/27/05

PURPOSE: To guide investigation of allegations in order to determine provider compliance with federal and state regulations.

IMPORTANT CONSIDERATIONS: This protocol provides guidelines for investigations covering a broad range of issues. Each complaint/incident is unique. The investigation is to be tailored to the issue/s and focused on those areas where Residential Care Services (RCS) has regulatory authority. Investigators may identify issues that need to be referred to other oversight and/or regulatory agencies for follow-up.

Effective communication is key to complaint/incident investigations. The investigator is to be courteous, respectful, objective, neutral and communicate with providers, staff, residents and collateral contacts in a clear and easily understood manner. Interviews are to be conducted using good communication principles. The investigation is to be thoroughly documented in an accepted RCS format.

OFFSITE PREPARATION

A. TASK 1 – Identify/Clarify Issues

1. Review CRU Intake Form
   - Identify preliminary issues
2. Contact Complainant:
   - *"Incidents"*– **Do not** interview Facility Reporter prior to going onsite
   - *"Complaints"* **– Do** interview** Complainant. Explain their confidentiality will be respected and that their name would only be disclosed in a legal hearing.

Questions to consider:

- When do they typically visit?
- What are their concerns?
- How did they become aware of the issues/s?
- When did it happen? Has it happened before?
- Did they tell anyone? If so, whom? Is the facility aware?
- What has the facility done about it?
- Is it still a problem?
- Has it happened before?
- How did it affect the resident?
- Is the resident able to describe what happened/identify perpetrator?
- If not, who could provide additional information?

- Have other residents been affected?
- Is there another resident/family member/visitor they are concerned about?
- Is there a particular staff member they are concerned about?
- When might that person be on duty/in the NH?
- Do they have any other concerns?

**As each situation is unique, the information in the Intake needs to be carefully reviewed and then, a decision made whether it is prudent to interview the complainant prior to the onsite investigation. This applies to both public and mandated reporter complainants.

B. Preliminary F tag and/or WAC Selection

Nursing home regulations include federal tags – CFR's (Code of Federal Regulations) and state WAC's (Washington Administrative Code for Nursing Homes)

Federal Tags:

- Appendix PP - CFR Part 483, Subpart B

State WAC's:

- Chapter 388-97 – Nursing Homes

RCW:

- 74.34 Abuse of Vulnerable Adults
- 70.02.050 – Disclosure without patient's authorization

Additional Resources:

- *Purple Book*
- *CMS Complaint Investigation Guidelines*
- *CMS Protocols*

The individual protocols list federal and state regulations most commonly involved with the concern that triggers the investigator to use that protocol. They also remind the investigator to consider any and all regulations pertinent to the complaint/incident report.

C. Review History –**Facility Complaints/Incidents (C/I) History**

*****Resources – QAN, Surveyors, NH File, License History Memo, NH Tracking System**

- **To View Complaint Intakes - RCS Complaints Report View web site** http://aasaweb.dshs.wa.gov/cru/complaintview
- **To Identify Complaint Frequencies/Dates and/or Priority Levels – NH File, NH Tracking System, Aspen Data Base, Quality Indicators, Oscar 3 & 4, Ombudsman and Aspen Complaint Tracking System (ACTS)**
- **For Summaries, Citations, Enforcement – NH File, NH Tracking System and License History Memo**

Alleged Victim/Alleged Perpetrator Complaints/Incidents (C/I)

- Review previous complaints/incidents with similar/same issues, victims, alleged perpetrators or residents

- Additional Sources for Alleged Victim/Alleged Perpetrator/Resident History – RCS Complaints Report View – website or CRU "Person Info View" - website http://aasatomcat1.dshs.wa.gov/cru/crupersoninfo
- RN/LPN/or other licensed professional history website: http://fortress.wa.gov/doh/hpqa1/hpqamain.htm.
- NAC/NAR history - check with the certified nursing assistant registry (OBRA) http://aasaweb.dshs.wa.gov/dohobra/default.htm

➢ **Status of Facility**

- License number, number of licensed and certified beds and where in the building the beds are located
- Most recent full survey and abbreviated survey findings
- Conditions on license
- Compliance status
- Enforcement History

➢ **Management/Ownership Issues**

- Recent changes

D. Plan Approach

1. Special Considerations

➢ **Process**

- Prepare a written plan
- Write the interview questions down
- Make preliminary regulation selection
- Do not take the Intake Routing form into the facility
- Take Appendix PP, Appendix Q, WACs, Nursing Home Reporting Guidelines (Purple Book), Criminal Conviction History (Blue Book)
- Bring a camera, film and batteries. Follow established procedure – MB 03-072 (including asking permission before taking pictures).

➢ **Confidentiality Concerns**

- Protect the confidentiality of the complainant, each resident involved and others identified in the complaint/incident
- Consider privacy when interviewing, not divulging names of those interviewed to staff, families or facility administration

➢ **Planning the Entrance**

Timing of Visit:

Attempt to coordinate with:

> Time of day and/day of the week the issue is most likely to reoccur
> When alleged perpetrator/caregiver is working

> When there might be short staffing (if that is an issue)

Coordination & Joint Visits:

- Review relevant police/medical or other outside agency report
- Coordination prior to onsite investigation for the following referrals (listed on Intake):
  > Local law enforcement (LLE) only – contact LLE to coordinate investigation
  > Resident Protective Program (RRP) only - no need to call to coordinate investigation with RPP
  > RPP and LLE - call RPP (who will coordinate with LLE)
  > APS only – coordinate with APS
- Coordinate investigative plan with Field Manager as needed
- Joint visit with another licensor/investigator for concerns of safety, uncooperative or hostile environment or a need to have a second set of "eyes & ears"

Tour – Full or Partial

- Full tour required for first visit to NH
- Partial tour when pertinent. Confine tour to issues.

2. Observation Planning

Focus the observations on the issues. If there is an existing protocol, use that protocol's observation section as a guide in conjunction with the following guidelines.

Pertinent to the concern:

Who needs to be observed? Resident/s? Staff? Others?

Resident:

Appearance, hygiene, apparel?
Demeanor - behaviors/mood - appear comfortable, relaxed, happy
Cognitive status? Communication capabilities?
Mobility - limitations/adaptive devices?
IV's, feeding tubes, catheters, splints, bruises, bandages, etc.
Injured/affected area of body (ask permission to observe)
Restraining devices or practices
Interactions – with staff and other residents
Resident's room – homelike? Personal belongings reflect history and/or preferences? Clear pathways? Safety issues?
Quality of life concerns?
Isolated/secluded – door closed, meals in room, controlled access unit

Staff:

Interactions – with residents, other staff
Respectful of resident privacy/dignity/independence?

Interventions/assistance provided to residents?
Redirection/cueing provided?
Adequate supervision/staffing?
Techniques, skills?

What needs to be observed?

General observations:

Atmosphere – welcoming, homelike versus sterile

Environment - odors, cleanliness, lighting, temperature, safety hazards – inside/outside, egress – restricted/blocked, clear pathways, pets, uneven surfaces, screens,/pests, oxygen storage & signage/handling. Safety issues in kitchenette/common areas.

Accommodations - accessible phones, lowered sinks, bedside commodes, siderails, etc.?

When/where should the observations be done?

> In conjunction with treatments, activities, mealtimes, time of day/day of week, specific shift(s), when certain staff/residents are present?
> Nursing home? Hospital or other setting?
> Specific location of incident/occurrence?

Number of observations – As indicated by the concern

3. Interview Planning

Based on the circumstances and information obtained, decide whether or not to interview the resident. Ask open ended questions. Establish a rapport. Avoid leading questions. Focus the questions on the issue/s and obtaining information for purposes of determining compliance. If there is a protocol specific to the reported issues(s), use that interview section in combination with this section to plan the interviews.

Pertinent to the concern:

Who needs to be interviewed?

> Residents, Residents alleged as victims and alleged as perpetrators, Resident Representatives, Administrators, Staff, Alleged Staff Perpetrators, Visitors, Family, Roommates, prior Residents, LTC & MH Ombudsmen, Health Care Providers, Other Agency Staff – HCS/DDD/MH Case Managers, Activity Centers, Local Law Enforcement, APS, etc.
> If targeted resident not in the home or to protect their confidentiality consider interviewing other residents

When/Where to do the interviews?

> Before going on site?
> Before or after observations?
> Best setting?
> Special accommodations needed?

> If targeted resident not in the NH, consider interviewing in new location (hospital, another residence, etc.)

General Questions:

- Are they aware of, or concerned about, the reported issues/s?
- How has this issue affected the resident(s)?
- How did they become aware of the problem?
- How long has it been going on?
- Have they told anyone?
- Is the facility aware?
- What has the facility done about it?
- Has the problem been corrected?
- Do they have any other concerns?

Resident Specific Questions:

- How long have you lived here?
- How do you feel about living here?
- How are you treated?
- Who takes care of you?
- What do they do for you?
- Do staff give you the assistance you/your condition requires?
- Do staff come when you call?
- How does staff/other residents talk to/treat you?
- Are there rules related to living heres? Bedtimes, mea times, visitor, etc.?
- Can you leave your room when you what to?
- How do you spend your time, like to do or are interested in, etc.?
- If dissatisfaction, boredom, fears, etc. are expressed, ask specifically what happened that caused them to feel that way.

Probes Related to Reported Concern:

> I heard this happened. Tell me about it. (who, what, where, when, why)

> How did it make you feel/affect you? Ask for specifics that describe/explain what type of outcome they had. i.e., “It made me nervous. I couldn’t sleep for a week”.

> Has this happened before? (when, where, what shift/what day of the week, etc.)

> Who did you tell? Is the facility aware of this concern?

> What has they done about it?

> Is it still a problem?

> Do you have any other concerns?

Family/Collaterals Questions:

- How often are they in the home and how recently?
- What have been their direct observations?
- Do they have concerns regarding care and services or other issues?

Staff:

- What residents have had issues like the reported concern or had a change in condition? (ask in a manner that avoids divulging the nature of the complaint)
- What can you tell me about it?
  - > How did they become aware of the problem?
  - > When did it happen?
  - > Has it ever happened before?
  - > What have they done about it?
  - > Is it still a problem?
  - > What do they think may have caused it?
- What process (facility practice) do you follow for concerns related to the reported concern/change of condition)?
- Who do you communicate with when the reported concern/change in condition occurs?
- How do you ensure staff is aware of changes in the resident/resident's care plan?
- Can you show me your documentation?
- Do they have concerns regarding care and services or other issues?

Issue Specific Questions:

- Refer to existing protocols and/or develop individual questions as indicated

4. <u>Record Review Planning:</u>

- Make preliminary decisions regarding which records need to be reviewed (MDS, etc.) and adjust/expand as needed based on information obtained on site.

ONSITE ACTIVITIES

TASK 2 - Onsite Process

The RCS investigator's role is not to do a criminal investigation, but to evaluate if the resident is safe and determine if there is failed facility practice.

- While onsite:
  - > For concerns regarding resident safety issues or criminal activity contact FM

1. Entrance Conference

- Investigator name/function/purpose of visit/business card
- If the licensee/administrator or designated facility representative is not present, request he/she be notified
- Establish a tone to encourage and facilitate communication
- Explain the purpose of the visit
- Provide a general description of issue/s. Avoid disclosing specific details
- Protect the confidentiality of those involved in the complaint, including the complainant
- Explain the investigation/inspection process
- Ask for documentation, information, etc. that need to be reviewed and let them know when it will be needed

2. Obtain Resident Census & Names of Staff on Duty

TASKS 3 (Modified)

3. Tour & Sample Selection

Tour as indicated by concern (modified Task 3)

TASK 4 - None

TASK 5

4. Observations

Initially observe the general environment of the home, staff and resident interactions and care and services being provided.

5. Interviews

- **Choose the best location considering:**
  - Privacy
  - Comfort/accommodation needs

- **Explain the process:**
  - Introduction/name/function/purpose of visit/business card
  - Ask the resident's permission to conduct the interview
  - Ask resident's permission to contact collaterals
  - Explain you will take notes
  - Explain that their information will be kept confidential (if they so choose) unless there is a care or safety issue that would require informing the provider or it goes to a hearing
- **Conduct the interview:**
  - Refer to pp. 5-6 of this document for interview guidelines.

6. Record Reviews:

- Decide which records need to be reviewed i.e., house policies, contracts, assessments, care plans, health care provider notes/orders, incident log, policy and procedure manuals, admissions and discharges, unofficial records such as bulletin boards and shift logs, personnel records, individual and group therapy schedules, work and recreational program content and schedules. Confine review to the issue(s).

Resident Records:

- **<u>Demographics</u>**
  - Name/s, Date of Birth; Date of Admission; Diagnosis; designated Resident Representative (w/telephone number); Primary Health Care Provider (w/telephone number), Room #
- **<u>Resident's – Care/ Services Needs/Interventions:</u>**
  - Baseline Data (pertinent to the issues):
    - > Risk factors, cognitive ability/psychosocial or behavioral status, communication ability, transfer/mobility status, ADL needs, dietary needs, medications, etc.
    - > Recent changes in medical/mental/physical/behavioral conditions and/or medications,
    - > History of related incidents/occurrences
    - > Other contributing factors
  - Documentation of incident/occurrence
  - Pertinent assessments – before and after incident/occurrence
  - Pertinent interventions – prior to and after incident/occurrence
  - Reevaluation after event
  - Notifications

•

Facility Records:

➢ **<u>Review Pertinent Sources of Information</u>**

Confine review to the issue(s) and focus on:

1) Policies and Procedures
2) Orientation and Training Records
3) Staffing Schedules
4) Facility investigative documentation including Incident Reports
5) Admission & Discharge List

➢ **<u>Personnel files</u>**

- Name/s, Date of hire
- Current background checks with disclaimer and no disqualifying convictions
- Qualifications – i.e., Orientation to NH, Prevention and Abuse training, Other training pertinent to the issue(s), Continuing Education, Current CPR/First Aid Card, TB results, HIV/AIDS
- Current license
- OBRA NAC Registry findings
- Continuing education (pertinent training)
- Reference checks
- Evaluations/counseling for similar issues

TASK 6

b) <u>Review & Analyze Data</u>

- **<u>Determine if sufficient information has been obtained:</u>**

> ***Prior To Occurrence for Resident(s) "at risk"***

a) <u>Identification</u> Risk/Contributing Factors – did/should facility have identified resident to be "at risk"

b) <u>Prevention</u> – did facility develop interventions addressing risk factors

c) <u>Intervention</u> - did facility implement preventive measures as planned

d) <u>Supporting Systems</u> – did facility put systems in place to ensure provision of preventive measures (including sufficient/trained staff and sufficient resources)

> ***Resident(s) - After Occurrence:***

a) <u>Facility Recognition and Response</u> - timely including protecting resident as necessary

b) <u>Evaluated/Assessed for Harm</u>

- **timely and thorough**
- **acute clinical management provided as needed for medical/physical/psychological issues**

c) <u>Assessment updated when indicated</u>

d) <u>POC revised</u> – as necessary

e) <u>Interventions Implemented</u> – timely and consistently

f) <u>Re-evaluated</u> – for effectiveness

> ***If Outcome*:**

a) Avoidable/preventable

b) Unavoidable

- <u>Is the facility's explanation of how and what happened consistent with the investigative findings?</u>

c) Conclusions validated with interviews, observations and record reviews

d) Investigation (when required) – thorough and in accordance with regulatory requirements

- <u>Did facility comply with reporting and notification requirements?</u>
- <u>Did facility recognize and address trends or patterns?</u>
- <u>If system problems, have they been corrected?</u>
- <u>Are appropriate interventions in place to prevent a reoccurrence for the resident and other "at risk" residents?</u>

- **<u>Determine If Failed Practice:</u>**

> **Did the allegation occur?**
> Compare findings to F tags/WAC's
> Is there failed practice?
> If yes, what is the scope & severity?
> Confer with Field Manager as needed

TASK 7

8. <u>Status Report On Exit</u>

Use this opportunity to explain findings including identified deficiencies to the administrator or facility designee. Provide them with an opportunity to ask questions and present additional information. Ensure administrator/facility designee is aware of issues that need immediate attention.

- Review issues and findings
- Identify deficient practices with the appropriate regulation and/or statute (F tags/WAC)
- Provide them with an opportunity to discuss, ask questions and present related additional information.
- Inform them of the process that will follow i.e., what to expect, including further data collection (if indicated), the Informal Dispute Resolution (IDR) process and the Statement of Deficiencies (SOD) report.
- Clarify that if further information is obtained the administrator or facility designee will be contacted by telephone if there will be any additions or significant changes to the deficiencies discussed during the exit.

Specific to Citations - Explain:

- **The SOD will be mailed within 10 working days from the last date of data collection**
  - > The SOD cover letter explains:
  - > Process to follow if a Plan of Correction is required
  - > Plan of Correction must be mailed back within 10 calendar days
  - > Field Manager is a resource for questions regarding the findings
- Ensure the licensee/administrator or facility designee has a business card

OFFSITE ACTIVITIES & FINALIZATION

A. Complaint/Incident Completion

1. *If Data Collection is Complete:*
   - **Follow established RCS Principle & Procedure to write narrative report, write SOD and forward to FM for review**
   - **Enter data into NH tracking system**
   - **Enter data into ACTS**
   - **Make referrals following established CRU Complaint/Incident Referral Processing Principle & Procedure**
2. *If Data Collection is not Complete:*
   - Complete data collection
   - Determine if failed practice
   - Status report with facility (onsite/on the phone)
   - Follow steps as listed is section 1.

   - *** Definition of Outcome – an actual or potential result or consequence directly or indirectly related to failed or deficient practices of the licensee. Harm to residents that is not related to the home's failure is not an outcome for these processes. Source – NH*

Enforcement Policy and Procedure for Statement of Deficiencies – p. 12 - Revised November 21, 2001

*******Note – These guidelines are meant to provide consistency and completeness across investigations. All citations are to be written to regulations, not to guideline and/ or best practice.***

Elements of Complaint Reports and Packets

The purpose of writing a narrative report of a complaint investigation is to convey to the reader in laymen's terms what alleged and unalleged issues were investigated, the methodology used, the investigative findings, the conclusion and the action taken for resolution. The report is composed of an introduction, a list of the issues, the findings, the conclusion(s) and the action taken. When the report is complete, forward the packet to your supervisor. The packet is usually composed of the report, the complaint intake form and a complaint closure sheet. It may also include a Statement of Deficiencies and Plan of Correction. A discussion of the report and other packet elements follows.

Introduction

The introduction contains general information about the complaint and its investigation. It starts with a heading that includes the:

- Complaint number.
- Name of the facility.
- Name of the investigator.
- Dates the investigation was initiated and concluded.

Issues

The issues are specifically listed, with each issue numbered.

Findings

This is a summary of the method that was used to investigate the issue(s) (interviews conducted, observations made and records reviewed) and the specific findings. The findings are a description of the facts for each complaint issue. Findings should:

- Describe what you found or didn't find, showing sensitivity, understanding, respect and concern for the welfare of the beneficiaries and loved ones.
- Respond to the allegation raised by the complainant.
- Be stated objectively.
- Be written in lay terms and stated in the past tense.
- Exclude speculation or your personal opinions, feelings, concerns or comments.
- Exclude information which might identify the beneficiary or the complainant.

Conclusion(s)

In this section the investigator describes what the investigation determined: whether the complaint was substantiated or unsubstantiated; whether the issue was classed as isolated, pattern or systemic; and whether the investigation determined that there was failed facility practice. Conclusions are in the form of summary statements for each issue. They note whether the alleged condition was present, whether it reflected a pattern, whether there was a violation of regulation and what actions were taken to correct the problem.

Action

In this section the investigator describes what action was taken to protect the beneficiary and any other beneficiaries affected by the issue (as applicable) for each issue. This section includes a description of the violation or deficiency for uncorrected deficiencies, including the tag number. In the case of resolved issues, it may state that no additional action was necessary, and why.

Statement of Deficiencies and Plan of Correction

Whether the report packet includes a Statement of Deficiencies and Plan of Correction depends on the status of the allegation after the investigation:

- Substantiated with failed practice: write a Statement of Deficiencies following the policies and procedures for an abbreviated survey. The facility will write a Plan of Correction and there may be a revisit, according to the revisit policy.
- Substantiated, but corrected, and issue resolved: discuss the situation with your supervisor. The action in this case is dependent on the definitions of neglect and what the facility did know or should have known.
- Unsubstantiated without failed practice: the report does not include a Statement of Deficiencies or Plan of Correction. Only the report is prepared.
- Unsubstantiated without failed practice, but failed practice was found in other areas: write a Statement of Deficiencies and obtain a Plan of Correction.

Entering a Complaint into ASPEN

1. Open a shell or create an event. There is one event for multiple complaints.

2. Enter the hours onsite on Form 670.

3. If citations are classed as D or above, proceed to the AEM. Complete the History memo.

4. If there are citations, list all the complaint numbers on the initial comments page.

5. Write narrative reports, complete Form 670 for offsite and complete tracking system sheets.

6. Keep all of the complaints for one event together.

7. Phone investigations of a complaint are rare. Such a complaint would have its own Form 670 completed.

8. For a complain investigation conducted with a full survey:
   a. After the complaint and full survey are completed, only one ASPEN event ID is created. The ID will contain both the full survey hours and the complaint survey hours. Hours should be split as accurately as possible between the two surveys.
   b. Separate copies of the completed Form 670 can be printed for the full survey and the complaint survey packet.
   c. Note: only one Form 670 is completed for the complaint survey, even if the survey addressed multiple complaints.

9. For multiple complaints conducted with one onsite visit:
   a. Create only one ASPEN event ID.
   b. Account for all hours of preparation, onsite investigation, travel and reporting, regardless of how many complaints were investigated or whether citations were written.
   c. Complete citations within four working days of the last day of data collection.
   d. Write a narrative report for each complaint.

10. Field staff are responsible for mailing the complainant a copy of the narrative report and cover letter as soon as the field manager approves it if the complainant has requested a report.

11. Support staff will complete the Nursing Home Complaint Tracking Log.

12. Support staff will also add the manager and support hours to Form 670 and ensure support hours.

Lesson 2-D-2: Role of the Regulator

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the overall objective of a survey and your role as a regulator.
- Describe scenarios in which you will intervene and in which you will wait and observe facility practice.
- Develop a balanced use of authority.
- Articulate decisions appropriate to the team meeting and how to support the team.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 2
  - Chapter 5, section 5420
  - Chapter 7, sections 7202, 7207B

State

(Insert State reference[s] here.)

Other

- Carnegie, D. (1981). *How to win friends and influence people.* New York: Pocket Books.
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Highlights

- Role of the regulator
- Objective of survey and certification
- Balanced use of authority
- Ethics and professionalism required of a surveyor
- Communication with others

Training Techniques

- Lecture
- Group discussion
- Small group and individual exercise
- Role play

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Pens or pencils, one per student

- Handouts:
  - *Effective Communication Self-Evaluation*
  - *The History of Your Communication Style*
  - *Psychology Test*
- Paper bag and pieces of paper labeled “P,” “A,” or “C,” one for each student

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-D-2:
Role of the Regulator

1

Slide 2-D-2-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the overall objective of a survey & your role as a regulator.
- Describe scenarios in which you will intervene & in which you will wait & observe facility practice.

2

Slide 2-D-2-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Develop a balanced use of authority.
- Articulate decisions appropriate to the team meeting & how to support the team.

3

Slide 2-D-2-3

Audiovisual

Definitions

- Regulate—to control or direct in agreement with rule
- Regulation—principle, rule or law designed for controlling or governing behavior
- Regulator—individual who regulates
- Oversight—watchful care or management

4

Slide 2-D-2-4

Outline or text of presentation

Definitions

(Review the definitions on slide 2-D-2-4.)

Together the definitions describe what is expected of you in your role as a regulator.

- You investigate care and services provided to beneficiaries on a regular basis through a mechanism called a survey. Your role is to do regulatory oversight (i.e., watchful care or management) over certified providers and suppliers.
- In order for you to become an expert in this oversight of regulations, you must develop the knowledge, skills and abilities to investigate and then determine compliance with laws and rules that govern that entity.
- Developing and using these skills and abilities is part science and part art.
  - The science part lies in the methodical activity, discipline or study—especially knowledge that is gained through experience.
  - The art is in the high quality of conception, execution or performance of a specific skill.

Surveyors are hired for their experience and education in a health-care profession. Much of this experience is useful in the new role, but it is often used in new ways. Many of the concepts, viewpoints and perceptions you have from prior experience may be challenged.

In order to learn how to use your tools differently (that is, to learn or alter the ways of perceiving the world around you), you must examine your training and experiences from a different perspective.

Audiovisual

Outline or text of presentation

The following story serves as an illustration of this idea.

(Read the following.)

A creativity teacher invited one of his students over to his house for afternoon tea. They talked for a bit and then came time for tea. The teacher poured some into the student's cup. Even after the cup was full, he continued to pour. The cup overflowed and tea spilled out onto the floor.

Finally the student said, "Master, you must stop pouring. The tea is overflowing! It's not going into the cup!"

The teacher replied, "That's very observant. The same is true with you. If you are to receive any of my teachings, you must first empty out what you have in your mental cup."

Moral: We need the ability to unlearn what we know before we can accept new information. Part of the unlearning is to be open to new ideas, new ways of looking at things.

Use of Skills in Different Way

- Education & experience
- Apply citation in science & art of surveying
- Perspective
  - Explorer
  - Artist
  - Judge
  - Warrior

5

Slide 2-D-2-5

Use of Skills in a Different Way

- Much of what you know as a professional today you read, studied or obtained by experience; you have learned the science of your profession.
- You have also learned the art of your profession through the application of your knowledge in providing and supervising care, determining the care needs and focusing on best practice.
- In your profession, you learned to observe, interview and review a medical record while focusing on a

Audiovisual	Outline or text of presentation
	specific person or persons. You learned to pay attention to the physical and mental changes that strayed from the "norm." • The experience and skills you came to surveying with are worthwhile and useful, but the focus of those skills has now shifted. Your job is to determine how someone else provides care and services. • In this new role your assessment skills are focused on determining what is being provided, at what level of quality and how it is being provided to beneficiaries. • You will then take this information, weigh it and compare it with the laws and regulations for the specific provider you are surveying. **Perspective** One other tool you will develop is perspective. • A physician continually monitors new information about a resident and must look at the resident from a fresh perspective while still not dismissing the old information. Each time you examine a facility or assess the care and services received by a resident, you will start with the same perspective as the physician. • To survey, you need to release your preconceptions or past experiences. Everyone and every facility can change for better or for the worse. Even if you know the history of the provider, each time you enter a facility you need to treat it as a fresh experience. As in reading a book, you should begin at the beginning and not read the end until you have read the whole book.

Audiovisual	Outline or text of presentation

	To describe the survey process, let's consider four roles:
	• Explorer—gathering raw material, facts, concepts, knowledge and feelings; investigating using different senses; and seeking a variety of information with an open, exploring mind.
	• Artist—taking different pieces of information to form a picture of the care and services beneficiaries receive.
	• Judge—critically evaluating services to beneficiaries.
	  – Assessing quality.
	  – Judging whether services fit what the individual wants and needs.
	  – Weighing the information and evidence.
	  – Questioning assumptions and listening to one's gut, but making determinations on facts.
	• Warrior—putting beliefs into action, acting as part general and part foot soldier.
	  – Overcoming and dealing effectively with the defensiveness and anger of and excuses from others.
	  – Maintaining the courage of convictions and communicating effectively to accomplish the goal.
	
	Remember, regulatory craft is part science and part art. It requires a creative mind. A hallmark of creative people is their mental flexibility, the ability to shift in and out of different types of thinking, perspectives and communication styles depending on the situation.

Audiovisual

Regulations

- Is regulation pervasive in our society?
- Can you think of anything that isn't regulated to some extent?
- Do all States regulate in same way?

6

Slide 2-D-2-6

Outline or text of presentation

Regulations

First let's talk about regulations.

- Is regulation pervasive in our society?
- Can you think of anything that is not regulated?
  - Even in people's backyards things are regulated: some by homeowners' associations, the fire department, Environmental Protection Agency, etc.
- Do all States regulate in the same way?
  - What accounts for some of the differences? Demographics: smaller or larger populations, urban versus rural, type of residents (e.g., fiercely independent, don't want government interfering in their business, etc.).

Regulations (cont.)

- Can we pick important problems & fix them?
- Do we really need regulations?

7

Slide 2-D-2-7

- In some ways it might seem that having less regulation would be a good thing.
  - Are there any disadvantages to less regulation? If so, what are they?
    - Less protection?
    - Less incentive to do the right thing, particularly for those vulnerable people in the care of others—children and adults.
    - Any others?
- Does this mean that we should not regulate ourselves?
  - It just means that society needs to be thoughtful before "fixing" problems. Often the "fixes" create more confusion and more problems.
- Are there necessary regulations?
  - What are some conditions that might lead to needing more regulations? If providers were able to operate facilities their own way without laws and rules, what might

Audiovisual

Outline or text of presentation

happen? Would vulnerable individuals, many of whom can't protect or advocate for themselves, be cared for appropriately?

- What about regulations within programs that have a "national" basis like Medicare?
  - We certainly try to regulate in the same way.
  - We try to gain the same perspectives wherever the program is.
  - Why?

Whom Do We Serve?

- CMS
- Our office
- Beneficiaries—patients, residents & clients in certified entities
- Advocacy organizations
- Ombudsmen
- Retirement organizations
- Each citizen

8

Slide 2-D-2-8

Whom We Serve

At minimum, we serve:

- CMS.
- Our office.
- Beneficiaries.

However, there are other groups interested in the job we do:

- Protection and advocacy organizations.
- Ombudsmen.
- Retirement organizations.
- Citizens who want to know that someone is looking to see that they will receive good health care when it is needed.

What Does a Surveyor Look Like?

9

Slide 2-D-2-9

What a Surveyor Looks Like

Dressing and demeanor

It is often said that a picture is worth a thousand words.

- Whenever you meet someone, that person immediately has a perception of what to expect based on your appearance, which leaves a lasting impression.
- While surveying, you will meet a wide variety of people:

Audiovisual	Outline or text of presentation
	– Administrators. – Residents. – Family. – Facility staff. – Ombudsmen and others. • If you are in a small community, everyone may know that the "government" is there. They may know who you are when you walk into a restaurant. They may sit next to you or be filling their car at the same gas station. • It is important to remember that while traveling and while surveying and visiting providers of all types, you as a surveyor are highly visible. **Clothing** • Clothing should be professional but fit in with that of the residents and providers: – Not overdressed; not underdressed. – Appropriate for the weather. – Comfortable but professional, especially shoes—you will be on your feet a lot. – Depending on what you are surveying, easily laundered. – A key question to answer when choosing what to wear is, "What do I want to communicate with the way I dress?" • Name tag should be visible at all times. • Also, bring your business cards. Having your identification with you can be important in gaining information and entrance in some situations.

Audiovisual

How Do I Act as Surveyor?

- Be prepared
- Conduct yourself appropriately
- Know survey process & regulations
- Communicate
- Maintain professional boundaries
- Observe, don't intervene unless absolutely necessary

10

Slide 2-D-2-10

Outline or text of presentation

Conduct as a Surveyor

Remember you are always "on duty."

Preparation

- Know where you are going and who is going to be on the survey team with you.
- Know who the team coordinator will be.
- Talk to your team coordinator and your team.
- Know when and where to meet.
- Review the protocols and tasks you have been assigned prior to entering the facility or provider location.
- Keep supervisors apprised of what you have found and what problems you are encountering.
- Be strong, firm and respectful.
- Gather information from observations and interviews. Verify the information with the resident records to determine whether the entity has met the requirements of the laws and regulations.
- Know and understand the regulations and their intent. This tells a surveyor what is expected of each provider.
- When you observe and gather data and information from interviews, you are weighing or comparing the data to regulations. The regulations are the minimum requirements but are not always minimal. They may appear to set high standards, but they reflect the expectations of most citizens.
- Surveyors are hired for their abilities to think critically and make determinations about compliance.

(Discuss conflicts of interest and confidentiality of survey schedules. Refer

Audiovisual	Outline or text of presentation
	to the SOM, Chapter 5, section 5420, and for long term care surveyors, Chapter 7, sections 7202 and 7207B.)
	Conduct in the facility Follow office policies in accepting gratuities from a provider.
	(Discuss your office policy about accepting beverages and food from a provider, as well as any other related policies regarding ethics.)
	Communication • The role of surveyor is already intimidating to the providers and their employees. No one likes being examined. We are all afraid of someone finding our flaws. However, remember that your authority is based on the regulations and the survey process. • Don't argue with colleagues in the building or during any time with providers or the provider's staff. You and your colleagues work as a team and will have disagreements. These are best worked out at your office away from others. Providers do not always agree with the analysis or deficiency determination of surveyors. When they don't agree, there are mechanisms for them to voice their disagreement. – For non–long term care providers and suppliers, the entity will provide written information in the Plan of Correction. – Long term care facilities will ask for review allowed in the Informal Dispute Resolution process. • Pay close attention to your body language, including the expression on your face and the tone or loudness of your voice. Sometimes people focus so

Audiovisual	Outline or text of presentation
	intently on what is being said or observed that they appear stern or angry. Practice looking in the mirror. *(Based on your experience or knowledge, provide students examples, such as:* *"I have surveyed with staff that dressed in power suits and behaved arrogantly. Residents did not want to talk with them. Facility staff were intimidated and frightened. The surveyors were perceived to be looking for noncompliance instead of trying to understand what was occurring and fact finding before making up their minds about compliance."* *"A certain amount of physical blending in helped when I was attempting to do observations. An open attitude, a relaxed smile and a calm voice help the surveyor learn information from both staff and beneficiaries.")* **Professional boundaries** • Don't engage in social activities with provider staff or residents during the survey. You are there to observe and focus on the care, services and environment. Remember your professional boundaries. Visiting or engaging in social activities before or after the survey may not necessarily be a violation of those boundaries but may appear to be inappropriate to the public and the people with whom you work. • Don't ask for personal favors from providers or their staff. Remember that even if you have met them in different professional or personal situations outside of your new position, you must maintain a professional boundary.

Audiovisual	Outline or text of presentation
	Movement from an observer role to a more active intervention role • Perhaps your previous professional and/or current personal role was one of providing support or care for others. In this new role you are mainly an observer. If you come to a situation where you think you may *have to intervene*, think first. Ask yourself what the provider would do or what would happen if you were not there. Imagine that you are not there, that what you are seeing is probably what happens on a daily basis with this provider. If you believe that a person needs help immediately, be the "gofer" and go for facility staff to assist the individual. • Ask the provider, if it requests your assistance, "What would you do if I weren't here?" It is the provider's job and responsibility to provide care and services and meet the regulations. • There may be times when you feel called upon to intervene, for example, when there aren't enough staff to evacuate residents in case of a fire. First consider each situation before acting, asking yourself if the situation is truly an emergency. • In most situations, immediate notification of facility staff is not warranted. *(Discuss some examples of situations where intervention is not required, such as monitoring a position change of a resident; the length of time a call light went unanswered; a person repeatedly calling out, "Nurse! Nurse!"; etc.)* Once sufficient information has been obtained to clearly identify those components of failed practice, facility staff

Audiovisual

Outline or text of presentation

or the provider should be made aware of the problem.

(Ask students why these concerns should be discussed with the provider.)

Survey

- In facility, surveyors have considerable power
  - Good or evil
  - Justice or injustice

11

Slide 2-D-2-11

The Survey

The focus of the survey is to recognize what components of care, services and the environment may be or are harmful to the beneficiary and do not meet a requirement or regulation. When the facility is not in compliance with a regulation, it is the provider's job to make changes as soon as possible to ensure the long-term health and safety of the residents.

In the facilities they survey, surveyors have considerable power to do good or evil, to dispense justice or injustice.

What do you think this last statement means?

(Discuss an example. One example follows.

On one survey I was assigned to work in a dementia care unit. Physically, the unit was in very poor condition: ceiling tiles were missing, the pipes in the ceiling were dripping into buckets placed up and down the hall and the paint was dark and not intact. Also, there were no individualized activities for residents, and several residents were restrained without need. Families were very unhappy and felt the provider was not responsive to the concerns they expressed. The rest of the building looked fine to the rest of the survey team, but the dementia unit was cited for the poor condition of the physical plant and lack of homelike environment. When I went back to do the followup

Audiovisual

Outline or text of presentation

survey, I was very pleased to see a totally different environment for the residents living there. We made a difference because of what we do and how we do it.

On another survey, the surveyors picked fights with the provider and communication shut down. Although the provider complied with the regulation, it was very superficial compliance. The surveyor's attitude and demeanor led to the provider closing communication down, either not hearing what was being presented or not respecting what was being presented as valid.

Shortly after concluding the survey, the same issues arose in the building. In the end, there was no lasting positive result for the residents.)

Our job is to survey, but our survey also assists providers in recognizing the problems and changing how they provide care and services to beneficiaries.

Survey (cont.)

- Surveyor role: Determine facility compliance with State &/or Federal regulations
  - Follow survey process & investigate
  - Make observations
  - Interview
  - Review documents

12

Slide 2-D-2-12

In Summary

In very simplified terms, your role as surveyor is to determine whether the facility is in compliance with State and/or Federal regulations. You do this by following a survey process and investigating—making observations, interviewing and reviewing documents—while in the facility.

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Surveyor

- Explorer—Systematically investigate
- Artist—Evaluate
- Judge—Speak on behalf of residents
- Warrior—Determine compliance

13

Slide 2-D-2-13

Outline or text of presentation

The following key words describe a surveyor:

- Explorer—takes a *systematic* look at the entity's practices.
- Artist—*evaluates* whether the residents' needs are met through systems and services.
- Judge—*speaks on behalf of* or in support of the resident.
- Warrior—*determines* whether the entity is in compliance with the regulations.

Role of Regulator

- Act as part of regulatory agency
- Ensure appropriate care & services
  - Appropriate environment
  - Vulnerable individuals
- Perceived as:
  - Police or enemy
  - Guardian angel

14

Slide 2-D-2-14

Role of the Regulator

Regulation and enforcement by their nature elevate broad public purposes above the interests of private parties. Therefore, regulators inhabit and are obliged to navigate a landscape of conflicting and shifting interests.

Regulators are not universally popular people. You may feel this is an understatement, and you would be right!

Often you will feel that you are the target of the provider's anger.

It may help to remember that the provider chose to sign a contract, the Provider Agreement, with Medicare and/or Medicaid to be a certified provider. When it signed, the provider chose to meet the regulations and to provide care and services in accordance with them at all times.

As health-care professionals, we are responsible by our choice of profession to follow the requirements of our State and/or national standards of practice and

Audiovisual

Outline or text of presentation

applicable regulations. If we do not, we are in violation and it is our responsibility.

Many things influence your ability to be an effective regulator:

- Your values and ethics.
- Your past professional roles and ethical beliefs.
- The mandates and philosophy of Medicare, Medicaid and your State agency.

Successful Survey

- For success:
  - Learn & study regulations & statutes
  - Have thorough understanding of:
    - Mission, values & philosophy of agency
    - Legislation that created agency
    - Law which agency was created to enforce & regulations which it is enforcing
  - Examine perceptions, filters for assumptions

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Slide 2-D-2-15

Successful Survey

For success:

- Learn and study the regulations and statutes.
- In order to understand the surveyor's role and authority, it is necessary to have a thorough understanding of the:
  - Mission, values and philosophy of the agency.
  - Legislation that created the agency.
  - Law which the agency was created to enforce and the regulations which it is enforcing.
- Examine your perceptions and your filters for assumptions.

Successful Survey (cont.)

- Keep focus on beneficiaries
- Resolve or clarify communication with provider if it becomes difficult
- Keep rested, well fed & calm
- Examine ethical beliefs, values
- Verify & clarify

16

Slide 2-D-2-16

- Keep your focus on the beneficiaries. Know clearly that your responsibility is to the beneficiary.
- Resolve or clarify communication with a provider if it becomes difficult or mixed up.
- Keep yourself rested, well fed and calm.
- Examine your ethical beliefs and your values.
- Verify and clarify what you thought was said or what you saw; verify perceptions of the resident, the facility's staff and the family. Evidence taken at face value can be deceiving.

Audiovisual	Outline or text of presentation
	To the public and especially to the industry, regulators may seem nitpicky, unreasonable, unnecessarily adversarial, rigidly bureaucratic and incapable of applying discretion sensibly. You may hear that it costs too much to meet regulations. *(Ask for examples of regulators being nitpicky, unreasonable, unnecessarily adversarial, rigidly bureaucratic, incapable of applying discretion sensibly and ineffective in achieving the missions/issues identified.)* Dale Carnegie's (1981) approach of how to "win friends and influence people" is a good one to follow. You can walk in as a regulator, but if you treat the provider and residents with courtesy and respect, you will generally be treated the same way. You cannot expect to be treated with courtesy and respect if you do not treat others this way. An example of poor judgment on our part is going in with an attitude that "I am the State/Federal surveyor and I know better." Remember that most providers know the regulations. If they don't, most are willing to learn. They are still people who do important work, providing care for vulnerable individuals in facilities we survey. Providers do not intentionally mean for bad things to happen to the people they care for.

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Authority

- "The power or right to give commands, enforce obedience, take action, or make final decisions: persons, especially in government, having the power or right to enforce orders, laws, etc."

Webster's New World Dictionary

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Slide 2-D-2-17

Outline or text of presentation

What Authority Is and Isn't

Definition of authority: "The power or right to give commands, enforce obedience, take action, or make final decisions: persons, especially in government, having the power or right to enforce orders, laws, etc." *(Webster's New World Dictionary)*.

Authority (cont.)

- Provider's role
  - Care for individuals
  - Identify means of compliance
- Your role
  - Set tone
  - Gather information
  - Communicate

18

Slide 2-D-2-18

The provider's role is to:

- Care for individuals.
- Identify the reasons it is not in compliance with regulations and what solutions will work within the facility to meet the requirements of the regulations when it has been determined it is not in compliance.

You do not "own" the provider's issues or problem. You do not know how to fix the problem for that entity—you can only guess at what may have caused it.

In every action, beneficiaries and providers ought to be respectful.

Remember that you have the power to set the tone for the survey being done. The tone you set will determine whether the provider will be receptive to the process or defensive and unreceptive.

The Goal of the Surveyor's Role

The focus of the regulatory craft is to enable the surveyor to be able to leave the facility

Audiovisual	Outline or text of presentation
	knowing about all aspects of the facility and its residents. This is an enormous task. Survey procedures for a number of providers and suppliers require a sample of beneficiaries who are closely observed and investigated through interviews and review of records. Surveyors do this in order to be able to extrapolate or make more general statements about the impact of the care and services provided by the facility. When you gather knowledge about the care and services provided, focusing on the individual and looking for actual and potential outcomes, it is called a "person-centered outcome focus." In all surveys, you will use three modes of obtaining information to help you in your determination of compliance: observations, interviews and review of documents. Let's talk about how these are involved in communication. **Communication** What do you get when you observe, interview and review records? You get information or, in another sense, the facility communicates to you how care and services are provided to beneficiaries. You communicate to it through interviewing and conducting the exit conference, when you describe what you found. You also write a Statement of Deficiencies—the written communication of decision making. Let's examine how communication impacts your ability to perform your role.

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Communication

- 9% writing
- 40% listening
- 35% talking
- 16% reading

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Slide 2-D-2-19

Outline or text of presentation

Communication is a refined art, whether it is written, spoken or otherwise conveyed.

Communication is a process. It consists of message, delivery, interpretation, reexpression and action.

(Draw a circle on the board with the words "message," "delivery," "interpretation," "reexpression" and "action" written within.)

Communication is interactive, responsive and complex.

How does communication work?

People generally spend different percentages of time in different modes of communication:

- Writing 9%
- Listening 40%
- Talking 35%
- Reading 16%

For regulatory skills you are concerned with:

- Observation.
  - Is a visual type of listening.
  - Answers the question: "What is it that I am seeing that is telling me about the care and services that are being provided?"
- Interviewing.
  - Is a verbal type of listening.
  - Answers the question, "What is it that I am hearing and what is it telling me?"
- Record review.
  - Is a written type of listening.
- Listening.
  - Involves intake of verbal and visual communication.

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Outline or text of presentation

Listening Levels

(This is a key concept.)

Listening is taking in information from speakers, other people or your surroundings while remaining nonjudgmental, acknowledging communication in a way that:

- Invites the communication to continue.
- Provides limited, but encouraging, feedback to the communication.
- Carries the communication one step forward.

Listening is one of the most demanding aspects of communication. It is a powerful force in human relationships and is a potent force for reducing stress and tension.

Communication is also impeded by stress, tension and high emotions. The stronger the emotion, the less effective the communication.

Listening Levels

- Level 1: Empathic listening
- Level 2: Hearing but not listening
- Level 3: Listening in spurts

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Slide 2-D-2-20

Three levels of listening

- Level 1: Empathic listening.
  - Refraining from judging the communicator and placing yourself in his/her position, attempting to see things from the communicator's point of view.
  - Being aware and "in the present moment."
  - Acknowledging and responding, not letting yourself be distracted, paying attention to the speaker's total communication, including body language, and suspending your own thoughts and feelings to give attention solely to listening.
  - Showing both verbally and nonverbally that you are truly listening.

Audiovisual	Outline or text of presentation
	• Level 2: Hearing words, but not really listening. – Not catching or understanding the deeper meaning of what you are observing or hearing. – Attempting to hear what the speaker is saying, but making little effort to understand the speaker's intent. – Concentrating only slightly on what the communicator says. – Lulling the speaker into a false sense of being listened to and understood. • Level 3: Listening in spurts. – Tuning in and tuning out, being somewhat aware of others, but mainly paying attention to yourself. – Following the discussion only enough to get a chance to talk. – Being quiet and passive without responding. – Faking attention while thinking about unrelated matters, making judgments or forming what you want to say or ask next. In all but the first level you are focusing on how you are going to respond rather than trying to understand what the speaker is saying. Most of us listen at all three levels over the course of a day. However, during a survey the goal is to listen in all situations. You are highly alert and highly focused. *(Ask students to take a moment and think about the last experience they had while observing a survey.* *Ask:* • *How often did you listen at level 1?* – *When and with whom?*

Audiovisual	Outline or text of presentation
	• *What is your characteristic listening approach?* *Give personal examples of not listening at level 1 during meetings, interviews, etc.)* Growth begins with awareness. By paying attention to your listening style, you can improve your communication skills. *(If you have not provided it during a previous lesson, distribute the handout "Effective Communication Self-Evaluation" on page 2-D-2-55 and ask students to fill out the questions and determine their scores.* *When students finish the handout, ask them to reexamine their responses and ask themselves:* • *What behavior do I want to modify and/or improve upon to improve regulatory skills?* • *What questions do I have about my ability to listen effectively at level 1 and how often do I perform at level 1?)* What are some of the advantages to listening effectively? • Increased productivity. • More information remembered and less misunderstanding. • Fewer mistakes because you listened and validated other information. • Increased respect, trust and rapport with team members, providers and residents. **Communication Components** • There are seven components to each message you give and receive. You will learn about three of them.

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Outline or text of presentation

- You will then find out how you got the style that you use the most and will explore how to change or become more aware of some of the ways you communicate with others.

Communication Components

- Interpersonal: interaction between 2 or more people
  - Share ideas
  - Solve problems
  - Make decisions
- Intrapersonal: constant, conscious dialogue inside head
  - Weigh assessment findings
  - Distracts you from listening

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Slide 2-D-2-21

The three components we are going to talk about today are:

- Interpersonal—interaction between two or more people; it helps share ideas, solve problems and make decisions.
- Intrapersonal—the constant, conscious dialogue inside your head; it helps you weigh assessment findings or distracts you from listening.

Communication Components (cont.)

- Nonverbal messages:
  - Personal appearance
  - Tone of voice
  - Facial expressions
  - Body language
  - Carry more weight than verbal messages

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Slide 2-D-2-22

- Nonverbal messages—personal appearance, tone of voice, facial expressions and body language carry more weight than verbal messages.

Development of communication skills

It starts in childhood with the messages you receive. For example:

- "Don't argue with me."
- "You don't know what you're talking about."
- "Children should be seen and not heard."
- "Don't be forward."
- "Be quiet."
- "Look at me when I am talking to you."

People respond to the verbal and nonverbal "strokes," both positive and negative, that they received as children and the ones they receive as adults.

Audiovisual	Outline or text of presentation
	People tend to duplicate the communication patterns they experienced in their early years throughout their lives. As a result of learned patterns, communication may be hampered. The perception of communication can make someone feel understood and worthwhile. You can positively affect others by how you listen, and your body posture can communicate your intent. *(Ask students: How do you think this learned communication style impacts:* • *Your role as a surveyor?* • *Your view of your role?* • *The provider's view of your role?)* The physical ways in which adults listen to children tell children something about themselves: • Interrupting their children. • Looking stern while listening. • Ignoring their children's feelings. • Turning away when their children are talking and sending a message that what the children have to say is stupid or unimportant. *(Ask students: Can you name a few nonverbal ways other people let you know they are listening to you and what they have felt, seen or heard as positive strokes?* *Examples:* • *Facial expression.* • *Body posture.* • *Gestures.* • *Tone of voice.)*

Audiovisual	Outline or text of presentation
	Once a pattern takes hold, it can be difficult to break. This means that if you were not communicated with positively as a child, you will likely as an adult communicate the very same way. You can give others the perception of positive strokes if you use similar nonverbal cues. Listening is a highly selective, subjective experience. Both the listener and speaker have power. Your perception about a person or situation can influence your reception and how much you will pay attention. *(As you are making the above statement, draw two people on the board. Put arrows in between each person pointing to the other person to show perception and reception.)* **History of family communication styles** What you learned from your family includes: • Direct verbal communication. • Your perception of yourself. • Some of your initial attitudes about others. • Roles. *(Activity: Have students complete the handout "The History of Your Communication Style" on page 2-D-2-59.)*

Audiovisual

Barriers to Communication

- Filters
- Emotions
- Speaking
- Environment/physical

23

Slide 2-D-2-23

Outline or text of presentation

Barriers to clear communication
There are four specific types of barriers to good listening and communication skills.

- Filters: One definition of a filter is an electric or optical device used to reject signals, vibrations or radiations of certain frequencies while allowing others to pass.
- Emotions: Strong emotions decrease your ability to listen and communicate clearly. The higher the internal emotion, the less clearly you will communicate.
- Power dynamics: One of the major barriers to effective listening is that in this society we equate speaking with mastery and power.
- Environmental and physical barriers.

Filters
(Ask the students to list examples of filters. Examples include:

- *Memories.*
- *Values.*
- *Interests.*
- *Strong feelings.*
- *Assumptions.*
- *Past experience.*
- *Prejudices.*
- *Physical environment.*
- *Attitudes.*
- *Beliefs.*
- *Images past and future.*
- *Expectations.)*

The first step in dealing with these filters is recognition.

Audiovisual	Outline or text of presentation
	Internal thought processes becoming filters Become aware of your internal thought process. It is difficult to understand others until you learn to listen effectively to yourself and how you affect the messages and the data you take in. *(Draw this diagram on the board:* *Situation* ⟶ *Thought Process* ⟶ *Behavioral Feeling* ⟶ *Belief* ⟶ *Thought Process* ⟶ *Behavioral Feeling* *Discuss how internal thoughts and beliefs can become dangerous filters if not clarified or verified against the facts of a situation.)* **Remaining nonjudgmental** First, focus on the fact that no one comes to work to do a bad job. Second, listen from the heart and focus on the resident. Your goal is clean communication. If the person you are listening to is becoming emotional, try to pull him/her back to what is important for well-being and quality of life. Keep refocusing the conversation. Rehearse "pat" answers or "focus statements" to use when the conversation appears to be escalating to anger, defensive statements or blaming statements. If you practice them you will be able to use them in stress-filled moments. *(Ask for examples of a statement or an answer regarding residents that could be used this way.*

Audiovisual	Outline or text of presentation
	Examples: • *"I hear what you are saying and I know you are as concerned about the residents as I am."* • *"It sounds like we have a different perspective on this issue. I believe it is important for both of us to focus on the resident's perspective and what is important to the resident. What would the resident have wanted?"* • "*Can we go and look?" Sometimes just moving to another location helps give breathing space and cools the conversation.)* By bringing the focus back to a resident's situation and lowering the emotional level both you and the provider can send and receive communication more clearly. *(Go back to the diagram on the board and point out areas where emotions can change communication in both the reception and transmission.)* Third, remember that everyone receives data in a unique way; they are not "raw data" but filtered and interpreted by the receiver. When you don't verify and clarify what you are hearing, you make assumptions; you can come to conclusions that are not connected to what is really happening. The one question to ask yourself is "Can I tell what actually took place or what I might have assumed took place?" Fourth, consider the time of day and energy level of the persons attempting to communicate.

Audiovisual	Outline or text of presentation
	As you and others become more fatigued during the day it is more difficult to communicate clearly and nonjudgmentally. It is important to remember timing and fatigue and to control for them when communicating with providers and beneficiaries. We are now going to talk about two concepts which reflect some of the perceptions we have about ourselves and others, how they affect communication and how some of our roles affect communication. In listening there is a theory of "OK-ness." **Communication through Body Movements and Language** *(Write the following on the board.)* In "OK-ness": • I'm OK—you're not OK. • I'm not OK—you're OK. • I'm not OK—you're not OK. • I'm OK—you're OK. **I'm OK—you're not OK** In this communication style, a listener: • Is quickly judging and criticizing what he/she has observed or what others say. • Seems to listen only to what he/she has to say or the ideals or opinions that he/she agrees with. • May also have had some preconceived ideas about what he/she would see or hear (filters). In other words the person is unaware of how his/her behavior is negatively affecting others.

Audiovisual	Outline or text of presentation
	I′m not OK—you′re OK In this communication style, the person: • Is often worried about himself/herself and how he/she appears. • Focuses on himself/herself rather than on what is going on between him/her and the resident. • Is more interested in the answer he/she is going to give than in understanding what the other person is trying to communicate. A staff member with this style is so busy trying to say the right thing that he/she usually doesn't say anything at all. The staff member usually listens at level 2 or 3, gathers information superficially and makes assumptions without validating them. A listener with this style: • Operates from the attitude of victim. • Allows his/her emotions to override objectivity and becomes defensive instead of listening. • Has an internal dialogue which distracts him/her from hearing what is being said. **I′m not OK—you′re not OK** This communication style is detrimental to listening and the entire communication process. Staff with this style: • Often do not hear others and do not make the effort to listen to what others say. • Find very little reason to bother listening and are rarely interested in what anyone has to say. • Seem to others to be "going around in circles" and cause frustration, anger and discouragement.

Audiovisual	Outline or text of presentation
	This communication style also operates from an attitude perspective of a persecutor or rescuer. **Persecutor communication style** People behaving in this mode: • Often fault-find and nitpick and can't wait to say "gotcha." • Find something wrong no matter what is observed or said. • Even circle a mistake in red to make sure it is recognized. • Are quick to form a rebuttal to what has been said and often promote how something is going to fail or not work. • Make people feel as if they are dumb and stupid children. **Rescuer style** Rescuers: • Take other people's issues and make the problems their own. • Rescue others who don't need or want to be rescued and aren't asking to be rescued because it's good for them. • Take on others' responsibilities when it would be better for others to be responsible for themselves. **I'm OK—you're OK** Listeners with this style: • Use active listening and focus attention on the speakers. • Make observations and conduct interviews without being judgmental and communicate through their faces, bodies and tone of voice and words that the speakers are important. The "OK-OK" style is usually open, relaxed, understanding, logical and nonjudgmental, and the "not OK" styles usually close off communication.

Audiovisual	Outline or text of presentation
	The OK–not OK concept points out how the way you feel about yourself impacts your communication with others. Similarly, others' feelings about themselves impact how they communicate with you. All of these listening and communication styles and attitudes play a major part in each person's listening and communication behavior. They are formed in early childhood and reflect some of one's self-concepts. They influence attitudes about others, which can affect your ability to gather data or communicate (both verbally and nonverbally) in the observations or interviews which are needed to do your job. Self-knowledge is an important ingredient for increasing the ability to communicate and interact effectively with others. Understanding how confident you are, how you feel about yourself, your job and your peers can impact your communication. The second concept we are going to discuss today on communication has to do with the many roles we take on in our lives. **Communication with facility and provider staff** Sometimes it's not what you say but how you say it. Three of the roles we take on, which translate into how we communicate, are: • P = Parent. • A = Adult. • C = Child.

Audiovisual

Outline or text of presentation

PAC concept of communication

- Communication with staff can sometimes be difficult and sets the tone of how you and your team are perceived.
- Communication can also influence how others listen or accept what is being said.

(Draw the PAC list on the chart pad or board and draw arrows as you speak about talking to the resident or provider.)

You or a Team Member	Resident or Provider
Parent	Parent
Adult	Adult
Child	Child

(After each discussion area ask:

- *What would a parent say?*
- *How does a parent act?*
- *What would a child say?*
- *How does a child act?*
- *What would an adult say?*
- *How does an adult act?*

When discussing the three roles, act out the body language and make a statement such as a parent, child or adult would make. For example:

- *Child: Stomp your foot and put your hands on hips, stick your nose in the air and say, "You can't make me," "You don't control what I do" or "I'll make you sorry."*
- *Parent: Point at someone and say, "You should do it this way," "I know the best way to take care of this issue," "I am older and wiser than you" or "I have more power than you do."*

Audiovisual	Outline or text of presentation
	Students usually laugh but understand the concepts.)
	Parent to child In the case in which you are communicating as a parent to a provider as a child, you are in a position of authority. Parents generally give advice, punish or correct when speaking to their children.
	However, you do not have the authority to punish; it is not your role. Enforcement and remedies are used only to the extent needed to gain compliance from the provider. Compliance is your focus, not punishment.
	It is good to remember that most providers do not intend to harm residents. There are two relevant sayings: "Nobody comes to work to intentionally do it wrong" and "Nobody purposefully comes to work to do a bad job."
	Parent to adult In the case in which you are communicating as a parent to an adult, you are still in the role of authority. When communicating this way, it is easy to slip into communicating as an advisor or consultant.
	However, your role is not one of advisor or consultant. The provider is able to and must develop systems that will result in compliance.
	Parent-to-adult communication may be perceived as disrespectful and condescending. Providers have expertise in their own right. They have difficult jobs. Surveyors also have difficult jobs. Communication in this style may place the

Audiovisual	Outline or text of presentation
	provider in a defensive position and result in a defensive response. **Adult to child** When you communicate as an adult to a provider communicating as a child, the provider may perceive an overuse of authority even though you are there only to determine whether the provider meets the required regulations. The provider may respond with a "you can't make me" attitude. It may be that this attitude results from fear and emotions or something that happened during the survey that made the provider feel defensive. The attitude may result from a previous event with a different surveyor which makes the provider work through a filter of experience that is not positive and respectful. As an adult and professional you will probably keep the attitude that the regulations are the requirements to which the provider agreed; however, a provider in the child attitude will probably not comply except superficially. **Child to adult or parent** In assuming this role, you have given up your position of authority to determine compliance. Becoming emotional or responding to a provider in this manner communicates an underuse of authority. It undermines the message you are trying to communicate. Why would the provider take direction or follow decisions of compliance from a child who appears unlearned and unrestrained? It may write a Plan of Correction, but it will communicate that it does not respect your opinion.

Audiovisual	Outline or text of presentation
	Child to child In these roles you are both communicating at a low, primitive level. This may result in finger pointing and in arguing back and forth. It accomplishes nothing. Everyone involved may end up pouting if this is their usual style of communication, or retaliation behavior may occur. Relating to the provider this way erodes the focus of your purpose for being there: the quality of care for and services to the residents. **Adult to adult** You and the provider are in equally powerful positions; neither should feel defensive, each respecting the other's positions, perceptions and experience. Information about compliance given in this manner will most likely be perceived as a balanced use of authority. Neither party will perceive the other as having the upper hand. You cannot control how providers behave or communicate. You can control your own communication styles so that providers are not put in submissive, defensive positions. Providers and others are more likely to respond and communicate in response to the position we communicate from. *(Place the pieces of paper labeled "P," "A" and "C" into the paper bag and have each student draw one. Group the students into teams of two. Have each team take a few minutes and role play a conversation between the two, each framing his/her conversation according to his/her piece of paper: as a parent, a child or an adult. Then have students switch partners and do the role play again.)*

Audiovisual

How Are You Perceived?

- By provider?
  - Person who has power to take it out of business
- By residents?
  - Someone who can intercede on their behalf . . . or someone who interferes
- By advocates?
  - Someone who should respond to their perception of problem

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Slide 2-D-2-24

Outline or text of presentation

How You Are Perceived

Let's look at the components and authority again in answering the following questions.

How are you perceived?

- By the provider?
  - The facility sees you as a person with the power to take it out of business.
- By the residents?
  - The residents see you as a person who can intercede on their behalf with the facility or as someone who interferes with their relationship with the facility.
- By the advocates?
  - The advocates see you as a person who should respond to their perception of the problem and how it should be resolved because they perceive you as the person with power to do what they want.

Overuse of Authority

- "I gotcha"
- "Midnight raider"
- "Manager"
- "Biased bigot"
- "Enforcer"

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Slide 2-D-2-25

Overuse of authority

- I gotcha = parent.
  - Overreacts to a situation prior to gathering, verifying and integrating all of the facts.
- Midnight raider = parent/child.
  - Abuses or overuses unannounced or drop-in visits; tends to be suspicious and wary of all providers.
- Manager = parent.
  - Believes that the concern for the welfare and protection of the resident or consumer overrides all other considerations and grants a measure of "power" which exceeds due process, rules or organizational constraints.

Audiovisual

Outline or text of presentation

- Biased bigot = parent.
  - Hides his/her bias behind a cloak of professionalism but uses surveying to pick on certain types of providers or individuals.
- Enforcer = parent.
  - Approaches surveying as if the rules were personal and he/she alone was responsible for enforcement.

A few more are:

- The manager who takes on the provider's responsibilities to "fix" things (parent).
- The pessimist who initiates every investigation with an attitude that there are violations occurring and they are being covered up (parent).
- The loner who avoids taking a situation to supervision or to peers for objective reality testing (child).
- The passive aggressor who is polite and deferential in face-to-face interactions with the provider but lowers the boom in written communication.

Underuse/Misuse of Authority

- "Consultant"
- "Social worker"
- "Follow-the-leader"
- "Optimist"
- "Overidentifier"

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Slide 2-D-2-26

Underuse/misuse of authority

- Consultant = parent.
  - Wants to use consultation exclusively.
- Social worker = child.
  - Like the consultant, confuses the role of surveying with that of a therapist.
- Follow-the-leader = child.
  - Allows the administration of the program being inspected to design or control the scope and means to conduct the investigation.
- Optimist = child.
  - Enters the investigation "knowing" that everything is all right.

Audiovisual

Balanced Use of Authority

- Not going beyond limits of regulations
- Understanding principles of gathering evidence & making objective, not subjective, decisions based on facts
- Keeping tuned to ourselves & working continually to improve our communication

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Slide 2-D-2-27

Outline or text of presentation

- Overidentifier = child.
  - Becomes overly identified with the provider and the pressures, circumstances or tragedy that may have occurred.

Balanced use of authority
(Discuss this as starting with the governing entity, continuing with the surveyor and ending with enforcement.)

- You use only what is needed to obtain compliance.
- You understand the principles of gathering evidence and know when to shift gears as the situation requires.
- You are comfortable in gathering facts and in making objective recommendations based on those facts.
- You check your filters, your emotions, and your feelings on a regular basis and work continually to recognize your communication styles and patterns and how they affect your communication.
- You work to communicate clearly and consistently with providers.

Remember your mission and the objectives you aspire to. These are the values that guide your daily work:

- Quality of life includes quality care, resident rights, choices and the feeling of safety, security and confidence.
- You have a commitment to consistency, fairness and common sense in your quality assurance and regulatory approach.

Values that guide you in your efforts:

- Values of the agency.
- Your values.
- Bringing your values to the job.

Audiovisual

Team

Individuals who:
- Work together for common purpose
- Communicate regularly & productively with each other
- Determine what information will be shared with facility staff & what needs further investigation

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Team (cont.)

- Help & support each other
- Communicate findings with facility staff in timely manner

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Slide 2-D-2-29

Outline or text of presentation

The Team

"A group is a collection of people who come together because they share something in common."

What they share could be as insignificant as the desire to get on the next bus that will arrive at the stop.

"A team is a group of people who share a common name, mission, history and set of goals or teambuilding ('the process needed to create, maintain and enrich the development of a group of people into a cohesive unit')."

Roles and norms
All teams develop sets of roles and norms. Although these are not generally discussed there are "norms"—unwritten rules. Each team has a different set, and they govern the cohesiveness, communication and interdependence of each member.

Each time a new member is added to the team changes occur. They occur in the cohesiveness, the communication between members and the roles and norms. It is good to remember that:

- Sometimes your team has been without a member for a while and has been "carrying the load" so to speak for an empty slot.
- Sometimes your team has had a member retire or move on. Your team may be grieving the change or the loss of a member. Even if you were not close to the member, the change creates a shift or disturbance within the team. You may also be relieved that an unhappy member of the team has moved on to a different position, but it is still a change.

Audiovisual	Outline or text of presentation
	• Although you are anxious to have good working relationships with others and anxious to learn about your new position, it may be helpful for you to be extra sensitive at this time when you are new. • One of the most important factors in building a team is the development of mutual trust in one another. This takes time. **Sequence of team development** • Forming: A group is just getting to know each other. • Storming: A time of stressful negotiation of the terms under which the team will work together. • Norming: A time in which roles are accepted, team feeling develops and information is freely shared. • Performing: When optimal levels are finally realized in productivity, quality, decision making and interpersonal interdependence. **Team meetings** A survey team meeting: • Should be held on a daily basis to share information, findings to date, areas of concern or any changes needed in the focus of the survey. It is a time for discussing strategies for gathering additional information. • Should maintain an open and ongoing dialogue with facility staff throughout the survey process. This gives the facility the opportunity to provide you with additional information before you make a deficiency decision. • Need not report every observation on a daily basis. Many observations need to

Audiovisual

Outline or text of presentation

be monitored over time to determine whether there is a deficiency. Wait until a trend has been established and the issue has been discussed with the team before notifying the facility of the problem.

Team communication with facility staff

- During the survey you may identify situations that lead you to believe that the facility may not be meeting a requirement not routinely reviewed in the survey or inspection. These need to be investigated further.
- Let the survey process lead you. Evidence should lead you to other investigations. The team should not routinely add items to investigate outside of the process unless triggered.
- T = Together
  E = Everyone
  A = Accomplishes
  M = More
- Remember that communication is a refined art whether it is written or spoken or is being absorbed.
- Communication is a process and consists of message, delivery, interpretation, reexpression and action.
- Your role is vital in the process of ensuring that beneficiaries are receiving the care and service they need in a safe environment at the standards set down by the regulations.

Responsibilities

Remember:
- Communication:
  - Is art
  - Can be refined through practice
  - Impacts success in new role
- Your role is vital in assuring that beneficiaries receive care & services they need
- You are trusted servant of public

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Slide 2-D-2-30

Activity 1
Take this psychology test.

(Refer students to the handout "Psychology Test" on page 2-D-2-61.)

Audiovisual	Outline or text of presentation
	There are five things going on simultaneously which need to be taken care of. 1. The telephone is ringing. 2. The baby is crying. 3. Someone knocks at the front door or rings the doorbell. 4. There is laundry hanging on the line outside and it begins to rain. 5. The water faucet in the kitchen is running. In what order do you take care of these problems? Jot them down in order. Each decision you make represents something in your life: 1. The phone represents your job or career. 2. The baby represents your family. 3. The visitor represents your friends. 4. The laundry represents your sex life. 5. The running water represents your money or wealth. How close did this test match your priorities in life? **Activity 2 preparation** *(Direct students.)* • Write your name on a small piece of paper. • Now crumple it up. *(If the class is large enough, divide the class into smaller teams.)* • Stand in a circle, close enough to touch each other's hands. • I am going to read a story and when I say "right" or "Wright" pass the paper to the person on your right; when I say "left" pass the paper to the person on your left.

Audiovisual	Outline or text of presentation
	(Read the following story as fast as you can without pausing or stopping until the end.)

Activity 2 story

Mrs. Wright eyed her grocery list carefully. "There won't be anything left of our budget after shopping," she sighed.

Mr. Wright looked up from his paper. "That's all right, my dear. There isn't anything left of it anyway at the end of the month."

"I'll be happy if it just sees the Wright family through the month."

As Mr. Wright turned to his paper he said, "Have you the right gift for Aunt Hattie Wright's birthday? She's been pretty lonely since her daughter left home right after she married. Uncle Harry left her a lot of money, but she does not know how to enjoy it, right?"

Eddie Wright was studying in the corner left side of the fireplace. "I wish Aunt Hattie Wright would ask me the right way to spend it," he said.

Eunice Wright sniffed and said, "She would not have much left if she did. Your weekly allowance is gone before you get it right in your hands, almost."

"And I suppose you have all of yours left, Miss Miser?!" retorted Eddie Wright.

"I don't have it all left, but I have enough left to buy Ninja Turtles with it, all right," Eunice Wright said.

Just then the door bell rang. Eunice Wright ran to answer it. The postman had left a

Audiovisual	Outline or text of presentation
	special delivery letter for the Wright family. She took it to Father Wright and he opened it. Inside were a letter and four right-new-looking ten dollar bills. Mr. Wright shouted, “It’s from Aunt Hattie Wright saying she has left town and decided to go right to her daughter’s house.” “Say, she’s all right,” shouted Eddie Wright. “Bless her heart,” said Mother Wright. “How wonderful of her,” said Eunice Wright. “It has each of us right happy to think she gave it to us before she left,” declared Father Wright. “At least it’s all right with everybody.” **Activity 2: Debrief** This can be just like a survey: lots of information coming in at the same time, while you and your team members are trying to concentrate. It also speaks about working within a team. How close did your team come to getting each member receiving the paper with his/her name on it? How much time did it take? *(Let the teams talk about their process and try it again.)* How did you do? What changed?

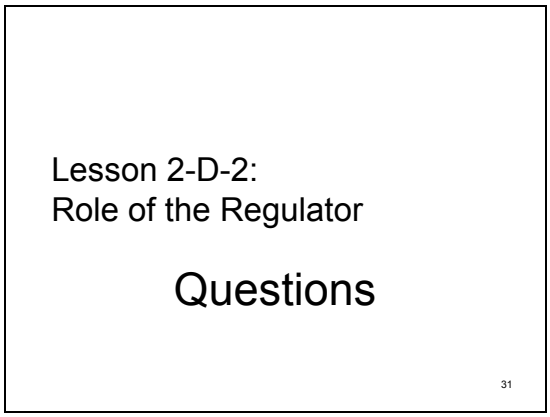
Audiovisual

Outline or text of presentation

Activity 3: Role plays

(Use the following scenarios as the basis.)

1. The discussion is about the way the medications are and are not labeled. One of you is the surveyor and one of you the administrator.
2. The discussion is about the way staff are talking to residents. One of you is the surveyor; one of you is the administrator.
3. The discussion is about the techniques used by a licensed nurse during administration of medications. One of you is the surveyor; one of you is the licensed nurse.
4. The discussion is about the poor transfer techniques the caregiver is using to assist the resident. One of you is the surveyor and one of you is the caregiver.



Slide 2-D-2-31

Skill Assessment

Role of the Regulator

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed the role of the regulator in general and specific terms.	
					Explained the objective of survey and certification.	
					Described an understanding of the objective of a survey, when to intervene on the beneficiary's behalf and when to wait and observe facility practice.	
					Defined the effect of different philosophies of regulation.	
					Defined the role of the individual as regulator, some difficulties associated with being a regulator and some attributes to develop.	
					Developed a balanced use of authority.	
					Identified the ethics and professionalism required of a surveyor/investigator.	

					Demonstrated good communication, including when to wait and when to immediately disclose concerns to facility staff.	
					Articulated decisions appropriate to the team meeting and how to support the team.	

Comments/Recommendations:

Effective Communication Self-Evaluation

To help you become more aware of your listening habits, complete the following listening self-evaluation. Place an "X" in the most appropriate column to reflect your usual style. Do you:

Communicating	Most of the time	Frequently	Occasionally	Almost never
1. Tune out people who say something you don't agree with or don't want to hear?				
2. Concentrate on what is being said even if you are not really interested?				
3. Assume you know what the talker is going to say and stop listening?				
4. Repeat in your own words what the talker has just said?				
5. Listen to the other person's viewpoint even if it differs from yours?				
6. Learn something from each person you meet, even if it is ever so slight?				
7. Find out what words mean when they are used in ways not familiar to you?				
8. Form a rebuttal in your head while the speaker is talking?				
9. Give the appearance of listening when you aren't?				
10. Daydream while the speaker is talking?				
11. Listen to the whole message (what the talker is saying verbally and nonverbally)?				
12. Recognize that words don't mean exactly the same thing to different people?				
13. Listen to only what you want to hear, blotting out the talk's whole message?				
14. Look at the person who is talking?				
15. Concentrate on the talker's meaning rather than how he or she looks?				
16. Know which words and phrases you respond to emotionally?				
17. Think about what you want to accomplish with your communication?				
18. Plan the best time to say what you want to say?				

Communicating	Most of the time	Frequently	Occasionally	Almost never
19. Think about how the other person might react to what you say?				
20. Consider the best way to make your communication (written, spoken, phone, bulletin board, memo, etc.) work?				
21. Think about what kind of person you're talking to (worried, hostile, disinterested, rushed, shy, stubborn, impatient, etc.)?				
22. Interrupt the talker while he/she is still talking?				
23. Think "I assumed he or she would know that"?				
24. Allow the talker to vent negative feelings toward you without becoming defensive?				
25. Practice regularly to increase your listening efficiency?				
26. Take notes when necessary to help you remember?				
27. Hear noises without being distracted by them?				
28. Listen to the talker without judging or criticizing?				
29. Restate instructions and messages to be sure you understand correctly?				
30. Paraphrase what you believe the talker is feeling?				

Scoring

Circle the number that matches the time frame that you checked on each of the items of the self-evaluation items. Add the circled numbers in each column. Which is the column with the highest score?

1	1	2	3	4
2	4	3	2	1
3	1	2	3	4
4	4	3	2	1
5	4	3	2	1
6	4	3	2	1
7	4	3	2	1
8	1	2	3	4
9	1	2	3	4
10	1	2	2	4
11	4	3	2	1
12	4	3	3	1
13	1	3	2	4
14	4	3	2	1
15	4	3	2	1
16	1	3	2	1
17	4	3	2	1
18	4	3	2	1
19	4	3	2	1
20	4	3	2	1
21	4	3	2	1
22	1	2	3	4
23	1	2	3	4
24	4	3	2	1
25	4	3	2	1
26	4	3	2	1
27	4	3	2	1
28	4	3	2	1
29	4	3	2	1
30	4	3	2	1
Total				

The History of Your Communication Style

The Family System

1. How did your parents listen to you when you were young?
   a. With complete attention.
   b. Asked so many questions I thought I was being interrogated.
   c. With divided attention.
   d. Reluctantly.
   e. Showed little interest.
   f. Interrupted me.
   g. Did something else while saying “Hmmm” or “Uh-huh.”
   h. Other.
      i. How did you respond to this kind of attention?
      ii. What did you say to yourself?
      iii. How do you think this kind of attention has affected your present listening habits?

2. Which of the following describe communication with your parents?
   a. It was indirect.
   b. It was direct.
   c. It was not really honest.
   d. It was honest.
   e. It was vague.
   f. It was clear.
   g. It was specific.
   h. It was open.
   i. It was closed.
   j. It was pleasant.
   k. It was unpleasant.
   l. It was painful.
   m. It was relaxed.
   n. It was stressful.
   o. It was uptight.
   p. Double messages were sent.
   q. What was said was meant.
   r. Other.

3. The rules in my family were:
   a. Flexible.
   b. Rigid.
   c. Formal.
   d. Human.
   e. Inhuman.
   f. Nonnegotiable.
   g. Negotiable.

h. Closed/open/binding.
i. Clearly defined.
j. Uncertain.
k. Hazy.
l. Understood.
m. Appropriate.
n. Changeable.
o. Unchangeable.

4. Were you allowed to be part of making the rules and setting your own limitations?

5. How does this family system affect you as an adult listener and communicator?

6. How does it affect you on the job?

Psychology Test

There are five things going on simultaneously which need to be taken care of.

1. The telephone is ringing.
2. The baby is crying.
3. Someone knocks at the front door or rings the doorbell.
4. There is laundry hanging on the line outside and it begins to rain.
5. The water faucet in the kitchen is running.

In what order do you take care of these problems? Jot them down in order.

Lesson 2-E:
The Hearing Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify a variety of legal remedies afforded the provider/supplier, including appeals about denial of certification, denial of exceptions, informal dispute resolution and departmental board appeals and hearings.
- Describe the roles of the provider/supplier, State agency and CMS Regional Office staff and legal counsel during these processes.
- Explain your role from the survey through the hearing process as you provide information to government legal counsel and testify.

Lesson Plan

References

Federal

- Social Security Act
- *Code of Federal Regulations:*
  - 42 CFR 498
- *State Operations Manual:*
  - Chapter 3
  - Chapter 7
  - Section 5160
  - Section 5180
  - Section 5360
  - Section 5590

State

(Insert State reference[s] here.)

Other

Highlights

- Basic information on the appeal and hearing process that the provider/supplier may pursue and on the role a surveyor may play in this process
- Identification of a number of legal remedies available to the provider/supplier
- Identification of the process and factors that may trigger an appeal or hearing
- Identification of surveyor responsibilities from the time of the survey through testifying
- The role Federal government counsel plays

Training Techniques

- Lecture
- Group discussion or role-play

Training Aids

- PowerPoint slides and handout

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Lesson 2-E
The Hearing Process

1

Slide 2-E-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify a variety of legal remedies afforded the provider/supplier, including appeals about denial of certification, denial of exceptions, informal dispute resolution & departmental board appeals & hearings.

2

Slide 2-E-2

Learning Objectives (cont.)

- Describe the roles of the provider/supplier, State agency & CMS Regional Office staff & legal counsel during these processes.
- Explain your role from the survey through the hearing process as you provide information to government legal counsel & testify.

3

Slide 2-E-3

Outline or text of presentation

At some point in your role as a surveyor you may need to testify at a hearing. It is a fact of surveyor life even though many surveyors fear testifying. To minimize your fear this lesson will provide you not only information about the process, but also about steps you can take from the time of your survey through testifying at a hearing.

While the State may have a similar process, this lesson will emphasize the Federal challenges to survey and certification work and the hearing process.

(Inform the students of the objectives.)

Audiovisual

Steps to Help Yourself

- Step 1—Follow survey process & document well
- Step 2—Review your documents, vow to do it better
- Step 3—Complete Form CMS-2567
  - Fully support each deficiency
  - Follow Principles of Documentation

4

Slide 2-E-4

Outline or text of presentation

Steps to Help Yourself

Let's begin at the beginning. How did you get to a hearing in the first place? The answer is that you participated in a survey.

Any provider or supplier may first challenge the survey findings during the survey or the exit conference. During the exit conference, remain calm. Keep in mind that the exit conference is a courtesy and all findings are preliminary and subject to supervisory and CMS review.

Remember that during the exit conference the facility has the option of recording your comments. Therefore, anything you say can be entered into the record. The tape provides an accurate record of what was said at a specific time.

Step 1

Your actions during a survey can play a significant role in the outcome of any hearing related to that survey. Therefore, the first step to successfully defend your survey findings is to conduct the survey process exactly as it is written and carefully and fully document your observations, interviews and record reviews, including the date, time, name and title of individuals and name and date of document as appropriate.

Step 2

The second step to help yourself is to review your documents after each survey and ask yourself, "Six months or a year from now could I review my notes and re-create the survey?" If not, consider what changes you need to make.

Audiovisual	Outline or text of presentation

	Step 3
	
	While you should always consider information presented by the provider or supplier at the exit conference, your next task is to write the Statement of Deficiencies (SOD). Follow the Principles of Documentation and clearly explain and fully support the reason(s) you cited each deficiency.
	
	Keep in mind:
	• The survey results and SOD should speak for themselves.
	  – Each deficiency must include all the information needed to defend your decision and the team's decision to cite a deficiency.
	  – Each deficiency should stand by itself so that if one is thrown out during a hearing, other deficiencies will remain unaffected.
	• All your notes and documents acquired during the survey may be subject to discovery (a legal procedure by which legal counsel for the provider/supplier will request documents from the survey). Counsel may use them in preparing any legal challenge. Therefore, don't record information that is not pertinent to the survey on your notes.

Audiovisual

Outline or text of presentation

Your Responsibility

- Provide responses
  - Factual
  - Accurate
  - Credible
- At:
  - Appeal
  - Hearing
  - Challenge

5

Slide 2-E-5

While it is important to remember that legal requirements are the responsibility of the attorney, your primary responsibility is to provide factual, accurate and credible responses to any appeal, hearing or challenge.

Evidence you present may involve any or all aspects of your investigation, your evidence and your determination of deficiencies. You may be questioned about documents you prepared and acquired, interviews you conducted and observations you made.

Counsel will aid you throughout this process. It is helpful to know what providers may allege and, therefore, what attorneys may need to know and how your response can assist counsel in preparing for your defense.

Enforcement

- Medicare survey
  - State agency conducts
  - State agency recommends action to RO
  - RO determines action

6

Slide 2-E-6

Background for Steps 4, 5 and 6

Enforcement

If a Medicare-certified entity is involved, the State agency recommends some action to the CMS Regional Office (RO) based on the findings of that survey. Staff in the RO consider the State's recommendation, the findings from the survey recorded on Form CMS-2567 (*Statement of Deficiencies and Plan of Correction*) and any other information available to them. CMS then determines the action it will take.

For non-long term care entities, if the State survey identifies that a Condition of Participation (CoP) or Condition of Coverage (CoC) is not met and the RO agrees, RO staff must begin to decertify the facility. That is, it must stop the

Audiovisual

Outline or text of presentation

Medicare funding, because CMS cannot continue to certify any entity not in compliance with all CoPs or CoCs. If the entity does not correct the CoP or CoC, CMS must decertify the entity. However, the entity can appeal CMS's action.

This will result in a formal hearing where you, as one of the surveyors, may have to testify or assist CMS's counsel.

For long term care, the Medicare- or Medicare-/Medicaid-certified facility may request appeal under the Informal Dispute Resolution (IDR) process—in nursing homes it is the first step in the appeal process. Non-long term care providers and suppliers do not have any right to appeal under the IDR process.

For Medicare-certified facilities, CMS makes final recommendations and takes action.

Provider/Supplier Appeal

- Provide written request to RO within 60 days
- Include:
  - Identification of specific issues
  - Findings of fact & conclusions of law which provider/supplier is appealing
  - Basis for contending findings are incorrect
  - Right to appeal

7

Slide 2-E-7

Provider/supplier appeal
A provider/supplier has appeal rights during particular portions of the certification process.

Providers may file a request for hearing with CMS, the Federal Office of the Inspector General, if appropriate, or the Office of Hearings and Appeals (OHA).

Provider responsibilities
It is the provider's responsibility to:

- Provide a written request for a hearing to the RO within 60 days of the date of the notice of the action (date the provider was informed) to appeal.
- All requests for a hearing must include:
  - Identification of the specific issues.
  - The findings of fact and conclusions of law which the provider/supplier is appealing.

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Outline or text of presentation

- The specific basis for contending that the findings and conclusions are incorrect.
- Reference to the termination decision and the right to appeal to an administrative law judge (ALJ).

If the provider/supplier appeals certification decisions, a hearing may be scheduled before an impartial party. In many ways, it is like some court cases you may see on television.

- The place, date and time for the hearing are set and all parties are notified.
- A judge (usually an ALJ) conducts the hearing and maintains appropriate decorum.
- Each party has an attorney.
- Either party may enter documents, pictures and other articles as evidence.
- People testify and are cross-examined.
- All testimony is recorded.
- The judge makes a binding judgment at a later time after considering all the information.

Parties in Action

- CMS
- CMS's legal counsel
- Staff from State survey agency
- Other relevant witnesses (e.g., expert witness)

8

Slide 2-E-8

Parties in the action

Though the State agency conducted the Medicare survey at the provider/supplier, in any legal action that is taken as a result of that survey, CMS and the provider/supplier will be the primary parties.

Because of the 1864 agreement (i.e., an agreement between the Secretary of Health and Human Services and the State survey agency as addressed in the Social Security Act, Section 1864), as the agent of CMS, the State agency and specific individuals in the State agency may have to defend the

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Outline or text of presentation

legal enforcement action. CMS and the State agency will work together to defend any legal enforcement action.

Parties to the action will include:

- CMS.
- Legal counsel from the Office of General Counsel.
- Staff from the State survey agency (which usually includes surveyors).
- Other relevant witnesses, depending upon the level and type of legal remedy (for example, an expert witness for the issue under dispute).

The provider/supplier will also have legal counsel and witnesses.

Surveyor Involvement

- Denial of initial certification
- Entity challenge to survey findings & enforcement actions
- Termination actions
- Denial of special requirements
- Denial of exclusions or special requirements

9

Slide 2-E-9

Surveyor involvement

Surveyors may be involved in the following:

- Denial of initial certification for an entity seeking certification.
- Survey findings the entity is challenging and any enforcement actions based on the survey (e.g., the long term care Informal Dispute Resolution process).
- Termination actions.
- Denial of exclusions or special requirements [e.g., denial of a Prospective Payment System (PPS) exclusion for a psychiatric or rehabilitation unit so that the hospital will continue to be paid according to patient diagnosis rather than at a higher reimbursement rate].

(Determine whether the students will survey primarily non-long term care or long term care providers and suppliers. Based on that determination, discuss the most frequent legal challenges to survey findings and the subsequent enforcement action based on those findings.)

Audiovisual

Credibility

10

Slide 2-E-10

Steps to Help Yourself

- Step 4—Grooming & professional clothing
- Step 5—Preparation
  - Prepare current resume
  - Review your notes
  - Review Form CMS-2567
  - Read regulation & surveyor guidance

11

Slide 2-E-11

Outline or text of presentation

Credibility
Someone may challenge your credibility as a testifying surveyor.

What does the term *credibility* mean to you?

(Ask students for examples of traits associated with credibility. Possibilities include:
- *Trustworthiness.*
- *Believability.*
- *Reliability.*
- *Integrity.*
- *Authority.*
- *Sincerity.)*

The credibility of your work and conduct during the survey becomes the focus of any legal actions taken by the provider and defended by CMS.

Step 4

Consider your appearance. You will want to dress professionally and present a well-groomed appearance.

Step 5

If you are called as a witness in a legal proceeding, counsel will represent you. This will involve preparation time and direction from the attorney representing you.

To prepare for the hearing:
- Prepare a current resume for the government attorney. Include:
  - Degrees, especially those relevant to health care.
  - CMS and State training classes you have attended.

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Steps to Help Yourself (cont.)

- Step 5—Preparation (cont.)
  - Clarify with attorney findings you wrote
  - Practice questions & answers with attorney
  - Become familiar with issues at hand
  - If asked, create chronology of events or witness preparation plan

12

Slide 2-E-12

Outline or text of presentation

  - If you are Surveyor Minimum Qualifications Test (SMQT)-qualified.
  - Years of experience in your health care profession.
  - The type of providers for which you have worked.
  - Years working in the type of entity that is appealing.
  - Any other relevant information to show you are competent.
- Review your notes to recall how you investigated.
- Review Form CMS-2567—know it well.
- Read the regulation and surveyor guidance relevant to the deficiency cited so you can explain the reason or intent of the regulation that is included.
- With the attorney, clarify which findings on Form CMS-2567 you wrote.
- Practice questions and answers with the attorney about your findings and the hearing process.
- Be familiar with specifics related to the issue(s) at hand and especially what is written on Form CMS-2567 for all deficiencies.
- If asked, create a chronology of events or a witness preparation plan for yourself or others in the matter to assist counsel.

Unless directed to do so by appropriate State or Regional Office staff, do not discuss your testimony with others, including family or the provider's attorney.

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Steps to Help Yourself (cont.)

- Step 6—Prepare mentally
  - Know how you respond under pressure
  - Identify legal ways to calm your anxiety
  - Rely on:
    - Quality of your survey
    - Your knowledge of facts
    - Cited deficiencies

13

Slide 2-E-13

Hearing

- Remember testimony is taken under oath & penalty of perjury
- *Always* know your limits—what you know, what you did
- *Always* speak truthfully—address facts, do not guess or speculate
- *Always* respond only to question asked

14

Slide 2-E-14

Outline or text of presentation

Step 6

Prepare mentally. It is helpful to know how you respond under pressure (e.g., do you become loud and angry or quiet and withdrawn?).

Identify legal methods to calm your anxiety (e.g., exercise, adequate sleep and proper diet).

Rely on the quality of your survey, your knowledge of the facts revealed during the survey, the deficiencies cited on Form CMS-2567 and your preparation.

The Hearing

Your testimony is taken under oath and penalty of perjury.

How do you explain your decisions and how do you respond to the questions posed? The attorney should prepare you for this and assist you through the process.

When you testify:

- Always know your limits—what you know, what you did.
- Always speak truthfully—address facts, not what you think. Do not guess or speculate. If you don't know, say it.
- Always respond only to the question asked. Do not volunteer information or try to expand on your answer unless asked to do so.
- Always remain dignified and composed. If you feel yourself getting stressed, remember your approach for reducing stress or anxiety (e.g., take a deep breath, count to 10, relax your muscles).

Credibility of the findings and of the surveyor will be an issue for challenge.

Audiovisual

Activity

- Role-play

15

Slide 2-E-15

Outline or text of presentation

Be prepared to:

- Describe your knowledge base.
- Explain your qualifications to perform this work and make a compliance determination.
- Provide a definition or explanation for any medical term you use. Remember, the judge and others may not be familiar with medical terminology.

In other words, the provider's/supplier's legal counsel will likely subject you to stringent scrutiny and challenge the evidence.

(Optional activities:

Option 1—Have the surveyors review a short Form CMS-2567 with significant findings. Then ask your agency's legal representative to participate in a role-play, having surveyors testify regarding a specific deficiency.

Option 2—Ask surveyors the following or other questions and discuss their answers.

- *What are your qualifications for this job?*
- *What training have you received?*
- *What resources did you use to formulate your decision?*
- *Did you use any print or personal resource? If yes, describe it in detail, or did you bring it with you?*
- *Describe your observation.*
- *The survey document states . . . Why were/weren't certain observations/ interviews/reviews of documents put into the Statement of Deficiencies?*

Audiovisual

Outline or text of presentation

Additionally, surveyors may be asked to describe and justify their observations, interviews, and documents in detail. For example:

- *What was the weather on the day of the survey when you made your decision?*
- *Was the television or radio playing in the room? Was there any outside distraction?*
- *Why did you use one reference instead of another?*

Continue to question students to demonstrate examples of possible challenges and responses to these challenges.)

In the end, remember, most appeals and hearings settle before trial.

After Hearing

- An official will rule
- An appeal may follow
  - Decision based on transcript of previous legal action & evidence

16

Slide 2-E-16

After the Hearing

After the hearing, the ALJ or other official will make a decision about the appeal. This may take several months.

Either the provider/supplier or the government can appeal the result. The appellant submits paperwork, and usually the appeal is decided on the evidence submitted during the previous hearing as well as on the transcript of the hearing. The entity involved and the types of appeals allowed by law will have a bearing on the final decision.

Regardless of the outcome of the hearing, your future interactions with the facility and its staff must be professional and objective.

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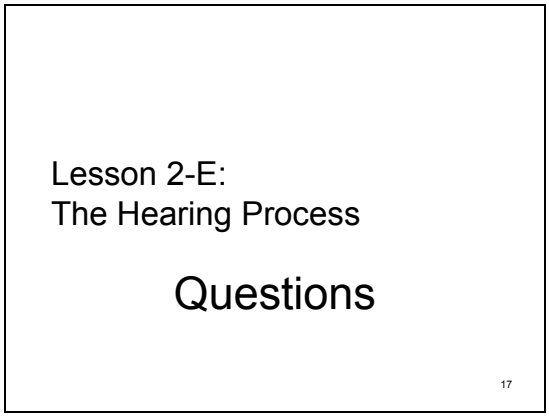
Outline or text of presentation



Slide 2-E-17

Skill Assessment

The Hearing Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described, for a specific provider/supplier type, basic steps from the end of the survey through the appeal process.	
					Described the role of the following entities: • Provider/supplier. • State agency. • CMS Regional Office for Medicare providers/ suppliers. • Legal counsel.	
					Explained the surveyor's role from the survey through the hearing.	

Comments/Recommendations:

Lesson 2-F: *Principles of Documentation*

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Understand the purpose of Form CMS-2567, Statement of Deficiencies and Plan of Correction.
- Identify and discuss the key elements of the *Principles of Documentation.*
- Write clear, concise and comprehensive citations.

Lesson Plan

References

Federal

- Survey and Certification letter in September 2000 issuing the revised *Principles of Documentation*

State

(Insert State reference[s] here.)

Other

Highlights

- Brief discussion of the importance of the use of documentation from the survey to complete Form CMS-2567, Statement of Deficiencies and Plan of Correction, using the *Principles of Documentation*
- The principles and information contained in the *Principles of Documentation*, issued in September 2000

Training Techniques

- Lecture
- Group discussion
- Small group and individual exercises

Training Aids

- PowerPoint slides and handouts
- Mandatory web-based training on the *Principles of Documentation* for all surveyors
- Handouts:
  - *Tips for Writing the Statement of Deficiencies*
  - *Owed to the Spell Checker*
  - *Principles of Documentation,* 2000 version
  - *Active-Voice Sentences*
  - *Changing Passive to Active*
  - *Active-Voice Exercises*
  - *Active-Voice Practice #1*
  - *Active-Voice Practice #2*
  - *Principles of Documentation Summary Sheet*
  - *SOD Worksheet*
  - *Principles of Documentation for Statement of Deficiency (CMS-2567) Review*
  - *ICF/MR Practice Sample #1*
  - *ICF/MR Practice Sample #2*
  - *HHA—G277: Scenario and SOD Example*

- *LSC—K038: Scenario and SOD Example*
- *LTC—F314: Scenario and SOD Example*
- *LTC—F316: Scenario and SOD Example*
- *ESRD—V449: SOD Example*
- *HHA—G158: SOD Example*
- *Hospice—L125: SOD Example*
- *Hospital—A350: SOD Example*
- *ICF/MR—W249: SOD Example*
- *LSC—K021: SOD Example*
- *LSC—K051: SOD Example*
- *LTC—F309: SOD Example*
- *OPT—I158: SOD Example*
- *RHC—J70: SOD Example*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-F: *Principles of Documentation* 1 Slide 2-F-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Understand the purpose of Form CMS-2567, Statement of Deficiencies & Plan of Correction. • Identify & discuss the key elements of the *Principles of Documentation.* 2 Slide 2-F-2	*(Inform the students of the objectives.)*
Learning Objectives (cont.) • Write clear, concise & comprehensive citations. 3 Slide 2-F-3	

Audiovisual

Statement of Deficiencies

- Document written following every survey
- Records result of survey/investigation
  - Follow survey process
  - Thoroughly investigate
  - Document findings with all required information

4

Slide 2-F-4

During the Survey

- To write Statement of Deficiencies, 3 elements must be completed:
  - Gather enough strong evidence
  - Differentiate finding & deficient practice or noncompliance
  - Based on regulation or requirement, recognize what entity failed to do

5

Slide 2-F-5

Outline or text of presentation

The Statement of Deficiencies (SOD) is a document written by surveyors following every survey of a facility. This includes initial, recertification, revisit, and complaint surveys and validation surveys of accredited providers.

This is the document that records the result of your survey—your investigation. Therefore, it cannot be emphasized enough that if you have not followed the survey process and thoroughly investigated and documented your findings with all required information, you will find it extremely frustrating to write the Statement of Deficiencies using the *Principles of Documentation*.

To write a Statement of Deficiencies, three elements must be completed:

- Gather enough strong evidence.
- Differentiate finding and deficient practice or noncompliance.
- Based on a regulation/requirement, recognize what the entity failed to do.

Don't wait until near the end of the survey. If you suspect a problem, get out the regulations, identify the potential deficiency and read the Interpretive Guidelines. Make notes about further investigation. Discuss it with the team and follow through with the investigation.

The problem in completing Form CMS-2567, Statement of Deficiencies and Plan of Correction, is not when you found the entity in compliance with all regulations. The problem is when you found evidence of noncompliance.

The Statement of Deficiencies is not the place to write your assumptions. It is where you write the facts and how those

Audiovisual

Outline or text of presentation

facts worked together to show that the facility was not in compliance with the regulation.

Note-Taking Tips

- Follow general guidelines
  - Record details
  - Use plain language
  - Be objective (surveyor notes are "discoverable")
- Organize notes
  - Make lists
  - Use columns or outlines

6

Slide 2-F-6

Note-Taking Tips

- Follow general guidelines.
  - Record details.
  - Use plain language.
  - Be objective (surveyor notes are "discoverable").
- Organize your notes.
  - Make lists.
  - Use columns or outlines.

Note-Taking Tips (cont.)

- Record observations
  - Record date & time (beginning & ending)
  - Note location
  - List individual(s) present
  - Summarize activity

7

Slide 2-F-7

- Record observations.
  - Record date and time (beginning and ending).
  - Note location.
  - List individual(s) present.
  - Summarize the activity.

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Note-Taking Tips (cont.)

- Document interviews
  - Record date & time (beginning & ending)
  - Specify location
  - List name & title of interviewee(s)
  - Summarize key points
  - Record direct quotes

8

Slide 2-F-8

Outline or text of presentation

- Document interviews.
  - Record date and time (beginning and ending).
  - Specify location.
  - List name and title of interviewee(s).
  - Summarize key points.
  - Record direct quotes.

Note-Taking Tips (cont.)

- Review documents
  - Source & date document written
    - Include time if included on document
  - Type of document
  - Date & time copies are made
  - Pertinent information

9

Slide 2-F-9

- Review documents.
  - Source and date document written.
    - Include time if included on document.
  - Type of document.
  - Date/time copies are made.
  - Pertinent information.

Note-Taking Tips (cont.)

- Quality of survey documentation influences later deficiency writing

10

Slide 2-F-10

In essence, the quality of your documentation recorded during the survey has a direct relationship to the information you will have to write any deficiency.

When you are finished with a survey, review your notes and ask yourself, “If I had to testify about this survey six months from now, would I be able to review my notes and re-create that survey?” The more strongly you can say, “Yes!” the easier it will be for you to write the Statement of Deficiencies.

Audiovisual

Writing SOD

- Each team member writes findings unless team decides otherwise
  - Use ASPEN
  - Before you write, know office or team writing standards
  - Check
    - Spelling & grammar
    - *Principles of Documentation*
    - Coherence of story

11

Slide 2-F-11

Outline or text of presentation

Team Members

Each team member writes his/her own findings unless mutually agreed otherwise.

- Use Automated Survey Processing Environment (ASPEN).
- Before you write, know your office or team writing standards. (*Distribute and discuss the handout "Tips for Writing the Statement of Deficiencies" on page 2-F-31.)*
- Check:
  - Spelling and grammar.
  - *Principles of Documentation*.
  - Coherence of story.

(Either divide students into small groups and have them correct a portion of the handout "Owed to the Spell Checker" on page 2-F-33 or have individuals read a portion aloud.)

Team Coordinator Responsibilities

- Team coordinator reviews:
  - Findings written at appropriate tag number & noncompliance supported
  - Clarification or revision from team members
  - Spelling & grammar
  - Adherence to *Principles of Documentation*
  - Document coherence
  - Consistency

12

Slide 2-F-12

The Team Coordinator

The team coordinator is then responsible for putting all the pieces together in a coherent manner.

- Ensures findings are written at appropriate tag number and noncompliance is supported.
- Requests clarification or revision from team members.
- Checks spelling and grammar.
- Checks for adherence to the *Principles of Documentation*.
- Ensures document is coherent.
- Ensures consistency.

Audiovisual

Form CMS-2567

- Statement of Deficiencies & Plan of Correction
  - Basis for certification/enforcement decision
  - Communication to provider
  - Legal document
  - Public record

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Outline or text of presentation

Form CMS-2567

- Statement of Deficiencies and Plan of Correction.
  - Basis for certification/enforcement decision.
  - Communication to the provider.
  - Legal document—would be submitted as evidence for a hearing or in court to defend any certification or enforcement action.
  - Public record—the Statement of Deficiencies and Plan of Correction (Form CMS-2567) is available to the public or media (e.g., newspaper and television) under the Freedom of Information Act.

Cause and Effect

The *Principles of Documentation* were written as an answer to a problem.

In 1990, Federal surveyors conducted over 150 surveys in long term care facilities within about a month. Afterward, they submitted all the Statements of Deficiencies to a team for review before they were issued to the facilities. The review team represented Federal surveyors and management staff from Federal Regional Offices throughout the United States. The review found inconsistencies in the manner the surveyors wrote deficiencies. As a result, the Centers for Medicare & Medicaid Services researched and issued the first *Principles of Documentation* reference. It was later modified to the version that was issued in the year 2000.

(Refer students to the "Principles of Documentation," included as a handout on page 2-F-35.)

Audiovisual

Principle 1: Entity Compliance

- Involves statement of compliance or noncompliance
- If entity is in compliance, Form CMS-2567 includes specific statement
  - Example: "The We-Cure-Em Home Health Agency is in compliance with 42 CFR, Part 484, Requirements for Home Health Agencies"
  - Use correct 42 CFR number for entity surveyed

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Slide 2-F-14

Outline or text of presentation

Principle 1: Entity Compliance

- Statement of compliance or noncompliance.
- If in compliance, includes specific statement.
  - Example: "The We-Cure-Em Home Health Agency is in compliance with 42 CFR, Part 484, Requirements for Home Health Agencies."
  - Use the correct 42 CFR number for the entity surveyed. For Life Safety Code, the reference changes based on certified entity (e.g., it is different for a hospital and a nursing home).

Principle 2: Using Plain Language

- Avoid jargon
- Explain abbreviations
- Use simple sentence structure
- Inform, don't impress
- Avoid vague terminology

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Principle 2: Using Plain Language

- No jargon—if you use a term not common to the public, give the meaning. For example, what is Alzheimer's disease, a sheet pan or self-abusive behavior?
- Explain abbreviations—the first time a common term appears in *each* deficiency, place the abbreviation behind it in parentheses. Remember to do this for director of nursing, registered nurse, certified nursing aide, etc.
- Use simple sentence structure—use the KISS method (i.e., keep it short and simple).
- Inform, don't impress—again keep it simple.
- Avoid vague terminology: "seems," "appear," "potential."

Audiovisual

Principle 2: Using Plain Language (cont.)

- Don't include:
  - Advice or consultation
  - Extra/extraneous information
  - Compliments or derogatory remarks
- Use active voice

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Slide 2-F-16

Outline or text of presentation

- Don't include:
  - Advice or consultation.
  - Extra/extraneous information—for example, if you are writing about a pressure sore, include only pertinent diagnosis—don't include a patient's pacemaker if it isn't directly related to the pressure sore. If the door was unlocked, don't include how many people lived near it—only the number of individuals who could have gone out the door.
  - Compliments or derogatory remarks.
- Use active voice—"X" did something to "Y."

Active Voice

- Try to eliminate "is," "was," "been" & "be"
  - "The water temperature measured 40 degrees Fahrenheit (F)," not "The water temperature was measured at 40 degrees F."
- Make sentence subject the "actor" or "doer"
  - "The resident ate half the noon meal," not "Half of the noon meal was eaten by the resident."

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Active Voice

- The tense may be past, present or future.
- Minimize words like "is," "was," "been" and "be."
  - "The water temperature measured 40 degrees Fahrenheit (F)," not "The water temperature was measured at 40 degrees F."
- Make the sentence subject the "actor" or "doer."
  - "The resident ate half the noon meal," not "Half of the noon meal was eaten by the resident."

Audiovisual

Active Voice (cont.)

- Make each verb act directly on person or thing
  - "The wedge held the door open," not "The door is held open by the wedge."

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Outline or text of presentation

- Make each verb act directly on a person/thing.
  - "The wedge held the door open," not "The door was held open by the wedge."

Changing to Active Voice

- Change verb to noun
  - ". . . was interviewed" to "Interview revealed"
- Reinsert "doer of the action" into sentence
  - "The door was held open" to "The wedge held the door open."

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Changing to the Active Voice

- Change a verb to a noun.
  - " . . . was interviewed" to "Interview revealed."
- Reinsert a "doer of the action" into the sentence.
  - "The door was held open" to "The wedge held the door open."

Changing to Active Voice (cont.)

- Eliminate prepositional phrase after verb
  - "The entity was in violation of the requirement" to "The entity violated the requirement."

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- Eliminate a prepositional phrase after the verb.
  - "The entity was in violation of the requirement," to "The entity violated the requirement."

Audiovisual

Solutions to Common Problems

- "The facility admitted Patient 1 on . . ." or "The resident moved to the facility on . . ."
- "At [time] on [date], observation revealed . . ."
- "At [time] on [date], interview with the Food Service Director revealed . . ."
- "Review of the [date] Minimum Data Set (MDS) found the facility identified the resident to have . . ."

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Outline or text of presentation

- Solutions to common problems:
  - "The facility admitted Patient 1 on . . . ," or "The resident moved to the facility on . . ."
  - "At [time] on [date], observation revealed . . ."
  - "At [time] on [date], interview with the Food Service Director revealed . . ."
  - "Review of the [date] Minimum Data Set (MDS) found that the facility identified the resident to have . . ."

(Distribute the handouts you determine are best fitted to your students. Discuss each or have students complete the exercise or practice(s). Choose from the following:

- *"Active-Voice Sentences."*
- *"Changing Passive to Active."*
- *"Active-Voice Exercises."*
- *"Active-Voice Exercises: Answer Sheet."*
- *"Active-Voice Practice #1."*
- *"Active-Voice Practice #1: Corrections."*
- *"Active-Voice Practice #2."*

Since each student will have to write independently, it is recommended that you have each work alone to complete exercises.

When students have completed the exercise(s)/practice(s), ask them to provide active-voice correction.)

Audiovisual

Principle 3: Components of Deficiency Citation

- Regulatory reference
- Deficient-practice statement
- Relevant facts & findings

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Outline or text of presentation

Principle 3: Components of a Deficiency Citation

- Regulatory reference.
- Deficient-practice statement.
- Relevant facts and findings.

Component 1: Regulatory Reference

- Survey data tag number
- CFR or LSC reference
- Regulation language
- "Not met" statement

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Component 1: Regulatory Reference

The regulatory reference is usually already in ASPEN. However, for new regulations that have been just issued, ASPEN may not yet have been updated. Therefore, you will need to write this information under tag number 9999 in ASPEN.

- Survey data tag number.
- Code of Federal Regulations (CFR) or Life Safety Code (LSC) reference.
- Regulation language.
- "Not met" statement.

Types of Requirements

- Structure
- Process
- Outcome

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Types of Requirements

- Structure requirements—for example bylaws or policies and procedures.
- Process requirements—how the entity must function (e.g., how often care plans have to be completed in long term care).
- Outcome requirements—results expected to maintain compliance (e.g., "maintain acceptable . . ." or ". . . does not develop . . .")

Knowing the type of requirement will help you know how to investigate it and the evidence needed to cite a deficiency.

Audiovisual

Component 2:
Deficient-Practice Statement

- Sources
- Deficient practice
- Extent
- Identifiers
- Outcomes

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Outline or text of presentation

Component 2: Deficient-Practice Statement

This may be referred to as the "based on" statement.

- Sources.
- Deficient practice.
- Extent.
- Identifiers.
- Outcomes.

Sources

- Observations
- Interviews
- Document review

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Sources

- Observations.
- Interviews.
- Document review.

What were the sources of information for the deficiency? It will be extremely rare that you use only one. The more sources the better.

It is important to ask staff if they have any other documents for you to review regarding your concern. If not, record the date, time and title of the individual and include it in the deficiency. Add the source "document review" to the deficient practice statement as a source—you reviewed for it, but did not have any to review.

Audiovisual

Deficient-Practice Statement

- State what entity failed to do
  - Action(s)
  - Error(s)
  - Lack of action
- Do not repeat regulatory language
- Make direct tie to statute or regulation

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Outline or text of presentation

Deficient-Practice Statement

- State what the entity failed to do or comply with.
  - Action(s).
  - Error(s).
  - Lack of action.

"Failed to"—provide, assure, prevent, assess, etc.

You can have several different deficient practices under the same regulation. For example, for the long term care regulation, the facility must "store, prepare, distribute and serve food under sanitary conditions." Deficient practices could include:

- "The facility staff failed to wash hands to minimize the potential of food-borne illness, following accepted standards of practice."
- "The facility failed to store foods and beverages in a manner that prevented contamination from rodents."
- "The facility failed to maintain perishable foods and beverages at temperatures that minimized the growth of bacteria."

All potentially could be cited at the same facility during the same survey at the same tag number.

When you have different deficient-practice statements:

- Each is easier to write than jumbling a number of different problems under one deficient practice.
- It makes it easier both for the facility to provide a Plan of Correction and for surveyors to determine compliance at the time of the revisit.
- Do not repeat regulatory language.

Audiovisual

Outline or text of presentation

For some regulations it is going to be difficult to write the deficient-practice statement. However, sometimes the Interpretive Guidelines may help you think of wording.

Extent

- Actual number of:
  - Individuals
  - Days
  - Some other factor
- Relative to number of possible:
  - Individuals
  - Days
  - Some other factor

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Extent

Phrased as the actual number of individuals, days or some other factor relative to the number of possible individuals, days or some other factor.

Extent is with respect to the universe of possible numbers. For example:

- You reviewed a sample of a total of how many individuals?
  - Of those, how many did you review for this issue?
  - With how many did you identify a problem?

The extent or universe could include all three numbers, but must include at least the number you reviewed for this issue and the number for which you identified a problem.

There are a number of regulations that do not address patients or something that is easily counted. Therefore, consider:

- The number of nursing units affected.
- The number of people who live on a unit. For Life Safety Code regulations, it could be the number of individuals who live within a smoke compartment.
- The number of badly maintained doors on a certain number of floors or nursing units or on one day of the survey.
- If it has the potential to affect all individuals, say that and give the number (e.g., failure of the call light

Audiovisual

Outline or text of presentation

system or computers when all medical records are accessible via computer).

Unique Identifiers

- Be sure references maintain confidentiality
- Use gender-neutral identifier
  - He/she
  - Individual
  - Resident/Patient/Client

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Unique Identifiers

- Be sure references maintain confidentiality.
- Use gender-neutral identifiers:
  - He/she.
  - Individual.
  - "The" or "a" resident/patient/client.

Do not use something publicly identifiable, such as a medical record number or social security number. Never refer to a person by the number of the room where he/she is located.

Outcomes

- Describe result or consequence
- Include actual negative outcomes
  - Deterioration
  - Failure to improve, maintain or implement
- Realize not all regulations have evident outcomes

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Outcomes

The "So what?" should reflect the actual outcome and the harm the patient/resident received from the failed practice or the potential for harm and outcome.

- Include the result or consequence.
  - Deterioration.
  - Failure to improve, maintain or implement.
- Realize not all regulations have evident outcomes.

Component 3:
Relevant Facts & Findings

- Answer "W" questions:
  - Who?
  - What?
  - When?
  - Where?
  - How?

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Facts and Findings

- Answer the "W" questions:
  - Who?
  - What?
  - When?
  - Where?
  - How?

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Component 3:
Relevant Facts & Findings (cont.)

- Consist of:
  - Observations
  - Interviews
  - Review of documents
    - Include at least 2 of 3
- Are listed in chronological order
- Include source of information

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Outline or text of presentation

- Consist of:
  - Observations.
  - Interviews.
  - Review of documents.
    - Include at least two of the three.
- Are listed in chronological order, not the order in which you discovered them.
- Include the source of the information for each finding.

The evidence should be self-evident. If you have to reread it because you have forgotten the deficient practice, review and revise it so the evidence is more self-evident.

Organize the examples for different patients/residents by considering:

- Severity: the one with the worst outcome always goes first.
- Topic or concept.
- Unit (e.g., nursing unit or floor).
- Chronological order.

It should be in *logical* order.

Observations

- Refer to information from 5 senses
- Include:
  - Date & time (beginning & ending)
  - Location
  - Participant-unique identifier
  - Actions &/or outcomes

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Observations

- Refer to information from the five senses.
- Include:
  - Date and time (beginning and ending).
  - Location: Use the term used by the facility, room number as long as it does not refer to a patient/resident.
  - Participant-unique identifier.
  - Actions and/or outcomes.

If appropriate, ask staff a question to verify what you observed.

Audiovisual

Interviews

- Refer to information from talking to people
- Consist of:
  - Date & time
  - Participant-unique identifier
  - Information obtained
    - Quote (…stated, "[ ]")
    - Paraphrase (stated that…)
- May be confidential

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Document Reviews

- Refer to information from reading & analyzing
  - Clinical records
  - Administrative records
- Consist of
  - Type of document
  - Date of document
  - Information

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Outline or text of presentation

Interviews

- Refer to information from talking to people—patients/residents, family, visitors, staff and management.
- Consist of:
  - Date and time (beginning and ending).
  - Participant-unique identifier.
  - Information obtained.
    - Direct quote: Place the exact quotation in double quotation marks. Example: the supervisor stated, "[ ]."
    - Paraphrase ("stated that . . .")
- May be confidential.

The *Principles of Documentation* state that the surveyor should record the date and time and add, "in a confidential interview . . ." However, if the individual asks not to be identified, ask whether that person knows anyone else who would talk to you about the subject. Furthermore, attempt to validate the information through observations and document review and an interview from another individual.

Document Reviews

- Refer to information from reading and analyzing:
  - Clinical records.
  - Administrative records.
- Consist of:
  - Type of document.
  - Date of document.
  - Information.

You can summarize information, for example, "Review of [name of document] from beginning date] to [ending date] revealed . . ."

Audiovisual

Outline or text of presentation

If the document is not dated, say it.

SODs are written for a serious audience that may or may not be well informed about the subject manner. Use a *strictly impersonal voice*. SODs should not refer to your opinions or feelings. They should have only the actual observations, interview results and record reviews. They should be deliberately neutral in tone—"let facts speak for themselves."

If the facts cannot "speak for themselves," then perhaps you did not gather enough evidence, or perhaps the evidence gathered was not strong. Review and ask if additional observations or interviews could have provided stronger evidence.

Talk to your teammates. Many times some investigated and have a piece of evidence that will strengthen what you are writing. Remember, a team is always stronger than one individual.

Principle 4: Relevance of Onsite Correction of Findings

- Cite as usual, corrected or not
  - Facility might not correct
- Facility may add correction to Form CMS-2567
- Immediate Jeopardy correction—follow Appendix Q

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Principle 4: Relevance of Onsite Correction of Findings

- Cite as usual, whether corrected or not.
  - Facility might not correct.
- Facility may add correction to Form CMS-2567.
- Immediate Jeopardy correction—follow Appendix Q.

Facilities are to be in compliance at all times. If you identify a deficiency and tell the facility, cite it regardless of whether the entity corrects it during the survey. The facility can provide the Plan of Correction and the date the deficiency was corrected on Form CMS-2567 when it receives the deficiency.

Audiovisual

Principle 5: Interpretive Guidelines

- Designed for:
  - Better understanding
  - Consistent application
  - Pathways of inquiry
- Not requirements that need to be met
- May include professionally recognized standards
  - Include reference to standard

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Outline or text of presentation

Principle 5: Interpretive Guidelines

- Designed for:
  - Better understanding.
  - Consistent application.
  - Pathways of inquiry.
- Not requirements that need to be met.
- May include professionally recognized standards.
  - Include the reference to the standard in the finding.

Principle 6: Citation of State or Local Code Violations

- Cite on Form CMS-2567 if:
  - Federal regulation requires compliance
  - State or local authority determines noncompliance
- Use more restrictive requirement

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Principle 6: Citation of State or Local Code Violations

- Cite on Form CMS-2567 if:
  - Federal regulation requires compliance.
  - State or local authority determines noncompliance.
- Use the more restrictive requirement.

Principle 7: Cross-Reference

- Each tag cited must stand alone
- Link to another should:
  - Provide added support
  - Show cause/effect relationship
  - Support Conditions of Participation/Coverage citation

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Principle 7: Cross-Reference

- Each tag cited must stand alone.
- Link to another should:
  - Provide added support.
  - Show cause/effect relationship.
  - Support Conditions of Participation/Coverage citation.

Each deficiency must stand alone so that if one is thrown out, it will not result in other deficiencies' also being thrown out.

The deficient practice for each deficiency is different. Therefore, the findings must not be repeated from one citation to

Audiovisual

Principle 8: Conditions of Participation/Coverage Deficiencies

- Written same as other deficiencies
- Include only practices that must be corrected to no longer have a Conditions of Participation/Coverage deficiency
- May reference subsidiary requirements

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Outline or text of presentation

another. Although you may copy the findings from one deficiency and paste them into another, you must reevaluate the findings and tailor them to each deficiency.

Principle 8: Conditions of Participation/Conditions of Coverage Deficiencies

- Written same as other deficiencies.
- Include only practices that must be corrected to no longer have a Conditions of Participation/Conditions of Coverage deficiency.
- May reference subsidiary requirements.

(Determine which of the following handouts will meet the needs of your students. Distribute and review as needed. For scenarios, have each student work independently while coaching him/her to write a deficiency.

- *"Principles of Documentation Summary Sheet," page 2-F-97.*
- *"SOD Worksheet," page 2-F-99.*
- *"Principles of Documentation for Statement of Deficiency (CMS-2567) Review," page 2-F-101.*
- *"ICF/MR Practice Sample #1," page 2-F-103.*
- *"ICF/MR Practice Sample #2," page 2-F-105.*
- *"HHA—G277: Scenario and SOD Example," page 2-F-107.*
- *"LSC—K038: Scenario and SOD Example," page 2-F-113.*
- *"LTC—F314: Scenario and SOD Example," page 2-F-117.*
- *"LTC—F316: Scenario and SOD Example," page 2-F-125.*
- *"ESRD—V449: SOD Example," page 2-F-131.*

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	• *"HHA—G158: SOD Example," page 2-F-133.* • *"Hospice—L125: SOD Example," page 2-F-135.* • *"Hospital—A350: SOD Example," page 2-F-137.* • *"ICF/MR—W249: SOD Example," page 2-F-139.* • *"LSC—K021: SOD Example," page 2-F-141.* • *"LSC—K051: SOD Example," page 2-F-143.* • *"LTC—F309: SOD Example," page 2-F-145.* • *"OPT—I158: SOD Example," page 2-F-147.* • *"RHC—J70: SOD Example," page 2-F-149.* *When each handout has been completed, have either the student or you, the trainer, review it using either a review form provided or your office form. Optionally, compare it with the State Performance Standard #2 for the current year [see Lesson 2-K].)* Documentation is a challenging task for several reasons. It is difficult to put perceptions into words. A lot of what you experience on a survey is based upon a combination of senses, and the overall feeling and conclusions that you reach about a facility can be very perceptual in nature. A surveyor described the task of documentation as "painting a picture in words." You need to relay your gut feelings in a written form and make a convincing case for your citation.

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	Surveyors describe how frequently they spend a large amount of time on the write-up and end by feeling that they have a strong case, only to find out later that the office did not agree. Examples or even whole deficiencies may be deleted and (in long term care) the scope and severity may change if you do not investigate and gather the information to support a deficiency citation. The surveyors were not able to communicate their feelings effectively in the documentation. Frequently surveyors say, “It’s difficult to relay what we’re feeling on paper.” Writing a “good” Form CMS-2567 can be difficult. You may inadvertently neglect to include information because certain things were so obvious to you that it did not occur to you to write them down. People reading the citation may have questions that you didn’t even think to address in the citation because you were there and it was so obvious to you. However, learning to survey is just that—a learning process. Overall, surveyors feel that documenting immediate-jeopardy cases is the most challenging because of the need to provide sufficient detail to fully support the citation. It’s difficult to write a jeopardy case. Usually when writing a citation, you want to be as brief and to the point as possible. However, with jeopardy it’s the opposite. You have to include all the details, so deficient-practice statements involving immediate jeopardy are usually very long.

Audiovisual

Outline or text of presentation

Copying Documents

Make a copy of documents that may be helpful in writing a deficiency and supporting facility noncompliance.

(Discuss the office procedures for copying, paying for copies, appropriate charge for each page and documentation of who provided the document at what time and on what date.)

Report writing is a difficult skill for most of us to develop, and it is different from other types of writing you may have done.

Remember:

- Your deficiencies will always be reviewed by the team coordinator and then by a supervisor. New eyes always find it easier to review a deficiency and see information that may be missing or what may be needed to make a stronger deficiency.
- It is normal even for experienced surveyors to be questioned and have to rewrite a deficiency.
- Do not become defensive, but learn what information is needed and vow to do a better job gathering the information next time.

Lesson 2-F:
Principles of Documentation

Questions

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Skill Assessment

Principles of Documentation

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					1. Wrote deficiencies following the *Principles of Documentation*: A. Clearly documented observations, interviews and record review information for who, what, when, where and how. B. Used language that clearly identified harm or potential harm. C. Followed the *Principles of Documentation* and State/Regional Office–directed format. *Note*: List any specific principle the trainee seems to have a problem with at the time this skill assessment is completed. Include recommendations for improvement if necessary.	

					2. Spelling, punctuation and grammar followed good writing practice.	
					3. Wrote in a manner specific enough to allow a reasonably knowledgeable person to understand the deficient practice and findings that supported noncompliance.	
					4. If information was identified during a confidential interview, the surveyor followed the *Principles of Documentation* when completing Form CMS-2567.	

Comments/Recommendations:

Tips for Writing the Statement of Deficiencies

Determine:

1. Who will write each deficient practice.

2. How to write the following:
   - The deficient practice statement (this includes the portion "Findings include:" or "The findings included:" or other).
   - Dates (e.g., 02/01/2005 or 2/1/05 or February 1, 2005, or other).
   - Time of day (e.g., 2:59 a.m. or 0259 or other).
   - Unique identifiers
     - Patients, residents or other (Patient #2 or patient 2 or other).
     - Staff (Director of Nursing or Licensed Nursing Staff A).

3. Who will read each other's work (if someone other than the team coordinator).

Owed to the Spell Checker

I have a spelling checker—
It came with my PC.
It plane lee marks four my revue
Miss steaks aye can knot sea.

Eye ran this poem threw it.
Your sure reel glad two no
It's vary polished in it's weigh—
My checker tolled me sew.

A checker is a bless sing.
It freeze yew lodes of thyme.
It helps me awl stiles two read,
And aides me when aye rime.

To rite with care is quite a feet
Of which won should be proud.
And we mussed dew the best wee can,
Sew flaws are knot aloud.

And now bee cause my spelling
Is checked with such grate flare,
There are know faults with my cite;
Of non eye am a wear.

Each frays come posed up on my screen
Eye trussed to be a joule.
The checker poured o'er every word
To cheque sum spelling rule.

That's why aye brake in two averse
By righting wants too pleas.
Sow now ewe sea why aye dew prays
Such soft wear for pea seas!

—Anonymous

EXHIBIT 7A

PRINCIPLES OF DOCUMENTATION

NOTE: Principles of Documentation are merely guidance for surveyors and do not impose obligations on either providers or surveyors for the suggestions contained in them.

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- Principle #2 - Using Plain Language
- Principle #3 - Components of a Deficiency Citation
  - A - Regulatory Reference
  - B - Deficient Practice Statement
  - C - Relevant Facts and Findings
- Principle #4 - Relevance of Onsite Correction of Findings
- Principle #5 - Interpretive Guidelines
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- Exhibit 1-1 - Effective Documentation for Principle #1
- Exhibit 1-2 - Effective CMS-2567L Documentation for Nursing Homes With an A level finding

Principle #2 - Using Plain Language

Principle #3 - Components of a Deficiency Citation

- Regulatory Reference
- Requirements
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Identifiers
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Exhibit 3-3 - Effective Documentation of Observation-Based Findings
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Appendix A - Components to be Documented in A Deficiency Citation

Introduction

This appendix provides guidance on how to structure a deficiency statement on the Form CMS-2567 after all the necessary information and evidence have been gathered. These guidelines include a general discussion of the legal aspects of the Statements of Deficiencies and identify and explain the principles considered in the citation of deficiencies to be documented on the Form CMS-2567. The principles are generic and apply to the documentation of survey results regardless of the particular program (Medicare, Medicaid or the Clinical Laboratory Improvement Amendments) or the particular provider or supplier type.

This guide does not replace or supersede the law, regulations, or State Operations Manual (SOM). Rather, this appendix is intended to provide guidance for documenting citations. Therefore, this appendix does not create additional substantive or procedural requirements that must be present to sustain a valid citation.

The CMS-2567 is the record of the survey where the survey team documents and justifies its determination of compliance and informs the provider or supplier of its state of compliance with the requirements for participation in the Federal programs. This information will serve as the basis for the facility to analyze its deficient practices or system failures and to develop plans of correction. The CMS-2567 may also document deficient practices identified by means other than an onsite survey, e.g., a review of compliance with the requirements to transmit comprehensive assessments to the State Agency.

Each principle is discussed in depth and includes an example of that principle. Each example is identified as being effective and is included to illustrate a particular documentation principle and may not represent a complete citation. In each case, there may be other language that may be as effective. The adequacy of any citation can be evaluated only in the context of the particular type and source of evidence, the extent and consequence of deficiency, and other relevant factors.

Definitions

Listed below are definitions that will be used throughout these materials.

COP - an abbreviation that commonly refers to a " condition of participation." COP also is used throughout this manual to refer to a "condition for coverage" relevant to suppliers. The Conditions of Participation are requirements with which an entity must comply in order to participate in the programs.

Deficiency Citation - an entry made on the Form CMS-2567 that includes: (1) the alpha prefix and data tag number, (2) the Code of Federal Regulations (CFR), or Life Safety

Code (LSC) reference, (3) the language from that reference which pinpoints the aspect(s) of the requirement with which the entity failed to comply, (4) an explicit statement that the requirement was "NOT MET" and (5) the evidence (the deficient entity practice statement and relevant individual findings or facts) to support the decision of noncompliance (see Exhibit 0-1).

Deficient Practice - the action(s), error(s), or lack of action on the part of the entity relative to a requirement (and to the extent possible, the resulting outcome). ("practice" and "entity practice" are used interchangeably throughout this manual.)

Deficient Practice Statement - a statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulation.

Entity - a generic term used to describe providers and suppliers under the Social Security Act or laboratories that participate in the CLIA program.

Evidence - an integral part of the citation that begins with a description of the deficient entity practice and identifies the relevant individual findings and facts that substantiate the failure of the entity to comply with the regulation.

Extent of deficient practice - the prevalence or frequency of a deficient entity practice.

Finding - a generic term used to describe each discrete item of information observed or discovered during the survey about practices of an entity relative to the specific requirement being cited as being not met.

Fact - an event known to have actually happened. A truth known by actual experience or observation.

Forms CMS-2567/CMS-2567L Statement of Deficiencies and Plan of Correction - the official document on which citations are recorded (see Appendix A).

Outcome - a result/consequence of entity practices (e.g., development of avoidable pressure sore/ulcer; reaction due to receipt of blood of wrong blood type.).

Recipient - one who receives services (a patient, resident or a client) from an entity regardless of whether or not that person is eligible for, or is receiving, Medicare or Medicaid.

Requirement - any structure, process or outcome that is required by the law, regulations, or the Life Safety Code (LSC).

S/S - In the LTC survey, symbol accompanied by a unique letter (A through L) that illustrates the effect of the noncompliance on the nursing home resident (severity) and the number of residents actually or potentially affected (scope) by the provider's

noncompliance. The symbol with the letter assigned to the noncompliance appears under the tag number on the Form CMS-2567L for nursing homes. (See Appendix P).

Universe - the total number of individuals, records, observations, objects, related to the entity practice or recipients at risk as a result of a deficient practice. Used as the denominator when determining the extent of a deficient practice.

Appendix P - Guidance to Surveyors - Long-Term Care Facilities

Appendix Q - Guidelines for Determining Immediate and Serious Threat to Patient Health and Safety

Legal Aspects of the Statement of Deficiencies

The survey and certification of an entity that participates in Medicare, Medicaid or the Clinical Laboratory Improvement Amendments (CLIA) of the Public Health Service Act, is a process that must adhere to legal requirements. These programs are administered under extensive laws, regulations, operation manuals and other guidelines. Surveys and the documentation from surveys become an important part of subsequent legal proceedings arising out of the certification process.

This section is a brief overview of the legal aspects of surveying and the importance of surveyor documentation to the decision making and appeals process. It is not intended to provide complete and detailed information on the mechanics of the process. Please refer to the State Operations Manual (SOM) for more detailed information.

The survey process determines, and the documentation records, the compliance or noncompliance of providers, suppliers, and CLIA laboratories. The surveyor provides the reasons justifying any resulting enforcement action and the record on which to defend that action in the appeals process. Consistent and accurate documentation is imperative in the entire certification process as it forms the basis for the record and the certification decision. Moreover, the documentation may also be reviewed in any subsequent appeal, i.e., reconsideration, hearing before an Administrative Law Judge (ALJ) of the Departmental Appeals Board (DAB), review by the Board's Appellate Division, and judicial review.

A certification of compliance or noncompliance with the applicable requirements by the State agency or the Federal Government is an official finding and determines whether or not the provider or supplier may participate in the Medicare or Medicaid program or whether a laboratory is issued a certificate to operate under CLIA. It also determines whether any of these entities are subject to other sanctions. The decision-making process and subsequent certifications are based on the documentation of the survey in the Statement of Deficiencies (Form CMS-2567), as well as, other documentation such as surveyor worksheets or notes.

A prospective provider, supplier or clinical laboratory may request a reconsideration of a

determination that it does not qualify to participate in the Medicare/Medicaid program. A formal reconsideration is a thorough, independent review of the prior decision and the entire body of evidence. If the reconsideration determination upholds the initial decision, the entity may request an evidentiary hearing before an ALJ.

If an entity is determined to no longer meet the requirements and is subject to termination or alternate remedies/sanctions, the actual or projected termination or remedy may be appealed through an evidentiary hearing before an ALJ. If a laboratory's certificate is subject to limitation, suspension, revocation, or is actually limited, suspended, or revoked, the actual or projected limitation, suspension or revocation may be appealed through an evidentiary hearing before an ALJ. During a hearing, the government has the responsibility to show why a provider or supplier should be terminated or be subject to alternate remedies, and/or a laboratory's certificate should be limited, suspended or revoked.

The evidence must provide the underlying reason, basis or rationale for the findings of noncompliance with the regulatory requirement(s). Such a hearing is an adversarial proceeding. At the hearing, witnesses testify for both the entity and for CMS, and are subject to cross-examination. The primary evidence is the Form CMS-2567, and any other documentation used to make the determination of survey results (e.g., worksheets, narratives, etc.). The ALJ relies on the testimony of witnesses and the documentation from the survey in making a decision. All documentation used at the hearing becomes part of the public record. The ALJ issues a written decision as to whether or not the entity should be found in compliance with the requirements of the program. The ALJ is usually not a health professional, therefore, it is important that the surveyor present the findings in plain language. For this reason, the Form CMS-2567 does not contain technical jargon or abbreviations that would not be readily understood by a lay person.

If either CMS or the entity is dissatisfied with an ALJ decision or dismissal, it may file a request for review to the DAB Appellate Division. The DAB considers the evidence introduced at the ALJ hearing to determine whether the ALJ's decision had a sound factual basis. An entity dissatisfied with the DAB decision has the right to seek judicial review, CMS does not. The survey documentation again becomes an important document of the proceedings. The review by the Court is limited to the record of the proceedings before the ALJ and the DAB's Appellate Division.

Documentation on the Form CMS-2567 remains the key element in the record to support a determination to certify compliance or noncompliance with applicable requirements and, if necessary, to defend the determination before the public, during the appeals process, or in court. The documentation of each and every survey should be treated as if it will be subject to close scrutiny. The determination of compliance, as well as noncompliance must be based on objective, factual observations and not vague conclusions. A judge will usually rely on surveyor judgment if the documentation is thorough and comprehensive.

If, during the course of the survey, information/evidence involving recipient outcomes is discovered, surveyors should make every effort to relate the deficiencies to the effect on the recipient and recipient's care. Citations must relate to the statutory or regulatory requirements.

In addition, a clear and comprehensive Statement of Deficiencies is necessary to provide the entity with the information necessary to analyze its problems, define appropriate corrective action and come into compliance with the requirements.

Overview

Listed immediately below for easy reference are the principles considered in the development and completion of the Form CMS-2567. Following this listing, each principle is explained in detail in a separate section.

Principle #1 - Entity Compliance and Noncompliance

When an entity complies with the requirements applicable to the survey conducted, the Form CMS-2567 should consist of an explicit statement that the entity is in compliance. If an entity does not comply with one or more applicable requirements, the Form CMS-2567 includes corresponding citations of noncompliance.

Principle #2 - Using Plain Language

The deficiency citation is written clearly, objectively and in a manner that is easily understood. The deficiency citation does not include consultation, advice, comments or direction aimed at the surveyed entity.

Principle #3 - Components of a Deficiency Citation

A deficiency citation consists of (A) a regulatory reference, (B) a deficient practice statement and (C) relevant findings.

A - Regulatory Reference

A Regulatory Reference includes the following components:

1. A survey data tag number,
2. The CFR or LSC reference,
3. The language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant.
4. An explicit statement that the requirement was "NOT MET."

B - Deficient Practice Statement

The statement of deficient practice is one component of the evidence. It includes:

1. The specific action(s),error(s), or lack of action (deficient practice),
2. Outcome(s) relative to the deficient practice, when possible
3. A description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases,
4. The identifier of the individuals or situations referenced in the extent of the deficient practice, and
5. The source(s) of the information through which the evidence was obtained.

C - Relevant Facts and Findings

The facts and findings relevant to the deficient practice, answer the questions: who, what, where, when, and how. They illustrate the entity's noncompliance with the requirement or regulation.

Principle #4 - Relevance of Onsite Correction of Findings

If, during the survey, the entity corrects the situation that resulted in the deficiency, a determination of "NOT MET" must be documented on the Form CMS-2567. The entity may indicate its correction in the right-hand column of the Form CMS-2567. If, during the survey, the entity initiates corrective actions that abate a finding of immediate jeopardy, follow the guidance described in Appendix Q.

Principle #5 - Interpretive Guidelines

The deficiency citation explains how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements.

Principle #6 - Citation of State or Local Code Violations

The entity's failure to comply with State or local laws or regulations is not documented in the Form CMS-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has effectuated an adverse action that has been sustained through the hearing process (such as removal of the license to operate), the Form CMS-2567 should note that the entity no longer has a license.

Principle #7 - Cross-References

The cross-referencing of requirements is an acceptable form of documentation on the Form CMS-2567 only when it is applicable and provides additional strength to the linked citations. Cross-referencing is most effective when the linked citations have a direct cause and effect relationship to the deficient practices described in both citations. In all instances, the linked citation must contain sufficient evidence to demonstrate noncompliance for the referenced regulation at the linked site.

Principle #8 - Condition of Participation Deficiencies

The COP citation includes deficient practice statements and findings to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings.

Principle #1 - Entity Compliance and Noncompliance

When an entity complies with the requirements applicable to the survey conducted, the Form CMS-2567 should consist of an explicit statement that the entity is in compliance for that particular survey. If an entity does not comply with one or more applicable requirements, the Form CMS-2567 includes corresponding citations of noncompliance. The statutes and implementing regulations are the legal authority for determining an entity's compliance with Federal requirements for participation or coverage in Medicare, Medicaid, and CLIA.

The Form CMS-2567 is the official document that communicates the determination of compliance or noncompliance with the Federal requirements. Also, it is the form that an entity uses to submit a plan to achieve compliance. It is an official record and is available to the public on request.

Exhibit 1-1 illustrates how to give official notice to the provider or any other interested parties of the compliance status of the entity when the surveyor has identified no deficiencies. The specific requirements with which the entity must comply, as contained in Title 42 of the Code of Federal Regulations (CFR), are included.

Exhibit 1-1 - Effective Documentation for Principle #1

Tag	Summary Statement of Deficiencies
G 000	The [Name] Home Health Agency is in compliance with 42 CFR Part 848, Requirements for Home Health Agencies.

If a nursing home has no deficiencies identified at the time of the survey, the entry on the Form CMS-2567 would read that the NH is in compliance with 42 CFR Part 483, "Requirements for Long Term Care Facilities."

For SNF/NF, if the provider's noncompliance is isolated and does not pose a risk of more than minimal harm (S/S=A), the deficiency is documented on the "A" Form - "Statement of Isolated Deficiencies Which Cause No Harm With Only A Potential For Minimal Harm for SNFs and NFs." (See Appendix Q?) In addition, the documentation on the Form CMS-2567L would state the SNF/NF is in substantial compliance.

Exhibit 1-2 - Effective CMS-2567L Documentation for Nursing Homes With an A level finding

Tag	Summary Statement of Deficiencies
F 000	The [Name] Nursing Home is in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities

If a nursing home is in substantial compliance but has deficiencies, other than the Isolated Deficiencies which Cause No Harm with Only A Potential For Minimal Harm (S/S=B, C), the deficiencies are documented on the Form CMS-2567L and no additional language regarding substantial compliance is entered on the Form CMS-2567L.

NOTE: The remainder of the principles of documentation address how to document citations, that is, situations in which the entity has been found not to comply with one or more requirements.

Principle #2 - Using Plain Language

The deficiency citation is written clearly, objectively and in a manner that is easily understood. Each deficiency citation relates to a requirement within the CFR or the LSC. The deficiency citation should contain only the evidence to support the determination of noncompliance. Exclude the use of consultation, advice, comments or directions aimed at the surveyed entity. The deficiency citation should contain only the evidence to support the determination of noncompliance.

Inclusion of extraneous comments or consultative remarks in citations may lead to confusion. The entity surveyed and the public may not be able to distinguish between what the survey team would like to see and what is legitimate evidence of noncompliance. To decrease confusion, documentation in the Form CMS-2567 contains only the citation and evidence to support the determination on noncompliance. Extraneous information that is not relevant to demonstrating noncompliance with the specific requirement should be avoided.

An example of an extraneous remark would be: When documenting a deficient practice of failure to complete a care plan, a comment regarding the Resident's lack of knowledge regarding her Medicaid benefits is included. The Resident's knowledge regarding her Medicaid benefits has no relevance to the deficient practice regarding the care plan and only confuses the reader.

The language used to write a deficiency citation should be as clear as possible. Many styles of writing are acceptable, and style is a matter of individual preference; however, surveyors should not use slang, unfamiliar terms and phrases.

Best practice is to:

- Put all relevant facts in chronological order.
- Keep sentences short.
- Use simple sentence structure.
- Use the active voice (e.g. "The DON reprimanded the CNA" not "the CNA was reprimanded by the DON.").
- Avoid undefined abbreviations, initials and technical jargon.
- Write in layman's terms.
- Write to inform, not impress.
- Avoid unnecessary words.
- Avoid vague terminology (such as, seems, appears, did not always).
- Avoid words that imply or state conclusions without including the facts to support them (e.g., "only," "just," "unsatisfactory," "unnecessary," or "inadequate").
- Ensure the accuracy of quoted material.

According to "Strunk and White," When you become hopelessly mired in a sentence, it is best to start fresh; do not try to fight your way through against the terrible odds of syntax. Usually what is wrong is that the construction has become too involved at some point; the sentence needs to be broken apart and replaced by two or more shorter sentences."

Principle #3 - Components of a Deficiency Citation

A deficiency citation consists of (a) a regulatory reference, (b) a statement of deficient practice, and (c) relevant findings. (For SNFs and NFs, the scope and severity decision is documented in the left column under the survey data tag number.). Since all relevant information demonstrating noncompliance have been provided in the deficiency citation, conclusion or summary remarks at the end of the deficiency citation are not necessary and should be avoided.

This principle addresses **all** of the components of a complete citation.

Regulatory Reference

When the entity's practice violates a regulation or requirement, determine the regulation that the entity may have violated. Examine the language of the regulation under which a deficiency could be cited. Determine if the requirement addresses the entity's policies and procedures, actions, or inaction.

A regulatory reference is composed of: (1) a survey data tag number, (2) the CFR or LSC reference, (3) the language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant, and (4) an explicit statement that the requirement was "NOT MET."

Regardless of the computer software used to produce the Form CMS-2567, essential components of the citation: survey data tag, CFR or LSC reference, language of the requirement for that reference, and an explicit statement that the requirement was not met are generated automatically on the Form CMS-2567. Each handwritten citation should include all of those components. The deficient entity practice statement and the relevant findings then follow these components.

If the approved CMS software program for documenting deficiencies does not capture the language of the requirement being cited at a particular data tag or the specific regulatory/statutory requirement, incorporate the language for the specific aspect of the requirement being cited as being deficient.

Federal certification requirements are located at Title 42 of the Code of Federal Regulations (CFR) or in the Life Safety Code. [1] (LSC) The requirements are further coded into a series of alpha numeric data tags (e.g., F201, A53, G156, etc.) that allow essential survey information to be retrieved and analyzed to determine trends and patterns of noncompliance. The numerical order of survey data tags approximates the order of the requirements within the CFR or LSC [1].

Tag	Summary Statement of Deficiencies
F 174 S/S (A-L)	42 CFR 483.10 (k) The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This requirement is NOT MET as evidenced by:

Requirements

Federal requirements for participation or coverage can be categorized as follows:

- **Structure - requirements** that specify the initial conditions that must be present for an entity to be certified to participate and that, in general, are expected to remain as is unless there is a need for major renovation, reorganization or expansion of services. Some examples of structure requirements include:

  The agency has by-laws that **or** Each bedroom measures

- **Process - requirements** that specify the ongoing manner in which an entity must operate. They do not allow the entity discretion to vary from what is specified. Examples of process requirements include:

  The plan of care must be reviewed by **or** The physical examination is conducted on an annual basis

[1] If a LSC chapter references another chapter or NFPA reference document, the referenced chapter or document should also be cited. For instance, 1985 Life Safety Code, 13-3.5.1: Sprinkler systems shall be in accordance with Chapter 7.7-7.1: Sprinkler systems shall comply with NFPA 13, Sprinkler systems… 4-4.1: Buildings shall be sprinkled throughout the premises.

- **Outcome - requirements** that specify the results that must be obtained or events that must occur or not occur following an act. Generally, these requirements are stated in terms of the recipient's response to receipt of needed services or conditions that must result from, or are prevented by, implementing one or more processes. Example of outcome requirements include:

  The facility must ensure that a resident maintains acceptable parameters of....

  F-314: Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates they are unavoidable.

The findings document the outcomes that occurred or failed to occur or failure to assist the individual(s) to achieve optimal improvement in overall functioning or to prevent avoidable regression or loss of function. The citation documents sufficient facts to illustrate the level of harm that has occurred or may occur.

Deficient Practice Statement

The statement of deficient practice must be written in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement that is (are) not met. They are also used to identify the levels of scope and severity of the deficiency. It includes what the entity did or did not do which caused the noncompliance.

The statement of deficient practice must not repeat the regulation, but should state what the facility did that was wrong or failed to do, to let the reader know what to look for in the findings. The statement of deficient practice presents the specific action(s), error(s), or lack of action(s) relative to the requirement.

The evidence for a citation begins with a statement of deficient practice that summarizes the issues that led to the determination that the entity was not in compliance with that requirement and contains all the objective findings. The statement of deficient entity practice includes: (1) the specific action(s), error(s), lack of action (deficient practice); (2) when possible, resultant outcome(s) relative to the deficient practice; (3) a description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases; (4) the code of the individuals or situations referenced in the extent of the practice; and (5) reference to the source(s) of the information through which the evidence was obtained.

Some certification requirements state multiple expectations at a single survey data tag. The entity must maintain compliance with each facet of the requirement in order to continue participation. The failure to comply with only one expectation may be sufficient evidence for a citation of the entire requirement. The deficient practice must be described

in concise clear terms so that the entity can determine which part of the regulation it has NOT MET. The deficient practice statement should be organized and presented in a logical manner and should relate to each part of the regulation with which the entity failed to comply.

Exhibit 3-2 - Effective Documentation of Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F 455	42 CFR 483.70 (c)(1) The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care. This requirement was NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a space and the equipment required for physical therapy services for 4 of 10 sampled residents (4, 6, 7, and 10) who needed mat exercises, ambulation in parallel bars, and weight training to improve their physical functioning. Findings include:

Extent

Extent is the prevalence or frequency of a deficient practice and is a numerical quantification of the deficient practice. The extent is expressed in a numerical format by identifying the number of deficient cases within the total number of relevant cases or universe. For example, 4 of 6 residents observed during lunch. The universe may be all of the recipients provided care and services by an entity, if the failed practice affects all the recipients, e.g., when a hospital does not provide adequate maintenance of the fire alarm system. When the failed practice does not affect all the recipients of care and services provided by an entity, the surveyor must attempt to determine the relevant universe or the total number of recipients who could be affected by the failed practice. For instance: The ESRD center does not provide adequate monitoring of anti-coagulant therapy. Only those patients on anti-coagulant therapy would be affected by the deficient practice. Therefore, the universe would be the total number of patients with orders for anti-coagulants.

The surveyor then determines the number of individuals within the sample or expanded sample on anti-coagulant therapy who were harmed or could be harmed by the failed practice. Did the ESRD center fail to monitor all of those patients on anti-coagulant therapy? If not, how many were not monitored? The total number of patients affected by the failed practice divided by the total number of patients that could have been affected

by the failed practice provides a numerical quantification in percent of the extent of the failed practice.

The extent of deficient practice will depend upon whether:

1. The requirement related to all cases or individuals served by the entity;
2. Surveyors had knowledge of all cases to which the requirement applied;
3. The requirement related to a subset of all the cases or individuals served by the entity or only a sample of applicable situations or cases;
4. The deficient practice was determined through only random opportunities for discovery.

> Based on observation, the facility failed to maintain appropriate lighting standards for 7 of 12 emergency exits and failed to test pressure back flows on 2 of 2 water lines. In this example, there are 3 separate expressions of extent: the deficient practice created a potential hazard/impact on the entire recipient population, there were 12 exits and the lighting was insufficient at 7 of those 12, and 2 of 2 water lines were deficient.

- Knowledge of all cases or situations

When the deficiency is based on knowledge obtained about all applicable cases or situations, both this total and the number of cases/situations that evidenced deficiency should be recorded within the body of the citation. The following phrases illustrate a variety of acceptable measures:

> In an interview with the pharmacist at 2:00 p.m. on 5/29/XX he stated that of 98 residents at the facility for whom Haldol had been prescribed, 74 had individual program plans that had not been developed with the participation of…
>
> The hospital's pharmacy committee minutes dated 01/11/XX confirmed that of the 86 patients to whom medications are administered, 45 (approximately 53%) were identified as being unable to...
>
> Nineteen of the 20 residential living units were observed to need the following repairs:
>
> Each of the 5 seclusion rooms used by the facility

- Sample of applicable situations

  When the requirement is not applicable to all of the cases or individuals served by an entity, the extent would be developed by using only the cases or individuals with a negative outcome as a result of the deficient practice divided by the total number of cases or individuals in the sample that could have been impacted by the deficient practice. The extent of deficiency should be reported in numeric, quantified terms. For example:

  Review of records for 10 of the 60 patients who received transfusions between 7/10/XX and 9/30/XX revealed that the facility failed to monitor the vital signs for 6 of the 10 patients...

  Records for 2 of the 4 surgical patients in the recovery room at 9 AM on 1/7/XX and 3 of the additional 9 records reviewed of patients having had surgery between 12/28/XX and 1/6/XX revealed that no history and physical had been documented or dictated.

  Based on record review, and patient and staff interviews, the facility failed to complete an incident and accident report for 1 of 8 sampled patients (#6) reviewed and failed to analyze incident reports for health/safety hazards for 16 of 16 incidents reviewed.

  Based on observation, interview and record review, the facility failed to respond to residents' requests for assistance in a manner that maintained or enhanced their dignity for 5 of 9 sample residents (#5, 9, 12, 18, 24).

  Resident Assessments of 5 residents in the sample of 10 had not been evaluated by...

  For 22 of 50 clients in the sample who have current restraint programs authorized, 19 were...

- Random opportunities for discovery

When the deficiency is based on random opportunities for discovery of the problem, all of the applicable cases or situations may not be known. Surveyors may quantify their observation but may not be able to reference a total number of cases or situations that apply. Even though this procedure does not yield as precise a measure as has been discussed above, the report of measure is valid, particularly when serious outcomes of the deficiency have been observed and reported.

For example:

In 3 of 4 random observations, the facility failed to honor the resident's requested preference for an alternate meal choice (RS #1, 2, 3).

Based on record review, interview and patient observation, the staff did not recognize and failed to assess the patient for the signs and symptoms of possible fecal impaction.

During the tour of Ward J-7 on XX/XX/XX at 10:00 am, three CNAs were observed addressing residents about their incontinent and personal hygiene in the solarium using extremely loud voices that could be heard down the hall. (RS #1, 2, 3, 4).

Based on observation, on XX/XX/XX the integrity of firewalls located between 1-East and 1-West was breached by a hole measuring 5 inches…

During tour on unit on XX/XX/XX at 2:15 p.m., RS #1 was observed to be mechanically restrained to his bed in locked leather cuffs while he was asleep…

Identifiers

An individual's name must not appear in the Form CMS-2567. The identity of the recipients of deficient practice or any persons, including surveyors, who will be referred to in the report, must remain confidential. They are included in the report by indicating their identifiers, which can be letters, numbers, or a combination or both. These identifiers also appear in the statement of deficient practice and in the findings.

When the person referred to in the report is an entity staff member, the person(s) may be addressed by their position, discipline, or job title, or be assigned an identifier.

Identification of each case found to be deficient provides the entity with information necessary to evaluate the context of the problem. When the evidence refers to individual recipients, the statement of deficient entity practice should reference by identifiers.

The coding system used to indicate the recipients should be decipherable by the entity, and retrievable by the RO or SA. Whenever possible, if a revisit or follow-up survey finds noncompliance for the same individual as in the standard survey, reassign the same identifier code. If it is not possible to use the same identifier, use a different set of numbers for revisits so that in the event of a hearing, the same identifier is not used for two different recipients. Every effort should be made to protect a recipient's privacy especially regarding information gathered during an in-depth interview. Do not identify recipients or family members without their permission. If the interviewee does not wish the entity to know the source of the information provided to you, that information may be recorded on the Form CMS-2567 without an identifier. The CMS-2567 would state, 'During a confidential interview...." However, the interviewee must be told that there is no guarantee this information will remain confidential as a court may require that confidential information be disclosed. If the interviewee's identity is not disclosed to the

entity, the Form CMS-2567 must contain sufficient information for the entity to correct the deficient practice, and to contest the deficiency, if it desires.

When the deficient entity practice references personnel files or staff training, a separate coding system should be developed to identify the staff affected by the deficient entity practice without using their names.

When random observations or recipients/cases/records beyond the original sample(s) are included in a citation, an identifier should be given to the individual so that the entity may evaluate the extent of the problem or patterns and correct the deficient entity practice.

For example:

> During dining observations in an ICFs/MR, 4 non-sample random clients are observed who were not given an opportunity for incidental training during their dining experience.

After further investigation focused on the identified concern, if a citation is developed, these randomly observed clients need to be assigned an identifier so that the entity may address the deficient practice in its POC.

Examples of identifiers include:

> Sample Recipient identifiers:...for 3 of the 5 clients in the sample (Clients 2340, 5496, and 0429). Staff identifiers: (Title or Position) Based on interview with the ADON responsible for infection control, the entity failed **OR** Staff Identifier Coding System: 7 of 10 CNAs did not receive the 12 hours of in service training (So, 2, 3, 4, 7, 9, 10). Confidential Interview Identifier: Based on record review, the ESRD (entity) failed to allow patient participation in the development of the long term care plan for 4 of 10 patients (#2, 4, 5, 10). In addition a confidential interview revealed...

Sources of the Evidence

The source of evidence is the manner through which the evidence was obtained. Sources of evidence may include: observation, interview, and record review. They contain specific information regarding the who, what, when, where, and how of the events(s) or situation(s) that contributed to the deficiency. It is best to utilize supporting evidence obtained from more than one source of evidence.

The sources of evidence are presented in the statement of deficient practice and are described in detail in the findings portion of the Form CMS-2567 report.

Each statement of deficient practice identifies the source(s) through which the evidence was obtained, that is, from observation, interview, or reviews of records or other documents. Sources identified in the entity practice statement must be represented in the findings. The findings describe the specifics regarding the sources.

For example:

> What was learned from the source; the date, time, and location of the observations; the date and time of the interviews; titles of the interviewed persons and the types and dates of records/documents used in the identification of the deficient practices.

Do not identify the recipients or families when using information from the interview. Use a generic term to identify the person who has been interviewed, e.g., a family member, or a resident. Identify by title those staff who were interviewed. If more than one of the same type is interviewed, then the number of staff should be identified.

Observations

Observation is the process by which a surveyor gathers information in accordance with the requirements, based on input obtained from the five senses. It is what the surveyor sees, hears, touches, smells or tastes during the survey that evidences an entity's deficiency. It must answer the who, what, where, when, and how questions. A surveyor may observe if the actions or outcomes described in a clinical or administrative record actually occur in the daily operation of the entity. Actions or outcomes that are described in a clinical or administrative record and observed are also recorded as an observation.

The surveyor must note the specific date and time the observations were made and describe the observation.

Detailed documentation of observations of deficient practice assists the provider in identifying when and where the deficient practice occurred. Time includes the number of observations in which the deficient practice was observed and, as appropriate, the duration of each observation. For example, a series of observations that identify the failure to deliver service from 4:00 P.M. to 6:00 P.M., may help the entity to identify staffing or supervisory concerns, such as, inadequate supervision or sufficient staffing on a particular shift. Terms such as "throughout the survey," " during observation on the second day of the survey," etc. are vague, too general and should be avoided. Exhibit 3-3 illustrates an appropriate manner to document the evidence that was obtained through observation.

Exhibit 3-3 - Effective Documentation of Observation-Based Findings

Tag	Summary Statement of Deficiencies
K 021	NFPA 101 STANDARD: LIFE SAFETY CODE STANDARD Doors in fire separation walls, hazardous area exposure, horizontal exits, or smoke partitions may be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: (a) The required manual alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed. 13-2.11.5 Based on observations, the facility used a door wedge (an unapproved Device) to hold open 1 of the 9 entry doors included in the facility's fire Safety system. Findings include On facility tour between 2:30 and 3:30PM on xx/xx/xx, a door wedge was Observed at the foot of the West entry door holding the door open. The Door was being held in an open position and could not automatically close in case of fire.

Interviews

The interview process largely consists of talking to individuals (e.g., patients, clients, residents, family, visitors, staff, physicians, ombudsman) to collect information in accordance with requirements about the entity practices. Information obtained through interviews can provide evidence to support a deficiency.

For example:

Surveyors talk with recipients to determine whether the entity fulfills the commitments it has made in records; staff are interviewed to determine their knowledge of the needs of the recipient and of entity polices and procedures. To the greatest extent possible, the surveyor verifies the information obtained from interview through observation or record review. In the absence of other objective validation of information, information may also be confirmed/verified through multiple interview sources.

Exhibit 3-4 - Effective Documentation of Interview Based on Findings

Tag	Summary of Statement of Deficiencies
F 252	42 CFR 483.15 (h)(1) The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This requirement was NOT MET as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for 2 of 15 sampled residents (#5, #6) whose rooms lacked individual decorations and any personal belongings. Findings include: 1. Observations made during the tour at 10 AM on xx/xx/xx, noted that Resident 5's room was barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 3:00 p.m., Resident #5 stated, "I miss my pictures; they are all I have left. I want them with me but no one will get them for me. I want my own toiletries too!" 2. At 10 AM on xx/xx/xx, Resident #6's room was observed to be barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 11:00 a.m., a family member of Resident #6 stated, "My (Resident #6) would like to have a rocking chair. I asked the nurse if I could bring it in and she said she would check on it and let me know. This was about three weeks ago and she has not yet told me if it was acceptable or not." During an interview with the director of nursing (DON) on XX/XX/XX at 1:00 p.m., the DON revealed that the facility was aware of the residents' requests for personal belongings but had tried to discourage displays of any personal items to reduce theft in the facility.

Review of Records and Other Documents

Evidence discovered during review of the entity's documentation is discussed with the staff to determine if additional documentation or other information exists. Record or document review is the process through which administrative (e.g., statements of policy and procedure, committee minutes, injury/incident reports) and clinical (e.g., comprehensive assessments and evaluations, consultations, laboratory reports, plans of care, progress notes) documents are read and analyzed. Through review of recipients' clinical records, surveyors determine the needs of individuals and the extent to which the

entity has addressed those needs. Through review of administrative documents, surveyors assess the entity's compliance with requirements for the maintenance and use of those documents.

When using information obtained through record review, identify the record that contained the information. If the deficiency results from a lack of documentation, make sure the documentation is requested from the staff member who might or who should know where the documentation can be found.

Obtain copies of the records, which show the deficient practice to prove the deficiency, and to show after-the-fact changes that may be made by the entity.

If the regulation requires a policy on specific issues, ascertain that the policy fails to address the necessary issues before determining it is deficient.

Examples of documenting information from records and some of the additional investigation necessary, include:

> Patient Y's medical record contained a urinalysis report dated XX/XX/XX for urine which was sent to a laboratory on XX/XX/XX. The report indicated the sample had been contaminated and recommended that a new sample be submitted. The record did not indicate that another specimen had been sent and the staff on XX/XX/XX were unable to determine if any had been sent.
>
> The medical record did not contain the results of the urinalysis for the sample sent to the lab on XX/XX/XX. Staff were unable to locate the report and reported upon inquiry of the lab that the results had not been sent to the facility.
>
> The initial Minimum Data Set (MDS), dated XX/XX/XX, documented that a resident was readmitted from home on XX/XX/XX with a reddened area. The nurses notes dated XX/XX/XX, documented a "reddened area to left ankle."

Exhibit 3-5 - Effective Documentation of Record Review-Based Findings

Tag	Summary Statement of Deficiencies
V 321	405.2137(b)(4)STANDARD: PATIENT CARE PLAN The care plan for patients whose medical conditions has not stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patient's ongoing needs. This STANDARD is NOT MET as evidenced by: Based on record review, the provider failed to address changes in therapies on the Patient Care Plan (PCP) for 2 of 7 patients (#1, #4). 1. Review of the admission progress note dated 4/10/XX showed that Patient #1 started receiving peritoneal dialysis (in the home) on 4/1/XX. Per the 10/2/XX Social Services note, Patient #1 was switched (at the request of the patient) from peritoneal to hemodialysis (in the dialysis center) on 9/11/XX. Review of the most current PCP dated 12/2/XX revealed that this change in treatment modality was not addressed in the PCP. 2. Patient #4 started hemodialysis (in the dialysis center) on 2/11//xx per the admission assessment. The 9/8/XX Physicians Progress note indicated that Patient #4 received a transplanted kidney on 4/5/XX, but restarted hemodialysis again on 8/1/XX after the transplant was rejected. Review of the PCP dated 12/2/XX revealed that the patient's changes in status were not addressed in the PCP.

Exhibit 3-6 - Effective Documentation of Record Reviews

Tag	Summary Statement of Deficiencies
F 225 S/S	42 CFR 483.13 (c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). This requirement was NOT MET as evidenced by: Based upon staff interview, review of medical records, and review of the policy and procedure manual, facility staff did not report to the administrator bruising of unknown origin for 2 residents in the sample of 20 (#15, 24). The findings include: 1. A record entry dated XX/XX/XX, for resident #24 noted that staff had observed bruises on the resident's genitals and inner thigh. During an interview at 1:00 p.m. on XX/XX/XX, the Director of Nurses stated that the Administrator had been ill for 2 months around that time and she had been acting Administrator. She said, "Staff did not report the bruises to me ...I have not investigated for the cause of the bruises." 2. A record entry, dated XX/XX/XX, for resident #15 noted that staff had discovered that the bridge of the resident's nose was very bruised and no indications of a possible cause were noted. An interview with the charge nurse on the south wing on XX/XX/XX at 10:00 a.m. confirmed that no one knew how the bruise occurred. The injury of unknown origin had not been reported to the administrator and had not been investigated. 3. Review of the policy and procedure manual on XX/XX/XX, did not provide evidence that the facility had established procedures in the manual that specify how allegations of abuse or injuries of unknown origin were to be reported. During interview on XX/XX/XX at 3:00 p.m., the administration confirmed that the facility had no current policy or procedure directing staff regarding when to report possible abuse or injuries of unknown origin.

The following are examples of complete citations that comply with the Principles of Documentation.

Exhibit 3-7 - This example reports the evidence in a way that the entity can understand that the requirement was not met and how the survey team determined that the requirement was not met. The facts are stated clearly, the deficient practice is apparent, and there is no extraneous information within the citation that might cause confusion. All of the components of a complete citation are included.

Exhibit 3-7 - Effective Documentation of Principle #3

Tag	Summary Statement of Deficiencies
L 210	418.94 (a)Standard: Supervision A registered nurse visits the home site at least every two weeks when aide services are being provided, and the visit includes an assessment of the aide services. This STANDARD is NOT MET as evidenced by: Based on review of 4 of 12 medical records (#5, 3, 9, 12) and interviews in 2 of 4 home visits (#5, 12), it was determined that the registered nurse visit did not include an assessment of whether the aide provided grooming services (shampoo and shower) to the patients. The findings include: 1. Review of medical records for Patient #5 revealed that: between 10/20/XX to 12/20/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The son of Patient #5 said, during an interview on 12/28/XX, "The aide never shampoos my Mom's hair and the nurse said that she is supposed to be doing that." During an interview at 10 a.m. on 12/29 with the nurse caring for the patient, the nurse acknowledged that the family member had mentioned the shampoos, the plan of care did indicate the patient was to receive shampoos, but she had not followed up with the aide about not doing them, nor had she verified what was reflected on the aide assignment sheet or what the aide had recorded. 2. Review of medical records for Patient #12 revealed that: between 10/28/XX to 12/28/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The family member of Patient #12 said, during an interview on 12/28/XX, "The aide did not give (my family member) a shower; instead the aide gave (my family member) a very quick bath in bed. I don't know why but the aide always comes late and leaves early."

Tag	Summary Statement of Deficiencies
	3. The same lack of documentation regarding registered nurse visits to the home site to assess aide services was found in medical records for Patients #3 for review period 03/10/XX to 05/07/XX; and #9 for review period 02/11/XX to 03/29/XX.

Each of the three sources may not be necessary to confirm a deficiency. Regardless of the particular avenue(s) through which information about an entity's compliance with requirements is gathered, the Principles of Documentation statement should include how the information was obtained.

Outcomes

To the extent possible, especially where described or anticipated in the requirement(s), the deficient practice indicates outcome(s). The statement of findings describes the specific results and consequences of the entity's deficient practice for the individual cases reported. Negative outcomes include deterioration, failure to improve or maintain, etc. Although no negative outcome may be evident from the deficient practice, a failure to comply with a requirement is a deficiency. Many requirements are not outcome oriented. An example of outcome requirements includes:

A resident who enters the facility without pressure sores does not develop pressure sores.

Exhibit 3-8 - Effective Documentation of Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F 314	42 CFR 483.25 (c) Based on a comprehensive assessment of a resident, the facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable: and This requirement was NOT MET as evidenced by: "Based on observation, staff interview, and record review, the facility failed to provide services to prevent the development of a pressure ulcer, to promote healing and to adhere to infection control measures (universal precautions) designed to prevent cross contamination resulting in the development of an avoidable Stage III pressure ulcer for 1 of 3 sample residents (R#2) with pressure sores. Resident #2 experienced ongoing pain, infection and was unable to continue activities of daily living." Findings include:

This example reports the evidence in a way that the entity can understand that the requirement was not met and how the survey team determined that the requirement was not met. The statement identifies the extent of the deficient entity practice, includes identifiers for the individuals affected by the deficient entity practice, identifies the sources from which the information was obtained, and clearly states the outcomes of the deficient entity practice.

Findings

Findings support or illustrate an entity's noncompliance with a requirement. Cite only findings attributable to the entity. Each statement of deficient practice is followed by the specific findings (**who, what, where, when, how**) that illustrate the entity's noncompliance for each case/issue referenced in the deficient practice statement. The facts are presented in a concise and logical sequence. The findings include the outcomes, descriptions of actions/situations, identifiers, and sources. Any evidence that supports a finding and affects the deficiency determination must be incorporated into the deficiency citation.

When details for a number of individual examples have been described to illustrate a particular deficient practice, a final entry may describe additional similar findings and identifiers to demonstrate the magnitude of the problem.

Facts

A fact is an actual occurrence, something known to exist or have happened. The findings are facts that allow the entity to compare what it did or failed to do, against what is required. The findings support the deficient practice statement. For example, if residents #1, 3, 5, and 7, are discussed in the deficient practice statement, the findings are the facts to support the noncompliance for residents #1, #3, #5,and #7.Without the presence of facts, the evidence can be construed to mean that an assumption was made, rather than a known conclusion about the entity's practice.

Failure to include pertinent facts may prevent the entity from discovering what contributed to the deficient practice. For example, there may be many reasons for the failure of a patient to receive a needed treatment, such as: the patient was not scheduled for a treatment; the staff had not been trained regarding how to provide the treatment; trained staff were not available to provide the treatment; trained staff were available but forgot to provide the treatment; proper authorization for treatment was not provided; or, the patient refused the treatment.

Identification of the pertinent facts gives the entity the means to examine the failure to comply, in light of the specific circumstances or contexts, which the failure occurred.

When writing a deficiency citation, try to provide answers to basic questions - Who?, What?, When?, Where?, and How?. Based on the nature of the deficiency, it may be

impossible or inappropriate to answer each question. However, this approach facilitates inclusion of the pertinent facts. Deficiency citations identify:

How the deficiency was determined, and how the evidence relates to the requirement;

What entity practice was noncompliant;

Who were the residents or staff involved;

Where the deficient practice occurred, e.g., specific locations in the entity or documents; and

When (e.g., for how long) the problem occurred. Include the number of observations and the duration of the observations. Include the specific dates or time period for the noncompliance. The findings also include documentation of verification or request for additional information through interviews with facility staff.

Exhibit 3-9 - The statement of the findings in this example illustrates how the relevant facts answer the basic questions of who, what, when, where and how.

Exhibit 3-9 - Documentation of Facts

Tag	Summary Statement of Deficiencies
F 369	F369 42 CFR 483.35(g)) The facility must provide special eating equipment and utensils for residents who need them. This requirement is NOT MET as evidenced by: Based on record review, observation and interview "HOW" the facility failed to provide adaptive fork and spoon "WHAT" for a resident (R#7) who was assessed to need these items. "WHO" The findings include: 1. The care plan, dated XX/XX/XX for Resident #7 "HOW" indicated that R#7, who has suffered from a recent "WHAT" stroke, needed adaptive utensils to eat meals independently. 2. R#7 was observed in the dining room during "HOW" and "WHERE" breakfast on XX/XX/XX and XX/XX/XX, "WHEN" lunch on XX/XX/XX and XX/XX/XX, and "WHEN" dinner on XX/XX/XX "WHEN"

Tag	Summary Statement of Deficiencies	
	struggling to eat, using a regular fork and spoon, and most of the food was falling off the utensils	"WHAT"
	The resident ate only about 25 percent of each meal	"WHAT"
	3. During an interview with the nurse aide on XX/XX/XX at 12:00 p.m., the nurse aide stated, "For a few days R#7 was given special utensils, but I don't know what happened to them	"HOW"
	I haven't seen them for a week or so."	"WHEN"
	4.R#7 said during an interview on XX/XX/XX at 12:25 p.m. "My right hand just doesn't work like it used to since I had this stroke. I was never good at using my left hand, I don't understand	"HOW"
	why they stopped giving me the special fork and spoon, I guess they just want me to eat with regular silverware."	"WHAT"

Organization of Findings

The findings should be organized in a chronological and logical order. Grouping related findings and facts under applicable statements of the deficient practice statement assists the entity in focusing on the development of plans to correct its deficient practices rather that on correction of the findings. The organization of the findings should clearly convey to the reader the sequential order of events that resulted in a citation. For example, situations or cases are presented in a logical sequence to show individual deterioration over time or date.

When setting forth a series of facts and events, start by setting out the relevant background facts (e.g., "Resident #1 was at risk for weight loss as set forth in the MDS dated XX/XX/XX.") Then, if possible, set out the events in chronological order.
The following example, Exhibit 3-10 illustrates a citation from the home health requirements. The citation is written based on two separate requirements contained in the language of the requirement. It includes two statements of deficient practice and organizes the relevant findings/facts under those statements.

Exhibit 3-10 - Effective Documentation of Two Deficient Practice Statement and Their Findings

Tag	Summary Statement of Deficiencies
G 108	42 CFR 484.10(c)(1)STANDARD:RIGHT TO BE INFORMED AND PARTICIPATE IN PLANNING CARE AND TREATMENT The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of the visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the agency failed to inform 2 of 12 patients (#3 and #9) reviewed about changes of the frequency of care to be furnished, and the facility failed to inform 2 of 12 patients (#7 and #10) in advance of changes to the plan of care. The findings include: Changes in Frequency of Care: 1. Patient #3 began receiving services on 10/15/XX due to a fractured hip. These services were to include physical therapy (PT) three times a week for 8 weeks for gait and balance training to restore ambulation ability. The PT note, dated 11/1/XX, states, "Increase in case load prohibits three sessions a week of treatment. Frequency to be once a week for reminder of treatment." Observation during the 12/7/XX home visit revealed that the patient is not ambulating. Interview on 12/7/XX during the home visit with Patient #3 indicates that the patient was not informed of the change of frequency of the PT services. Telephone interview with the physical therapist on 12/7/XX confirms that this patient is not ambulating due to the decreased frequency of treatment and that the patient was not informed of the change of frequency. 2. Patient #9 began receiving services on 9/10/XX due to a stiff shoulder....

	Changes in Plan of Care 1. Patient #7 began receiving services on 11/20/XX. The plan of care dated 11/23/XX, indicated that services were to include skilled nursing services for wound care and home health aide assistance for activities of daily living. On 11/28/XX, the nurse's note states: "care plan revised as the home health aide can do wound care. Sufficient healing has occurred so that skilled services are not indicated. Wound needs to be cleansed during bathing." Observation on the 12/8/XX home visit indicated that the wound was healed. Interview with Patient #7 indicated that the patient wondered about the whereabouts of the nurse who used to come to clean the wound. She had not seen her in a long time. Interview with the nurse indicated that as the person was progressing well, there was no need to inform her about the change in the plan of care. 2. Patient #10 was admitted for service on 11/13/XX.The plan of care, dated 11/13/XX, identified an occupational therapy (OT) consultation to determine if environmental modifications to the home were indicated. An OT note of 11/17/XX states: "Consultation not indicated." No additional information was recorded. Interview with Patient #10 on 12/8/XX indicates that he was satisfied with the services received, but, "I hope that the person who is supposed to help with the arrangement of the house gets here soon. It is difficult for me to get around here." Interview with the Director of Services on 12/8/XX confirmed that the person was not informed of the changes to the plan of care."

Principle #4 - Relevance of Onsite Correction of Findings

If, during the survey, a deficiency is found, but the entity corrects the situation as soon as they become aware, a determination of "NOT MET" must be documented on the Form CMS-2567. The entity may indicate its correction in the right-hand column of the Form CMS-2567. If, during the survey, the entity initiates corrective actions that abate a finding of immediate jeopardy, follow the guidance described in Appendix Q. The entity may indicate its correction in the right-hand column of the Form CMS-2567.

If an entity demonstrates practices that cause it to be out of compliance, there may be a system failure. The findings used as part of the evidence illustrate the result of that failure; the findings are not the cause of it. Mere correction of the findings reported to the entity prior to the exit conference would not necessarily assure that the cause of the finding had been addressed. The entity, not the survey team must ascertain the cause and correct the systems failure that caused the deficient entity practice.

Exhibit 4-1 demonstrates how to document a deficient practice even though the entity may have addressed the effects of the practice during the survey.

Exhibit 4-1 - Effective Documentation for Principle #4

Tag	Summary Statement of Deficiencies
G 145	483.14(g)Standard Coordination of patient services A written summary report for each patient is sent to the attending physician at least every 62 days. This standard is NOT MET as evidenced by; Based on record review and staff interview, it was determined the home health agency failed to ensure a written summary report which included a compilation of pertinent factors of patient's clinical progress had been sent to the physicians' office for 2 of 2 sampled patients (#4, and 5) who required a 62 day summary. Findings include: 1. Patient #4 was admitted for home health services on XX/XX/XX. The plans of care for the certification periods XX/XX/XX to XX/XX/XX and XX/XX/XX to XX/XX/XX included goals which stated "Patient will experience stable cardiopulmonary status as evidenced by clear lung sounds, no chest pain, SaO2 (saturation of arterial blood) greater than or equal to 92%." Summary reports addressing the patients progress or lack of progress were not available as part of the Patient's clinical record. 2. Patient #5 was admitted for home health services on XX/XX/XX with the diagnosis of pressure ulcer and congestive heart failure. The plan of care for them certification period XX/XX/XX to XX/XX/XX included goals that stated " Patient will have pressure ulcer healed with no sign or symptoms in 10 weeks." The summary report addressing the status of the patient's wound was not available as part of the clinical record. Staff interview on XX/XX/XX confirmed the HHA had not sent written summary reports to the physicians, until after the surveyor inquiry when summary reports were then completed and faxed to the physician during the survey.

Correction of Immediate Jeopardy (IJ) During Survey

Exhibit 4-2 documents noncompliance with a participation requirement that resulted in a situation of immediate jeopardy. The CMS-2567 includes the facility's actions to remove the immediate jeopardy while the survey team was onsite; however, as stated above, mere correction of the findings does not assure that necessary corrections, at the systems level, have taken place. Follow the directions for immediate jeopardy located in Appendix Q of the State Operations Manual.

Exhibit 4-2 - Effective Documentation for Correction of IJ during Survey-Principle #4

Tag	Summary Statement of Deficiencies
F 223 S/S = J	42 CFR 483.13(b)Requirement Abuse…The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The requirement is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to prevent 1 of 21 sample residents (#5) from being assaulted by staff and failed to report the assault to the appropriate authorities in a timely manner and failed to take actions to prevent further such incidents to residents resulting in immediate jeopardy. Findings include: Interviews with 3 CNAs A, B, C, on duty on 7/10/XX, indicated that they observed a certified nursing assistant (CNA)(E-1) "throw" a resident (R#5)to the ground during a picnic at the facility on 5/26/XX. The CNA, who observed R#5 becoming agitated, went to the resident to bring him back into the facility. When the resident became "uncooperative and irritated" and refused to go into the building, the CNA gave the resident a "bear hug." The resident fell to the ground at which time the CNA dragged the resident by the back of his shirt into the facility, a distance of approximately 30 - 40 feet. Nurses notes on 6/1/XX state that the resident had abrasions on the lower lumbar and upper left thoracic regions, but was not able to say how he got them. During an interview with the facility administrator on 7/11/XX, the administrator said, "I was not aware of the incident until 6/1/XX when a staff member asked for medication to put on [resident #5's[cuts. I notified the health department on 6/1/XX." The administrator acknowledged he did not remove the CNA from providing resident care until questioned by the surveyor on 7/11/XX.

	The administrator was notified of the immediate jeopardy at 2:00 p.m. on 7/11/XX. At 3:00 p.m. the administrator notified the survey team that the involved CNA had been removed from duty and that the CNA would be fired.

Principle #5 - Interpretive Guidelines

The deficiency citation demonstrates how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements. Various appendices to the SOM contain "Interpretive Guidelines" or "Guidance to Surveyors." These Guidelines were designed to assist surveyors to develop a better understanding of the requirements, to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although surveyors must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation, and therefore, may not be used as the basis for a citation. However, they do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist surveyors in making determinations about an entity's compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the surveyor must indicate such on the Form CMS-2567.

Surveyors should carefully consider how the practices of the entity relate to the illustrations within the Interpretive Guidelines, and then compare the entity's practice to the specific language and requirement of the regulation before determining that a deficiency exists.

Exhibit 5-1 - Interpretive Guidelines

Regulation	Guidance To Surveyors
42 CFR 483.35 (h)(2) "Sanitary Conditions." The facility must (2) store, prepare, distribute, and serve food under sanitary conditions; and	Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit, etc... Referenced guidance 1999 FDA Food Code.

Exhibit 5-2 illustrates how material in Interpretive Guidelines can be used to support the citation. The critical factor is whether or not the evidence relates directly to the language and requirement within the regulation.

Exhibit 5-2 - Effective Documentation for Principle #5

Tag	Summary Statement of Deficiencies
W 214	42 CFR 483.440 (c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This Standard is NOT MET as evidenced by: Based on observations, staff interview, and record review, the facility failed to include in the comprehensive functional assessment, the client's cognitive ability for 2 of the 4 clients in the home (#2, #3). The findings include: Review of Client #3's medical records, dated between XX/XX/XX and XX/XX/XX, revealed 11 evaluations conducted by the professional staff. None of the evaluations specified any deficits that may have contributed to his diagnosis or his reported developmental level of functioning. Observations on XX/XX/XX and XX/XX/XX confirmed that...In an interview on XX/XX/XX, LPN1 said, "I am unclear about the client's identified strengths."

Principle #6 - Citation of State or Local Code Violations

The entity's failure to comply with State or local laws or regulations is not documented in the Form CMS-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has effectuated an adverse action that has been sustained through the hearing process (such as removal of the license to operate), the Form CMS-2567 should note that the entity no longer has a license.

Federal certification requirements are uniform throughout the United States. However, States and localities may have additional requirements that the entity must meet in order to continue to operate within those jurisdictions. Some licensing requirements may be more stringent or prescriptive than Federal requirements. Licensure surveys are conducted to determine an entity's compliance with specific State or local laws and regulations. Entities that do not meet the State or local requirements for licensure may not be certified for participation in the Medicare/Medicaid programs.

In the event of a difference in the stringency of a Federal certification requirement and a corresponding State or local (e.g., licensing) requirement, the entity is to comply with the

more stringent of the two. However, when enforcement of the more stringent requirement comes from an authority other than the Federal requirement, the evidence may be recorded on the Form CMS-2567 only in the manner prescribed by CMS.

Failure of the entity to meet State or local requirements is recorded on the Form CMS-2567 at a Federal data tag for one of two reasons:

1. The language of the Federal regulation explicitly requires compliance with State or local laws and codes. Deficiency citations made under these requirements should include a reference to the particular State or local code with which the entity is noncompliant. This insures that there is legal authority to describe any conditions or practices described as deficient. Surveyors always should review their findings relative to the specific Federal requirement to determine if and when an entity's failure to achieve compliance with a licensure requirement is sufficient evidence to cite noncompliance with a Federal certification requirement.

Exhibit 6-1 is consistent with Principle #6. The entity's practice of using LPNs to conduct the health status review was deficient specifically relative to the requirement; or

Exhibit 6-1 - Effective Documentation for Principle #6

Tag	Summary Statement of Deficiencies
W 345	42 CFR 483460(d) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section. This STANDARD was NOT MET as evidenced by: Based on record review, the facility for the period between 7/1/XX and 9/30/XX, utilized Licensed Practical Nurses (LPNs) to review the health status of residents for 4 of 10 sampled records (2, 6, 12, 19).Section 76543 of the Code of Professional Health Practices (State Requirement) requires that this function be performed only by Registered Nurse (RNs).

2. The authority having jurisdiction has made a determination of noncompliance with State or local law, has taken and sustained an adverse action (See Exhibit 6-2.). An adverse action is any procedure taken by a State Agency that goes beyond the approval of a plan of correction, such as, fines, ban on admissions, loss of license, etc. The authority having jurisdiction is the person or persons who have the authority to make a final determination of noncompliance and are responsible for signing the correspondence notifying the facility of the adverse action. A final determination means the determination has not been appealed or is no longer being appealed by the entity.

Exhibit 6-2 - Effective Documentation for Principle #6

Tag	Summary Statement of Deficiencies
F 492	42CFR483.75(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This requirement is NOT MET as evidenced by: Based on evidence in the attached notice of determination of noncompliance, the entity did not meet (state or local) Law #XXX. An adverse action was taken against the entity by (the authority having jurisdiction.) See attached.

Principle #7 - Cross-References

The cross-referencing of requirements is an acceptable form of documentation on the Form CMS-2567 only when it is applicable and provides additional strength to the linked citations. Descriptive evidence (facts and findings) from one citation may be linked into the evidence for a citation at another requirement. The evidence being linked into that requirement must support the determination of noncompliance with that requirement. Each citation must contain all components described in this document independent of the additional information being linked into that citation. Cross-referencing is most effective when the linked citations have a direct cause and effect relationship to the deficient practices described in both citations. In all instances, each citation must contain sufficient evidence to demonstrate noncompliance for the referenced regulation. Additional guidance for cross-referencing for COP level citations is provided in POD #8.

Tag	Summary Statement of Defciencies
G 170	G170 42 CFR 484.30 Skilled Nursing Services The HHA furnishes skilled nursing services in accordance with the plan of care. This requirement is NOT MET as evidenced by: Staff interview and review of seven clinical records requiring RN skilled services revealed that the RN did not comprehensively assess the patients or furnish the frequency of visits required by the Plan of Care for 4 of the 7 patients (H3 H5, H6, H7). See G174 for additional information regarding patients H3, H5, and H7.

	1. Review of H3's clinical record indicated physician orders for twice daily RN visits from 10/01 to 10/08/XX to administer IV antibiotics, assess the stats of and perform a dressing change to the Stage 3 ulcer of the left heel. The aide sheet for 10/04 reflected that the aide had changed the heel dressing that a.m. The record shows two LPN visits and an evening dressing change by the LPN on 10/04 but does not contain information of an RN visit, assessment or dressing change on 10/04/XX. Interview at 10:30 a.m. on 11/10/XX with supervising nurse confirmed that on 10/04/XX an aide had performed the a.m. dressing change on H3's Stage 3 pressure ulcer of the heel. The supervising nurse reported that although the RN was ill and had not made the planned a.m. or p.m. visits that day, the agency's LPN had performed the visits and supervised the aide. 2. Review of H5's clinical record indicated that the Plan of Care for H5 required RN visits from 4 to 5 times the week of 10/07/XX and 3 times a week for 3 weeks beginning 10/4/XX to assess the patient's response to changes in the medication to control her angina and blood pressure. The RN visited only 3 times (10/07, 10/08 and 10/10) during the week of 10/07 and limited her assessment to checking breath sounds and blood pressure. The RN did not evaluate for signs and symptoms or complications of either hypo or hypertension or for compliance with dietary restrictions or known side effects which accompany the use of calcium channel blockers. 3. Review of H6's clinical record indicated the RN did not visit H6 twice daily as required by the Plan of Care to monitor the institution of sliding scale insulin for the newly diagnosed brittle diabetic. The Plan of Care required twice daily visits from --- to ---. The actual visit frequency was ---.

Tag	Summary Statement of Deficiencies
G 170	G170 42 CFR 484.30 (Cont.) 4. Review of H7's clinical record indicated the RN did not assess, record, and report to the physician the change in the status of the suture line of the hip wound on 10/21/XX.The Plan of Care required RN visits 5 times a week for 1 week then 3-5 times a week for 2 weeks or until the wound healed to change the dressing and assess the character of the post operative wound. The therapist's progress notes from the therapy visit on 10/21 at 10 a.m. (3 hours prior to the RN visit) reflect that the patient complained to the therapist of burning and dampness at the suture line.

Principle #8 - COP Deficiencies

The evidence for the citation of noncompliance with a Condition of Participation explains how the extent or severity of deficient practices justifies a conclusion of noncompliance at the COP level. The COP citation includes a statement(s) of deficient entity practice(s) and findings to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings. The COP citation includes ONLY those requirements that must be corrected to achieve compliance with the COP.

The determination that an entity is not in compliance with an applicable COP is one of the most serious decisions the RO or SA can make. The decision as to whether there is compliance with a particular COP depends upon the manner and degree to which the entity satisfies the various requirements and standards within each COP. If a COP is determined to be deficient, the Form CMS-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these subsidiary requirements may be referenced under the COP citation.

For certain provider and supplier types, a COP may stand alone at a single survey data tag without accompanying standards or other requirements. The text of the particular COP may have multiple components. Based on the evaluation of the evidence, an entity can be cited at a COP level even if it violates only one component of multi-component regulations.

For example, in the Ambulatory Surgery Center program, 42 CFR 416.43 Condition for Coverage Evaluation of Quality (tag Q 9) has multiple requirements:
(1) conduct an ongoing , comprehensive self-assessment of the quality of care provided, (2) include active participation of the medical staff, (3) include review of the medical necessity of the procedures performed and appropriateness of care, (4)

use the findings, when appropriate, in the revision of the center policies and (5) use the findings, when appropriate, in the consideration of clinical privileges.

There may be entity practices relevant to standards that are deficient, yet not essential for a determination of compliance with the COP. Most likely it is because the nature of these practices, individually or collectively, does not justify a conclusion of noncompliance and warrant an adverse action. Such requirements are not referenced at the COP citation. They are included at the appropriate tag number and corresponding CFR reference in the Form CMS-2567.

Exhibit 8-1 - Effective Documentation for Principle #8

Tag	Summary Statement of Deficiencies
Q 003	416.41 Condition Governing Body and Management The ambulatory surgical center must have a governing body, that assumes full responsibility for determining, implementing and monitoring policies governing the centers total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these services are provided in a safe and effective manner. This Condition is NOT MET as evidenced by: Based on staff interview and review of administrative records, policies and procedures, and infection control and quality assurance documentation, it was determined that the ambulatory surgery center's governing body failed to assume full responsibility for determining, implementing and monitoring policies governing the center's total operation. The governing body failed to ensure that practitioners had been appointed to the medical staff and had been granted privileges to practice at the ASC (refer to Q19, Q20, Q21, and Q22), failed to ensure that a comprehensive quality assurance program was in place (refer to Q9); failed to ensure that an effective infection control program had been established (refer to Q14). The cumulative effect of these systemic problems resulted in the surgery center's inability to ensure the provision of quality health care in a safe environment.

Conclusion

All requirements are binding. The structures, processes and outcomes required by the regulations are necessary for the entity to provide quality care, prevent negative outcomes, and facilitate positive outcomes. Failure of the entity to provide any of the

required services or to meet required conditions constitutes evidence of noncompliance regardless of the presence of outcomes. The purpose of these Principles of Documentation is to provide structure and consistency to the construction of a citation.

Correctly documenting the "Statement of Deficiencies and Plan of Correction" (Form CMS-2567) is the key to the success of the survey and certification process. Effective documentation of the survey signals the provision or denial of financial participation in the Medicare/Medicaid program, as well as the provision of or lack of quality care in health care settings.

Keep in mind that one of the roles of the surveyor is to ensure that quality health care is provided by those entities participating in the Medicare/Medicaid program. It is the surveyor's knowledge of the regulations and how to interpret and apply these regulations in a consistent manner during the survey that will produce a clear description of the entity's deficient practice. When the deficient practices are resolved by the entity, quality of care and quality of life can be a reality in health care settings.

Appendix A - Components to be Documented in A Deficiency Citation

COMPONENTS TO BE DOCUMENTED IN A DEFICIENCY CITATION

Data Tag				
In CFR/LSC/CLIA order				
CFR/LSC/CLIA Reference				
CFR/LSC/CLIA Requirement				
Statement that requirement is "Not Met"				
Evidence: Each Statement of deficient practice with corresponding findings (repeat each practice)	**YES(Y)**	**NO (N)**	N/A	
Extent of deficient practice				
Identifiers (confidential)				
Description of violation of regulation				
Source of evidence				
State/local code reference, if applicable				
Findings/Facts:				
Who				
What				
When				
Where				
How				
Outcome				
Observations: date, time, location				
Record/document reviews: date(s), record type				
Sequential organization of facts				
Is the Deficiency Citation…	**Yes**	**No**	N/A	
Applicable to requirement cited?				
Written in plain language?				
Free of extraneous remarks and advice				

Active-Voice Sentences

Active-Voice Rule

The voice of a verb refers to the relationship between verb and subject . . . who or what is performing the action or agent doing it and is the subject of the verb. There are two voices in English: active and passive.

The most basic active-voice sentence takes the pattern: subject + verb + object.

Subject: the *actor* or doer in the sentence.
Verb: the *"doing"* word; a word for actions or processes.
Object: the person or thing that is *acted upon* or has the action done to it.

For example:

Hercules was strong.
Hercules had a bad temper.
Hercules went to Hades to find Cerberus.

Ask yourself:

(1) Who or what is the *doer* of the action?
(2) Which is the *action* word?
(3) Who or what is the *object* of the action?

Be aware that a subject or an object can consist of more than one word.

Examples

Find the doer of the action and make it the subject.

The meeting <u>was opened</u> by the president. (Passive)
The president opened the meeting. (Active)

The book <u>was read</u> by most of the class. (Passive)
Most of the class read the book. (Active)

Comparison of Paragraphs (a) and (b)

(a) When passive voice <u>is used</u>, sentences <u>are robbed</u> of powers. Strong verbs <u>are weakened</u> by this construction, and awkwardness <u>is caused</u>. Although there are reasons to use passive voice, it <u>is often employed</u> unintentionally and unnecessarily by beginning writers.

(b) When journalists use passive voice, they rob their sentences of power. This construction weakens strong verbs and causes awkwardness. Although passive voice has its place, novice writers often use it unintentionally and unnecessarily.

Read Paragraph (a) again. Do the sentences sound awkward? Look at the verbs. Are they powerful words that propel their sentences? In the first paragraph all three sentences use passive-voice constructions.

In Paragraph (b) each sentence is in the active voice. Compare both versions. If you recognize the awkwardness and false formality of the first paragraph and if you can see the lifeless verbs, then you are on your way to recognizing and avoiding passive-voice construction.

Don't confuse tense and voice. Verbs can be present, past or future tense. The same verbs can appear in active voice or passive voice.

Exercise

Revise these passive voice sentences to make them active.

1. The computer class <u>was attended</u> by many students.
2. The issues <u>were clouded</u> and the listeners inflamed by the irate speakers.
3. The call to arms <u>was responded</u> to eagerly by many who <u>were motivated</u> by a thirst for liberty.
4. For a violinist to be a success, many types of bowing and scales <u>must be mastered.</u>
5. The fact that the town <u>was obliterated</u> by the hurricane was bad enough, but it <u>was also further victimized</u> by looters.

Active vs. Passive Sentence Construction

Consider the following examples.

1. The brilliant essay <u>was written</u> by John.
2. John wrote the brilliant essay.

John is the person who wrote the essay, so he is the agent in both of these sentences. Sentence 1 is passive because the agent is "disguised" as the object of a preposition and the receiver of the action is occupying the subject slot. Sentence 2 is active because the agent is also the grammatical subject of the sentence. Notice that the active sentence is shorter and more direct than the passive sentence.

1. A book <u>can be read</u> in which Caesar <u>was killed</u> by Brutus.
2. You can read a book detailing how Brutus killed Caesar.

Differentiating between the Active and Passive Voice

In the active voice the subject of the sentence performs the action of the verb. For example, "The dog bit the boy." The dog, the subject of the sentence, is performing the action of biting.

In the passive voice the subject of the sentence receives the action of the verb**.** For example, "The boy was bitten by the dog." The doer of the action in the passive voice may either appear in a prepositional ("by the…") phrase or be left out.

Spotting the Passive Voice

Look at the verb phrase. The passive voice will always include a form of the "to be" verb, such as "is," "are," "was," or "is being." Look for a prepositional phrase ("by the . . ."). The doer of the action, if named, is in this "by the . . . " phrase.

Suggestions for Choosing the Active Voice

The active verb is often easier to understand than the passive because the active voice states specifically who or what is doing the action.

- Less clear: The entrance exam was failed by over one-third of the applicants to the school.
- Revised: Over one-third of the applicants to the school failed the entrance exam.

The active verb is more concise than the passive verb because fewer words are needed.

- Wordy: The action on the bill was considered by the committee.
- Better: The committee considered acting on the bill.

The active voice emphasizes the doer of the action and is often more direct and dramatic.

- Less direct and dramatic: The brakes of the car were slammed on by the driver as her car sped down the hill.
- Direct and dramatic: She slammed on the brakes as her car sped downhill.

The passive voice is useful when the doer of the action is unknown or unimportant.

- The lock was broken when the police arrived on the scene of the crime.
- The experimental liver transplant was performed successfully.

The passive voice focuses attention on the action rather than on the doer of the action.

- "Rules are made to be broken," he said defiantly.

The passive verb is sometimes preferred in scientific writing—but not always.

- The hydrogen experiment was used to verify the previous results.

Some Further Suggestions

Avoid starting the sentence in the active voice and switching to the passive voice.

Many customers in the restaurant found the coffee too bitter to drink, but it was still ordered frequently.

Revised: Many customers in the restaurant found the coffee too bitter to drink, but they still ordered it frequently.

Avoid dangling modifiers caused by shifts to the passive voice.

To save time, the paper was written on a computer.

Revised: To save time, Kristin wrote the paper on a computer.

Don't trust grammar checkers on computers. Many grammar checkers will flag all passives, and you may want to keep some passive phrasing.

Changing Passive to Active

If you want to change a passive-voice sentence to an active-voice one, find the agent in a "by the..." phrase or consider carefully who or what is performing the action expressed by the verb. Make that agent the subject of the sentence and change the verb accordingly.

Passive:

The book is being read by most of the class.
Results will be published in the next issue of the journal.
A policy of whitewashing has been pursued.
Mistakes were made.

Active:

Most of the class is reading the book.
The researchers will publish their results in the next issue of the journal.
The CIA director and his close advisors have pursued a policy of whitewashing.
We made mistakes.

Advantages of Using the Active Voice

Clearly defined agent action by verbs creates immediacy and strong declarative structure.

There are two primary reasons to avoid the passive voice. First, the passive voice is impersonal. Second, the passive voice generally leads to more complex grammatical constructions which are more challenging to read.

Using the Passive Voice

Passive sentence structure sometimes occurs when the agent is unknown, in business and social settings, to avoid the appearance of blame or unfair accusation or to emphasize the receiver of the action. In certain instances, the recipient of the action is more important (or more newsworthy) than the performer of the action. So, in all fairness, there may be a time and a place for passive-voice construction, but it usually has no place in writing deficiency reports.

Changing Passive to Active

Usually—but not always—when these forms of the verb "to be" are in front of the verb, the sentence becomes passive. Note that these forms used with the present participle (-*ing* form) of a verb usually indicate active voice.

Singular	**Plural**
Is	Are
Has been	Have been
Was	Were
Had been	Had been
Will be	Will be
Will have been	Will have been
Is being	Are being
Was being	Were being

Examples:

1. Resident 2 *was being transferred* by Nurse C and Nurse H. (passive)

Nurse C and Nurse H transferred Resident 2. (active)

Nurse C and Nurse H were transferring Resident 2. (active)

2. The fire alarm system *was observed* on 3/21/XX at 9:05 a.m. (passive)

Observation of the fire alarm system on 3/21/XX at 9:05 a.m. revealed . . . (active)

3. On 6/2/XX, at 10:15 a.m., an interview was conducted with Staff F. (passive)

On 6/2/XX, at 10:15 a.m., interview with Staff F revealed . . . (active)

Placing "am," "is," "was," "were," "are," "be," "being," and "been" in front of a verb usually—but not always—makes it passive. Be careful with "-*ing*" forms of verbs. When used with a form of "to be," they usually are active voice. So use "helpers" carefully.

Active-Voice Exercises

Name_____ Date_____

In the space below each passive-voice sentence, rewrite the sentence in the active voice.

1. The resident‘s back and thighs were lying against the urine-soaked pads and sheets. The resident’s urine-soaked pads and sheets had not been changed by the duty nurse.

2. The hot water temperature was tested by the maintenance person with the facility‘s thermometer.

3. At 4:00 p.m. on XX/XX/XX, a home visit was conducted at Client 8’s apartment. Registered Nurse Staff B was observed to clean the wound, which had purulent drainage.

4. No written physician‘s orders for the medications were contained in the medical record.

5. The patient was ordered intravenous replacement with antibiotics.

6. A door wedge was observed at the foot of the door holding the door open.

7. Dialysis was initiated on XX/XX/XX.

8. On XX/XX/XX at 9:00 a.m., the written preventive maintenance program was reviewed. The written program lacked evidence that preventive maintenance had been completed.

9. The patient was moved to the nursing facility.

10. The patient needing rehabilitative therapy was identified by the facility staff because the patient was contracted in the upper extremities.

Active-Voice Exercises: Answer Sheet

Name_____ Date_____

In the space below each passive voice sentence, rewrite the sentence in the active voice.

1. The resident's back and thighs were lying against the urine-soaked pads and sheets.
   Observation revealed the resident's back and thighs lying on urine-soaked pads and sheets.

   The resident's urine-soaked pads and sheets had not been changed by the duty nurse.
   The duty nurse had not changed the resident's urine-soaked pads and sheets.

2. The hot water temperature was tested by the maintenance person with the facility's thermometer.
   The maintenance person tested the hot water temperature using the facility's thermometer.

3. At 4:00 p.m. on XX/XX/XX, a home visit was conducted at Client 8's apartment. Registered Nurse Staff B was observed to clean the wound, which had purulent drainage.
   Beginning at 4:00 p.m. on XX/XX/XX during the home visit to Client 8, observation revealed Registered Nurse B cleaning the client's [part of body] wound, which had purulent (that is, odorous) drainage.

4. No written physician's orders for the medications were contained in the medical record.
   Review of the medical record found no physician's orders for medications.

5. The patient was ordered intravenous replacement with antibiotics.
   Review of the medical record revealed the physician had ordered intravenous replacement with antibiotics on [date].

6. A door wedge was observed at the foot of the door holding the door open.
   Observation found a wedge at the bottom of a door holding it open.

7. Dialysis was initiated on XX/XX/XX.
   The patient started dialysis on XX/XX/XX.

8. On XX/XX/XX at 9:00 a.m., the written preventive maintenance program was reviewed. The written program lacked evidence that preventive maintenance had been completed.
   On XX/XX/XX at 9:00 a.m., review of the written preventive maintenance program found a lack of evidence that it had been completed.

9. The patient was moved to the nursing facility.
   The facility transferred the patient to the nursing facility.

10. The patient needing rehabilitative therapy was identified by the facility staff because the patient was contracted in the upper extremities.
    Facility staff identified the patient needing rehabilitative therapy because the patient was contracted in the upper extremities.

Active-Voice Practice #1

Use the *Principles of Documentation* and revise the following deficiency report. Be sure to check for use of *all* the elements in Principles #2 and #3.

Tag

F282: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

Statement of Deficient Practice

Based on observation and record review, the facility failed to provide services in accordance with the resident's written plan of care. Facility census was thirty-nine residents. The sample was nine residents, with six additional residents included for interviews. Concerns were identified for one resident.

Findings

When the NA toileted Resident 2, she said the resident should have been toileted before lunch but was not because she did not get back from her lunch break in time to do it.

Resident 2 was identified on her 1/21/00 MDS as requiring total staff assistance to transfer and toilet.

The resident was monitored on 2/29/00 from 9:55 a.m. until 2:52 p.m. She was not toileted, checked or changed until 2:52 p.m., making it at least 5 hours between checks.

The 1/21/00 care plan had directed staff to check the resident every 1½ to 2 hours to ensure the resident was clean and dry. The care plan was not observed to be followed.

Active-Voice Practice #1: Corrections

Use the *Principles of Documentation* and revise the following deficiency. Be sure to check for use of *all* the elements in Principles #2 and #3.

Tag

F282: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

Statement of Deficient Practice

Based on observation and record review, the facility failed to provide services in accordance with the resident's written plan of care. Facility census was 39 residents. The sample was nine residents, with six additional residents included for interviews. Concerns were identified for one resident.

Comments
Interview source not included. Statement of Deficient Practice repeats the regulatory language. You cannot remove the passive voice until you write the extent as an equation. Resident identifier not included. Extraneous information included.

Revision
Based on observation, record review, and interview, the facility failed to toilet 1 of 9 sampled residents (Resident 2) in accordance with the resident's written plan of care. Facility census was 39.

Findings

When the NA toileted Resident 2, she said the resident should have been toileted before lunch but was not because she did not get back from her lunch break in time to do it.

Comments
This should be the last finding listed. No identification of source included. No date and time of interview included. Abbreviation "NA" not defined. Feminine pronoun "she" used. Written in passive voice. Extraneous information included.

Revision
In an interview on 2/29/00 at 2:52 p.m., Nursing Assistant (NA) B confirmed that staff should have toileted Resident 2 before lunch but had not.

Resident 2 was identified on her 1/21/00 MDS as requiring total staff assistance to transfer and toilet.

Comments
This should be the first finding listed. No identification of source included. Written in passive voice. Gender pronoun "her" used. Abbreviation "MDS" not identified. "MDS" might also be considered jargon and, therefore, might need defining.

Revision
Review of Resident 2's Minimum Data Set (MDS) (a federally mandated comprehensive assessment tool used for care planning) dated 1/21/00 revealed the resident required total staff assistance to transfer and toilet.

The resident was monitored on 2/29/00 from 9:55 a.m. until 2:52 p.m. She was not toileted, checked or changed until 2:52 p.m., making it at least 5 hours between checks.

Comments
This should be the third finding. No identification of source included. Gender-related pronoun "she" used. Both sentences written in passive voice.

Revision
Observation on 2/29/00 showed that Resident 2 received no toileting, checking, or changing from 9:55 a.m. until 2:52 p.m., which is a time span of almost 5 hours.

The 1/21/00 care plan had directed staff to check the resident every 1½ to 2 hours to ensure the resident was clean and dry. The care plan was not observed to be followed.

Comments
This should be the second finding listed. No identification of source included. Second sentence written in passive voice.

Revision
Review of Resident 2's care plan dated 1/21/00 revealed direction for staff to check the resident every 1½ to 2 hours to keep the resident clean and dry.

Information to Strengthen the Deficiency Statement

- Was the resident wet or dry?
- What was the resident's continence status (continent or incontinent)?
- Was there a recent change in continence (continent to incontinent or increase in incontinence)?
- Was the resident interviewable and, if so, how did the resident feel about not being toileted?
- Was toileting offered and how many times? Did she refuse? Has this occurred before, etc.? (Listing the times checked rather than a time span might be better.)
- Did this occur more than one time in the survey?
- Is this the correct tag for this deficiency or is there a better one?

Active-Voice Practice #2

Use the *Principles of Documentation* and revise the following deficiency report.

The following deficiencies relate to the Iowa Administrative Code (IAC), Chapter 63.

Tag

63.9(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

Employees shall have a physical exam at least every four years, including an assessment of tuberculosis status.

Statements of Deficient Practice

Based on record review and staff interview, it was determined that one of two staff employed at this house did not have a current physical and tuberculin status. Findings include:

_____
_____
_____
_____
_____

Staff S1's file had 12/22/95 as the date of the last physical and tuberculin test. This was longer than four years.

_____
_____
_____
_____
_____

Principles of Documentation Summary Sheet

PRINCIPLE OF DOCUMENTATION	COMPONENT/ELEMENT
Principle 1: Entity Compliance	Include an **"In Compliance"** statement if you find no deficiency.
Principle 2: Using Plain Language	**Clear Style:** Include an explanation of abbreviations.
	Exclude jargon, extraneous information, and advice.
	Write in the **active voice**.
Principle 3: Components of a Deficiency Citation	**Regulatory Reference.** Include: • The Survey Data Tag Number. • A CFR or LSC reference. • The language of the regulation. • A "NOT MET" statement.
	Deficient Practice Statement. Include: • The sources of evidence. • The clearly identified deficient practice, not a repeat of the wording of the regulation. • The extent: Both the number deficient and the possible universe. • The identifiers of the recipients. • The outcomes, if applicable.
	Facts and Findings. Include: • Items written in chronological order of occurrence. • Observation facts: Date, time, location, identifiers and information. (Use numbers for recipients and letters for staff.) • Interview facts: Date, time, identifiers and information. (Use numbers for recipients and letters for staff.) • Confidential interview facts: Date, time, wording "in a confidential interview" and information. • Record review facts: Date, time of record and record type.
Principle 4: Relevance of Onsite Correction	Write as for any other deficiency. Do not state the correction(s) unless there is an immediate jeopardy finding.
Principle 5: Interpretive Guidelines	State how the regulation is not met, not how the guidelines are not met.
Principle 6: Citation of State/Local Code Violation	Include only if required by the Federal regulations.
Principle 7: Cross-Referencing	Cross-reference a Quality of Care Tag to an Assessment of Care Planning Tag
	Cross-reference a Condition of Participation Deficiency to each subsidiary requirement deficiency.
Principle 8: Condition of Participation Deficiencies	A deficient practice and findings must support the Condition of Participation citation.

SOD Worksheet

Page 1 of the SOD:

1. The term "unannounced" and the type of inspections were identified.
2. The start date and end date, the name of the home and address of the home along with the sample size and the home's census were identified.
3. The surveyor/investigator/licensor's initials were included.
4. The unit information was included.

The failed practice and the findings reflect the regulation.

The "based on" statement:

The failed practice in the "based on" statement was clear and specific about the issue.

The scope was clearly identified.

The correct universe was identified.

Resident identifiers were used.

Findings:

Sources of evidence identified in the "based on" statement reflected what was found in the findings.

The citation had multiple sources of information and verification of the issues.

The most severe example was listed first.

Findings supported the failed practice statement.

Findings painted a clear picture of the failed practice.

Extraneous information was not present. All information was relevant to the issue.

Findings were neutral in tone and mood was used only to describe emotions that were observed. Gender was neutral.

Past tense and active voice were used. Lay terminology was used and medical and other terminology were defined when necessary.

Cross-references were used where needed, but each citation stood on its own.

Grammar and text style were correct and consistent throughout the document.

Principles of Documentation for Statement of Deficiency (CMS-2567) Review

Principle of Documentation	ELEMENT	YES	NO	N/A	COMMENTS
Principle 1: Entity Compliance	Includes **"in compliance" statement** if there are no deficiencies?				
Principle 2: Using Plain Language	**Clear style**: explains abbreviations and contains no jargon, extraneous information, and/or advice?				
	Uses **active voice** throughout the entire deficiency?				
Principle 3: Components of a Deficiency Citation	Regulatory reference: Includes **CFR or LSC reference** (e.g., 42 CFR 483.35(g), 42 CFR 483.70(a), etc.)?				
	Regulatory reference: cites the **correct tag** number (e.g., F214, K029)?				
	Regulatory reference: Would you delete this deficiency?				
	Includes the statement of **"not met"**?				
	Deficient practice statement: Are **extent, universe, identifiers, sources** included?				
	Deficient practice statement: Is the **deficient practice clearly identified** not just a restatement of the regulation?				
	Facts/findings: **Who, what, when, where, how** are included?				
	Facts/findings: Are they written in a **sequence that is easy to follow** (i.e., in order of how the events occurred)?				
	Observations: Are **date, time, and location** included?				
	Interviews: Are **date, time, and identifiers** (1, 2, 3 for residents; A, B, C for staff) included?				
	Record/document review: Are **date, time, record type** included?				
Principle 4: Relevance of On-site Correction of Findings	Is **"not met" statement for all findings** included, even if findings corrected during survey?				
Principle 5: Interpretive Guidelines	Explains **how regulation was not met**, not how the Interpretive Guidelines were not met?				
Principle 6: Citation of State/Local Code Violation	Does the deficiency **include federal not just state/local** regulation violations?				
Principle 7: Cross Reference	Cross-reference: Does the deficiency **reference care tag to assessment or care plan tag?**				
	Cross-reference: Is **each tag supportable on its own** if the other tag is deleted?				
	Do findings cross-referenced support the COP citation?				
Principle 8: Condition of Participation Deficiencies	Do deficient practice and findings support COP citation?				

TAG NUMBER: _____ **DATE OF REVIEW:** _____ **TEAM MEMBERS:**

ICF/MR Practice Sample #1

Revise the following deficiency report to meet the requirements of the *Principles of Documentation*. Be sure to check for *all* of the elements in Principles #2 and #3. At the end or on the back of the sheet, list any additional information that could have strengthened the deficiency report.

Statement of Deficient Practice

For two of three bathrooms in the residence, hot water used by four of four clients (1, 2, 3, and 4) for bathing and hand washing exceeded 115 degrees F. There was a potential for burns. Findings are based on observation, interview and record review.

Revision
In two of three bathrooms in the residence (west and north bathrooms), the hot water used by four of four clients (1, 2, 3, and 4) for bathing and hand washing exceeded 115 degrees Fahrenheit (F.), causing a potential for burns. Observation, interview and record review are the basis of the findings.

Statement of Deficient Practice

Hot water temperatures were taken by the surveyor on X/XX/XX at 4:45 p.m. in the west bathroom and 6:00 p.m. in the north bathroom. The west bathroom sink was 152 degrees F. and the north bathroom sink and bathtub was 154 degrees F.

Revision
Hot water temperature measurements on X/XX/XX revealed the hot water in the west bathroom sink at 152 degrees F at 4:45 p.m. and in the north bathroom sink at 154 degrees F. at 6:00 p.m.

Statement of Deficient Practice

When interviewed during the testing of the west bathroom water temperatures, Client 3 stated he had never been burned by hot water but the bathroom water was too hot to stick his hand into at times.

Revision
An interview with Client 3 on X/XX/XX at 4:45 p.m. revealed that although never burned by the hot water in the bathroom, the client found the water was at times too hot for washing.

Statement of Deficient Practice

Records were reviewed for Clients 1 and 2 (residential assessments for each dated XX/XX) and showed that each could regulate water temperatures independently. However, Client 1's Individual Program Plan (IPP) dated XX/XX/XX documented he had a history of seizures. Incident reports showed he had seizured within the last two months.

Revision
A record review of the Residential Assessments dated XX/XX for Clients 1 and 2 revealed each client's ability to regulate water temperatures independently. A review of Client 1's Individual Program Plan (IPP) dated XX/XX/XX revealed a history of seizures. A review of Incident Reports revealed seizure activity for Client 1 within the last two months.

Statement of Deficient Practice

When interviewed during testing of north bathroom water temperatures, the residential supervisor was not sure that all of the clients at the residence could adequately monitor and adjust the hot water independently and agreed that the hot water temperature should be turned down to ensure the clients' safety.

Revision
An interview with the Residential Supervisor on X/XX/XX at 6:00 p.m. revealed the supervisor did not know the clients could monitor temperatures and independently adjust the hot water. There was agreement that the hot water temperature needed lowering to ensure client safety.

Information to Strengthen the Deficiency Statement

- Second temperature readings to demonstrate the temperatures were routine and not a one-time occurrence. If the agency kept a temperature log, information from the log could support the continued, elevated readings.
- Evidence to show that Client 3 was capable of making believable statements.
- The connection between Client 1's seizure activity and the increased risk for burns.
- The dates of the Incident Reports reviewed and whether any of the incident reports recorded burns or not.
- Evidence related to Client 4 who appears in the deficient practice statement but not in the evidence.

ICF/MR Practice Sample #2

Revise the following deficiency report to meet the requirements of the *Principles of Documentation*. Be sure to check for *all* of the elements in Principles #2 and #3. At the end or on the back of the sheet, list any additional information that could have strengthened the deficiency report.

Tag

W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Statements of Deficient Practice

One of four clients reviewed was not always receiving an active treatment program at the Day Service. This finding was based on observation and staff interview.

Client 1 was observed on XX/XX/XX from 8:30 a.m. until 10:57 a.m. and from 1:40 p.m. until 2:26 p.m. Out of 13 observed opportunities to be encouraged by staff to move his wheelchair, only one time did the DSS direct Client 1 to move his wheelchair.

Out of six observed opportunities for him to go get training supplies, only one time did the DSS direct Client 1 to go to a shelf to choose an activity. At the other opportunities, staff were either observed giving him materials that he had asked for or placing materials in front of Client 1 that had not been asked for.

When interviewed during the p.m. observation, the DSS on duty said they had been trained to implement Client 1's training programs, which were to propel his own wheelchair and gather his own training supplies. It was also stated that, when training the "gathering supplies" program, Client 1 would tell staff what he wanted to do and the staff would go get the supplies.

When the DS Director was interviewed after completion of observations, it was stated that Client 1 was to be encouraged to move his wheelchair at every opportunity to increase his independence. Also, Client 1 was to go to a shelf in the training area and get what he wanted to work on.

Record review was conducted and verified the management staff's version of the training program. However, as previously mentioned, these programs were not being implemented consistently and at every opportunity.

HHA—G227: Scenario and SOD Example

Scenario

Tag

G227, 42 CFR 484.36(c): Assignment and duties of the home health aide. Duties include completing appropriate records.

Surveyor's Notes

1. Sample size was 15 with five home visits and a current agency census of 44.

2. Surveyor notes:
   a. Patient 2—Plan of Care dated 05/01/XX to 06/30/XX lists tasks to be completed by the aide on each visit as AROM to upper and lower extremities × 15 reps, empty urinary drainage bag and change over to the urinary leg bag, assist the patient to a standing position 5 repetitions, transfer with gait belt and apply right-hand splint after bath.

      36 Aide Treatment forms reviewed from dates 05/01/XX to 06/27/XX. No documentation found on 11 visits for AROM, 27 visits for assist the patient to a standing position 5 repetitions, 2 visits for emptying of the urinary drainage bag and changing over to the urinary leg bag, 34 visits for right-hand splint being applied.

      Interview with patient—During home visit on 6/27/XX at 11 a.m., all tasks were being completed. Pleased with care and services.

   b. Patient 3—Plan of Care dated 04/04XX to 06/03/XX lists tasks to be completed by aide on each visit as AROM to lower extremities every visit, empty urinary drainage bag every visit and position the hospital bed in low position with side rails up before leaving.

      45 Aide Treatment forms reviewed from 04/04/XX to 06/03/XX. No documentation found on 35 visits for AROM, 26 visits for emptying urinary drainage bag and 22 visits for hospital bed in low position with side rails up before leaving.

      Surveyor observation—6/26/XX at 1:00 p.m., all tasks completed as listed on the Plan of Care by Jean HHA. Catheter bag contained 600 cc of cloudy urine. Lower extremities stiff during ROM exercises and aide unable to completely straighten legs at knees. Patient repeatedly stated "that it hurts so much" during the exercises.

      Staff interview with Jean—6/26/XX at 1:30 p.m., assigned duties correctly without referring to written instructions. Stated has "so many to care for, does not always have time to chart. Sometimes forgets." When questioned regarding

AROM exercises, aide stated "has been getting stiffer over the last several visits. Probably should let the nurse know to see if therapy needs to get involved."

c. Patient 4—Plan of Care 04/03/XX to 06/02/XX lists tasks to be completed by aide on each visit as assist with transfers, AROM exercises to left upper extremity, ambulate with quad cane, hospital bed to be in low position with side rails up before leaving.

   26 Aide Treatment forms reviewed from 04/03/XX to 06/02/XX. No documentation found on 4 visits for assist with transfers, 26 visits for AROM exercises, and 24 visits for hospital bed to be in low position with side rails up before leaving.

   Patient interview—6/26/XX at 10 a.m., states exercises and walking is done each time the aides come and the aide does place the hospital bed in low position with the side rails up before leaving.

d. Patient 6—Plan of Care 04/28/XX to 06/28/XX lists tasks to be completed by aide on each visit as skin massage to back and legs with lotion every visit, assist with patient transfers and PROM exercise to left hand, fingers and wrist × 10 repetitions.

   18 Aide Treatment forms reviewed from 04/28/XX to 06/27/XX. No documentation found on 14 visits for skin care, 17 visits for assist with transfers, and 1 visit for PROM exercises.

   Surveyor observation—6/27/XX at 2 p.m., all tasks completed by John HHA except lotion applied only to legs and PROM exercises were done to all extremities. Patient refused to have lotion applied to his back.

   Staff interview with John—6/27/XX 2:30 p.m., "know that I'm supposed to put lotion on his back but he always refuses. Says it's too much trouble." Also stated, "I exercise everything to stimulate the circulation" regarding questions about the PROM exercises.

   Interview with wife as patient confused and does not respond appropriately to questions—via phone 6/27/XX at 3 p.m., "I wish they'd rub his back when they're here. I know it feels good and sometimes the skin is red from sitting so long when I finally get him to bed, but sometimes my husband just refuses."

e. Patient 10—Plan of Care 05/10/XX to 07/10/XX lists tasks to be completed by aide on each visit as assist with transfers and ambulate with walker and gait belt.

   20 Aide Treatment forms reviewed from dates 05/10/XX to 06/28/XX. No documentation found on 10 visits for assist with transfers and 3 visits for ambulate with walker with gait belt.

   Surveyor observation—06/28/XX at 9 a.m., John completed all tasks as ordered.

SOD Example

Tag

G227, 42 CFR 484.36(c): Assignment and duties of the home health aide. Duties include completing appropriate records.

Findings

This requirement is NOT MET as evidenced by:

Based on clinical record reviews, observations, patient and staff interviews, the agency failed to ensure the home health aide (HHA) documentation followed the written HHA plan of care as ordered by the physicians for 5 of 15 sampled patients (Patient 2, 3, 4, 6 and 10.)

A. Review of clinical record for Patient 2 revealed physician certification orders dated 05/01/XX to 06/30/XX required the HHA to provide the following care every visit:

- Active range of motion (AROM) for 15 repetitions to the upper and lower extremities.
- Assist the patient to a standing position for 5 repetitions.
- Assist the patient with transfers using a gait belt.
- Empty the patient's urinary drainage bag and change the bag to a urinary leg bag after the bath.
- Apply the patient's right hand splint after the bath.

Review of 36 aide treatment forms for Patient 2 completed for the dates 05/01/XX to 06/27/XX revealed the HHA failed to document the following:

- AROM during 11 visits.
- Assisting the patient to a standing position for the ordered 5 repetitions during 27 visits.
- Emptying the urinary drainage bag and changing to the urinary leg bag during 2 visits.
- Application of the patient's right hand splint during 34 visits.

During a home visit on 06/27/XX, interview at 11:00 a.m. with Patient 2 confirmed that the HHA provided all cares as ordered by the physician.

B. Review of clinical record for Patient 3 revealed the physician certification orders dated 04/04/XX to 06/03/XX required the HHA to provide the following care every visit:

- AROM to the lower extremities.
- Empty the urinary drainage bag.
- Position the hospital bed in low position with the side rails up before leaving.

Review of 45 aide treatment forms for Patient 3 completed for the dates 04/04/XX to 06/03/XX revealed the HHA failed to document the following:

- AROM during 35 visits.
- Emptying the urinary drainage bag during 26 visits.
- Positioning the hospital bed in a low position with the side rails up before leaving during 22 visits.

During a home visit on 06/26/XX at 1:00 p.m., observation showed that the HHA 'A' provided all cares as ordered by the physician.

In an interview during the home visit on 06/26/XX at 1:30 p.m., HHA A stated that there is not always enough time to chart and sometimes charting is forgotten.

C. Review of clinical record for Patient 4 revealed the physician certification orders dated 04/03/XX to 06/02/XX required the HHA to provide the following care every visit:

- Assist with patient transfers.
- AROM exercises to upper left extremity.
- Ambulate the patient with a quad cane.
- Position the hospital bed in low position with the side rails up before leaving.

Review of 26 aide treatment forms for Patient 4 completed from 04/03/XX to 06/02/XX revealed the HHA failed to document the following:

- AROM during 26 visits.
- Assisting with patient transfers during 4 visits.
- Positioning the hospital bed in a low position with the side rails up before leaving during 24 visits.

During the home visit on 06/26/XX, interview with Patient 4 at 10:00 a.m. confirmed that the HHA provided all cares as ordered by the physician.

D. Review of clinical record for Patient 6 revealed the physician certification orders dated 04/28/XX to 06/28/XX required the HHA to provide the following care every visit:

- Skin massage to the patient's back and legs with lotion.
- Assist with patient transfers.
- Passive range of motion (PROM) to the patient's left hand, fingers and wrist for 10 repetitions.

Review of 18 aide treatment forms for Patient 6 completed from 04/28/XX to 06/27/XX revealed the HHA failed to document the following:

- Skin massage to the patient's back and legs with lotion during 14 visits.
- Assisting with patient transfers during 17 visits.
- PROM to the patient's left hand, fingers and wrist for the ordered 10 repetitions during 1 visit.

E. Review of clinical record for Patient 10 revealed the physician certification orders dated 05/10/XX to 07/10/XX required the HHA to provide the following care every visit:

- Assist with patient transfers.
- Ambulate with a walker and a gait belt.

Review of 20 aide treatment forms for Patient 10 completed from 05/10/XX to 06/28/XX revealed the HHA failed to document the following:

- Assisting the patient with transfers during 10 visits.
- Ambulating the patient with a walker and gait belt during 3 visits.

During the home visit on 06/28/XX, observation of HHA B at 9:00 a.m. revealed Patient 10 received all cares as ordered by the physician.

LSC—K038: Scenario and SOD Example

Scenario

Tag

K038, NFPA 101: Exit access is so arranged that exits are readily accessible at all times. LSC 5-5, 13-2.1.

Surveyor's Notes

Name: Bob Fireman, LSC Specialist
Date & time: 5/22/XX, from 1:00 p.m. to 3:00 p.m.

History of the building:
Bedrest Care Center is a one-story brick building built in 1954. The building is not sprinklered. Total census of the building is 56. There are three exit doors from the building. There is one nursing station with 3 halls: 100 Hallway (24 beds), 200 Hallway (8 beds), and 300 Hallway (24 beds.)

Observations during tour of building:
At 1:10 p.m., Bob saw 5 boxes of canned food stacked on the floor in the hallway outside the kitchen. In the 200 Hallway, Bob also saw a metal cart with a missing wheel, a bed mattress and 2 wheelchairs in the hallway. Fred told Bob that the larger broken items always accumulated there because their tool shed was too small. Fred complained that the administrator went and bought a rider mower and that stupid thing has to be kept indoors all the time so there's no space in there to make repairs.

At 1:18 p.m., Bob noticed that both laundry doors were held open with doorstops. These laundry doors had automatic closing devices. Lucy Laundry told Bob that it gets so hot in the laundry area that they prop the doors open to cool it down.

At 1:32 p.m., Bob noticed that the door to the linen room on the 300 Hallway, which was a converted closet, would not latch. Fred Fixit, the maintenance supervisor, told Bob during the tour that he didn't know what had happened to the door or where the door was. At 2:45 p.m., Bob went back and still saw the items were still in the hallway.

Staff interviews:
At 1:15 p.m., Winnie Whiner, RN, told Bob during his tour that the med room had a squeaky door. She whined to Bob that she can't understand why things were just let go. She also complained that the sweet rolls didn't have enough frosting like they used to.

At 1:40 p.m., Molly Mop, the housekeeper who is also the supervisor for the department of two, asked Bob if it would be OK to lock the main door when she mops the floor so people wouldn't track on her clean floors. Molly told Bob those boxes of food in the hallway by the kitchen were a nuisance, too. She said she likes things just so and they got in the way whenever they were there.

Record reviews:
At 2:15 p.m., Bob looked at the logbook for the emergency generator and the tests were okay.

At 2:30 p.m., Bob looked at the record book for the fire drills. Bob found a note on the page for the 2/1/XX fire drills that said, “Drill slowed due to rear service exit clutter! Staff should stop storing furniture there.”

At 2:35 p.m., Bob then looked at the preventive maintenance records of the equipment. Bob found that the facility had a contract with a group that routinely came out to the facility to check the range hood.

SOD Example

Tag

K038, NFPA 101: Exit access is so arranged that exits are readily accessible at all times. LSC 5-5, 13-2.1 S/S = D.

Findings

This requirement is NOT MET as evidenced by:

Based on observations, record review and interview with facility staff, the facility failed to ensure that one of 3 exits areas (200 Hallway) of the building was cleared at all times to provide readily accessible exits. Failure to maintain exit corridors free from obstruction puts the residents at risk during a fire or other emergency requiring evacuation since the obstruction can delay or hinder the escape of the residents from the building. The resident census was 56.

1. On 5/22/XX at 1:10 p.m., observation revealed 5 boxes of canned food stacked on the floor outside the kitchen, a metal cart with a missing wheel, a bed mattress and 2 wheelchairs obstructing the 200 Hallway exit corridor. Eight residents use the 200 Hallway exit corridor should they need to evacuate the building during a fire or other emergency.

2. On 5/22/XX at 2:45 p.m., observation showed the boxes of canned food, the metal cart, the bed mattress and the two wheelchairs continued to obstruct the 200 Hallway exit corridor.

3. On 5/22/XX at 1:10 p.m., during the tour of the nursing home, the maintenance supervisor verified that items needing repairs were stored in the 200 Hallway exit corridor because there is not enough space in the tool shed to repair large items.

4. Review of the facility fire drill records dated 2/1/XX recorded: “Drill slowed due to rear exit clutter! Staff should stop storing furniture there.”

LTC—F314: Scenario and SOD Example

Scenario

Tag

F314, 42 CFR 483.25(c): Based on the comprehensive assessment of a resident, the facility must ensure that:

1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infections and prevent new sores from developing.

Survey Packet Information

Survey dates are 3/21/XX through 3/24/XX and survey sample size was 16 from a census of 78. 2 of the sampled residents had pressure sores. For 1 of those 2, the surveyor identified concerns.

Medical record information for Sarah Jane Jones (Resident 1):

Minimum Data Set (Full) Dated 8/9/XX	Minimum Data Set (Quarterly) Dated 11/4/XX	Minimum Data Set (Quarterly) Dated 2/20/XX
Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs (activities of daily living) except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days."	Diagnoses: Alzheimer's, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." "Rashes" was checked for skin problems. Skin treatments included pressure-relieving devices for bed and chair, application of ointments and other preventative skin care.	Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Did not consume all/most all liquids provided in last 3 days" was checked. Stage II pressure ulcer was marked "1." Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments and other preventative skin care.

Physician's orders:
12/20/XX—Cleanse wound on coccyx with NS and apply Duoderm. Change PRN to keep area covered.
1/15/XX—Bactrim DS 1 BID × 10 days for UTI. Obtain follow-up UA.
1/21/XX—Change diet to regular with ground meat.

Care Plan with latest update 2/20/XX:
1) Problem—Potential for alter nutrition related to lack of dentures. Goal—Will consume 100% of diet. Approaches—Monitor food intake, obtain dental referral to fix broken dentures, give ground meat and soft, easy-to-chew foods.
2) Problem—Potential for skin breakdown. Goal—Will have no open areas × 90 days. Approaches—Egg crate mattress/pad in both bed and w/c, repo q 2 hrs with massage to boney prominence, treat open areas per MD orders.
3) Problem—Recurrent UTI. Goal—Will have no UTI × 90 days. Approaches—Follow aseptic technique for cath care, encourage fluids, give cranberry juice TID with meals.

Surveyor observation notes:

1. 3/22/XX: At 6:45 a.m. NAs, Sally and Rita, transferred Sarah Jane to w/c with mechanical lift. Bed remained at lowest position during entire procedure. They rolled Sarah Jane to left side and positioned lift seat under her. They then rolled Sarah Jane to right side, straightened lift seat beneath her, and rolled her on to back. Bottom edge of lift seat was at level of mid-buttocks. Each NA grabbed a leg strap of the seat and tugged it down into position. Sally then unhooked cath bag from side of bed and hooked it to her uniform pocket. Rita connected the lift seat to the lift frame and raised Sarah Jane into air. Sally swung Sarah Jane around and Rita pushed lift frame to position her over the chair. Rita lowered Sarah Jane into the w/c. As Sally made the bed (which was covered with a blue foam mattress overlay), Rita provided oral care to Sarah Jane and took her to the dining room for breakfast. Sarah Jane remained in the dining room until after lunch. At 9:00 a.m., another resident, John Henry, conducted devotions in the dining room. Then there was group exercise conducted by Maude Hurry, Activities Director, at 10:00. Then the kindergarten class from Jeff Davis Public School came at 11:00 and sang for the residents. Maude said, "Sarah Jane doesn't care much for John's devotional services. He had a run-in with her husband several years ago and they've been enemies even since. She's kind of lazy and won't exercise either but we keep her out for the socialization. But she sure enjoys the kids." At 12:30 p.m., same 2 NAs transferred Sarah Jane from the w/c back into bed using the mechanical lift. When they removed Sarah Jane's incontinent brief, no dressing covered the wound on her coccyx, which was about the size of a quarter and staged at a II. Sally said, "Boy, that looks nasty! It's bigger than when I saw it last week!" Rita said, "Yeah, I told Betty that the dressing was off this morning and she said they couldn't put a new one on until tomorrow." Sarah Jane remained in bed on left side until observations ended at 4:30 p.m.

2. 3/23/XX: At 8:30 a.m., Sarah Jane was in the dining room eating breakfast which consisted of scrambled eggs, oatmeal, toast with butter and strawberry jelly, 6 oz glass of milk, 4 oz glass of orange juice, and cup of coffee. At 8:40 a.m., Jane (NA) took Sarah Jane from the dining room and returned her to her room. Sarah Jane had eaten ½ of her oatmeal and drank only her coffee. Sarah Jane remained seated in her w/c in her room watching TV throughout morning until taken to dining room for lunch at 11:30 a.m. At 1:00 p.m., Betty Bopp (RN) requested that Jane lay Sarah Jane down so she could do the wound treatment. Betty did Sarah Jane's wound treatment at 1:30 p.m. She turned Sarah Jane onto her left side and exposed Sarah Jane from the waist down. Betty said,

"Tsk, Tsk. This looks redder than when we have it covered with a dressing. I wish they'd let us order dressings more than once a week. We always seem to run out and have to wait for a new supply to come in." Betty then washed wound with soap and water and applied Duoderm dressing. Sarah Jane remained on left side until observation ended at 4:00 p.m.

SOD Example

Tag

F314, 42 CFR 483.25(c): Based on the comprehensive assessment of a resident, the facility must ensure that:

1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infections and prevent new sores from developing.

Findings

This requirement is NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to provide repositioning, treatment, and nutritional interventions to promote the healing of pressure sores for 1 of 2 sampled residents (Resident 1) with pressure sores from a sample size of 16. Facility census was 78.

1. Record review of Resident 1's latest Minimum Data Set (MDS), a federally mandated comprehensive assessment tool, dated 2/20/XX showed the following information:
   - Diagnoses of Alzheimer's disease and recent stroke with paralysis, wheelchair bound with no ambulation.
   - A stage II pressure sore (a partial thickness loss of skin layers either dermis or epidermis that presents clinically as an abrasion, blister or shallow crater).
   - Skin treatments including pressure-relieving devices for bed and chair, application of dressing, application of ointments and other preventative skin care.

Review of Resident 1's Care Plan updated 2/20/XX documented the identified problem of "potential for skin breakdown" with approaches consisting of egg crate mattress on bed and in wheelchair, reposition every 2 hours, and treat open areas per physician's orders.

Observation showed Resident 1 sat in the wheelchair on 3/22/XX from 6:45 a.m. until 12:30 p.m. without change of position to relieve pressure on the buttocks and coccyx. On 3/23/XX, Resident 1 sat in the wheelchair from 8:30 a.m. until 1:00 p.m. Observation also showed Resident 1 remained in bed positioned on left side without benefit of repositioning from 12:30 p.m. until observation ended at 4:30 p.m. on 3/22/XX and again from 1:00 p.m. until observation ended at 4:00 p.m. on 3/23/XX. (Routine repositioning relieves the pressure from areas where bones are close to the skin surface. Unrelieved pressure causes a decrease in circulation, which results in death of skin tissue and the development of pressure sores.)

Review of physician's orders showed an order dated 12/20/XX to cleanse the coccyx wound with normal saline (NS) and keep covered with a Duoderm dressing. Observation showed that the coccyx wound remained uncovered from 12:30 p.m. on 3/22/XX until RN A

completed the wound treatment at 1:30 p.m. on 3/23/XX. Interview with RN A on 3/23/XX at 1:30 p.m. confirmed deterioration in the wound due to the wound being uncovered.

Review of the latest diet order dated 1/21/XX showed Resident 1's diet to be a regular diet with ground meat. Review of the Care Plan updated 2/20/XX showed no nutritional interventions identified to address the need for increased protein for wound healing. Observation of breakfast meal on 3/23/00 showed consumption of less than ½ the diet without intake of protein foods.

F314: Points for Questions Related to SOD

CMS Representative (Pro)	Facility Representative (Con)
AHCPR Guidelines for Treatment Ulcers show the need for pressure-reducing devices in bed and chair (foam mattresses/pads need to be 3–4 inches thick, which blue egg crates are not).	No interview with Sarah Jane or staff related to whether she refused to go to bed and wanted to stay up through the morning.
AHCPR Guidelines for Treatment Ulcers show to avoid sitting for long periods if the sore is in areas affected by sitting. The coccyx would be.	No interview with Sarah Jane or staff related to whether she preferred the left side and refused to lay any other way.
AHCPR Guidelines for Treatment Ulcers show low protein and nutrient intake contributes to pressure sore development and delays healing.	No observation of pressure relief in the wheelchair.
Care plan identifies only a "potential" for skin breakdown and does not address the actual breakdown.	No interview with Sarah Jane or staff related to food preferences and what was offered to increase protein.
Staff is aware that the wound should be covered but is not because of the ordering policies of the facility and the lack of dressing material.	No exact measurements were taken of the wound and no review of wound care documentation done.
	No additional meal observations besides breakfast on 3/23/XX.

LTC—F316: Scenario and SOD Example

Scenario

Tag

F316, 42 CFR 483.25(d)(2): A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Survey Packet Information

Sample size was 16 from a census of 78. 2 of the sampled residents had indwelling catheters. The surveyor identified concerns for 1 of those 2 residents.

Resident 44:

Minimum Data Set (Full) Dated 8/9/XX	Minimum Data Set (Quarterly) Dated 11/4/XX	Minimum Data Set (Quarterly) Dated 2/20/XX
Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs (activities of daily living) except eats independently, does not ambulate and is wheelchair bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." Stage IV pressure ulcer was marked with "1" and "Rashes" was checked. Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.	Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair bound. Occasionally incontinent of bowel and has a Foley catheter. "Did not consume all/most all liquids provided in last 3 days" was checked. Stage II pressure ulcer was marked "1" and Stage IV "0." Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.	Diagnoses: Alzheimer's, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair bound. Occasional incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." "Rashes" was checked for skin problems. Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.

Surveyor observation notes:

1. 3/22/XX at 11:45 a.m. 2 NAs transferred resident to wheelchair with mechanical lift. Bed remained at its lowest height during entire procedure. Catheter bag that contained 500 cc urine removed from far side of bed by NA (Sally) and handed across resident to NA (Rita) on near side of bed who hooked it to pocket of uniform. No strap or tape was securing catheter to thigh. Resident rolled to face far side of bed and lift seat positioned under resident. Resident rolled to face near side and lift seat straightened. Lift seat connected to lift frame, raised and transfer made to wheelchair. Resident positioned in wheelchair. While NA (Sally) straightened bed, other NA (Rita) unhooked catheter bag from pocket and laid it on floor under wheelchair. NA (Rita) went around back of wheelchair and reached from behind wheelchair to pick up bag. NA (Rita) place bag in cover while holding bag behind resident at resident shoulder level then attached bag to cord running from one side of back to other at seat level. Drainage tubing looped from front of chair seat to drainage bag hanging in back and touching on the floor. Catheter bag did not have antireflux valve.

2. 3/22/XX at 1:30 p.m. Same 2 NAs transferred resident from wheelchair to bed. Drainage tubing was still touching the floor. Bed remained at its lowest height during entire procedure. While one NA (Rita) pulled back covers to open bed, other NA (Sally) removed catheter bag from back of wheelchair and laid it on floor under chair. NA (Sally) then went around to front of wheelchair, picked bag up from floor, removed cover and hooked to pocket of uniform. Lift seat was attached to lift frame, resident raised and transferred to bed. With NA on each side of bed, resident was rolled to face near side and lift seat rolled up under resident. Resident was rolled to face far side of bed, lift seat removed and positioned on that side. NA (Sally) removed catheter bag hook from pocket and handed bag across resident to other NA (Rita). Catheter bag was hooked to bed frame and tubing left dangling from edge of bed.

3. 3/23/XX at 6:00 a.m. provision of pericare. NA (Jane) brought washcloths and towel from linen room. Knocked on door, entered, placed linen on bed stand and washed hands. Then got washbasin from resident's bed stand and filled with water in bathroom. Placed basin with linen on bed stand and put on gloves. Told resident was going to "clean around catheter" and pulled back covers exposing resident. Moistened washcloth, applied soap, and formed mitt around hand. Spread labia with fingers of one hand and wiped front-to-back with washcloth on each side of labia. While still holding labia apart, dipped mitt in basin of water, squeezed water out, and wiped each side of labia using same motion. Labia released, mitt dipped in basin, rubbed on soap bar, and each side of outside of labia wiped front-to-back. Rinse process repeated. Mitt placed in basin, towel picked up and outer labia patted dry. Powder sprinkled liberally on peri-area.

Resident interview:
3/23/XX at 9:30 a.m. The "catheter sometimes pulls during transfers or repositioning. At times it feels like I have to go bad and it burns down there." Likes staff. Has no complaints about treatment or care. Doesn't like to drink water, never has. Prefers coffee.

Additional chart review:
Urine analysis on 2/17/XX: Cloudy, WBC 120, nitrate + leukocyte esterase + bacteria large.
Culture results: E. coli; sensitive to all tested antibiotics.
Physician's order on 2/18/XX for antibiotic for 10 days with UA 2 days after antibiotic finished. Diagnosis: UTI (urinary tract infection).

Staff interviews:
NA (Rita) on 3/22/XX at 12:15 p.m. Catheter straps kept in utility room but a nuisance when used because need to be moved and repositioned to prevent skin irritation. Procedure is to keep catheter bag below bladder level at all times.

Director of Nursing on 3/23/XX at 2:30 p.m. Catheter bags facility uses do not have anti-reflux device. Policy is to keep catheter bag below bladder level at all times so reflux does not occur. Catheter bags and tubing are not to touch the floor.

Policy and procedure review:

a. Policy/procedure for "Caring for a Foley Catheter" dated June XXXX states catheter bags are to be positioned below bladder level with tubing coiled and placed at or below bladder level at all times to prevent reflux of urine from the tubing and/or drainage bag into the bladder which could cause a UTI. To prevent contamination, the drainage bag and tubing should never touch the floor. Drainage tubing is to be attached to the upper thigh using a catheter strap to prevent tension on the catheter.

b. Policy/procedure for "Catheter Care" dated June XXXX states it is to be provided twice daily, with a.m. and HS cares. The labia are to be spread and the urinary meatus and 4 inches down the catheter to be washed with soap and water and rinsed first. Then the inside of the labia is to be washed with soap and water using a different portion of the washcloth for each stroke, then rinsed. A front-to-back cleansing motion is to be used. The labia are then released and the outside of the labia should be washed and rinsed in the same manner. A clean washcloth is to be used whenever the cloth becomes soiled. The labia are to be patted dry. The insides of the thighs are to be cleaned in the same manner. The resident is then to be turned on the side and the rectal area cleansed in the same manner. Powders and lotions are not to be used unless ordered as a moisture barrier.

SOD Example

Tag

F316, 42 CFR 483.25(d)(2): A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Findings

This requirement is NOT MET as evidenced by:

Based on observations, staff interview, and record review, the facility failed to provide treatment and services to prevent urinary tract infections for 1 of 2 sampled residents with indwelling catheters (Residents 44 and 57). Total sample size was 16 in a facility with a census of 78.

Record review conducted on 3/21/XX for Resident 44 revealed diagnoses of Alzheimer's disease, Parkinson's disease, recent cerebrovascular accident (CVA) with paralysis, and history of decubitus ulcer. Review of the last three Minimum Data Sets (MDSs) completed for Resident 44 documented the resident has an indwelling catheter.

Laboratory report dated 2/17/XX showed the following results: appearance cloudy, WBCs (white blood cells) 120 (normal is 3 to 4), nitrates positive (normal is negative), leukocyte esterase positive (normal is negative), and large amount of bacteria (normal is negative). A physician's order dated 2/18/XX documented a diagnosis of urinary tract infection (UTI) and prescribed a 10-day course of antibiotics.

During observation of transfer of Resident 44 from bed to wheelchair on 3/22/XX at 11:45 a.m., NA C (a nursing assistant) lifted catheter drainage bag over top of resident lying in bed to hand it to NA B, who hooked it to uniform pocket. Resident 44's bed was at its lowest height, causing the drainage bag to be suspended above bladder level prior to the transfer. After the transfer was completed, NA B placed the catheter bag on the floor underneath the wheelchair, went around to the back of the wheelchair, and picked up the bag from behind the wheelchair. NA B then placed catheter drainage bag in a cover holding the bag at the height of the resident's shoulders. NA B then hooked the drainage bag to the back of the wheelchair below bladder level with the tubing looped under the wheelchair from front to back with the tubing touching the floor. Check of the catheter drainage bag at the time of observation revealed that the bag did not contain an antireflux valve between bag and drainage tubing.

Observation of another transfer of Resident 44 on 3/22/XX at 1:30 p.m. revealed NA B and NA C again hooking the catheter bag to a pocket, above the level of the resident's bladder. During the transfer, the catheter tubing again came in contact with the floor.

3/23/XX at 9:30 a.m. During interview, Resident 44 said the "catheter sometimes pulls during transfers or repositioning. At times it feels like I have to go bad and it burns down there."
In an interview conducted on 3/23/XX at 2:30 p.m., the Director of Nursing confirmed that the catheter drainage bags used by the facility do not contain antireflux valves. The Director of Nursing stated that, due to the bags' not containing antireflux valves, it is the policy of the facility to keep the catheter tubing and drainage bags below the residents' bladder level at all times.

Review of facility policy titled "Caring for a Foley Catheter" dated June XXXX confirmed "catheter bags are to be positioned below bladder level with tubing coiled and placed at or below bladder level at all times to prevent reflux of urine from the tubing and/or drainage bag into the bladder which could cause a UTI (urinary tract infection)."

During observation of catheter care for Resident 44 on 3/23/XX, at 6:00 a.m., NA D did not cleanse the urinary meatus, the Foley catheter tubing, or the thighs and rectal area. NA D sprinkled the perineal area liberally with powder.

Review of the facility policy and procedure titled "Catheter Care" dated June XXXX directed staff to wash around the urinary meatus and up to four inches of the catheter, followed by the outer labia, thighs, and finally the rectal area.

ESRD—V449: SOD Example

Tag

42 CFR 405.2163(d): The dietitian, in consultation with the attending physician, is responsible for assessing the nutritional and dietetic needs for each patient, recommending therapeutic diets, counseling patients and their families on prescribed diets, and monitoring adherence and response to diets.

Findings

This requirement is NOT MET as evidenced by:

Based on record review, facility policy and procedure review, and interview with facility staff, the facility failed to ensure dietitian services for 2 of 2 sampled ESRD (end stage renal disease) patients (Patients 3 and 4) diagnosed with ESRD, diabetes and hypertension.

1. Review of facility policy #949 titled "Dietetic Services" revision date 1/5/XX, stated that the "Dietitian shall assess each new patient in the facility within the first 4 weeks after initiation of dialysis." Further review of facility policy #949 recorded the dietitian is to evaluate and educate the new patient for knowledge level and understanding of diet related to diabetes, hypertension, ESRD and fluid restrictions within the first week after initiation of dialysis.

2. Review of the 9/4/XX history and physical of Patient 3 revealed an 82-year-old patient with diagnosis of diabetes, hypertension and ESRD. Review of the comprehensive Care Plan revealed dialysis began on 9/4/XX and the patient's diet order stated: 1500 calorie ADA (American Dietetics Association), 60 gram protein, 2 gram sodium, 2 gram potassium, less than 1 gram phosphorus, 1200 cc (cubic centimeters) fluid restriction per day. Review of social services evaluation and Care Plan notes revealed the patient moved to a skilled nursing home on 9/20/XX due to transportation difficulties from home to the dialysis facility. Review of the patient's medical record showed no dietitian evaluation of Patient 3.

   During an interview on 10/8/XX at 2:00 p.m., the charge nurse confirmed that the dietitian did not evaluate Patient 3. Further interview with the charge nurse revealed that the dietitian was scheduled to consult with Patient 3 on 9/25/XX.

3. Review of the 9/10/XX history and physical of Patient 4 revealed a 76-year-old patient with diagnosis of diabetes, hypertension and ESRD. Review of the comprehensive Care Plan revealed dialysis began on 9/10/XX and the patient's diet order stated: 1800 calorie ADA, 60–75 gram protein, 2 gram sodium, 2 gram potassium, less than 1 gram phosphorus, 1500 cc (cubic centimeters) fluid restriction per day. Review of the dietary evaluation and Care Plan notes showed no dietitian evaluation of Patient 4.

During interview on 10/8/XX at 2:00 p.m., the charge nurse confirmed that the dietitian had not evaluated Patient 4. Further interview with the charge nurse revealed that the dietitian was scheduled to consult Patient 4 on 9/25/XX.

HHA—G158: SOD Example

Tag

42 CFR 484.18: Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

Findings

This Standard is NOT MET as evidenced by:

Based on observation, patient interview, agency staff interview and clinical record reviews, the agency failed to develop and/or follow written physician plans of care for 3 of 11 patients (Patients 1, 2, and 5) related to cares in regards to medication changes, elevated blood sugars and wound care.

1. Patient 2's clinical record review on 5/8/XX revealed the following. The skilled nurse (SN) documented a change of physician on 4/6/XX. The clinical record failed to contain orders from the new attending physician. On 4/6/XX, the SN documented that the new attending physician discontinued the patient's Theophylline and started Atrovent (both bronchodilating medications). The patient's clinical record contained no written physician's orders for these medication changes.

   Interview on 5/9/XX at 7:45 a.m. with the SN case manager for Patient 2 confirmed that the new attending physician did not write orders for Patient 2.

2. Patient 5's clinical record review on 5/8/XX revealed the following. The primary diagnosis for Patient 5 is diabetes mellitus. Physician certification orders dated 3/24/XX to 5/24/XX included that the skilled nurse is to visit the patient two times a week. During these visits, the SN is to perform a blood glucose fingerstick in the morning before meals and the administration of the morning medications. The SN is to notify the physician if the patient's blood sugar exceeds 200 mg/dl (milligrams per deciliter)

   Review of Patient 5's clinical record further revealed that the SN documented on 3/27/XX that the patient's blood sugar as 321 mg/dl at 8:00 a.m. before the patient consumed meals and medications. On 3/30/XX, the SN documented the patient's blood sugar as 279 mg/dl at 8:00 a.m. before the patient consumed meals and medications. On 4/3/XX, the SN documented the patient's blood sugar as 282 mg/dl at 7:45 a.m. before the patient consumed meals and medications. There was no documentation the SN notified the physician of the elevated blood sugars on 3/27, 3/20 or 4/3/XX. On 4/6/XX, the SN documented that "Patient did not answer the door." On 4/7/XX the SN documented a transfer OASIS (Outcome Assessment and Information Set) assessment, a federally mandatory comprehensive assessment document, recording the patient's admission to an acute care facility on 4/6/XX for treatment of hyperglycemia (high blood sugar level).

Interview with the SN case manager for Patient 5 on 5/9/XX at 8:00 a.m. confirmed that the physician was not notified of the elevated blood sugars as ordered by the physician.

3. Patient 1's clinical record review on 5/8/XX revealed the following. Diagnosis of diabetes mellitus and a physician order of 4/11/XX included the SN is to provide wound care every other day to the patient's right foot. This wound order stated " Use Skintegrity to cleanse the wound then rinse the wound with sterile normal saline, apply a Strasorb dressing to the wound, then apply an abdominal dressing securing the dressing with paper tape." Review of the wound treatment record showed the SN documented cleansing the patient's right foot with hydrogen peroxide then applying a Duoderm dressing on 4/12, 4/14, 4/16, 4/18, 4/20, and 4/22/XX.

   During a home visit on 5/8/XX at 4:00 p.m., observation revealed the SN cleansed Patient 1's right foot wound with hydrogen peroxide then applied a Duoderm dressing to the wound. During interview at 4:30 p.m., Patient 1 revealed that today's wound care procedure was "no different than any other day." Patient further stated: "I don't like the burning and it's not getting any better."

Hospice—L125: SOD Example

Tag

42 CFR 418.56(d): The hospice retains the responsibility for payment for services.

Findings

The Standard is NOT MET as evidenced by:

Based on interviews, and review of clinical record, written agreement and billing records, the hospice failed to develop a written agreement that did not limit its financial responsibility. In addition, the hospice failed to retain payment for hospice-related services including supplies, diagnostic tests and medications for 1 of 1 hospice patient (Patient 3) that resided in a skilled nursing facility.

1. Review of the hospice written agreement between the hospice and the SNF (skilled nursing facility) dated and signed by both contracting parties on 12/9/XX revealed the following. The agreement at Exhibit C.II.(b)(i) states: "Hospice will: (i) Provide the following supply items identified to be appropriate according to the Hospice plan of care . . . disposable diapers (36 per week); blue pads (28 per week); Depends (15 per week); ostomy bags if ostomy is the result of terminal diagnosis (7 per week); Foley catheter (one change per month); wound care supplies." This written agreement between the SNF and the hospice limits the financial responsibility of the hospice for the medical supplies of its terminal patients.

2. Review of physician's progress notes in the SNF clinical record for Patient 3 revealed the following. Patient admitted to hospice services on 12/13/XX with the admitting diagnosis of multiple sclerosis. Patient had an indwelling catheter. The physician orders of 9/1/XX stated: "Catheter to be changed monthly or as needed if leaking or pulled out. Catheter bag to be changed every two weeks."

Interview with hospice director on 1/22/XX at 3:00 p.m. revealed that the hospice did not have billing records of Patient 3's catheter supplies. Upon request by the hospice director after the surveyor requested billing information, the SNF faxed to the hospice copies of health insurance claim forms submitted to Medicare by the SNF for the following catheter supplies.

a. Dates of service 12/10/XX to 12/31/XX documented charges for one catheter tray at a cost of $39.30.
b. Dates of service 1/1/XX to 1/9/XX documented charges for two urinary draining bags at $10.49 each for a total cost of $20.98.
c. Dates of service 1/10/XX to 2/9/XX documented charges for insertion catheter tray for $39.30 and a urinary drainage bag for $10.49.

Further interview with the hospice director on 1/22/XX at 4:00 p.m. revealed the hospice will pay the bill for the catheter supplies and will not bill Medicare.

3. Review of SNF clinical record for Patient 3 revealed the following. History and physical dated 10/6/XX that included: "Respiratory difficulties secondary to the multiple sclerosis." On 12/28/XX, the physician ordered a chest X-ray for the patient. The X-ray summary report dated 12/28/XX stated: "Left base pneumonia, mild. The recurrence and/or persistence of this pneumonia does suggest underlying pathology and definitive follow-up is recommended to rule out pathology." Because of the chest X-ray diagnosis of pneumonia on 12/28/XX, the physician ordered intravenous replacement with antibiotic treatment. The patient received the treatment of D5NS (5% Dextrose solution) at 75 cc (cubic centimeters) per hour for 7 days with Levaquin 500 mg (milligrams), an antibiotic, every 24 hours for 7 days. The patient began on oxygen at 2 liters per nasal cannula when the patient's oxygen level dropped below 90% blood saturation levels. The hospice medication sheet included the physician order dated 1/3/XX for Albuterol 0.5 cc with Atrovent 2.5 cc (both bronchodilator drugs) three times per day via nebulizer. A copy of the hospice ongoing plan of care documented that the Albuterol, Atrovent and nebulizer treatments were "non-covered items."

On 1/20/XX at 11:00 a.m., interview with the SNF Director of Nurses revealed that she was unaware who was to be billed for Patient 3's 12/28/XX pneumonia care. The care for Patient 3's pneumonia included the following charges: chest X-ray, intravenous therapy treatments for fluid replacement and intravenous antibiotic treatments, oxygen, and nebulizer treatments.

Interview with hospice Director of Nurses on 1/20/XX at 1:00 p.m. confirmed that no one had contacted the physician but would do so on 1/20/XX to verify if the patient's 12/28/XX diagnosis of pneumonia is related to the terminal diagnosis of multiple sclerosis for Patient 3. Review of a fax from the physician dated 1/20/XX at 1:30 p.m. confirmed the diagnosis of pneumonia on 12/28/XX had a relationship to the patient's terminal diagnosis of multiple sclerosis.

Hospital—A350: SOD Example

Tag

42 CFR 482.43(a): Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Findings

This standard is NOT MET as evidenced by:

Based on patient and staff interviews, review of facility policies, and review of 2 of 10 patients' medical records (Patients 10 and 25), the facility failed to identify and implement patient needs for home health care and colostomy teaching prior to discharge.

1. The hospital policy and procedure #9999 entitled "Discharge Planning" reviewed on 6/2/XX at 10:30 a.m. stated that "A Discharge Plan is to be initiated by the social worker and the nursing staff within 24 hours of admission on every patient who is over the age of 62, . . . anyone living alone, or anyone likely to need postdischarge care."

   Medical record review of Patient 25 on 6/2/XX at 8:30 a.m. revealed patient had surgery for a permanent colostomy on 5/26/XX due to cancer of the colon. Interview with the patient on 6/2/XX at 1:00 p.m. revealed that the patient was worried because the patient lives alone and feels very weak. During the interview, the patient revealed anticipating discharge in a couple of days. Patient 25 further stated, "I'm not sure how I will manage the colostomy at home," and needs to know how to take care of the colostomy before going home.

   Review of nursing policy #999A "Colostomy Training" effective on 1/1/XX showed that "Colostomy training must be initiated within 24 hours postoperatively so as to make sure the patient is able and willing to take care of the colostomy at home."

   Review of Patient 25's medical record on 6/2/XX at 5:30 p.m. seven days after Patient 25's surgery revealed no evidence in Patient 25's medical record of initiation of colostomy teaching.

   On 6/3/XX at 9:00 a.m., the unit manager revealed in interview that the nursing staff should have initiated colostomy training with Patient 25 to prepare the patient for discharge. The unit manager stated that colostomy training for Patient 25 would start immediately. Clinical record review on 6/3/XX at 5:30 p.m. revealed no evidence of colostomy teaching by hospital staff with Patient 25. During interview with Patient 25 on 6/3/XX at 6:00 p.m., the patient stated: "They haven't talked to me yet about my colostomy."

2. On 6/2/XX at 9:00 a.m., record review of Patient 10's closed medical record revealed the following from the 4/30/XX history and physical. Patient 10 is a 75-year-old admitted on 4/30/XX with abdominal pain. Patient 10 diagnosed with cholecystitis had a cholecystectomy (removal of gallbladder) performed on the same day. Three days later the patient developed a surgical wound infection. The wound required packing with gauze moistened with normal saline three times a day. Review of the physician's progress notes dated 5/4/XX further revealed that Patient 10's discharge occurred on 5/4/XX with a physician's order to continue with the dressing changes at home under the care of a home health agency. There was no documented evidence in Patient 10's medical record that demonstrated coordination of care with a home health agency.

   During an interview on 6/3/XX at 9:00 a.m., the unit manager confirmed that the social worker failed to coordinate the discharge plans with the home health agency. In an interview on 6/3/XX at 11:00 a.m., the social worker assigned to the unit that cared for Patient 10 stated: "I am aware of the policy but I have been very busy and unable to evaluate every patient on my assigned unit. Sometimes, by the time I realize it, the patients have gone home without a discharge plan."

ICF/MR—W249: SOD Example

Tag

42 CFR 482.440(d)(1): As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Findings

This requirement is NOT MET as evidenced by:

Based on observation, record review and staff interview, the facility failed to assure that 1 of 58 clients (Client 34) sampled received continuous active treatment programs to support the behavioral needs of each client.

On 2/22/XX at 6:20 p.m., observation revealed Client 34 sat in the dining room, away from the table facing the TV (television). The TV was off. The client's back was to the other clients who were at the table. A radio played quietly as other clients finished supper. Client 34 sat with two beanie babies in the wheelchair, head down, and eyes closed.

During an interview on 2/22/XX at 6:20 p.m., the developmental aide on duty (DA I) said Client 34 received tube feedings and nothing by mouth. DA I also said Client 34 came to the dining room during meals for the social time. At 6:30 p.m. DA I gave Client 34 a child's driving simulator toy (Tiny Tot Driver). The client immediately began pushing buttons on the toy. The client still sat facing the TV with back to the other clients. This continued until 7:00 p.m. (30 minutes).

During observation on 2/29/XX at 5:30 p.m., Client 34 sat facing the TV away from the table. The TV was not on. Client 34 continued to sit there until 6:40 p.m. (70 minutes).

On 3/1/XX at 5:00 p.m., observation revealed that Client 34 sat in the dining room away from the table facing the TV. The TV was not on, and the client engaged in no activity. At 5:05 p.m. DA I turned Client 34 around to face the table, but did not push the client up to the table (approximately 6 feet away). At that time, DA I stated the clients go to the dining room after the afternoon programming. The clients stay in the dining room and do activities until the serving of the evening meal. At 5:25 p.m. (20 minutes had passed), Client 34 still sat back from the table with no activity and continued to sit there until 6:10 p.m. (65 minutes) with no activity. At 6:10 p.m. DA I gave Client 34 a toy (Tiny Tot Driver). The client immediately began pushing the buttons on the toy.

On 3/2/XX at 9:00 a.m. observation revealed Client 34 sitting in the dining room back from the table and not engaged in any activity. The client sat with a stuffed brown bear in the wheelchair, head down and eyes closed. At 9:05 a.m. the DA K said Client 34 came to the dining room for social activity. Client 34 continued to sit back from the table and engaged in

no activity until 9:30 a.m. (30 minutes). The other clients were at the door, lined up to leave the dining room.

The PCP (person-centered plan) dated 1/20/XX documented interventions for Client 34 were visual/tactile and/or audio/visual stimulation during social time at meals (e.g., peg boards, tactile stimulation, etc.)

LSC—K021: SOD Example

TAG	SUMMARY STATEMENT OF DEFICIENCIES
K021	NFPA 101 STANDARD: Life Safety Code Standard Doors in fire separation walls, hazardous area exposure, horizontal exits, or smoke partitions may be held open only by devices arranged to automatically close such doors by zone or throughout the facility upon activation of: a) the required manual system and b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and c) the automatic sprinkler if installed. 13-2.11.5 This requirement was NOT MET as evidenced by: Based on observation and staff interview, the facility failed to allow the automatic closure of 1 of 9 fire separation doors (West Fire Door) included in the facility's fire safety system by use of a door wedge (an unapproved device which prevents automatic door closure). Findings are: On facility tour between 2:30 and 3:30 p.m. on XX/XX/XX, observation revealed a door wedge at the foot of the West Entry door holding the door open. The door wedge held the door in the open position and prevented automatic closure in case of fire, which breaks the fire separation barrier and allows the spread of smoke and fire into and out of that fire containment zone. In an interview conducted at the time of observation (between 2:30 and 3:30 p.m. on XX/XX/XX), custodial staff member D stated that during the summer wedges routinely held open the West Entry door to allow for air flow in the laundry area when the dryers are running.

LSC—K051: SOD Example

Tag

A fire alarm system, not a presignal type, with approved component devices or equipments installed to provide effective warning of fire in any part of the building. Pull stations in patient sleeping area may be omitted at exits if located at all nurses stations, are visible and continuously accessible and travel distances of 7-6.2.4 are not exceeded. Required sprinklers, detectors, etc. are arranged to activate the fire alarm system and operate devices such as dampers, door holders, etc. Fixed extinguishment protective systems protecting commercial cooking equipment in kitchens protected by a complete automatic sprinklers need not initiate the building fire alarm system. The fire alarm system is connected to automatically transmit an alarm to summon the local fire department. (13-3.4.2, 13-3.4.3, 13-3.4.4)

Findings

This requirement is NOT MET as evidenced by:

Based on observation, staff interviews and record reviews, the facility failed to provide a fire alarm that was audible in 6 of 6 fire zones which placed all 112 residents at risk for unsafe evacuation in case of fire.

An interview with the administrator conducted on 3/21/XX at 9:05 a.m. revealed the fire alarm company updated the facility fire alarm system with work completion on 3/1/XX.

A review of the facility “Fire Drills and Safety” records for the year XXXX confirmed, on 3/1/XX, the update to the facility’s fire alarm system.

Observation and testing of the fire alarm system on 3/21/XX, at 9:30 a.m., revealed that the 6 horizontal exit doors closed but the fire alarm horns did not sound.

An interview with the maintenance supervisor on 3/21/XX, at 9:50 a.m., revealed that the maintenance department conducted no testing of the fire alarm system since the fire alarm company completed work on 3/1/XX.

An interview with the administrator on 3/21/XX, at 1:00 p.m., revealed contact with the fire alarm company and reactivation of the fire alarm audible signal resulting in the facility having no audible fire alarm signal for at least 20 days.

LTC—F309: SOD Example

Tag

42 CFR 483.25: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Use F309 for quality of care deficiencies not covered by 42 CFR 483.25(a)–(m).

Findings

Severity and Scope: G

This requirement was NOT MET as evidenced by:

Based on observations, interviews and record review, the facility failed to assess, monitor, and provide timely interventions after a fall for 1 of 8 residents (25) facility staff assessed as at risk for falling. The facility census was 39 residents.

Review of Resident 25's Minimum Data Set (MDS), dated 9/5/XX, documented the following:

- Diagnoses of osteoarthritis and Parkinson's disease.
- No long-term memory problems.
- Modified independence with decision-making abilities (some difficulty with new situations only).
- Confusion.
- No history of pain.
- Dependent on staff assistance for personal hygiene, transfers and walking.

During an interview on 10/12/XX, at 1:30 p.m., Resident 25's family member revealed the following information:

- Upon arrival at the facility on 10/6/XX at 10:45 a.m. to prepare Resident 25 for a 2:00 p.m. previously scheduled visit to the physician, found Resident 25 in bed, moaning and grimacing.
- Resident 25 said, "I hurt and nobody believes me. I fell to the floor during the night and stayed there until I could crawl back into bed."
- Upon examining the resident's room, two broken picture frames were on the nightstand. The frames were intact the day before.
- Because the resident continued to complain of pain in the back area, the family member checked Resident 25 and discovered a large crescent shaped bruise on the resident's back.
- Staff was immediately summoned and the DON (Director of Nursing) entered the resident's room. The family member told the DON that the resident fell and was in great pain. The DON said the resident did not fall, but only dreamt of falling. The family member showed the DON the large bruise on the resident's right side of back and the DON said the bruise was new.

- At the family member's insistence, facility staff notified the resident's physician at 11:15 a.m.
- Resident 25 continued to moan with severe pain. The resident kept repeating, "I fell, could get no one to help, and had to crawl back into bed alone."
- At 11:30 a.m. the family member followed up with a call to the physician's office, reporting the resident's fall, the bruise, and pain.

Review of physician orders dated 10/6/XX revealed an order for an immediate transfer to the hospital for X-rays. Review of a copy of the X-ray report dated 10/6/XX in the resident's medical record revealed that Resident 25 had new fractures of four ribs and three vertebrae.

During an interview on 10/12/XX at 4:30 p.m., the physician revealed the following information:

- The call from the facility staff indicated no urgency or need for transfer because there was no report of pain or injury.
- On first examination of the resident in the hospital, the resident's injured areas were quite tender. The resident described the pain as "jump-out-of-bed" kind.
- Resident 25 developed pneumonia as a direct result of the fractured ribs.

Review of the nurses' notes showed only one note for 10/6/XX at 12:00 midnight and documented that Resident 25 had dreamt of falling.

On 10/13/XX at 10:00 a.m., observation of Resident 25's bath revealed the presence of a fading yellow bruise (2 × 4 inches in size) on the right lower rib area of the back. During the observation, Resident 25 complained of pain in the side and back area upon movement, when coughing, and when staff touched the area.

OPT—I158: SOD Example

Tag

42 CFR 485.713(c): The organization establishes a written preventive maintenance program to ensure that:

(1) The equipment is operative and is properly calibrated and
(2) The interior and exterior of the building are clean and orderly and maintained free of any defects, which are a potential hazard to patients, personnel and the public.

Findings

The Standard is NOT MET as evidenced by:

Based on review of the OPT's (outpatient physical therapist's) written preventive maintenance program and staff interview, the OPT failed to ensure that 2 of 3 machines (1 of 2 ultrasound machines and the electrical stimulation machine) received equipment maintenance and/or calibration.

1. On 6/15/XX at 9:00 a.m., review of the written preventive maintenance program revealed a lack of documentation for completion of the preventive maintenance and calibration review for ultrasound machine #2 and the electrical stimulation machine.

2. During interview on 6/15/XX at 10:00 a.m., the physical therapist director confirmed an absence of preventive maintenance checks and calibrations for ultrasound machine #2 or for the electrical stimulation machine.

RHC—J70: SOD Example

Tag

42 CFR 481.10(a)(3) For each patient receiving health care services, the clinic maintains a record that includes, as applicable:

(i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
(ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
(iii) All physician's orders reports of treatments and medications and other pertinent information necessary to monitor the patient's progress;
(iv) Signatures of the physician or other health care professional.

Findings

This requirement is NOT MET as evidenced by:

Based on record review and staff interview, the clinic failed to maintain consent for treatment forms for 3 of 6 patient clinical records (Patient 1, 3, 5).

1. Review of the policy titled "Content of Clinical Records" with the office manager revealed that clinical records are to include consent forms signed by the patient.

2. On 6/2/XX review of the clinical records revealed the following:
   - Patient 1's record revealed an absence of consent for treatment signed by the patient.
   - Patient 3's record revealed a diagnosis of senile dementia and an absence of a signed consent for treatment by the patient or a responsible party.
   - Patient 5's record revealed an absence of consent for treatment signed by the patient.

3. On 6/2/XX at 10:15 a.m., interview with the office manager confirmed that Patients 1, 3, and 5 did not have signed consent forms for treatment and were currently receiving services. Further interview with the office manager revealed that the clinic staff needed to work on ensuring that all patients signed consents for treatment.

Lesson 2-G: The Person-Centered Approach to Surveying

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Articulate the facets that make a person unique.
- Demonstrate your knowledge of the person-centered approach rather than a medical-centered or facility-centered approach.

Lesson Plan

References

Federal

None

State

(Insert State reference[s] here.)

Other

- Hospice Foundation of America
  - http://www.hospicefoundation.org/hospiceInfo/
- American Medical Association, Patient-Centered Communication
  - http://www.ama-assn.org/ama/pub/category/11929.html
- The Person-Centered Planning Education Site
  - http://www.ilr.cornell.edu/ped/tsal/pcp/
- Lesson 3-K, Quality of Life
- Walz, T. H., & Blum, N. S. (1988). The age cohort factor in activities programming for the elderly. *Activities, Adaptation and Aging*, *12*, 1–12.

Highlights

- Facets that make a person unique
- Knowledge of the person-centered approach rather than a medical-centered or facility-centered approach

Training Techniques

- Lecture
- Group discussion
- Individual exercise

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - *Concentrating on the Person: It's a Mindset*
  - *Age Cohort Differences*
- Video (optional):
  - *Person Centered Planning,* transmitted February 27, 1998

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Lesson 2-G
The Person-Centered Approach to Surveying

1

Slide 2-G-1

Outline or text of presentation

Other lessons will discuss the aging process, individuals with developmental disabilities and cultural diversity, but as a surveyor it is important for you to consider each individual in a health-care setting as a unique individual. Only then can you begin to assess if the person is receiving appropriate care and services in a manner befitting that individual.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Articulate the facets that make a person unique.
- Demonstrate your knowledge of the person-centered approach rather than a medical-centered or facility-centered approach.

2

Slide 2-G-2

(Inform the students of the objectives.)

Stereotypes

- Label, typecast & pigeonhole individuals
- Categorize according to oversimplified, standardized image or idea

3

Slide 2-G-3

Stereotypes

In most of the health-care settings you will survey, you will be assessing the care and services facilities provide to a unique group of individuals.

When we think of people, we tend to form a stereotypical image of them. As we grew up, we all learned the connotations of certain terms. For example, tell me what the following words mean to you if applied to a person:

Audiovisual

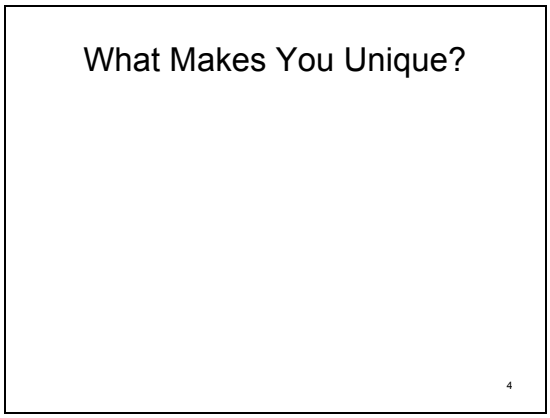
Outline or text of presentation

- Fat.
- Thin.
- Male.
- Female.
- Old.
- Young.
- Religious.

Stereotyping an individual labels, typecasts or pigeonholes the individual. It categorizes that individual or group according to an oversimplified standardized image or idea held by one person or group about another.

Labeling an individual will make most people think of the stereotype rather than of the person he or she really is. Each individual is unique and is special in some way.

Although we can identify similarities between men and women and people at different stages of their lives, each individual is unique.



Slide 2-G-4

What are some of the things that make you unique? Let's list them.

(Record answers on a chart pad. Begin by listing something that makes you unique. After students have answered, coach them to categorize the answers. Categories should include at least the following:

- *Gender.*
- *Age.*
- *Roles.*
- *Education.*
- *Experience.*
- *Cultural heritage.*
- *Religion.*
- *Interests.*
- *Finances.*

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Approaches to Assessing Individuals

- Medical
- Holistic
- Patient-centered
- Hospice
- Person-centered

5

Slide 2-G-5

Outline or text of presentation

If you have not received answers that include all areas, list the area(s) missed and ask for input.)

All these factors that make you unique make others unique. Consider them when assessing the care provided to an individual in a health-care setting.

Approaches to Assessing Individuals

Medical approach
During any survey, the individuals being assessed are receiving care in a health-care setting. Therefore, it is expected that we evaluate the medical care and services planned for and provided to that individual. However, you are expected to evaluate not only the medical care but also the other needs of the individual.

Holistic approach
The term "holistic approach" usually refers to holistic medicine. Alternative medicine, holistic healing, complementary medicine, natural remedies, spirituality and body/mind/spirit are terms commonly associated with this approach.

Holistic healing may involve lifestyle changes, medical therapy, mind therapy (such as relaxation techniques) and alternative therapy (supplements, acupuncture, hot or cold packs, botox injections or posture and body movement techniques).

Patient-centered approach
Since the term includes the word "patient," we would expect it to refer to patients in a health-care setting, and it does. Patient-centered communication is a concept used by the American Medical Association (AMA). This organization

Audiovisual	Outline or text of presentation
	believes that the patient should always receive high-quality care from his/her physicians and the health-care organizations visited. Unfortunately, according to the AMA, many research studies have shown that the current health-care system in the United States is faltering in its efforts to provide uniformly high-quality care, specifically for vulnerable patient populations. These populations face cultural and other barriers and experience glaring disparities in health-care quality and health outcomes. The AMA is developing a framework that will involve the community but also include help for health-care providers to communicate and elicit health needs, beliefs and expectations, build trust and convey information that is understandable and empowering. The AMA is encouraging organizations to create an environment that respects patients of diverse backgrounds and to help staff to understand the sociocultural factors that affect patients' health beliefs and their ability to interact with the health-care system. **Hospice approach** The term "hospice" was originally used to describe a place of shelter for weary and sick travelers returning from religious pilgrimages. During the 1960s, Dr. Cicely Saunders, a British physician, began the modern hospice movement by establishing Saint Christopher's Hospice near London. Saint Christopher's organized a team approach to professional care giving and was the first institution to use modern pain management techniques to care

Audiovisual	Outline or text of presentation
	compassionately for the dying. The first hospice in the United States began in New Haven, Connecticut, in 1974.
	Hospice is not so much a place as it is a concept of care designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to cure-oriented treatments. The goal of hospice care is to improve the quality of a patient's last days by offering comfort and dignity.
	A team-oriented group of specially trained professionals, volunteers and family members provides care. The team addresses all symptoms of a disease, with a special emphasis on controlling a patient's pain and discomfort. The team also deals with the emotional, social and spiritual impact of the disease on the patient and on the patient's family and friends.
	We expect you, as a surveyor, to assess not only the person's medical needs but also his/her emotional, social and spiritual needs.
	Therefore, perhaps the concept you will find most useful when surveying is that of person-centered planning.

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Person-Centered Approach

- For individual—what is desirable
- For provider of service—learn about individual
- Core:
  - For individual—each is unique & has worth
  - For facility staff—sharing power, giving up control, responding in flexible & meaningful way based on unique interests & needs of focus person

6

Slide 2-G-6

Outline or text of presentation

Person-centered approach

Person-centered planning is a process-oriented approach that empowers the person. It focuses on the person and his/her needs and not only allowing, but also actively helping, the person determine the direction of his/her life. It does not focus on the systems that may or may not be available to serve him/her. This ultimately leads to greater inclusion as valued members of both community and society.

Person-centered planning is an effort to offer people who need services the opportunity to describe and define the characteristics and conditions of life they want now and in the future.

It is an effort to offer people who deliver these services an opportunity to learn from and to grow alongside the person who is at the core of the planning process—the patient, resident or client in a health-care setting.

The person-centered concept is an effort to influence how the systems that provide these services respond to the requests and desires of their customers.

The core of person-centered planning is obviously the person and the extraordinary gifts and capacities of each person. This means recognizing that each individual is unique and has worth.

For facility staff, it is about sharing power and giving up control over another human being. It requires them to respond in a flexible and meaningful way based on the unique interests and needs of the patient, client or resident.

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Person-Centered Approach (cont.)

- "This has been a good day!"
- "This was not a good day!"

7

Slide 2-G-7

Outline or text of presentation

A person-centered approach entails the basic belief that there are core elements in day-to-day living related to quality of life that matter deeply to any one of us.

One way to illustrate a person-centered approach is to consider one aspect of what may be important to an individual. Let's take you as an example.

What are two or three things that, if they happened, would make you say, "This has been a good day"?

(Ask students to write their answers on a piece of paper. Then, go around the room and ask them to verbalize those they want to share. The point is that, for each individual, different things are important.

Then ask them to list two or three things that, if they happened, would make them say, "This was not a good day!" Again, go around the room and ask them to verbalize those they want to share.)

Do you think that in a health-care setting you survey that facility staff can work to plan and actually implement a plan to incorporate these important aspects of your life?

Do you think it is possible that a health-care provider can change to limit things that would not make it a good day for you?

(Discuss the issues, trying to enhance the concepts each surveyor has of what is possible and doable in the health-care setting they will likely survey.)

Audiovisual

Assessment of Individual

- Is mindset
- Changes over time
  - Cultural
  - Societal
  - Attitudinal
  - Behavioral

8

Slide 2-G-8

Outline or text of presentation

Assessment of the Individual

As surveyors, it will be important for you to identify how the health-care facility has assessed the person as a unique individual and has involved that person in choosing the care and services provided. This means not just *telling* the individual what care and services staff have planned for the individual; it also means weighing the extent to which the individual has the knowledge and understanding required to have input into those plans, based on that individual's unique perspective. It is important for you to find the "person" in the care.

(Distribute the handout on page 2-G-17, "Concentrating on the Person—It's a Mindset," and have students read through it. Based on the provider or supplier the students will most likely survey, ask students to give examples.)

Changes over Time

As time goes on, cultural, societal and other changes have resulted in attitudinal and behavioral changes affecting care and services.

(Distribute and review the handout on page 2-G-19, "Age Cohort Differences.")

Although the reference work on which the handout is based was originally written to identify the need for different activities, the information can be considered when assessing the individual.

Summary

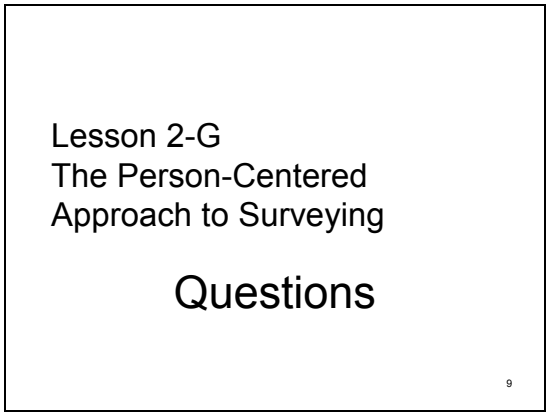
In summary, each person represents a combination of many factors that affect

Audiovisual

Outline or text of presentation

his/her wants, desires and behaviors. As a surveyor your tendency may be to look at only the medical needs of the individual. Instead, you need to develop the mindset of looking at the individual as a unique person. The more you can do that, the better you will be able to assess whether the staff in the health-care setting is meeting the person's unique needs and providing care and services in a setting appropriate for that individual.

(Optional: Show video, "Person Centered Planning.")



Slide 2-G-9

Skill Assessment

The Person-Centered Approach to Surveying

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Articulated at least five facets that make a person unique.	
					Demonstrated understanding of a person-centered approach to care and services.	

Comments/Recommendations:

Concentrating on the Person—It's a Mindset

Person-Centered	Facility-Centered
We plan *with* you.	We plan *for* you.
We talk *with* you.	We talk *about* you.
We listen to your words and the meaning behind them.	We hear you.
We do things *with* you when and where *you* want them.	We do things *to* you when and where *we* want.
You have a life.	You follow *our* program.
You make choices and decisions.	*We* tell you what to do.
We suggest, but *you* decide.	*We* set your goals.
We *share* control.	*We* are in control.
We encourage, support, assist and help *you* as you want us to.	*We* let and allow you.
We don't hide things from *you.*	*We* tell you what we think is good for you.
We see *you* as a person.	We see you as someone we have to care for.

Age Cohort Differences

Persons born in the early part of the twentieth century (pre–World War II) share the following attitudinal/behavioral characteristics:

- A work ethic.
- A religious orientation.
- A family orientation.
- A patriotic orientation (love of country and respect for formal authority).
- Acceptance of well-differentiated sex roles.
- A view of leisure as respite from work.
- A respect for food as a basis for survival and goods as scarce.
- Sex as a private matter and a need or drive to be controlled.
- Time as seasonal (more than clock-bound).
- Respect for the forces of nature and a need to maintain harmony with nature.
- A belief in rugged individualism and limited interference by government in human endeavors.

Persons born in the post–World War II era share the following attitudinal/behavioral characteristics:

- A leisure work ethic (leisure and work are of equal value).
- A secular orientation.
- An individualistic orientation (the family as a collection of individuals).
- A more jaundiced view of patriotism and sometimes an irreverent attitude toward authority.
- A more unisex view of sex roles.
- Food and goods as abundant consumer commodities.
- Sex as a public matter, a need to be fulfilled.
- Life as clock-time ordered.
- Respect for harmony with machines and technology.
- Acceptance of public dependency as a right of citizenship (with a host of qualifications).

Source: Walz and Blum (1988).

Although the source on which the handout is based was originally to identify the need for different activities, the information may be helpful when assessing the individual:

- Work and leisure.
- Religion.
- Family and friends.
- Patriotism.
- Gender roles.
- Use of food and commodities.
- Nature and technology.
- Individualism and dependency.

Lesson 2-G-1: The Aging Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the physiological and some psychological factors of normal aging.
- Describe common chronic illnesses of older adults.

Lesson Plan

References

Federal

None

State

(Insert State reference[s] here.)

Other

- Pipher, M. (1999). *Another Country: Navigating the Emotional Terrain of Our Elders.* New York: The Berkley Publishing Group

Highlights

- Discussion of the physiological and some psychological factors of normal aging
- Description of common chronic illnesses of older adults

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Lesson 2-G-1
The Aging Process

1

Slide 2-G-1-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss the physiological & some psychological factors of normal aging.
- Describe common chronic illnesses of older adults.

2

Slide 2-G-1-2

Outline or text of presentation

During this lesson, you will learn about the aging process. Mary Pipher, Ph.D., a psychologist, in her book *Another Country: Navigating the Emotional Terrain of Our Elders,* describes age:

"If age is another country, then we must all learn to speak its language…We need a language that bridges the gap between generations and takes into account that our elders can be just as reluctant to ask for or even accept our time and our efforts as we are eager to understand the wants and needs of people who lived before television, Freudian psychology, e-mail, and the first trip to the moon. They are living longer, but in a culture that has come to worship youth. They grew up in real communities, whether rural or urban, where people looked out for one another and children and grandchildren lived nearby. Today families have dispersed. Communities have broken down. Older people are isolated. Adults in two-career families struggle to divide their time among their kids, their jobs and their aging parents. The landscape of age is truly that of another country."

(Inform the students of the objectives.)

Audiovisual

Aging

- Series of developmental changes
  - Biological
  - Psychological
  - Sociological
- Changes occur throughout our life span

3

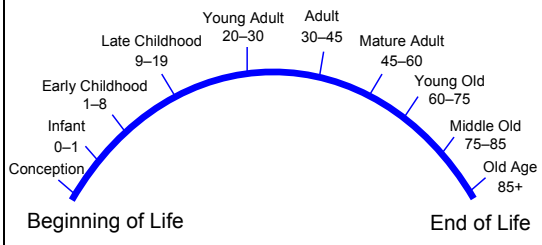
Slide 2-G-1-3

Outline or text of presentation

Aging and the Life Span

Aging is not old age. It is a series of developmental changes which occur over our life span. In the absence of disease, normal aging is a fairly benign process. Aging involves the steady physical decline of organ functioning and of the regulation of body systems. Changes may not be noticeable except during maximum exertion and stress. Some individuals may experience slower reactions to stimuli, wider variations in functioning and slower returns to resting states as they age.

The Aging Process



4

Slide 2-G-1-4

The Aging Process

You have some control over what your life will be like in the various stages of development.

You have choices to make in many areas: job, education, income, friends, marital status, residence, financial planning, personal growth and development, recreation and use of leisure time.

The Aging Process (cont.)

- Influenced by past & current life choices:
  - Diet
  - Exercise
  - Refraining from drug & alcohol abuse
  - Good health habits
  - Managing stress & anxiety
- Requires planning

5

Slide 2-G-1-5

As we age, our general well-being can be influenced by past, as well as current, choices in activities and lifestyle such as:

- Diet and exercise maintained throughout life.
- Refraining from drug and alcohol abuse.
- Good health habits (rest, relaxation).
- Managing stress and anxiety.

Each of us needs to consider these factors and plan for our future.

Audiovisual

Introduction

- Gerontology—studies specific changes of aging & related social issues
  - Biology & physiology
  - Psychology
  - Sociology
- Geriatrics—explores diagnosis & treatment of diseases & problems of older individuals

6

Slide 2-G-1-6

Outline or text of presentation

Introduction

Gerontology is the study of aging, which examines specific changes in older individuals and the broader social issues that affect them.

Biology and physiology investigate physical aging in the following terms:

- The gradual growth and decline of bodily strength and function.
- Observable changes in face and body.
- The increasing probability of disease and eventual death.

Psychology of aging explores:

- Emotional stability.
- Changes in intellect.
- Coping and adaptive behavior.
- Self concept.
- Personality—how people express themselves as they age.

Sociology studies roles and responsibilities in situations in which older persons interact with others, such as:

- Family.
- Education.
- Work.
- Leisure.
- Community.

Geriatrics is the medical specialty that explores the diagnosis and treatment of diseases and problems of older individuals.

Audiovisual

Other Factors

- Personality—usually consistent
  - Changes—result of social or biological event
- Loss—more likely with age
  - Adjustment responses—denial, depression, anger & rage
- Life style—95% in community
- Mental health

7

Slide 2-G-1-7

Outline or text of presentation

Other Factors

Personality is consistent. How you behave as a young adult is usually how you behave as an older adult. If personality changes, it is usually traced to a social or biological event (e.g., death, retirement or admission to a nursing home).

The older you are, the more likely you are to face loss: loss of friends and family, loss of job as you retire, loss of income and possibly loss of the home you lived in for years, to name just a few. Some people have difficulty adjusting to loss: denial, depression, anger and rage are common responses.

In the US, 4.5% of people 65 and older live in nursing homes. This means that over 95% live independently or with family members.

Now let's discuss the body and common changes that occur as we age.

Brain

Weight—3 lb.
Size—Med. cauliflower
100 billion neurons
100 trillion synapses

8

Slide 2-G-1-8

The Brain

The brain manages many of the body functions that happen without your knowledge or direction (e.g., breathing, blood circulation and digestion). It also directs all the functions you carry out consciously (speech, movement, vision, memory, emotions and decision making) because of the complicated mix of chemical and electrical processes that take place in your brain.

What sets people apart from other animals is the huge number of nerve cells we have in the cerebral cortex, regions of which are proportionally much larger in humans than in any other animals. The many

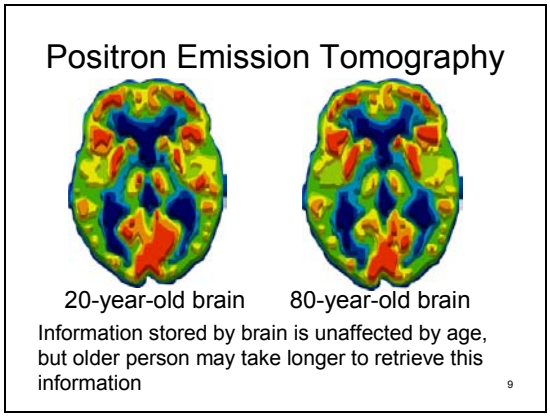
Audiovisual	Outline or text of presentation
	interconnections among the nerve cells in these regions also make us different from other animals. Nerve cells—or neurons—are key to many brain functions. These functions include cognitive functions, like thinking, learning, speaking, remembering, and making decisions. The cerebral hemispheres account for 85% of the brain's weight. The billions of neurons in the two hemispheres are connected by a thick bundle of nerves called the corpus callosum. Scientists now think that the two hemispheres differ not so much in what they focus on (the "logical versus artistic" notion), but rather in how they process information. The left hemisphere appears to focus on details (such as recognizing a particular face in a crowd), whereas the right hemisphere focuses on the broad background (such as understanding the relative position of objects in a space). The cerebral hemispheres have an outer layer called the cerebral cortex. This is where the brain processes sensory information received from the outside world, controls voluntary movement and regulates conscious thought and mental activity. The cerebellum takes up a little more than 10% of the brain. It's in charge of balance and coordination. The cerebellum also has two hemispheres. They are always receiving information from the eyes, ears, muscles and joints about the body's movements and position. Once the cerebellum processes the information, it works through the rest of the brain and spinal cord to send out instructions to the body. The cerebellum's work allows you to walk smoothly, maintain your balance

Audiovisual

Outline or text of presentation

and turn around without even thinking about it.

The brain stem sits at the base of the brain. It connects the spinal cord with the rest of the brain. Even though it's the smallest of the three main parts of the brain, its functions are crucial to survival. The brain stem controls the functions that happen automatically to keep you alive—your heart rate, blood pressure and breathing. It also relays information between the brain and the spinal cord, which then sends out messages to the muscles, skin and organs. Sleep and dreaming are also controlled by the brain stem.



Slide 2-G-1-9

The aging brain

As a person gets older, changes occur in all parts of the body, including the brain.

- Some neurons shrink, especially the large ones in areas important to learning, memory, planning and other complex mental activities.
- Tangles and plaques develop in neurons and surrounding areas, though in much smaller amounts than with Alzheimer's disease.
- Damage by free radicals increases (free radicals are a kind of molecule that reacts easily with other molecules).

What is the impact of these changes?

- Healthy older people may notice a modest decline in their ability to learn new things and retrieve information (e.g., remembering names).
- Healthy older people may perform worse on complex tasks of attention, learning and memory. However, if given enough time to perform the

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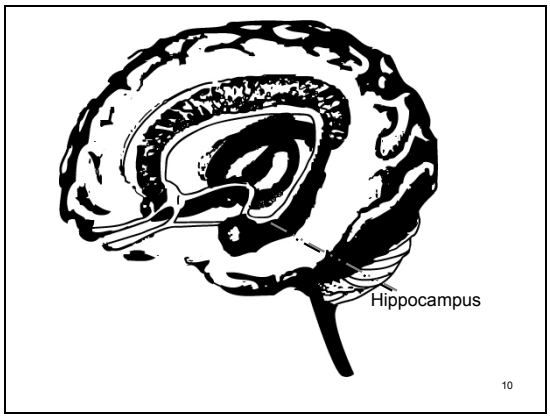
task, healthy people in their 70s and 80s often produce the same results as young adults.

- As they age, adults often improve their vocabulary and other forms of verbal knowledge.



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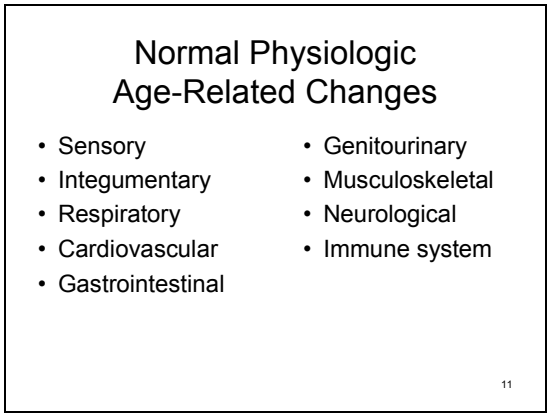
Hippocampus
This part of the brain assists in changing short-term memory into long-term memory. This is the primary area that is impaired in Alzheimer's disease.



Slide 2-G-1-11

Normal Physiologic Age-Related Changes

- Sensory.
- Integumentary—skin, nails and hair.
- Respiratory.
- Cardiovascular.
- Gastrointestinal.
- Genitourinary.
- Musculoskeletal.
- Neurological.
- Immune system.

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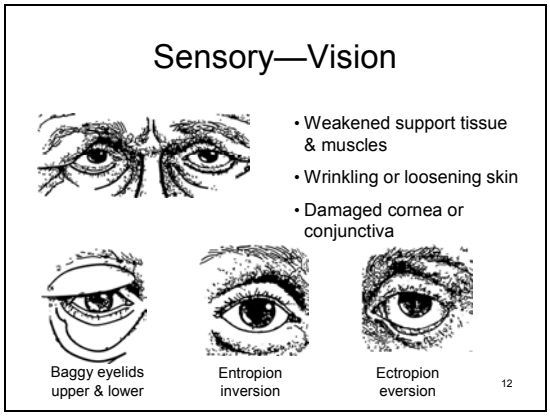

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Outline or text of presentation

Sensory Changes

Vision: eyelid malposition

Aging can have a variety of effects on the outward appearance of the eyes and surrounding areas.

The skin on the upper lids becomes looser with time and can hang down over the eyes. This is cosmetically unappealing for some and visually significant for others, as the skin may interfere with vision when looking up or to the side or when reading. This condition is known as dermatochalasis.

In some people, the eyes can accumulate excess fat that collects in a pocket in the lower eyelids. We naturally have fat pockets in the lower lids. The pockets can accumulate too much fat, however, and the fat can even herniate forward, creating the cosmetic problem of puffy or baggy eyes. Eyelid surgery can successfully correct both of these problems.

Dermatochalasis, or excess skin, is treated by removing a small amount of the excess skin from the upper lids. This surgery is called a blepharoplasty.

Another upper eyelid problem is ptosis (toe-sis). Ptosis is when the muscles of the upper eyelids weaken and the eyelid droops because of it. This can occur in addition to dermatochalasis. To correct ptosis, a similar incision is made as in blepharoplasty. Instead of removing excess skin, the surgeon shortens and lifts the eyelid muscle. The shortened muscle can then lift the eyelid fully.

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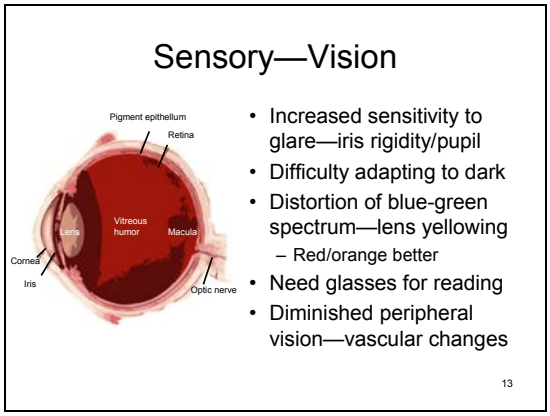
Some individuals may have lower eyelid malposition such as in-turning eyelids (entropion) or pulled-down lower eyelids (ectropion).

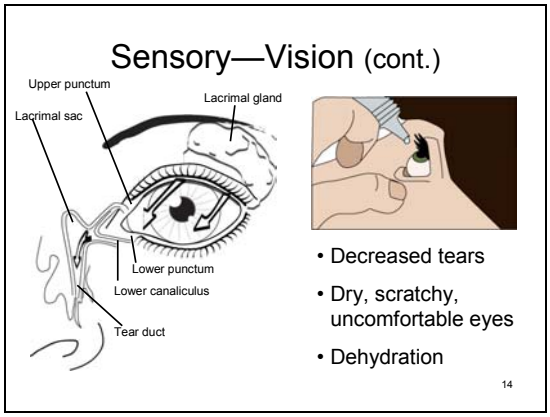


Slide 2-G-1-13

Vision changes as we age are often caused by the lens yellowing, becoming more rigid and being less pliable.

Macular degeneration
A small area on the retina, the macula, is responsible for focusing the eye. As it deteriorates, the ability to focus diminishes and, eventually, vision becomes blurry.

Conjunctiva
The sclera is covered by a thin transparent membrane known as the conjunctiva, which reflects back onto the underside of the eyelids. Normally, it's invisible except for the fine blood vessels that run through it. When infected or otherwise inflamed, this layer can appear quite red, a condition known as conjunctivitis. By gently applying pressure and pulling down and away on the skin below the lower lid, you can examine the conjunctival reflection, which appears pale if the patient is significantly anemic.



Slide 2-G-1-14

Additional eye changes
Tears are produced constantly by the lacrimal gland, which is located under the upper eyelid.

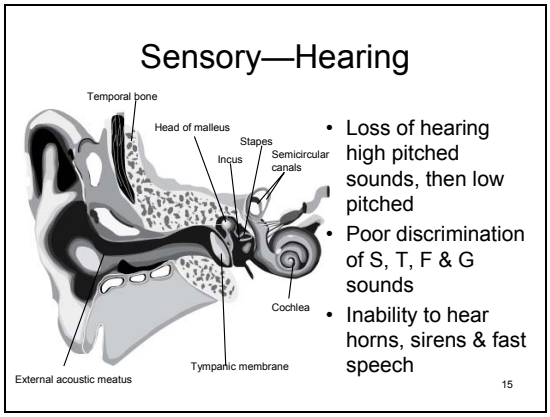
Tears are essential, because they form a thin film that coats the front surface of the eye and prevents it from becoming dry. Normally, tears are quickly drained from the eye through a complex system of channels that lead from the inner corner of the eyelids into the nose. This system of channels is called the lacrimal drainage system.

Audiovisual

Outline or text of presentation

Various conditions cause dry eyes. The most common culprit is age. The glands and cells that produce the tears simply wear out.

Dehydration in the body can also cause dry eyes. If dryness occurs in the morning, it can be caused by incomplete closure of the eyelids during sleep—the tears evaporate.



Slide 2-G-1-15

Hearing

The ear can be divided into the external (outer) ear, the middle ear (or tympanic cavity) and the internal ear (or labyrinth).

The external auditory canal is a slightly curved structure with its concavity facing downwards and forwards. It is composed of two portions—an external part which is cartilaginous (and not very sensitive) and an inner part which is formed of bone (and very sensitive).

The tympanic membrane is set obliquely at the inner end of the external auditory canal in such a way that the roof and anterior wall are shorter than the floor and anterior wall. It is convex towards the tympanic cavity. It consists of three layers—an outer epithelial layer, a middle fibrous layer and an inner mucosal layer.

The eustachian tube is more horizontal and relatively wider and shorter in the child than in the adult. The upper third of the eustachian tube is bony, with the lower two thirds cartilaginous. The opening into the lateral wall of the nasopharynx lies on a level with the inferior turbinate.

Sound waves make your eardrum vibrate. Then, the small bones in your ear vibrate, and the vibrations go through the snail-like cochlea, which turns them into nerve impulses to your brain.

Audiovisual

Outline or text of presentation

Wax, or *cerumen*, is a normal secretion in the ceruminous glands in the outer part of the meatus and can obscure or partially obscure the ear drum.

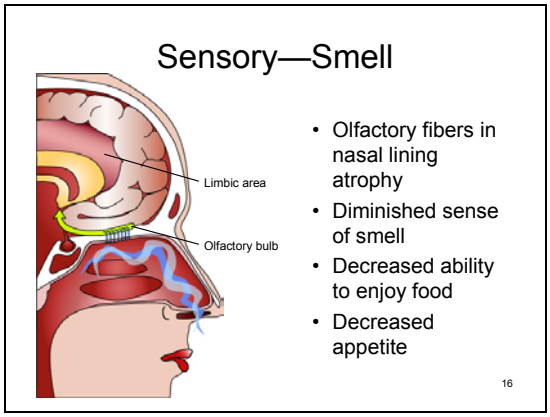
When it is first produced, cerumen is colorless and semi-liquid in consistency, but with time it changes from pale yellow, to golden yellow, to light brown and finally to black. As the wax darkens it also hardens, and the darker the color, the denser the consistency.

During aging, ceruminous glands decrease in number and activity. Drier cerumen may result in wax impaction.

Impaction means that several layers of earwax have been pushed together and may be stuck in the ear.

What causes it?

- Normal wax builds up in the outer part of the ear canal, not near the eardrum.
- If a patient has build-up near the eardrum, it is usually because the wax has been pushed there.
- Patients who are trying to clean their ears with a cotton swab (Q-tip) or twisted tissue sometimes actually push the wax deeper into the ear.



Slide 2-G-1-16

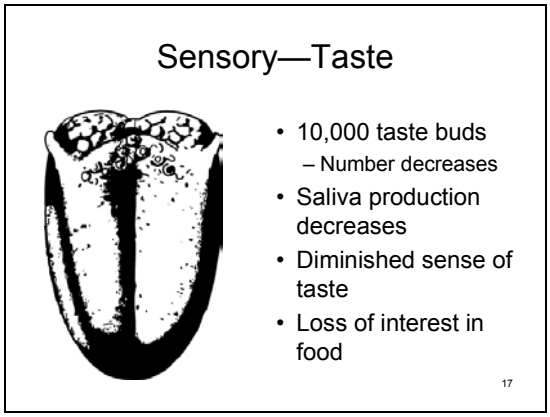
Smell

During aging, olfactory fibers in nasal lining atrophy. This process diminishes the sense of smell. Usually it is completely lost by age 80.

Why is this important? Individuals who can't smell have a decreased ability to enjoy foods, and therefore a possible decreased appetite.

The part of the brain that is related to smell is in the limbic region and is connected to feeling and memory. Odor particles drift

Audiovisual



Slide 2-G-1-17

Outline or text of presentation

into your nose and cause your smell receptors to send messages to your brain.

Taste

Younger individuals have 10,000 taste buds in their mouths. The tongue is roughly divided with buds that sense sweet and salty flavors, which are least sensitive, and buds that sense bitter flavors, which are the most sensitive.

Molecules of food stimulate the taste cells, which send messages to your brain.

However, as we age, we lose taste buds. It is estimated that we have lost at least one-third by the time we are age 65. This results in a diminished sense of taste. Foods have to have a stronger flavor to be perceived as well as before.

Saliva production decreases. Therefore, dry foods, such as ground meat or plain roast beef, may be difficult to swallow. The reason is that the saliva would normally act as a binding agent to help the individual form a viscous bolus that would more easily slide down the esophagus.

Some individuals who have a cardiovascular accident have a blood clot in the head that destroys the portion of the brain that perceives taste. The individual will eat but will be unable to perceive the taste of the food.

The combination of these factors may result in a loss of interest in eating.

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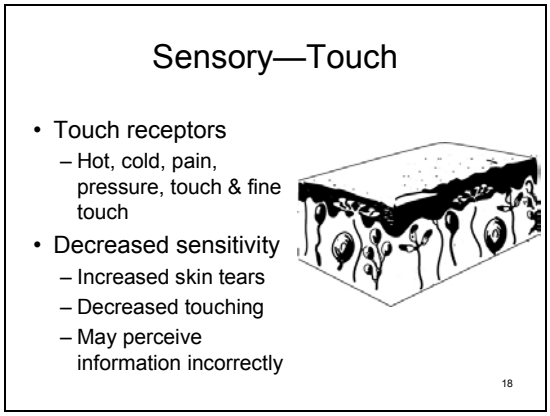

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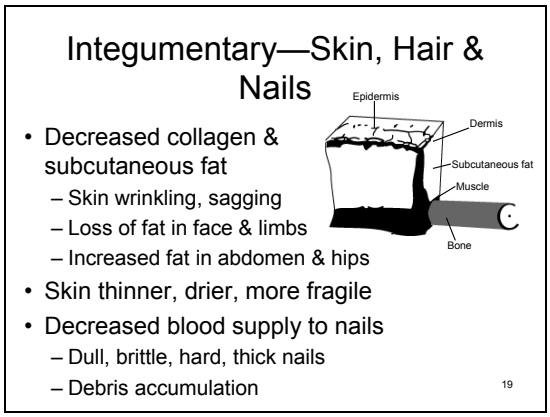

Slide 2-G-1-19

Outline or text of presentation

Touch

There are at least six types of touch receptors in your skin—hot, cold, pain, pressure, touch and fine touch.

Skin loses sensitivity during aging which can lead to heating pad burns, sunburn and bruising.

Effect of Aging on Senses

Senses bring in information from the outside world. Perception is how the brain evaluates that information. When people see or hear something, they evaluate what is seen or heard and take action. Individuals with a decline in sensory perceptions may perceive information incorrectly (e.g., with altered sensory perceptions, the individual may not recognize danger).

Integumentary—Skin, Hair and Nails

With age, all parts of the skin diminish in size and function. The skin becomes thinner, drier and more fragile. Pigment cells are less active, so the skin tans less easily.

Sun exposure injures the skin, and skin remembers previous injury. It keeps track of all of the sun damage that has accumulated over the years. The cumulative effects of sun exposure are wrinkling, blotchy pigmentation and roughness. Sun-damaged skin becomes less flexible and more easily bruised. The likelihood of development of skin cancer increases dramatically with extensive sun exposure.

Audiovisual

Integumentary—Skin, Hair & Nails (cont.)

- Sweat glands diminish in number, size & function
  - Less sweating
  - Inability to regulate body temperature
  - Hypothermia, heat stroke

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Slide 2-G-1-20

Outline or text of presentation

- Sweat glands diminish in number, size and function.
  - Less sweating.
  - Inability to regulate body temperature.
  - Hypothermia, heat stroke.

Integumentary—Skin, Hair & Nails (cont.)

- Decreased capillaries
  - Anemic appearance
- Larger vessels surface
  - Bruise easily
- Hair becomes finer, thinner & gray
- Nails may have distinctive changes because of some disease conditions

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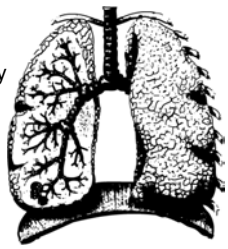
Slide 2-G-1-21

- Decreased capillaries.
  - Anemic appearance.
- Larger vessels surface.
  - Easy bruising.
- Hair becomes finer, thinner and gray.
- Nails may have distinctive changes because of some disease conditions.

Respiratory System

- Fewer alveoli
  - Decline in oxygen levels
  - Decreased normal activity
  - Shortness of breath & dyspnea
- Poor ciliary function
  - Slowed cough reflex
  - Increased chance of infection



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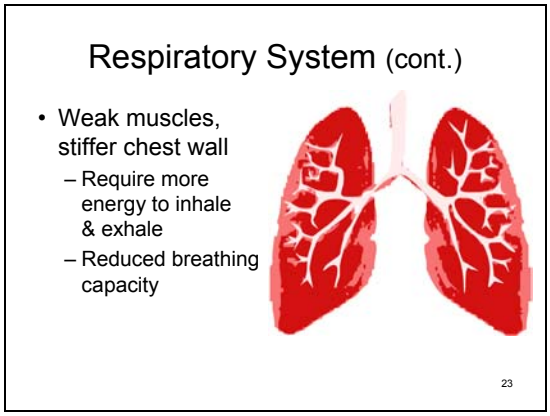
Slide 2-G-1-22

Respiratory System

In the respiratory system, changes associated with aging are as follows:

- Fewer alveoli.
  - Decline in oxygen levels.
  - Decreased normal activity.
  - Shortness of breath and dyspnea.
- Poor ciliary function.
  - Slowed cough reflex.
  - Increased chance of infection.

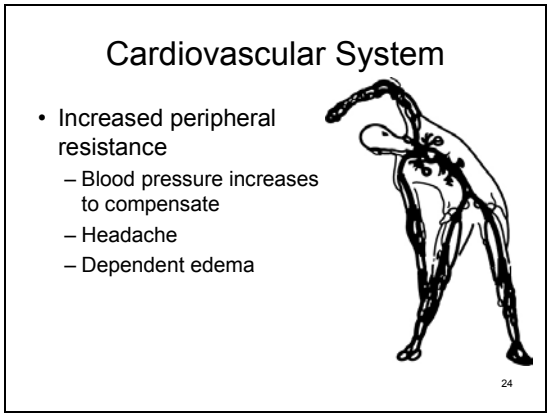
Audiovisual



Slide 2-G-1-23

Outline or text of presentation

- Weak muscles, stiffer chest wall.
  - Require more energy to inhale and exhale.
  - Reduced breathing capacity.

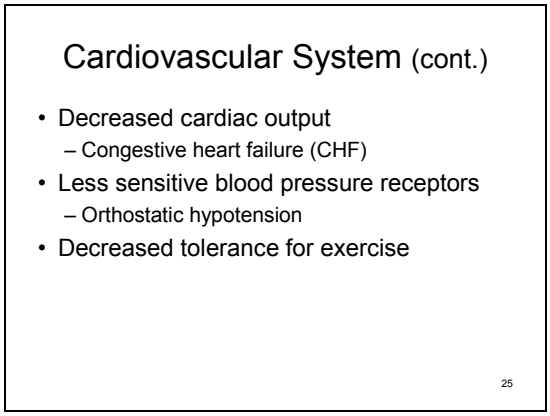


Slide 2-G-1-24

Cardiovascular System

In the cardiovascular system, changes associated with aging are as follows:

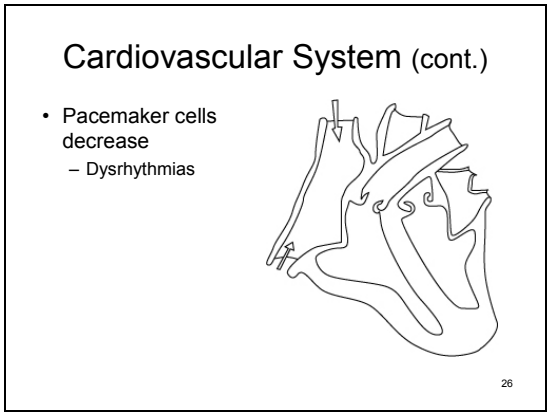
- Increased peripheral resistance.
  - Blood pressure increases to compensate.
  - Headache.
  - Dependent edema.



Slide 2-G-1-25

- Decreased cardiac output.
  - Congestive heart failure (CHF).
- Less sensitive blood pressure receptors.
  - Orthostatic hypotension.
- Decreased tolerance for exercise.

Audiovisual



Slide 2-G-1-26

Outline or text of presentation

- Fewer pacemaker cells.
  - Dysrhythmias.

Diseases common to the cardiovascular system include:

- Hypertension.
- CHF.
- Peripheral vascular disease.
- Cardiovascular accident ("stroke").
- Transient ischemic attack.

Gastrointestinal System

Discussion of the gastrointestinal system begins where the process starts: in the mouth. As you age, changes occur in the mouth.

Individuals who may not have had routine dental care may have dental caries (i.e., cavities) or missing teeth. You bite with your front teeth, but chew with your molars at the back of the mouth. These are the teeth that are most frequently missing, that have chipped or that have been removed.

The saliva in the mouth diminishes as you age, so older individuals usually prefer to consume foods with gravies or sauces rather than dried food. The gravy and sauce provide the liquid to help form a bolus of food and keep food particles together when swallowing.

The tongue's function as a muscle does not decline except where there has been a medical problem. Cancer of the tongue or mouth may result in a portion of the tongue being removed. Also, a stroke can affect the tongue, causing problems with

Audiovisual

Outline or text of presentation

forming a bolus of food or liquids. Older individuals may pocket food in the cheek because that side of the tongue does not work as well as the other.

Gastrointestinal System

- Decreased esophageal tone
  - Swallowing problems
  - Heartburn
  - Hiatal hernia
- Gastric mucosa atrophy
  - Altered absorption

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Slide 2-G-1-27

In the gastrointestinal (GI) tract itself, aging results in:

- Decreased esophageal tone.
  - Swallowing problems—perhaps due to a cardiovascular accident (i.e., stroke).
  - Dripping nose or coughing.
  - Esophageal reflux—"heartburn" from stomach acid in the esophagus.
  - Hiatal hernia—individuals need to remain upright after meals.
- Gastric mucosa atrophy.
  - Altered absorption.

Gastrointestinal System (cont.)

- Reduced liver blood flow & cells
  - Decreased drug metabolism
- Decreased peristalsis
  - Chronic constipation
- Decreased sphincter tone
  - Rectocele
  - Fecal impaction, incontinence

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Slide 2-G-1-28

- Reduced liver blood flow and cells.
  - Decreased drug metabolism.
- Decreased peristalsis.
  - Chronic constipation.
- Decreased sphincter tone.
  - Rectocele.
  - Fecal impaction, incontinence.

Other diseases related to the GI tract include:

- Hepatitis—may cause liver function to further decrease, decreasing its ability to produce bile (affecting fat metabolism).
- Gall stones—may block the gallbladder, causing pain and reducing the body's ability to digest fat.
- Cancer or diverticulosis—usually of the large intestine, may result in removal of part of the large intestine. The individual may have a colostomy.
- Hemorrhoids.
- Diarrhea—due either to food intolerance or drug reaction.

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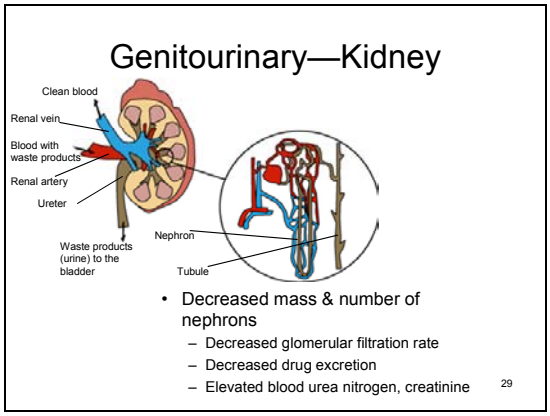


Slide 2-G-1-29

Outline or text of presentation

Genitourinary

Kidney

Inside the kidney, the blood is filtered through very small networks of tubes called nephrons. Each kidney has approximately one million nephrons. Inside the nephrons, waste products in the blood move across from the bloodstream (the capillaries) into the urine-carrying tubes inside the nephron. These tubes are called tubules.

As the blood passes through the blood vessels of the nephron, waste is taken away. Any chemicals needed by the body are kept or returned to the bloodstream by the nephrons. In this way, the kidney helps to regulate the levels of chemicals in the blood, such as sodium, potassium and phosphorus, so the right levels are maintained to keep the body healthy.

In addition to filtering waste products, another important function of the kidneys is the production of three important hormones:

- Erythropoietin, which tells the bone marrow to make red blood cells.
- Renin, which regulates blood pressure.
- Calcitriol (a form of Vitamin D), which helps the intestine absorb calcium from the diet and so helps keep the bones healthy.

Items that are filtered out of the blood into the Bowman's capsule include glucose, urea, salts and water.

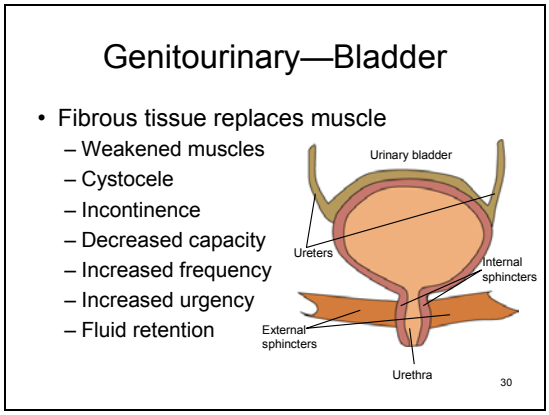
Items that remain in the blood are red blood cells, white blood cells, platelets and large chemicals like hormones. Glucose must be returned to the blood by active transport at the loop of Henle.

Audiovisual

Outline or text of presentation

The remaining wastes, now called urine, are transported out through the collecting tubule known as the renal pelvis (a collecting area) from which the urine passes into the ureter and then to the bladder.

A kidney disease common in older individuals is end stage renal disease. The individual may need hemodialysis or peritoneal dialysis. Dietary restrictions used to include potassium, sodium, protein, phosphorus and fluids, but they have now been liberalized.



Slide 2-G-1-30

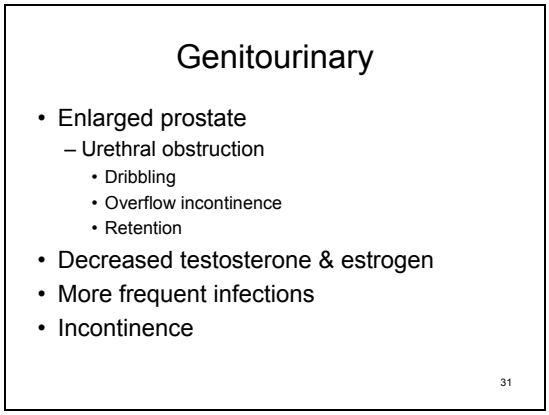
Bladder

- Fibrous tissue replaces muscle, resulting in:
  - Weakened muscles.
  - Cystocele.
  - Incontinence.
  - Decreased capacity.
  - Increased frequency.
  - Increased urgency.
  - Fluid retention.

These changes may result in a higher incidence of urinary tract infections, which may affect not only the bladder but also the kidneys.

Cancer of the bladder may require the individual to have an ileostomy. An individual may also develop a neurogenic bladder.

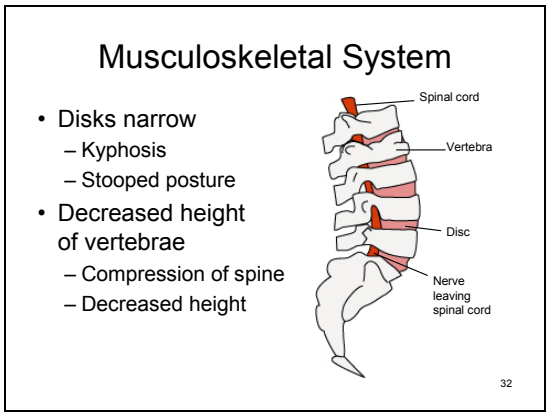
Audiovisual



Slide 2-G-1-31

Outline or text of presentation

- Enlarged prostate.
  - Urethral obstruction.
    - Dribbling.
    - Overflow incontinence.
    - Retention.
- Decreased testosterone and estrogen.
- More frequent infections.
- Incontinence.



Slide 2-G-1-32

Musculoskeletal System

- Disks narrow.
  - Kyphosis.
  - Stooped posture.
- Decreased height of vertebrae.
  - Compression of spine.
  - Decreased height.

The musculoskeletal system includes the muscles and tendons, bones, joints, ligaments and connective tissues of the body, together with the neurological elements responsible for locomotor control. Muscles and bones form a framework that protects the vital organs of the body and holds them in place.

Musculoskeletal disorders and injury are prime causes of short-term disability (e.g., trauma, back pain) and chronic disability (e.g., arthritis). Many people develop musculoskeletal disorders related to overuse of weak or improperly stretched muscles, tendons or ligaments. Strenuous daily vocational activities, such as lifting, bending or prolonged typing, can cause musculoskeletal pain through constant stress on the musculoskeletal system.

Audiovisual

Outline or text of presentation

As the population ages, more and more individuals complain of pain related to osteoarthritis, contracture and degenerative disk disease. All of these disorders may interfere with normal vocational and recreational activities.

In the modern system of medicine, the drugs often used in the treatment of musculoskeletal disorders are anti-inflammatories, analgesics, antipyretics and muscle relaxants. These drugs offer good symptomatic relief but have a number of side effects, like nausea, vomiting, acid-peptic disorders, liver and kidney damage, etc. In chronic cases, the treatment is obviously prolonged.

Musculoskeletal System (cont.)

- Decreased number of muscle fibers; muscle atrophy
  - Decreased lean body mass (muscle)
  - Decreased movement, strength, endurance
- Increased fat in muscle tissue

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Slide 2-G-1-33

- Decreased number of muscle fibers—muscle atrophy.
  - Decreased lean body mass (muscle).
  - Decreased movement, strength and endurance.
- Increased fat in muscle tissue.

Musculoskeletal System (cont.)

- Loss of elasticity of ligaments, tendons & synovial membranes
  - Stiffening & mild flexion of joints

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Slide 2-G-1-34

- Loss of elasticity of ligaments, tendons and synovial membranes.
  - Stiffening and mild flexion of joints.

Audiovisual

Musculoskeletal System (cont.)

- Decreased bone density
  - Osteoporosis
  - Falls
    - Hip fractures
- Deterioration of articular cartilage
  - Osteoarthritis
    - Pain, stiffness & joint hypertrophy

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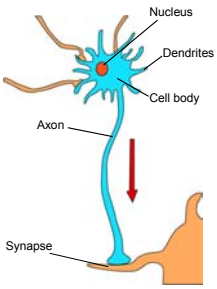
Slide 2-G-1-35

Outline or text of presentation

- Decreased bone density.
  - Osteoporosis.
  - Falls.
    - Hip fractures.
- Deterioration of articular cartilage.
  - Osteoarthritis.
    - Pain, stiffness, joint hypertrophy.

Neurological System

- Reduced blood flow to brain
- Fewer neurons
  - Short-term memory loss
  - Longer processing time
  - More difficulty learning
- Decrease in neurotransmitters



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Slide 2-G-1-36

Neurological System

- Reduced blood flow to brain.
- Fewer neurons.
  - Short-term memory loss.
  - Longer processing time.
  - More difficulty learning.
- Decrease in neurotransmitters.

Immune System

- Decreased response to foreign antigens
- Infections more severe
  - Tuberculosis (TB), influenza, varicella-zoster

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Slide 2-G-1-37

Immune System

Your immune system protects you against threats, including viruses, bacteria and parasites that cause infectious diseases, from ordinary flu to full-blown malaria.

The white blood cells of the defense system are produced in the marrow of your bones. The cells are carried in the blood to specialized organs, where they develop and communicate to launch immune responses against infections.

Audiovisual

Outline or text of presentation

Immune responses are aggressive and must be controlled. They should be activated only when the body is threatened by disease. To learn how to start or stop the immune system you must understand how microorganisms and sick cells are recognized by white blood cells.

The immune system has several cell types that form a network of interacting elements: cell-mediated immunity (T lymphocytes or T cells), humoral immunity (B lymphocytes or B cells) and nonspecific immunity (monocytes and polymorphonuclear neutrophil leukocytes).

Some white blood cells, such as macrophages, destroy and eat bacteria and damaged cells. B cells produce antibodies, which can neutralize viruses, bacteria or toxic proteins in the blood and other body fluids. T cells can trace microorganisms that leave the body fluids to invade cells. Each T killer cell carries receptors for one type of foreign substance, an "antigen." T cells can bind to infected cells and kill them. This can prevent spread of the microorganism within the body. But how can the T cells specifically identify or "recognize" the infected cells?

Immune System (cont.)

- Infectious diseases occur more often & are usually more severe in elderly, probably because aging affects host defenses
  - Diminished vigor of immune response
  - Common chronic disorders increase susceptibility to infection
  - Potential for exposure greater in hospitals & nursing homes

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Slide 2-G-1-38

Infectious diseases occur more often and are usually more severe in the elderly, probably because aging affects host defenses. Immune senescence, as well as time lapse between primary exposure and rechallenge with pathogens, diminishes the vigor of the immune response. Aging and age-related disorders not only increase the susceptibility to infection but also depress the vigor of immune responses. Many chronic disorders common in the elderly (e.g., chronic obstructive pulmonary disease, cancer and diabetes) also increase

Audiovisual

Outline or text of presentation

susceptibility to infection. The potential for exposure is greater in hospitals and nursing homes.

Immune System (cont.)

- Increased risk reactivation
  - TB, varicella-zoster (shingles)
- Diminished response to vaccines
  - Influenza, pneumococcus, tetanus

39

Slide 2-G-1-39

In old age, T cell function declines, resulting in diminution of cell-mediated immunity, humoral immunity and self-tolerance. These changes lead to a decline in the response to foreign antigens and the emergence of more autoantibodies but not autoimmune disease (peak middle age). Since they have a diminished hypersensitivity to common skin-testing antigens [candida, mumps, tuberculosis (TB)], the aged have more severe reactions to infections, such as TB, influenza and varicella-zoster viruses. The aged have an increased risk of reactivation of TB, which correlates to the presence of other diseases and immunosuppressant therapy. They have more common reactivation of varicella-zoster, causing shingles. They have diminished antibody response to influenza, parainfluenza, pneumococcus and tetanus vaccines.

Poor Health Changes Everything

"My own belief is that loss of health is what delineates the two stages of old age (the young old & the old old). Until people lose their health, they are in young old category. Until people are ill, many keep their old routines & add some new pleasurable ones…However, poor health changes everything."

Mary Pipher, Ph.D. psychologist

Another Country: Navigating the Emotional Terrain of Our Elders

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Slide 2-G-1-40

Mary Pipher, in *Another Country: Navigating the Emotional Terrain of Our Elders,* states: "My own belief is that loss of health is what delineates the two stages of old age (the young old and the old old). Until people lose their health, they are in young old category. Until people are ill, many keep their old routines and add some new pleasurable ones…However, poor health changes everything."

Audiovisual

Chronic Diseases

- Arthritis
- Hypertension
- Heart disease
- Hearing & visual impairments
- Cancer
- Diabetes

41

Slide 2-G-1-41

Outline or text of presentation

Chronic Diseases

There is increased risk for certain disease processes in the older body. Some degree of physical decline is inevitable in everyone. Disease is not inevitable.

Disease is the result of other factors. Can you name any?

(Answers include: genetic propensities, lifestyle, socioeconomic level, diet, exercise and psychological attitudes.)

These are the six most common chronic diseases, listed in order of highest frequency:

- Arthritis.
- Hypertension.
- Heart disease.
- Hearing and visual impairments.
- Cancer.
- Diabetes.

Characteristics of chronic diseases include:

- Unknown cause.
- Debilitation.
- Curable and incurable conditions.
- Multiple illnesses simultaneously.

The leading causes of death are heart disease and cancer.

(Discuss with the students:

- *Why are we living longer?*
- *What does the word "old" mean to you?)*

Audiovisual

Aspects of Aging

- Psychological aspects include:
  - Emotional stability
  - Changes in intellect
  - Coping & adaptive behavior
  - Self concept
  - Personality—how people express themselves as they age

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Slide 2-G-1-42

Outline or text of presentation

Psychological and Sociological Aspects of Aging

Psychological aspects include:

- Emotional stability.
- Changes in intellect.
- Coping and adaptive behavior.
- Self concept.
- Personality—how people express themselves as they age.

Aspects of Aging (cont.)

- Sociological aspects include:
  - Family
  - Education
  - Work
  - Leisure
  - Community

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Slide 2-G-1-43

Sociological aspects include:

- Family.
- Education.
- Work.
- Leisure.
- Community.

It may be difficult to separate the psychological and sociological aspects of aging from the medical conditions—each impacts the others.

(Leave this slide on the screen. Read the following scenarios, and after each, discuss potential, but realistic, impacts.)

A couple has been married for approximately 40 years. One spouse dies, and the other individual is left to live alone in the house or apartment. This individual assumes all responsibilities, including shopping, food preparation, cleaning, taking care of the car, paying the bills and handling all the finances and maintaining the dwelling, as well as communicating with friends and family. The individual is still able to get out of the house, attend church, and visit family and friends, because the person drives and has a car.

Audiovisual	Outline or text of presentation
	(Ask students: • *Might this person have any psychological problems?* • *Might this person have any social problems?* • *Does it make a difference if the person is a woman or a man?)* Suppose the individual has increased medical conditions that prevent him/her from driving and leaving the home without assistance. *(Ask students:* • *What psychological problems are likely to emerge?* • *What social problems may emerge?* • *What additional medical problems may emerge?)* Suppose the individual has no children or close relatives. *(Ask students:* • *What psychological problems are likely to emerge?* • *What social problems may emerge?* • *What additional medical problems may emerge?* *Ask summary questions:* • *Are these scenarios likely?* • *Are there individuals in our State for whom, because of cultural influences, these scenarios would be different? How?)*

Audiovisual

Future

- Plan for your future!
- Examine your current life choices:
  - Diet & exercise
  - Refraining from drug & alcohol abuse
  - Good health habits
  - Managing stress & anxiety
  - Nonwork & social interests

44

Slide 2-G-1-44

Outline or text of presentation

The Future

- Plan for your future!
- Examine your current life choices:
  - Diet and exercise.
  - Refraining from drug and alcohol abuse.
  - Good health habits.
  - Managing stress and anxiety.
  - Nonwork and social interests.

Future (cont.)

"As we care for our parents, we teach our children to care for us. As we see our parents age, we learn to age with courage & dignity. If the years are handled well, the old & young can help each other grow."

Mary Pipher, Ph.D. psychologist
Another Country: Navigating the Emotional Terrain of Our Elders

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Slide 2-G-1-45

"As we care for our parents, we teach our children to care for us. As we see our parents age, we learn to age with courage and dignity. If the years are handled well, the old and young can help each other grow."

Lesson 2-G-1
The Aging Process

Questions

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Slide 2-G-1-46

Skill Assessment

The Aging Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed physiological and, as appropriate, psychological factors of normal aging for the following body systems: • Brain. • Senses. • Skin, nails and hair. • Respiratory. • Cardiovascular. • Gastrointestinal. • Bladder and kidneys. • Musculoskeletal. • Neurological. • Immune.	
					Described the body changes that can result in the following chronic illnesses of older adults: • Arthritis. • Hypertension. • Heart disease. • Hearing and visual impairments. • Cancer. • Diabetes.	

Comments/Recommendations:

Lesson 2-G-2: Individuals with Developmental Disabilities

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss information learned about individuals who have developmental disabilities.
- Describe the factors related to a survey involving an individual who has developmental disabilities.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix J, Intermediate Care Facilities for Persons with Mental Retardation
- *Code of Federal Regulations:*
  - 42 CFR
- CMS satellite transmissions:
  - *Interviewing People with Developmental Disabilities*, transmitted on August 22, 1997
  - *Aging and People with Developmental Disabilities*, transmitted on September 19, 1997
  - *Person Centered Planning*, transmitted on February 27, 1998
  - *How People with Severe Disabilities Learn*, transmitted on January 30, 2004 – Required viewing by all individuals who survey Intermediate Care Facilities for Persons with Mental Retardation

State

(Insert State reference[s] here.)

Other

Highlights

- Pretest to evaluate the student's knowledge and perceptions of individuals with developmental disabilities and mental retardation
- Definitions of developmental disabilities and mental retardation
- Information regarding mental retardation, including levels of retardation and support services likely needed
- Significant factors for surveyor investigation regardless of the health care setting

Training Techniques

- Pretest
- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - *"What Do You Think?"—Self Quiz*
  - *Examples of People First Language*
  - *Review of Self Quiz "What Do You Think?"*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Observation and student performance
- Return demonstration

Audiovisual

Outline or text of presentation

Lesson 2-G-2:
Individuals with
Developmental Disabilities

1

Slide 2-G-2-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Discuss information learned about individuals who have developmental disabilities.
- Describe the factors related to a survey involving an individual who has developmental disabilities.

2

Slide 2-G-2-2

(Inform the students of the objectives.)

(Distribute the handout "What Do You Think?—Self Quiz" to each student to use as a pretest.

Give the following instructions to the students.

Before we begin discussing individuals with developmental disabilities, please complete the self quiz. Read each statement and then circle "T" if the statement is true or "F" if the statement is false.)

Audiovisual

Individuals with Developmental Disabilities

- Definitions vary
  - Functional
  - Operational
  - Legal

3

Slide 2-G-2-3

Outline or text of presentation

Individuals with Developmental Disabilities

Definitions of what constitutes developmental disabilities come from a variety of sources, including Federal and State laws and regulations, national and State professional organizations and provider organizations and service agencies throughout the United States. These definitions range from the legal perspective to the operational and functional perspectives.

Functional Perspective

Relates to ability to:
- Learn
- Perceive deceit
- Grasp complexities of life
- Communicate
- Move
- Care for self

4

Slide 2-G-2-4

Functional perspective
The *functional perspective* regards individuals with developmental disabilities as people who can run, laugh, love, jump, fly a kite and enjoy a picnic.

As disabled adults, many hold jobs, live in their own houses or apartments, go to movies, attend church, bowl, drive cars and visit with their neighbors.

People with even mild developmental disabilities are vulnerable because they learn more slowly, are easier to deceive, and are less likely to grasp many of the complexities of modern life. They may not be able to balance a checkbook, drive a car, compare prices at the grocery store, follow a recipe, find a job on their own or program a VCR or a cellular phone.

Individuals with more severe developmental disabilities may never be able to learn to speak or speak clearly or to walk or dress themselves.

Audiovisual

Operational Perspective

Relates to:
- Mental retardation
- Related conditions
  - Cerebral palsy
  - Epilepsy
  - Developmental: autism, attention deficit/hyperactivity disorder (ADHD), Rett's disorder, childhood disintegrative disorder, Asperger's disorder

5

Slide 2-G-2-5

Operational Perspective (cont.)

- Other neurological: spina bifida, muscle disorders, dyslexia
- Long-term physical, mental, social impairments that occur before person is 22 years old
  - Can be inherited or from illness
  - May be physical, mental or social

6

Slide 2-G-2-6

Outline or text of presentation

Operational perspective

The *operational perspective* regards individuals with developmental disabilities as persons with *mental retardation* (also referred to as persons with cognitive disabilities) and several related conditions that can (but don't always) produce similar results: cerebral palsy, epilepsy, and pervasive developmental disorders. Pervasive developmental disorders include autism *(which in some States includes attention deficit/hyperactivity disorder [ADHD])*, Rett's disorder, childhood disintegrative disorder and Asperger's disorder.

Other neurological disorders similar to mental retardation are also considered developmental disabilities. These include spina bifida and muscle disorders, and dyslexia.

In the operational perspective, developmental disabilities are long-term physical, mental, or social impairments that occur before a person is 22 years old. They are called developmental because they appear during the development from an infant to an adult.

The source of a disability does not determine whether or not it is called a developmental disability. Some developmental disabilities are inherited. Some result from illness.

Audiovisual

Operational Perspective (cont.)

- Operational criteria of developmental disability:
  - Is acquired during developmental period
  - Has permanent effects
  - Affects independent functioning

7

Slide 2-G-2-7

Outline or text of presentation

In short, the operational criteria necessary for identification of a developmental disability are that it occurred during the developmental period, appears to have permanent effects and significantly affects independent functioning.

Legal Perspective

Relates to Federal definition of developmental disability

- Developmental Disabilities Assistance & Bill of Rights Act of 2000 (Public Law 106-402)
- Developmental disability is severe, chronic disability
  - Attributable to mental, physical impairment
  - Manifested before age 22

8

Slide 2-G-2-8

Legal perspective

The *legal perspective* originates from the Federal definition of developmental disabilities and appears in most States' and professional organizations' definitions. The Federal definition comes from the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law 106-402:

- Developmental disability means a severe, chronic disability.
- The disability:
  - Stems from mental or physical impairment or combination of mental and physical impairments.
  - Appears before the individual reaches 22.

Audiovisual

Legal Perspective (cont.)

– Likely to continue indefinitely
– Resulting in substantial functional limitations in 3 or more of following areas
  • Self-care
  • Receptive & expressive living
  • Economic self-sufficiency
  • Reflects individual's need for combination & sequence of special, interdisciplinary or generic services, individualized support or other forms of lifelong or extended, individually planned & coordinated assistance

9

Slide 2-G-2-9

Legal Perspective (cont.)

• When applied to individual from birth to age 9, developmental disabilities means:
  – Substantial developmental delay or specific congenital or acquired condition
  – May be considered developmental disability without meeting 3 or more of criteria for substantial limitation
  – Without services & supports, individual has high probability of meeting those criteria later in life

10

Slide 2-G-2-10

Outline or text of presentation

– Is likely to continue indefinitely.
– Results in substantial functional limitations in three or more of the following:
  - Self-care.
  - Receptive and expressive living.
  - Economic self-sufficiency.
  - Need for a combination and sequence of special, interdisciplinary or generic services, individualized support or other forms of extended or lifelong assistance that are planned and coordinated to meet the person's needs.

When applied to infants and children, a developmental disability means that an individual from birth to age nine has a substantial developmental delay or specific congenital or acquired condition. The individual may be considered to have a developmental disability without meeting three or more of the criteria for substantial limitation. These are individuals who, without services and supports, have a high probability of meeting the legal criteria for developmental disability later in life.

In short, an individual with a developmental disability can do or many times learn to do activities that we take for granted. However, we need to use language that reflects that image and shows respect for the person who happens to have a developmental disability.

(Distribute and discuss the handout "Examples of People First Language" on page 2-G-2-25.)

Audiovisual

Alternate Definition of Mental Retardation

- American Association of Mental Retardation definition (2002)
  - Disability characterized by significant limitations both in intellectual functioning & in adaptive behavior as expressed in conceptual, social & practical adaptive skills
  - This disability originates before age 18

11

Slide 2-G-2-11

Alternate Definition of Mental Retardation (cont.)

- Begins in childhood
- Has many dimensions
- Can be positively affected by supports

12

Slide 2-G-2-12

Outline or text of presentation

Alternate Definition of Mental Retardation

Although not a legal definition, that of the American Association of Mental Retardation (2002) appears perhaps as often as the Federal definition: "Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before the age of 18. A complete and accurate understanding of mental retardation involves realizing that mental retardation refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individualized supports. As a model of functioning, it includes the contexts and environment within which the person functions and interacts and requires a multidimensional and ecological approach that reflects the interactions of the individual with the environment, and the outcomes of that interaction with regards to independence, relationships, societal contributions, participation in school and community, and personal well-being."

In short, a disability refers to personal limitations that may present a disadvantage when functioning in society. Therefore, a disability should always be considered within the context of the environment, personal factors and need for individualized supports.

Audiovisual

Criteria for Mental Retardation

- Significant sub-average general intellectual functioning
- Onset before age 18

13

Slide 2-G-2-13

Outline or text of presentation

Mental retardation is defined by three criteria:

- Significant sub-average general intellectual functioning.
- Onset before age 18.

Criteria for Mental Retardation (cont.)

- Significant limitations in adaptive functioning in at least two areas:
  - Communication
  - Self-care
  - Home living
  - Social & interpersonal skills
  - Use of community resources
  - Functional academic skills
  - Work
  - Leisure
  - Health
  - Safety
  - Self-direction

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Slide 2-G-2-14

- Significant limitations in adaptive functioning in at least two of the following skill areas:
  - Communication.
  - Self-care.
  - Home living.
  - Social/interpersonal skills.
  - Use of community resources.
  - Self-direction.
  - Functional academic skills.
  - Work, leisure, health and safety.

Mental retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ) or IQ-equivalent obtained by assessment with one or more of the individually administered standardized intelligence tests (e.g., Wechsler Intelligence Scales for Children-Revised, Stanford-Binet and Kaufman Assessment Battery for Children).

Audiovisual

Outline or text of presentation

Significant subaverage intellectual functioning implies an IQ of about 70 or below (approximately two standard deviations below the mean). Note that there is a measurement error of approximately five points when assessing IQ, although this may vary from instrument to instrument.

Mild Mental Retardation

- IQ about 70 or below
- Live with families or in their own home
- Children attend school
- Adults
  - Need help with money management, household skills, job coaching
  - Need minimum structure provided by others

15

Slide 2-G-2-15

Mild retardation

Approximately 80% of people with mental retardation are *mildly mentally retarded*. Generally, people with mild mental retardation live with their families or in their own home or apartment. Children attend school; adults need help with money management, household skills and coaching for typical job settings. They need a minimum structure provided by others.

Moderate Mental Retardation

- Most children live at home or supported by families
- Adults need:
  - Help with money handling, shopping, cooking, household skills, public transportation
  - More structure & supervision to live in own home
  - More structured employment

16

Slide 2-G-2-16

Moderate mental retardation

Approximately 18% of people with mental retardation are *moderately mentally retarded*. Most children enjoy family support and live at home. They receive respite and personal help. Adults need help with money handling, shopping, cooking, household skills and riding public transportation. Adults generally need more structure and more supervision to live in their own apartment or home or to hold a job.

Audiovisual

Severe or Profound Mental Retardation

- 24-hour supervision & structure
- Support & training with basic self-care functions: eating, dressing, grooming & toileting
- Additional help with money handling, shopping, cooking, household skills & public transportation
- Very structured employment

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Slide 2-G-2-17

Outline or text of presentation

Severe or profound retardation
Approximately 2% of people with mental retardation are *severely or profoundly mentally retarded.* Generally they need 24-hour supervision and structure provided by family members or other caregivers. They need support and training with basic self-care functions such as eating, dressing, grooming and toileting. Adults need additional help with money handling, shopping, cooking, household skills and riding public transportation. Employment needs much structure.

Cerebral Palsy

- Nonprogressive pathologic lesion during early development
- Permanent motor impairment
- Variable degree of disability

18

Slide 2-G-2-18

Cerebral Palsy (CP)

This is a nonprogressive pathologic lesion in the developing infant's or child's brain causing permanent motor impairment. The degree of disability is highly variable, ranging from slight clumsiness of hand movement and gait to complete immobility. Other nervous system disorders, such as hearing defects or epileptic seizures, may be present.

Many affected children are also mentally retarded, although a proportion have normal or high intelligence. In the United States, approximately two to six babies per 1,000 develop cerebral palsy.

Cerebral Palsy (cont.)

- Possible hearing defects
- Possible epileptic seizures
- Small proportion of mental retardation
- Rate: 2–6/1,000 births

19

Slide 2-G-2-19

Audiovisual

Outline or text of presentation

Epilepsy

- Clinical disorder of recurrent paroxysmal episodes of central nervous system dysfunction
- Possible loss of consciousness, convulsive movements (seizures) &/or disturbances of feelings or behaviors such as confusion or acting out in anger

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Slide 2-G-2-20

Epilepsy (Convulsive Disorder)

This is a clinical disorder characterized by recurrent paroxysmal episodes of central nervous system dysfunction. It may be manifested as loss of consciousness, convulsive movements (seizures) or disturbances of feelings or behaviors such as confusion or acting out in anger.

Autism

- Syndrome first appearing in very early years of life
  - Extreme withdrawal
  - Language impairment
  - Inability to relate & respond
  - Repetitive motor behaviors
  - Inappropriate responses to external stimuli

21

Slide 2-G-2-21

Autism

This is a syndrome first appearing in the very early years of life characterized by:

- Extreme withdrawal.
- Language impairment.
- Inability to form emotional relationships.
- Frequent lack of responsiveness to other people.
- Repetitive motor behaviors.
- Inappropriate responses to external stimuli.

Autism (cont.)

- Obsessive urge for maintenance of sameness
- Functional areas affected (2 of following):
  - Social interaction
  - Language as used in social communication
  - Symbolic or imaginative play
  - Intellectual capacities may be severely impaired

22

Slide 2-G-2-22

- Obsessive urge to maintain sameness.
- Functional areas affected (2 of the following):
  - Social interaction.
  - Language as used in social communication.
  - Symbolic or imaginative play.

Many, but not all, children may be severely impaired in inherent intellectual capacities.

Audiovisual

Related Developmental Disabilities

- Refers to specific syndromes & neurological conditions
- Qualify for:
  - Appropriate treatments to develop skills to compensate for disability
  - Early intervention

23

Slide 2-G-2-23

Related Developmental Disabilities (cont.)

- Supports: cares or needs
- Interdisciplinary teams determine supports needed
  - Teaching & education
  - Home & community living activities
  - Employment
  - Health & safety
  - Behavioral & social activities
  - Protection & advocacy

24

Slide 2-G-2-24

Outline or text of presentation

Related Developmental Disabilities

This classification generally refers to individuals with developmental delay, autism and autism spectrum disorders, fetal alcohol syndrome or any of hundreds of specific syndromes and neurological conditions that can result in impairment of general intellectual functioning or adaptive behavior, similar to that of a person with a cognitive or intellectual disability such as mental retardation.

People with developmental disabilities can receive a range of appropriate treatments to assist them in developing skills and to compensate for areas of their disability. Early intervention programs can help young children and their families develop to their fullest potential.

Special education services, as well as those through public schools, assist school-aged children in obtaining relevant, appropriate education. A range of services for adults with disabilities, including employment assistance, residential and personal supports, transportation and assistant technology, offers the opportunity for a full, productive and satisfying life.

The term “supports” appears extensively in the literature related to individuals diagnosed with developmental disabilities. Supports generally include the resources and individual strategies used to promote the education, interests and personal well-being of individuals with mental retardation and other developmental disabilities.

Audiovisual

Outline or text of presentation

Interdisciplinary teams determine the type and number of supports needed. The teams review comprehensive functional assessments and determine individual developmental needs:

- Teaching and education.
- Home living activities.
- Community living activities.
- Employment.
- Health and safety.
- Behavioral activities.
- Social activities.
- Protection and advocacy activities.

Settings Encountered Surveying

- Intermediate care facilities for persons with mental retardation (ICFs/MR)
- Long term care
- Hospital
- Other

25

Slide 2-G-2-25

Surveyor Investigation

A surveyor encounters individuals with developmental disabilities primarily in health care settings such as intermediate care facilities for persons with mental retardation (ICFs/MR), in home and community based services (HCBS) residential homes, in residential care facilities (RCFs) and occasionally in long term care (LTC) facilities such as nursing homes. Although rare, one may find an individual with mental retardation or a developmental disability in a hospital.

The primary reason for encountering such cases in nursing homes results from a decision parents or family have made. They will likely reside in the nearby community and will be involved with care and treatment.

Audiovisual

Factors to Investigate

- Individual's level of comprehension
- Staff's thoroughness in assessing needs
- Extent of family's or guardian's awareness of needs

26

Slide 2-G-2-26

Outline or text of presentation

Regardless of the health care setting in which one encounters an individual with developmental disabilities, one can state with full confidence that either a State human service agency or a public educational entity has diagnosed and assessed the individual and initiated treatment and training at some point in the individual's past through age 21.

The key determinant for the surveyor remains whether the health care setting he/she is currently surveying is providing all regulatory services to all individuals within the setting to ensure that they are realizing their maximum potential.

Therefore, regardless of the entity, the surveyor needs to investigate and make an independent evaluation of the following:

- The individual's level of communication and comprehension of the current setting.
- Depending on the current setting, the degree to which facility staff have comprehensively assessed the individual and planned appropriate care to meet the person's current needs and to support the individual's ability to acquire additional skills and abilities.
- The extent to which facility staff have informed a parent or legal guardian of the individual's care, services and condition.

("Review the Self Quiz 'What Do You Think?'"

If time permits, ask students to provide the answer to each question. If time does not permit review of the answers, distribute the handout, "Review of Self Quiz 'What Do You Think?'" to each student.)

Audiovisual

Outline or text of presentation

Lesson 2-G-2:
Individuals with
Developmental Disabilities

Questions

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Slide 2-G-2-27

Skill Assessment

Individuals with Developmental Disabilities

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed individuals who may have developmental disabilities including at least: • Legal definition. • Functional abilities. • Potential supports needed.	
					Described factors the surveyor investigated during any survey when encountering an individual who has developmental disabilities.	

Comments/Recommendations:

What Do You Think?—Self Quiz

T F 1. Persons with developmental disabilities are, by definition, persons who have mental retardation.

T F 2. Mental retardation is a disease.

T F 3. Mental retardation is a form of mental illness.

T F 4. The diagnosis of mental retardation can change over a person's lifetime.

T F 5. If a person has an IQ of 70–75 or below, the person should be diagnosed as having mental retardation.

T F 6. One percent of the population in the U.S. experiences mental retardation.

T F 7. Most persons with mental retardation live independently in their own homes.

T F 8. The best place for a person with developmental disability or mental retardation to live is in a setting where there is staff supervision.

T F 9. Most persons with mental retardation work in sheltered workshops or work activity centers.

T F 10. People with mental retardation can know that they are different from others.

T F 11. Most people in ICFs/MR facilities today are people with both physical and mental impairments.

T F 12. Most persons with mild mental retardation in the U.S. live in ICFs/MR facilities.

T F 13. Some persons with developmental disabilities have such severe disabilities that they are incapable of benefiting from intervention.

T F 14. Persons with mental retardation or other developmental disabilities can only learn to do the things that others teach them to do.

T F 15. People with mental retardation or other developmental disabilities have the same feelings as other people.

T F 16. Physicians are the best resource in training persons with mental retardation or other developmental disabilities.

T F 17. Active treatment is the most effective way to help persons with mental retardation or other developmental disabilities develop new skills.

T F 18. The priority needs of persons with mental retardation or other developmental disabilities are always medical care and a safe, protected environment.

T F 19. Direct care staff are qualified to provide active treatment.

T F 20. Client training, conducted by professional staff, is the prime focus of active treatment.

T F 21. An active treatment program that occurs for at least five hours per day is sufficient for compliance.

T F 22. Most persons living in ICFs/MR facilities experience severe or profound mental retardation.

T F 23. All persons with mental retardation require lifelong specialized training.

T F 24. For a person with mental retardation or other disabilities the best place to live is in an ICF/MR.

T F 25. Services provided in small group home settings in the community are better than services provided in large institutions.

T F 26. If more community services were available for persons with mental retardation or developmental disabilities, fewer would be in large institutions.

T F 27. All individuals with mental retardation/developmental disabilities who are of school age, no matter how severe their disability, are entitled to a free, appropriate public education designed to meet their needs.

T F 28. Persons with severe or profound mental retardation can hold competitive jobs.

T F 29. Mental retardation is not contagious.

T F 30. People with mental retardation are usually unable to have children.

T F 31. People with Down syndrome are by nature happier and more contented than others.

T F 32. People with mental retardation have more similarities to people without mental retardation than differences.

T F 33. Persons with mental retardation share similar likes and dislikes.

T F 34. Persons with mental retardation are more sexually active than others.

T F 35. It is unhealthy to ask a person with mental retardation or other developmental disabilities to take risks or meet challenges.

T F 36. Every State has a system to investigate abuse and neglect in facilities for persons with mental retardation or developmental disabilities.

T F 37. The U.S. Department of Justice has the authority to investigate allegations of abuse and neglect in public ICFs/MR.

T F 38. Persons with mental retardation will be child-like throughout their lives.

T F 39. Persons with mental retardation or other developmental disabilities who engage in self-abusive behavior can learn to change their behavior.

T F 40. Some people have such severe disabilities that they will always need to be in a large institution.

T F 41. As a child Thomas Alva Edison, inventor of the light bulb, was labeled intellectually slow.

T F 42. Individuals with developmental disabilities or mental retardation cannot make choices.

T F 43. Individuals with developmental disabilities or mental retardation can learn to handle money.

T F 44. Active treatment is not required when individuals have health problems.

T F 45. When individuals with mental retardation or developmental disabilities retire in an ICF/MR, the active treatment requirement does not apply.

T F 46. An ICF/MR must have every professional or clinical discipline represented on staff.

T F 47. Individuals with severe or profound mental retardation cannot usually communicate.

T F 48. It is unrealistic to expect individuals with mental retardation to work in competitive jobs.

T F 49. Individuals who have developmental disabilities or mental retardation cannot learn to vote.

T F 50. Most individuals with mental retardation need full guardianship.

Examples of People First Language

Labels Not to Use…	People First Language…
he's in special ed	he receives special ed services
birth defect	congenital disability
the handicapped or disabled	people with disabilities
the mentally retarded; he's retarded	people with mental retardation; he has a cognitive impairment
my son is autistic	my son has autism
she's a Down's kid; a Mongoloid	she has Down syndrome
he's learning disabled	he has a learning disability
I'm a paraplegic	I have paraplegia
she's crippled	she has a physical disability; she has a mobility impairment
he's a dwarf (or midget)	he's of short stature
she's emotionally disturbed	she has an emotional disability
he's wheelchair bound or confined to a wheelchair	he uses a wheelchair or a mobility chair
normal and/or healthy kids	typical kids or kids without disabilities
handicapped parking, bathrooms, etc.	accessible parking, bathrooms, etc.
she has a problem with…	she has a need for…

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Review of Self Quiz "What Do You Think?"

Discussion
Ask participants to retrieve the self quiz that they took at the beginning of the lesson. Use a discussion format to (1) ask whether the statement is true or false; (2) ask someone with the correct answer to provide the explanation; (3) correct the answer if no one had it correct; and (4) provide the information listed after each statement if not included with the participant's explanation.

"What Do You Think?"

F 1. Mental retardation is one of many conditions that may result in a developmental disability. Other conditions include cerebral palsy, autism or epilepsy. A diagnostic label does not necessarily indicate a developmental disability. It is the significant functional impairment in major life activities that is the chief determinant of whether or not a developmental disability exists.

F 2. It is a condition.

F 3. Mental retardation is not a mental illness. It is a particular state of functioning.

T 4. For some individuals, and based on the 2002 definition of mental retardation of the AAMR, mental retardation may not be of lifelong duration.

F 5. There must be a lack of significant adaptive skill in at least two or more skill areas and the lack must predate the individual's 18th birthday.

T 6. Although prevalence estimates range from as low as 0.67 percent to a high of 3 percent, an estimate of 1 percent is generally accepted.

T 7. Nearly 90 percent of people with mental retardation have only a mild level of retardation. Most of them are generally self-sufficient as adults.

F 8. The best setting is the least restrictive and meets the unique needs of the individual.

F 9. Most are competitively employed.

T 10. People with mental retardation can know they are different from others, just as some people know they have brown eyes and others have blue eyes.

T 11. As deinstitutionalization has progressed, people residing in ICFs/MR facilities are more severely and multiply impaired than in former years.

F 12. According to Lakin et al. (1989), 12 percent of people with mental retardation in ICFs/MR experience *mild* mental retardation, a very small portion of the total number of people with mild mental retardation.

F 13. ICF/MR regulations assert, and field experience supports, that all people with developmental disabilities can benefit from intervention.

F 14. Incidental learning also takes place.

T 15. People with mental retardation are first *people* like everyone else. They have the same basic human characteristics we all have.

F 16. Physicians are not trainers. They are trained to practice medicine, which involves medical diagnosis and medical treatment.

T 17. Regulations reflect this.

F 18. People with mental retardation have the same basic needs as all, including the need to be independent, make choices and take risks.

T 19. Regulations require it. There are no qualifications to provide active treatment, with the exception of competency.

F 20. *All* staff should be engaged in the provision of active treatment, not just professional staff.

F 21. The regulations state that active treatment must be continuous. Every interaction with a client is an opportunity for active treatment.

T 22. In state institutions serving over 50 percent of ICF/MR beneficiaries, nearly 84 percent were people with either severe or profound mental retardation (Lakin et al., 1993).

F 23. Some people with mental retardation require virtually no specialized training; others require short-term training and others life-long training.

F 24. ICFs/MR are only for people with significant developmental disabilities who are in need of continuous, active treatment. The best living situation for a person with a developmental disability is a setting that most supports that person's independence, productivity, and integration into the community.

F 25. Not necessarily. Quality does not depend on location alone.

T 26. The deinstitutionalization movement has resulted in waiting lists and a great demand for community residential services.

T 27. Public Law 94-142, The Education of All Handicapped Children Act, now The Individuals With Disabilities Education Act (IDEA), guaranteed this right to students with disabilities in 1975.

T 28. Such people may need special support to hold a competitive job. With the recent advent of supported employment, it is more and more common to see people with severe disabilities working in competitive settings.

T 29. Mental retardation is not contagious.

F 30. There is no evidence to show that sterility occurs in people with mental retardation in any proportion different from that of the general population.

F 31. There is no evidence to show that people with Down syndrome have attitudes that are any different from those of the rest of the population.

T 32. People with mental retardation do have more similarities to people without mental retardation than differences.

F 33. This is like saying that people with blue eyes have similar likes and dislikes.

F 34. There is no evidence to show that people with mental retardation are different in their sexual activity than the rest of the population.

F 35. Just as facing challenges and making choices is part of growth and development for all people, so it is for people with mental retardation and other developmental disabilities.

T 36. There is a protection and advocacy system in every State with the authority to investigate possible abuse and neglect of people with developmental disabilities who live in congregate care settings.

T 37. Under the Civil Rights of Institutionalized People Act (CRIPA), the Department of Justice has authority to investigate for patterns of abuse and neglect in institutions. The Department of Justice has investigated several ICFs/MR.

F 38. People with mental retardation can grow and develop throughout their lives. Although their intellectual functioning will remain below average, this does not prevent maturation and the acquisition of new skills.

T 39. A range of sophisticated behavior modification techniques is available today. The techniques can result in changes in even the most severe behavior problems.

F 40. Many community-based programs can coordinate the use of consultants and generic or specialized services to address even the most severe and complex needs. Many families cope with these problems all the time!

T 41. What if Thomas Edison had allowed himself to believe that he was, in fact, slow? How might that have altered his view of himself? How might it have affected his accomplishments?

F 42. People with mental retardation can make, or can be taught to make, varying kinds of choices, such as selecting friends, a roommate or a job; spending money; deciding what to wear; choosing how they want their living area to look; deciding what to eat or drink or, in what order; determining which activity they would enjoy.

T 43. People with mental retardation can learn to recognize coins, use coin cards, make change, write checks and budget. Their money management skills vary just like those of people without cognitive disabilities.

F 44. Since active treatment is designed specifically for each individual, such a program would consider the individual's health status.

F 45. Active treatment is required for everyone in an ICF/MR. An older individual's program should include the types of skills and activities commonly associated with the phases of life in which retirement occurs.

F 46. The facility must have available the professional and clinical expertise required to develop, implement and supervise an active treatment program for each client. This does not require that these individuals are necessarily staff.

F 47. Many people with severe or profound mental retardation can speak. Other forms of communication include smiles, facial expressions, gestures, body language, sometimes even the exhibition of an inappropriate behavior. The level of retardation does not eliminate communication. Everyone communicates in some way.

F 48. There is an increasing amount of documentation, particularly from supported employment programs, that people with all levels of retardation can compete and work in community employment.

F 49. Choice and decision making are skills which the ICF/MR must teach. Voting is one aspect of this type of program and is one way the facility can help to ensure client's rights.

F 50. Most individuals can make decisions about their lives. But some form of limited or temporary guardianship may be necessary for major or high-risk decisions.

Lesson 2-G-3: Cultural Diversity

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Articulate cultural prejudices, expectations and attitudes that may affect surveying.
- Articulate cultural issues in the provision of health-care services.

Lesson Plan

References

Federal

- CMS satellite transmission, *Delivery of Care to a Diverse Population*, broadcast July 22, 2005
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (July 2004). Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2002. *Vital and Health Statistics, Series 10, Number 222. DHHS Pub. No. (PHS) 2004-1550.*

State

(Insert State reference[s] here.)

Other

- Teachers First Resource Selections [On-line]. Available: http://www.teachersfirst.com

Highlights

- A culture includes many components
- A surveyor first needs to be aware not only of his/her own culture and the learned behaviors and preferences of that culture, but also those of other cultures to understand and work with individuals of another cultural heritage
- A surveyor needs to evaluate whether an entity has considered the patient's/resident's/client's cultural preferences, beliefs and practices and incorporated them into the care and services offered and provided

Training Techniques

- Lecture
- Group discussion
- Individual exercise

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - *Your Cultural Heritage*
  - *Clues to Cultural Diversity*
  - *National Center for Health Statistics Centers for Disease Control and Prevention Data for the United States in 2002*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Lesson 2-G-3:
Cultural Diversity

1

Slide 2-G-3-1

Outline or text of presentation

The United States is a country of immigrants: even Native Americans originally immigrated from other parts of the world. Today, as a nation, we have many individuals who were born and reared in another country or were raised in a home with a strong cultural heritage. Yet health-care providers may neglect to assess the impact of cultural heritage on an individual's preferences, behaviors or acceptance of care and services. It will be your job as a surveyor to determine how well the health-care provider gives appropriate care and services to all individuals in a culturally diverse world.

The topic of cultural diversity is so huge it is difficult to know where to start, what to include and when to stop. This lesson will provide information that may stimulate your curiosity to learn more.

(Distribute the handout "Your Cultural Heritage" on page 2-G-3-21 and ask students to complete it individually. Student responses will be used later in the lesson.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Articulate cultural prejudices, expectations & attitudes that may affect surveying.
- Articulate cultural issues in the provision of health-care services.

2

Slide 2-G-3-2

(Inform the students of the objectives.)

Audiovisual

Outline or text of presentation

Culture

Culture is set of rules or standards shared by members of society, which when acted upon by members produce behavior that falls within range of variation members consider proper & acceptable

3

Slide 2-G-3-3

Definition of Culture

Culture is a set of rules or standards shared by members of a society, which when acted upon by the members produce behavior that falls within a range of variation the members consider proper and acceptable.

No two cultures are alike. Although all cultures are composed of the same elements, how those elements are expressed is different with each culture.

Cultural Boundaries

- May be identified with:
  - Place
  - Society
  - Class
  - Civilization
  - Nation
  - Time

4

Slide 2-G-3-4

Culture may be identified with a particular civilization, nation or place and society, class or time to which people belong.

Cultural Elements

- Values
- Beliefs
- Customs
- Social behavior

5

Slide 2-G-3-5

Culture includes the sum total of values (e.g., the importance of the family or independence, how money is spent), beliefs (e.g., what is right and wrong), customs (e.g., holiday celebrations; proposal of marriage; how individuals are buried; and garments and jewelry worn by men and women, young and old) and social behavior (e.g., who eats first, who eats last, the place a person of importance will sit at the table, who can talk with whom, etc.) that each individual learns when part of that culture.

Audiovisual

Outline or text of presentation

We express our culture through the way we speak, the garments we wear, our grooming, what we eat, the music we listen to, what we read, how we spend our money, how we spend our leisure time, how we work, how we treat others of the same and opposite sex and how we treat the young and the old.

Other Definitions of Culture

- Philosophy or particular set of attitudes that characterizes group of people

6

Slide 2-G-3-6

Culture can be a philosophy or particular set of attitudes that characterizes a group of people.

For example, you are learning a new culture as a surveyor: the attitudes and behaviors that reflect the work a surveyor does.

Important Cultural Aspects

- Dynamic
- Learned
- Shared

7

Slide 2-G-3-7

Culture is dynamic: it changes over time.

Culture is learned: it is not something you are born with but is something you are taught and perceive as you mature. The cultural behaviors and preferences you exhibit will not necessarily reflect the same aspects of life as your parents' or grandparents', and what is acceptable to you today likely would not have been acceptable for your parents at your age.

Culture is shared: if it weren't, we would not be able to understand one another. The fact that culture is shared allows us to understand the actions of others and lets us know that our actions are within the societal norms of acceptance.

Audiovisual

Discussing Cultural Diversity

- Ancestral heritage
- Community characteristics
- Holiday celebrations
- Traditional healing techniques

8

Slide 2-G-3-8

Outline or text of presentation

Any time you think of a group of people, you can probably think of a set of acceptable and unacceptable behaviors for that group.

(Ask the students to discuss acceptable behaviors and unacceptable behaviors for:

- *Attending a sports activity.*
- *Eating with an extended family for a holiday.*
- *A night out with the guys or girls.)*

Let's consider the different cultural heritages you represent.

(On the handout "Your Cultural Heritage" on page 2-G-3-21, proceed through the first four questions one by one, asking students to share their answers.

In summary, ask whether the students' groups represent the cultural diversity in your State. If not, elicit responses or provide input about other cultures the students are likely to encounter while surveying. Address behaviors, values and other aspects most significant to the surveyor. The handout "Clues to Cultural Diversity" on page 2-G-3-23 can be used to aid brainstorming.)

Your familiarity with some cultures and people that have a strong cultural heritage can depend on communication. Television, radio, newspapers and periodicals that you see, hear and read may provide you some information about some cultural practices but not all that you may encounter.

Audiovisual

Individual Differences

- Some bases for differences:
  - Education
  - Social standing
  - Religion
  - Personality

9

Slide 2-G-3-9

Stereotyping

- Avoid categorization based on oversimplification
- Communicate carefully
- Allow for language or communication barriers

10

Slide 2-G-3-10

Outline or text of presentation

Individual Differences Within a Culture

Each individual in a culture will not reflect all aspects of that culture. Education, social standing, religion, personality, belief structure, past experience and other factors will affect an individual's behavior and other expressions of the culture.

It is important to take individual as well as cultural differences into account during your work as a surveyor: in the office, with the people you work with directly, with the provider/supplier employees and with the patients, residents and clients.

Paying attention to customs and cultural differences can give you a better chance of acceptance. Ignoring them can cause miscommunication or misperception.

Avoidance of Stereotyping

Our perceptions of cultures and people in general can get in the way of objectivity. Remember, stereotyping is categorizing individuals or groups according to an oversimplified standardized image or idea.

For example, what do you think of when you hear the following:

- German.
- Scandinavian.
- Chinese.
- Japanese.
- Native American.
- Hispanic.

Labeling or pigeonholing dehumanizes an individual. We expect you not to stereotype but rather to look at the individual. When you see or hear something you don't understand, ask about

Audiovisual	Outline or text of presentation
	it. Communicate before making a judgment. Different cultures may have standards of behavior or thought processes different from those with which you are familiar. Individuals differ in their participation in cultural behavior. In particular, allow for language or communication barriers that may make it more difficult to communicate and understand. As a surveyor, you brought certain "baggage" with you: • Upbringing. • Learned behaviors. • Media bias. • Stereotypes. • Ignorance. • Closed mind. **Strategies for Dealing with Cultural Diversity** • Be aware of your own attitudes, stereotypes and expectations. • Don't ignore cultural differences. • Be understanding and show respect. • Be open to learning. • Don't be afraid of possible tension or conflict. • Explain and engage (be aware of your own hesitance to interfere). • Be a role model. **Communicating Across Cultures** • Learn to observe (e.g., body language, facial expressions, deference or respect shown to certain individuals, clothing, etc.). • Learn to listen (e.g., words said and not said, how the person refers to individuals, etc.).

Audiovisual

Cultural Differences

- Diet
- Activity participation & sleeping practices
- Customs associated with food
- Hygiene & greeting practices
- Kosher

11

Slide 2-G-3-11

Outline or text of presentation

- Adjust to the communication of others.
- Communicate clearly and fairly.
- Test for understanding.

Examples: Taking Culture into Account

(Change the following examples to reflect the cultures the surveyor will likely encounter and possible situations.)

Examples

Example 1: A Federal surveyor went to another State to conduct a survey in a long term care facility. From the beginning of the survey, it was apparent that the long term care facility cared primarily for individuals who came from or had ancestors from Eastern Europe. During the noon meal, the surveyor noticed that the residents received steak tartare as the appetizer. Steak tartare is raw hamburger mixed with onion and some other ingredients, and it was a common food for most individuals in the facility.

(Ask the students how they would react and how they would take culture into account if they encountered this during a survey.

Answers might include interviewing individuals who were served the food and individuals who did not eat the food, investigation of kitchen practices for the significant potential for food-borne illness and communicating investigation results to the team.)

Example 2: During another survey, a surveyor observed an individual from an Asian culture who sat on the bed during the day with legs crossed and had a blanket spread on the floor. When interviewed, nursing staff reported the individual did

Audiovisual	Outline or text of presentation
	not participate in health-care decisions and slept on the floor at night. *(Ask the students how they would react and how they would investigate the individual's culture and individual preferences to determine whether the provider or supplier staff had made appropriate considerations when planning care.* *Answers might include reviewing the Plan of Care, attempting to interview the individual and, if the individual were cognitively impaired, interviewing a family member or visitor.)* Example 3: During a visit to Russia, a male tourist was invited out to dinner with his host and the host's wife. At the end of the meal, the tourist was offered a banana by the host's wife. He politely declined, but thought, "What would be the polite thing to do?" So he asked if she would like a banana. When she accepted, he politely peeled the banana for her. Several visits later, he was told that when a man peels a banana for a lady, it means he has a romantic interest in her. Example 4: In Japan, it is considered unhygienic to touch another individual. Therefore, would you shake the hand of a person from Japan? Example 5: Orthodox Jews follow strict laws regarding the preparation of foods (kosher). The rules regarding kosher foods do not allow meat (this means beef and poultry, because kosher foods do not include pork) to be prepared with or served at the same meal as milk or dairy (milk and cheese and foods made with milk and cheese). In a kosher kitchen you will find one set of pots and pans, utensils and

Audiovisual

Outline or text of presentation

dishes for meat and another set for dairy. Would you ever find meat lasagna on the menu? Would a thermometer used to test the temperature of meat be used to test the temperature of a food made with cheese?

In short, your understanding of what is acceptable in your culture may not be acceptable in another or may mean very different things.

(Refer the students to the handout "Your Cultural Heritage" on page 2-G-3-21 and ask the students to share answers to the last question to elicit other examples that might be encountered.)

Cultural Competence

- Attitudes, skills, behaviors & policies that foster effective health care to individuals from different cultures
- Emphasizes systematic consideration of cultural diversity

12

Slide 2-G-3-12

Cultural Competence

Cultural competence, like respect for cultural diversity and cross-cultural communication, is another concept relevant to the provision of health care. It is defined as a set of attitudes, skills, behaviors and policies that can help organizations or staff to work effectively with people of different cultures.

A culturally competent system of care acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally unique needs.

Cultural competence involves a systems perspective which values differences and is responsive to diversity at all levels of an organization. This includes considerations within written policies, administrative decisions and their impact and working

Audiovisual

Outline or text of presentation

with others from a different culture and for others who exhibit the behaviors and beliefs of a different culture.

The concept of cultural competence emphasizes promotion of quality services to underserved racial or ethnic groups through finding value in the differences and integrating cultural attitudes, beliefs and practices both into diagnostic and treatment methods and throughout the system to ensure that services are delivered in a culturally competent manner.

Cultural Elements Relevant to Health Care

- Understanding of life processes
- Definition of health & illness
- Methods of maintaining wellness
- Beliefs about causes of illness
- Methods of healing
- Delivery & receipt of care

13

Slide 2-G-3-13

Culture and Health Care

Cultural elements relevant to health care
The concepts of illness, health and wellness are part of a cultural belief system. Health-care staff need to understand:

- How a particular culture understands life processes.
- How a particular culture defines health and illness.
- What the particular cultural group does to maintain wellness.
- What a particular cultural group believes to be the causes of illness.
- How healers cure and care for members of the cultural group.
- How the cultural background of the health-care provider influences the way in which care is delivered and that of the patient influences the way care is received.

Health care in a culturally diverse environment requires the use of various approaches to provide culturally appropriate care that incorporates an individual's cultural values, beliefs and practices. Both you and the health-care provider need to be sensitive to the

Audiovisual

Outline or text of presentation

environment from which the individual comes and to which the individual may ultimately return. Knowledge of cultural diversity is vital at all levels of health-care practice. It can be used to strengthen and broaden health-care delivery.

Intersection of Cultural Systems in Health Care

- Three systems:
  - Provider's culture
  - Client's culture
  - Culture of setting

14

Slide 2-G-3-14

Intersection of cultural systems in health care

Health-care providers bring their personal cultural heritage as well as the cultural and philosophical view of their education into the professional setting. Therefore, it is important to understand that provider-patient, resident or client encounters include the interaction of three systems: the culture of the health-care provider, the culture of the client and the culture of the setting.

Culture & Medical History

- Ethnicity
- Strength of affiliation
- Gender role
- Language
- Religious preference
- Food preferences
- Family relationships
- Pattern of family decision making
- Health practices
- Beliefs about medical care
- Level of acculturation
- Immigration status
- Race

15

Slide 2-G-3-15

Culture and medical history

A cultural assessment is frequently neglected in history taking. Knowing when and what cultural data to collect and how to interpret and make use of the information is key to providing culturally relevant health care. Throughout the course of care, caregivers should identify and communicate to other caregivers major values, beliefs and behaviors that may influence a patient's, resident's or client's response to acute and chronic illness as well as foods, activities and interactions with others.

The initial assessment should identify the individual's:

- Ethnicity and strength of affiliation with an ethnic group.
- Gender roles.
- Language(s) spoken and fluency.
- Religious preference.
- Food preferences.

Audiovisual

Outline or text of presentation

- Family relationships and patterns of decision making.
- Health practices and beliefs about medical care.
- Level of acculturation.
- Immigration status (implications for the kinds of services and rights vary for people of refugee, immigrant or undocumented status).

Further information may be needed to develop a culturally appropriate Plan of Care.

Biocultural Issues: African-Americans

- Diabetes mellitus
- Hypertension
- Heart disease
- Obesity
- Lactose intolerance

16

Slide 2-G-3-16

Biocultural Issues

Whether due to genetics or environment, based on studies reported by the Centers for Disease Control and Prevention, individuals from certain cultures and groups appear to have a higher incidence of some disease conditions that should be evaluated during the assessment process.

African-Americans:

- Diabetes mellitus.
- Hypertension.
- Heart disease.
- Obesity.
- Lactose intolerance.

Audiovisual

Biocultural Issues:
Hispanics or Latinos

- Obesity
- Heart disease
- Diabetes mellitus
- Dental caries
- Over- or undernutrition

17

Slide 2-G-3-17

Outline or text of presentation

Hispanics or Latinos:

- Obesity.
- Heart disease.
- Diabetes mellitus.
- Dental caries.
- Over- or undernutrition.

Biocultural Issues: Asians

- Stomach cancer
- Lactose intolerance
- Low incidence of heart disease, bowel cancer & breast cancer

18

Slide 2-G-3-18

Asians:

- Stomach cancer.
- Lactose intolerance.
- Low incidence of heart disease, bowel cancer and breast cancer.

(Distribute the handout "National Center for Health Statistics Centers for Disease Control and Prevention Data for the United States in 2002" on page 2-G-3-25 and review the information, comparing health statistics of different groups with the students.)

Audiovisual

Improving Cross-Cultural Communication

- Bear in mind:
  - Inter- & intracultural variations
  - Historical, health-care, spiritual & religious contexts
  - Cultural characteristics of groups most commonly surveyed
  - Your own cultural values & biases
  - Nonverbal communication
  - Biocultural differences

19

Slide 2-G-3-19

Outline or text of presentation

Here are some suggestions to improve cross-cultural communication and recognition of cultural diversity on survey:

- Recognize that values and beliefs vary not only among different cultures (intercultural variations) but also within a culture (intracultural variations).
- View values and beliefs from different cultures within historical, health-care, spiritual and religious contexts.
- Learn as much as you can about the language, customs, beliefs and values of different cultural groups, especially those with which you have the most contact.
- Be aware of your own cultural values and biases.
- Be alert to and try to understand the nonverbal communications of your own and various cultures, such as personal space preferences and body language.
- Be aware of cultural differences that might be manifested in a physical exam, in types of illness or in response to drugs. These cultural differences may be reflected in health-care practices.

Lesson 2-G-3:
Cultural Diversity

Questions

20

Slide 2-G-3-20

Skill Assessment

Cultural Diversity

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Articulated cultural prejudices, expectations and attitudes that may affect survey.	
					Articulated cultural issues in the provision of health-care services.	

Comments/Recommendations:

Your Cultural Heritage

1. From where did your ancestors immigrate and about how many generations ago (e.g., your parents, grandparents, great-grandparents, etc.)?

2. Where did you grow up: was it in the city, a suburb or the country, and in what manner did your community reflect your cultural heritage?

3. List a favorite holiday and tell me how your family celebrates. Address family members involved, location, food, decorations and activities.

4. List a few of the methods that have been used in your family to heal illnesses (e.g., chicken soup, shaman, etc.). Where did these healing techniques come from (e.g., culture, family member, friend, television, etc.)?

5. If possible, describe one situation that you have encountered in your professional career in which more awareness of a culture could have resulted in better communication or an improvement in the understanding, assessment and/or care provided to an individual.

Clues to Cultural Diversity

1. How do people greet each other: Shake hands? Bow? Embrace? How else? How do they part?

2. On what occasions would you present or accept a gift? What gifts are considered appropriate? If flowers, what kind, since some have special meanings?

3. Are children usually present and do they participate at social gatherings? How about elderly members of the family? Women of the family?

4. How are children disciplined at home? At school?

5. In schools, are children segregated? If so, how (e.g., class, caste, sex, religion, grade level, age, etc.)?

6. Do most people read and write?

7. How are public sanitation, hygiene and garbage dealt with?

8. What is the normal dress of women? Of men?

9. What foods are taboo? What actions are taboo?

10. If, as a customer, you touch or handle things that are for sale, will you be considered knowledgeable or inconsiderate?

11. Is television available? How widely is it used? What programs are available?

12. What is the attitude toward drinking? Gambling?

13. How do adults and children spend their leisure time?

14. What is the normal pattern of work days and days off? What are normal working hours for men and for women?

15. What are the important holidays? How is each observed?

16. How do people get married? Who makes the arrangements? What is the attitude toward divorce?

17. What is the common language? What other languages are used?

18. What is the principal religion? Is it a state (i.e., official) religion? What are its basic doctrines? Who are its originators and shapers?

19. What is the attitude of believers in the principal religion toward other religions and their followers?

20. Who are the country's national heroes (are they women as well as men)? For what kinds of achievements are they celebrated?

Adapted from Teachers First Resource Selections, http://www.teachersfirst.com.

National Center for Health Statistics
Centers for Disease Control and Prevention
Data for the United States in 2002

	White	Hispanic /Latino	African American	Asian/ Pacific Islander	American Indian or Alaska Native
Population	234 million	38 million	38 million	13 million	3 million
Health Status					
Percent of persons in fair or poor health	8.8	9.6	11.9	5.1	11.6
Percent of persons with an activity limitation due to one or more chronic health conditions	12.4	7.9	12.9	4.9	16.4
Percent of adults 65 years and over with no natural teeth	26.4	32.7	35.3	—	—
Health Risk Factors					
Percent of adult men who currently smoke	25.4	21.8	26.9	19.5	31.6
Percent of adult women who currently smoke	21.3	11.7	19.1	6.9	36.7
Percent of men 20 years and over who are overweight	69.9	—	61.7	—	—
Percent of women 20 years and over who are overweight	58.2	—	76.8	—	—
Percent of men 20 years and over with hypertension	28.1	—	35.8	—	—
Percent of women 20 years and over with hypertension	32.8	—	42.0	—	—
Access to Health Care					
Percent of persons under 65 years without health insurance coverage	15.2	33.2	18.9	17.4	39.0
Percent of children without a usual source of health care	4.8	11.6	5.4	12.2	5.2
Percent of adults without a usual source of health care	12.6	28.2	14.4	20.9	15.1
Mortality					
Number of deaths	2,102,589	117,135	290,051	38,332	12,415
Deaths per 100,000 population	895.7	302.2	768.4	299.5	403.6

Number of deaths for leading causes of death:					
• Heart disease	610,638	27.090	77,674	9,428	2,402
• Cancer	479,651	22,371	62,170	9,792	2,155
• Stroke	140,465	—	19,002	3,497	—
• Accidents (unintentional injuries)	—	9,523	—	—	1,361

Lesson 2-H: Infection Control

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify those regulations and interpretive guidelines pertaining to infection control in the *State Operations Manual (SOM)*.
- Apply current infection control standards and practices in determining causes and means of transmission of infections.
- Determine whether the facility has an effective control program for identifying, investigating, controlling and preventing infections.

Long term care surveyors—see Lesson 3-T, Infection Control Survey Component for Long Term Care.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Federal Regulations on Infection Control
  - 42 CFR 482.42 Condition of participation: Infection control
  - 42 CFR 485.725 Condition of participation: Infection control
  - 42 CFR 405.2140 (a)(5)(ii) Water quality requirements
  - 42 CFR 405.2140 (b) Standard: favorable environment for patients
  - 42 CFR 483.470 (l) Standard: Infection control
  - 42 CFR 485.62 (b) Standard: Sanitary environment
  - 42 CFR 416.44 (a) Standard: Physical environment
  - 42 CFR 483.65 Infection control
- CDC Guidelines for the Prevention and Control of Nosocomial Infections
- CDC Guidelines for Isolation Precautions in Hospitals
- CDC "Norovirus Infection" http://www.cdc.gov/ncidod/diseases/submenus/sub_norwalk.htm
- Tablan, O.C., Anderson, L.J., Besser, R., Bridges, C., and Hajjeh, R. (2004, March 26). Guidelines for Preventing Health Care–Associated Pneumonia, 2003: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. *Morbidity & Mortality Weekly Report* [On-line Serial], 53 (RR-3). Available: http://www.cdc.gov/mmwr/PDF/RR/RR5303.pdf
- Schulster, L., and Chinn, R.Y.W. (2003, June 6). Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HIPAC). *Morbidity & Morality Weekly Report* [On-line Serial], 52 (RR-10). Available: http://www.cdc.gov/PDF/RR/RR5210.pdf
- Bridger, C.B., Harper, S.A., Fukuda, K., Uyeki, T., Cox, N.J., and Singleton, J.A. (2003, April 25). Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morbidity & Mortality Weekly Report* [On-line Serial], 52 (RR-8). Available: http://www.cdc.gov/mmwr/PDF/RR/RR5208.pdf
- Boyce, J.M., and Pittet, D. (2002, October 25). Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *Morbidity & Mortality Weekly Report* [On-line Serial], 51 (RR-16). Available: http://www.cdc.gov/mmwr/PDF/RR/RR5116.pdf

- Centers for Disease Control and Prevention (2001, April 27). Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients. *Morbidity & Mortality Weekly Report* [On-line Serial], 50 (RR-5). Available: http://www.cdc.gov/mmwr/PDF/RR/RR5005.pdf
- Centers for Disease Control and Prevention (1994, October 28). Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Facilities, 1994. *Morbidity & Mortality Weekly Report* [On-line Serial], 43 (RR-13). Available: http://www.cdc.gov/mmwr/PDF/RR/RR4313.pdf
- *Occupational Safety and Health Administration*, "Bloodborne Pathogens Standards" 29 CFR 1910.1030
- Satellite transmission:
  - Preventing Spread of Severe Acute Respiratory Syndrome (SARS), broadcast on April 4, 2003

State

(Insert State reference[s] here.)

Other

Highlights

- Sources for standards of practice
- Current standards and practices:
  - Hand washing
  - Medication administration and disposal of sharps
  - Treatments, specifically pressure sores (long term care facilities and hospitals)
  - Infectious waste handling
  - Linen handling
  - Housekeeping
  - Isolation procedures
  - Processing of medical instrumentation (hospitals and ambulatory surgical centers)
  - Water treatment and analysis (end stage renal disease)
  - Personal protective equipment
- Common microorganisms:
  - Severe acute respiratory syndrome (SARS)
  - Norwalk virus
  - Methicillin-resistant *Staphylococcus aureus* (MRSA)
  - *Clostridium difficile* (C-Diff)
  - Vancomycin-resistant enterococcus (VRE)
  - Tuberculosis (TB)
  - Pneumococcus
  - Scabies
  - Hepatitis
  - Human immunodeficiency virus (HIV)

- Survey elements:
  - Initial tour of the facility (for long term care, use Form CMS-802, *Roster/Sample Matrix*)
  - Inclusion of individuals with infections into the sample selection (for long term care, end stage renal disease and hospital settings) and review of staff providing care and services related to infection control
  - Review of the facility protocol for preventing, controlling, minimizing and monitoring specific infections
  - Interview with the facility's infection control coordinator or practitioner
  - Review of employee health records
  - Review of the in-service education documents for facility staff and contractors

Training Techniques

- Self-study
- Lecture
- Group discussion
- Review of facility documents during the survey

Training Aids

- PowerPoint slides and handouts
- Pertinent articles from professional journals and periodicals
- CDC, MMWR and AAMI Guidelines
- Sample infection control policies and procedures and facility documents, if available
- Handout:
  - *Tips for Surveying Infection Control*
- Video (optional):
  - *Preventing Spread of Severe Acute Respiratory Syndrome (SARS)* from CMS satellite transmission on April 4, 2003

Methods of Evaluation

- Discussion about specific standards and practices of infection control
- Questions and answers
- Observation of investigative skills during the survey
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-H: Infection Control 1 Slide 2-H-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Identify those regulations & interpretive guidelines pertaining to infection control in the *State Operations Manual (SOM).* • Apply current infection control standards & practices in determining causes & means of transmission of infections. 2 Slide 2-H-2	*(Inform the students of the objectives.)*
Learning Objectives (cont.) • Determine whether the facility has an effective control program for identifying, investigating, controlling & preventing infections. 3 Slide 2-H-3	

Audiovisual

Outline or text of presentation

Evaluation of a facility's compliance with infection control requirements begins the moment the survey team enters the facility. But first the surveyor must understand the current standards and practices that apply to infection control, especially as they relate to the development of nosocomial infections—those infections transmitted and acquired while in the facility.

(Inform the students of the key topics in this presentation.)

Key Topics

- Current standards & practices
- Common microorganisms
- Surveyor investigation
- Regulations for specific providers or suppliers
- Resources

4

Slide 2-H-4

Goal of Infection Control Standards

- Minimize spread of communicable organisms

5

Slide 2-H-5

Today, we are going to talk about infection control issues and the standards of practice you should see facility staff follow. The goal of these standards of practice is to minimize the spread of communicable diseases.

(Emphasize that, whatever the mode of transmission or the microorganism, the goal is to minimize its spread.)

Audiovisual

Standards of Practice for Infection Control

- Universal precautions
- Hand washing
- Medication administration & disposal of sharps

6

Slide 2-H-6

Standards of Practice for Infection Control (cont.)

- Care & treatments
  - Separation of dirty & clean materials
  - Pressure sores
  - Intravenous (IV) catheters
  - Infusion systems
  - Urinary catheters

7

Slide 2-H-7

Standards of Practice for Infection Control (cont.)

- Infectious waste handling
- Linen handling
- Housekeeping
- Use of disinfectants, antiseptics & germicides in accordance with manufacturer's instructions

8

Slide 2-H-8

Outline or text of presentation

Let's talk about infection control practices and issues you will encounter when surveying most providers or suppliers.

(Read the slides and, for each bullet, comment regarding the provider or supplier the surveyor(s) will most likely survey. Discuss as appropriate:

- *The standard of practice.*
- *Elements to observe.*
- *Appropriate questions to ask.*
- *Documents to review.)*

Audiovisual

Outline or text of presentation

Standards of Practice for Infection Control (cont.)

- Isolation procedures
  - Gloves
  - Respiratory protection
  - Gown

9

Slide 2-H-9

Standards of Practice for Infection Control (cont.)

- Air movement
  - From clean to less clean areas
  - Tissue test
  - Exterior exhaust for contaminated or odiferous air

10

Slide 2-H-10

Standards of Practice for Infection Control (cont.)

- Unique to different providers or suppliers
  - Processing of medical instrumentation (hospital, ambulatory surgical center)
  - Water treatment & analysis (end stage renal disease)
  - Personal protective equipment

11

Slides 2-H-11

Audiovisual

Microorganisms

- Severe acute respiratory syndrome
- Norwalk virus
- Methicillin-resistant *Staphylococcus aureus*
- *Clostridium difficile*
- Vancomycin-resistant enterococcus
- Tuberculosis
- Pneumococcus
- Scabies
- Hepatitis
- Human immunodeficiency virus

12

Slide 2-H-12

Outline or text of presentation

Here are several commonly known microorganisms.

(As appropriate, discuss:

- *Why the organism is well known.*
- *Where it is likely found in the individual or setting.*
- *How it is transmitted.*
- *If it requires isolating the patient.)*

Investigate Throughout Survey

- Observe
- Interview
- Review documents

13

Slide 2-H-13

While touring the facility, you should watch for signs of infection control issues that you need to investigate during the survey. Observations and interviews can provide evidence that the facility is or is not in compliance with the requirements. If you see, hear or read something that indicates a potential infection control problem, investigate.

(Cover the following points if you have not already done so.)

- Do staff know why the individuals currently in isolation are there?
- Does the facility have an infection control program?
- How are staff educated about infection control issues?
- Are standard precautions used for all patients and residents?
- Is there an adequate supply of gloves to fit all staff?
- Do staff properly dispose of contaminated gowns and gloves?

Audiovisual	Outline or text of presentation
	• Do staff wash hands appropriately when moving from one patient to another? • Do hand-washing stations include soap and a paper towel dispenser? • After hand washing, do staff dry their hands with paper towels and, with paper towels, turn off the faucet without contaminating their hands again? • Are there nonconnected utility rooms for clean and soiled materials? • Do all staff (including nurses, housekeepers and physicians) consistently use correct infection control procedures? • Are long-sleeved gowns used for dealing with individuals in isolation? • Do staff wear gowns and gloves outside isolation rooms? Do staff reuse them? • Do staff carry equipment in their pockets and use it without proper sanitizing? • Is soiled linen handled properly, placed in covered collection bins, appropriately transported and laundered? • Are physical therapy staff familiar with procedures to clean whirlpools, paraffin baths and moist hot pack units? • Are hand-washing stations provided in all locations where staff provide care and services (e.g., the physical therapy gym)? • Is air movement from clean to less clean areas? Is there an exterior exhaust for contaminated or odiferous air? • Do respiratory therapy staff process any patient care equipment? Do they follow standard infection control practices?

Audiovisual

Outline or text of presentation

General Tour of Facility

- Cleanliness & environment
- Use of personal protective equipment
- Hand washing
  - Stations include soap & paper towels
- Linen handling
  - Clean: covered storage
  - Soiled: closed containers, off floor

14

Slide 2-H-14

Investigate any issues discovered during the tour.

(Discuss information on the slides.)

General Tour of Facility (cont.)

- Appropriate storage of supplies
  - Nonconnected utility rooms for clean & soiled materials
  - Hand-washing station & work counter in 1 room
  - Hand-washing station, counter, clinical sink & separate & covered containers for soiled linens & waste in another room
- Isolation technique, as necessary
- Handling of infectious waste

15

Slide 2-H-15

Sample Selection

- Include patients or residents in sample
- Observe all staff providing care & services (including non-nursing staff)
  - Medication administration
  - Treatments (pressure sore, wound, etc.)
  - Tube feeding
  - Incontinence care
  - Special care (IV, catheter, ostomy, etc.)

16

Slide 2-H-16

(Discuss information on the slide.)

Observe care of patients or residents with infections. Interview staff to evaluate the appropriateness of the facility's infection control procedures.

Audiovisual

Long Term Care

- During initial tour or at other times:
  - If you note breaks in technique, verify there are ways to monitor staff infection control practices
  - "Ask direct care giver staff what do they do & who do they notify when an infection is noted" 42 CFR 483.65 (a)

17

Slide 2-H-17

Long Term Care Challenges

- Current standards address following:
  - Measures for prevention of infections associated with IV therapy, indwelling catheters, tracheotomy care, stoma care, respiratory care, immunosuppression, pressure sores, bladder & bowel incontinence & factors compromising resident's resistance to infection

18

Slide 2-H-18

Outline or text of presentation

(If the participants are to survey the same provider, direct them to their Appendix from the State Operations Manual for that specific provider or supplier. Review regulations and interpretive guidelines specific to that provider or supplier.

Following are slides with issues appropriate to different providers and suppliers. Discuss those most pertinent to the participants.)

In long term care, facility practices should consider the resident's psychosocial needs and quality of life when the resident requires isolation precautions for an extended period of time.

Observation of and interviews with facility staff should reflect knowledge of appropriate hand-washing techniques, use of personal protective equipment, aseptic techniques required for treatments and wound care, medication administration procedures including proper disposal of sharps, handling of infectious waste and handling of infectious linen.

Evaluation of infection control issues should include an interview with the person responsible for infection control in the facility and a review of the facility's protocol for investigating, controlling, minimizing and monitoring specific infections.

This should include a protocol for cultures and a method of reporting infections to the State, following established guidelines. Review of the Infection Control Committee minutes takes place. Appropriate review of employee health records should occur. Quality improvement is an important part of this portion of the survey.

Audiovisual

Outline or text of presentation

Other Long Term Care Standards

- Risk assessments of occurrence of communicable disease for residents & staff
- Measures to prevent communicable disease outbreaks (TB, scabies, flu, MRSA, etc.)
- Procedures to inform & involve local or State epidemiologist as necessary
- Authority, indications & procedures for obtaining cultures & isolating residents

19

Slide 2-H-19

Intermediate Care Facility for Mentally Retarded Individuals (ICF/MR)

- Storage & use of personal hygiene items must not promote cross-contamination
- Staff with illness or communicable disease transferable through direct contact must not work with individuals or their food

20

Slide 2-H-20

ICF/MR (cont.)

- "Individuals do not have access to soiled diapers, linens, bandages or any other potentially infectious material"
- "Bathroom fixtures & surfaces are free from bodily wastes" 42 CFR 483.470 (i)

21

Slide 2-H-21

Audiovisual

Outline or text of presentation

Acute Care

- Is infection control (IC) program hospital-wide & department-specific?
- Is IC program integrated into hospital-wide quality assurance & program improvement?
- Is there active IC committee?
- Is there an IC representative on policy & procedure, P&T committees?

22

Slide 2-H-22

Ambulatory Surgical Center

- Methods to minimize sources & transmission of infection
- Sterilization techniques
- Procedures for isolation
- Procedures for orientation & in-service in infection control for employees
- Aseptic techniques
- Ongoing log of reported infections

23

Slide 2-H-23

End Stage Renal Disease (ESRD)

- Face shield in use at patient stations
- Water treatment & analysis
- Medical device reuse
- Disinfection of equipment & bacteriological testing
- Isolation capability
- Handling of bloody linen & clothing
- Assessment of patient's risk of disease

24

Slide 2-H-24

Audiovisual

Outline or text of presentation

ESRD (cont.)

- Staff education about infection control
- Screening of staff for diseases
- Safe environment consistent with Centers for Disease Control and Prevention & Occupational Safety & Health Administration recommendations

25

Slide 2-H-25

Outpatient Physical Therapy or Speech Pathology

- IC committee consists of 2 or more individuals
- Written procedures for hand washing & cleanliness of whirlpools, paraffin baths & moist hot pack units
- Existing procedures for soiled linen removal & storage
- Pest control program

26

Slide 2-H-26

Comprehensive Outpatient Rehabilitation Facility

- Interpretive guideline: "Pay particular attention to policies, procedures & reports concerning the care & debridement of wounds & the cleaning & disinfection of equipment such as whirlpools & paraffin baths & respiratory therapy equipment"

  42 CFR 485.62 (b)

27

Slide 2-H-27

Audiovisual

Outline or text of presentation

Respiratory Care

- Do respiratory staff process any patient care equipment? Where? How?
- Do respiratory practitioners follow standard infection control practices, approved by committee that includes an infection control practitioner?

28

Slide 2-H-28

Resources

- CDC (Centers for Disease Control and Prevention)
- MMWR (Morbidity & Mortality Weekly Report)
- AORN (Association of periOperative Registered Nurses)
- AAMI (Association for the Advancement of Medical Instrumentation)
- OSHA (Occupational Safety & Health Administration)

29

Slide 2-H-29

A provider or supplier should know current infection control standards of practice. Sources for those standards are listed here.

(Discuss resources. Provide a current Internet address. If possible, have a copy of the resource present for surveyors to review.)

Facility Policies & Procedures

- Request specific policies & procedures if you identify concerns
- Review entire manual if problems are identified with number of infection control practices

30

Slide 2-H-30

Review facility policies and procedures for specific concerns (e.g., hand washing, tube feeding administration).

Audiovisual

Other

- Interview infection control person
- For employees in various departments & contractors:
  - Review employee health records
  - Review in-service education in departments where concerns identified
- Review regulations & interpretive guidelines

31

Slide 2-H-31

Lesson 2-H:
Infection Control

Questions

32

Slide 2-H-32

Outline or text of presentation

Interview infection control person and review records. Review your regulations to see whether there are other aspects of infection control you need to investigate further.

Skill Assessment

Infection Control

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified regulations pertaining to infection control in the Appendix of the *State Operations Manual (SOM)* the surveyor will use.	
					Stated the correct standard of practice for: • Hand washing. • Medication administration and disposal of sharps. • Treatments. • Pressure sores. • Linen handling. • Housekeeping. • Isolation procedures. • Personal protective equipment. • Processing medical instruments. • Water treatment and analysis.	

					Stated basic principles of infection control for: • SARS. • Norwalk virus. • MRSA. • C. Diff. • VRE. • Tuberculosis. • Pneumococcus. • Scabies. • Hepatitis B. • HIV.	
					Correctly investigated infection control issues by: • Making appropriate observations. • Interviewing appropriate individuals. • Reviewing applicable documents.	
					Made appropriate compliance decisions regarding infection control practices.	
					Documented infection control deficiencies under the appropriate Federal regulation.	

Comments/Recommendations:

Tips for Surveying Infection Control

What to observe:

- Medication passing.
- Caring for wounds.
- Hand-washing technique.
- Using personal protective equipment.
- Gowning and gloving for isolation.
- Instrument processing.

Who to interview:

- Direct care staff.
- Infection control practitioner or person responsible.
- Medical director.
- Quality assurance coordinator or risk manager.
- Nurse managers.
- Director of housekeeping.
- Director of central sterile supply [hospitals, ambulatory surgical centers (ASCs)].
- Chief biomedical technician (ESRD).

What documents to review:

- Infection control log.
- Infection Control Committee minutes.
- Laboratory results.
- Medical records.
- In-service records.
- Employee health records.
- Policies and procedures:
  - Hand washing.
  - Housekeeping.
  - Dietary.
  - Nursing.
  - Linen handling.
  - Infectious waste handling.
  - Isolation.
  - Aseptic technique.
  - Surgery (hospitals and ASCs).
  - Instrument processing (hospitals and ASCs).
  - Water analysis (ESRD).

Lesson 2-H-1: Infection Control in the Acute Care Environment

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe standards of practice for infection control in the acute care environment that are not found in the general environment.
- Evaluate the facility's infection control practices appropriately when determining its compliance with regulations.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix L, Guidance to Surveyors: Ambulatory Surgical Services
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

State

(Insert State reference[s] here.)

Other

Highlights

- Significant aspects of an active infection control program
- Sterilization, disinfection and areas of surgery
- Potential infection control issues in different departments
- Survey tips
- Federal regulations appropriate to the student

Training Techniques

- Lecture
- Group discussion
- Review of deficiencies

Training Aids

- PowerPoint slides and handouts
- *State Operations Manual (SOM):*
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix L, Guidance to Surveyors: Ambulatory Surgical Services
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs
- Handout:
  - *Infection Control—Definitions*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Observation of student performance

Audiovisual

Lesson 2-H-1:
Infection Control in the Acute Care Environment

1

Slide 2-H-1-1

Outline or text of presentation

The acute health-care setting in hospitals, critical access hospitals and ambulatory surgical centers requires the surveyor to know infection control standards of practice that do not apply to nursing homes and facilities for the mentally retarded or in patients' homes.

The reason is that the hospital cares for patients with significant communicable diseases and infections, and, like the ambulatory surgical center, it performs surgery. The incidence of post-surgical nosocomial infections has been well documented in medical literature.

You will need to investigate how well the facility identifies practices that may transmit an infection and how it trains staff and implements practices consistently to minimize infections in patients.

(Inform the students of the objectives.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe standards of practice for infection control in the acute care environment that are not found in the general environment.

2

Slide 2-H-1-2

Audiovisual

Learning Objectives (cont.)

- Evaluate the facility's infection control practices appropriately when determining its compliance with regulations.

3

Slide 2-H-1-3

Outline or text of presentation

Facility staff must evaluate infection control policies and procedures and implement and train staff to consistently practice them. Various regulations in hospitals, critical access hospitals and ambulatory surgical centers address infection control. Some are listed here.

For each provider type you will find requirements that address quality assurance activities, physical environment and staff training as well as other requirements that relate to infection control practices.

We are going to concentrate on those aspects of infection control that you may not be familiar with or may want to review. Near the end of this lesson, the regulations that address infection control for a specific provider will be studied.

(Inform the students of the major content areas of this lesson.)

Selected Regulations

- Hospital
  - 42 CFR 482.42
- Critical Access Hospital
  - 42 CFR 485.635(a)(3)(vi)
- Ambulatory Surgical Center
  - 42 CFR 416.42
  - 42 CFR 416.44(a)(3)

4

Slide 2-H-1-4

Audiovisual

Lesson Highlights

- Significant aspects of infection control program
- Sterilization & disinfection
- Potential infection control issues in different departments
- Survey tips
- Federal regulations

5

Slide 2-H-1-5

Outline or text of presentation

Lesson Highlights

- Significant aspects of an infection control program.
- Sterilization and disinfection.
- Potential infection control issues in different departments.
- Survey tips.
- Federal regulations.

(Discuss each slide, providing examples to illustrate significance.)

Infection Control Staff

- Infection Control Manager
- Committee of individuals representing areas significant to infection control, such as:
  - Quality assurance
  - Surgery
  - Nursing
  - Safety
  - Housekeeping

6

Slide 2-H-1-6

Infection Control Staff

- Infection Control Manager.
- Committee of individuals representing significant infection control areas:
  - Quality assurance.
  - Surgery.
  - Nursing.
  - Safety.
  - Housekeeping.

Infection Control Program Goals

- Ensure that effective & efficient program for reporting & evaluating infections & maintaining records of infections occurs at institution for patients, staff & others
- Monitor for occurrence of infection & develop appropriate control measures

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Slide 2-H-1-7

Infection Control Program Goals

- Ensure that the institution has an effective and efficient program for reporting and evaluating infections and maintaining infection records.
- Monitor the occurrence of infection and develop appropriate control measures.

Audiovisual

Surveillance Program

- Include specific measures of nationally recognized mechanisms
- Cover basic components:
  - Collect information
  - Analyze data
  - Identify methods to implement action plans
  - Educate all staff including physicians & other practitioners
  - Ensure staff implements corrective action plans
  - Reevaluate & revise

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Policies & Procedures

- Facility should have infection control policies & procedures for all departments, including:
  - Dietary, Housekeeping, Nursing, Maintenance, Central Supply, etc.
- Analyze mechanisms in place to identify, investigate & report infection control concerns
- Observe & determine whether policies & procedures are effective

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Nosocomial Infections

- Unlike a community-acquired infection, nosocomial infection is acquired after admission to facility & is caused by something in facility

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Slide 2-H-1-10

Outline or text of presentation

Surveillance Program

- Include specific measures of nationally recognized mechanisms.
- Cover basic components:
  - Collect information.
  - Analyze data.
  - Identify methods to implement action plans.
  - Educate all staff including physicians and other practitioners.
  - Ensure staff implements corrective action plans.
  - Reevaluate and revise.

Policies and Procedures

- Facility should have infection control policies and procedures for all departments, including:
  - Dietary, Housekeeping, Maintenance, Nursing, Central Supply, etc.
- Analyze mechanisms in place to identify, investigate and report infection control concerns.
- Observe and determine whether policies and procedures are effective.

Nosocomial Infections

- Unlike a community-acquired infection, a nosocomial infection is acquired after admission to the facility and is caused by something in the facility.

Audiovisual

Nosocomial Infections (cont.)

- Nosocomial rate below 1% is not realistic
- Average facility infection percentages:
  - 25%–45% related to Foley catheters
  - 17%–24% respiratory in nature
  - 20% from surgical wounds
  - 7% from IV technique bacteria

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Outline or text of presentation

- A nosocomial rate below 1% is not realistic.
- Average facility infection percentages:
  - 25%–45% related to Foley catheters.
  - 17%–24% respiratory in nature.
  - 20% from surgical wounds.
  - 7% from IV technique.

Nosocomial Infections (cont.)

- Monitoring for nosocomial infection must include patients:
  - With elevated temps
  - On antibiotics
  - In isolation
  - With Foley catheters
  - With tracheostomies
  - With central lines

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- Monitoring for nosocomial infection must include patients:
  - With elevated temperatures.
  - On antibiotics.
  - In isolation.
  - With Foley catheters.
  - With tracheostomies.
  - With central lines.

Nosocomial Infections (cont.)

- Monitoring for nosocomial infection may also include:
  - Patients with white blood count over 12,000
  - Changes in chest x-rays
  - Significant microbiology culture reports

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- Monitoring for nosocomial infection may also include:
  - Patients with a white blood count over 12,000.
  - Changes in chest x-rays.
  - Significant microbiology culture reports.

Audiovisual

Infection Tracking—Data Sources

- Admission logs
- Laboratory reports
- Medical records
- X-ray reports
- Records from patient rounds
- Verbal reports
- Periodic or random employee physicals

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Outline or text of presentation

Infection Tracking—Data Sources

- Admission logs.
- Laboratory reports.
- Medical records.
- X-ray reports.
- Records from patient rounds.
- Verbal reports.
- Periodic or random employee physicals.

Required Data

- Date of identification
- Patient name & room
- Site of infection
- Microorganism
- Care & services providers
- Risk factors (e.g., surgical procedure, catheter, tracheostomy, respiratory therapy, burn, patient's resistance to infection, etc.)

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Required data

- Date of identification.
- Patient name and room.
- Site of infection.
- Microorganism.
- Care and services providers.
- Risk factors (e.g., surgical procedure, catheter, tracheostomy, respiratory therapy, burn, patient's resistance to infection, etc.).

Policies & Procedures

- Personnel
  - Screening of health care workers
  - Employee health policies
  - Method of reporting requirements
  - Provision of program evaluation
  - Providing safe environment

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Policies and Procedures

- Personnel.
  - Screening of health care workers.
  - Employee health policies.
  - Method of reporting requirements.
  - Provision of program evaluation.
  - Providing a safe environment.

Audiovisual

Policies & Procedures (cont.)

Report infections to local health authorities

- AIDS
- Anthrax
- Botulism
- Diphtheria
- Hepatitis (all types)
- Infant mortality
- Legionnaires' disease
- Malaria
- Polio
- Rocky Mountain spotted fever
- Sexually transmitted diseases
- Tuberculosis
- Typhoid fever

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Policies & Procedures (cont.)

- Methods for monitoring practices of asepsis
  - Techniques for hand washing, sterilization, laundry, etc.
  - Requirements for disinfectants

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Researching Microorganisms

- For example, tuberculosis:
  - Centers for Disease Control (CDC) guidelines:
    - CDC website for new guidelines: http://www.cdc.gov/ncidod/dhqp/gl_environ infection.html
  - Environment:
    - Acid-fast bacillus: Isolation room at negative pressure to surrounding areas
    - High-efficiency particulate air (HEPA) filters or ultraviolet lights in ventilation systems
    - Maximum achievable air changes per hour

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Outline or text of presentation

Report infections and related conditions to local health authorities

- AIDS.
- Anthrax.
- Botulism.
- Diphtheria.
- Hepatitis (all types).
- Infant mortality.
- Legionnaires' disease.
- Malaria.
- Polio.
- Rocky Mountain spotted fever.
- Sexually transmitted diseases.
- Tuberculosis.
- Typhoid fever.

Monitor asepsis practices

- Methods for monitoring practices of asepsis.
  - Techniques for hand washing, sterilization, laundry, etc.
  - Requirements for disinfectants.

TB policies and procedures

- Centers for Disease Control (CDC) guidelines:
  - CDC website for new guidelines: http://www.cdc.gov/ncidod/dhqp/gl_environinfection.html
  - Environment.
    - Acid-fast bacillus: Isolation room at negative pressure to surrounding areas.

Audiovisual

Researching Microorganisms (cont.)

- High-risk areas
  - Emergency rooms
  - Clinic waiting areas
  - Respiratory therapy
- High-risk procedures
  - Endotracheal intubation & suctioning
  - Bronchoscopies
  - Sputum inductions
  - Aerosol drug administration
  - Autopsies

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Outline or text of presentation

- o High-efficiency particulate air (HEPA) filters or ultraviolet lights in ventilation system.
- o Maximum achievable air changes per hour.

– High-risk areas.
- o Emergency rooms.
- o Clinic waiting areas.
- o Respiratory therapy.

– High-risk procedures.
- o Endotracheal intubation and suctioning.
- o Bronchoscopies.
- o Sputum inductions.
- o Aerosol drug administration.
- o Autopsies.

Types of Precautions

- Standard precautions: for all patients
- Precautions related to isolation procedures & requirements for infected or immunosuppressed patients
- Precautions related to airborne transmission
  - Illness transmitted by airborne droplets (e.g., measles, tuberculosis (TB), etc.)

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Types of Precautions

- Standard precautions: for all patients.
- Precautions related to isolation procedures and requirements for infected or immunosuppressed patients.
- Precautions related to airborne transmission.
  - Illness transmitted by droplets (e.g., measles, tuberculosis (TB), etc.).

Audiovisual

Types of Precautions (cont.)

- Droplet
  - Illnesses transmitted by large-particle droplets:
    - Meningitis
    - Pneumonia & sepsis
    - Diphtheria
    - Pertussis
    - Mumps
    - Rubella

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Slide 2-H-1-22

Outline or text of presentation

- Droplet.
  - Illnesses transmitted by large-particle droplets:
    - Meningitis.
    - Pneumonia and sepsis.
    - Diphtheria.
    - Pertussis.
    - Mumps.
    - Rubella.

Types of Precautions (cont.)

- Contact
  - Illnesses easily transmitted by direct patient contact:
    - Gastrointestinal ailments
    - Respiratory illnesses
    - Wound infections
    - Diphtheria
    - Impetigo
    - Scabies

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- Contact.
  - Illnesses easily transmitted by direct patient contact:
    - Gastrointestinal ailments.
    - Respiratory illnesses.
    - Wound infections.
    - Diphtheria.
    - Impetigo.
    - Scabies.

Sterilization Guidelines

- Association of periOperative Registered Nurses (AORN) *Recommended Practices for Sterilization* (2002)

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Sterilization Guidelines

- Association of periOperative Registered Nurses (AORN) *Recommended Practices for Sterilization* (2002).

Audiovisual

Sterilization Guidelines (cont.)

- Decontaminate items to be sterilized in controlled environment
- Control factors:
  - Room temperature & humidity
  - Ventilation
  - Separation of decontamination & sterilization processes
  - Thorough cleansing & drying
  - Appropriate personal & protective attire

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Outline or text of presentation

- Decontaminate items to be sterilized in a controlled environment.
- Control factors:
  - Room temperature and humidity.
  - Ventilation.
  - Separation of decontamination and sterilization processes.
  - Thorough cleansing and drying.
  - Appropriate personal and protective attire.

Sterilization Guidelines (cont.)

- Package items to be sterilized according to guidelines established in AORN's *Recommended Practices for Selection & Use of Packaging Systems*
  - Association for the Advancement of Medical Instrumentation (AAMI) also provides guidelines for density of packages

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- Package items to be sterilized according to the guidelines established in AORN's *Recommended Practices for Selection and Use of Packaging Systems*.
  - Association for the Advancement of Medical Instrumentation (AAMI) also provides guidelines for density of packages.

Sterilization Guidelines (cont.)

- Sterilize instruments in opened & unlocked position
  - Wrapped sets must be mass specified by manufacturer
  - Use perforated mesh tray or container systems

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- Sterilize instruments in an opened and unlocked position.
  - Wrapped sets must be of a mass specified by the manufacturer.
  - Use perforated mesh tray or container systems.

Audiovisual

AAMI Sterilizer Parameters

Pre-vacuum	3–4 minutes at 270–272 °F
Gravity displacement	15–30 minutes at 250–254 °F or 10–25 minutes at 270–272 °F
Steam, flash/pressure	20 minutes at 250–254 °F or 3–4 minutes at 270–272 °F

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Outline or text of presentation

AAMI Sterilizer Parameters

- Pre-vacuum.
  - 3–4 minutes at 270–272 °F.
- Gravity displacement.
  - 15–30 minutes at 250–254 °F or 10–25 minutes at 270–272 °F.
- Steam, flash/pressure.
  - 20 minutes at 250–254 °F or 3–4 minutes at 270–272 °F.

Steam Sterilization

- Saturated steam under pressure is preferred method of sterilization & should be used to sterilize heat- & moisture-stable items
  - If container system is used, follow manufacturer's guidelines
  - Cool packages thoroughly before handling

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Steam sterilization

- Saturated steam under pressure is the preferred method of sterilization to sterilize heat- and moisture-stable items.
  - If a container system is used, follow manufacturer's guidelines.
  - Cool packages thoroughly before handling.

Flash Sterilization

- Flash sterilization must be used only in carefully selected clinical situations when following parameters are met:
  - Proper cleaning & decontamination of instruments can take place
  - Work area can provide for direct delivery of sterilized items to scrub nurse
  - Procedures for handling sterile instruments that were flash-sterilized should exist

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Slide 2-H-1-30

Flash sterilization

- Flash sterilization must be used only in carefully selected clinical situations when the following parameters are met:
  - Proper cleaning and decontamination of instruments can take place.
  - Work area can provide for direct delivery of sterilized items to the scrub nurse.
  - Procedures for handling sterile instruments that were flash sterilized should exist.

Audiovisual

Flash Sterilization (cont.)

– Exposure times & temperature settings must follow manufacturer's instructions
– Do not wrap items that will be flash-sterilized
– *Implantable medical devices must not be flash-sterilized because of possible patient complications*
– *Physicians & operating room personnel must properly plan ahead*

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Outline or text of presentation

– Exposure times and temperature settings must follow manufacturer's instructions.
– Do not wrap items that will be flash-sterilized.
– *Implantable medical devices must not be flash-sterilized because of possible patient complications.*
– *Physicians and operating room personnel must properly plan ahead.*

Sterilization QA

- Monitor, record & examine time, temperature & pressure associated with flash sterilization after each use
- When sterilizing implantable items in-house, avoid using them until completing biological monitoring of sterilizer
- Monitor sterilizer function with mechanical, chemical & biological indicators to meet all monitoring standards
  – Use monitoring device with each flash sterilization load

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Sterilization QA

- Monitor, record and examine the time, temperature and pressure associated with flash sterilization after each use.
- When sterilizing implantable items in-house, avoid using them until completing biological monitoring of the sterilizer.
- Monitor sterilizer function with mechanical, chemical and biological indicators to meet all monitoring standards.
  – Use a monitoring device with each flash sterilization load.

Indicators

- Chemical indicator:
  – Shows exposure, not sterilization
  – Is on outside of package & changes color when subjected to sterilization
  – Indicator is placed inside of package or in open flash sterilization trays & indicates that sterilization substance penetrated wrapping & also reached contents within

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Indicators

- Chemical indicator:
  – Shows exposure, not sterilization.
  – Is on the outside of the package and changes color when subjected to sterilization.
  – The indicator is placed inside the package or in open flash sterilization trays and indicates that the sterilization substance penetrated the wrapping and also reached the contents within.

Audiovisual

Indicators (cont.)

- Biological indicator:
  - Commercially prepared spores currently best method for confirming effectiveness of sterilization
  - Use biological indicators with implantable objects
- If spore test is positive, retest:
  - If positive again, recall all items from suspect loads
  - Service & retest sterilizer

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Outline or text of presentation

- Biological indicator:
  - Commercially prepared spores are currently the best method for confirming the effectiveness of sterilization.
  - Use biological indicators with implantable objects.
- If a spore test is positive, retest.
  - If positive again, recall all items from suspect loads.
  - Service and retest the sterilizer.

Ethylene Oxide Sterilization

- Ethylene oxide (ETO) sterilization may be used for sterilization of heat- & moisture-sensitive surgical items
  - Clean & dry all items before sterilization
    - Include lumens
  - Load sterilizer according to manufacturer's instructions

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Ethylene oxide sterilization

- Ethylene oxide (ETO) sterilization may be used for sterilization of heat- and moisture-sensitive surgical items.
  - Clean and dry all items before sterilization.
    - Include lumens.
  - Load sterilizer according to manufacturer's instructions.

Ethylene Oxide Sterilization (cont.)

- Document sterilization parameters
  - Temperature
  - Time
  - Humidity
  - Sterilant concentration

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Slide 2-H-1-36

  - Document sterilization parameters:
    - Temperature.
    - Time.
    - Humidity.
    - Sterilant concentration.

Audiovisual

Ethylene Oxide Sterilization (cont.)

- Properly aerate items sterilized in ETO sterilizers in mechanical aerator to remove ETO
  - ETO is occupational health hazard
    - ETO is human carcinogen that can cause reproductive problems in humans [Occupational Safety & Health Administration (OSHA)]
    - When using separate aerator, personnel must self-protect from ETO vapors & residue
      - Use rubber gloves
      - Wear goggles, masks & gowns
    - Pull, rather than push, items in cart

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Ethylene Oxide Sterilization (cont.)

- Aeration time factors:
  - Item composition & size
  - Item preparation & packaging
  - Type of ETO sterilizer used
  - Type of aerator used
  - Temperature penetration pattern of aerator
- Items must remain in the aerator until time has been completed

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Slide 2-H-1-38

Outline or text of presentation

- Properly aerate items sterilized in ETO sterilizers in a mechanical aerator to remove ETO.
  - ETO is an occupational health hazard.
    - ETO is a human carcinogen that can cause reproductive problems in humans [Occupational Safety and Health Administration (OSHA)].
    - When using a separate aerator, personnel must self-protect from ETO vapors and residue.
      - Use rubber gloves.
      - Wear goggles, masks and gowns.
    - Pull, rather than push, items in cart.
  - Aeration time factors:
    - Item composition and size.
    - Item preparation and packaging.
    - Type of ETO sterilizer used.
    - Type of aerator used.
    - Temperature penetration pattern of the aerator.
  - Items must remain in the aerator until time has been completed.

Audiovisual

Ethylene Oxide Sterilization (cont.)

– Program for monitoring occupational exposure to ETO is mandatory
  • Program must comply with OSHA's requirements
  • Monitoring & sampling must ensure that environmental ETO concentrations have not exceeded OSHA action level

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Slide 2-H-1-39

Outline or text of presentation

– A program for monitoring occupational exposure to ETO is mandatory.
  - The program must comply with OSHA's requirements.
  - Monitoring and sampling must ensure that environmental ETO concentrations have not exceeded the OSHA action level.

Lot Control Numbers

• Every sterilized item should have lot control number
  – Lot control number identifies sterilizer used, cycle or load number & date of sterilization
  – Information allows item retrieval if sterilizer malfunctions

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Slide 2-H-1-40

Lot control numbers

- Every sterilized item should have a lot control number.
  – The lot control number identifies the sterilizer used, the cycle or load number and the date of sterilization.
  – This information allows item retrieval if a sterilizer malfunctions.

Transportation of Sterilized Items

• Control transportation of sterile items
  – Written policies & procedures are essential
  – Facility must guarantee integrity of package

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Transportation of sterilized items

- Control transportation of sterile items.
  – Written policies and procedures are essential.
  – The facility must guarantee the integrity of the package.

Audiovisual

Quality Control Program, Sterilization

- Establish quality control program
- Quality control parameters:
  - Sterilizer maintenance history
  - Sterilizer monitoring via biological, chemical or mechanical devices
  - Air removal testing via Bowie-Dick test for pre-vacuum steam sterilizers
  - Visual inspection of packaging materials
  - Lot control & traceability of load contents

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Sterilization Documentation

Required sterilization information:

- Type of sterilizer
- Control number
- Load contents
- Exposure time & temperature
- Operator's name
- Results of sterilization-process monitoring
- Chemical or biological testing

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Slide 2-H-1-43

Maintenance

- Qualified health-care personnel following manufacturer's written instructions must perform preventive maintenance on sterilizers on scheduled basis
  - Keep maintenance records & all sterilizer testing data

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Outline or text of presentation

Quality control program, sterilization

- Establish a quality control program.
- Quality control parameters:
  - Sterilizer maintenance history.
  - Sterilizer monitoring via biological, chemical or mechanical devices.
  - Air removal testing via Bowie-Dick test for pre-vacuum steam sterilizers.
  - Visual inspection of packaging materials.
  - Lot control and traceability of load contents.

Sterilization documentation

- Required sterilization information:
  - Type of sterilizer.
  - Control number.
  - Load contents.
  - Exposure time and temperature.
  - Operator's name.
  - Results of sterilization-process monitoring.
  - Chemical or biological testing.

Maintenance

- Qualified health-care personnel following manufacturer's written instructions must perform preventive maintenance on sterilizers on a scheduled basis.
  - Keep maintenance records and all sterilizer testing data.

Audiovisual

Policies & Procedures

- Policies & procedures for sterilization processes must be:
  - Developed
  - Reviewed periodically
  - Readily available

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Slide 2-H-1-45

Outline or text of presentation

Policies and procedures

- Policies and procedures for sterilization processes must be developed and reviewed periodically. They must also be readily available.

Creutzfeldt-Jakob Disease

- Follow guidelines for Creutzfeldt-Jakob disease (CJD) presented on CDC website (http://www.cdc.gov/ncidod/dvrd/cjd/infection_control_cjd.htm#reprocessed):
  - Use disposable instruments
  - Organism or prion resistant to sterilization & disinfection

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Creutzfeldt-Jakob disease

- Follow guidelines for Creutzfeldt-Jakob disease (CJD) presented on the CDC website (http://www.cdc.gov/ncidod/dvrd/cjd/infection_control_cjd.htm#reprocessed):
  - Use disposable instruments.
  - Organism or prion is resistant to sterilization and disinfection.

Disinfection: Cleaning & Decontamination

- Thoroughly clean & decontaminate before disinfection
  - Pre-soaking
  - Manual cleaning
  - Ultrasonic cleaning
  - Washer-sterilizer

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Cleaning and decontamination

- Thoroughly clean and decontaminate items before disinfection.
  - Pre-soaking.
  - Manual cleaning.
  - Ultrasonic cleaning.
  - Washer-sterilizer.

Audiovisual

Disinfection: Cleaning & Decontamination (cont.)

- Use FDA-cleared chemical agent to achieve chemical, high-level disinfection
  - Immerse item for specific period in chemical agent
  - Completely immerse item
  - Flush lumens

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Outline or text of presentation

Disinfection

- Use an FDA-cleared chemical agent for chemical, high-level disinfection.
  - Immerse item for a specific period in a chemical agent.
  - Completely immerse item.
  - Flush lumens.

Disinfection: Cleaning & Decontamination (cont.)

- Thoroughly rinse items with sterile water after required exposure time
- Most chemical disinfectant agents effective for only specific period of time
- Testing devices for chemical disinfectants available
  - Use test strips to monitor potency of solutions

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- Thoroughly rinse items with sterile water after the required exposure time.
- Most chemical disinfectant agents are effective for only a specific period of time.
- Testing devices for chemical disinfectants are available.
  - Use test strips to monitor the potency of solutions.

Disinfecting Agents

- Glutaraldehyde, hydrogen peroxide & peracetic acid are dependable high-level disinfectants
  - If contact time long enough, can be sterilants

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Slide 2-H-1-50

Disinfecting agents

- Glutaraldehyde, hydrogen peroxide and peracetic acid are dependable high-level disinfectants.
  - If contact time is long enough, they can be sterilants.

Audiovisual

Outline or text of presentation

Disinfection

- Practice settings must provide safe environments for personnel when using chemical germicides
  - Keep germicides in covered containers & use in well ventilated areas
    - Personnel wear protective apparel (i.e., goggles, gloves, masks, gowns)
    - OSHA regulates occupational exposure to toxic chemicals

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Disinfection

- Practice settings must provide safe environments for personnel when using chemical germicides.
  - Keep germicides in covered containers and use in well ventilated areas.
    - Personnel wear protective apparel (i.e., goggles, gloves, masks, gowns).
    - OSHA regulates occupational exposure to toxic chemicals.

Policies & Procedures

- Accessible written policies & procedures for high-level disinfection are required

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Slide 2-H-1-52

Policies and procedures

- Accessible written policies and procedures for high-level disinfection are required.

Levels of Disinfection

- High-level disinfection
  - Process that destroys all microorganisms with exception of high numbers of bacterial spores
  - High levels of disinfectants inactivate hepatitis B virus, human immunodeficiency virus (HIV) & TB
  - Don't inactivate virus-like prion for CJD

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Slide 2-H-1-53

Levels of Disinfection

- High-level disinfection.
  - A process that destroys all microorganisms except high numbers of bacterial spores.
  - High levels of disinfectants inactivate hepatitis B, human immunodeficiency virus (HIV) and TB.
  - They do not inactivate the virus-like prion for CJD.

Audiovisual

Levels of Disinfection (cont.)

- Intermediate-level disinfection
  - Inactivates TB, vegetative bacteria, most viruses & most fungi but does not necessarily kill bacterial spores
- Low-level disinfection
  - Kills most bacteria, some viruses & some fungi but is not certain to kill resistant microorganisms such as TB or bacterial spores

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Outline or text of presentation

- Intermediate-level disinfection.
  - A process that inactivates TB, vegetative bacteria, most viruses and most fungi but does not necessarily kill bacterial spores.
- Low-level disinfection.
  - A process that kills most bacteria, some viruses and some fungi but is not certain to kill resistant microorganisms such as TB or bacterial spores.

Types of Surgical Areas

- Unrestricted
  - Central point to monitor entrance of patients, personnel & materials
  - Street clothes are sufficient
- Semi-restricted
  - Support, storage & work areas
  - Surgical attire required

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Slide 2-H-1-55

Types of Surgical Areas

- Unrestricted.
  - A central point to monitor the entrance of patients, personnel and materials.
  - Street clothes are sufficient.
- Semi-restricted.
  - Support, storage and work areas.
  - Surgical attire required.

Types of Surgical Areas (cont.)

- Restricted
  - Operating & procedure rooms
  - Scrub sink areas
  - Full surgical attire required
  - Masks if opening supplies or if scrub personnel are present

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- Restricted.
  - Operating and procedure rooms.
  - Scrub sink areas.
  - Full surgical attire required.
  - Use of masks if opening supplies or if scrub personnel are present.

Audiovisual

Surgical Areas—Survey Tips

Environment
- Access to OR & post-anesthesia recovery unit is limited
- All aseptic & sterile techniques strictly followed

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Outline or text of presentation

Surgical Areas—Survey Tips

Environment
- Access to operating room (OR) and post-anesthesia recovery unit is limited.
- All aseptic and sterile techniques strictly followed.

Surgical Areas—Survey Tips (cont.)

- Entire area appropriately cleaned between cases
- No dust or dirt
- Vents in OR—isolated from hospital; filters should be clean
- Anything posted on walls questioned
- Sterile supplies & equipment must be separated from contaminated items by space, time & traffic pattern
  - Thoroughly cleaned, disinfected & dried

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- Entire area appropriately cleaned between cases.
- No dust or dirt.
- Vents in OR—isolated from hospital; filters should be clean.
- Anything posted on the walls questioned.
- Sterile supplies and equipment must be separated from contaminated items by space, time and traffic pattern.

Surgical Areas—Survey Tips (cont.)

- Shipping containers unpacked prior to entry into OR
- Equipment from outside OR should be appropriately disinfected
- Room temperature & humidity controlled

Personnel
- Patient:
  - Clean gown & linens
  - Masked if having respiratory procedure

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- Shipping containers unpacked prior to entry into the OR.
- Equipment from outside the OR should be appropriately disinfected.
- Room temperature and humidity controlled.

Personnel
- Patient:
  - Clean gown and linens.
  - Masked if having respiratory procedure.

Audiovisual

Surgical Areas—Survey Tips (cont.)

- Staff:
  - Clothing appropriate to area
  - Sterile techniques followed
  - Information recorded as required for sterilizing, tracking implants, etc.

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Outline or text of presentation

- Staff:
  - Clothing appropriate to the area.
  - Sterile techniques followed.
  - Information recorded as required for sterilizing, tracking implants, etc.

Surgical Areas—Survey Tips (cont.)

Supplies & equipment

- Sterile packages labeled & stored to ensure sterility
- Shelf life of package relative to:
  - Type of packaging
  - Number of times handled
  - Open or closed shelves
  - Use of dust covers
  - Whether sterile item was dropped to floor

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Supplies and equipment

- Sterile packages are labeled and stored to ensure sterility.
- Shelf life of package is relative to:
  - Type of packaging
  - Number of times handled.
  - Open or closed shelves.
  - Use of dust covers.
  - Whether the sterile item was dropped to the floor.

Surgical Areas—Survey Tips (cont.)

- Equipment available for rapid & routine sterilization
- Equipment monitored for effectiveness
- Implants sterilized, not flash-sterilized
- System exists to track implants back through sterilization process

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- Equipment is available for rapid and routine sterilization.
- Equipment is monitored for effectiveness.
- Implants are sterilized, not flash-sterilized.
- System exists to track implants back through sterilization process.

Audiovisual

Overall Survey Process

- Tour facility
- Observe environment & staff actions
- Interview staff in all departments on following:
  - Procedures for caring for patients with infections or suspected infections
  - Practices between patients
  - Routine cleaning & disinfection
  - Procedures for staff practicing when ill or injured

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Outline or text of presentation

Overall Survey Process

- Tour the facility.
- Observe the environment and staff actions.
- Interview staff in all departments on the following:
  - Procedures for caring for patients with infections or suspected infections.
  - Practices between patients.
  - Routine cleaning and disinfection.
  - Procedures for staff practicing when ill or injured.

Infection Issues in Specific Areas

- Emergency room
  - Patient with potential infection (cough, etc.)
- Nursing
  - Hang times & mixing of tube feedings
- Pharmaceutical services
  - Maintenance of hoods & mixing techniques
- Laboratory
  - Water system connections

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Infection issues in specific areas:

- Emergency room.
  - Patient with potential infection (cough, etc.).
- Nursing.
  - Hang times and mixing of tube feedings.
- Pharmaceutical services.
  - Maintenance of hoods and mixing techniques.
- Laboratory.
  - Water system connections.

Infection Issues in Specific Areas (cont.)

- Food & dietetic services
  - Food preparation techniques
  - Food & beverage holding & serving temperatures
  - Dishroom staffing & machine operating temperatures

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- Food and dietetic services.
  - Food preparation techniques.
  - Food and beverage holding and serving temperatures.
  - Dishroom staffing and machine operating temperatures.

Audiovisual

Infection Issues in Specific Areas (cont.)

- Rehabilitation
  - Visitors & children
- Respiratory
  - Use of equipment & one-use items
- Housekeeping
  - Mixing of chemicals
  - Discharge cleaning—normal & isolation rooms

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Outline or text of presentation

- Rehabilitation.
  - Visitors and children.
- Respiratory.
  - Use of equipment and one-use items.
- Housekeeping.
  - Mixing of chemicals.
  - Discharge cleaning—normal and isolation rooms.

Overall Survey Process

- Interview infection control officer to verify following points:
  - System to identify, investigate, report & prevent spread of infections throughout facility
  - System extent: facility-wide & program-specific

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- Interview the infection control officer to verify the following points:
  - A system to identify, investigate, report and prevent the spread of infections throughout the facility.
  - System extent: facility-wide and program-specific.

Overall Survey Process (cont.)

- Developed policies governing asepsis & infection control issues
- Implementation of facility policies
- System covering outbreak of communicable diseases among patients & personnel
- Involvement with facility-wide orientation & in-service education

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- Developed policies governing asepsis and infection control issues.
- Implementation of facility policies.
- A system covering the outbreak of communicable diseases among patients and personnel.
- Involvement with facility-wide orientation and in-service education.

Audiovisual

Overall Survey Process (cont.)

- Facility must have:
  - System to maintain log of incidents related to infections & communicable diseases
    - System to know whether patient identified infection shortly after discharge
  - Monitoring of contracted staff
  - Monitoring of laundry, food or other services that are done offsite or under contract

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Outline or text of presentation

- Facility must have the following:
  - A system to maintain a log of incidents related to infections and communicable diseases.
    - A system to know whether patient identified infection shortly after discharge.
  - Monitoring of contracted staff.
  - Monitoring of laundry, food or other services that are done offsite or under contract.

Overall Survey Process (cont.)

- Review infection control log
  - Look for various types of infections
  - Look for clusters of infections
  - Look for frequency of staff providing care or services
  - Interview infection control officer about how facility handled various infection types

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- Review the infection control log.
  - Look for various types of infections.
  - Look for clusters of infections.
  - Look for frequency of staff providing care or services.
  - Interview the infection control officer about how the facility has handled various infection types.

Overall Survey Process (cont.)

- Review documents
  - Organizational chart
  - Infection control manual
  - Surveillance plan
  - Infection control meeting minutes
  - Log of infections for completeness
  - Reports of monitoring systems
  - Quality assurance reports

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- Review documents.
  - Organizational chart.
  - Infection control manual.
  - Surveillance plan.
  - Infection control meeting minutes.
  - Log of infections for completeness.
  - Reports of monitoring systems.
  - Quality assurance reports.

Audiovisual

Lesson 2-H-1:
Infection Control in the Acute Care Environment

Questions

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Outline or text of presentation

Skill Assessment

Infection Control in the Acute Care Environment

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described standards of practice for infection control in the acute care environment that are not found in the general environment.	
					Evaluated the facility's infection control practices appropriately when determining their compliance with regulations.	

Comments/Recommendations:

Infection Control—Definitions

Airborne precautions	Precautions that reduce the risk of an airborne transmission of infectious airborne droplet nuclei.
Air-removal test (Bowie-Dick test)	A diagnostic test to determine the adequacy of air removal from the chamber of a pre-vacuum steam sterilizer. The air removal test is not a test for sterilization.
Alcohol-based preparations	Products used for hand antisepsis that are increasingly used as an alternative to the traditional surgical hand scrub, using detergent-based antiseptic agents. Formulations include foams and liquid rinses. These agents do not remove soil; therefore, when used by surgical team members, application must follow a soap-and-water wash.
Barrier material	Material that prevents the penetration of microorganisms, particulates and fluids.
Biological indicator	A sterilization-process monitoring device commercially prepared with a known population of highly resistant spores that tests the effectiveness of the method of sterilization being used. The indicator is used to demonstrate that conditions necessary to achieve sterilization were met during the sterilizer cycle that was monitored.
Chemical disinfectant or germicide	A generic term for a government-registered agent that destroys microorganisms. Germicides are classified as sporicides, general disinfectants, hospital disinfectants, sanitizers and others.
Chemical indicator	A sterilization-monitoring device used to monitor certain parameters of a sterilization process by means of a characteristic color change (i.e., chemically treated paper, pellet sealed in a glass tube or pressure-sensitive tape).
Cleaning	A process using friction, detergent and water to remove organic debris; the process by which any type of soil, including organic material, is removed.
Confine and contain	A principle that recommends prompt cleanup of items contaminated with blood, tissue or body fluids.
Contact precautions	Precautions designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

Contaminated	A condition indicating the presence of potentially infectious pathogenic microorganisms on animate or inanimate objects.
Decontamination	Any physical or chemical process that serves to reduce the number of microorganisms on any inanimate object to render that object safe for subsequent handling.
Disinfection	A process that destroys some forms of microorganisms, excluding bacterial spores; a process that kills most forms of microorganisms on inanimate surfaces.
Droplet precautions	Precautions that reduce the risk of large-particle droplet transmission of infectious agents.
Epidemic infection	An infectious outbreak in a community in excess of normal infection rates.
Facility-approved agent	A microorganism-killing agent registered with the United States Environmental Protection Agency (EPA).
Foam surgical scrub products	Scrub agents that are mixed with air as they are dispensed through a specialized nozzle. Some may be applied by rubbing onto dry skin, while others are applied to wet skin.
High-level disinfection	A process that destroys all microorganisms with the exception of high numbers of bacterial spores. High-level disinfectants can inactivate the hepatitis B virus (HBV), human immunodeficiency virus (HIV) and TB. High-level disinfectants do not inactivate the viron-like, prion-causing CJD.
Hospital disinfectant	A chemical germicide with label claims for effectiveness against *Salmonella choleraesuis, Staphylococcus aureus* and *Pseudomonas aeruginosa.*
Infection	An illness produced by microorganisms or other infectious agents.
Infection control	A health-care organization's program, including policies and procedures, for the surveillance, prevention and control of infection. All patient care and patient care support services are included in the program. Standards are applied to evaluate the quality of an institution's infection control program.
Infectious waste	Medical waste that is capable of producing infectious diseases. Examples include blood, body fluids and sharps.

Intermediate-level disinfection	A process that inactivates TB, vegetative bacteria, most viruses and most fungi but does not necessarily kill bacterial spores.
Low-level disinfection	A process that kills most bacteria and some viruses and fungi but cannot be relied on to kill resistant microorganisms, such as TB or bacterial spores.
Mechanical indicator	An automated device that monitors the sterilization process. Examples include graphs, gauges and printouts.
Nosocomial infection	An infection acquired after admission to an institution and caused by something in the facility, as opposed to a community-acquired infection.
Personal protective equipment	Specialized equipment or clothing used by health-care workers to protect themselves from direct exposures to patients' blood, tissue or body fluids. This includes intact gloves, gowns, masks and goggles.
Regulated medical waste	Sharps (both used and unused), cultures and stocks of infectious agents, carcasses and bedding of animals inoculated with infectious agents, pathological waste and human blood.
Rigid sterilization container system	Specifically designed heat-resistant, metal, plastic or anodized aluminum receptacles used to package items, usually surgical instruments, for sterilization.
Standard precautions	The primary strategy for successful nosocomial infection control and reduction of worker exposure; precautions used for care of all patients regardless of their diagnosis or presumed infectious status.
Sterilization-monitoring device	A device used to monitor sterilization processes. Sterilization-monitoring devices can be biological, chemical or mechanical.
Strike-through	Penetration of microorganisms, particulates or fluids through fabric.
Ultrasonic cleaner	A processing unit that transmits ultrasonic waves through the cleaning solution in a mechanical process known as cavitation. The sound waves produce tiny air bubbles on instrument surfaces. When the air bubbles implode, they produce a scouring action that cleans the instrument's surfaces. This process is effective in removing soil deposits from hard-to-reach areas.

Universal precautions	Precautions taken that ensure that human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood-borne pathogens.
Washer-decontaminator	A processing unit that cleans by a spray-force action known as impingement. The machine combines a vigorous agitation bath with jet-stream air to create underwater turbulence. This unit cleans, decontaminates and removes excessive amounts of dried debris from instruments.
Washer-sterilizer	A processing unit that cleans by spray-force action known as impingement. It combines a vigorous agitation bath with jet stream air to create underwater turbulence. A sterilization cycle follows the washing cycle.

Lesson 2-I: Information Analysis for Deficiency Determination: Team Consensus Building

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Define a finding.
- Discuss the impact that thinking, questioning, assumptions and mental channels have on perception of findings and noncompliant practices.
- Know what findings to look at.
- Discuss the difference between a finding and the determination of noncompliance.
- Discuss the ways teams build consensus and how decision making is affected by team dynamics.

Lesson Plan

References

Federal

- Satellite transmissions:
  - *Decision Making,* transmitted on April 30, 2004
  - *Scope and Severity,* transmitted on July 13, 1998
- *State Operations Manual (SOM):*
  - Chapter 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, Section 7400E1

State

(Insert State reference[s] here.)

Other

- *Webster's II New College Dictionary.* (1999). Boston: Houghton Mifflin Company.

Training Techniques

- Lecture
- Group discussion
- Activities

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - *Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix*
  - *Teams and Teamwork*
  - *Basic - NH Complaint/Incident Investigation Protocol*

Methods of Evaluation

- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 2-I: Information Analysis for Deficiency Determination: Team Consensus Building 1	
Slide 2-I-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Define a finding. • Discuss the impact that thinking, questioning, assumptions & mental channels have on perception of findings & noncompliant practices. • Know what findings to look at. 2	*(Inform the students of the objectives.)*
Slide 2-I-2	
Learning Objectives (cont.) • Discuss the difference between a finding & the determination of noncompliance. • Discuss the ways teams build consensus & how decision making is affected by team dynamics. 3	
Slide 2-I-3	

Audiovisual

Outline or text of presentation

Compliance

Surveying involves more than simply marking the right box in a series of checklists or mindlessly following procedures. It is more than reviewing paper documents.

It is an active thinking process that requires analysis, critical thinking, judging and decision making.

Because regulations are not black and white, compliance is not always obvious. Skilled surveyors have learned to make accurate assessments and good decisions despite the complexities of their job.

Surveyors rely on lessons learned from past experience to assess the extent to which facilities are in compliance with Medicare and Medicaid standards.

Experience enables surveyors to accurately assess difficult situations and make sound decisions when beneficiary safety and welfare are at risk.

Novice vs. Expert

- What do expert surveyors notice that their less experienced counterparts do not?
- How do they make sense of environment in given facility or provider?
- How do they make judgments, assessments & decisions within survey that help them come to decision of compliance?

4

Slide 2-I-4

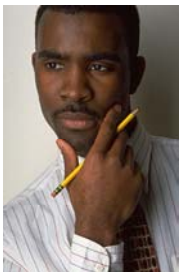
By answering the following questions and uncovering aspects of surveying expertise, we can help understand the cognitive subtleties of the surveying task that can help the novice surveyor toward his/her goal of becoming an expert surveyor:

- What do expert surveyors notice that their less experienced counterparts do not?
- How do they make sense of the environment in a given facility or provider?
- How do they make judgments, assessments and decisions within a survey?

Audiovisual

Critical Thinker

- Open-minded
- Flexible
- Fair minded in evaluation
- Honest in facing personal bias
- Willing to consider other ways of doing things
- Diligent in seeking relevant information
- Persistent in seeking truth in matters under investigation



5

Slide 2-I-5

Outline or text of presentation

In a previous lesson we learned to gather data, make observations, perform interviews and do a concise record and document review of only the information needed. Now we need to use critical thinking to move forward into decision making regarding compliance.

Critical thinking
(Read the definition of critical thinking.)

Critical thinking is:

- The cognitive process of actively and skillfully questioning with reason, open-mindedness and flexibility.
- Being fair minded in evaluation.
- Being honest in facing personal bias.
- Being willing to consider other ways of doing things.
- Being diligent in seeking relevant information.
- Being persistent in seeking the truth in matters under investigation.

(Ask students to provide some of the characteristics of a critical thinker. Then add some from the list below.)

A true critical thinker:

- Asks pertinent questions.
- Assesses statements and arguments.
- Is able to admit inability to understand some information.
- Has a sense of curiosity.
- Is interested in finding new solutions.
- Is willing to examine beliefs, assumptions and opinions and to weigh them against facts.
- Suspends judgment until all facts are found.
- Looks for proof.

Audiovisual

Compliance

- Compliance is meeting of standards within Code of Federal Regulations
  - Substantial compliance
    - Compliance with participation requirements
  - Conditions of Participation
    - Groupings of standards

6

Slide 2-I-6

Outline or text of presentation

- Looks for evidence to support assumptions and beliefs.
- Listens carefully to others and is able to give feedback.
- Diligently seeks the truth.
- Bases judgments on facts and evidence.

Now we need to make the determination of compliance.

What Is Compliance?

Before we discuss information analysis, findings and determination of compliance, surveyors need to come to an understanding of what compliance is for different providers and suppliers within the Federal system.

Compliance is the meeting of the standards within the *Code of Federal Regulations*. We say that a facility or provider is in compliance when it has met or reached those standards.

We say a facility or provider is in *substantial* compliance when it has deficiencies that pose no greater risk to residents or safety than the potential for causing *minimal harm.* Substantial compliance constitutes compliance with participation requirements.

Federal standards have been placed into groupings called Conditions of Participation (CoP). For some providers and/or entities, surveyors cite noncompliance at the Condition level, and for other providers and/or entities, noncompliance citations are written on the individual or Standard level within a CoP.

Audiovisual

Outline or text of presentation

Non–Long Term Care (LTC)
Surveyors of non–long term care providers and suppliers determine noncompliance with Standard-level (individual level) and Condition-level regulations. Although an entity may have Standard-level deficiencies, the entity must be in compliance with all Conditions of Participation or Coverage for that type of provider or supplier in order to remain certified.

LTC
Although there are Condition-level regulations, long term care surveyors cite noncompliance at the Standard level.

Conditions of Participation

Facilities or providers must be in compliance with following numbers of CoPs:

• LTC	15
• Hospitals	23
• Home health	15
• Rural health clinics	8
• Hospice	24
• Critical access hospitals	14

7

Slide 2-I-7

Facilities or providers must be in compliance with the following numbers of CoPs:

- LTC, 15.
- Hospitals, 23.
- Home health, 15.
- Rural health clinics, 8.
- Hospice, 24.
- Critical access hospitals, 14.
- Psychological hospitals, 3.
- End stage renal disease facilities, 13.
- Intermediate care facilities for persons with mental retardation, 8.

Conditions of Participation (cont.)

• Psychological hospitals	3
• End stage renal disease facilities	13
• Intermediate care facilities for persons with mental retardation	8

8

Slide 2-I-8

Levels of Compliance

Citations are written under different citation groupings or at the Standard level, depending on whether the provider and/or entity is LTC or non–LTC. One portion of determination is the level of harm the evidence reveals.

When we talk about the level of the standards, the definitions of the terms “minimum” and “minimal” come into the discussion.

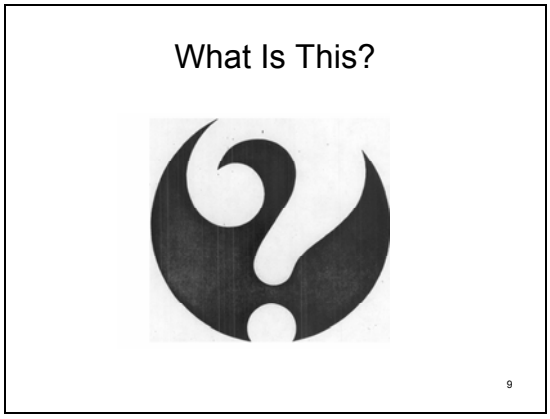
Audiovisual	Outline or text of presentation
	• Minimum—The least possible quantity or degree, the lowest possible amount or degree allowable. • Minimal—The smallest degree or amount. The standards are not minimal, and they are not the lowest, but they are the minimum the regulations expect. **LTC** In LTC, surveyors determine not only compliance and noncompliance, but also the amount of harm experienced or the potential for harm by determining the "scope and severity" of the evidence. "Scope" refers to how pervasive the issue or potential harm is within the facility, and "severity" refers to the amount or the potential amount of harm experienced by a resident. Scope and severity are determined by letter assignments. Scope and severity will be discussed in a later lesson within LTC surveyor training; however, for this section, an introduction of the terms of different levels of compliance will assist in the surveyors' understanding later. We say a facility or provider is in *substantial* compliance when it has deficiencies that pose no greater risk to resident health or safety than the potential for causing *minimal harm.* Substantial compliance constitutes compliance with participation requirements. In LTC, a facility or provider is in *Substandard Quality of Care* when it has deficiencies related to participation requirements under Resident Behavior and Facility Practices, 42 CFR 483.13; Quality

Audiovisual	Outline or text of presentation
	of Life, 42 CFR 483.15; or Quality of Care, 42 CFR 483.25 at: • A level that constitutes immediate jeopardy to resident health or safety (level J, K or L). • A pattern of widespread actual harm that is not immediate jeopardy (level H or I). • A widespread potential for more than minimal harm but less than immediate jeopardy with no actual harm (level F). **Non–LTC** Non–LTC facilities do not determine scope and severity for noncompliance. Typically, the survey team first determines whether the entity is in compliance with those regulations included under each Condition of Participation or Coverage. The team determines if, based on an egregious instance, a trend or lack of a significant system, the facility is additionally not in compliance with the Condition-level requirement. The team does not have to determine that a certain number of deficiencies is cited under a Condition before deciding whether the Condition is not in compliance. When noncompliance with a CoP is noted, the determination of whether a lack of compliance is at the Standard or Condition level depends upon the nature (how it affected patients, how dangerous, how critical, etc.) and extent (how prevalent, how many, how pervasive, how often, etc.) of the lack of compliance. The cited level of the noncompliance is determined by the interrelationship between the nature and extent of the noncompliance. The State supervisor will review the survey team's decision to cite regulations; however, for all non–LTC Medicare-

Audiovisual	Outline or text of presentation
	certified providers and suppliers, if the team determines the entity is not in compliance with a Condition of Participation or Coverage, the State forwards the Statement of Deficiencies to the Federal Regional Office. State staff include a document that recommends that the Regional Office begin decertification of the entity. The recommendation is based on the entity's noncompliance with a Condition-level deficiency. The Social Security Act does not allow a Medicare-certified entity to remain certified if it is not in compliance with all Conditions. Staff at the RO will review the State's recommendation and Form CMS-2567 that resulted from the survey. If RO staff agree with the State's recommendation, they will initiate the decertification process. Rather than cite all instances of noncompliance, surveyors cite the entity for an egregious instance of noncompliance, a trend in noncompliance or lack of a system that ensures appropriate care and services are provided under safe and appropriate conditions. The findings must be found currently in the facility. If the entity was not in compliance at a previous time but has corrected its problems and is in compliance at the time of the survey, the team cannot cite the facility for previous noncompliance. *(Hand out the table in SOM Chapter 7, Section 7400E1, Factors That Must Be Considered When Selecting Remedies.)* In this lesson we are going to focus on how we first begin to think that something we see, hear or read may be out of compliance.

Audiovisual	Outline or text of presentation
	• How do we identify problems or "red flags" that need in-depth investigation (some surveyors call this the second level of questioning)? • How do we step back and take a broad, objective look at the information we have obtained both individually and as a team? • How do we analyze what we and the team have? • How do we "determine compliance" and come to a team decision? • What is the correct answer? What is the "truth" about a situation, and is it out of compliance with the regulations? To ultimately make an accurate assessment about a facility's level of compliance with regulations, surveyors must be able to detect problems or "red flags." There are certain problems that are very obvious and "smack you in the face," as one experienced surveyor noted. For example, there is no doubt that there is a problem when you see a resident in a wheelchair entering a stairwell or when you see someone getting strangled by his/her bedsheets. In some ways, glaring problems result in easier surveys, because the problems are so apparent. The surveys that really pose challenges to surveyors are those in which the problems or the signals for the problems are more subtle.

Audiovisual



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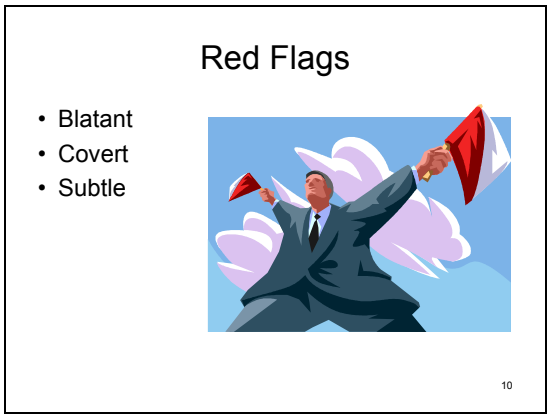


Slide 2-I-10

Outline or text of presentation

(Activity: What do you see? Ask students what they see in the picture. A seal with a ball on its nose, a question mark, a swan. Each person will "see" different cues.)

Key concept
One of the differences between experienced and novice surveyors is the ability to pick up on some of the more subtle or "covert" cues that indicate that a particular area should be investigated more thoroughly.

Surveyors must be aware of and be able to detect these subtle cues to make an accurate assessment of the facility's compliance with regulations.

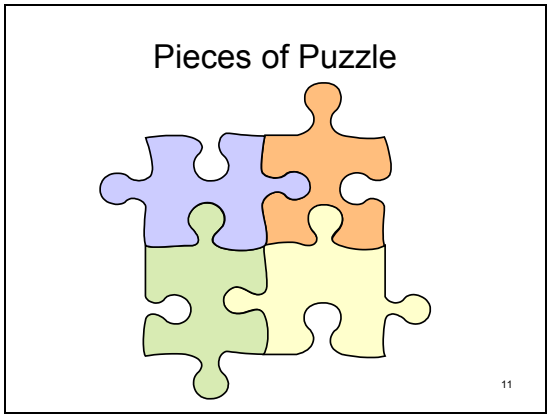
A sample of the types of cues that experienced surveyors may view as potential red flags are presented in the list below.

Cues that might raise a red flag:

- Inconsistencies in records.
- Urine odors.
- A lack of staff present in a given area.
- Residents crying because they're hungry.
- Problems with the physical environment, such as holes in the walls.
- Filthy toilets.
- Discrepancies between records and what the staff says.
- Residents that look exceptionally thin.
- Residents that appear to be afraid of staff.
- Residents that are inactive or that look bored or residents that are sitting asleep in the hallway, slouched over in their wheelchairs.

Audiovisual	Outline or text of presentation
	• Staff who cannot answer a question about a resident without consulting a record. • Inability of staff to produce records of showers or skin checks. • Residents whose skin is red and mushy. • Call lights not being answered. • Dried stool in resident's incontinent products. In certain cases, it is a single cue by itself that will alert a surveyor, but other times it is a combination of cues within a particular context that indicates a potential problem. For example, consider a situation in which a meal is brought to a resident, but the staff does not help to feed him/her. This, by itself, may not raise a red flag, because many residents eat without assistance. Upon further observation and record review, however, let's say you find that the resident is dependent and cannot eat by himself/herself. The fact that the staff did not feed the resident, in combination with the finding that he/she is dependent, suggests a serious problem. In this case, it is the combination of cues that raises the red flag.

Audiovisual



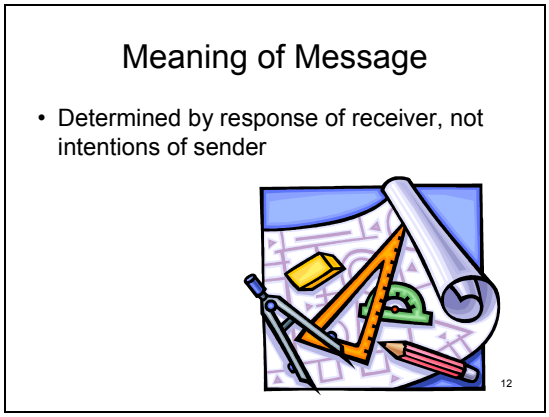
Slide 2-I-11

Outline or text of presentation

By themselves, some of the cues listed above might appear innocuous to an outside observer or a new surveyor.

For example, a talkative staff member may be seen as just that: talkative. An administrator who offers you a drink may simply be seen as friendly and hospitable. A staff member may take a long time to retrieve a particular record for you simply because he/she was sidetracked with a more pressing concern. However, experienced surveyors know that a pattern of these behaviors could indicate a serious problem of cover-up. Surveyors must be alert to such cues, given that cooperation of staff and administration is critical to the outcome of the survey. Surveyors must put together the pieces of the puzzle.

Unfortunately, due to many reasons including fear, embarrassment and the severe penalties associated with the citation, staff and administrators sometimes deliberately deceive or hide information from surveyors. It means that sometimes one or two of the puzzle pieces are missing, which makes the surveyors' work more difficult.



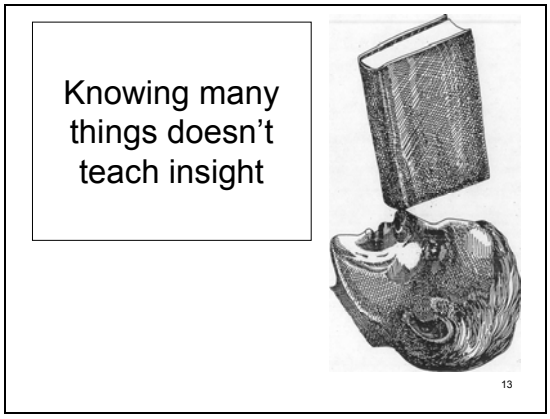
Slide 2-I-12

Key concepts

An important finding to highlight is that the way in which a surveyor interprets or attaches meaning to a cue (i.e., whether he/she views it as a "red flag") might be influenced by his/her professional background.

It is a fact that the facility or provider staff do not recognize the message they are sending; if they did they might change their practice. It is up to the surveyor to listen to the message and attach the meaning of the impact to the resident.

Audiovisual



Slide 2-I-13

Outline or text of presentation

For example, one surveyor recounted a survey in which members of her team with different backgrounds interpreted a cue quite differently:

". . .during the tour, a member of my team who was a very experienced surveyor (and a social worker) walked into a room where there was a blood stain on the carpet outside the bathroom. Because there were no residents in the room, she disregarded it. Another surveyor (who was a registered nurse with nursing home experience) walked by the room and saw the spot on the floor. She decided to ask the cleaning woman what happened. The woman told her that she couldn't get the blood stain out of the carpet, which was caused by the resident falling and cracking her head open. The second surveyor found the resident and examined her, only to see her face badly bruised, with a cut down the middle of her forehead . . ."

In this particular case, one surveyor saw the blood stain as a red flag although the other did not.

The social worker needed to see the resident in the room to put the cues together to determine that there was a problem. The registered nurse just needed to see the stain to wonder what really happened and to investigate further. Given that surveys (particularly annual surveys) are often conducted by teams, it is essential that surveyors be aware that a person's background can influence how he/she interprets certain cues.

Audiovisual

Team Decision

- Sharing ideas
- Sharing cues
- Sharing observations
- Sharing random pieces of information
- Questioning & seeking incongruent information
- Discussion

14

Slide 2-I-14

Outline or text of presentation

Although this can be a complicating factor in a survey, it can also provide added value to the team. This is one reason why team discussions and sharing are vital to the outcome of the survey.

Noticing different cues and bringing that to the table when it is time for the team to make decisions can add to the completeness and accuracy of the final assessment of compliance.

The Right Answer and Hard and Soft Thinking

How do we know, in the case of the regulator, what to pay attention to? How do you learn how to set your mental channel?

All subjects have logic to them. Each is a system that enables us to reason effectively, yet most students try to learn not by reason but by rote memorization. They blindly memorize someone else's answers.

- One factor that influences what you pay attention to is your formal education.
  - You learn what is appropriate care for the population being served.
  - Unfortunately, or fortunately, this changes not only in medicine but also in our society, as we learn new information and make new discoveries.
    - Long ago, residents were regularly tied up (restrained with bedsheets), and facility staff never thought about sitting down and talking to them. They moved from resident to resident as though on an assembly line.

Audiovisual	Outline or text of presentation
	Staff gave good care for the time, because they didn't know better; society at that point in time institutionalized the elderly and "protected" adults and children who were ill in acute care settings. Facility staff provided the "standard of care" for that time. – Currently, survey focuses on the quality of life of residents. Although we recognize that sometimes people can no longer live independently, we focus on a homelike environment, and the residents' needs and wishes are put on a higher plane of importance. • Another factor that influences what people pay attention to is questioning and probing surroundings. – By doing this you learn where to search for information, which ideas to pay attention to and how to think about these ideas. – Over the next few months you may learn some new ideas about residential living and about the standards of care in acute care and other provider standards. Ask a lot of questions and seek new and different answers. – Let's start by looking at our perspectives and how we choose the right answer. In a recent magazine article by Steven Johnson regarding the brain's circuits, Antonio Damasio's theories regarding speed and the function of the brain are discussed. • Antonio Damasio is a neuroscientist that is researching the question, In a society that moves at a faster pace than the brains that created it, can the brain keep up?

Audiovisual	Outline or text of presentation
	• Damasio's theory is that emotions are essential to our rational decision-making processes. If we didn't have those gut responses, we'd get caught in an endless cycle of analysis, drawing infinite lists of pros and cons in our heads. – For example, it is not necessary to stop other people on the street and ask them whether they believe the comedian Steve Martin is joking in some of his movies and television programs. We can tell right away by the tone of his voice, his mannerisms and his physical carriage that he is not serious. Tone of voice, mannerisms and physical carriage are cues that we respond to emotionally. – Another example might be when we watch the evening news and a news clip shows a child who was killed crossing the street. Our emotional response triggers our questions about what happened. • Damasio's work has been with people whose specific central nervous system areas that have to do with emotions have been damaged by strokes, accidents or tumors. The pattern in all of these cases was very similar. What people had lost was not in the realm of knowledge or skill. They could learn new things and could deal with the logic of a problem. All of these people shared one common trait: their emotions were compromised; they were flattened emotionally. Social emotions, such as shame and embarrassment, were specifically compromised. Emotions help you concentrate on making the right decision. • You still have to do some of the work, but the emotions give you a head start.

Audiovisual	Outline or text of presentation
	So, part of Damasio's theory is that emotions can adapt to the increasing speed with which modern society confronts people with difficult choices. He discusses that when we feel emotions, we are taking a survey of either our actual physiological state or an "as if" simulation. • For example, "If I were he and that happened, how would I feel?" We draw on somatic markers or past emotional experiences, and they serve as guides for the present decision. If you have no somatic markers, it is difficult for you to get the same emotional response. Somatic markers take time to develop. It is part of the body's system in which the fibers are unmyelinated and conduction is very slow. • The danger in decision making and recognizing cues is not that our cognitive thinking will short out; we have the ability to process large amounts of factual data. The danger is that our emotional response sometimes shorts out. When our emotional responses are intact, we are ethically grounded and are able to respond appropriately to society's standards. When our emotional responses are shorted out, we become ethically rudderless and do not identify cues that should alert us to problems. What Damasio's theory is using is soft thinking. There are generally two types of thinking: soft and hard. Soft thinking tries to find similarities and connections or shades of gray or diffuse light. It relies on intuition and emotions.

Audiovisual	Outline or text of presentation
	Hard thinking tries to differentiate between the right and wrong answer or black and white. Both types of thinking are important; however, overemphasis on either can inhibit your thinking by placing filters on information you are taking in. For example, if you rely on logic you may increase your mental filter so that you do not respond to how the resident "feels" and over-rely on how you perceive the resident would like to be treated (i.e., calling a resident "Grandma"). Logic can comprehend only those things that have a consistent and noncontradictory nature. When you see a facility's staff member strike a resident, logic tells you this is not acceptable, that it is inappropriate and that it requires immediate attention. There is nothing to question here. However, ambiguity, inconsistency and contradiction are all hallmarks of human existence. As a result, the number of things that can be thought about in a logical manner is small. It is the soft thinking, the intuitive hunch, that may be one of your most valuable methods of thinking as a regulator. In some areas where soft thinking is needed, surveyors who rely on initial perceptions and checklists bypass the questioning and searching process, which decreases the ability to critically consider and analyze what is going on.

Audiovisual

Outline or text of presentation

The use of intuitive thinking increases your ability to take apparent disparate pieces of information and combine them into an answer or picture.

- Intuitive thinking uses ambiguity as a powerful stimulant . . . letting a random piece of information stimulate your thinking. It's the red flag effect.
- Ambiguous situations are those that can be interpreted in more than one way.
  - They're confusing.
  - They cause communication problems, so we avoid them.
- A little ambiguity can push you into asking what regulators call second-level questions, such as:
  - What's going on here?
  - What does this mean?
  - How else can this be interpreted?

Cross out six letters so that the remaining letters, without altering their sequence, spell a familiar English word.

B S A I N X L E A T N T E A R S

15

Slide 2-I-15

(Activity: Cross out six letters so that the remaining letters, without altering their sequence, spell a familiar English word.

B S A I N X L E A T N T E A R S

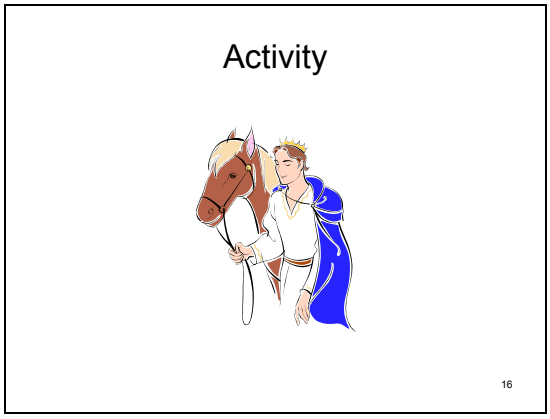
Let students think about the answer while you proceed.

People's minds are constantly recording, connecting and sorting unrelated knowledge, experiences and feelings. This disparate information is combined to form hunches and answers to the problems you are facing. If you simply ask, trust and listen, these hunches, for no apparent logical reason, might lead you to a different decision about the facility or provider. Question your assumptions.

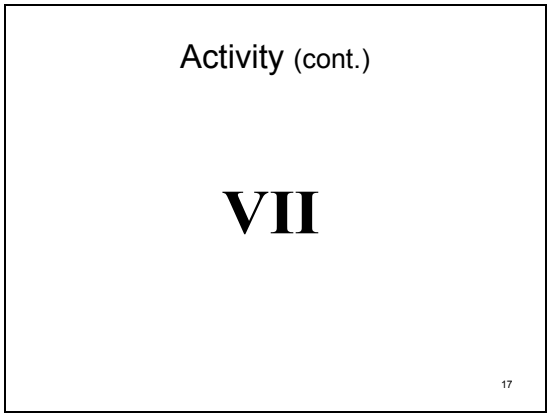
Audiovisual	Outline or text of presentation
	Answer: Most people look at the problem and think, there are 16 letters, so to solve this problem I should cross out six of them; it means I'm looking for a 10-letter word. *Cross out the letters SIXLETTERS.)* Soft and hard thinking affect the data that you gather and how you "artistically" place the data together to create a picture. In Lesson 2-D-2, "Role of the Regulator," we discussed the four roles within the survey process: • The explorer, who gathers raw material facts, concepts, knowledge and feelings, investigates using different senses and seeks a variety of information with an open, exploring mind. • The artist, who takes different pieces of information to form a picture of the care and services beneficiaries receive. • The judge, who critically evaluates services provided to beneficiaries. • The warrior, who puts beliefs into action. It is the artist's role that requires surveyors to exhibit flexible thinking. The key strategy that expert surveyors described to help them with this challenge is sharing information, comparing notes and observations, with team members. If the true underlying issues can be identified through the investigative work and data sharing among team members, it will ultimately facilitate the decision-making processes. What does that mean to a new surveyor and to an experienced surveyor?

Audiovisual	Outline or text of presentation
	• For a new surveyor it means that even when you know the process of survey and even when you know all of the regulations, it will be difficult for you to recognize harm from an emotional basis until and unless you can relate to the experience of the beneficiary in the situation he/she is in. • All surveyors rely on soft (emotional and intuitive) thinking and hard thinking for the investigational work. • Regulations themselves are logical, and they define right and wrong; however, life is ambiguous. It has gray areas. Surveyors need to recognize the conflicts and gray areas and realize that critical thinking is required for determination of compliance. • The team concept is critical in assisting the new surveyor in decision making. • For experienced surveyors it may mean that burnout or overloading of the emotional system can cause them to minimize the harm or emotional connection to the beneficiary. Problems become so ordinary that we stop paying attention to our surroundings. • Surveyors have to be aware of their internal perceptions and their emotional status. *(Say, "We are now going to move on and discuss perceptions, context and the right answer in decision making."* *Activity: Read the following and ask the questions. Tell students you will give them time to consider the answers. This can be done just before a break.*

Audiovisual



Slide 2-I-16



Slide 2-I-17

Outline or text of presentation

1. *An eccentric old king wants to give his throne to one of his two sons. He decides that a horse race will be run and the son who owns the slower horse will become king. The sons, each fearing that the other will cheat by having his horse run less fast than it is capable, ask the court fool for his advice. With only two words, the fool tells them how to make sure that the race will be fair. What are the two words?*

2. *What is this figure?*

Shown below is the Roman numeral seven; by adding only a single line, turn it into an eight.

VII

*Answer: All you have to do is add a vertical line to the right to create an eight. (*VIII*).*

Below is the Roman numeral nine; by adding only a single line, turn it into a six.

IX

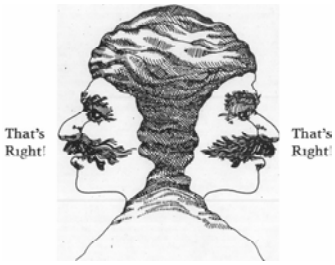
Answer: Put a horizontal line through the center, turn the page upside down, and then cover the bottom.

Answer: Put an S in front of the IX to create six. If you did this you have taken the IX out of the context of Roman numerals and put it into the context of Arabic numerals, spelling them out in English. Why didn't you do it this way? People get locked into the context of the Roman numerals.

Audiovisual	Outline or text of presentation
	Answer: Another solution might be to add the number 6 after IX. Then you get IX6 or one times six, which is six. The X no longer represents 10 or the English letter X but rather the multiplication symbol.
	(This section can be done after a break, or the facilitator can return after continuing within the lecture portion for a while.)
	Answer to the question: *1. Now, what about the horses?* • *Switch horses.)*
	It is our perception, our first question and the answer to that question, that we jump to first. Moving to the second level of questioning for "the true" answer or a verified "truth" of the situation is vital to becoming a successful surveyor and investigator.
	The point is, everybody has a lot of knowledge. By shifting the context in which you think about it, you will discover new ideas, new perceptions and a new right answer.
	Observations are more than just looking to see what is there; they also involve looking to see what is not there. The expertise of the job lies in seeing what isn't happening.

Audiovisual

Truth is all around you; what matters is where you place your focus



18

Slide 2-I-18

Outline or text of presentation

So, why is it important for a regulator to continually check his/her perceptions and perspective?

- We are frequently taking small bits of information, our small perceptions of what is happening to the resident, and using it as the "right answer." To really determine the "right" answer we need to verify or clarify the small bit of information.
- In inspections and surveys, we need to look at the resident's perception and validate our small "finding" through observations of other beneficiaries and interviews with the beneficiary and other beneficiaries, the facility and or provider staff and family members of the beneficiary.
- We start from our own individual "perceptions and perspective," which may or may not be true for the beneficiary.

(Say, "As you gain experiences, check the following list to see where you are in the process of becoming an expert surveyor.")

Some of the aspects of surveyor expertise associated with this task are:

- Knowledge of the rules and regulations.
- Knowledge of what compliance and noncompliance "look like" for general groupings of regulations.
- Awareness that there is more than one way to be in compliance with regulations.
- Understanding of the variety of ways in which a particular regulation (or groupings of regulations) could be met.
- Ability to step aside from emotions or personal preference (just because you don't agree and what you see is not how you would take care of the resident or set up the system of care, it does not

Audiovisual	Outline or text of presentation
	mean it is not compliant with the regulation). How do you open the mental locks that lock us into our preconceived perceptions? • By accepting and acknowledging that we set our mental channels, we start to open our mental locks. Become aware of them. • By temporarily forgetting preconceived ideas when trying to generate new ideas. • Alternatively, by challenging our first answer to enable us to look at the other answers. – What did I expect to see? – What did I expect to hear? How do we challenge our mental channels, and how do we decide what observations or pieces of information to investigate further? Surveying can be like a big, noisy party with people talking, music playing and glasses clinking. Even with all of this noise, it's possible for you to understand the person across from you or a person 30 feet away. That's because our attention is selective, so we can tune in certain things and tune out others. It has to do with "mindset" or "mental channels." *(Activity: Look around where you are sitting and identify what and how many items have the color red in them.* *Say to the students, "How many did you find? Before I asked you the question, did you notice the red things when you entered the room today or yesterday? Remember, our attention is selective; we can tune in to specific things and tune out of specific things present in our surroundings.")*

Audiovisual

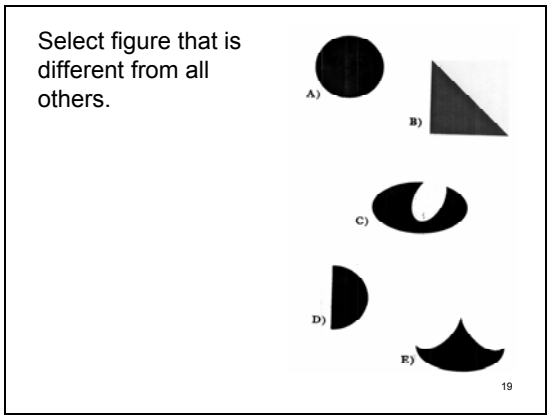
Outline or text of presentation

An example of selective attention is when you get a new car. You begin to think everyone has that make and model of car. If you look for beauty, you'll find beauty; if you look for bad things, you'll find bad things.

To help focus your mental channel, look for three areas that fail to meet the beneficiary's needs in survey that:

- Aren't there that should be or are not performed consistently (omissions).
- Are not performed at the standard expected (commission).
- Indicate gaps in care and services.

One of the things we can do is know what the "right answer" is. In the case of a regulator we need to be careful about how our mental filters and our perspective move us to choose "one truth."



Slide 2-I-19

(Activity: Look at the five-figure slide. Select the figure that is different from all the others.

Answers:

1. *If you chose B, congratulations; you picked the right answer. Give yourself a pat on the back. Figure B is the only one that has all straight lines.*
2. *If you chose C, thinking that C is unique because it's the only one that is asymmetrical, you are also right; C is the right answer.*
3. *A case can also be made for A; it's the only one with no points, and therefore it is the right answer.*
4. *What about D? It is the only one that has a straight line and a curved line, so D is the right answer.*
5. *What about E? E is the only one that looks like a projection of a non-Euclidean triangle into a Euclidean*

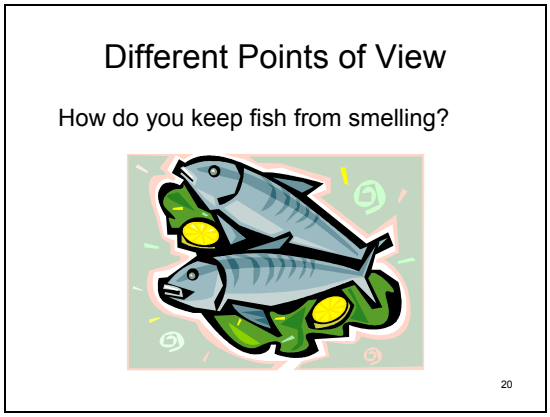
Audiovisual	Outline or text of presentation
	space, so E is the right answer. A Euclidean triangle is a triangle that is within three dimensions. If you picture a triangle that is curved along the three legs of the triangle it places it in three dimensions. Wrap a flat triangle around a ball and you have the figure on the slide.)
	In other words, they are all right depending on your point of view.
	• In school, much of our educational system is geared toward teaching people to find the right answer. • By the time the average person finishes college, he or she will have taken over 26,000 tests, quizzes and exams. • The "right answer" becomes deeply ingrained in our thinking.
	This may be fine for some mathematical problems in which there is in fact only one right answer.
	• The difficulty is that most of life isn't that way. Life is ambiguous, and there are many right answers, depending on what you are looking for. • If you think there is only one right answer, then you'll stop looking as soon as you find it. You will be satisfied with what you have. It is the same with survey. • If you look at one finding and believe it is communicating the whole picture, you will be satisfied and stop looking for validation or other instances of the same issue of care or quality of life. • In survey and complaint investigations, the regulator needs to use validation to confirm that the facility or provider is not compliant or that residents have the potential for harm or have been harmed

Audiovisual

Outline or text of presentation

due to the facility's or provider's practice or lack of provision of care and services.

Key concept
Most people don't like problems; when they encounter them they usually react by taking the first way out they can find, even if they solve the wrong problem. For more effective thinking we need different points of view; otherwise we'll get stuck looking at the same things and miss seeing things outside our focus.



Slide 2-I-20

(Activity: Ask, "How do you keep a fish from smelling?"

Answers:
1. *Cook it as soon as you catch it.*
2. *Freeze it.*
3. *Wrap it in paper.*
4. *Leave it in the water.*
5. *Switch to chicken.*
6. *Keep a cat around.*
7. *Burn incense.*
8. *Cut off its nose.)*

Key concept
Remember, one technique for finding more answers is to change the wording in your questions during interviews. Use the types of words the person you are interviewing is using and then verify the meaning. For example, what is molesting? Does the resident really mean that someone came in and physically touched him/her inappropriately or that someone invaded his/her space? Continue to request descriptions from the person being interviewed as a means to verify that both you and the person being interviewed are clear about the meaning of the words being used.

Audiovisual

Outline or text of presentation

Findings vs. Deficient Practice

These two concepts are different yet connected. Sometimes we interchange the terms, but in reality they are separate concepts.

What is a finding? *Webster's II New College Dictionary* defines it as "something found, or to discover by looking for, or a conclusion reached after an investigation or examination."

For our purposes, a finding is a small bit of information which is observed or discovered during the survey or the investigative process.

A finding is a piece or pieces of information obtained through observation, interview or record review about the facility's or provider's practice.

A piece of information is like a musical note. A musical note can only be understood in relation to other notes (melodies or chords).

A finding is best understood in the context of other findings . . .

Findings are not always negative. As a facility or provider is surveyed, there will be many findings that lead to the surveyor analyzing that the provider is providing the care and services the beneficiary needs and at the standard required by the CFR.

Generally surveyors focus on the negative findings, because they represent a service that was not provided or provided incorrectly, a policy or procedure that is not being followed or a structural requirement that is not in place.

Audiovisual	Outline or text of presentation
	A finding is not deficient practice until all data are analyzed to determine the failure of the facility or provider in relation to the standard, the CFR. A one-time observation of failure to provide a service or poor provision of service must be followed up with additional data gathered by all members of the team; however, even one finding can be determined to be deficient practice. How can that be? **What is deficient practice?** The determination of deficient practice is the result of analysis of findings for sampled beneficiaries and comparison to the requirements under the regulations. This means that the surveyor must have knowledge about regulations to analyze the findings to determine noncompliance. Deficient practice is a bigger picture, perhaps better defined as the sum of the findings. *Webster's II New College Dictionary* defines deficient "as lacking an essential quality or element and inadequate in amount of degree." Practice is defined as "a habitual or customary action or manner of doing something." Practice, by definition, is more than one happening or occurrence. Surveyors have a responsibility to look at multiple opportunities to determine whether the errors were singular events or truly reflective of a pattern or habit of behavior.

Audiovisual	Outline or text of presentation
	If one resident received poor pericare, it is not possible to determine whether this finding represents deficient practice in the system of providing quality care without observing more opportunities with different residents and different staff members. That is not to say that one-time observations of pericare for an individual resident can never be cited as deficient practice. One severe incident with one resident can result in a deficiency. So, how do we know when one occurrence is considered deficient practice or that many occurrences constitute deficient practice? The regulations tell us what is required. The wording in each regulation tells the investigating staff whether one observation of one resident is sufficient to determine deficient practice or whether the regulation is system-focused. For example, the regulatory words "each resident" indicate that only one resident needs to have experienced poor care or services to determine deficient practice, whereas the words "the facility is required to have an infection control system" indicates that there are many parts to a system and that multiple observations might be needed to establish that the system is noncompliant. Now you have a finding. One of your responsibilities is to look at multiple opportunities to determine whether the finding was a single event. Alternatively, was it a reflection of a pattern of behavior? Situations encountered in facilities are highly complex, and what is seen on the surface does not necessarily reflect the "true" problem. Instead, the surface indicators may actually be symptoms of a much deeper issue. As one of our surveyors stated, "It's like an iceberg.

Audiovisual	Outline or text of presentation
	Sometimes you see what's on top and then find out there's a whole mess underneath." Even for highly experienced surveyors, uncovering the underlying issue is generally not straightforward. This is largely because similar symptoms might reflect different underlying problems. For example, if residents are not being fed, it might be because the kitchen staff doesn't get the food out on time, or it might be because the nursing staff leaves the food sitting outside the resident's door. If the number of falls is high, it might be because preventative measures are not in place, or it could be because the staff is not following correct procedures. Uncovering the true nature of the problem requires patience, thoroughness, and a lot of investigative "digging." As one surveyor noted, uncovering the true problem "is like peeling an onion." Surveyors have to go several levels down to find the core problem. Finding the root cause of the problem can be even more challenging in complaint surveys due to the need to maintain confidentiality of the complainant. During a complaint investigation, you do not want the facility administration and staff to know exactly what you are investigating, so it can be tricky to uncover the real problem without "tipping your hand." Another complicating factor during a complaint survey is that you may not be able to interview the resident in question because he/she is gone (due to death, hospitalization or transfer to another facility), or he/she has a condition that

Audiovisual	Outline or text of presentation
	makes it difficult or impossible to speak with him/her. Needing to rely on records and staff alone can make the task exceedingly tricky. Experienced surveyors have several strategies for dealing with the challenge of uncovering the underlying problems. One surveyor described a strategy of using a mental checklist to determine the root of the problem. During an annual survey, this particular surveyor observed an incident in which a resident stopped breathing, and the staff did not do anything about it until a significant amount of time had passed. In his mental checklist, the surveyor was considering: • What did the staff do? What didn't they do? And when? • Did they do ABC (airway, breathing, circulation)? • What is the facility's policy on codes? • Do they have a crash cart (defibrillators, etc.)? Where is it located? Who's in charge of bringing the crash cart to the code? • What is the facility's system for determining someone's code status? Do the nurses know this system? • Do all the units handle a code status the same way? Using this mental checklist of questions helped the surveyor uncover the underlying problem in this incident and ultimately assign a tag.

Audiovisual

Types of Regulations & Tags

- Outcome
- Structure
- Process

21

Slide 2-I-21

Outline or text of presentation

How do you develop this checklist of questions?

- The regulations can help you determine whether your findings are deficient practice.
- There are generally three types of tags and then there are some with combinations:
  1. Outcome.
  2. Structure.
  3. Process.
  - As we have previously discussed, beneficiary outcomes remain a primary focus.
  - In each provider and facility type that is surveyed, the regulations also have some process and structure regulations.
  - These regulations, by their wording, can help the surveyor determine the kind of evidence and the perspective or the intent of the regulation.
  - You can think of structure and process regulations as the 2 by 4s, the foundation on which the outcomes are built. To truly have quality outcomes, the structure and process must be consistently followed; otherwise what you have is an occasional or random good outcome.
  - If a building is missing some of its 2 by 4s and does not have the correct size rafters, or the carpenters didn't build the foundation and then the walls and then the ceiling (in other words they didn't follow a process), the floor and ceiling sag and you see cracks and bowing in the ceiling or the ceiling falls in (outcomes). When you walk into a home you don't see the structure or the building process that it took to make it, but what you do see is the outcome.

Audiovisual	Outline or text of presentation
	– Survey processes are the same. Surveyors first notice the outcomes, but, like a building inspector, we have to try to determine what portions of the structure or process failed and led to the outcomes.
	The regulatory language discusses how there are generally three types of regulations. They give us clues about the types of evidence they need to prove compliance or noncompliance, and they help us to focus in on their intent.
	• Structure—Structure regulations must be met in the absolute sense. Either they have it, or they don't. It is generally a black and white question and answer. – Each room must be so many square feet, and there must be so many bathrooms. • Process (system)—Policies and procedures, system of quality assurance, system of abuse prevention. – Assessments and care plans were not done, which resulted in the nurse's aides not knowing what the beneficiary needed for care, and the result was poor care, an outcome of which is pressure ulcers. This is specific to a process. The regulation states the facility or provider will have a process or system or a standard way of doing things. • Outcome—Have direct cause and effect to the beneficiary, what care he/she gets and what quality is expected. – The development of pressure ulcers due to the failure to provide the care and services needed to prevent or treat.

Audiovisual	Outline or text of presentation
	• Combinations—There are combinations of regulation types. These regulations require not only process but also have components of outcome. Failures within systems and process regulations have the "potential to cause harm," but many times they do not have the clout of a high-level severity determination, nor should they without the outcome. The larger the facility, the more formalized the processes need to become. In smaller homes with stable staff and stable resident populations, less formalized processes will sometimes suffice to effect good outcomes. It has been said that you can have good outcomes by chance; however, to have durable, consistent outcomes or to have a high probability of good outcomes, systems and processes need to be in place. This is one of the reasons that surveyors need to look not only at negative outcomes but also at the potential for negative outcomes. First we look for the outcomes and then we look back at the facility's systems and processes and try to figure out what didn't happen or should have happened that caused the outcome. This can result in a citation regarding the outcome and a citation regarding the failed system or process. For example, the facility failed to implement skin precautions and failed to perform ongoing monitoring of the skin, the result of which was a pressure ulcer. In LTC this is cited under a regulation with a focus on outcome or potential outcome (the development of a skin issue and/or the failure to implement precautions). This

Audiovisual	Outline or text of presentation
	could also result in the lack of ongoing assessment, which could be a process citation. There are also special words to help the surveyor determine the focus of the regulation: • "Each resident"—means that for every single resident care and services must be given. The outcome is more focused on the consequences or potential for consequences to the specific beneficiary. • The "facility must" is a structure or process regulation. The evidence in the structure or process proves that either it was done or it wasn't. If findings are collected and there is still a question of noncompliance or the types of deficient practice, look to the regulations for guidance. Remember, surveyors look at the practice of the facilities and providers and compare it to the expectations of the regulations. Another way surveyors use mental models is in knowing how the hundreds of regulations break down into major groupings for investigation. Grouping the regulations in a particular way helps to better guide their investigation as opposed to trying to remember every individual regulation. New surveyors can use these to help focus on obtaining the strongest evidence needed within the CoP. For example, in a CoP of Quality of Life the beneficiary's feeling about the provider's practice is critical; therefore, interviews are critical and are one of the strongest pieces of evidence.

Audiovisual	Outline or text of presentation
	Determining what to cite is largely based upon the interpretation of regulations. As mentioned previously, regulations are not clear-cut and are open to quite a bit of subjective interpretation. How a regulation is interpreted by surveyors affects whether they cite something as noncompliant. This is not the only factor that influences the determination of what to cite, however. This decision is also dependent upon what evidence the surveyors have accumulated throughout the course of the survey. Surveyors note that you cannot cite something just because you have a gut feeling. For your citations to hold up in court, you must have the evidence to support them (e.g., detailed notes of conversations, copies of records, specific descriptions of observations, etc.). Often, surveyors are required to change their citations for this very reason. Once a citation write-up is reviewed by the supervisor, the surveyor may be asked to drop the citation or change it because of insufficient evidence to support it. Determining the actual tags to assign is based largely upon what have been determined to be the root causes through the course of the investigative work. However, given that the underlying issues aren't always straightforward, determining what tags to assign is not always clear-cut either. Sometimes there can be several different tags that would make sense to assign. A surveyor provided the following example: "We were watching a nurse do treatment for a pressure ulcer. She did things improperly and contaminated the area.

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Outline or text of presentation

One surveyor thought the incident should be written up under a tag specific to pressure ulcers. I thought it should go under an infection control tag."

(Activity: Read the following story.

The Blind Men and the Elephant
There is a story about six blind men. Although they could not see, they learned about the world in many ways. They could hear the music of the flute with their ears. They could feel the softness of silk with their fingers. They could smell the scent of food cooking and taste its spicy flavor. One day they heard that the prince had a new elephant. They had never met one and went to the prince to ask whether they could touch the elephant.

The first blind man touched the elephant's side. "It is strong and wide; I think an elephant is like a wall."
The second blind man touched the elephant's long round trunk. "Oh, it is just like a snake."
The third blind man touched the elephant's smooth ivory tusk. "Why, an elephant is as sharp as a spear."
The fourth blind man touched the elephant's leg. He thought it was round and firm as a tree.
The fifth blind man held the elephant's ear. The ear was very, very big and flapped gently. He said, "It's just like a fan."
The sixth blind man touched the elephant's long, thin tail. He said, "An elephant is just like a rope."
The men sat down together and started to talk about the elephant, each giving his own idea of what the elephant looked like. They became angry and shouted at each other, each thinking he was right and the others were wrong.

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	The prince, hearing all the shouting, came out and asked what was wrong. Upon hearing the story he laughed softly. He said, "You are all right. The elephant is all of those things. To know what an elephant is really like, you must put all those parts together."
	
	The moral of the story for survey is that wisdom comes from seeing the whole, and it takes the whole team to see all of the elephant. The whole team must share and weigh the evidence and put the pieces together.)
	
	Weighing Evidence
	
	Evaluate your findings and your conclusions, first individually, then as a team. Ask yourself the following:
	• Is the information you obtained by physical evidence, interview or record review consistent?
	  – Are the stories different or consistent?
	  – If they are different, is there someone on the team that can explain the differences or that has evidence that explains the differences? If not, then ask, Do I have enough information to verify which story is more "correct" or plausible?
	  – Where could I get more information?
	• Is the information credible, or is credibility an issue?
	  – How do you determine whom to believe?
	  – How was it determined?
	  – Why do we believe or not believe the person we interviewed?
	  – Are there other facts that verify the information or that present more contradictions? Which version is true?

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	• What does the documentation in the record or your documentation tell you?
	  – Is it accurate?
	  – How do you know?
	• Do the findings support each other?
	• What else do I need?
	  – Determine what other facts would clarify the situation.
	  – Who or which staff member is closest to providing the services or care that is in question?
	  – What other records could be reviewed to clarify the situation?
	  – What other observations could be made?
	
	An analysis of a group of findings or the validation of a finding should lead to a conclusion about:
	1. The care and services the facility is providing.
	2. Whether the practices are compliant under statutes and regulations.
	3. The impact the finding has on the resident.
	4. What happened at the facility that allowed us to make a valid determination whether the facility is in compliance.
	
	If, at this point, a determination on failed practice or noncompliance cannot be made, the team will need to do more observations, interviews and record reviews.
	
	Scope and severity
	After a team determines that a deficiency(ies) exists they:
	• Assess the effect on the beneficiary (severity).
	• Determine how harmful it was for other beneficiaries at risk.
	• Determine the number of residents potentially or actually affected (scope).

Audiovisual

Team Decision

- It is *team* decision to cite noncompliance based on evidence gathered during survey & presented to *team* for determination

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Outline or text of presentation

(View CMS videos, Decision Making and Scope and Severity and review Scope and Severity Determinations in Chapter 7 of the SOM.)

The team decision
Decision making in survey is a team decision. It is made by consensus.

Consensus decision making
A consensus is a collective opinion, a group opinion. A consensus is a negotiated decision.

Team members do not always agree on the compliance or noncompliance within a facility. They may not agree on the scope and severity of the noncompliance; however, in the end, the team must negotiate among its members, weigh the evidence and come to a team decision.

A team proceeding through the following process is more likely to reach a consensus.

Team information analysis process
- Review worksheets for identified concerns and supporting evidence.
- Prioritize concerns according to the requirements.
- Focus on the resident.
- Reach consensus on the deficient practices identified.

(Ask, "Are the people you work with a group or a team?" Discuss with the group what a team is. Say, "A group of people may work together in the same place, doing the same tasks; however, teamwork is defined as a cooperative effort by members of a group to achieve a common goal.")

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	Summary There are many things that differentiate the expert surveyor from the novice surveyor. Expert surveyors: • Reflect on their experience and learn. Surveyors who remain at a basic level don't reflect on their experiences and therefore do not learn from experiences. • Use both soft and hard thinking to guide them. • Use the regulations and Conditions of Participation to guide them. • Are aware of typical categories of problems that should be investigated—pressure sores, restraints, etc. • Have the ability to prioritize areas for investigation. • Understand how the initial focus, overall decision making and critical thinking will impact the entire survey outcome. • Communicate with team members using effective listening and negotiating skills. • Use team consensus to facilitate critical thinking and decision making. *(Activity: Direct students to the handout "Teams and Teamwork" on page 2-I-53 and have them work through the questions in teams. Then discuss each team's answers.)*

Audiovisual

Outline or text of presentation

Lesson 2-I:
Information Analysis for
Deficiency Determination:
Team Consensus Building

Questions

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Skill Assessment

Information Analysis for Deficiency Determination: Team Consensus Building

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Defined a finding.	
					Discussed the impact that thinking, questioning, assumptions and mental channels have on perception of findings and noncompliant practices.	
					Knew what findings to look at.	
					Discussed the difference between a finding and the determination of noncompliance.	
					Discussed the ways teams build consensus and how decision making is affected by team dynamics.	

Comments/Recommendations:

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX

Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1
Actual harm that is not immediate	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F PoC Required* Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A No PoC No remedies Commitment to Correct Not on CMS-2567	B PoC	C PoC
	Isolated	Pattern	Widespread

Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

Teams and Teamwork

Scenario

Your team is on the third day of the annual survey at Happy Days Convalescent Home. It is a 140-bed dually certified facility. When the team entered, the census was 98 residents. The resident sample is 12 in Phase 1, eight in Phase 2, five comp, 12 focused.

During one of the interviews, the resident states that he has been awakened three times this month in the early morning between 4 and 5 a.m. to have his shower. When the surveyor asked what his preference was regarding bathing, the resident stated that he preferred to shower when he got up around 8:00 a.m. but that staff had told him if he wanted a shower at all that week he needed to stay on the schedule. When asked how it affected him, he said he couldn't go back to sleep and then he was tired the rest of the day and ended up sleeping through some of the activities he wanted to participate in.

A review of the shower schedule revealed that for the 98 residents, there were only two shower aides scheduled Monday through Friday, and they were responsible for all the residents' showers.

Data

Of 12 sample residents interviewed, eight stated that they were woken up very early for showers or had to wait until late in the day for bathing. Two residents stated that they had not been bathed in the last two weeks, because they missed their scheduled time. Of the eight residents, three had been assessed by the facility to have severe impairments in decision making. Severe impairments means the resident rarely or never made decisions despite being provided with opportunities and appropriate cues.

The facility was aware of the shower schedules and shower aide schedules. The shower aides were interviewed and stated that for them to get everything done residents had to stick to the schedule.

Issue

The surveyor who found the issue states this is a "G," as residents are not getting bathed, their preferences are not being acknowledged or accommodated and it impacts their quality of life. Some of the surveyors don't agree and believe it is an "H." Others believe it is an "E." One surveyor wants to interview the other sample residents and ask questions regarding the issue at the group meeting.

The team has 10 minutes to resolve the disagreement and come up with a solution.

Observer

1. What different roles did you see enacted?

2. Did the group accomplish its task within the prescribed time limit? Why or why not?

3. What dynamics among the group members did you note? How did they treat one another?

4. Describe how your current team functioned in the *Teams and Teamwork* exercise.

Note: The following document is a sample of a State-developed protocol.

BASIC - NH COMPLAINT/INCIDENT INVESTIGATION PROTOCOL

Draft #15a 6/27/05

PURPOSE: To guide investigation of allegations in order to determine provider compliance with federal and state regulations.

IMPORTANT CONSIDERATIONS: This protocol provides guidelines for investigations covering a broad range of issues. Each complaint/incident is unique. The investigation is to be tailored to the issue/s and focused on those areas where Residential Care Services (RCS) has regulatory authority. Investigators may identify issues that need to be referred to other oversight and/or regulatory agencies for follow-up.

Effective communication is key to complaint/incident investigations. The investigator is to be courteous, respectful, objective, neutral and communicate with providers, staff, residents and collateral contacts in a clear and easily understood manner. Interviews are to be conducted using good communication principles. The investigation is to be thoroughly documented in an accepted RCS format.

OFFSITE PREPARATION

A. TASK 1 – Identify/Clarify Issues

1. Review CRU Intake Form
   - Identify preliminary issues
2. Contact Complainant:
   - "*Incidents*"– **Do not** interview Facility Reporter prior to going onsite
   - "*Complaints*" – **Do** interview** Complainant. Explain their confidentiality will be respected and that their name would only be disclosed in a legal hearing.

   Questions to consider:
   - When do they typically visit?
   - What are their concerns?
   - How did they become aware of the issues/s?
   - When did it happen? Has it happened before?
   - Did they tell anyone? If so, whom? Is the facility aware?
   - What has the facility done about it?
   - Is it still a problem?
   - Has it happened before?
   - How did it affect the resident?
   - Is the resident able to describe what happened/identify perpetrator?
   - If not, who could provide additional information?

- Have other residents been affected?
- Is there another resident/family member/visitor they are concerned about?
- Is there a particular staff member they are concerned about?
- When might that person be on duty/in the NH?
- Do they have any other concerns?

**As each situation is unique, the information in the Intake needs to be carefully reviewed and then, a decision made whether it is prudent to interview the complainant prior to the onsite investigation. This applies to both public and mandated reporter complainants.

B. Preliminary F tag and/or WAC Selection

Nursing home regulations include federal tags – CFR's (Code of Federal Regulations) and state WAC's (Washington Administrative Code for Nursing Homes)

Federal Tags:

- Appendix PP - CFR Part 483, Subpart B

State WAC's:

- Chapter 388-97 – Nursing Homes

RCW:

- 74.34 Abuse of Vulnerable Adults
- 70.02.050 – Disclosure without patient's authorization

Additional Resources:

- *Purple Book*
- *CMS Complaint Investigation Guidelines*
- *CMS Protocols*

The individual protocols list federal and state regulations most commonly involved with the concern that triggers the investigator to use that protocol. They also remind the investigator to consider any and all regulations pertinent to the complaint/incident report.

C. Review History –**Facility Complaints/Incidents (C/I) History**

*****Resources – QAN, Surveyors, NH File, License History Memo, NH Tracking System**

- **To View Complaint Intakes - RCS Complaints Report View web site** http://aasaweb.dshs.wa.gov/cru/complaintview
- **To Identify Complaint Frequencies/Dates and/or Priority Levels – NH File, NH Tracking System, Aspen Data Base, Quality Indicators, Oscar 3 & 4, Ombudsman and Aspen Complaint Tracking System (ACTS)**
- **For Summaries, Citations, Enforcement – NH File, NH Tracking System and License History Memo**

Alleged Victim/Alleged Perpetrator Complaints/Incidents (C/I)

- Review previous complaints/incidents with similar/same issues, victims, alleged perpetrators or residents

- Additional Sources for Alleged Victim/Alleged Perpetrator/Resident History – RCS Complaints Report View – website or CRU "Person Info View" - website http://aasatomcat1.dshs.wa.gov/cru/crupersoninfo
- RN/LPN/or other licensed professional history website: http://fortress.wa.gov/doh/hpqa1/hpqamain.htm.
- NAC/NAR history - check with the certified nursing assistant registry (OBRA) http://aasaweb.dshs.wa.gov/dohobra/default.htm

➢ **Status of Facility**

- License number, number of licensed and certified beds and where in the building the beds are located
- Most recent full survey and abbreviated survey findings
- Conditions on license
- Compliance status
- Enforcement History

➢ **Management/Ownership Issues**

- Recent changes

D. Plan Approach

1. Special Considerations

➢ **Process**

- Prepare a written plan
- Write the interview questions down
- Make preliminary regulation selection
- Do not take the Intake Routing form into the facility
- Take Appendix PP and Appendix Q
- Bring a camera, film and batteries. Follow established procedure – MB 03-072 (including asking permission before taking pictures).

➢ **Confidentiality Concerns**

- Protect the confidentiality of the complainant, each resident involved and others identified in the complaint/incident
- Consider privacy when interviewing, not divulging names of those interviewed to staff, families or facility administration

➢ **Planning the Entrance**

Timing of Visit:

Attempt to coordinate with:

> Time of day and/day of the week the issue is most likely to reoccur
> When alleged perpetrator/caregiver is working
> When there might be short staffing (if that is an issue)

Coordination & Joint Visits:

- Review relevant police/medical or other outside agency report
- Coordination prior to onsite investigation for the following referrals (listed on Intake):
  - > Local law enforcement (LLE) only – contact LLE to coordinate investigation
  - > Resident Protective Program (RRP) only – no need to call to coordinate investigation with RPP
  - > RPP and LLE – call RPP (who will coordinate with LLE)
  - > APS only – coordinate with APS
- Coordinate investigative plan with Field Manager as needed
- Joint visit with another licensor/investigator for concerns of safety, uncooperative or hostile environment or a need to have a second set of "eyes & ears"

Tour – Full or Partial

- Full tour required for first visit to NH
- Partial tour when pertinent. Confine tour to issues.

2. Observation Planning

Focus the observations on the issues. If there is an existing protocol, use that protocol's observation section as a guide in conjunction with the following guidelines.

Pertinent to the concern:

Who needs to be observed? Resident/s? Staff? Others?

Resident:

Appearance, hygiene, apparel?
Demeanor – behaviors/mood - appear comfortable, relaxed, happy
Cognitive status? Communication capabilities?
Mobility – limitations/adaptive devices?
IV's, feeding tubes, catheters, splints, bruises, bandages, etc.
Injured/affected area of body (ask permission to observe)
Restraining devices or practices
Interactions – with staff and other residents
Resident's room – homelike? Personal belongings reflect history and/or preferences? Clear pathways? Safety issues?
Quality of life concerns?
Isolated/secluded – door closed, meals in room, controlled access unit

Staff:

Interactions – with residents, other staff
Respectful of resident privacy/dignity/independence?
Interventions/assistance provided to residents?

Redirection/cueing provided?
Adequate supervision/staffing?
Techniques, skills?

What needs to be observed?

General observations:

Atmosphere – welcoming, homelike versus sterile

Environment – odors, cleanliness, lighting, temperature, safety hazards – inside/outside, egress – restricted/blocked, clear pathways, pets, uneven surfaces, screens,/pests, oxygen storage & signage/handling. Safety issues in kitchenette/common areas.

Accommodations - accessible phones, lowered sinks, bedside commodes, siderails, etc.?

When/where should the observations be done?

> In conjunction with treatments, activities, mealtimes, time of day/day of week, specific shift(s), when certain staff/residents are present?
> Nursing home? Hospital or other setting?
> Specific location of incident/occurrence?

Number of observations – As indicated by the concern

3. Interview Planning

Based on the circumstances and information obtained, decide whether or not to interview the resident. Ask open ended questions. Establish a rapport. Avoid leading questions. Focus the questions on the issue/s and obtaining information for purposes of determining compliance. If there is a protocol specific to the reported issues(s), use that interview section in combination with this section to plan the interviews.

Pertinent to the concern:

Who needs to be interviewed?

> Residents, Residents alleged as victims and alleged as perpetrators, Resident Representatives, Administrators, Staff, Alleged Staff Perpetrators, Visitors, Family, Roommates, prior Residents, LTC & MH Ombudsmen, Health Care Providers, Other Agency Staff – HCS/DDD/MH Case Managers, Activity Centers, Local Law Enforcement, APS, etc.
> If targeted resident not in the home or to protect their confidentiality consider interviewing other residents

When/Where to do the interviews?

> Before going on site?
> Before or after observations?
> Best setting?
> Special accommodations needed?
> If targeted resident not in the NH, consider interviewing in new location (hospital, another residence, etc.)

General Questions:

- Are they aware of, or concerned about, the reported issues/s?
- How has this issue affected the resident(s)?
- How did they become aware of the problem?
- How long has it been going on?
- Have they told anyone?
- Is the facility aware?
- What has the facility done about it?
- Has the problem been corrected?
- Do they have any other concerns?

Resident Specific Questions:

- How long have you lived here?
- How do you feel about living here?
- How are you treated?
- Who takes care of you?
- What do they do for you?
- Do staff give you the assistance you/your condition requires?
- Do staff come when you call?
- How does staff/other residents talk to/treat you?
- Are there rules related to living here? Bedtimes, meal times, visitor, etc.?
- Can you leave your room when you what to?
- How do you spend your time, like to do or are interested in, etc.?
- If dissatisfaction, boredom, fears, etc. are expressed, ask specifically what happened that caused them to feel that way.

Probes Related to Reported Concern:

> I heard this happened. Tell me about it. (who, what, where, when, why)

> How did it make you feel/affect you? Ask for specifics that describe/explain what type of outcome they had. i.e., "It made me nervous. I couldn't sleep for a week".

> Has this happened before? (when, where, what shift/what day of the week, etc.)

> Who did you tell? Is the facility aware of this concern?

> What has they done about it?

> Is it still a problem?

> Do you have any other concerns?

Family/Collaterals Questions:

- How often are they in the home and how recently?
- What have been their direct observations?
- Do they have concerns regarding care and services or other issues?

Staff:

- What residents have had issues like the reported concern or had a change in condition? (ask in a manner that avoids divulging the nature of the complaint)
- What can you tell me about it?
  - > How did they become aware of the problem?
  - > When did it happen?
  - > Has it ever happened before?
  - > What have they done about it?
  - > Is it still a problem?
  - > What do they think may have caused it?
- What process (facility practice) do you follow for concerns related to the reported concern/change of condition)?
- Who do you communicate with when the reported concern/change in condition occurs?
- How do you ensure staff is aware of changes in the resident/resident's care plan?
- Can you show me your documentation?
- Do they have concerns regarding care and services or other issues?

Issue Specific Questions:

- Refer to existing protocols and/or develop individual questions as indicated

4. Record Review Planning:

- Make preliminary decisions regarding which records need to be reviewed (MDS, etc.) and adjust/expand as needed based on information obtained on site.

ONSITE ACTIVITIES

TASK 2 - Onsite Process

The RCS investigator's role is not to do a criminal investigation, but to evaluate if the resident is safe and determine if there is failed facility practice.

- While onsite:
  - > For concerns regarding resident safety issues or criminal activity contact FM

1. Entrance Conference

- Investigator name/function/purpose of visit/business card
- If the licensee/administrator or designated facility representative is not present, request he/she be notified
- Establish a tone to encourage and facilitate communication
- Explain the purpose of the visit
- Provide a general description of issue/s. Avoid disclosing specific details
- Protect the confidentiality of those involved in the complaint, including the complainant
- Explain the investigation/inspection process
- Ask for documentation, information, etc. that need to be reviewed and let them know when it will be needed

2. Obtain Resident Census & Names of Staff on Duty

TASKS 3 (Modified)

3. Tour & Sample Selection

Tour as indicated by concern (modified Task 3)

TASK 4 - None

TASK 5

4. Observations

Initially observe the general environment of the home, staff and resident interactions and care and services being provided.

5. Interviews

- **Choose the best location considering:**
  - Privacy
  - Comfort/accommodation needs
- **Explain the process:**
  - Introduction/name/function/purpose of visit/business card
  - Ask the resident's permission to conduct the interview

- Ask resident's permission to contact collaterals
- Explain you will take notes
- Explain that their information will be kept confidential (if they so choose) unless there is a care or safety issue that would require informing the provider or it goes to a hearing

➢ **Conduct the interview:**

- Refer to pp. 5-6 of this document for interview guidelines.

6. Record Reviews:

- Decide which records need to be reviewed i.e., house policies, contracts, assessments, care plans, health care provider notes/orders, incident log, policy and procedure manuals, admissions and discharges, unofficial records such as bulletin boards and shift logs, personnel records, individual and group therapy schedules, work and recreational program content and schedules. Confine review to the issue(s).

Resident Records:

➢ **<u>Demographics</u>**

- Name/s, Date of Birth; Date of Admission; Diagnosis; designated Resident Representative (w/telephone number); Primary Health Care Provider (w/telephone number), Room #

➢ **<u>Resident's – Care/ Services Needs/Interventions:</u>**

- Baseline Data (pertinent to the issues):
  - > Risk factors, cognitive ability/psychosocial or behavioral status, communication ability, transfer/mobility status, ADL needs, dietary needs, medications, etc.
  - > Recent changes in medical/mental/physical/behavioral conditions and/or medications,
  - > History of related incidents/occurrences
  - > Other contributing factors
- Documentation of incident/occurrence
- Pertinent assessments – before and after incident/occurrence
- Pertinent interventions – prior to and after incident/occurrence
- Reevaluation after event
- Notifications

Facility Records:

➢ **<u>Review Pertinent Sources of Information</u>**

Confine review to the issue(s) and focus on:

1) Policies and Procedures
2) Orientation and Training Records
3) Staffing Schedules
4) Facility investigative documentation including Incident Reports
5) Admission & Discharge List

➢ **Personnel files**

- Name/s, Date of hire
- Current background checks with disclaimer and no disqualifying convictions
- Qualifications – i.e., Orientation to NH, Prevention and Abuse training, Other training pertinent to the issue(s), Continuing Education, Current CPR/First Aid Card, TB results, HIV/AIDS
- Current license
- OBRA NAC Registry findings
- Continuing education (pertinent training)
- Reference checks
- Evaluations/counseling for similar issues

TASK 6

b) Review & Analyze Data

- **Determine if sufficient information has been obtained:**

> ***Prior To Occurrence for Resident(s) "at risk"***

a) Identification Risk/Contributing Factors – did/should facility have identified resident to be "at risk"

b) Prevention – did facility develop interventions addressing risk factors

c) Intervention - did facility implement preventive measures as planned

d) Supporting Systems – did facility put systems in place to ensure provision of preventive measures (including sufficient/trained staff and sufficient resources)

> ***Resident(s) - After Occurrence:***

a) Facility Recognition and Response - timely including protecting resident as necessary

b) Evaluated/Assessed for Harm

- **timely and thorough**
- **acute clinical management provided as needed for medical/physical/psychological issues**

c) **Assessment updated when indicated**

d) **POC revised – as necessary**

e) **Interventions Implemented – timely and consistently**

f) **Re-evaluated – for effectiveness**

> ***If Outcome*:**

a) **Avoidable/preventable**

b) **Unavoidable**

- Is the facility's explanation of how and what happened consistent with the investigative findings?

c) **Conclusions validated with interviews, observations and record reviews**

d) **Investigation (when required) – thorough and in accordance with regulatory requirements**

- Did facility comply with reporting and notification requirements?
- Did facility recognize and address trends or patterns?
- If system problems, have they been corrected?
- Are appropriate interventions in place to prevent a reoccurrence for the resident and other "at risk" residents?

- **Determine If Failed Practice:**

> **Did the allegation occur?**
> Compare findings to F tags/WAC's
> Is there failed practice?
> If yes, what is the scope & severity?
> Confer with Field Manager as needed

TASK 7

8. Status Report On Exit

Use this opportunity to explain findings including identified deficiencies to the administrator or facility designee. Provide them with an opportunity to ask questions and present additional information. Ensure administrator/facility designee is aware of issues that need immediate attention.

- Review issues and findings
- Identify deficient practices with the appropriate regulation and/or statute (F tags/WAC)
- Provide them with an opportunity to discuss, ask questions and present related additional information.

- Inform them of the process that will follow i.e., what to expect, including further data collection (if indicated), the Informal Dispute Resolution (IDR) process and the Statement of Deficiencies (SOD) report.
- Clarify that if further information is obtained the administrator or facility designee will be contacted by telephone if there will be any additions or significant changes to the deficiencies discussed during the exit.

Specific to Citations - Explain:

- **The SOD will be mailed within 10 working days from the last date of data collection**
  - > The SOD cover letter explains:
  - > Process to follow if a Plan of Correction is required
  - > Plan of Correction must be mailed back within 10 calendar days
  - > Field Manager is a resource for questions regarding the findings
- Ensure the licensee/administrator or facility designee has a business card

OFFSITE ACTIVITIES & FINALIZATION

A. Complaint/Incident Completion

1. *If Data Collection is Complete:*
   - **Follow established RCS Principle & Procedure to write narrative report, write SOD and forward to FM for review**
   - **Enter data into NH tracking system**
   - **Enter data into ACTS**
   - **Make referrals following established CRU Complaint/Incident Referral Processing Principle & Procedure**
2. *If Data Collection is not Complete:*
   - Complete data collection
   - Determine if failed practice
   - Status report with facility (onsite/on the phone)
   - Follow steps as listed is section 1.
   - *** Definition of Outcome – an actual or potential result or consequence directly or indirectly related to failed or deficient practices of the licensee. Harm to residents that is not related to the home's failure is not an outcome for these processes. Source – NH Enforcement Policy and Procedure for Statement of Deficiencies – p. 12 – Revised November 21, 2001*

*******Note – These guidelines are meant to provide consistency and completeness across investigations. All citations are to be written to regulations, not to guideline and/ or best practice.***

Lesson 2-J:
Exit Conference

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the value of team preparation and coordination before the exit conference, including the importance of information gathering, communicating findings to facility staff during the survey and documenting decisions regarding the facility's compliance.
- Coordinate with team members to conduct an exit conference, following both Federal and State guidelines.
- Demonstrate appropriate conduct, including professional attitude, behavior and appearance during the exit conference.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 2, The Certification Process, Sections 2722–2726 and 2728B
  - Chapter 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, Section 7304D
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
  - Appendix H, Guidance to Surveyors: End-Stage Renal Disease Facilities
  - Appendix M, Guidance to Surveyors: Hospice
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

State

(Insert State reference[s] here.)

Other

Highlights

- Individual and survey team preparation prior to the exit conference
- *State Operations Manual (SOM)* directives and survey process requirements that address the exit conference
- Responsibilities of the survey team coordinator
- Appropriate conduct, including professional attitude, behavior and appearance during the exit conference

Training Techniques

- Lecture
- Group discussion
- Return demonstration
- Role-playing or script reading

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - *Exit Conference—A Procedure*

- *Exit Conference—Sample Script for Non–Long Term Care*
- *Exit Conference—Sample Script for Long Term Care*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Lesson 2-J:
Exit Conference

1

Slide 2-J-1

Outline or text of presentation

Exit Conference

At the end of every survey, under normal circumstances, the survey team provides an exit conference for facility representatives.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the value of team preparation & coordination before the exit conference, including the importance of information gathering, communicating findings to facility staff during the survey & documenting decisions regarding the facility's compliance.

2

Slide 2-J-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Coordinate with team members to conduct an exit conference, following both Federal & State guidelines.
- Demonstrate appropriate conduct, including professional attitude, behavior & appearance during the exit conference.

3

Slide 2-J-3

Audiovisual

Outline or text of presentation

Exit Conference

- At end of every survey, under normal circumstances, provide exit conference to facility representatives

4

Slide 2-J-4

Whether you survey a facility by yourself or as part of a team, you are expected to conduct an exit conference at the end of your survey, before you leave the facility.

Preparation

- Team members communicate concerns to facility staff throughout survey
- Team coordinator makes arrangements for exit conference:
  - Date
  - Time
  - Location

5

Slide 2-J-5

Preparation
Conducting a good exit conference begins with good preparation.

The team coordinator is responsible for working with other team members to identify a date and time for the exit conference. Team members need to keep the team coordinator informed of their progress in the survey and any concerns identified that need further investigation.

Team members need to communicate their concerns to facility staff during the survey, allowing staff the time to gather information to resolve the concerns. If not shared before the exit conference in sufficient detail, the facility can prolong the meeting with questions that need answers or documents that need review before the surveyors can leave.

The team coordinator arranges the date, time and location of the exit conference with the administrator or his/her designee.

Audiovisual

Preparation (cont.)

- Team members meet before exit conference to:
  - Determine deficiencies by consensus
    - Method to assure that each deficiency is discussed
  - Determine who will present findings

6

Slide 2-J-6

Outline or text of presentation

Team meeting

During the team meeting before the exit conference, team members need to reach consensus on the deficiencies they will cite. This is when the team shares information and coordinates it to make compliance decisions.

During this meeting the team needs to:

- Note the regulation number, paraphrase the regulation and note findings that support the noncompliance; it will make the exit conference easier.
- List all the deficient practices to discuss and have a method to ensure that none are missed; this can also help later when writing the deficiency report.
- Lastly, agree on how to conduct the meeting and present findings to facility staff.

Conducting the exit conference

The team coordinator can conduct the exit conference in one of two ways:

1. The coordinator alone talks.
2. The coordinator provides opening remarks and introduces the team members and then calls on each individual to present his/her findings or discuss certain deficiencies before the team coordinator provides closing remarks and gives the facility staff an opportunity for questions.

(Distribute the handout "Exit Conference—Sample Script for Non–Long Term Care" or "Exit Conference—Sample Script for Long Term Care" on pages 2-J-21 and 2-J-23, respectively.)

Audiovisual

At Exit Conference

- Team coordinator
  - Thanks facility staff for their cooperation
  - Introduces team members individually
  - Discusses reason for survey & survey process
  - Explains that exit conference is informal meeting covering preliminary findings
  - Explains ground rules for meeting
  - Presents findings of noncompliance

7

Slide 2-J-7

Outline or text of presentation

During the exit conference, the team coordinator:

1. Thanks everyone for his/her cooperation throughout the survey.
2. Introduces all team members, mentioning any who have finished their portion of the survey and have already left the facility.
3. Discusses the reason for the survey (i.e., annual, complaint, revisit, validation) and the general survey process.
4. Explains that the exit conference is an informal meeting to discuss preliminary findings.
5. Explains how the team will conduct the conference and lists any ground rules (e.g., wait until a surveyor finishes discussing each deficiency before commenting, or wait until all findings have been presented before commenting). The coordinator states whether the provider will have the opportunity to present additional information or submit additional evidence before the team departs.
6. The team presents the findings of noncompliance, explaining why each is a violation of a regulation. If asked, the team will paraphrase the regulation.

Present information in a manner understandable to all present. If you discuss an individual, do not use the person's name or information that would easily identify that person.

Audiovisual

At Exit Conference (cont.)

– Concludes discussion of survey findings by explaining what happens after team leaves facility:
  - Statement of Deficiencies
  - Plan of Correction
  - Time frames

8

Slide 2-J-8

Outline or text of presentation

After discussing the survey findings, the team coordinator explains what happens after the team leaves the facility. The team writes its findings and submits its report to their supervisor. The office then mails the official Statement of Deficiencies to the facility within 10 calendar days.

For non–long term care facilities
If the team identifies immediate jeopardy, the team coordinator explains the significance and the need for immediate correction.

For long term care facilities
If the team identifies either substandard quality of care or immediate jeopardy, the team coordinator explains the significance. For immediate jeopardy, the coordinator explains the need for immediate correction.

For non–long term care and long term care facilities
Once the facility receives the Statement of Deficiencies, staff has 10 working days to provide a Plan of Correction (POC).

For deemed providers and suppliers
Once the facility receives the Statement of Deficiencies, if a Condition of Participation is cited, staff has 10 working days to provide a POC. If the facility does not have a Condition of Participation that is not in compliance, CMS requests that the facility provide a POC that may be released to the public if CMS receives an inquiry.

For non–long term care facilities
For each deficiency and each deficient practice within each deficiency include:

- Corrective action to be taken for each individual affected by the deficient practice, including systemic changes.

Audiovisual

Outline or text of presentation

- The position of the person who will monitor the action and the frequency of the monitoring.
- Completion dates.

For long term care facilities
For each deficiency and each deficient practice within each deficiency include:

- Corrective action for each resident affected by the deficient practice.
- Corrective action for each resident *at risk* for the same deficient practice.
  - Include planned system changes to ensure the deficient practice will not occur again.
- The position of the person who will monitor the action and the frequency of monitoring.
- Completion dates.

Meeting Tension

- Team coordinator may refuse to continue exit conference if:
  - Environment is overly hostile or intimidating
  - Facility legal counsel tries to make it evidentiary hearing
- Team coordinator contacts supervisor for direction

9

Slide 2-J-9

If a problem arises (such as the facility arguing about a finding or verbalizing the same information provided earlier), the team coordinator handles it. Under these circumstances, it is suggested that the team coordinator:

1. Stop the exit conference and call the team's supervisor for further direction.

or

2. State that the exit conference is concluded and that the survey agency will contact the facility.

In the case of #2, the team leaves the facility immediately and the team coordinator contacts the supervisor immediately after leaving.

The team leader explains that a Plan of Correction must be submitted and accepted by the survey agency and, possibly, the CMS Regional Office. The facility will receive a letter detailing all necessary information.

Audiovisual

Outline or text of presentation

Once Exit Is Completed

- All team members leave together immediately following meeting
- If facility presents further information, team decides who will remain for review

10

Slide 2-J-10

Immediately following the exit conference, all team members leave the facility together. If facility staff present additional information for review, the team decides who should remain (it is suggested that two surveyors remain).

Team Member Responsibilities

- Dress appropriately
- Be prepared with information you will provide
- Refrain from making general comments (i.e., "Overall, the facility is very good.")
- Follow team coordinator's lead

11

Slide 2-J-11

New surveyors must:

- Dress appropriately.
- Be prepared with information you will provide—you may want to write it out.
- Refrain from making general comments, such as, "Overall, the facility is very good."
- Follow team coordinator's lead.

The *State Operations Manual (SOM)* includes information about the exit conference.

(Read and discuss SOM Sections 2722 through 2726. Review and discuss the handouts "Exit Conference—A Procedure," "Exit Conference—Sample Script for Non–Long Term Care" and "Exit Conference—Sample Script for Long Term Care" on pages 2-J-17, 2-J-21 and 2-J-23, respectively.

Based on the provider or supplier the students will likely survey, review the appropriate Appendix (listed in the Federal references at the beginning of this lesson) and read the information regarding the exit conference.

Audiovisual

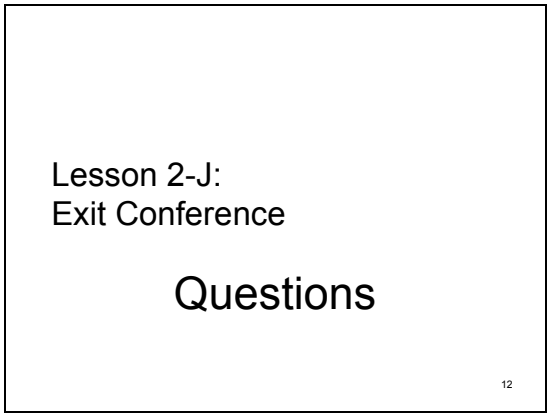
Outline or text of presentation

For more information on conducting an exit conference at a long term care facility, see Lesson 3-W, Exit Conference.

Role-play: read the appropriate sample script. Model proper surveyor conduct, including:

- *Maintaining an appropriate, professional demeanor.*
- *Displaying discretion.*
- *Avoiding undesirable behaviors and attitudes.*

One role-play should be a good example and one a bad example. After the first role-play, make a list of good and bad characteristics.)



Slide 2-J-12

Skill Assessment

Exit Conference—Team Coordinator

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					With facility staff and team: • Confirmed date, time and location of exit conference. • Organized team presentation.	
					For a long term care facility: • Invited Ombudsman and resident representatives. • If team chose, additionally held and appropriately communicated deficiencies during an abbreviated exit conference specifically for residents after the facility staff exit conference. • If an extended survey had not yet been completed, advised facility staff that deficiencies may be amended upon completion of the extended survey.	

					Communicated ground rules early in the exit conference.	
					Provided facility staff with an opportunity to discuss and supply additional pertinent information. (Because of ongoing dialogue, facility staff should have been made aware of all concerns prior to the exit conference and should have had an opportunity to present additional information.)	
					As necessary, discontinued the exit conference under conditions as described in the *SOM* (e.g., hostile, overly intimidating, inconsistent with nature of exit conference).	
					If immediate jeopardy was identified, explained its significance, need for immediate action and implications.	
					Followed *SOM* regarding taping of exit conference.	

Comments/Recommendations:

Skill Assessment

Exit Conference—Team Member

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Explained the value of preparation before the exit conference, including information gathering, communicating with facility staff and documenting decisions regarding facility's compliance.	
					Communicated findings with facility staff and survey team members throughout the survey.	
					Coordinated with team members to conduct the exit conference, following team decision regarding how to conduct it, using State and Federal directives.	
					Demonstrated appropriate conduct during the exit conference (i.e., professional appearance and demeanor).	

					Presented information clearly to those present and described the findings to substantiate a deficiency.	
					Refrained from arguing with facility staff. Remained receptive to disagreement.	
					Accurately and thoroughly explained the process of preparation of Statement of Deficiencies, timing and parts of an acceptable Plan of Correction based on the provider surveyed.	

Comments/Recommendations:

Exit Conference—A Procedure

Before the Exit Conference

1. Notify the administrator or designee of the date and time of the exit conference and any recommendations for who should be present. Arrange the location of the meeting.

   For long term care surveys:
   - Either invite two residents (and make arrangements for facility staff to assist them as needed) or plan an exit conference for residents at a specific location after the facility staff exit conference.
   - Notify or invite the Ombudsman, if applicable.

2. Team members meet to determine facility noncompliance and to document the regulation number(s) being cited, phrasing of the regulation(s) and supporting findings.

3. The team determines who will provide the findings of the survey (e.g., the team coordinator will provide all information, each team member will provide information or another method will be used).

4. If team members feel that they may encounter a problem during the exit conference, contact the supervisor or manager beforehand. Allow sufficient time to respond to any directions received.

During the Exit Conference

1. The team coordinator is responsible for the following actions:

   - Thanking everyone for his/her cooperation throughout the survey.
   - Introducing all team members, mentioning any that have finished their portion of the survey and left the facility.
   - Explaining the kind of survey (i.e., annual, complaint, revisit, validation).
   - Explaining that the exit conference is an *informal* meeting to discuss *preliminary* findings.
   - Explaining how the team will conduct the conference, and listing any ground rules (e.g., wait until a surveyor finishes discussing each deficiency before commenting, or wait until all findings have been presented before commenting).
   - Stating whether the provider will have the opportunity to present additional information or submit additional evidence before the team departs.

2. Throughout the exit conference, team members should refrain from making general comments such as, “Overall, the facility is very good.”

3. The team coordinator or team members present the findings of noncompliance, explaining why they are citing a violation and providing the regulatory basis if asked. In so doing, paraphrasing the regulation is allowed.

    - Present information in a manner understandable to all present.
    - *Do not identify individuals.*
    - *Do not provide either the regulatory tag number or scope and severity.* Remember, you are providing preliminary team decisions, not individual decisions, and your office will make the final determination of deficiencies.

4. If the team identified a condition of immediate jeopardy or potential substandard quality of care, the team coordinator explains the significance and the need for immediate correction. (Consequences vary according to provider type.)

5. If a problem arises such as the facility staff arguing about a finding, the team coordinator handles it. The *State Operations Manual (SOM),* Section 2724, states:

    > If the provider is represented by counsel (all participants in the exit conference should identify themselves), surveyors may refuse to continue the conference if the entity's lawyer tries to turn it into an evidentiary hearing; or
    >
    > Any time the provider creates an environment that is hostile, overly intimidating, or inconsistent with the informal and preliminary nature of an exit conference, surveyors may refuse to conduct or continue the exit conference.

    Under the above circumstances, the team coordinator should (1) stop the exit conference and call the team's supervisor for further direction, or (2) state that the exit conference is concluded and that the survey agency will contact the facility. In the latter case, the team leaves the facility immediately and the team coordinator contacts the supervisor immediately after leaving.

    SOM Section 2724 also states:

    > . . .If the facility wishes to audiotape the exit conference, it must tape the entire meeting and provide the surveyors with a copy of the tape at the conclusion of the conference. Videotaping is also permitted if it is not disruptive to the conference, and a copy is provided at the conclusion of the conference. It is at the sole discretion of the surveyor(s) to determine if videotaping is permitted.

6. The team coordinator explains that the facility will receive a Statement of Deficiencies within 10 days. The facility is to write a Plan of Correction and has 10 days to provide it to the survey agency. The administrator must sign the form before returning it.

7. The team coordinator also explains the parts of the Plan of Correction, consistent with the requirements for the type of provider:

   Long Term Care

   SOM Section 7304D states that an acceptable Plan of Correction must:

   - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
   - Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   - Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. (The facility must develop a plan for ensuring that corrective action is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The Plan of Correction is integrated into the quality assurance program).
   - Include dates when corrective action will be completed. (The corrective action completion dates must be acceptable to the State. If the Plan of Correction is unacceptable for any reason, the State will notify the facility in writing. If the Plan of Correction is acceptable, the State will notify the facility by phone or e-mail. Facilities should be cautioned that they are ultimately accountable for their own compliance and that responsibility is not alleviated in cases where notification about the acceptability of their Plan of Correction is not made timely. The Plan of Correction will serve as the facility's allegation of compliance.)

   For long term care surveys, if requested, the surveyors provide a list of residents included in the standard survey sample.

   Non–Long Term Care

   SOM Section 2728B states that an acceptable Plan of Correction must contain the following elements:

   - A plan for correcting the specific deficiency. The plan should address the processes that led to the deficiency cited.
   - The procedure for implementing the acceptable Plan of Correction for the specific deficiency cited.
   - The monitoring procedure to ensure that the Plan of Correction is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements.
   - The title of the person responsible for implementing the acceptable Plan of Correction.

   In addition, the facility is to list the date when it will be in compliance for each deficiency or deficient practice.

8. The team coordinator explains that the facility must submit a Plan of Correction which the survey agency and, possibly, the CMS Regional Office reviews for acceptance. The facility will receive a letter with all necessary information.

9. Following Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, the team coordinator gives facility staff a list of all patients or residents whose records surveyors reviewed during the survey.

After the Exit Conference

All team members leave the facility together immediately following the exit conference. If facility staff presents additional information for review, the team decides who should remain. It is suggested that two surveyors remain.

Exit Conference—Sample Script for Non–Long Term Care

Follow survey agency protocol, but it is recommended that all attendees sign a signature sheet with their name and position.

"Good [morning, afternoon]. Thank you for coming. This is the exit conference for the [annual/validation/revisit/complaint] survey. It will be an informal meeting to discuss the team's preliminary findings. I am [ ], the team coordinator for this survey. Permit me to introduce my team members."

The team members may also introduce themselves.

Depending on the number in attendance and other circumstances, ask facility staff to introduce themselves, or the administrator may introduce his or her staff and attendees (e.g., consultants, attorneys, governing body members, etc.).

The team leader addresses the administrator.

"I want to thank you and your staff for your courtesy and cooperation during the days of our survey. I also want to recognize and thank the patients/clients. As voluntary participants of the Medicare/Medicaid program for which this facility receives Federal monies, the facility is required to be in compliance with all Federal regulations."

"To determine compliance with the Federal regulations, we have been onsite for the last [ ] days and have determined our findings through multiple observations of care and services, of administration of medications and of meals; through interviews with patients or clients, families, direct care and administrative staff; and through review of medical records and facility documents."

"The purpose of this exit conference is to share the team's preliminary findings with facility staff. We will address our individual findings, but not specific tag numbers as directed by Federal procedures. Since we have shared our findings with you throughout the survey, there should be no surprises. The team will address questions at the end of this presentation, so please hold your questions until then."

"Now I'll call on each team member individually."

Provide findings using language understood by all present. Do not use an individual's name. Avoid statements such as, "The condition was not met."

When all are finished, address the team members.

"Is there anything else that needs to be addressed?"

Ask facility staff, *"Do you have any questions?"*

"We will submit these findings to a supervisor for review. We will mail Form CMS-2567, Statement of Deficiencies and Plan of Correction, to the facility within 10 working days. The facility may be required to submit a Plan of Correction. If so, for each deficiency, address the following:

- *The plan for correcting the specific deficiency. The plan should address the processes that led to the deficiency cited.*
- *The procedure for implementing the acceptable Plan of Correction for the specific deficiency cited.*
- *The monitoring procedure to ensure that the Plan of Correction is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements.*
- *The title of the person responsible for implementing the acceptable Plan of Correction.*
- *The date of compliance for each deficiency or deficient practice."*

"Our office will provide written instructions to you."

If the team identified a condition of immediate jeopardy, add the following:

"During the survey, we identified that at least one individual was in immediate jeopardy for personal health and safety. We discussed this with our supervisor and have brought this serious finding to the attention of your staff. The facility needs to identify and implement corrective action as soon as possible. If not corrected quickly, it will jeopardize the facility's participation in the Federal Medicare program."

"Here is a list of all patients whose records we reviewed during the survey."

"Thank you again for your hospitality."

Exit Conference—Sample Script for Long Term Care

Follow survey agency protocol, but it is recommended that all attendees sign a signature sheet with their name and position.

"Good [morning, afternoon]. Thank you for coming. This is the exit conference for the [annual/validation/revisit/complaint] survey. It will be an informal meeting to discuss the team's preliminary findings. I am [ ], the team coordinator for this survey. Permit me to introduce my team members."

The team members may also introduce themselves.

Depending on the number in attendance and other circumstances, ask facility staff to introduce themselves, or the administrator may introduce his/her staff and attendees (e.g., consultants, attorneys, governing body members, etc.).

The team leader addresses the administrator.

"I want to thank you and your staff for your courtesy and cooperation during the days of our survey. I also want to recognize and thank the residents. As voluntary participants of the Medicare/Medicaid program for which this facility receives Federal monies, the facility is required to be in compliance with all Federal regulations."

"To determine compliance with the Federal regulations, we have been onsite for the last [ ] days and have determined our findings through multiple observations of care and treatments, of administration of medications and of meals; through interviews with residents, families, direct care and administrative staff; and through review of medical records and facility documents."

If the team identified substandard Quality of Care, use the following wording:

"During the survey, team members identified substandard quality of care and have discussed this with our supervisor. As a result, we investigated regulations in addition to those normally included in a survey."

"The purpose of this exit conference is to share the team's preliminary findings with facility staff. We will address our individual findings, but not specific tag numbers or the scope and severity of findings as directed by Federal procedures."

"Since we have shared our findings with you throughout the survey, there should be no surprises. The team will address questions at the end of this presentation, so please hold your questions until then."

"The medication error rate for the facility was [ ]."

"Now I'll call on each team member individually."

Provide findings using language understood by all present. Do not use an individual's name.

When all are finished, address the team members.

"Is there anything else that needs to be addressed?"

Ask facility staff, *"Do you have any questions?"*

"We will submit these findings to a supervisor for review. We will mail Form CMS-2567, Statement of Deficiencies and Plan of Correction, to the facility within 10 days. The facility may be required to submit a Plan of Correction. If so, for each deficiency, address the following:

- *How corrective action will impact each resident affected by the deficient practice.*
- *How facility staff will identify other residents potentially affected by the same deficient practice.*
- *What measures the facility will put into place or systemic changes it will make to ensure that the deficient practice will not recur.*
- *How the facility plans to monitor its performance in sustaining the solutions.*
- *Dates by which to complete the corrective action."*

"Our office will provide written instructions to you."

If the team identified a condition of immediate jeopardy, add the following:

"During the survey, we identified that at least one individual was in immediate jeopardy for personal health and safety. We discussed this with our supervisor and have brought this serious finding to the attention of staff. The facility needs to identify and implement corrective action as soon as possible. If not corrected quickly, it will jeopardize the facility's participation in the Federal Medicare program."

"Here is a list of all residents whose records we reviewed during the survey."

If requested, provide a list of residents included in the standard survey sample.

"Thank you again for your hospitality."

Lesson 2-K: Completion of Form CMS-2567

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Understand the purpose and uses of Form CMS-2567, *Statement of Deficiencies and Plan of Correction.*
- Verbalize ways to avoid problems identified by others when reviewing Form CMS-2567.
- Successfully complete Form CMS-2567.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Section 2728

State

(Insert State reference[s] here.)

Other

Highlights

- Understand the purpose and uses of Form CMS-2567, *Statement of Deficiencies and Plan of Correction*
- Verbalize ways to avoid problems identified by others when reviewing Form CMS-2567
- Successfully complete Form CMS-2567

Training Techniques

- Lecture
- Group discussion
- Small group or individual exercise

Training Aids

- PowerPoint slides and handouts
- Handout:
  - *State Performance Standard #2 - Fiscal Year 2005, Following the Principles of Documentation*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 2-K:
Completion of Form CMS-2567

1

Slide 2-K-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Understand the purpose & uses of Form CMS-2567, *Statement of Deficiencies & Plan of Correction.*
- Verbalize ways to avoid problems identified by others when reviewing Form CMS-2567.
- Successfully complete Form CMS-2567.

2

Slide 2-K-2

(Inform the students of the objectives.)

Decision Making

- Deficiency will be determined only when team can demonstrate that circumstances constitute deficiency under particular regulatory requirement
- Record tag number, comment about regulation & patients or other factors affected
  - Have we made needed observations?

3

Slide 2-K-3

Decision Making

A survey requires an investigation and the cooperation and support of each team member.

At the end of the survey, the team will determine the entity's compliance with regulations. A deficiency will be determined only when the team can demonstrate that the circumstances constitute a deficiency under a particular regulatory requirement.

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Decision Making (cont.)

– Have we interviewed all individuals for needed information?
– Have we reviewed all related documents & asked staff whether there are other documents available for review?
– Do we have copies of medical records, policies & procedures & other documents to support our decisions?
• Note & get missing pieces before exit conference

4

Slide 2-K-4

Outline or text of presentation

If a tag number is not required by a specific survey procedure and you determine the entity is not in compliance, you should record the tag number and a comment about the regulation and the patients, clients, residents or other factor affected or potentially affected.

Always ask:

- Have we made the needed observations?
- Have we interviewed all individuals for the needed information?
- Have we reviewed all related documents and asked the staff whether there are other documents available for review?
- Do we have copies of the medical records, policies and procedures and other documents to support our decisions?

Make sure you have all missing pieces before you conduct the exit conference.

At some point, you will complete the *Statement of Deficiencies and Plan of Correction*, Form CMS-2567.

Purposes of Form CMS-2567

• Communication to provider
• Basis for certification decision
• Legal document
• Public record

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Slide 2-K-5

Purposes of Form CMS-2567

- Communication to the provider.
- Basis for certification decision.
- Legal document.
- Public record provided upon request under the Freedom of Information Act, or in long term care facilities posted for the public to read.
- Direct evidence of noncompliance with a regulatory requirement.

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Purposes of Form CMS-2567 (cont.)

- Shows direct evidence of noncompliance with regulatory requirement
- Information of factual & objective nature:
  - Observations
  - Interviews
  - Review of documents
  - Identification of potential or actual outcome(s)

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Slide 2-K-6

Outline or text of presentation

- Information of a factual and objective nature:
  - Observations.
  - Interviews.
  - Review of documents.
  - Identification of potential or actual outcome(s).

Any survey may result in a hearing. Therefore, from the beginning you need to think ahead to that potential hearing. Will the judge need certain information to uphold your claim of a deficiency? If so, your investigation must obtain that information, and the *Statement of Deficiency* must report it in a manner the judge would understand.

The problem with Form CMS-2567 is that, although you will write it, State agency supervisory staff and perhaps CMS Regional Office staff will review it. Therefore, let's discuss some of the problems they frequently identify.

Problem #1: Survey Process Not Followed

Potential problem areas:

- Observation
- Interview
- Document review

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Slide 2-K-7

Problem #1: Survey Process Not Followed

Potential problem areas:

- Observation.
- Interview.
- Document review.

One of the questions frequently asked is: Did the team follow the survey process and investigate using appropriate observations, interviews and document review?

For example:

- A long term care deficiency report could address a resident's not walking with facility staff one day, but not address walking on the other days of the four-day survey.

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Outline or text of presentation

- A hospital deficiency report could state medications were unlocked in one nursing unit on one day, but not have information about medications being unlocked in other nursing units or on other days of the survey.
- The Life Safety Code deficiency report may include an observation, but not include mention of an interview or, if appropriate, a review of a facility policy and procedure or other relevant facility document.

Problem #2: Survey Did Not Document Information Needed Later

- Document information that answers following questions:
  - Who?
  - When?
  - Where?
  - What?

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Slide 2-K-8

Problem #2: Survey Did Not Document Information Needed Later

Not carefully documenting information you may need later is a problem.

As a rule, you should document information that answers the following questions:

- Who?
- When?
- Where?
- What?

(Stop and review what must be included when documenting an observation, an interview and a document review.)

If a quote or information from the facility document will support your deficiency, get a copy. If the facility has a related policy and procedure, get a copy.

In addition, if the facility appeals the findings of your survey and the enforcement action taken, opposing counsel often reviews your surveyor notes. The Federal Office of General Counsel may use them as hearing exhibits. Organize them logically. Use official forms when required. Express your

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Outline or text of presentation

thoughts in complete sentences so that you will be able to remember what you meant when you review them, possibly several months later.

If possible, note both the question and the answer so the judge will understand the issue. If the entity provided information showing it thought it met the regulation, explain in Form CMS-2567 why you judged the practice was deficient despite that information.

Problem #3: Survey Team Did Not Share Findings or Investigate Further

Potential problem areas:
- Observations
- Interviews
- Document review
- Issues or regulations common throughout surveyed entity
- Active or closed records

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Slide 2-K-9

Problem #3: Survey Team Did Not Share Findings or Investigate Further

Potential problem areas:
- Observations—were not made when appropriate throughout the survey or throughout the entity.
- Interviews—were not conducted with all staff appropriate to the issue.
- Document review—did not include review for the same issue by all surveyors.
- Issues or regulations common throughout the surveyed entity.
- Active or closed records—team focused on closed records rather than active records.

When the team meets, each member needs to begin to think and verbalize, “What is the problem?” and “What is the regulation that the practice may violate?”

Examine the regulatory language and its meaning. Is it directed toward entity policies, entity action or something else? Watch for “and” and “or” to determine whether there are two parts to the regulation that you must investigate.

Audiovisual	Outline or text of presentation
	Check the *Guidance to Surveyors (Interpretive Guidelines).* If the guidelines indicate specific ways you should investigate to determine a deficiency under a particular tag, make sure you do so. Check the guideline referrals to other regulations that specific actions may violate. Make sure guidelines do not interpret the requirements differently from the way you interpret them. If they do, discuss your interpretation with the team and your supervisor. Recognize professional standards. Be prepared to specify the standard and back it up with a specific resource that is nationally recognized. If the entity omitted something on the care plan, why is it a deficiency? What is "proper" hydration and health? Did the facility follow a different standard, but one that is still nationally accepted? If there is a repeated deficiency, review what the entity committed to do in the prior Plan of Correction and investigate to determine whether it fulfilled the specific commitments it made. If not, why not? Remember, individuals who work together as a team are always better than individuals in a group who work alone. You are a team, and we expect you to work together!

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Problem #4: Survey Team Did Not Identify Right Regulation or Significance of Findings

Potential problem areas:
- Lack of:
  - Training
  - Survey experience
  - Other
- Substandard quality of care or Condition of Participation or Coverage
- Immediate jeopardy

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Slide 2-K-10

Outline or text of presentation

Problem #4: Survey Team Did Not Identify the Right Regulation or the Significance of the Findings

Potential problem areas:
- Lack of:
  - Training.
  - Survey experience.
  - Other (e.g., lack of communication of all the facts).
- Substandard quality of care or Condition of Participation or Coverage.
- Immediate jeopardy.

Cite only practices attributable to the entity. If the deficiency resulted from its failure to do something, show that the entity should have known what action was required. If the deficiency discusses involvement of a physician or other individual, explain why the deficiency is attributable to the entity and not the physician.

Take a mental step back and evaluate what you are hearing and saying. Do you have an instance that is egregious or a pattern of problems or a system that is not in place and has or could cause serious harm to patients, clients or residents? Do you need to get out Appendix Q and review it for immediate jeopardy before you exit?

If there is actual harm, obtain evidence to show why there is a deficiency in the particular requirement. Get evidence that shows that harm resulted from the deficiency. In long term care facilities, you should be able to explain why the potential for harm is more than minimal harm.

It is always easier to read Form CMS-2567 as a person who was not on the survey and find the holes in the team's investigation.

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Problem #5: Poor Documentation

Recommended solutions:
- Address audience
- Write facts in chronological order
- Include only relevant information
- Be attentive to details

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Slide 2-K-11

Outline or text of presentation

You have to learn to mentally examine your information while you are still conducting the survey.

Problem #5: Poor Documentation

Recommended solutions:
- Address your audience.
- Write facts in chronological order.
- Include only relevant information.
- Be attentive to details.

Address your audience. Judges, lawyers and lay public are not health professionals. Explain medical terms and diagnoses not generally known. For example, if it is a medication, explain its nature and use (e.g., it helps control blood sugar or blood pressure, etc.). When citing abnormal laboratory values, give the range that is normal for results. If there was weight loss, cite not only the pounds but also the percentage. Use short, simple sentences.

Write facts in chronological order, but if the findings are long, consider summarizing them at the top of the chronological narrative so the reader knows what to look for later.

Include only the information relevant to the deficiency under that tag. However, include ALL the information relevant to that tag rather than cross-referencing to another tag.

Be attentive to details:
- Make sure the deficiency is listed under the right survey data tag.
- Check the spelling for each deficiency, then print the actual Form CMS-2567 and read all of it, including the regulations.

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Outline or text of presentation

- Compare the regulation to the deficient practice. Does the deficient practice reflect noncompliance with that regulation or another?
- Correctly identify patients, clients or residents and verify numbers. For example, if you cite problems with four individuals, do you list four individuals? Are the numbers in the extent or universe the same as the findings listed to support the deficiency?
- Check the month and year for accuracy.

Activity

Critique of Form CMS-2567

12

Slide 2-K-12

Optional Activities

(Option 1—Before the lesson, make copies of Form CMS-2567s that demonstrate one or more of the problems addressed above. Divide the students into groups and ask each group to review and identify the issues. Then have each group present its identified issues to the entire group.

Option 2—Distribute the handout "State Performance Standard #2 - Fiscal Year 2005, Following the Principles of Documentation." Review it and ask surveyors to use it to compare the requirements with Form CMS-2567 for the provider or supplier they are most likely to survey. Have each group report its findings to the entire group.)

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Outline or text of presentation

Lesson 2-K:
Completion of Form CMS-2567

Questions

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Slide 2-K-13

Skill Assessment

Completion of Form CMS-2567

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified at least three ways Form CMS-2567 is used in the certification of a health care entity.	
					Verbalized at least one way to avoid the following problems: • Not following the survey process. • Not documenting needed information. • Not investigating further. • Not citing findings at the right level (e.g., substandard quality of care, Condition level or immediate jeopardy).	
					Verbalized at least three items to check after writing Form CMS-2567.	

Comments/Recommendations:

State Performance Standard #2 – Fiscal Year 2005
Following the Principles of Documentation

	Criteria	Guidance and References
1	The citation has the full regulatory reference.	Include: (1) a survey data tag number, (2) the CFR or Life Safety Code (LSC) reference number, (3) the language from the regulatory reference, and (4) an explicit statement that the requirement was "NOT MET." [LSC is adopted by regulation. LSC (K-tags) and National Fire Protection Association (NFPA) numbers are NOT regulatory. LSC must cite the regulation (e.g., 483.70(a) for nursing homes) in introductory comments.] NOTE: The regulatory reference in ASPEN may not be correct. ASPEN may not be updated before new regulations go into effect. Regulatory reference is not automatic in all cases; e.g. F698 and LSC. Not all regulations have data tags, e.g. 483.20, 483.70(a), 482.41(b).
2	Evidence supports determination of noncompliance at the cited regulation.	Include the deficient practice(s) and findings that support a deficiency at the cited regulation. Note: In some cases the cited regulation may not always be the "best" tag, however, the evidence must have relevance to the cited regulation. REMINDER: Evidence is <u>both</u> a deficient practice AND its findings. 1. <u>Compare the survey date to the evidence dates</u>. Deficient practices, which occurred before the survey, must have evidence that the noncompliance is still present during the survey. If the noncompliance occurred in the past and does not exist on the current survey, <u>the entity is currently in compliance</u>. Example, a survey 06/01/03, with evidence 03/21-29/03 that <u>has been</u> corrected, does not show current noncompliance and Fails Criterion #2. 2. Carefully relate the evidence to the exact words and intent of the regulation. 3. There must be at least one deficient practice <u>and</u> one finding <u>showing the deficient practice</u> that relates to the regulation. The deficient practice may be inferred from the finding and need not be a "lead-in". However, a

		simple list of outcome findings such as descriptions of pressure sores, or a list of falls is not acceptable. 4. Criterion #5 evaluates the Condition-Standard-Element level while Criterion #3 evaluates the quality of deficient practices, Criterion #7 evaluates findings, and Criterion #11 evaluates plain language, including extraneous information.
3	Each Deficient Practice Statement clearly summarizes the provider/supplier failure(s) and quantifies a relevant extent.	To pass this criterion, answer "yes" to each of the following: • Does(Do) the deficient practice statement(s) summarize what the provider/supplier has failed to do to be in compliance with this regulation? • Does(Do) the Deficient Practice Statement(s) describe the resulting outcome or potential outcome for individuals, when relevant? • Does(Do) the Deficient Practice Statement(s) numerically identify the prevalence or frequency of the deficient practice? The deficient practice must: a. accurately and specifically summarize the findings, b. provide the reason basis or rationale for the findings of noncompliance AND c. quantify a relevant extent. Extent quantifies how many beneficiaries were affected and may be affected by the deficient practice. In non-nursing homes, a Condition is cited when, "...the deficiencies are of such a character as to limit the provider's or supplier's capacity to furnish adequate care..." 488.24(b) and 488.26(b). The extent must show a "limited capacity to furnish adequate care" if that is the basis for noncompliance. Example: Fifty of fifty psychiatric patients' care plans failed to demonstrate how staff is to evaluate the efficacy and side-effects of antipsychotic drug therapy. The deficient practice <u>should</u> explain the outcome and meaning of findings, but Criterion #3 does not automatically fail if outcome/potential outcome are not shown. Actual or potential outcomes must not be stated to be caused by unobservable events. Example: "Staff did not recognize symptoms of low potassium. The patient died because his potassium was 1.9 mEQ/l." "The facility failed to prevent pressure sores." Such statements may be derogatory or inflammatory and usually cannot be proven.

4	(For nursing homes) The scope accurately reflects the evidence and the residents who are, or may be, affected by the deficient practice.	Refer to the SOM, Appendix P, revision 10, page P-72. The assigned scope must accurately reflect the evidence. Examples: • Do not assign isolated scope when review shows a pattern of failure. • Do not assigns widespread scope when findings do not show that all (or most of the) residents are potentially or actually affected. You may assign G for one resident actually harmed or F-Substandard Quality of Care when the findings are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. (Appendix page P-72).
5	The severity rating in nursing homes or the Condition, Standard, Element level cited reflects the evidence and the actual and/or potential outcome to beneficiaries*.	The Condition, Standard or Element identifies noncompliance at the level cited. *"Beneficiaries" means clients, residents, and all persons receiving care. 1. Actual and/or potential beneficiary outcomes determine severity in all provider types. 2. Criterion #5 evaluates whether severity shows compliance or noncompliance in all provider and supplier types. 3. Nursing homes and LSC: consider only the severity level. Do not consider Scope. Do not consider Extent. 4. Non-nursing home providers and suppliers: • A Condition is cited when, "...the deficiencies ... adversely affect the health and safety of patients." 488.24(b) and 488.26(b). Thus, a Condition is cited for immediate and serious threat (I&ST) to health and/or safety or immediate jeopardy (IJ). • Apply Appendix Q for I&ST and IJ. • <u>Standards and elements:</u> If your review shows a Standard contains Condition-level noncompliance, the reviewer will verify that the Condition was also correctly cited to pass Criterion #5.
6	Each person referred to in the citation is uniquely identified.	Identify all persons (staff and others) in the citation with a unique identifier that preserves their confidentiality. It is acceptable to refer to a confidential interviewee without providing an identifier.

		1. Requires 100% compliance to pass. 2. Confidential identifiers must be unique. 3. "CNA", "staff", "licensed nurse", and "administrative staff" can refer to more than one person in the facility and, therefore, are not acceptable.
7	The observations, interviews and record reviews support the deficient practice statement and illustrate the entity's noncompliance.	Evaluate that: • the findings describe and support the deficient practice(s); • the findings describe the who, what, where, when and how, when possible, of the deficient practice; • <u>what</u> entity practice was noncompliant; • <u>who</u> were the beneficiaries affected or staff involved; • <u>where</u> the deficient practice occurred, e.g., specific locations in the entity or documents; • <u>when</u> (e.g., for how long) the problem occurred; and • <u>how</u> the deficiency was determined; • the findings are organized in a logical order, generally chronological, with the most serious findings first. 1. The findings must answer all relevant what, who, where, when, and how questions. 2. To pass Criterion #7, the findings also must be logically organized. Chronological order refers to the <u>order of beneficiary events</u>. An interview during the survey is chronological when placed on the date of the events, not the date of the interview. Example: The incident report dated 10/12/03 states that Resident #1 was found on the floor on 10/10/03 at 11:30 pm. On 02/03/04, licensed Staff #1 and DON stated this was Resident #1's first fall.
8	Descriptions of <u>observations</u> of provider/supplier practice include date, time, duration, (when appropriate), and location.	The observation of provider/supplier practice describes the specific date and time of the observation(s) and, when appropriate, the frequency, location and duration.
9	Descriptions of <u>interviews</u> include dates and times and who was interviewed.	The interview describes who was interviewed and the dates and times of interviews.

10	Record review includes date of entry, exact title of record, and verifies lack of additional records with a knowledgeable person.	Include the date and type/title of referenced records used in the identification of the deficient practices. 1. Consider the importance of the missing date or time in showing noncompliance. Criterion #10 does not require the date a record was reviewed (records which may be altered after surveyor review should be photocopied). 2. Identify what parts of "the record" were reviewed and which were deficient. Acceptable is: "nurses notes," "progress notes," "MAR," etc. Unacceptable is: "clinical record," "medical record," "resident record." Validate staff interview with a knowledgeable person of lack of additional records.
11	Evidence is written in plain language that is clear, concise and easily understood.	Include: • an explanation of abbreviations and acronyms when first used in each deficiency citation; common abbreviations may be placed in introductory comments; • short, concise sentences; • explanation of medical terminology; • an absence of critical spelling errors; • active voice (subject—verb—object); • an absence of extraneous information, defined as findings that are not relevant to demonstrating noncompliance; • an absence of vague terminology (such as, seems, appears, did not always, only, just, unsatisfactory, unnecessary, or inadequate); • an absence of unsupported conclusions. The majority of the citation is in plain language, is mostly understandable and the chronology of beneficiary decline and facility failure are clear. If compliant findings clarify a beneficiary's decline, they are relevant.

Lesson 2-K-1: Acceptable Plans of Correction

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the correlation among the Statement of Deficiencies, acceptable Plan of Correction or credible allegation, revisit survey and continued certification and licensure.
- List and apply the elements which must be included in an entity's Plan of Correction.

Lesson Plan

References

Federal

- *Code of Federal Regulations (CFR):*
  - 42 CFR 488.28(a)
- *State Operations Manual (SOM):*
  - Section 1016
  - Section 2728
  - Section 7304D
- *Principles of Documentation,* issued in 2000

State

(Insert State reference[s] here.)

Other

Highlights

- The correlation among the Statement of Deficiencies, acceptable Plan of Correction or credible allegation, revisit survey and continued certification and licensure
- The essential elements of an entity's Plan of Correction
- The process to accept or deny the Plan of Correction submitted by the entity

Training Techniques

- Lecture
- Group discussion
- Independent exercise

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - *Form CMS-2567, Statement of Deficiencies and Plan of Correction*
  - *Plan of Correction—Definitions*
  - *Plan of Correction—Sample Memorandum to Long Term Care Providers*
  - *Plan of Correction—Sample Memorandum to Non–Long Term Care Providers Who Are Not "Deemed"*
- Summary of deficiencies with the original, unacceptable Plan of Correction

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

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Lesson 2-K-1:
Acceptable Plans of Correction

1

Slide 2-K-1-1

Outline or text of presentation

When a survey finds an entity is not in compliance with Federal regulations, the State agency (SA) or, in some cases, the Regional Office (RO) will issue a letter stating that the entity is not in compliance and enclose Form CMS-2567 from the recent survey. The letter will also request that facility staff prepare and provide in writing a plan to correct each deficiency. Commonly, we refer to this as the Plan of Correction (POC). CMS encloses instructions with Form CMS-2567 describing how to formulate a POC. This helps the providers or suppliers ensure that they don't omit any required elements.

(Inform the students of the objectives.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the correlation among the Statement of Deficiencies, acceptable Plan of Correction or credible allegation, revisit survey & continued certification & licensure.
- List & apply the elements which must be included in an entity's Plan of Correction.

2

Slide 2-K-1-2

Statement of Deficiencies & Plan of Correction

- Used to determine continued Federal certification & State licensure
- Available to public

3

Slide 2-K-1-3

Significance of the Statement of Deficiencies and Plan of Correction

The significance of the Statement of Deficiencies (SOD) is that the State agency can certify to Centers for Medicare & Medicaid Services (CMS) that:

- A provider meets or does not meet the Conditions of Participation (COP).
- A supplier meets the Conditions of Coverage.

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Statement of Deficiencies & Plan of Correction (cont.)

- Process to accept
  - POC
  - Credible allegation

4

Slide 2-K-1-4

Outline or text of presentation

- The long term care facility substantially meets the necessary requirements.

With the exception of long term care facilities, 42 CFR 488.28(a) allows certification of providers or suppliers with deficiencies at the Standard level only if the facility has submitted an acceptable POC for achieving compliance, within a reasonable period of time.

Failure to submit a POC could result in the termination of the provider agreement and the cessation of Medicare or Medicaid payments to the facility for services provided to beneficiaries covered by those plans.

After receiving the POC, usually the SA, but sometimes the RO, determines its appropriateness.

Form CMS-2567, the SOD and POC, is the basic document available to the public from either the SA or the nearest RO.

The Freedom of Information Act allows the public to request and receive documents held by the Federal government. The public most frequently requests the SOD. It tells the public about the facility's deficiencies and actions to remedy them. If there is a newspaper article about a survey, the newspaper has probably requested a copy of the SOD and POC.

POC and Credible Allegation

There are two different terms used depending on the entity: POC and credible allegation. They are not necessarily the same thing.

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Credible Allegation

- Written statement of compliance
- Less voluminous than POC
- POC usually allegation of compliance

5

Slide 2-K-1-5

Provider Options

- Accept deficiency(ies) & provide written POC
- Record objections on SOD & submit POC
- Record objections & show evidence that citation is not valid

6

Slide 2-K-1-6

Outline or text of presentation

POC
The *State Operations Manual (SOM)* addresses the information that an acceptable POC must include.

Credible allegation
For some entities, such as hospitals, the facility must provide a written allegation of compliance that is found to be credible—thus, the term credible allegation.

A credible allegation does not have to include all the information required in a POC. However, usually when an allegation of compliance is reviewed, it is found to be unacceptable if it does not include the information required in a POC.

A POC is usually an *allegation* of compliance.

Provider options
When the provider or supplier receives the SOD, it has three options:

1. Accept the deficiencies and submit a POC.
2. Record objections to the cited deficiencies on the SOD and submit a POC.
3. Record objections to deficiencies cited on Form CMS-2567 and do not submit a POC but provide convincing arguments and documented evidence that the deficiencies cited are not valid.

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Provider Options (cont.)

- May refute accuracy of citation
- May not refute:
  - Judgment of surveyor
  - Level, extent, scope or severity of citation

7

Slide 2-K-1-7

Processing Criteria

- Is it legible? (See note about legibility as criterion)
- Does it address problem or issue cited?
- Does it provide all requested information?
- Does it appear appropriate & reasonable?
- Does it propose reasonable correction date?

8

Slide 2-K-1-8

Outline or text of presentation

Although an entity may refute the accuracy of the findings, it may *not* refute the professional judgment of the surveyor or the level, extent, scope or severity of the deficiency. Our office then has to review the documents provided and consult with surveyors if needed.

Sometimes we will receive a copy of a facility document the surveyor may have reviewed. The surveyor is encouraged to copy any facility document that supports any deficiency he/she writes. If facility staff copy documents for you, document the date and time when you receive the copy as well as the name of the staff member who gave you the copy.

However, if a provider makes an allegation that we do not find credible, the facility can no longer be certified to participate in the Medicare or Medicaid programs.

SA or RO response

The SA or RO can respond to the allegation of compliance in a number of ways.

For each deficiency staff have to determine whether the POC:

- Is legible.
- Addresses the problem or issue in the cited deficiency.
- Provides all the information requested. (See *SOM, Section 2728B.)*
- Seems appropriate and reasonable, based on the reviewer's knowledge of the regulation and experience with that type of institution.
- Proposes a reasonable date to correct the deficiency.

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Elements of POC for Non–Long Term Care

- Specific deficiency
- Procedure for correction
- Monitoring to correct & sustain correction
- Title of person responsible
- Date of correction

9

Slide 2-K-1-9

Outline or text of presentation

Elements of the POC

The POC must include certain elements that are slightly different for long term care facilities and non–long term care facilities.

For non–long term care providers and suppliers, an acceptable POC contains four key elements:

1. The plan for correcting the specific deficiency. The plan should address the processes that led to the deficiency cited.
2. The procedure for implementing the acceptable POC for the deficiency cited.
3. The monitoring procedure to ensure that the POC is effective and that the specific deficiency cited remains corrected and in compliance with regulations.
4. The title of the person responsible for implementing the acceptable POC.

In addition, the facility is to list a compliance date for each deficiency or deficient practice cited.

Elements of POC for Long Term Care

- How corrective action will be accomplished for any residents affected by deficiency practice
- How facility will identify other residents that potentially could be affected by deficient practice
- Measures that will be put into place or systemic changes made to ensure that deficient practice will not recur

10

Slide 2-K-1-10

Requirements for skilled nursing facilities and nursing facilities

For skilled nursing facilities (SNFs) and nursing facilities (NFs), an acceptable POC must address:

1. How corrective action will be accomplished for any residents affected by the deficiency practice.
2. How the facility will identify other residents that potentially could be affected by the deficient practice.
3. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.

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Elements of POC for Long Term Care (cont.)

- How facility will monitor its performance to make certain that solutions are sustained. Plan must be developed & implemented & corrective action evaluated for effectiveness. POC must be integrated into Quality Assurance program
- Dates when corrective action will be completed

11

Slide 2-K-1-11

Date of Correction

- Reasonable
- For long term correction:
  - Not to exceed 6 months for long term care facilities, 1 year for hospitals & intermediate care facilities for individuals with mental retardation
  - Milestones
  - Life Safety Code waiver
    - "Meets Life Safety Code, based upon waiver(s)"

12

Slide 2-K-1-12

Outline or text of presentation

4. How the facility will monitor its performance to make certain that solutions are sustained. A plan must be developed and implemented, and the corrective action evaluated for effectiveness. The POC must be integrated into the Quality Assurance program.
5. The dates when corrective action will be completed.

The provider or supplier records the response to each deficiency in the right column on Form CMS-2567, opposite the deficiency.

Date of correction

The POC must include the facility's plan of action to correct the deficiency and its expected completion date. The date must be specific and realistic.

A "reasonable period of time" to achieve compliance is usually no more than 60 days. The correction dates for individual deficiencies may be less or greater than 60 days, depending upon the circumstances of each deficiency.

Some deficiencies may take extensive time to correct (e.g., a structural change to the building). The facility is expected to identify the completion dates of specific steps or milestones so the surveyor can determine progress during a revisit.

Major Deficiencies Requiring Long Term Correction

Some Life Safety Code deficiencies require longer term POCs (e.g., installation of a sprinkler system usually takes 18 to 36 months). POCs may not be accepted for a period of time that exceeds six months for SNFs and NFs, and one year for hospitals

Audiovisual

Procedure for Long Term Correction

- Recommend waiver for correction period
- Include timeline for accountability

13

Slide 2-K-1-13

Outline or text of presentation

and intermediate care facilities for mentally retarded individuals.

The procedure for handling a longer term correction is as follows:

- Recommend a waiver for the length of time it will take to correct the deficiency.
- Include in the waiver a timeline for design and construction to help determine during subsequent visits whether work is progressing as planned.

In the interim, the SA should certify the facility as "Meets Life Safety Code, based upon waivers."

The facility's administrator or a designee must sign and date the POC. The provider or supplier may attach additional information to help demonstrate compliance. If a deficiency was corrected during the survey, the correction should be indicated, along with the date, the measures enacted or the systemic changes made to ensure that the deficient practice does not recur.

The provider or supplier retains a copy of the POC and submits the original to the State within 10 calendar days of receipt.

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Procedure for Long Term Correction (cont.)

- Additional time to develop POC
  - Must complete interim POC
  - Must follow with more specific plan as soon as possible
- Public disclosure:
  - Within 90 days for non–long term care
  - Within 14 days for long term care

14

Slide 2-K-1-14

Review of POC

- Reviewers:
  - SA
  - RO
- Acceptable or unacceptable:
  - If not accepted, written request for revised plan issued
  - Revisions require facility sign-off

15

Slide 2-K-1-15

Outline or text of presentation

If the facility requests additional time to develop the POC, it is permitted provided the facility immediately writes an interim plan that is as precise as possible and provides a more specific plan as soon as possible.

The administrator should know that the law requires that Form CMS-2567 be made available for public disclosure within 90 days of the last date of the survey. For SNFs and NFs, public disclosure is made within 14 calendar days after Form CMS-2567 is available to the provider.

Review of POCs by the SA

The SA and, in some cases, the RO review the POC for legibility, completeness and appropriateness. If it is not properly completed, or if the reviewers have questions, the SA contacts the provider or supplier to obtain clarification or an appropriate modification of the plan.

If the POC is unacceptable, the SA rejects it and, in writing, requests an acceptable one from the facility. A POC is not amended without the provider's concurrence. A facility representative must sign off on the changes. If adjustments are minor, the SA may contact the facility by telephone, make the necessary changes on Form CMS-2567 and then submit the form to the provider for signature.

Although we may have accepted the POC, the entity may always modify the POC and submit it at any later time. If the POC is acceptable, the SA will officially notify the facility.

Facilities are ultimately accountable for their own compliance, and that

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Outline or text of presentation

responsibility is not alleviated in cases in which notification about the acceptability of the POC is not made timely. The POC will serve as the facility's allegation of compliance.

Copies of the POC stay in the certification file and, if required, the original goes to the RO.

Revisit

- Not required of entities deemed within compliance with COPs/COCs
- Telephone followup permitted
- Onsite visit required for quality-of-care deficiencies

16

Slide 2-K-1-16

Revisit

Verification of the corrections is reported after the next scheduled resurvey or revisit except for entities deemed to meet Federal regulations, because they are accredited by certain organizations (some hospitals, critical access hospitals, home health agencies, ambulatory surgical centers and hospices).

For accredited and deemed entities, you will conduct a revisit only if the facility is not in compliance with a COP. However, once the entity meets all COPs, even if it continues to have deficiencies, you will not conduct another revisit.

For others, the SA follows up on all deficiencies cited on Form CMS-2567. In some cases, telephone contact with the provider or supplier will suffice in lieu of an onsite visit. This is acceptable as long as the SA has no reason to question the validity of the reported corrections.

An onsite visit is generally required for quality-of-care deficiencies. Because the long term care survey focuses on care, revisits are almost always necessary to verify correction of deficiencies.

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Outline or text of presentation

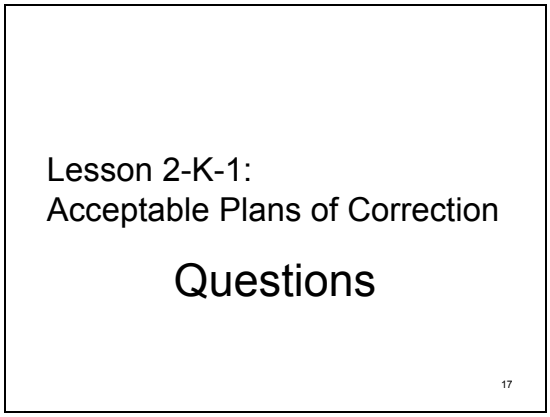
Certifying compliance based on acceptable POC

Certifying compliance based on the POC indicates that the provider or supplier meets the COP, or Conditions of Coverage. It also implies that the provider or supplier has submitted an acceptable POC or request for waiver and can furnish care that does not jeopardize the health and safety of patients, residents or clients while making corrections.

(Have students review case studies of an SOD with the POC for a specific entity and identify the elements that have or have not been met for each deficient practice.

Have students explain which POCs are "acceptable."

Have students explain whether the time criteria for submission have been met.)



Slide 2-K-1-17

Skill Assessment

Acceptable Plans of Correction

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed the correlation of the SOD, POC, revisit and continued certification and licensure.	
					Discussed significant points required in the POC for the provider or supplier most commonly surveyed.	

Comments/Recommendations:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
_____
_____

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**

This document contains a listing of deficiencies cited by the surveying State Agency (SA) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. **FORM COMPLETION**

Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies –** Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction –** In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers –** Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*) –** The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature –** This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

According to the Paperwork Reduction Act of 1995, no persons are required to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0391. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Plan of Correction—Definitions

Condition of Participation (COP) or Conditions of Coverage (COC)	Federal terms that refer to a subset of regulations for certain providers and suppliers (e.g., for hospitals, COP include medical staff and nursing services). The entity must comply with all COPs applicable to that entity to participate in the Medicare program.
Deficiency Citation	An entry made on Form CMS-2567, Statement of Deficiencies and Plan of Correction, that includes the data tag number, Code of Federal Regulations or Life Safety Code reference, the language of the regulation, an explicit statement that the requirement was "NOT MET," the deficient practice of how the entity did not meet the regulation and relevant information to support the decision of noncompliance.
Deficient Practice Statement	A statement of the action(s), error(s) or lack of action on the part of the entity relative to a requirement and, to the extent possible, the resulting outcome [e.g., "Based on observations, interviews and review of documents, the facility failed to (do what to how many people and what was the effect)."]
Entity	A generic term used to describe providers and suppliers under the Social Security Act or laboratories that participate in the *Clinical Laboratory Improvement Amendments* (of 1988) program.
Finding	A generic term used to describe each discrete item of information observed or discovered during the survey about practices of an entity relative to the specific requirement being cited as being not met (i.e., the specifics of what was wrong).
Plan of Correction (POC)	A written statement from the provider or supplier, which serves as the *allegation* of compliance.
Statement of Deficiencies (SOD)	A document which includes the statement and evidence written by the survey team to communicate what deficient practices were found.

Reference: Principles of Documentation, issued in 2000 by CMS

Plan of Correction—
Sample Memorandum to Long Term Care Providers

To: Administrator
All licensed and/or certified Health Care Providers and Suppliers

From: (Insert State agency or Regional Office name here.)

Subject: Plan of Correction (POC)

When a survey reveals a deficient practice, the facility must provide a Plan of Correction (POC) in writing and return it to the (Insert name of agency here.).

The POC for each deficient practice must include the following elements:

- The corrective actions(s) that will be accomplished for residents affected by the deficient practice.
- The method by which facility staff will identify other residents who may be affected by the same deficient practice and the corrective action that will be taken.
- The remedial measures or the systemic changes that will ensure that the deficient practice does not recur.
- The method of monitoring the corrective action to ensure that the deficient practice will not recur (i.e., the quality assurance or continuing quality improvement program to monitor the continued effectiveness of the systemic change).
- The title of the facility employee responsible for implementing and monitoring for compliance.
- The date on which each item addressed on the POC will be corrected.

Mail your POC to:

(Insert State Agency or Regional Office address here.)

Once it is received in our office, we will review the POC. If it is found unacceptable, we will contact you. This process may require additional information or clarification and may delay or affect your Medicare or licensure status.

If you have questions concerning these instructions, please contact the person referenced in your letter.

Plan of Correction—
Sample Memorandum to Non–Long Term Care Providers Who Are Not "Deemed"

To: Administrator
All licensed and/or certified Health Care Providers and Suppliers

From: (Insert State agency or Regional Office name here.)

Subject: Plan of Correction (POC)

When surveyors identify a deficient practice, the facility must provide a Plan of Correction (POC) in writing and return it to the (Insert name of agency here.).

The POC for each deficiency must include the following elements:

- The plan for correcting the specific deficiency. The plan should address the processes that led to the deficiency cited.
- The procedure for implementing the Plan of Correction for the specific deficiency cited.
- The monitoring procedure to ensure that the Plan of Correction is effective and that the specific deficiency cited remains corrected and in compliance with the regulations.
- The title of the facility employee responsible for implementing the acceptable Plan of Correction.
- The date on which each deficiency will be corrected.

Mail your POC to:

(Insert State agency or Regional Office address here.)

Once it is received in our office, we will review the POC. If it is found unacceptable, we will contact you. This process may require additional information and clarification and may delay or affect your Medicare or licensure status.

If you have questions concerning these instructions, please contact the person referenced in your letter.

Lesson 2-L: Transition to Independent Surveyor

Learning Objective

At the conclusion of this lesson, you will be able to:

- Demonstrate understanding of the process, communication, expectations and assessment or evaluation(s) during the transition period between the end of the surveyor's formal training and the start of working independently as a qualified surveyor.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Sections 4009C and 4009.1
- CMS Survey and Certification letter S&C-03-05, *Fiscal Year (FY) 2003 Training Requirements for End Stage Renal Disease (ESRD), Home Health Agency (HHA), Hospice and Intermediate Care Facility for the Mentally Retarded (ICF/MR) Surveyors,* issued November 14, 2002

State

(Insert State reference[s] here.)

Other

Highlights

- Based on your office policies and procedures, this lesson addresses the process, communication, expectations and assessment or evaluations during the transition period between the end of formal training and working independently as qualified surveyor.

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Handout (optional—State-supplied):
  - *Office Policy and Procedure for the Transition Period*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Background

For you to present this lesson, your office should have a system in place that documents the process to determine when the surveyor is fully qualified to conduct a survey for a specific provider or supplier. It is highly recommended that this system be written as policies and procedures.

Both the new surveyor and the experienced surveyor who is learning to survey a new provider or supplier need training. Policies and procedures may address the following:

- Formal training.
- The transition period (i.e., the period of time between the end of formal training and the start of working independently within a team).
- Required Federal training.
- Formal or informal assessments by individuals to whom the surveyor does not formally report.
- Formal or informal evaluation(s) by the individual to whom the surveyor does report.
- Periodic feedback from the trainee regarding training received and specific training still needed.
- Actions to be taken if the surveyor is not able to perform the survey independently at the time of the required formal evaluation.

Federal directives require individuals who conduct surveys of home health agencies, hospices, end stage renal disease facilities and intermediate care facilities for persons with mental retardation to attend a class developed and sponsored by the Centers for Medicare & Medicaid Services that provides basic surveyor training for that type of facility. For the surveyor of long term care facilities, the surveyor must additionally take and pass the Surveyor Minimum Qualifications Test. These requirements must be met before the surveyor can independently survey any of these types of providers or suppliers alone for compliance with Federal regulations.

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Outline or text of presentation

Lesson 2-L:
Transition to Independent Surveyor

1

Slide 2-L-1

Learning Objective

At the conclusion of this lesson, you will be able to:

- Demonstrate understanding of the process, communication, expectations & assessment or evaluation(s) during the transition period between the end of the surveyor's formal training & the start of working independently as a qualified surveyor.

2

Slide 2-L-2

(Inform the students of the objective.)

Basic Qualifications

- Have education required to qualify as surveyor
- Successfully complete State agency or Regional Office orientation program
- Attend CMS basic surveyor training class within first 12 months of employment

3

Slide 2-L-3

Basic Qualifications

To survey certified providers and suppliers, you must have the necessary knowledge, skills and abilities. This means that you must:

- Have the education required to qualify as a surveyor.
- Successfully complete the State agency or Regional Office orientation program.
- Attend a basic surveyor training class developed under CMS auspices within the first 12 months of employment.

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Basic Qualifications (cont.)

- Until you have completed appropriate basic class you can be only trainee when you survey:
  - Home health agencies
  - Hospices
  - End stage renal disease facilities
  - Intermediate care facilities for those with mental retardation

4

Slide 2-L-4

Outline or text of presentation

You can only survey as a trainee (rather than as a surveyor with full responsibility and independence) when you survey home health agencies, hospices, end stage renal disease facilities or intermediate care facilities for persons with mental retardation until you have attended the basic surveyor training class for that type of facility. In addition, if you are going to survey long term care, you must not only attend the Basic Long Term Care class but also take and successfully pass the Surveyor Minimum Qualifications Test (SMQT).

Basic Qualifications (cont.)

- For LTC, you must attend Basic LTC class & pass Surveyor Minimum Qualifications Test (SMQT)

5

Slide 2-L-5

Transition Period

- Becoming independent surveyor is not overnight occurrence:
  - Move from formal training to independent survey
  - Work with preceptor, supervisors & fellow surveyors

6

Slide 2-L-6

Transition Period

Becoming an independent surveyor is not an overnight occurrence.

The period between the end of formal training and the time when you can function independently can be called the transition period. This is the time when you will have additional opportunity to practice what you have learned more independently than during formal training. Because a formal training program exposes new surveyors to the knowledge and skills required to function only at the most basic

Audiovisual

Outline or text of presentation

levels of surveying, it is critical that you continue to develop your skills in investigation, analysis and documentation as well as broaden your knowledge base and experience.

Although the preceptor retains a key role for you during the transition, this period also requires special commitment and attention from both your supervisor and fellow surveyors.

Primary Objective of the Transition Period

The primary objective of the transition period is to prepare you to assume all responsibilities of the position in which you are employed.

Ultimate Responsibilities

- Follow written survey process
- Investigate using:
  - Observations
  - Interviews
  - Document review
- Interpret & apply regulations accurately

7

Slide 2-L-7

Ultimate responsibilities

Your ultimate responsibilities are to:

- Follow the written survey process.
- Investigate using observations, interviews and document review.
- Interpret and apply regulations accurately.

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Ultimate Responsibilities (cont.)

- Work efficiently & independently
- Work effectively within team
- Communicate effectively with:
  - Team members
  - Your supervisor
  - Others with whom you come in contact

8

Slide 2-L-8

Outline or text of presentation

- Work efficiently and independently.
- Work effectively within a team of other surveyors.
- Communicate effectively with team members, your supervisor and others with whom you come in contact.

Ultimate Responsibilities (cont.)

- Use & complete forms correctly
- Complete survey packet as required
- Follow established procedures while continuing to work with another surveyor
- Attend required CMS basic surveyor training class
- Take & pass SMQT (LTC surveyors)

9

Slide 2-L-9

- Use and complete forms correctly.
- Complete the survey packet as required.
- Follow established procedures while continuing to work with another surveyor.
- Attend the required CMS basic surveyor training class.
- Take and pass the SMQT (if you are an LTC surveyor).

Work in Your Assigned Office

- Work with others
- Training needs identified
  - Others' assessments of your skills
  - Feedback from you regarding
    - Training received
    - Specific training needed
- Formal evaluation(s)

10

Slide 2-L-10

Work in Your Assigned Office

This transition period, which usually lasts *[enter time period for your office],* will take place in your assigned office.

(Provide information relevant to your office procedures regarding:

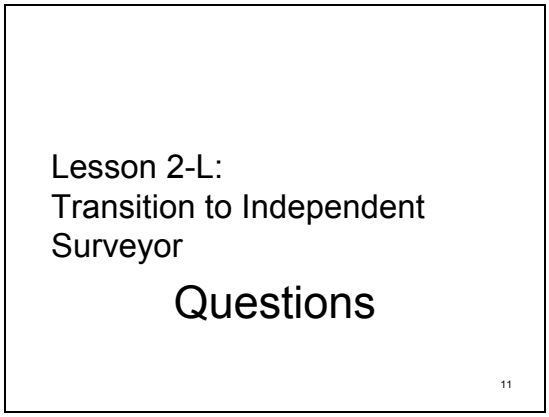
- *The role of the preceptor or team coordinator during the transition period.*
- *Assessment of continued learning.*

Audiovisual	Outline or text of presentation
	• *The role of the student's supervisor during this period, including any evaluations conducted by this individual.)* While you continue to gain experience in your job, all remaining training experiences during the transition period will be based on the needs identified by you and others. *(Have the students refer to the information provided above and describe how these needs will be identified. For example, preceptors may meet weekly with the new surveyor and that person's supervisor to plan and coordinate the training still needed to best prepare the surveyor to work independently.* *Have the students describe policy and procedures for assessing the acquisition of knowledge, skills and abilities required to perform the job as expected. For example, during this transition period the procedure may include utilizing appropriate evaluation forms, samples of which are provided in Lesson 3-Z and an appendix of this manual, or forms developed by your office to assess the new surveyor's performance.* *Potentially, such assessment continues until the new surveyor is able to perform the survey independently or at a level acceptable to his/her supervisor. If the preceptor is not present during a particular training activity or survey, the new surveyor may be responsible for having the team coordinator complete the appropriate skill assessment form. Usually it remains the responsibility of the preceptor to review each new surveyor's performance onsite or use skill assessment forms completed by others to coordinate*

Audiovisual

Outline or text of presentation

experiences and to communicate as needed in his/her office organization. This includes the State agency or Regional Office lead trainer or designee, the new surveyor's supervisor and the team coordinator for any survey where the preceptor will not be present. The assessment should include a method for the trainee to provide input regarding his/her training in specific areas.)



Slide 2-L-11

Skill Assessment

Transition to Independent Surveyor

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Accurately demonstrated the following regarding the transition period: • Communicated with significant individuals. • Met expectations. • Identified continued learning needs. • Participated in assessment(s) and formal evaluation(s). • Completed requirements to be a qualified surveyor.	

Comments/Recommendations:

Lesson 2-M: Appendix Q, Immediate Jeopardy

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the primary goals of immediate jeopardy guidelines.
- Define the following terms applicable to all certified Medicare/Medicaid entities:
  - Immediate jeopardy.
  - Actual harm.
  - Potential harm.
- Accurately identify circumstances which constitute immediate jeopardy or have the potential to be identified as such.
- Describe the survey process once immediate jeopardy has been identified.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Section 3005E
  - Sections 3010–3012
  - Sections 7307–7309
  - Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Task 4
  - Appendix H, Guidance to Surveyors: End Stage Renal Disease Facilities, Task 15
  - Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Persons With Mental Retardation, Task 8C
  - Appendix M, Home Health Agencies, Task 4
  - Appendix P, Survey Protocol for Long Term Care Facilities, Task 6, Section G, "Special Circumstances"
  - Appendix Q, Guidelines for Determining Immediate Jeopardy
  - Appendix W, Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs, Task 4
  - Exhibit 7A, Principles of Documentation
- *Code of Federal Regulations:*
  - 42 CFR 489.3, Definitions
  - 42 CFR 488.301, Definitions
- *Abuse and Neglect—Detection and Prevention Training Manual,* issued in 1999
- Satellite transmissions:
  - *Investigating Elder Abuse,* transmitted on July 1, 1997
  - *Forensic Wound Identification and Documentation,* transmitted on October 31, 2003
  - *Abuse and Neglect in Psychiatric Hospitals,* transmitted on May 14, 2004 (required viewing for all individuals who survey psychiatric hospitals)

State

(Insert State reference[s] here.)

Other

Highlights

- Only one individual need be at risk for immediate jeopardy to be present
- Immediate jeopardy may exist when abuse or neglect is cited for some providers/suppliers

- Immediate jeopardy may exist when there is a *high potential* for serious harm, injury, impairment or death to occur in the very near future
- Immediate jeopardy triggers guide

Training Techniques

- Lecture
- Group discussion
- Small group exercise
- Case study

Training Aids

- PowerPoint slides and handouts
- Easel pad with colored markers
- Optional PowerPoint:
  - *25 Signs That Someone Is Lying to You*
- Handouts:
  - *State Operations Manual,* Appendix Q, Guidelines for Determining Immediate Jeopardy
  - *Immediate Jeopardy Worksheet*
  - *Severity and Scope Matrix* (for long term care)
  - *Immediate Jeopardy—Definitions* (optional)
  - *Immediate Jeopardy Issues and Triggers* (optional)
  - *Immediate Jeopardy—Seven Key Components of Systemic Approach to Prevent Abuse and Neglect* (optional)
  - *25 Signs That Someone Is Lying to You*
  - *State Operations Manual,* sections 3010 and 3012 (optional for non–long term care providers and suppliers)

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Completion of scenario case(s)

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Lesson 2-M:
Appendix Q, Immediate Jeopardy

1

Slide 2-M-1

Outline or text of presentation

Immediate jeopardy is a term used in the Federal survey process. It is a situation that you will find infrequently but need to watch for during every survey.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Explain the primary goals of immediate jeopardy guidelines.

2

Slide 2-M-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Define the following terms applicable to all certified Medicare/Medicaid entities:
  - Immediate jeopardy.
  - Actual harm.
  - Potential harm.

3

Slide 2-M-3

Audiovisual

Learning Objectives (cont.)

- Accurately identify circumstances which constitute immediate jeopardy or have the potential to be identified as such.
- Describe the survey process once immediate jeopardy has been identified.

4

Slide 2-M-4

Outline or text of presentation

(Refer to Appendix Q, Guidelines for Determining Immediate Jeopardy.)

Appendix Q of the *State Operations Manual (SOM)* states that immediate jeopardy is interpreted as a crisis situation in which the health and safety of individual(s) are at risk (*SOM*, Section 3010).

Definition: Immediate Jeopardy

- 42 CFR 489.3

" . . . a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

5

Slide 2-M-5

Definition: Immediate Jeopardy

Let's talk about immediate jeopardy, commonly referred to as "IJ."

What is it?

(Refer to definition on slide.)

This definition is applicable to all certified providers and suppliers. Appendix Q identifies several principles related to IJ.

(Refer students to Appendix Q, p. 3.)

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Outline or text of presentation

Definition: Abuse

- 42 CFR 488.301

"The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish."

6

Slide 2-M-6

Definition: Abuse (Long Term Care)

(Refer to the definition of long term care on the slide or substitute a definition from the regulations the students will most likely use.)

Perpetrators of Abuse

- Staff
- Consultants or volunteers
- Family members
- Visitors

7

Slide 2-M-7

Perpetrators of abuse
Individuals must not be subjected to abuse by *anyone* including, but not limited to, entity staff, consultants or volunteers, family members or visitors.

(Ask for and discuss examples relevant to the provider/supplier the student will survey.)

Definition: Neglect

"Failure to provide goods & services necessary to avoid physical harm, mental anguish, or mental illness."

8

Slide 2-M-8

Definition: Neglect (Long Term Care)

(Refer to the definition of long term care on the slide or substitute a definition from the regulations the students will most likely use. If not included in those regulations, omit the "neglect" portion of the presentation.)

For example, consider neglect when an individual receiving care and services is harmed by a cognitively impaired individual due to the entity's failure to provide care and services. This failure

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Outline or text of presentation

results in physical harm, mental anguish or mental illness.

(Ask for and discuss examples relevant to the provider/supplier the student will survey.)

Principles

- Timing of serious harm, injury, impairment or death:
  - Past
  - Present
  - Likely in very near future

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Slide 2-M-9

Principles

Timing
Serious harm, injury, impairment or death:

- May have occurred in the past.
- May be occurring at present.
- May be likely to occur in the very near future.

Principles (cont.)

- Actual vs. potential harm
  - Harm does *not* have to occur
  - High potential for harm also constitutes immediate jeopardy

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Slide 2-M-10

Actual vs. potential harm
Serious harm, injury, impairment or death does *not* have to occur before an individual is in immediate jeopardy.

The *high potential* for harm, injury, impairment or death to occur in the very near future also constitutes immediate jeopardy.

(Ask for and discuss examples of actual and potential harm, injury, impairment or death relevant to the provider/supplier the student will survey.)

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Principles (cont.)

- Only *one* individual need be at risk
  - Identification for one individual will prevent risk to other individuals in similar situations

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Slide 2-M-11

Outline or text of presentation

Principles of Immediate Jeopardy

Only *one individual* needs to be at risk. Identification of immediate jeopardy for one individual will prevent risk to other individuals in similar situations.

Principles (cont.)

- Serious psychological harm considered as significant as serious physical harm
- Serious harm can result from both abuse & neglect

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Slide 2-M-12

Psychological harm is *as serious as* physical harm.

Immediate jeopardy should be considered any time a team cites abuse and neglect.

Culpability

- Entity knows or should have known about situation

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Slide 2-M-13

Culpability

IJ includes the concept of culpability. Did the entity know or should it have known about the situation which resulted in serious harm or potential for serious harm, injury, impairment or death to an individual?

Audiovisual

Outline or text of presentation

Noncompliance

- Did entity create situation or allow situation to continue?

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Slide 2-M-14

Noncompliance
IJ includes determining whether the entity created a situation or allowed a situation to continue in which serious harm or potential for serious harm, injury, impairment or death to an individual resulted.

Failure to Implement Corrective Measures

- Did entity have opportunity to implement corrective measures?

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Slide 2-M-15

Failure to implement corrective measures
You will have to determine whether the entity had an opportunity to implement corrective or preventive measures.

Applicability of Principles

- All Medicare & Medicaid providers
- Derive from responsibility for quality care in safe setting

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Slide 2-M-16

Applicability of principles
The principles of immediate jeopardy apply to *all* Medicare and Medicaid entities.

Although a specific Federal regulation may not be found for each situation, all entities providing services under Medicare and Medicaid have a responsibility to provide quality care in a safe setting.

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Issues

- Failure to:
  - Protect from abuse
  - Prevent neglect
  - Protect from psychological harm
  - Protect from undue adverse medication consequences or provide medications as prescribed
  - Provide adequate nutrition or hydration

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Slide 2-M-17

Outline or text of presentation

Immediate Jeopardy Issues and Triggers

(Refer students to Appendix Q, page 5.)

The guide in Appendix Q includes situations that are most likely to create jeopardy to an individual's psychological and/or physical health and safety. They include the following.

(Read this slide and the next.)

Issues (cont.)

- Protect from widespread nosocomial infections
- Correctly identify individuals
- Safely administer blood products & safely monitor organ transplantation
- Provide safety from fire, smoke & environmental hazards & educate staff in handling emergency situations

18

Slide 2-M-18

Triggers

- Not all-inclusive & can apply to more than one issue
- Refer to Appendix Q, pages 5–8, issues A–J

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Slide 2-M-19

The triggers are general examples and are not all-inclusive.

Triggers may apply to more than one issue.

The surveyor (if you are surveying alone) or the team (if you are surveying as a team) must investigate and use professional judgment to determine whether the situation has caused, or is likely to cause, serious harm, injury, impairment or death.

Audiovisual

Outline or text of presentation

Examples of Failure to Prevent Abuse

- Triggers:
  - Serious injuries such as head trauma or fractures
  - Bruises around breast or genital area
  - Unexplained serious injuries that have not been investigated
  - Nonconsensual sexual interactions

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Slide 2-M-20

The listed triggers do not automatically equal immediate jeopardy.

Note: Harm does *not* have to occur before considering IJ. Consider both potential and actual harm when reviewing triggers in the table.

Examples of Failure to Prevent Neglect

- Triggers:
  - Failure to adequately monitor & intervene for serious medical or surgical conditions
  - Lack of supervision for individual with known special needs

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Slide 2-M-21

Survey Process

- Preparation
- Investigation
- Decision making

22

Slide 2-M-22

Survey Process

The survey process for IJ consists of preparation, investigation and decision making.

Audiovisual

Preparation

Be familiar with:
- Appendix Q
- Seven Key Components of entity's systemic approach to prevent abuse & neglect
  - Apply to all certified Medicare & Medicaid entities

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Slide 2-M-23

Outline or text of presentation

Preparation

Be familiar with the contents of Appendix Q and the seven Key Components of prevention of abuse and neglect.

(Refer students to Appendix Q, Attachment C.)

Apply Appendix Q and the Key Components in Attachment C to all certified Medicare and Medicaid entities.

Key Components of Prevention

- Screening
- Training
- Prevention
- Identification
- Investigation
- Protection
- Reporting/response

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Slide 2-M-24

Key Components of prevention of abuse and neglect
Include:
- Screening.
- Training.
- Prevention.
- Identification.
- Investigation.
- Protection.
- Reporting/response.

Surveyor or Team Actions for Immediate Jeopardy

- Notify team coordinator immediately when immediate jeopardy situation is *suspected*
  - Immediate jeopardy investigation becomes team's *first priority*

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Slide 2-M-25

Surveyor or team actions for immediate jeopardy
Notify the team coordinator immediately when immediate jeopardy is suspected. Follow the office protocol. Either the team coordinator or the team as a whole will need to call your supervisor. Investigation of the potential IJ becomes the team's first priority.

Audiovisual

Investigation

- *Must* proceed until IJ is:
  - Confirmed
    or
  - Ruled out

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Slide 2-M-26

Outline or text of presentation

Investigation

The investigation process *must* proceed until IJ is either confirmed or ruled out.

Investigation Process

- Observe
- Interview
- Review documents
- Document investigation
- Copy significant documents

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Slide 2-M-27

Gather information:

- Observe: This is a key component of any investigation. Document date, time, location and exact observation.
- Interview: Notes must be clear and detailed. Document the date, time and full name of the individual interviewed. Include witnesses present at the interview.
- Review all documents related to both the IJ and the Key Components. Use record review to support observations and interviews.
- Document, document, document.
- Copy significant documents—obtain copies of relevant documentation to support IJ findings (e.g., nurses' notes, investigation reports, etc.)

If the case involves a potential criminal action, be aware that any physical evidence must be preserved for law enforcement agencies.

Audiovisual	Outline or text of presentation
Investigation Process (cont.) • *Who* was involved in jeopardy situation? 28	Investigate who, what, when, where and why. • *Who* was involved: staff, individuals receiving care and services and others? *(Suggest examples.)*
Slide 2-M-28	
Investigation Process (cont.) • *What* harm has occurred, is occurring or most likely will occur? 29	• *What* harm has occurred, is occurring or most likely will occur? *(Suggest examples.)*
Slide 2-M-29	
Investigation Process (cont.) • *When* did situation first occur? 30	• *When* did the situation first occur? *(Suggest examples.)*
Slide 2-M-30	

Audiovisual

Investigation Process (cont.)

- *Where* did potential or actual harm occur?

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Slide 2-M-31

Outline or text of presentation

- *Where* did the potential or actual harm occur?
- Is this an isolated incident or an entity-wide problem?

(Suggest examples.)

Investigation Process (cont.)

- *Why* did potential or actual harm occur?

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- *Why* did the potential or actual harm occur?

(Suggest examples.)

Investigation Process (cont.)

- Gather information:
  - Immediate jeopardy preventable?
  - Preventive system in place?
  - Repeat of deficient practice?
  - Pattern of deficient practice?
- Validate

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Slide 2-M-33

Gather information:

- Was the IJ preventable?
- Is there a system in place to prevent further occurrences?
- Is this a repeat deficient practice?
- Is there a pattern of similar deficient practices?

Validate the gathered information with facility staff.

Communicate with your supervisor (if you are alone) or with team members to ensure you have gathered all relevant information.

Audiovisual

Components of Immediate Jeopardy

- Harm
- Immediacy
- Culpability

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Slide 2-M-34

Outline or text of presentation

Components of immediate jeopardy
The team should begin the decision-making process once it has gathered and validated sufficient information to address the three components of immediate jeopardy:

- Harm.
- Immediacy.
- Culpability.

Decision Making—Harm

- Actual serious harm
  - Does harm meet definition of immediate jeopardy?
  - Is harm *likely* to recur in *very near future*?
- Potential serious harm
  - Is there likelihood of potential serious harm?
  - Does potential serious harm meet definition of immediate jeopardy?

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Harm:

- Actual: Was there an outcome of harm?
- Does the harm meet the definition of IJ (e.g., has the provider's or supplier's noncompliance caused serious injury, harm, impairment or death to an individual)?
- Potential: Is there a likelihood of potential harm?
- Does the *potential* harm meet the definition of immediate jeopardy (e.g., is the provider's or supplier's noncompliance likely to cause serious injury, harm, impairment or death to an individual)?

Decision Making—Immediacy

- Is potential outcome likely to occur in very near future if no action is taken?
  - Individual
  - Others in entity

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Immediacy:

- Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity if immediate action is not taken? (Refer to the *SOM*, Section 3010(B)(6), for guidelines during normal termination. Optionally, provide a handout of Section 3010.)

Audiovisual

Decision Making—Culpability

- Did entity know about situation?
  - If so, when did it first become aware?
- Should entity have known about situation?
- Did entity thoroughly investigate circumstances?

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Outline or text of presentation

Culpability:

- Did the entity know about the situation?
  - If so, when did the entity first become aware?
- Should the entity have known about the situation?
- Did the entity thoroughly investigate the circumstances and is there documented evidence of the investigation?

Decision Making—Culpability (cont.)

- Did it implement corrective measures?
- Has it reevaluated measures to ensure situation was corrected?

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Slide 2-M-38

- Did the entity implement corrective measures?
- Has the entity reevaluated the measures to ensure the situation was corrected?

Team Actions

- Follow Appendix Q
- Share collected data
- Complete IJ worksheet

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Slide 2-M-39

Team Actions

- Follow Appendix Q.
- Share collected data.
- Complete IJ worksheet.

(Refer students to the handout "Immediate Jeopardy Worksheet" on page 2-M-31.)

Audiovisual

Team Actions (cont.)

- Decide whether you have enough information for decision
- Identify & clarify inconsistencies or contradictions
- Determine most appropriate Federal regulation(s) for situation
- Consult supervisor

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Outline or text of presentation

- Decide whether you have enough information to make a decision. If not, continue the investigation.
- Identify, then clarify, any inconsistencies or contradictions among interviews, observations and record reviews.
- Determine the specific Federal regulation(s) for the situation.
- Consult with your supervisor.

Implementation

- Notify entity administration of identified circumstances
  - Verbal notice
  - Specific details
  - At-risk individuals
- Encourage entity to provide evidence of corrective measures

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Slide 2-M-41

- Notify the entity's administration of the immediate jeopardy. A verbal notice should be given with the specific details, including the individuals at risk. Strongly encourage the entity to immediately implement corrective measures to prevent repeat jeopardy situations.
- Encourage the entity to provide documented evidence of its implementation of corrective measures.

Documentation

- Document immediate jeopardy deficient practice
  - If not corrected, follow *SOM,* Section 3010
- Take action
  - Medicaid-certified: State determines
  - Medicare-certified: State forwards recommendation to CMS Regional Office

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Slide 2-M-42

Documentation

- Document the immediate jeopardy deficient practice.
  - If not corrected, follow *SOM,* Section 3010.
- Take action.
  - Medicaid-certified facility: State determines.
  - Medicare-certified facility: State forwards recommendation to CMS Regional Office.

Audiovisual

Citations: All Entities

Immediate jeopardy not removed:

- Inform administration that termination procedures will be initiated
  - 23-day termination (*SOM,* Section 3010)

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Outline or text of presentation

Citations: All Entities

(Review the following to reflect the provider/supplier students will most likely survey as well as your office policies.)

Immediate jeopardy not removed

- Consult with your supervisor regarding what you should specifically include in the exit conference, but at least inform administration that the State will recommend that termination procedures be initiated.
  - 23-day termination (*SOM*, Section 3010).

Citations: All Entities (cont.)

Confirmation of removal of immediate jeopardy:

- Only onsite confirmation of corrective action justifies determination that immediate jeopardy has been corrected

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Confirmation of removal of immediate jeopardy

- Only onsite confirmation of implementation of the facility's corrective actions justifies a determination that the immediate jeopardy has been removed.

Citations: SNFs/NFs

- Cite immediate jeopardy on Form CMS-2567

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Citations: Skilled Nursing Facilities/Nursing Facilities (SNFs/NFs)

(Refer students to the handout "Severity and Scope Matrix" on page 2-M-33.)

Audiovisual

Citations: SNFs/NFs (cont.)

Immediate jeopardy removed; deficient practice corrected:

- Cite immediate jeopardy at immediate jeopardy severity & scope (J, K or L)
- Document evidence of facility actions
- Include dates & times facility removed immediate jeopardy & corrected deficient practice

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Slide 2-M-46

Outline or text of presentation

Immediate jeopardy removed; deficient practice corrected

- If the facility removes the immediate jeopardy before the survey team leaves the facility, cite the immediate jeopardy at the immediate jeopardy severity and scope (J, K or L).
- Document evidence of the facility's actions, including the date and time that the facility removed the immediate jeopardy and corrected the deficient practice.
- Show the date of full correction on Form CMS-2567B.

Citations: SNFs/NFs (cont.)

Immediate jeopardy removed; deficient practice present:

- Cite immediate jeopardy at immediate jeopardy severity & scope
- Include documentation to support remaining deficient practice

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Immediate jeopardy removed; deficient practice present

- If the immediate jeopardy is removed, but an associated deficient practice still exists at a lesser severity and scope, cite the immediate jeopardy at the immediate jeopardy severity and scope.
- Include the documentation to support the remaining deficient practice.

Citations: SNFs/NFs (cont.)

- Document level of harm & identified residents in Statement of Deficiencies
- Attach corrective measures submitted by facility as immediate Plan of Correction

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Slide 2-M-48

- Document the level of harm and the identified individuals in the Statement of Deficiencies.
- Attach the corrective measures submitted by the facility as an immediate Plan of Correction.

Audiovisual

Citations: SNF/NF (cont.)

Immediate jeopardy not removed; deficient practice present:

- Inform administrator that RO will be notified of immediate jeopardy & termination procedures initiated

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Slide 2-M-49

Outline or text of presentation

Immediate jeopardy not removed

- If the facility is unable or unwilling to remove the immediate jeopardy before the end of the survey, inform the administrator that the RO will be notified of the immediate jeopardy and termination procedures will be initiated.

Citations: Non–Long Term Care

Immediate jeopardy:

- Must be *current*—if not, cannot cite immediate jeopardy
- Cite at Condition of Participation/Condition of Coverage level on Form CMS-2567 as well as at most appropriate regulation(s)

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Citations: Non–Long Term Care

- Immediate jeopardy must be *current*—if not, the team cannot cite immediate jeopardy.
- Immediate jeopardy is always cited at the Condition level on Form CMS-2567.

Citations: Non–Long Term Care (cont.)

Immediate jeopardy removed & corrected during survey:

- Cite at Condition level—include corrective actions taken by provider or supplier
- If deficient practice at same Condition
  - Cite Condition—include immediate jeopardy corrective actions
  - Cite deficient practice at appropriate level (Condition or Standard)

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Immediate jeopardy removed; deficient practice corrected

- If the entity is able to remove the immediate jeopardy and correct associated deficient practices before the team exits, cite the immediate jeopardy at the Condition level on Form CMS-2567.
- Include corrective actions taken by the provider or supplier in the Form CMS-2567 documentation.
- Show the date of full correction on Form CMS-2567B.

Audiovisual

Non-LTC Decertification

- Immediate jeopardy remains:
  - 23-day decertification (*SOM,* Section 3010)
- If corrected but any Condition not yet met:
  - 90-day decertification (*SOM*, Section 3012)
- All Conditions met—decertification stopped

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Slide 2-M-52

Outline or text of presentation

Immediate jeopardy not removed

- If the entity is unable or unwilling to remove the immediate jeopardy before the team's exit, inform the administration that the RO will be notified of the immediate jeopardy situation and termination procedures will be initiated.

Immediate jeopardy removed; deficient practice present at Condition level

- If the entity is able to employ immediate corrective measures that remove the immediate jeopardy, but an associated deficient practice still remains at the Condition level for the same Condition of Participation, cite the Condition of Participation as "not met" and proceed with 90-day termination procedures. Include documentation of both the immediate jeopardy with subsequent removal and the remaining deficient practice in this citation.

(Refer to SOM, section 3012.)

Immediate jeopardy removed; deficient practice present at Standard level

- If the entity is able to employ immediate corrective measures which remove the immediate jeopardy but an associated deficient practice still remains at the Standard or elemental level, cite the immediate jeopardy at the

Audiovisual

Outline or text of presentation

Condition of Participation level on the CMS-2567. Cite the remaining deficiency at the most appropriate standard tag. Show the date of removal of the immediate jeopardy on Form CMS-2567B.

Scenario—Case 1

- Trigger:
  - Lack of supervision of developmentally challenged, cognitively impaired or court-committed individuals with known elopement risk
- Category:
  - Failure to prevent neglect

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Slide 2-M-53

(Optional activity 1: For Case 1, ask surveyors to brainstorm a scenario by filling in the details (who, what, etc.). Coach as needed to brainstorm and discuss levels of harm, immediacy and culpability. Use slides 54–58 to guide discussion. Have students fill out Forms CMS-2567 based on the Case 1 scenario.)

Review: Investigation

- Who
  - Who is this person?
- What
  - What happened?
- When
  - When did person first attempt to elope?

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Slide 2-M-54

Audiovisual

Outline or text of presentation

Review: Investigation (cont.)

- Where
  - Where did person live?
- Why
  - Why was person placed at risk?

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Slide 2-M-55

Review: Decision Making

- Has person been harmed?
- Does harm meet definition of immediate jeopardy (e.g., serious injury, harm, impairment or death for individual)?
- Is there likelihood of serious harm?

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Slide 2-M-56

Review: Decision Making (cont.)

- Does potential serious harm meet definition of immediate jeopardy?
- Is potential serious harm likely to occur in very near future if no action is taken?
- Did facility or entity have knowledge of situation?
  - If so, when did it first become aware?

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Slide 2-M-57

Audiovisual

Outline or text of presentation

Review: Decision Making (cont.)

- Did it thoroughly investigate circumstances?
- Did it implement corrective measures?

• Does this meet definition of immediate jeopardy?

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Scenario—Case 2

• Trigger:
- Nonconsensual sexual interactions (e.g., sexual harassment, sexual coercion or sexual assault)

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Slide 2-M-59

(Optional activities 2–5: Brainstorm scenarios based on cases 2–5 for situations students may find at the provider/supplier they are most likely to survey.)

(Optional activity 6: Review actual Forms CMS-2567 with immediate jeopardy for various issues.)

Scenario—Case 3

• Trigger:
- Fire in operating room

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Slide 2-M-60

Audiovisual

Outline or text of presentation

Scenario—Case 4

- Trigger:
  - Significant side effects from drug interactions

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Scenario—Case 5

- Trigger:
  - Nonfunctioning or lack of emergency equipment &/or power source

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Slide 2-M-62

Lesson 2-M:
Appendix Q, Immediate Jeopardy

Questions

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Slide 2-M-63

Skill Assessment

Appendix Q, Immediate Jeopardy

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Defined or provided at least three examples pertinent to the provider/supplier the individual will most likely survey: • Immediate jeopardy. • Actual harm. • Potential harm.	
					Verbalized basic steps of the survey process from the time that one surveyor has identified potential immediate jeopardy through at least writing the Form CMS-2567.	

Comments/Recommendations:

Immediate Jeopardy Worksheet

Harm—physical or psychological injury or damage.

Immediate Jeopardy—a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death of a resident.

Abuse—the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish.

Neglect—failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Part 1: Problem Identification

Identify the issue(s) (may be more than one):
1.
2.

Identify the triggers(s) (may be more than one):
1.
2.

Part 2: Data Analysis

Yes	No	Date	
			Has actual harm occurred?
			Is there a likelihood of potential harm?
			Does the potential serious harm meet the definition of immediate jeopardy?
			Is the potential outcome likely to occur in the very near future if no action is taken?
			Did the entity have the knowledge of the situation?
			If so, when did it first become aware?
			Did it thoroughly investigate the circumstances?
			Did it implement corrective actions?
			Is the problem ongoing?
			Has the situation been abated (corrected) on the survey?
			Is past noncompliance F698 corrected prior to survey?

Part 3: Decision Making

Yes	No	Tag #	
			Does this meet the definition of immediate jeopardy?
			Which is the most appropriate tag to define the failed practice?
			Cite the most appropriate tag at the Condition of Participation/Coverage level for immediate jeopardy if it continues to exist.

Severity and Scope Matrix

SEVERITY	J	K	L	Immediate jeopardy to resident health and safety.
	G	H	I	Actual harm is not immediate jeopardy.
	D	E	F	No actual harm with the potential for more than minimal harm.
	A	B	C	Substantial compliance—no actual harm with the potential for no more than minimal harm.
	Isolated	Pattern	Widespread	
		SCOPE		

Immediate Jeopardy—Definitions

Immediate Jeopardy	"A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a individual." (See 42 CFR Part 489.3)
Abuse	"The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish." (See 42 CFR Part 488.301)
Neglect	"Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." (See 42 CFR Part 488.301)
Verbal Abuse	"…the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to individuals or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability…."
Sexual Abuse	"…includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault."
Physical Abuse	"…includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment."
Mental Abuse	"…includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation."
Involuntary Seclusion	"…separation of an individual from other individuals or from his/her room or confinement to his/her room (with or without roommates) against the individual's will, or the will of the individual's legal representative."
Misappropriation of resident property	"…the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

Immediate Jeopardy Issues and Triggers

Triggers or situations that surveyors should further investigate to determine whether immediate jeopardy exists. The listed triggers do not automatically equal immediate jeopardy. The team must investigate and use professional judgment to determine whether the situation has caused or is likely to cause serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive. Serious harm, injury impairment or death does not have to occur before the surveyors consider a finding of immediate jeopardy. Consider both potential and actual harm when reviewing the triggers.

A Failure to Protect from Abuse

1. Serious injuries such as head trauma or fractures.
2. Non-consensual sexual interactions (e.g., sexual harassment, sexual coercion or sexual assault.)
3. Unexplained serious injuries that have not been investigated.
4. Staff striking or roughly handling a resident.
5. Staff yelling, swearing, gesturing or calling an individual derogatory names.
6. Bruises around the breast or genital area.
7. Suspicious injuries (e.g., black eyes, rope marks, cigarette burns and unexplained bruising).

C Failure to Protect from Psychological Harm

1. Application of chemical/physical restraints without clinical indications.
2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate and recent or sudden changes in behavior by individuals.
3. Lack of intervention to prevent individuals from creating an environment of fear.

D Failure to Protect from Undue Adverse Medication Consequences and/or Failure to Provide Medications as Prescribed

1. Administration of medication to an individual with a known history of allergic reaction to that medication.
2. Lack of monitoring and identification of potential serious drug interaction, side effects and adverse reactions.
3. Administration of contraindicated medications.
4. Pattern of repeated medication errors without intervention.
5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction.
6. Lack of timely and appropriate monitoring required for drug titration

B Failure to Prevent Neglect

1. Lack of timely assessment of individuals after injury.
2. Lack of supervision for individuals with known special needs.
3. Failure to carry out doctor's orders.
4. Repeated occurrences such as falls that place the individual at risk of harm without intervention.
5. Access to chemical and physical hazards by individuals who are at risk.
6. Access to hot water of sufficient temperature to cause tissue injury.
7. Non-functioning call system without compensatory measures.
8. Unsupervised smoking by an individual with a known safety risk.
9. Lack of supervision of cognitively impaired individuals with known elopement risk.
10. Failure to adequately monitor individuals with known severe self-injurious behavior.
11. Failure to adequately monitor and intervene for serious medical/surgical conditions.
12. Use of chemical/physical restraints without adequate monitoring.
13. Lack of security to prevent abduction of infants.
14. Improper feeding/positioning of individual with known aspiration risk.
15. Inadequate supervision to prevent physical altercations.

E Failure to Provide Adequate Nutrition and Hydration to Support and Maintain Health

1. Food supply inadequate to meet the nutritional needs of the individual.
2. Failure to provide adequate nutrition and hydration resulting in malnutrition (e.g., severe weight loss and abnormal laboratory values).
3. Without nutrition and hydration without advance directive.
4. Lack of potable water supply.

Immediate Jeopardy: A situation in which the providers' noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. *Only one individual* needs to be at risk. Identification of immediate jeopardy for one individual will prevent risk to other individuals in similar situations.

F. Failure to Protect from Widespread Nosocomial Infections (e.g., Failure to Practice Standard Precautions, Failure to Maintain Sterile Techniques during Invasive Procedures and/or Failure to Identify and Treat Nosocomial Infections).

1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease.
2. High number of infections or contagious diseases without appropriate reporting, intervention and care.
3. Pattern of ineffective infection control precautions.
4. High number of nosocomial infections caused by cross-contamination from staff and/or equipment/supplies.

G Failure to Correctly Identify Individuals

1. Blood products given to the wrong individual.
2. Surgical procedure/treatment performed on the wrong individual or wrong body part.
3. Administration of medication or treatments to the wrong individual.
4. Discharge of an infant to the wrong individual.

H Failure to Safely Administer Blood Products and Safely Monitor Organ Transplantation

1. Wrong blood type transfused.
2. Improper storage of blood reactions.
3. High number of serious blood reactions.
4. Incorrect cross-match and utilization of blood products or transplantation organs.
5. Lack of monitoring for reactions during transfusions.

Determine:

1. Who was involved?
2. What harm has occurred?
3. When did the situation first occur?
4. Where did the potential/actual harm occur?
5. Why did the potential/actual harm occur?

J Failure to Provide Initial Medical Screening, Stabilization of Emergency Medical Conditions and Safe Transfer of Individuals and Women in Active Labor Seeking Emergency Treatment (Emergency Medical Treatment and Active Labor Act)

1. Individuals turned away from ER without medical screening exam.
2. Women with contractions not medically screened for their status of labor.
3. Absence of ER and OB medical screening records.
4. Failure to stabilize emergency medical condition.
5. Failure to appropriately transfer an individual with an unstabilized emergency medical condition.

K Failure to Provide Safety from Fire, Smoke and Environment Hazards and/or Failure to Educate Staff in Handling Emergency Situations

1. Nonfunctioning or lack of emergency equipment and/or power source.
2. Smoking in high-risk areas.
3. Incidents such as electrical shock or fires.
4. Ungrounded/unsafe electrical equipment.
5. Widespread lack of knowledge of emergency procedures by staff.
6. Widespread infestation by insects/rodents.
7. Lack of functioning ventilation, heating or cooling system placing individuals at risk.
8. Use of non-approved space heaters, such as kerosene or electrical in resident or patient areas.
9. Improper handling/disposal of hazardous materials, chemical and waste.
10. Locking exit doors in a manner that does not comply with NFPA 101.
11. Obstructed hallways and exits preventing egress.
12. Lack of maintenance of fire or life safety systems.
13. Unsafe dietary practices resulting in high potential for food-borne illnesses.

Note: Harm does *not* have to occur before considering immediate jeopardy. Consider both potential and actual harm when reviewing the triggers.

Immediate Jeopardy—Seven Key Components of Systemic Approach to Prevent Abuse and Neglect

Key Components applicable to all providers:

1. Prevent.
   The facility or system has the capacity to prevent the occurrence of abuse and neglect and review specific incidents for "lessons learned" which form a feedback loop for necessary policy changes.

2. Screen.
   The facility or system provides evidence and maintains efforts to determine if persons hired have records of abuse or neglect.

3. Identify.
   The facility or system creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.

4. Train.
   The facility or system, during its orientation program, and through an ongoing training program, provides all employees with information regarding abuse and neglect and related reporting requirements, including prevention, intervention and detection.

5. Protect.
   The facility or system must protect individuals from abuse and neglect during investigation of any allegations of abuse or neglect.

6. Investigate.
   The facility or system ensures, in a timely and thorough manner, objective investigation of all allegation of abuse, neglect or mistreatment.

7. Report/Respond.
   The facility or system must ensure that any incidents of substantiated abuse and neglect are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal law.

25 Signs That Someone Is Lying to You

Is Someone Lying to You?

25 Signs that someone is lying to you:

1. Touching the chin or rubbing the brow
2. Crossed arms or legs
3. Playing with hair
4. Perspiring on the brow if it isn't a warm day
5. Saying "no" several times
6. Continually denying accusations

1

Handout Slide 2-M-1

25 Signs Someone Is Lying to You

1. Touching the chin or rubbing the brow.
2. Crossed arms or legs.
3. Playing with hair.
4. Perspiring on the brow if it isn't a warm day.
5. Saying "no" several times.
6. Continually denying accusations.

Is Someone Lying to You? (cont.)

7. Being extremely defensive
8. Providing more information & specifics than necessary
9. Inconsistencies in what is being shared
10. Body language & facial expressions don't match what is being said such as saying "no," but nodding the head up & down
11. Being smug

2

Handout Slide 2-M-2

7. Being extremely defensive.
8. Providing more information and specifics than necessary.
9. Inconsistencies in what is being shared.
10. Body language and facial expressions don't match what is being said such as saying "no," but nodding the head up and down.
11. Being smug.

Is Someone Lying to You? (cont.)

12. Placing a barrier, such as a desk or chair in front of self
13. Being uncommonly calm
14. Being unwilling to touch spouse or significant other during conversation
15. Being hesitant
16. Slouching
17. Being rigid or fidgeting

3

Handout Slide 2-M-3

12. Placing a barrier, such as a desk or chair in front of self.
13. Being uncommonly calm.
14. Being unwilling to touch spouse or significant other during conversation.
15. Being hesitant.
16. Slouching.
17. Being rigid or fidgeting.

Is Someone Lying to You? (cont.)

18. Changing behaviors; not acting in a usual fashion
19. Making unnatural or limited arm & hand movements
20. Making a partial shrug
21. Not pointing fingers
22. Showing unusual voice fluctuations, word choice, sentence structure

4

Handout Slide 2-M-4

18. Changing behaviors; not acting in a usual fashion.
19. Making unnatural or limited arm and hand movements.
20. Making a partial shrug.
21. Not pointing fingers.
22. Showing unusual voice fluctuations, word choice, sentence structure.

Is Someone Lying to You? (cont.)

23. Stalling the conversation by repetitive use of pauses & comments like “um” or “you know”
24. Not using contractions; emphasizing “not” when talking
25. Avoiding eye contact, glancing to the right, staring past you or turning away from you while talking

5

Handout Slide 2-M-5

23. Stalling the conversation by repetitive use of pauses and comments like “um” or “you know.”
24. Not using contractions; emphasizing “not” when talking.
25. Avoiding eye contact, glancing to the right, staring past you or turning away from you while talking

Section 3:
Long Term Care Surveyor Training

Lesson 3-A: Introduction to the Outcome-Oriented Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the outcome-oriented survey process.
- Describe the concept of a "reasonable person."
- Describe how perspectives can influence our behavior.
- Describe the importance of considering cultural background and viewing people in a holistic manner.
- Assess survey information for a negative outcome, accounting for the effects of personal perspectives and using a holistic approach.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities

State

(Insert State reference[s] here.)

Other

Highlights

- Presentation of the concept of "outcome-oriented"
- Definition and guidance regarding negative outcomes
- The concept of the "reasonable person"

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Student worksheets
- Handouts:
  - *Examples of Outcomes*
  - *Assessment of Outcome—1*
  - *Assessment of Outcome—2*
  - *Assessment of Outcome—3*
  - *Assessment of Outcome—4*

Methods of Evaluation

- Verbalization/discussion of understanding
- Effective use of information during future training sessions
- Completion of skill assessment

Audiovisual

Lesson 3-A:
Introduction to the Outcome-Oriented Survey Process

1

Slide 3-A-1

Outline or text of presentation

CMS maintains oversight of the survey and certification of nursing homes and continuing care providers, including hospitals, home health agencies, end-stage renal disease facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries. CMS provides information to beneficiaries, providers/suppliers, researchers and State surveyors regarding these activities.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the outcome-oriented survey process.
- Describe the concept of a "reasonable person."
- Describe how perspectives can influence our behavior.

2

Slide 3-A-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Describe the importance of considering cultural background & viewing people in a holistic manner.
- Assess survey information for a negative outcome, accounting for the effects of personal perspectives & using a holistic approach.

3

Slide 3-A-3

Audiovisual

Outline or text of presentation

Types of Surveys

- Standard
- Abbreviated
- Partial extended
- Revisit
- Extended

4

Slide 3-A-4

There are several types of long-term care surveys: standard, abbreviated, partial extended, revisit and extended.

Survey Characteristics

Standard survey is:

- Periodic (every 9 to 15 months)
- Resident-centered
- Conducted to determine compliance with Federal and State requirements

5

Slide 3-A-5

A nursing home standard survey is a periodic (every 9 to 15 months), resident-centered inspection that gathers information about the quality of care furnished in a facility. The survey is conducted to determine compliance with Federal and State requirements.

Emphasis on Resident

- Surveys are "resident-centered" when:
  - They are based on investigation of care & services provided to meet individual needs & preferences of residents

6

Slide 3-A-6

Any survey should be:

- Resident-centered.
- Outcome-oriented.

Resident-Centered

Surveys are "resident-centered" when they are based on the investigation of care and services provided to meet individual needs and preferences of the residents.

Audiovisual

Emphasis on Outcomes

- "Outcomes" include:
  - Actual & potential negative outcomes
  - Effectiveness of facility in helping residents achieve their highest practicable level of well-being

7

Slide 3-A-7

Framework

Standard survey assesses:

Compliance with resident rights	Quality of care & services
Accuracy of assessments	Effectiveness of physical environment

8

Slide 3-A-8

Outline or text of presentation

Outcome-Oriented

"Outcomes" include both actual and potential negative conditions, occurrences, and results, as well as the failure of a facility to help residents achieve their highest practicable level of well-being.

(Ask the students to brainstorm and classify outcomes using the handout "Examples of Outcomes" on page 3-A-21.)

The outcome-oriented survey process for SNFs (skilled nursing facilities), NFs (nursing facilities), HHAs (home health agencies) and ICFs/MR (intermediate care facilities for those with mental retardation) focus on individual resident outcomes.

A Framework for Assessing Outcomes

Based on the procedures detailed in the *SOM,* Appendix P, Survey Protocol for Long Term Care Facilities, a standard survey assesses:

- Compliance with residents' rights and quality of life requirements.
- Accuracy of residents' comprehensive assessments and adequacy of care plans based on those assessments.
- Quality of care and services furnished as measured by indicators of:
  1. Medical, nursing, rehabilitative care and drug therapy.
  2. Dietary and nutrition services.
  3. Activities and social participation.
  4. Sanitation and infection control.
- Effectiveness of the physical environment in:
  1. Empowering residents.
  2. Accommodating needs.
  3. Maintaining safety.

Audiovisual

Components

Standard survey includes:
- Tour of facility
- Case-mix stratified sample
- Evaluation of all aspects of care
- Audit of written Plans of Care
- Review of compliance with residents' rights requirements

9

Slide 3-A-9

Outline or text of presentation

To gather information about outcomes, a standard survey includes:
- A full tour of the facility.
- A case-mix stratified sample of the residents.
- The measuring of medical, nursing, rehabilitative care, dietary, nutrition, activities, social participation, sanitation, infection control and physical environment.
- An audit of written Plans of Care and resident assessments to determine accuracy and adequacy.
- A review of compliance with the residents' rights requirements.

Resident Focus

- Focus survey on resident
  - Do not "check off boxes"
  - What about cultural influences?
- View holistically

10

Slide 3-A-10

The Resident

The purpose of the survey is to ensure proper treatment of residents in Federally funded facilities. We use Federal and State regulations to achieve this goal.

The survey process is much more than checking off boxes to ensure compliance. It is paramount to focus the investigation on the resident. Being sensitive to the influences of culture and viewing the resident with a holistic perspective are imperative. This will assist you in determining whether the facility is providing services to each resident in the most effective manner possible.

Audiovisual

Aspects of Whole Person

- Culture
- Upbringing
- Religious beliefs
- Education
- Life experience

11

Slide 3-A-11

Outline or text of presentation

As health care professionals, we are aware of the many facets that make us unique as individuals. Our perspectives are shaped by our culture, upbringing, religious beliefs, education and life experience, to name a few.

The manner in which we perceive residents may influence our view of them, before they even utter a word. It is crucial to be cognizant of this fact and develop the ability to see individuals objectively.

During the survey, consider whether the facility conducted a cultural assessment if you deem it important. Since values, beliefs and behaviors influence our actions, choices and decisions regarding health care, the lack of appropriate assessment has huge implications. Doesn't it seem important that the facility assess the residents' views and background as a tool to develop a Plan of Care most appropriate to the individual?

During the survey, try to determine what makes each person unique and what he/she finds important. Look beyond the medical needs, and determine whether residents' psychosocial and psychological needs are being met.

In summary, each person is a combination of many factors. Do not fall into the trap of looking only at the medical needs of the resident; rather, look at the *whole person*.

Audiovisual

Symptoms & Causative Factors Relating to Outcomes

- Depression
- Problem behaviors
  - Wandering, physical aggressiveness, verbal abuse, etc.
- Weight loss
- Dehydration

12

Slide 3-A-12

Outline or text of presentation

Symptoms and Causative Factors

Here are examples of symptoms and possible causative factors of psychological changes in the older adult. These also may be helpful in assessing outcomes.

Depression

- Changes in medical condition.
- Lifestyle changes.
- Loss of significant other.
- Medication side effects.

Problem behaviors (wandering, physical aggressiveness, verbal abuse, etc.)

- Depression.
- Mental status change.
- Staff behaviors/staff person.
- Environment (noise, routine, time of day, etc.).

Weight loss

- Dislike of foods.
- Mental status.
- Body stress (after surgery, infection, fever).
- Lack of staff assistance.
- Medication side effect.

Dehydration

- Cognitive impairment.
- Staff behaviors (do not provide fluids, encouragement).
- Swallowing problem.
- Increased needs for fluids (heat, fever, diarrhea).

Audiovisual

Symptoms & Causative Factors Relating to Outcomes (cont.)

- Pressure sores
- Limited ROM
- Urinary tract infection
- Pain

13

Slide 3-A-13

Symptoms & Causative Factors Relating to Outcomes (cont.)

- Decline in ADLs
- Incontinence
- Vision or hearing
- Delirium

14

Slide 3-A-14

Outline or text of presentation

Pressure sores
- Moisture.
- Lack of position change.
- Poor nutrition and hydration.

Urinary tract infection
- Improper peri-care.
- Inadequate hydration.
- Catheter.

Limited ROM
- Inadequate assessment.
- Lack of exercise.

Pain
- Inadequate assessment.
- Inadequate medication/timing of medication.

Decline in ADLs
- Mental status.
- Pain.
- Broken hip/limb.
- Decline in ROM.
- Environmental factors (lighting, etc.).

Vision/hearing
- Lack of appropriate consults/medical care.
- Outdated equipment.
- Disease progression.

Incontinence
- Untimely staff assistance.
- Medications (e.g., diuretics).
- Medication side effects.
- Physical restraint.
- Medical condition (impaired cognition, loss of strength).
- Access to toilet.

Delirium
- Dehydration.

Audiovisual

Outline or text of presentation

- Infection.
- Medication side effects.

Survey Process

- Based on actual or potential negative outcomes
- Negative outcome
  - Physical, mental or psychosocial deterioration
  - Inability of resident to achieve his/her highest practicable physical, mental or psychosocial well-being

15

Slide 3-A-15

The Process

The survey process is focused on actual or potential negative outcomes. Investigate whether the resident has been, or could potentially be, affected by a deficient practice of the facility. A negative outcome may be a physical, mental or psychosocial deterioration, or the inability of the resident to achieve his/her highest practicable physical, mental or psychosocial well-being.

Example

- How would you assess for negative outcome related to ADL ability for this resident?

16

Slide 3-A-16

Example
You observe the ADL care of a resident. You see the nurse's aide dress the resident and brush his teeth. You do not see the staff encourage the resident to perform these tasks on his own. At this stage, you are not familiar with this individual; however, you believe he is here for rehabilitation following a stroke and you note that he does not seem to have made much progress.

How would you assess for a negative outcome related to ADL ability for this resident?

(Ask the students to suggest resources for assessing whether there is a negative outcome. You may use the handouts "Assessment of Outcome—1" on page 3-A-23 and "Assessment of Outcome—2" on page 3-A-25.)

Audiovisual

Outline or text of presentation

1. Review records to determine whether and/or how the facility assessed the resident.
2. Review the Plan of Care. Are there instructions regarding the resident's ADL ability and suggestions to maintain or improve function?
3. Observe the resident and staff. Are there specific measures on the care plan, and if so, are staff implementing them?
4. Interview the resident. Has the resident's self-care ability diminished since being in the facility? Does he/she know why? Do staff take time to assist as needed and guide the resident? Do nurse's aides complete the task for the resident because they are too busy to help him/her?
5. Interview the staff. Do they institute the instructions on the care plan? Do they say the resident is difficult? Have they noticed the resident used to participate but lately has become combative or weak? If so, have they notified the nurse?

Deficient Practice?

- Maybe…
- Evidence of resident deterioration alone does not necessarily show deficient care
- Information needs to be validated

17

Slide 3-A-17

Finding evidence of resident deterioration does not necessarily mean there is a deficient practice. This information needs to be validated.

Audiovisual

Questions to Ask

Is deterioration:
- Natural progression of resident's physical or mental condition?
- Due to resident choice?
- Result of facility practice or inaction?

18

Slide 3-A-18

Outline or text of presentation

If you believe the resident has not achieved his/her highest practicable level of well-being, then ask yourself:

1. Is the deterioration a natural progression of the resident's physical or mental condition?
2. Is it a result of choices the resident has made (for example, choosing to stay in bed)?
3. Is it the result of a facility practice or inaction?
   - If so, does the practice constitute a failure to meet the requirements of participation?
   - How has the practice caused the residents failure?

(You may use the "Assessment of Outcome—3" handout on page 3-A-27.)

Information gathered from asking these questions may then lead you down a different path.

For example: You now review the resident assessments and care plan. The care plan does not specify interventions to promote functioning related to ADLs, and the nurse's aides do not realize the resident is here for rehabilitative services. From reviewing the chart, you see the resident was indeed admitted for the sole purpose of rehabilitation following a stroke. This information would now focus your investigation towards accurate assessment issues, rather than deficient ADL care.

(You may use the worksheet "Assessment of Outcome—4" on page 3-A-29.)

Audiovisual

Negative Outcome

- Physical, mental or psychosocial deterioration of resident

OR

- Compromise of resident's ability to achieve highest practicable physical, mental or psychosocial well-being

19

Slide 3-A-19

Outline or text of presentation

Definition of negative outcome:

The physical, mental or psychosocial condition of the resident has deteriorated.

OR

The ability of the resident to achieve the highest practicable physical, mental, or psychosocial well-being has been compromised.

"Reasonable Person" Standard

- Used by judicial system as means to apply principles on consistent basis
- Purpose:
  - To evaluate impact of deficiencies for somewhat intangible concepts such as self-esteem & dignity

20

Slide 3-A-20

Reasonable Person

What would a "reasonable person" do or how would a "reasonable person" feel in a particular situation?

The "reasonable person" standard has been used by the judicial system as a means to apply principles on a consistent basis. The purpose of this standard is to evaluate the impact of deficiencies for somewhat intangible concepts such as self-esteem and dignity.

The standard is: What would a "reasonable person" do or how would a reasonable person feel or react to this situation?

Who Is Reasonable Person?

- Abstract & hypothetical character
- Prudent & careful
- Model of all proper qualities
- Ideal individual in circumstances in which resident has been observed

21

Slide 3-A-21

The "reasonable person" is:

- An abstract and hypothetical character who personifies a community ideal of reasonable and responsible behavior.
- A model of all proper qualities, with only those human shortcomings and weaknesses that the community will tolerate.
- Prudent, careful and always up to a standard.
- Responsive to institutional conduct in the manner of an ideal individual in the

Audiovisual

Outline or text of presentation

circumstances in which the resident has been observed (and who reacts more strenuously with the repetition of the same or similar conduct).

The "reasonable person" is assumed to have the same physical characteristics and limitations as the resident being observed. Therefore, the reaction you expect of this "reasonable person" would take into account your knowledge of the resident's condition and the care required.

The mental capacity and emotional state of the "reasonable person" is that of a person with normal intellect and even temperament, regardless of the actual emotional state of the observed resident.

The "reasonable person" also is knowledgeable about his/her characteristics, medical condition, current treatments and is not concerned with caregiver retaliation.

Applying Standard

How would reasonable person react to:

Unshaven beard?	Being physically abused?
Wearing dirty clothes?	Being mentally abused?
Having incontinent episode?	Being neglected?

22

Slide 3-A-22

Example

How would the "reasonable person" react to:

- Having an unshaven beard or uncombed hair?
- Wearing a stained, torn or dirty clothing item?
- Being asked to wait for assistance to the bathroom and having an incontinent episode?
- Being physically and/or mentally abused?
- Being neglected?

Using the "reasonable person" concept is a means to help you determine whether the residents are receiving appropriate care.

Audiovisual

Outline or text of presentation

Lesson 3-A:
Introduction to the Outcome-Oriented Survey Process

Questions

23

Slide 3-A-23

Skill Assessment

Introduction to the Outcome-Oriented Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified the components of a standard survey.	
					Described the "outcome-oriented" survey process.	
					Described the "reasonable person" concept.	
					Assessed an outcome using the four factors a standard survey considers.	
					Assessed for a negative outcome, accounting for the effects of personal perspectives and using a holistic approach.	

Comments/Recommendations:

Examples of Outcomes

	Actual	Potential	Positive	Negative
Example				
Nonexample				

Assessment of Outcome—1

You observe the ADL care of a resident. You see the nurse's aide dress the resident and brush his teeth. You do not see the staff encourage the resident to perform these tasks on his own. At this stage, you are not familiar with this individual; however, you believe he is here for rehabilitation following a stroke and you note that he does not seem to have made much progress.

Ideas/resources for assessing outcome:

Resident rights:

Quality of care/services:

Accuracy of assessments:

Effectiveness of the physical environment:

Cultural factors:

Upbringing:

Religious beliefs:

Education:

Life experience:

Possible personal perspectives affecting the assessment:

Strategies for assuring a holistic perspective:

Assessment of Outcome—2

Assess the possible relation of these factors to the observation:

Factor	Possibly related?
Depression	
Problem behavior	
Weight loss	
Dehydration	
Pressure sore	
Urinary tract infection	
Limited ROM	
Pain	
Decline in ADLs	
Vision/hearing	
Incontinence	
Delirium	

Assessment of Outcome—3

How might the situation be a result of:

Natural progression?

Resident choice?

Facility practice or inaction?

Assessment of Outcome—4

You now review the resident assessments and care plan. The care plan does not specify interventions to promote functioning related to ADLs, and the nurse's aides do not realize the resident is here for rehabilitative services. From reviewing the chart, you see the resident was indeed admitted for the sole purpose of rehabilitation following a stroke.

Actual, potential, positive or negative outcome:

Ideas for subsequent investigation:

What would a "reasonable person" do, or how would a "reasonable person" feel in this situation?

Lesson 3-B: Offsite Survey Preparation

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Gather forms needed to conduct a standard survey.
- Describe the procedure for contacting a facility's State ombudsman's office.
- Restate and apply the information from OSCAR Reports, QIs and other sources.
- Complete Form CMS-801, *Offsite Survey Preparation Worksheet*.
- Complete Form CMS-802, *Roster/Sample Matrix*.
- Translate complaint information into concerns and resident selection.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
- *Facility Guide for the Nursing Home Quality Indicators* [On-line]. Available: https://www.cms.hhs.gov/MinimumDataSets20/09_HistoricalFiles.asp#TopOfPage

State

(Insert State reference[s] here)

Other

- *National Long Term Care Ombudsman Resource Center* [On-line]. Available: www.ltcombudsman.org/static_pages/ombudsmen.cfm

Highlights

- General objectives of offsite survey preparation
- Information sources for offsite survey preparation
- Team coordinator responsibilities
- Offsite survey team meeting

Training Techniques

- Internet scavenger hunt (to be done prior to the delivery of the lesson). For:
  - Name and contact information of the State ombudsman
  - Forms on the CMS website
  - Appendix P on the CMS website
  - OSCAR, PASRR and QI reports, if the surveyors have access
  - Facility Guide for the Nursing Home Quality Indicators
- Lecture
- Group discussion/game
- Brainstorming

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Paper and pens/pencils
- Highlighters, or colored markers for use with overhead transparencies
- Internet access
- Forms: CMS-801, CMS-802 and CMS-806B
- Sample reports and forms from a facility: OSCAR Report 3, OSCAR Report 4, PASRR, QI reports, Form CMS-672, Form CMS-2567 and Form A (optional: make overhead transparencies of these to facilitate group discussion)

- Copies of the handout *Excerpts from: Facility Guide for the Nursing Home Quality Indicators*
- Copies of the worksheet *Resources*
- Copies of the worksheet *Quality Indicators*

Methods of Evaluation

- Verbalization/discussion of understanding
- Review of surveyor documentation
- Effective use of information during future training sessions
- Completion of skill assessment for the lesson

Audiovisual

Lesson 3-B:
Offsite Survey Preparation

1

Slide 3-B-1

Outline or text of presentation

(Begin by conducting an Internet scavenger hunt to locate the forms used in the lesson, the State ombudsman contact information, sample OSCAR and QI reports and Appendix P. You may use the worksheet "Resources" on page 3-B-25 to record the pertinent web addresses and locations of information.

It will be helpful for the students to print copies of the forms and Appendix P if each does not have access to a printed copy.)

Offsite survey preparation is the first step of the standard nursing home survey. It allows the survey team to plan and focus investigations prior to the actual start of the survey. Recall that according to Federal requirements, an annual or standard survey is to be completed within a 9- to 15-month period. The State is to maintain an average of 12 months between surveys for all long-term care facilities.

(Inform the students of the objectives.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Gather forms needed to conduct a standard survey.
- Describe the procedure for contacting a facility's State ombudsman's office.
- Restate & apply the information from OSCAR Reports, QIs & other sources.

2

Slide 3-B-2

Audiovisual

Learning Objectives (cont.)

- Complete Form CMS-801, *Offsite Survey Preparation Worksheet*.
- Complete Form CMS-802, *Roster/Sample Matrix*.
- Translate complaint information into concerns & resident selection.

3

Slide 3-B-3

Objectives of Preparation

To analyze various sources of information available about facility to:

- Identify & preselect concerns for Phase 1 of survey
- Preselect residents for Phase 1 of survey based on Resident Level Summary

4

Slide 3-B-4

Objectives of Preparation (cont.)

- Note concerns based on other sources of information & note residents who might be added to sample
- Determine whether areas of potential concerns or special features of facility require addition to team of any specialty surveyors

5

Slide 3-B-5

Outline or text of presentation

Preparation Objectives

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

- Identify and preselect concerns for Phase 1 of the survey.
- Preselect potential residents for Phase 1 of the survey based on the Resident Level Summary.
- Note concerns based on other sources of information and note other residents who could be selected for the sample.
- Determine whether the areas of potential concerns or special features of the facility require the addition to the team of any specialty surveyors.

Audiovisual

Information to Obtain

- From previous survey:
  - CMS 2567, *Statement of Deficiencies*
  - Form A, *Statement of Isolated Deficiencies Which Cause No Actual Harm With Only Potential for Minimal Harm*
- OSCAR Reports 3, 4 & 40

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Information to Obtain (cont.)

- Quality Indicators (QIs)
- Waivers or variances
- Information from State ombudsman's office
- Preadmission Screening & Resident Review reports (PASRR)
- Other pertinent information

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OSCAR Report 3

Report contains:

- Prior 4 years of standard survey information
  - Deficiencies cited & when cited
  - Scope & severity level of deficiencies
- Facility name & address
- Provider number

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Slide 3-B-8

Outline or text of presentation

Information

For a survey, you must obtain the following information:

- *The Statement of Deficiencies* (Form CMS-2567) and *Statement of Isolated Deficiencies Which Cause No Actual Harm With Only Potential for Minimal Harm* (Form A)—The statements of deficiencies from the previous survey should be reviewed.
- OSCAR Reports 3, 4 and 40.
- Quality Indicators.
- Waivers or variances.
- Information from the State ombudsman's office.
- Preadmission Screening and Resident Review reports (PASRR).
- Other pertinent information.

OSCAR Report 3

Resource for:

- Prior 4 years of survey information.
- Deficiencies cited and when they were cited.
- What the scope and severity level of the deficiencies were.
- The most recent census breakdown of Title 18, 19, 18/19 and other complaint survey information with dates and results (substantiated or unsubstantiated).
- Type of ownership.
- Facility name and address.

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Outline or text of presentation

- Provider number (you will be recording this later on all your worksheets).

OSCAR Report 3 (cont.)

- Telephone
- Compliance status
- Resident census
- Total certified beds—Titles 18 & 19
- Dates & results from previous surveys
- Complaint survey information

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Slide 3-B-9

OSCAR Report 3 lists:

- Telephone number.
- Type of ownership.
- Compliance status.
- Resident census at the time of the last survey.
- Suspension dates when the facility was prevented from admitting new residents.
- Total certified beds—Titles 18 and 19.
- Dates and results from previous surveys both for the health portion of the survey and the Life Safety Code portion.
- Type of deficiency—This section is relevant to your review of the report and does need to be reviewed.
- Complaint survey information will provide dates that complaints were investigated.

OSCAR Report 4

- Information compiled from Form CMS-672
- Deficiencies cited
  - Average number of deficiencies in State, region & nation
- Facility number of residents with specific conditions
- Percentage "ranking" comparing facility with State, region & nation

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OSCAR Report 4

- This information is compiled from the *Resident Census and Condition* form (Form CMS-672) that the facility filled out on the previous annual survey:
  - Resident characteristics.
  - Total number of deficiencies cited and the average number of deficiencies in the State, region and nation.
  - Facility number of residents with specific conditions/diagnosis.
  - Facility's percentage "ranking" with State, region and nation.

Audiovisual

OSCAR Report 4 (cont.)

- Scope & severity for each deficiency
- Regulation that was not met
- Date deficiency was corrected
- Status of deficiency
- Frequency at which regulation is cited—State, region & nation
- Resident characteristics
- Waivers

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Slide 3-B-11

Outline or text of presentation

- The scope and severity for each deficiency cited on the previous standard survey, which will range from "A" to "L":
  - "A" means that only isolated problems were identified that would potentially not harm the resident.
  - "L" means that the majority of residents in the facility are at risk or have experienced serious harm that may even threaten their lives.
- The regulation that was not met.
- The date the deficiency was corrected.
- The status of the deficiency.
- The frequency that the regulation is cited in the State, the region and the nation. What you are looking for here are any regulations that are cited more or less frequently.
- Resident characteristics are the actual number of residents with certain characteristics who lived in the facility at the time of the last survey.
- Waivers—Waivers may be granted for Life Safety Code regulations and the regulation for licensed nurses. Review these waivers. Waivers have to be reviewed yearly at the time of the survey to determine if they are still needed. The *State Operations Manual (SOM)* provides guidance for reviewing waivers.

Audiovisual

OSCAR Report 40

- Complaints
- Allegations
- Sources of allegations
- Identification of complaint regulation heading (Quality of Care, Quality of Life, Dietary & Staffing)

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Slide 3-B-12

OSCAR Report 40 (cont.)

- Results of complaint investigations
- Review information from complaints:
  - Investigated since previous standard survey
  - Filed with survey agency but not yet investigated

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Slide 3-B-13

Outline or text of presentation

OSCAR Report 40

Complaints, allegations, sources of the allegations and the identification of the complaint regulatory heading (Quality of Care, Quality of Life, Dietary and Staffing).

- 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.
- 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.
- Information from the State ombudsman's office—Note any potential areas of concern reported by the ombudsman's office. Also note resident names reported as potential sample residents, residents for closed record review, or family interviews and the reasons for their recommendation by the ombudsman.
- 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 whether there are any potential concerns and note names of residents for possible inclusion in the sample.

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Outline or text of presentation

- 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.

Pertinent information from the OSCAR Reports 3, 4, 40 and QIs and complaint investigations must be recorded on Form CMS-801. The information on the complaint is confidential. It should never be:

- Shown to anyone other than State agency staff.
- Left unattended.
- Left in the facility.

Although it lists the person who filed the complaint, you must make every effort not to reveal who the person is.

Role of Team Coordinator (Leader)

- Contact ombudsman's office
- Gather:
  - Quality Indicator Reports
    - Facility Characteristics
    - Facility Quality Indicator Profile
    - Resident Level Summary
  - *Statement(s) of Deficiencies* (Form CMS-2567)

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Team Coordinator Role

The team coordinator (leader) contacts the ombudsman's office in accordance with the policy developed between the State survey agency and State ombudsman agency. Notify the ombudsman of the proposed day of entrance and obtain any information the ombudsman wishes to share with the survey team. Ask if the ombudsman will be available if residents participating in the group or individual interviews wish her/him to be present.

Team coordinator (or designee) responsibilities:

1. Contact the ombudsman's office.
2. Gather the following information:

- Quality Indicator Reports:
  - Facility Characteristics.

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Role of Team Coordinator (Leader) (cont.)

– *Statement of Isolated Deficiencies Which Cause No Actual Harm With Only Potential for Minimal Harm* (Form A)
– OSCAR Report 3
– OSCAR Report 4
– Results of complaint investigations
– Waivers or variances
– PASRR
– Other pertinent information

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Additional Team Leader Duties

- Copy & distribute facility floor plan
- Make extra copies of unmarked OSCAR Reports 3 & 4 & 3 QI reports
- Obtain extra copy of group interview form (Form CMS-806B)

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Outline or text of presentation

  - Facility Quality Indicator Profile.
  - Resident Level Summary.
- *Statement(s) of Deficiencies* (Form CMS-2567).
- *Statement(s) of Isolated Deficiencies Which Cause No Actual Harm With Only Potential for Minimal Harm* (Form A).
- OSCAR Report 3.
- OSCAR Report 4.
- Results of complaint investigations.
- Information about waivers or variances.
- Information from the State ombudsman's office.
- Preadmission Screening and Resident Review reports (PASRR).
- Other pertinent information.

Complete the following additional duties:

- Copy and distribute the floor plan to the team if the team is unfamiliar with facility layout.
- Make extra copies of the unmarked OSCAR Reports 3 and 4 and the three QI reports to be given to the facility's administrator.
- Obtain an extra copy of the group interview form (Form CMS-806B) to be given to the resident council president.

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Offsite Team Meeting

- Review Facility Characteristic Report
- Highlight concerns for Phase 1 on *Roster/Sample Matrix* (Form CMS-802)

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Slide 3-B-17

Outline or text of presentation

Offsite Survey Preparation Team Meeting

Present copies of the information obtained to the survey team members for review at a team meeting offsite.

(Use highlighters on paper copy or colored pens on overhead transparencies to mark up the sample facility OSCAR, QI and other information to help select areas of concern.

"Work of Art" game: As areas of concern/residents to include are identified, note these on Form CMS-801 and Form CMS-802. At the end of the lesson, post the completed forms on a wall or table, unsigned. Allow the students to review the samples. Reconvene the class, discuss reactions and vote on the clearest, most complete "work of art.")

The team must prepare for the survey offsite, so they are ready to begin the entrance conference and initial tour immediately after they enter the facility. The team should:

1. Review the Facility Characteristic Report. Note the facility's demographics to identify whether the facility's population is unusual (high prevalence of young or male residents, high percentage of significant change assessment, etc.).
2. Use a copy of the *Roster/Sample Matrix* (Form CMS-802) to highlight concerns the team identifies for Phase 1 of the survey and to list residents preselected and the QI conditions for which each was selected. Mark the offsite block on this form to distinguish it from the Phase 1 version.

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Offsite Team Meeting (cont.)

- Check sentinel health events
  - Fecal impaction
  - Dehydration
  - Prevalence of pressure sores (low risk)
- Check for QIs flagged at 90th percentile
- Check for unflagged QIs at 75th percentile or greater

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Outline or text of presentation

3. Select any sentinel health event QI that is flagged. A "sentinel health event" is a QI that represents a significant occurrence that must be selected as a concern, even if it applies to only one or a few residents. Sentinel health event QIs are Prevalence of Fecal Impaction, Prevalence of Dehydration and Prevalence of Pressure Ulcers (low risk). If even one resident has any of these conditions, this QI will "flag," 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, it is not necessary to select all of them.
4. Select any other QI that is flagged at the 90th percentile.
5. Select any unflagged QI at the 75th percentile or greater.

The team can select any other concerns that are of interest because they are related to QIs that have been selected or the percentile number is extremely low in comparison to the QIs. The team may also identify other areas of concern derived from sources of information other than the QI reports.

Facility Quality Indicator Profile

- Denominator
- General indicators
- Incidence
- Numerator
- Percentile rank

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Slide 3-B-19

Facility Quality Indicator Profile (QIs)

(Review the handout, "Facility Guide for the Nursing Home Quality Indicators" on page 3-B-27.

Alternatively, students may use the handout "Quality Indicators" on page 3-B-33 to restate the meaning and give the number of each. Divide the students into two groups. One group will write clues for the odd-numbered QIs and the other will write clues for the even-numbered QIs. The groups will then take turns providing clues

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Outline or text of presentation

for the other group to look up in the QI list. The team most successful at giving clues that the other team guesses on the first try wins.)

Facility Quality Indicator Profile
(cont.)

- Prevalence
- Risk groups
- Sentinel health events
- Thresholds
- Number in numerator

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Slide 3-B-20

Facility Quality Indicator Profile
(cont.)

- Number in denominator
- Facility percentage
- Comparison group percentage
- Percentile rank
- QIs that have crossed investigative threshold

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Slide 3-B-21

The Facility QI Profile provides facility status for each of the Minimum Data Set (MDS)-based QIs as compared to a peer group of the facilities in the State. The QI reporting system includes 24 QIs based on the MDS. The MDS is electronically submitted by the facility to the State agency (SA) monthly.

Audiovisual	Outline or text of presentation
	Quality Indicators and QI Reports are derived from MDS data. The QIs cover the following 11 domains or care areas: Accidents; Behavior/Emotional Patterns; Clinical Management; Cognitive Patterns; Elimination/Incontinence; Infection Control; Nutrition/Eating; Physical Functioning; Psychotropic Drug Use; Quality of Life; and Skin Care. QIs are also closely related to the Resident Assessment Protocols (RAPs) component of the Resident Assessment Instrument (RAI), which is covered in another lesson. The QIs are generated using the most current MDS records in the State database at the time the report was generated. The system excludes residents who have only an initial MDS record in the system. The Facility Quality Indicator Profile does not include information for residents who are new admissions or readmissions, since the MDS data for them is most likely to reflect care they received before they were admitted to the facility being surveyed. The Facility Characteristics Report (Report 1) contains demographic information by percentages both for the facility and for the State. It may be used to identify areas for further emphasis or investigation during the survey process. This report is informative, but the best information may be gained when state-wide percentages are reviewed against the facility percentages. *(As a group, review a sample Facility Characteristics Report. Discuss and compare the facility percentages and state-wide percentages. Identify significant comparisons such as a facility with a large number of male residents, higher than*

Audiovisual	Outline or text of presentation
	average number of residents with psychiatric disorders, or residents with mental retardation.)
	The Facility Quality Indicator Profile (Report 2) shows the facility percentage and how the facility compares with other facilities in the State for each QI. The report assists in identifying possible areas for further investigation during the survey or emphasis in quality improvement activities.
	Resident Level Summary (Report 3) lists each resident in the facility. It assists in choosing concerns for the survey. It may also be used to detect patterns of quality indicators and which residents are affected.
	As you prepare for the survey and review these reports, think about selecting residents for review who flag on: • Multiple QIs that are at 90th or 75th percentile or above. • Sentinel Health Event Quality Indicators. • One or two QIs in an area of concern for the facility noted from your review of the Quality Indicator profile. • An area of concern for the survey highlighted on the Facility Quality Indicator Profile and complaint reports.
	Column Information
	The *first column* is the "Number in the Numerator." This is the actual number of residents who flagged on the QI. These are the people who "have" the QI. For the purposes of calculating the percentage(s), it is the numerator.
	The *second column* is "Number in the Denominator." This is the number of

Audiovisual	Outline or text of presentation
	people in the facility who "could have" the QI. For the purposes of calculating percentage(s), it is the denominator. Most of the time, the number of residents who could have the QI will be the total facility population, excluding those whose most recent assessment is for an admission; but there are some QIs that use a specific subgroup as those who "could have" the QI. A good example of this subgroup is the QI 19, "Antipsychotic Uses in the Absence of Psychotic and Related Conditions." The only residents who "could have" this QI are those without a psychotic disorder or other related conditions. In the case of incidence QIs, the group of residents who could have the QI includes only people who did not have the QI condition in the previous period. This is because incidence QIs measure the development of the QI where it did not exist previously. An example of an incidence QI with a specific subgroup is QI 17, "Incidence of Cognitive Impairment." The denominator ("could have it") for this QI is only those residents who, on their previous assessment, *were not* cognitively impaired and who, on their current assessment, *are* cognitively impaired. The *third column* is the "Facility Percentage." This column tells you what percentage of residents who could have the QI actually did have it. If 60 people could flag on a QI (denominator, column 2) and 30 people actually have it (numerator, column 1), the facility proportion (percentage, ratio) would be 50%. The *fourth column* is the "Comparison Group Percentage." This column tells you what the state-wide percentage is for the QI so that you can make comparisons with the facility. This column can be very

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Outline or text of presentation

helpful in pointing toward those facilities that may be above or below the state-wide percentage of proportion. These facilities are called "outliers," meaning their percentages are out of line with respect to the rest of the State.

The *fifth column* is the "Percentile Rank." This column ranks facilities relative to other facilities in the State on each QI. The higher the ranking, the more likely the QI needs to be reviewed as part of the facility quality improvement process or to be emphasized on the survey.

Offsite Sample

- At team meeting:
  - Review all sources of information
  - Record this information on *Offsite Preparation Worksheet* (Form CMS-801) & *Roster/Sample Matrix* (Form CMS-802)

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Use a copy of the *Roster/Sample Matrix* (Form CMS-802) to highlight any concerns the team identifies for the offsite sample. The total resident census, including bedhold (places held temporarily for residents on physician-approved therapeutic visits with friends or family), will be what determines the sample size for your offsite case mix.

Building a sample by selecting representatives of different case groups in the facility population is referred to as selecting a "case-mix stratified" sample. By statute, heavy and light care, interviewable and noninterviewable cases must be represented.

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Offsite Sample (cont.)

- Identify outstanding complaints needing investigation
- Establish preliminary surveyor assignments
- Keep in mind:
  - OSCAR information is approximately 1 year old
  - QI information may be 2 to 6 months old

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Slide 3-B-23

Summary

- Select case-mix stratified sample of facility residents
  - Base sample on QIs & other offsite & onsite sources of information
- Assess compliance with resident-centered long term care requirements

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Summary (cont.)

- Use Table on page 35 of Appendix P to determine minimum number of residents to be selected for case-mix sample

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Outline or text of presentation

Use Table 1 on page 35 of Appendix P to preselect a few more residents (three to five) than the actual number that will be required for the Phase 1 sample. This will accommodate the fact that some residents who have been preselected may no longer be at the facility (these residents could fill closed record slots). List residents that have been preselected and mark the block for any concerns each resident has. Remember to include the WHP group (W—unintended weight loss, H—hydration and P—pressure sore).

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Outline or text of presentation

Lesson 3-B:
Offsite Survey Preparation

Questions

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Slide 3-B-26

Skill Assessment

Offsite Survey Preparation

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Gathered forms needed to conduct a standard survey.	
					Described the procedure for contacting a facility's State ombudsman's office.	
					Restated and applied the information from OSCAR Reports, QIs and other sources.	
					Completed Form CMS-801, *Offsite Survey Preparation Worksheet*.	
					Completed Form CMS-802, *Roster/Sample Matrix*.	
					Translated complaint information into concerns and resident selection.	

Comments/Recommendations:

Resources

State ombudsman's name and contact information	

Resource/Form	Internet Location
Appendix P	
CMS-801	
CMS-802	
CMS-806B	

Facility Report/Resource	Location
OSCAR Report 3	
OSCAR Report 4	
PASRR	
QI—Facility Characteristics	
QI—Facility Quality Indicator Profile	
QI—Resident Level Summary	
CMS-2567	
Form A	
CMS-562	
CMS-672	

Excerpts from: FACILITY GUIDE FOR THE NURSING HOME QUALITY INDICATORS

National Data System

September 28, 1999

Center for Health Systems Research and Analysis, University of Wisconsin - Madison

The Facility Guide for the Nursing Home Quality Indicators (the "Guide") was developed at the Center for Health Systems Research and Analysis' (CHSRA) by the Nursing Home Quality Indicators Development Group (the "NHQIDG") with support from the Health Care Financing Administration. CHSRA and the NHQIDG is associated with the University of Wisconsin-Madison.

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Key Concepts And Terms

(from "Facility Guide for the Nursing Home Quality Indicators")

The following are important terms and concepts that are necessary to understand before the QIs can be interpreted correctly.

DENOMINATOR: The number of facility residents who could have the QI.

GENERAL INDICATORS: Quality Indicators for which some occurrence in the facility is expected. (For example, Prevalence of Bladder or Bowel Incontinence or Prevalence of Pressure Ulcers that occur in a High Risk population.)

INCIDENCE: The QI type that provides a description of what new conditions have developed over the course of the last two assessments. It is used to show the development of conditions for a single resident, or for the facility. Note that resident who do not have a previous assessment will be excluded from incidence QIs. Also, pay careful attention to the denominator definitions as resident that meet the QI flagging criteria on the previous assessment are excluded from the QI calculation. Last, note that the Decline in ROM and Incidence of Late Loss ADLs exclude residents whose previous assessment indicates that no further decline is possible.

NUMERATOR: The actual number of residents who flagged on the QI. These are the residents who "have" the QI.

PERCENTILE RANK: A means of ranking facilities based on how they compare with each other on each separate QI. Facilities that rank very high, that is, they are at a high percentile, will "flag" on a specific QI. The higher the percentile, the more potential for a care concern in the facility.

PREVALENCE: The QI type that gives a point in time measure. Most of the QIs are prevalence measures. They provide the facility with the percentage of residents who flagged on a QI, on the basis of their "current" assessment.

RISK GROUPS: An assessment of the likelihood that a resident will develop the condition expected in the QI is incorporated into the QI itself. The results are QIs that flag for both those persons identified at HIGH risk and all others (LOW RISK). This concept has implications for assessing how facilities intervene with residents who are vulnerable to certain conditions and how they intervene with residents who are not vulnerable.

SENTINEL HEALTH EVENTS: Quality Indicators that should occur very infrequently, if at all, in a facility. The nature of these indicators is serious enough to warrant investigation if it occurs only once or twice. (For example, Prevalence of Fecal Impaction, Prevalence of Dehydration, or Prevalence of Pressure Ulcers occurring in a Low Risk population.)

THRESHOLDS: A set point for each QI at which the likelihood of a problem is sufficient to warrant emphasis or at least further investigation by the facility or by a survey team.

A Quick Guide to the QIs

The following is intended for use as a quick guide to the QIs. It does not offer the complete definition(s) and descriptions found in the QI matrix (Appendix A). It is intended as a ready reference. It is important to note that, for all Prevalence QIs, the data come from the most recent assessment in the data file[1]. For the Incidence QIs, the data come from both the most recent assessment and the assessment immediately previous to it. Incidence QIs look at the development of an event or situation across two assessment periods.

It is also important to remember that Risk Adjustment is crucial to how you interpret a QI, and how you go about assessing a facility's response to a resident who is at HIGH RISK versus one who is at LOW RISK.

QI 1 Incidence of new fractures
Residents who have a hip fracture or other fracture that is new since the last assessment. This QI is not risk adjusted and the denominator is all residents who did not have a fracture on the previous assessment.

QI 2 Prevalence of falls
Residents who have been coded with a fall within the time frame of the most recent assessment (past 30 days). This QI is not risk adjusted and the denominator is all residents[2].

QI 3 Prevalence of behavioral symptoms affecting others
Residents who have displayed behaviors affecting others on the most recent assessment. Behavioral symptoms are defined as verbal abuse, physical abuse, or socially inappropriate/disruptive behavior. The behavior has had to occur at least once in the assessment period (7 days).

This QI is RISK ADJUSTED. Residents are considered more likely (are at HIGH RISK) to exhibit behavioral symptoms if they are cognitively impaired on the most recent assessment or have diagnoses of manic depression or psychotic disorders on the most recent or on the most recent FULL assessment (See Footnote 1). Residents who do not have any of these conditions are at LOW RISK.

QI 4 Prevalence of symptoms of depression
Residents with symptoms of depression on the most recent assessment. This is a complex definition. Residents are considered to have this QI if they have a sad mood <u>and</u> have 2 or more symptoms of functional depression (defined below).

The symptoms of functional depression that are used in deciding whether a person meets one of these criteria are also complex. There are five symptoms, and some involve more than one item. These symptoms occurring within the most recent assessment period are: (1) negative statements exhibited up to 5 days or more per week; (2) agitation or withdrawal exhibited up to 5 days or more per week, or resists care at least 1-3 days in the last 7 days, or withdrawal from activities or reduced social

[1] For QIs 3, 19, and 20 which have exclusions or risk adjustments that include individuals with psychotic or related diagnoses or manic depression, some data related to these diagnoses is carried forward from the last full assessment, if the assessment was a quarterly assessment.
[2] Technically, not all residents are included in the QI calculation for the Facility Quality Indicator Profile report. The calculations exclude those residents whose current/most recent assessment is an <u>admission</u> assessment, since it is unlikely the QI condition they have was acquired in the facility. For a description of which assessments are used in calculation of the various QI reports see TABLE 1 on Page 20.

activity exhibited up to 5 days or more per week; (3) waking with an unpleasant mood up to 5 days or more per week, or not being awake most of the day and not comatose; (4) being suicidal or having recurrent thoughts of death up to 5 days or more per week; and (5) weight loss. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 5 Prevalence of depression with no antidepressant therapy
Residents with symptoms of depression and no antidepressant therapy on the most recent assessment. Symptoms of depression are defined using the same criteria described in the previous QI and no antidepressant therapy was provided. This QI is not risk adjusted and the denominator is all residents.

QI 6 Use of 9 or more different medications
Residents who received 9 or more different medications on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 7 Incidence of cognitive impairment
This QI identifies those residents who were not cognitively impaired on the previous assessment, but who are cognitively impaired on their most recent assessment. Cognitive impairment is defined as having impaired decision-making abilities, and short term memory problems. The denominator is only those residents who were not cognitively impaired on the previous assessment. This QI is not risk adjusted.

QI 8 Prevalence of bladder or bowel incontinence
Residents who were determined to be incontinent or frequently incontinent on the most recent assessment. The denominator for this QI does not count those people who were comatose, had indwelling catheters, or ostomies on the most recent assessment.

This QI is RISK ADJUSTED. Residents are considered more likely to be incontinent if they have severe cognitive impairment or are totally dependent (self-performance) in ADLs having to do with mobility (bed mobility, transfer, and locomotion). These residents are at HIGH RISK for incontinence. Residents who do not have these conditions and are not excluded from the QI are considered LOW RISK.

QI 9 Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan
Residents who are assessed as incontinent, either occasionally or frequently, and who do not have a toileting plan noted on the most recent assessment. In this case, the denominator would be those residents who are coded with frequent or occasional incontinence on the current assessment. This QI is not risk adjusted.

QI 10 Prevalence of indwelling catheters
Residents noted to have an indwelling catheter on their most recent assessment. The denominator is all residents.

QI 11 Prevalence of Fecal Impaction
Residents who have been noted with fecal impaction on their most recent assessment. This QI is considered to be a *sentinel health event*, meaning that even if one person has this QI, it is of sufficient concern to require a review. This QI is not risk adjusted and the denominator is all residents.

QI 12 Prevalence of urinary tract infections
Residents identified on the most recent assessment as having had a urinary tract infection. This QI is not risk adjusted and the denominator is all residents.

QI 13 Prevalence of weight loss
Residents noted with a weight loss (5% or more in the last 30 days or 10% or more in the last 6 months) on the most recent assessment. This QI is not risk adjusted and the denominator is all residents.

QI 14 Prevalence of tube feeding
Residents noted with a feeding tube on the most recent assessment. This QI is not risk adjusted and the denominator is all residents.

QI 15 Prevalence of dehydration
Residents who have been coded with condition of dehydration (MDS check box) or with a diagnosis of dehydration (MDS ICD-9 CM 276.5). This QI is not risk adjusted and the denominator is all residents. This QI is considered a *sentinel health event.*

QI 16 Prevalence of bedfast residents
Residents determined to be bedfast on the most recent assessment. This QI is not risk adjusted and the denominator is all residents. The definition of bedfast is very specific and is found in the RAI Manual.

QI 17 Incidence of decline in late-loss ADLs
A decline in ADL functioning (self-performance) over two assessment periods -the most recent and the assessment immediately prior. Late-loss ADLs are those considered the "last" to decline or deteriorate (i.e., bed mobility, transferring, eating, and toileting). Over the assessment periods, there has been a one level decline in at least two of these ADLs OR there has been a two level decline in one of them. In other words, the resident has experienced a gradual decline in two or more areas or has experienced a rather significant decline in one.

The denominator does not include residents who already were determined to be totally dependent or comatose on the previous assessment. This QI is not risk adjusted.

QI 18 Incidence of decline in ROM
Residents who have had an increase in functional limitation in Range of Motion (ROM) between the previous and most recent assessments.

This QI includes only residents with the previous and most recent assessments on file, with the exclusion of residents with maximal loss of ROM on the previous assessment.

QI 19 Prevalence of antipsychotic use in the absence of psychotic or related conditions
Residents who are receiving antipsychotics on the most recent assessment. The denominator for this QI excludes those residents who have psychotic disorders, Tourette's, or Huntington's on the most recent assessment (See Footnote 1) or on the most recent FULL assessment or those with hallucinations on the most recent assessment.

This QI is RISK ADJUSTED. Residents who exhibit both cognitive impairment and behavior problems on the most recent assessment are considered at HIGH RISK to receive antipsychotic medication(s). All others (except those excluded) are considered at LOW RISK.

QI 20 Prevalence of any antianxiety/hypnotic use
Residents who received antianxiety medication(s) or hypnotic(s) on the most recent assessment. The denominator for this QI excludes those residents with one or more psychotic disorders, Tourette's or Huntington's on the most recent assessment or the most recent FULL assessment (See Footnote 1) or those with hallucinations on the most recent assessment. This QI is not risk adjusted.

QI 21 Prevalence of hypnotic use more than two times in the last week
Residents who received hypnotics more than twice in the last week on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 22 Prevalence of daily physical restraints
Residents who were restrained (trunk, limb, or chair) on a daily basis on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 23 Prevalence of little or no activity
Residents who, on the most recent assessment, were noted with little or no activity. The denominator includes all residents, except those who are comatose. This QI is not risk adjusted.

QI 24 Prevalence of Stage 1-4 pressure ulcers
Residents who have been assessed with a pressure ulcer(s) Stage 1-4 on the most recent assessment--either in the coding area for pressure ulcers or with an ICD-9 code. The denominator is all residents on the most recent assessment.

This QI is RISK ADJUSTED. Residents are considered HIGH RISK for the development of pressure ulcers if they have any one or more of the following conditions: they are impaired for bed mobility or transfer; or are comatose; or have malnutrition; or have an end stage disease on the most recent assessment. All other residents are considered to be LOW RISK. Residents at low risk that flag should be reviewed since this would be considered a *sentinel health event*.

Quality Indicators

Quality Indicator	QI #	Clue
1. Incidence of cognitive impairment		
2. Incidence of decline in late-loss ADLs		
3. Incidence of decline in ROM		
4. Incidence of new fractures		
5. Prevalence of daily physical restraints		
6. Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan		
7. Prevalence of antipsychotic use in the absence of psychotic or related conditions		
8. Prevalence of any antianxiety/hypnotic use		
9. Prevalence of bedfast residents		
10. Prevalence of behavioral symptoms affecting others		
11. Prevalence of bladder or bowel incontinence		
12. Prevalence of dehydration		
13. Prevalence of depression with no antidepressant therapy		
14. Prevalence of falls		
15. Prevalence of fecal impaction		
16. Prevalence of hypnotic use more than two times in the last week		
17. Prevalence of indwelling catheters		
18. Prevalence of little or no activity		

19. Prevalence of Stage 1–4 pressure ulcers		
20. Prevalence of symptoms of depression		
21. Prevalence of tube feeding		
22. Prevalence of urinary tract infections		
23. Prevalence of weight loss		
24. Use of nine or more different medications		

Lesson 3-C: Entrance Conference and Onsite Preparatory Activities

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify required paperwork to obtain prior to the survey.
- Identify the necessary paperwork to provide to the facility's administrator during the entrance conference.
- Answer questions about the survey process from facility staff.
- Evaluate the accuracy/completeness of the CMS forms returned by the administrator.
- Conduct the entrance conference with confidence.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I

State

(Insert State references[s] here.)

Other

Highlights

- Discussion and demonstration regarding information to provide and questions to ask during the entrance conference
- Checking Forms CMS-671, CMS-672 and CMS-802 for accuracy and completeness

Training Techniques

- Lecture
- Large group discussion
- Role-play

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Form CMS-671, *Long Term Care Facility Application for Medicare and Medicaid*
- Form CMS-672, *Resident Census and Conditions of Residents*
- Form CMS-802, *Roster/Sample Matrix*
- Form CMS-806B, *Quality of Life Assessment: Group Interview*
- Form CMS-1513, *Disclosure of Ownership and Control Interest Statement*
- Form CMS-855, *Medicare Federal Health Care Provider/Supplier Enrollment Application*
- Handouts:
  - *Entrance Conference Checklist*
  - *Entrance Conference Script*

Methods of Evaluation

- Return demonstration
- Review of surveyor documentation
- Effective use of information during future training sessions
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 3C:
Entrance Conference & Onsite Preparatory Activities

1

Slide 3-C-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify required paperwork to obtain prior to the survey.
- Identify the necessary paperwork to provide to the facility's administrator during the entrance conference.
- Answer questions about the survey process from facility staff.

2

Slide 3-C-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Evaluate the accuracy/completeness of the CMS forms returned by the administrator.
- Conduct the entrance conference with confidence.

3

Slide 3-C-3

Audiovisual

Entrance Conference

- Make a good first impression
- Begin to collect data
- Identify issues to investigate
  - Team leader takes lead
  - Team members enter at same time

4

Slide 3-C-4

Outline or text of presentation

Entrance Conference

The entrance conference is where you make your first impression on facility staff. Here you begin to collect information and identify issues to investigate during the survey. Your demeanor throughout the entrance conference should be one of quiet, confident professionalism.

Whenever possible, the survey team members should try to enter the facility at the same time. Therefore, the survey team coordinator generally arranges with other team members to meet at a certain time, on a certain day, in a certain location prior to entering the facility. This is usually another location nearby the facility, such as restaurants or a corner of a large parking lot.

Off-Hours Survey

Survey started before 8 a.m. or after 6 p.m. or on Saturday or Sunday:

- Announce survey
- Determine who's in charge
- Notify facility administration
- Modify & complete entrance conference as appropriate

5

Slide 3-C-5

Off-Hours Survey

If the survey is to be initiated outside the usual business hours of 8 a.m. to 6 p.m., or on a Saturday or Sunday, announce the survey once onsite, ascertain who is in charge, and ask the person to notify the administrator that a survey has begun.

Modify the entrance conference taking into account the staff available, and complete the task and the onsite preparatory activity as appropriate. Facility staff may be limited and information may not be available during unusual hours of entrance.

When entering the facility, the survey team coordinator will take the lead to begin the survey.

Audiovisual

Meet Administrator

- If administrator is not present, ask, "Who is in charge?"
- Team coordinator:
  - Announces survey
  - Introduces team members
  - Requests staff to accompany surveyors on initial tour

6

Slide 3-C-6

Outline or text of presentation

Meet the Administrator

First, the team coordinator either goes to the administrator's office or finds the nearest nursing station and requests directions to that office.

You are to try to meet the administrator. Begin the survey by introducing yourself and the team members to the facility administrator. If that individual is not present, ask, "Who is in charge?" and meet the individual. If the facility staff do not know who is in charge, ask for the nurse in charge at that time. If the administrator is offsite, request assistance from the ranking person in charge to find a place for your personal effects and staff to begin the initial tour.

The team coordinator introduces himself/herself and the team members. After the introduction, the other team members should proceed to the initial tour (Task 3), while the team coordinator conducts the entrance conference. Request that the administrator provide facility staff assistance so other surveyors can begin the tour. Facility staff should be knowledgeable about the residents and the care and services currently received by each resident. This will be discussed in Lesson 3-D, Initial Tour.

Team Coordinator Duties

- Requests copy of actual working schedule
- Informs staff of team communication throughout survey
- Explains survey process & answers questions
- Obtains description of facility's special features
- Arranges for private meeting with residents

7

Slide 3-C-7

Team Coordinator Duties

During the entrance conference, 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.
- Inform facility staff the survey team will be communicating with them throughout the survey and will ask

Audiovisual	Outline or text of presentation
	for facility assistance when needed. Advise them 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 the three quality indicator (QI) reports and the OSCAR 3 and 4 reports that are being used for the survey. Briefly explain these reports and how the survey team used them in Task 1. – If there are discrepancies between the OSCAR information and the QI Facility Characteristics report, ask 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. • 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 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.

Audiovisual

Entrance Checklist

- Provide copy of checklist & review with administrator

8

Slide 3-C-8

Outline or text of presentation

Ask the administrator to provide the following information:

(See "Entrance Conference Checklist," page 3-C-17 and "Entrance Conference Script," page 3-C-19.)

Ask the facility personnel 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: Form CMS-802 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.

Within one hour of the conclusion of the entrance conference you should request:

1. A list of key facility personnel and their locations (e.g., the administrator; directors of finance, nursing services, social services, and activities; dietitian or food service supervisor; rehabilitation services staff; charge nurse; pharmacy consultant; plant engineer; housekeeping supervisor; person responsible for infection control and quality assurance; health information management professional; and the medical director).
2. A copy of the written information provided to residents regarding their rights.
3. A list of meal times; dining locations; copies of all menus, including therapeutic menus, that will be served for the duration of the survey.

Audiovisual	Outline or text of presentation
	4. A list of medication pass times (by unit, if variable). 5. A list of admissions during the past month and a list of residents transferred or discharged during the past three months with destinations. 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, and other payment sources). 8. A list of 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 current resident activity schedule/calendar. *Note*: The facility is not required by Federal regulations to maintain this record. 11. The names of any residents age 55 and under. 12. The names of any residents who communicate with non-oral-communication devices or sign language or who speak a language other than the dominant language of the facility.

Audiovisual	Outline or text of presentation
	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), a *Resident Census and Conditions of Residents* (Form CMS-672), and the completed ownership document (Form CMS-1513), if not obtained through other State mechanisms. 2. A list of Medicare residents who requested demand bills (bills to Medicare for services in cases "demanded" by the resident where coverage has been billed to the resident by the provider) in the last six months (skilled nursing facilities [SNFs] or dually participating skilled nursing facilities/nursing facilities [SNF/NFs] only). 3. A list of all employees hired within the last four months. Also, ask the administrator the following questions: 1. Which, if any, rooms have less square footage than required? Do you have a variance? Are you prepared to request a variance for any such rooms? Do you have any waivers? (F458) 2. Do you have any rooms occupied by more than four residents? (F457) 3. Is there at least one window to the outside in each room? (F461) 4. Do you have any bedrooms not at or above ground level? (F461) 5. Do all bedrooms have access to an exit corridor? (F459) 6. What procedures do you have in place to ensure that water is available to essential areas when there is a loss of normal supply? (F466) 7. Do you have a CLIA waiver?

Audiovisual

Onsite Preparatory Activities

- Post signs
- Contact president of resident council
  - Provide copy of questions
  - Ask permission & review minutes
  - Check with ombudsman

9

Slide 3-C-9

Outline or text of presentation

Onsite preparatory activities:

1. Ask the facility to post signs announcing that a survey is in progress 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 to introduce himself/herself and to announce the survey.
   - Provide the president with a copy of the blank group interview form and solicit any concerns.
   - Ask the council president for permission to review council minutes for the past three months. 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, select a resident representative to assist in arranging a 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 and 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 noninterviewable residents are not part of this meeting.

Team coordinator follow-up:

- Use your entrance conference checklist to verify the information you receive from the administrator.

Audiovisual

Lesson 3C:
Entrance Conference & Onsite Preparatory Activities

Questions

10

Slide 3-C-10

Outline or text of presentation

(To practice, conduct a role-play of an entrance conference and initial preparation. Suggestions:

- *An experienced surveyor may pose as the administrator/designee.*
- *Have one student or an experienced surveyor use the Role-Play Skill Assessment to collect data for a debrief session.*
- *The rest of the students, if any, may take turns in the role of the coordinator, take other roles or function as alternate observers.*

A "Role-Play Skill Assessment" is provided on pages 3-C-21 to 3-C-25 for use in observing the role-play.)

Skill Assessment

Entrance Conference and Onsite Preparatory Activities

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Obtained the paperwork required to begin the survey.	
					Provided the necessary paperwork to the administrator during the entrance conference.	
					Answered questions from facility staff about the survey process.	
					Evaluated the accuracy and completeness of the CMS forms returned by the administrator.	
					Conducted the entrance conference independently with confidence.	

Comments/Recommendations:

Entrance Conference Checklist

Facility Name _____ **Survey Date** _____

Census _____ **Bed holds** _____ **Time** _____

ITEM	REQUIRED ITEM	DUE	REC'D
1.	Completed *Roster/Sample Matrix* (Form CMS 802)	End of tour	
2.	Copy of working schedules for all RNs and LVNs on duty now	End of tour	
3.	List of key personnel and locations	1 hour	
4.	Copy of information given to residents regarding rights	1 hour	
5.	Meal times, dining locations, copies of all menus (including therapeutic menus) that will be served for the duration of the survey	1 hour	
6.	Medication pass times (by unit, if variable)	1 hour	
7.	List of admissions during the past month and a list of residents transferred or discharged during the past three months with destinations	1 hour	
8.	Copy of facility layout, if not obtained in Task 1	1 hour	
9.	Copy of the facility's admission contract(s) for all payer types	1 hour	
10.	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	1 hour	
11.	Evidence of system to prevent, monitor and record accidents and incidents*	1 hour	
12.	Current resident activity schedule/calendar**	1 hour	
13.	Names and room numbers of residents age 55 and under	1 hour	
14.	Names and room numbers of residents who communicate with non-oral-communication devices, sign language, or other than facility dominant language	1 hour	
15.	Name and room number of president of resident council	1 hour	
16.	Completed Form CMS-671, *Long Term Care Facility Application for Medicare and Medicaid*	24 hours	
17.	Completed Form CMS-672, *Resident Census and Conditions of Residents*	24 hours	
18.	Completed Form CMS-1513, *Disclosure of Ownership and Control Interest Statement*	24 hours	
19.	List of Medicare residents who requested a demand bill within last six months (SNFs & dually participating SNF/NFs only)	24 hours	
20.	List of all employees hired within last four months	24 hours	
ASK	Room with less square footage than required? Y/N Any waivers? Y/N Rooms without outside windows? Y/N Rooms occupied by more than four residents? Y/N Rooms below ground level? Y/N All bedrooms with access to an exit corridor? Y/N What are your emergency water supply procedures? Y/N Any special features: Care? Treatment? Case mix? Do you have a CLIA waiver? Prior to going onsite…was CLIA Certificate current? Y/N		

Give administrator copies of QI reports and OSCARs.
Post signs announcing the survey.
*This evidence, at the discretion of the facility, could include or be a record of accident and incident reports.
**Facility is not required by Federal regulations to maintain this record.

Entrance Conference Script

Good morning/afternoon:

My name is _____ and I am the team coordinator for this survey. (Introduce the other team members.) During this entrance conference for your facility's annual recertification survey I will clarify our process and afford you time for questions you may have about how we will be communicating with your staff.

Throughout the course of our survey, my colleagues and I will be asking for additional information, for clarification of issues, for your facility's policies and procedures and for other pertinent information. We will also be conducting interviews with residents, family members and friends. These interviews are conducted privately, unless the interviewees request the presence of a staff member. We ask that you 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.

Please inform your staff that we will be communicating with them throughout the survey and when needed will ask for their assistance. Please advise them that they have the opportunity to provide the team with any information that would clarify an issue that has been raised during the survey process. Of paramount importance is that your staff are aware they are responsible for communicating the type and nature of information that we have asked for during the survey process.

During the survey, we may identify a deficiency and during the survey you may correct that deficiency. The correction of a deficiency during the survey does not mean that the deficiency will not appear on our final report.

Your Plan of Correction (POC) for that deficiency should be treated like any other Plan of Correction and contain all of the required elements of a Federal POC.

I would be happy to explain the survey process if you would like. Have you been involved in a survey before?

Before I go on with the required paperwork, do you have any questions? I'd like to go on with the required paperwork and then join my colleagues on the tour.

Do you have any questions…or shall we begin?

[Provide the administrator with copies of the three QI reports and OSCAR 3 and 4 reports that are being used for the survey. Briefly explain these reports and how the survey team in Task 1 used them. If there are discrepancies between the OSCAR information and the QI Facility Characteristics report, ask the administrator or person designated by the administrator to explain the discrepancies.]

Role-Play Skill Assessment

Entrance Conference and Onsite Preparatory Activities

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Entrance Conference Team coordinator: 1. Informed administrator of survey. 2. Introduced team members. Other team members began initial tour.	
					With the administrator, the team coordinator: 1. Explained survey process. 2. Accurately answered staff questions. 3. Advised staff they will have an opportunity to provide information to clarify issues. 4. Asked administrator to identify special features of care and treatment programs, organization, and resident case mix. 5. Advised that interviews needed to be conducted privately unless interviewee/family/	

					group requested presence of staff. 6. Provided copy of OSCAR 3 and 4 and gave a brief explanation of their use by the team.	
					7. Asked administrator for: • *Roster/Sample Matrix* or equivalent by end of tour, if possible, including all residents in facility and with a bed hold (modifications for accuracy or additional information allowed within 24 hours). • Copy of actual working schedules for all licensed and registered nursing staff for this time period.	
					8. Asked for (to be provided within one hour): • List of key personnel and locations. • Copy of information given to residents regarding their rights. • Meal times, dining locations, copies of all menus for the duration of the survey. • Medication pass times (by unit if variable). • List of admissions during the past month, and a list of residents transferred	

					or discharged during the past three months with destinations. • Copy of facility layout, if not obtained in Task 1. • Copy of the facility's admission contract for all payer types. • Facility policies and procedures to prohibit and investigate allegations of abuse and the name of the person the administrator designates to answer questions about what the facility does to prevent abuse. • Evidence of a system to prevent, monitor and record accidents and incidents. • Current resident activity schedule/calendar. • Names of residents who communicate with non-oral-communication devices, sign language, or other than facility's dominant language. • Name and room number of president of resident council.	
					9. Asked for (to be delivered in 24 hours):	

					• Forms CMS-671, CMS-672, and CMS-1513. – Reviewed completed CMS-671, CMS-672 and CMS-1513 for completeness and accuracy. – Compared Form CMS-672 with Form CMS-802. • List of Medicare residents who requested a demand bill within the last six months. • List of employees hired within last four months.	
					10. Asked the administrator if he/she has: • Rooms with less square footage than required. • Rooms without outside windows. • Rooms below ground level. • Emergency water supply procedures. • A CLIA waiver.	
					Onsite survey activities: • Survey signs posted. • Arranged group meeting. • Contacted resident group president. • Provided copy of group questions. • Requested permission to review council minutes for the last three months.	

					• Arranged for date, time and place. • Advised facility staff that noninterviewable residents are not included.	

Comments/Recommendations:

Lesson 3-D: Initial Tour

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Use information about facility concerns identified offsite, and modify concerns based on information from the initial tour.
- Verify whether residents preselected for the Phase 1 sample still reside in the facility.
- Identify other residents that may be candidates for the sample.
- Obtain an initial evaluation of the facility environment, including the facility kitchen.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
- *Code of Federal Regulations:*
  - 42 CFR 483.13, Resident Behavior and Facility Practice
  - 42 CFR 483.15, Quality of Life
  - 42 CFR 483.25, Quality of Care

State

(Insert State reference[s] here.)

Other

Highlights

- Preparation for the initial tour
- Tips for recording information
- Role-play of initial tour

Training Techniques

- Internet scavenger hunt
- Lecture
- Brainstorming
- Group discussion
- Role-play

Training Aids

- PowerPoint slides and handouts
- Internet
- Forms CMS-802, CMS-803, CMS-804 and CMS-807
- Role-play skill assessment
- Handouts:
  - *Highlighting Concerns Confidentially*

Methods of Evaluation

- Review of surveyor documentation
- Verbalization/discussion of understanding

- Effective use of information in a future training session
- Completion of skill assessment

Audiovisual

Outline or text of presentation

(Preparatory work: conduct an Internet scavenger hunt to find and print copies of Forms CMS-802, CMS-803, CMS-804 and CMS-807 to refer to and use during the lesson.)

(Inform the students of the objectives.)

Lesson 3-D:
Initial Tour

1

Slide 3-D-1

Learning Objectives

- Use information about facility concerns identified offsite & modify concerns based on information from the initial tour.
- Verify whether residents pre-selected for the Phase 1 sample still reside in the facility.

2

Slide 3-D-2

Audiovisual

Outline or text of presentation

Learning Objectives (cont.)

- Identify other residents that may be candidates for the sample.
- Obtain an initial evaluation of the facility environment, including the facility kitchen.

3

Slide 3-D-3

The initial tour is where you form your first impression of the facility, its environment and the manner in which staff are caring for residents.

During the offsite survey preparation, the team reviewed information to identify possible problems that you will find in the facility. The team also preselected residents to be included in a Phase 1 sample. In the initial tour you begin to determine whether those problems still exist. This process confirms or corrects any presurvey information or identifies new areas of concern to be investigated.

Have a method to remind you what areas of concern were identified during offsite survey preparation. For example, some surveyors highlight words on Form CMS-802, *Roster/Sample Matrix* that they use during the tour. Others have a list and refer to it when questioning facility staff about residents. The method must keep the preselected areas of concern secret from the facility staff.

(Brainstorm ways to highlight concerns efficiently and confidentially. You may use the handout "Highlighting Concerns

Audiovisual

Preparing to Tour

- Meet & greet administrator
  - Introduce team members
  - Request place to put belongings
- Modify survey to accommodate off-hours timing
- Plan brief look at facility's kitchen

4

Slide 3-D-4

Outline or text of presentation

Confidentially" on page 3-D-17. Share/evaluate ways to use the CMS forms to accomplish this in a group discussion.)

Preparing to Tour

When you enter the facility, the team coordinator finds the administrator or person in charge and introduces the team members. The team coordinator then works with facility staff to identify a place where you can leave your things and to identify facility staff to tour with you and provide you information about the residents.

When a standard survey begins at times outside the business hours of 8 a.m. to 6 p.m. or on a Saturday or Sunday, the initial tour must be modified in recognition of the residents' activities (e.g., sleep, religious services) and types and number of staff available upon entry.

The tour should include a first, brief look at the facility's kitchen. One surveyor is assigned to conduct this observation, observing the sanitation practices and cleanliness of the kitchen. This includes whether foods are left on the countertops or steam tables in a potentially hazardous manner, the way in which foods are thawed, cleanliness and sanitary practices and the appearance of kitchen staff. Document your findings on Form CMS-804, *Kitchen/Food Service Observation and Food Service Evaluation*.

Audiovisual

Outline or text of presentation

Facility Resources

Staff could be:
- Charge nurse
- Medication nurse
- Social service person
- Activity person
- Anyone who knows about residents

5

Slide 3-D-5

Facility Resources

Facility staff chosen to accompany you on the tour are usually the charge nurse, medication nurse, social service person or activity person. The key is to have someone who can tell you about each resident, the resident's cognitive status, the current care needed by that resident and how the resident has changed since the last survey.

Status of Residents/Concerns

For residents preselected for Phase 1, determine whether:
- Still in facility
- Interviewable

Seek family members of noninterviewable

6

Slide 3-D-6

Determining Status of Preselected Residents

Your objectives at this point are to:
1. Determine whether each resident preselected for the Phase 1 sample is still in the facility.
2. Determine which, if any, of the preselected Phase 1 sample residents are interviewable residents who can participate in the Quality of Life resident interview or group interview.
3. If possible, determine whether there are family members of noninterviewable residents in the preselected Phase 1 sample that are candidates for a Quality of Life family interview.

Observation of Residents

- Identify residents with no family or significant others
- Newly admitted (within 5–14 days)
- Potential discharge/transfer (in next 30 days)
- Residents who are
  - Interviewable
  - Special care needs

7

Slide 3-D-7

Resident Observation

1. Have staff identify residents who have no family or significant others (you may include one or more in the Phase 2 sample for investigation of Quality of Life issues).
2. Have staff identify newly admitted residents (those admitted within 5 to 14 days). These are candidates for possible inclusion in the sample to investigate decline or deterioration that may have

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Outline or text of presentation

occurred before Minimum Data Set (MDS), other resident assessment information and care planning was completed.

3. Have staff identify any residents to be transferred or discharged within the next 30 days.
4. Note residents who are interviewable or have special care needs, listed in Task 4 (Sample Selection).

Staff Status

While on tour, identify licensed and registered nursing staff currently on duty. At the end of the tour, compare the observed staff with the duty roster the facility provides. If there are discrepancies between the duty roster and staff observed onsite, ask the person in charge to explain the discrepancies.

Quality of Life

- Identify licensed & registered nursing staff on duty
- Resident grooming, dress & footwear
- Staff-resident interactions
- Scheduled activities taking place

8

Slide 3-D-8

Key Observations

During the tour, focus on the following:

Quality of Life

1. Resident grooming, dress and appropriate footwear.
2. Staff-resident interactions and whether residents are spoken to when care is given.
3. Scheduled activities taking place and appropriateness to the residents.

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Emotional & Behavioral Conduct of Residents

- Resident behaviors
- Staff response to residents' behavior

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Slide 3-D-9

Outline or text of presentation

Emotional and behavioral conduct of the residents and the reactions and interventions by staff

1. Resident behaviors such as crying out, disrobing, agitation, rocking and pacing.
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.

Care Issues/Special Care Needs

- Skin conditions
- Skin tears, bruising & fractures
- Dehydration risk factors
- Edema, emaciation & contractures
- Poor positioning or restraints
- Side effects of antipsychotic drugs

10

Slide 3-D-10

Care issues and the prevalence of special care needs

1. Skin conditions (e.g., excessive dryness or wetness).
2. Skin tears, bruising or evidence of fractures that warrant investigation.
3. Dehydration risk factors including availability of water, the amount and color of urine in tubing and collecting bags, dependence on staff, the presence of strong urinary odors, resident complaints of dry mouth and lips.
4. 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 lip, tongue or other involuntary movement.
7. Presence and number of infections.
8. Pressure sores or scars from old pressure sores.
9. Amputation.
10. Significant weight loss.
11. Feeding tubes and/or improper positioning while feeding in infusing.
12. Ventilators, oxygen or intravenous therapies.

Care Issues/Special Care Needs (cont.)

- Infections
- Pressure sores
- Amputation
- Significant weight loss
- Feeding tubes/improper positioning
- Ventilators, oxygen or IV therapies

11

Slide 3-D-11

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Environment/Safety Issues

- Infection control practices
- Functional & clean equipment
- Clean, homelike environment
- Assistive devices

12

Slide 3-D-12

Outline or text of presentation

Impact of the facility environment and safety issues

1. Infection control practices (e.g., hand washing, glove use and isolation procedures).
2. Functional and clean equipment, including kitchen equipment.
3. Presentation and maintenance of a homelike and clean environment.
4. Availability, use and maintenance of assistive devices.

Note: If the initial tour is conducted during a mealtime, include an initial brief observation of the dining room. Note any concerns with meal service, quality of life, positioning, sufficient space, etc.

(Refer to Forms CMS-802, CMS-803 and CMS-807.)

During the survey process, use only the approved CMS and State forms.

Use Form CMS-802, *Roster/Sample Matrix*, or Form CMS-807, *Surveyor Notes Worksheet*, to record information regarding residents as you tour. If you use Form CMS-802, you can use Form CMS-807 or Form CMS-803, *General Observations of the Facility*, to record any environmental problems you see.

Begin Tour

- Tour with staff
- Staff not available?
  - Interview residents
  - Make observations
- Staff limited?
  - Share staff person
- Introduce/explain
  - Staff
    - Information needed
    - Form CMS-802
  - Resident
    - Purpose of visit
    - Permission to enter & survey

13

Slide 3-D-13

Beginning the Tour

Try to tour with staff. However:

1. If staff members are not available, begin the tour by yourself. Interview as many residents as you can regarding their condition and care received, and make appropriate observations without touching the resident, clothing or bedding.
2. If an inadequate number of staff is available, two surveyors may share one

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Outline or text of presentation

staff person by alternately asking about a resident, then independently going into the resident's room to interview and observe the resident while the other surveyor asks about another resident.

3. Begin the tour by introducing yourself to the staff person who will assist you. Tell the person the topics you will be asking about. Consider giving a blank copy of the Roster/Sample Matrix, Form CMS-802 to the staff person who will accompany you on the tour. Review the form and resident characteristics with the person touring with you. Ask the staff person to identify the characteristics specific to each resident. Also ask staff to identify interviewable and noninterviewable residents so that you can identify residents to be included in the group, individual and family interviews.

What to Record

- Name/title of person touring
- Time
- Each resident's name & room number
- Significant observations
  - Time, place
- Whether staff protect resident's rights
- Interviewable or noninterviewable

14

Slide 3-D-14

What to Record

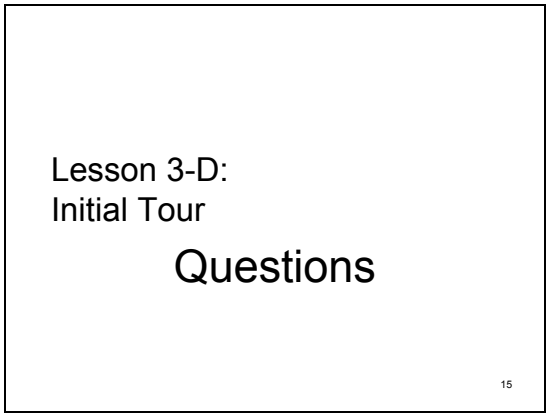
Find a method to remind you what areas of concern were identified during the offsite survey preparation.

For all observations and information, begin by recording the name of the person you are touring with and that person's title. Record the time. Next, record each resident's name and room number.

Periodically, or for any significant observation, record the time of the observation. This can become important later if you need to include the information from the observation in a deficiency.

Try to meet as many residents, family visitors and staff as possible. Before entering a room, observe to see if staff knock first and wait for an answer. Be sure

Audiovisual	Outline or text of presentation
	to knock and wait yourself, if you are entering alone. Introduce yourself to the resident, staff or other individuals who may be present, and explain that you are in the facility to conduct the annual survey. For residents, ask some questions to determine their ability to be interviewed. For example, "Tell me about (how you get dressed/when you use the walker/what you had for breakfast/etc.)," or, "Tell me how the staff member helps you with breakfast," or "Tell me how the staff member helps you with your daily routines." *(At this point, the preceptor and another experienced surveyor should lead a role-play tour for sampled residents, to enable students to practice.* *Take Form CMS-802 and brainstorm a preselected sample. Students may play the roles of the residents and the surveyor; the experienced surveyor the role of the staff member. For maximum benefit, students should all get a turn at being the surveyor. One or two students may evaluate the performance of the surveyor using the handout "Role-Play Skill Assessment" on page 3-D-19.)*



Slide 3-D-15

Skill Assessment

Initial Tour

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Used information about facility concerns identified offsite, and modified concerns based on information from the initial tour, using Form CMS-802.	
					Verified whether residents preselected for the Phase 1 sample still reside in the facility.	
					Identified other residents that may be candidates for the sample.	
					Obtained an initial evaluation of the facility environment, including the facility kitchen, using Forms CMS-803, CMS-804 and CMS-807.	

Comments/Recommendations:

Highlighting Concerns Confidentially

Idea	Pro(s)	Con(s)

Role-Play Skill Assessment

Initial Tour

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Observed and documented using Form CMS-802, CMS-803 or CMS-807.	
					Documented dates, times, who, where and how during observations: 1. Confirmed or invalidated presurvey concerns.	
					2. Identified new concerns.	
					3. Identified residents preselected for Phase 1 sample selection.	
					4. Identified interviewable residents.	
					5. Identified family members of noninterviewable residents.	
					6. Identified newly admitted residents.	
					7. Identified residents who will be discharged.	

					8. Observed how staff interact with residents.	
					9. Observed how care is provided.	
					10. Identified residents with special needs.	
					11. Observed activities taking place.	
					12. Performed brief initial tour of the kitchen.	
					Identified licensed nursing staff on duty.	
					Introduced yourself and established rapport with residents and staff: 1. Did the surveyor ask permission to enter the room and survey the room?	
					2. Did the surveyor protect the residents' rights and maintain confidentiality?	
					3. Did the surveyor question staff to clarify observations?	
					Did the surveyor properly use: Form CMS-802, *Roster/Sample Matrix*? Form CMS-803, *General Observations*? Form CMS-807, *Surveyor Notes Worksheet*?	

Comments/Recommendations:

Lesson 3-E: Sample Selection

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the reasons for selecting residents for the sample.
- Compare and contrast comprehensive, focused and closed record review.
- Describe the reasoning for selecting focused areas for review for both Phase 1 and Phase 2.
- Select a case-mix stratified sample of facility residents for Phase 1 and Phase 2 based on Quality Indicators, OSCAR reports, and other offsite and onsite sources.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
- *Facility Guide For The Nursing Home Quality Indicators*. [On-line]. Available: https://www.cms.hhs.gov/MinimumDataSets20/09_HistoricalFiles.asp#TopOfPage

State

(Insert State reference[s] here.)

Other

Highlights

- General objective
- Confidentiality of survey visits
- Case-mix stratified sample
- General procedures
- Definitions
  - Interviewable resident
  - Comprehensive review
  - Focused review
  - Closed record review
  - *Roster/Sample Matrix* (Form CMS-802)
- Protocol
  - Phase 1 sample selection
  - Phase 2 sample selection
  - Special factors to consider in sample selection
  - Other Phase 2 tasks
  - Substituting residents
  - Supplementary sample

Training Techniques

- Internet scavenger hunt
- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- Computer and projector
- Chart pad with colored markers
- Sample *Roster/Sample Matrix* from a facility
- Blank Forms CMS-672, CMS-802, CMS-802S, CMS-805 and CMS-806A
- Sample Quality Indicators (QI), OSCAR Reports 3, 4 and 40, sample Form CMS-672; all from a sample facility
- Highlighters
- Handouts:
  - *Sample Selection*
  - *Phase 1 Flowchart*
  - *Phase 2 Flowchart*
  - *SOM* Appendix P, Survey Protocol for Long Term Care Facilities - Part I, page 23

Methods of Evaluation

- Verbalization/discussion
- Review of individually completed Form CMS-802
- Completion of skill assessment

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Lesson 3-E:
Sample Selection

1

Slide 3-E-1

Outline or text of presentation

(Pre-work: Internet scavenger hunt—have the students obtain blank Forms CMS-672, CMS-802, CMS-802S, CMS-805 and CMS-806A from the CMS website, www.cms.hhs.gov.

Have the students review Form CMS-802S and SOM Appendix P, page 23, Phase 1 – "Sample Selection."

Learning Objectives

- Describe the reasons for selecting residents for the sample.
- Compare & contrast comprehensive, focused & closed record review.
- Describe the reasoning for selecting focused areas for review for both Phase 1 & Phase 2.

2

Slide 3-E-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Select a case-mix stratified sample.

3

Slide 3-E-3

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Objective of Sample Selection

- Select case-mix stratified sample of facility residents
  - Based on QIs & other offsite & onsite sources of information
  - To assess compliance with resident-centered long term care requirements

4

Slide 3-E-4

Outline or text of presentation

(Introduce the objective of sample selection.)

Survey Confidentiality

It is important to note that all types of surveys—complaint, follow-up and standard—are considered confidential. Federal law (42 CFR 488.307) states that anyone providing information to a non-State survey agency employee can be fined $2,000. It is also likely that an employee would be reprimanded (if not terminated) for such action. Survey schedules should never be taken into a facility and should not even be shared with friends. As for your family, [*discuss State directives*].

Assuring a Good Sample—Team Composition

The *SOM* 7201 (42 CFR 488.314) directs that a registered nurse participate in a survey of Federal compliance if more than one person makes up the team. One person on each survey must be a qualified surveyor. This means that at least one person has to have completed local/State/regional training, attended a Basic Long Term Care surveyor training course provided by CMS, and successfully passed the Surveyor Minimum

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Outline or text of presentation

Qualifications Test (SMQT). It is the responsibility of each person to know which surveys he/she is scheduled to conduct and to contact the team for information.

While you are in training, a qualified surveyor on the team is responsible not only for observing your work, but for assuring that you are demonstrating the ability to conduct portions of the survey. Therefore, you will have someone looking over your shoulder during the survey. This is in your best interest.

General Procedures

(Students may use the handout "Sample Selection" on pages 3-E-31 and 3-E-32 to note characteristics of Phase 1 and Phase 2.)

Sample selection falls into two phases:

- Phase 1 refines the preselected sample.
- Phase 2 focuses on specific concerns.

Phase 1 Sample

- Preselected during Task 1, Offsite Survey Preparation
  - Based on QIs & other areas of concern
  - Reviewed during sample selection meeting
- Residents are retained for sample unless:
  - Discharged
  - Team has another reason to substitute

5

Slide 3-E-5

Phase 1

A sample is preselected during Task 1—offsite survey preparation—based on QIs and other areas of concern. The preselected list of residents is used during the initial tour to determine whether these residents still reside in the facility. The survey team finalizes the Phase 1 sample with information gathered during the tour and from information the facility has provided. The team reviews the preselected sample during the sample selection meeting. Residents are retained for the sample unless they have been discharged or the team has another reason to make a substitution.

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Outline or text of presentation

The team coordinator should use Form CMS-802, *Roster/Sample Matrix* and proceed through each listed focus area. This should be done quickly and systematically.

Phase 2

- Based on:
  - Phase 1 information
    - Shaped by sample selection
  - Information from interviews, investigation & record reviews

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Slide 3-E-6

Phase 2
The team selects the Phase 2 sample onsite, partway through the survey, after collecting enough information to determine the focus of the remainder of the survey. Phase 2 sample residents are selected to represent new or ongoing concerns. Additions also continue further investigation of Phase 1 concerns to determine scope of a given problem or where reviews proved inconclusive.

To summarize: sample selection plays a key role in shaping the survey.

Phase 2 Responsibilities

- Each team member:
  - Is assigned to review certain number of residents
  - Must complete all facets of review that have been selected, including any quality of life assessment protocols selected for these residents

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Slide 3-E-7

Responsibilities
Each team member will be assigned to review a certain number of residents, and must complete all facets of review that have been selected, including any quality of life assessment protocols selected for these residents.

Organizing the Sample

Several important concepts organize the sample:

- Interviewable resident.
- Comprehensive review.
- Focused care review.
- Closed record review.
- *Roster/Sample Matrix*.

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Definitions

- Interviewable resident
- Comprehensive review
- Focused care review
  - Phase 1
  - Phase 2
- Closed record review

8

Slide 3-E-8

Outline or text of presentation

Interviewable resident
An interviewable resident has sufficient memory and comprehension to answer the majority of questions contained in the *Resident Interview* (Form CMS-806A) coherently. These residents can make day-to-day decisions in a reasonably consistent and organized manner.

Comprehensive review
After observing and talking with the resident, the surveyor conducts a comprehensive review. This includes:

- Minimum Data Set (MDS): a set of specific coded items detailing the resident's condition. Check for accuracy of coding.
- Resident Assessment Instrument (RAI): an overall review of the facility's completion of the RAI process.
- Care Plan: a review of the implementation of the care plan and resident response.
- Drug Regimen: a review of the resident's drug regimen to the resident's condition.
- WHP: a review of any of the following conditions that apply to the resident:
  - Weight loss.
  - Dehydration.
  - Pressure sores.

All residents selected for comprehensive reviews should have one or more of these concerns checked on the QI reports (unless there are no residents with these concerns in the facility).

- Dining: An evaluation of the resident's dining experience.

Audiovisual	Outline or text of presentation
	Focused care review Phase 1 This review includes observations, interviews, and record review. It focuses on care areas that were checked on the Resident Level Summary and any additional pertinent care items checked by the team. Additionally, all areas that the team checks on the *Roster/Sample Matrix* are reviewed whether or not they have been highlighted as concerns for the survey. **Focused care review Phase 2** This stage of the review includes only observations, interviews and record review of areas of concern for which the team requires additional information. **Closed record review** Includes record review of former residents' care issues and transfer and discharge requirements. You can select some or all of the closed records from the offsite case mix, if any of those residents were discharged or deceased. Look for information to determine compliance with quality of care and other requirements such as: • Assessment and care of infections. • Pressure sores. • Significant weight loss. • Restraints. • Multiple falls or injuries. • Discharge planning. • Transfer and discharge requirements. Focus the review on: • Appropriateness of care and treatment surrounding the resident's discharge or transfer. • Events leading up to the discharge or transfer.

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Outline or text of presentation

- Documentation related to the transfer, discharge and bedhold.
- The facility's discharge planning, notices and reasons for the move.

Check to see whether the facility conveyed the deceased resident's personal funds and a final accounting to the individual or probate jurisdiction administering the resident's estate as provided by State law (CFR 483.109(c)(6) [F160]).

Roster/Sample Matrix
Form CMS-802 is used to document the sample for Phase 1 and Phase 2.

(You may compare and contrast review types to summarize.)

Timing of Phase 1

- Final Phase 1 sample selection occurs after:
  - Initial tour is completed
  - Facility has provided completed *Roster/Sample Matrix*, Form CMS-802
- *Do not* delay Phase 1 selection if facility's roster has not arrived

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Slide 3-E-9

Protocol

Phase 1 sample selection
(Refer to the copies of Forms CMS-802 and CMS-802S printed in the pre-work activity. Note the column on the left side of the form headed "Review.")

The Phase 1 final sample selection occurs after the initial tour is completed and the facility has provided the completed *Roster/Sample Matrix* (Form CMS-802) or a computer-generated list in the same format as Form CMS-802. Do not delay Phase 1 selection if the facility's roster has not arrived.

(If time permits at this point, you may begin to lead the students through filling out blank Form CMS-802S using actual samples.)

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Eliminating Concerns

- Determine whether any preselected concerns should be dropped due to QI data not representing conditions of current residents
- For example: tube feedings were preselected QI concern, but on rounds there were no residents receiving tube feedings

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Slide 3-E-10

Outline or text of presentation

First, determine whether any preselected concerns should be dropped because the QI data do not represent the conditions of current residents.

For example: tube feedings were a preselected QI concern, but on rounds there were no residents receiving tube feedings.

Further Adjustments

- Determine whether:
  - There are any new concerns
  - Preselected residents can be evaluated for new concerns
- Add residents with new concerns to case-mix

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Slide 3-E-11

Second, determine whether there are any new concerns. If so, determine whether some of the preselected residents can be evaluated for the new concerns. If not, add residents with the new concerns to the case-mix.

Discuss the following information:

- Potential areas of concern from the off-site preparation.
- New areas of concern.
- Information gathered during the initial tour that either supports keeping the area of focus or provides information that shows the area is no longer a concern.
- Problems that seem to exist in a particular area of the facility.
- Potential residents or areas of the facility identified either by the ombudsman or during Task 1.

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Outline or text of presentation

Facility *Roster/Sample Matrix*

- Review facility's roster
  - Compare it to findings from tour
  - Determine whether there is reason to substitute another resident for any of residents from offsite sample
  - If preselected resident is no longer in facility, this resident can be selected as closed record review

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Slide 3-E-12

The team leader should compare the facility's *Roster/Sample Matrix* with information from the initial tour.

Substitutions

- If *any* resident is substituted for preselected resident, include short explanation on offsite *Roster/Sample Matrix* next to that resident's name (e.g., "discharged")

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Slide 3-E-13

If any resident is substituted for a preselected resident, write a short explanation on the offsite roster next to the person's name (e.g., "discharged").

Phase 1 *Roster/Sample Matrix*

- Check "Phase 1" on blank copy of roster
- Highlight column for each identified concern

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Slide 3-E-14

The team coordinator should use a blank copy of the *Roster/Sample Matrix* as follows:

- 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.
- Write in the provider number.
- Write in the current census (including bedhold).
- Highlight the column for each identified concern for Phase 1.

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Minimum for Sample

- Use Table 1 (*SOM* Appendix P, page 35) to determine minimum number of residents to be selected

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Slide 3-E-15

Outline or text of presentation

- Use the table on page 35 of *SOM* Appendix P to find the minimum number of residents to be selected. Take the total resident census (including bedhold) to determine the number of comprehensive and focused reviews, closed records, resident and family interviews, and the minimum number of residents who have weight loss, hydration risk and/or pressure sores (WHP group).

(Have the students look up the minimum sample composition for a facility census of 96.)

Minimum for Sample (cont.)

- Use total resident census to determine number of
  - Comprehensive & focused reviews
  - Closed records
  - Resident & family interviews
  - Residents who have weight loss, hydration risk &/or pressure sores (WHP group)

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Slide 3-E-16

Sampling Example

- Suppose facility census is 96 residents
- You would have 12 residents on Phase 1:
  - 5 comprehensive reviews
  - 7 focused reviews
  - 6 WHP
  - 5 resident interviews
  - 2 family interviews
  - 3 closed record reviews

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Slide 3-E-17

- For example, if the facility census is 96 residents, you would have 12 residents on Phase 1:
  - Five comprehensive reviews.
  - Seven focused reviews.
  - Six WHP.
  - Five resident interviews.
  - Two family interviews.
  - Three closed record reviews.

Write this information in the block above "Resident Name." The "Total Sample" will be the total of residents from Phase 1 and Phase 2.

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Continuing *Roster/Sample Matrix* Completion for Phase 1

- Resident number
- First & last name
- Resident number & room number
- Surveyor assigned
- Individual/family interview
- Closed/comprehensive/focused
- Surveyor assignments

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Slide 3-E-18

Outline or text of presentation

- Use the block "Resident Number" to fill in the Resident Identifier number, which would be 1–12 if the facility census is 96 residents.
- Each resident selected must be listed on Form CMS-802 by his or her first and last name.
- Each resident selected must be entered on Form CMS-802 with resident number and room number.
- In the "Surveyor Assigned" column identify the surveyor who will complete Form CMS-802 by putting his/her initials in the column.
- In the column "Interview: Indiv/Fam" mark an "I" by the resident who has been selected for an individual interview and an "F" by the resident who has been selected for a family interview.
- In the column "Closed Rec/Comp/Focus" mark:
  - "Cl" for residents for whom a closed record review will be completed.
  - "C" for residents for whom a comprehensive review will be completed.
  - "F" for residents for whom a focused review will be completed.
- Determine which surveyor will review the resident and place that person's initials by the resident's name, in the appropriate column on the form.

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Outline or text of presentation

Timing of Interviews & Reviews

- You may conduct resident & family interviews in both Phase 1 & Phase 2
- *All* comprehensive reviews are completed in Phase 1
- Be sure to select residents from WHP group if these are in sample
- Closed record reviews can be selected during Phase 1 or Phase 2

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Slide 3-E-19

All residents selected for comprehensive reviews must have their reviews completed in Phase 1. Residents selected for focused reviews, closed record reviews, individual and family interviews have their reviews performed in Phase 1 and Phase 2.

Phase 1 Review

- Comprehensive Care Review
  - Includes observations, interviews & record review for all care areas for sampled resident
- Focused Review
  - Observations, interviews & record reviews for all highlighted areas of concern pertinent to resident

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Slide 3-E-20

Form CMS-805

- Each resident team selects *must* have Form CMS-805 (blue sheet) completed
- Surveyor assigned to complete resident review *must* complete Sections A, B, C & D
  - If no identified concerns are found, initial sections

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Form CMS-805 is covered in another lesson.

Audiovisual

Things to Remember

- Document resident room number & resident identifier
- Check any columns that pertain to your resident, whether or not they are highlighted as concern
- Each resident will be reviewed for each checked area, not just those that are highlighted

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Slide 3-E-22

Outline or text of presentation

Check any columns (1–33) that pertain to the resident, whether or not they are highlighted as concerns for Phase 1. Each resident will be reviewed for each checked area, not just the areas that are highlighted.

Unlisted Concerns

- If there are any concerns about resident that are not listed on roster & team decides to investigate, then blank columns (34 & 35) at far right can be used

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Slide 3-E-23

Use columns 34 and 35 for anything about the resident that the team needs to investigate for which there is no numbered column. For example, if the team wants to investigate a ventilator, then write "ventilator" in one of the blank columns and make a checkmark in that column for that resident.

(Students should compare Form CMS-802 and the sample Form CMS-672.)

After Phase 1 and before the Phase 2 sample selection, a member of the team (usually the team leader) should compare the number of residents selected for each focused area with information provided both on the facility *Roster/Sample Matrix* and Form CMS-672, *Resident Census and Conditions of Residents*. When discrepancies are found, the team coordinator should request clarifying information from the facility to assure as much consistency between the forms as possible.

Audiovisual

Phase 2

- Select residents who represent one or more areas of concern team has selected
- Minimum number of residents to be completed in Phase 2 is based on facility census & number

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Slide 3-E-24

Things to Remember

- Case-mix stratification
  - Include residents who:
    - Are interviewable & noninterviewable
    - Require heavy & light care
  - At least one resident in sample must represent each of these categories

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Slide 3-E-25

Outline or text of presentation

Phase 2 Sample Selection

After the team has obtained enough information to decide what concerns need further investigation, the team should meet to determine the areas of concern for Phase 2 of the survey and to select the remaining residents to be reviewed.

Select concerns for Phase 2 based on the following:

- Initial concerns noted during the offsite survey preparation or the initial tour that have not yet been reviewed.
- Unreviewed concerns that are related to those concerns investigated in Phase 1.
- Current concerns for which information gathered is inconclusive.

Select residents for Phase 2 sample who represent one or more of the areas of concern the team has selected. You must select a “case-mix stratified” sample (for the total sample). At least one resident in the sample must represent each of the categories.

For example: in Phase 1 no residents were selected for hydration, and if any residents during Phase 1 appear to have risk factors for dehydration, select at least one resident at risk and review the care area of dehydration.

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Phase 2 Sample Selection

- Fill out clean copy of *Roster/Sample Matrix* worksheet
  - Check "Phase 2" on copy
  - Highlight column for each identified concern
  - First, last name
  - Resident number, room number
    - Note: resident number starts after last number of Phase 1

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Slide 3-E-26

Phase 2 Sample Selection (cont.)

- Surveyor assigned
- Individual/family interview
- Closed/focused
  - Note: check only highlighted columns

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Slide 3-E-27

Outline or text of presentation

On a clean copy of Form CMS-802, *Roster/Sample Matrix* complete the following items:

- Check (✓) "Phase 2" on the copy of the form.
- Highlight the column for each identified concern.
- Each resident selected must be entered on Form CMS-802, first and last name.
- Each resident selected must be entered on Form CMS-802 with resident number, and room number.
- The "Resident Number" column continues from Phase 1. For example, the last resident number on Phase 1 was 12, so the first resident number on Phase 2 is 13.
- In the "Surveyor Assigned" column, identify the surveyor who will complete Form CMS-802.
- In the column "Interview: Indiv/Fam" mark an "I" by residents selected for an individual interview and an "F" by residents selected for a family interview.
- In the column "Closed Rec/Comp/Focus" mark "Cl" for closed record review residents, or mark an "F" for focused review residents.

Make checkmarks (✓) only in the highlighted columns. These residents will be reviewed for these concerns and any other concerns that are discovered.

Audiovisual

Phase 2 Reviews

Focused review for additional information :
- Observations
- Interviews
- Record review

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Slide 3-E-28

Outline or text of presentation

The residents you select for Phase 2 will require a focused review or a closed record review.

A focused review includes observations, interviews and record review on those areas of concern for which the team requires additional information.

Phase 2 Reviews (cont.)

Closed record review:
- Care prior to discharge or death
- Notification of physician, family, responsible party
- Disposition of funds
- Care issues, transfer & discharge requirements
- Quality of care, quality of life

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Slide 3-E-29

A closed record review is for residents who are no longer in the facility and covers:
- Care prior to discharge or death.
- Notification of physician and family or responsible party.
- Disposition of funds.
- Resident's care issues and transfer and discharge requirements.

Assess quality of care and quality of life requirements that relate to the identified areas for the sampled resident. (These topics are covered in other lessons.)

Number of Reviews

- Complete required number of:
  - Resident interviews
  - Family interviews
  - Closed record reviews
  - Focused reviews
- Refer to *SOM* Appendix P, page 35

30

Slide 3-E-30

Be sure to complete the required number of resident interviews, family interviews, focused reviews and closed record reviews according to the facility census and the Table on page 35 of *SOM* Appendix P.

Audiovisual

Outline or text of presentation

Other Concerns

If:	Then select:
• There are no outstanding areas of concern & • Sample includes: – Interviewable – Noninterviewable – Heavy care – Light care	• Unhighlighted area team believes should be assessed • Living units not represented • Special factors not reviewed

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Slide 3-E-31

Other concerns

If there are no outstanding areas of concern and the team has already selected interviewable, noninterviewable, heavy care and light care residents, then select the remaining residents from the following list:

- An area of concern that the team believes should be assessed.
- Living units that have not been represented.
- Special factors that have not been reviewed.

Special Factors

Residents:

- Newly admitted
- At most risk of neglect & abuse
- In rooms which have been granted variance
- Receiving hospice services
- With end stage renal disease (ESRD)

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Slide 3-E-32

Special factors for sample selection

If during the sample selection the team identifies many more residents than can be selected to represent the concerns of interest, the team may decide to consider the factors listed below:

- New admissions, especially if admitted in the previous 14 days.
- Residents most at risk of neglect and abuse. For example: residents with dementia, no visitors, behavior dysfunction, psychosocial, interactive, or who are bedfast and totally dependent on care.
- Residents in rooms where variances have been granted for room size and/or number of beds in room.
- Residents receiving hospice services.
- Residents with end stage renal disease (ESRD).

Audiovisual

Outline or text of presentation

Special Factors (cont.)

- Under age of 55
- With mental illness or mental retardation
- Who communicate with:
  - Non-oral communication devices
  - Sign language
- Who speak language other than dominant language of facility

33

Slide 3-E-33

- Residents under the age of 55.
- Residents with mental illness or mental retardation.
- Residents who communicate with non-oral communication devices or sign language, or who speak a language other than the dominant language of the facility.

The *SOM* does not require the team to choose residents with these areas of concern for the sample. If the team moves into Phase 2 with no concern areas to investigate, the areas listed above should be considered.

Substituting Residents

If:	Then:
Resident must be removed	Select another, similar case
	Substitute as soon as possible
	Note reason on roster

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Slide 3-E-34

Substitution
If during the survey the team finds it necessary to remove a resident from the sample (for example, for refusing to be interviewed), replace this resident with another who best fulfills the reasons the first resident was selected. Make the substitution as soon as possible. Note on the roster the substitution and reason why.

Supplementary Sample

If:	Then:
Sample chosen is not adequate for: • Deficiency determination • Determining substandard quality of care	Add residents for categories of care to be represented

35

Slide 3-E-35

Supplementary sampling
If sampled residents are found not to provide enough information to make deficiency determinations concerning specific requirements or to determine substandard quality of care (SQC) (Task 6), then the team may add residents who fit the area or areas of concern.

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Other Tasks Relevant to Sampling

- Checking surety bond amount against resident's managed funds
- Infection control
- Quality Assessment Assurance Review (see Task 5)
- Identifying concerns for group interview

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Slide 3-E-36

Outline or text of presentation

Other Phase 2 Tasks Relevant to the Sample

If there are concerns about the residents' trust funds, the survey team must check to see if the amount of the surety bond is at least equal to the amount of the residents' total funds that the facility manages.

If there are concerns with infection control, the survey team must review the policies and procedures that focus on the preventative infection control practices the facility has in place.

Complete Task 5F, the Quality Assessment Assurance Review.

Discuss what special concerns to ask about during the resident group interview.

If the facility has or has requested a nurse staffing waiver, review the requirement at 42 CFR-483.30 (F353–F355).

Lesson 3-E:
Sample Selection

Questions

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Slide 3-E-37

(Optional: students may flowchart Phase 1 and Phase 2 sample selection independently, then pair with another student and cooperatively critique the drafts. They may use the worksheets "Phase 1 Flowchart" and "Phase 2 Flowchart" on pages 3-E-33 and 3-E-35, respectively.

To ensure a firm grasp of the protocol, have the students use Forms CMS-801 and CMS-802 and select Phase 1 and Phase 2 samples independently, then pair with another student and cooperatively critique the drafts.

Two assessment forms are included, one brief assessment on page 3-E-25 for the

Audiovisual	Outline or text of presentation
	beginning student after the classroom presentation, and one optional detailed one on page 3-E-27, for use in the field.)

Skill Assessment (Beginner)

Sample Selection

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described the reasons for selecting residents for the sample.	
					Compared and contrasted comprehensive, focused and closed record review.	
					Described the reasoning for selecting focused areas for review for both Phase 1 and Phase 2.	
					Selected a case-mix stratified sample of facility residents for Phase 1 and Phase 2 based on Quality Indicators, OSCAR reports, and other offsite and onsite sources.	

Comments/Recommendations:

Skill Assessment (Field Practical)

Sample Selection

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Selected a case-mix stratified sample of residents to investigate resident-centered requirements, concerns of the team.	
					1. Final Phase 1 Sample Selection: a. Did not delay task when facility's roster not yet completed.	
					b. Discussed potential areas of concern identified during offsite preparation and investigated during tour.	
					c. Discussed concerns identified during the tour.	
					d. Reviewed and used tour information and facility roster.	

					e. Compared residents preselected offsite with tour information.	
					f. Selected additional residents for the areas of concern and special factors, as necessary.	
					g. Selected accurate number of residents, including comprehensive and focused review.	
					h. Was able to choose residents/family for interviews.	
					i. Chose stratified case-mix sample (heavy/light care, interviewable and not).	
					2. Attempted to include in sample (if not, gave appropriate reason): a. New resident admitted within previous 14 days.	
					b. Resident most at risk of neglect and abuse (dementia, no visitors, bedfast).	
					c. Resident under age 55.	
					d. Resident with mental illness/mental retardation.	
					e. Resident in room with variance for room size or number of beds.	
					f. Resident with communication problem.	

					3. Phase 2 a. Discussed areas of concern not yet investigated, needing more investigation, new concerns.	
					b. Determined areas of concern.	
					c. Selected residents representative of areas of concern.	
					d. Selected required number for final focus.	
					4. **If no outstanding areas of concern** after Phase 1 review: a. Investigated area of concern not highlighted during Phase 1, but which believed should be assessed.	
					b. Considered living units that were unrepresented, special factors that had not been reviewed.	
					5. At end of Phase 2: a. Chose closed record for care issues identified after Phase 1 reviews.	
					b. Closed record reviewed for transfer/discharge.	
					c. Reviewed entrance conference forms to see if correct.	

Comments/Recommendations:

Sample Selection

Phase 1
Phase 2
Interviewable resident

Sample Selection (cont.)

Comprehensive review	Focused review	Closed record review
MDS	**Phase 1**	
RAI	**Phase 2**	
Care plan		
Drug regimen		
WHP		
Dining		

Phase 1 Flowchart

Phase 2 Flowchart

Lesson 3-F: Evaluating the Environment

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Locate environment-related regulations.
- Observe and document findings relevant to the regulations using Forms CMS-803, -805 and -807.
- Evaluate effectiveness of the physical environment in empowering residents, accommodating resident needs and maintaining safety.
- Identify facility noncompliance with environment-related regulations.
- Refer specific observations to other team members.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities
- CMS Survey & Certification letters:
  - S&C-04-18, Subject: HIPAA impact on posting survey results
  - S&C-03-03, Subject: BIPA staff posting requirement

State

(Insert State references here.)

Other

Highlights

- Directions in the *SOM* for conducting this task
- How to interpret a facility layout
- Discussion of handout which lists Federal regulations relevant to specific rooms of the facility
- How to document findings

Training Techniques

- Lecture/storytelling
- Demonstration
- Group discussion
- Small group exercise

Training Aids

- Form CMS-803, *General Observations of the Facility*
- Form CMS-805, *Resident Review Worksheet*
- Form CMS-807, *Surveyor Notes Worksheet*
- Paper and transparencies
- Sample facility layout on transparencies, with associated survey data sufficient to simulate an actual tour
- PowerPoint slides and handouts
- Handouts:
  - *Tour of the Environment*
  - *S&C-03-03*
  - *S&C-04-18*

Methods of Evaluation

- Completion of skill assessment

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Lesson 3-F:
Evaluating the Environment

1

Slide 3-F-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Locate environment-related regulations.
- Observe & document findings relevant to the regulations using Forms CMS-803, -805 & -807.

2

Slide 3-F-2

Outline or text of presentation

(Prerequisite: practice in observation, interviewing and reviewing records.

Preparatory work:

- *Have students engage in an Internet scavenger hunt for Forms CMS-803, -805 and -807, and print copies for use during the lesson.*
- *Have the students access the Federal website:* http://www.gpoaccess.gov/cfr *and locate 42 CFR 483.15 and 42 CFR 483.70.*
- *Have the students locate the local source of Forms CMS-803, -805 and -807, the SOM and the reference copy of 42 CFR.)*

(Inform the students of the objectives.)

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Learning Objectives (cont.)

- Evaluate effectiveness of the physical environment in empowering residents, accommodating resident needs & maintaining safety.

3

Slide 3-F-3

Learning Objectives (cont.)

- Identify facility noncompliance with environment-related regulations.
- Refer specific observations to other team members.

4

Slide 3-F-4

General Observations of Facility

- This task in long term care survey requires surveyors to make general observations of environment
- No perfect facilities

5

Slide 3-F-5

Outline or text of presentation

"General Observations of the Facility" is the task in the long-term care survey that requires surveyors to make general observations of the environment.

In surveying the environment, recognize that there are no ideal or perfect solutions to the organization of rooms or interior design. Every facility you survey will be slightly different because of the people who work there and the individuals who live in the facility. The resident retains the right to affect the contents and arrangement of his/her room.

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General Observations of Facility (cont.)

- Primary Federal regulations
  - Quality of Life, 42 CFR 483.15
  - Physical Environment, 42 CFR 483.70

6

Slide 3-F-6

General Observations

- Do not include kitchen
- Distinguish areas inaccessible/accessible to residents
- Vary times of observations
- Usually done by 1 surveyor
- Use Forms CMS-803, -805 & -807

7

Slide 3-F-7

Outline or text of presentation

(Refer the students to their copies of 42 CFR.)

The regulations are primarily found under the large regulatory areas of Quality of Life, 42 CFR 483.15, and Physical Environment, 42 CFR 483.70. They address cleanliness, maintenance, and safety of the environment. More importantly, they focus on how the resident can control his/her environment and have both the environment and staff behaviors change to accommodate his/her needs. This requires the facility to be proactive in communicating with the resident, observing him/her and identifying needs affected by the environment.

Note: Do not document kitchen sanitation and food service findings in this section.

Throughout the review of the environment, you will need to distinguish between areas accessible by residents and those used solely by staff and visitors. Different regulations cover different areas of the building.

Observations should be made at different times during the survey. This could be during different times of the day and/or different days of the survey. The facility environment should be observed while the surveyor is performing other survey tasks.

(Refer the students to their copies of Forms CMS-803, -805 and -807.)

One person on the survey team usually conducts the general observations of the facility and completes Form CMS-803. However, each surveyor who reviews a resident will use the Form CMS-805, *Resident Review Worksheet*, to look at

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Outline or text of presentation

specific environmental factors for that resident.

Before you begin this tour, ask the other surveyors if they identified any environmental problems during the initial tour. If they found any problems, record them in as much detail as needed to follow up on their findings.

Tour of Facility Environment

- Layout or map of facility
- Facility staff role

8

Slide 3-F-8

Tour of the Facility Environment

Where do you start?

The review should start with the layout of the facility. A layout or map is obtained either during offsite survey preparation or from the administrator during the entrance conference.

(Ask the students to look at the sample layout and locate the following:

- *The main entrance.*
- *The main living area(s).*
- *The main dining room and the kitchen.*
- *The nurses' stations and the resident rooms for each.*
- *The common bathrooms and showers for each hall.*
- *The clean and soiled utility rooms for each hall.*
- *Resident rooms and bathrooms for each.*
- *The activity room.*
- *The laundry.)*

As you prepare onsite, decide whether to have facility staff tour with you. If a capable staff member is with you, that person will have access to all areas and will be able to confirm your observations. In some instances, you may not want to have a staff member with you. For example, if you identify problems in the

Audiovisual

Outline or text of presentation

first of four shower rooms, the staff person could correct the same problem in the other shower rooms before you can get there. Discuss this with your team and decide whether you want a facility staff member with you on all parts of the environment tour.

(Lead participants through the layout example. Follow the layout logically, just as you would while conducting the task. Go through the "Tour of the Environment" handout on page 3-F-15 and discuss what to look for in each room.)

Federal Regulations

- Quality of Life
- Physical Environment
- S&C memoranda

9

Slide 3-F-9

Federal Regulations

Let's see what regulations actually are written.

(Review the Quality of Life and Physical Environment regulations from the SOM, Appendix PP.

These regulations are supplemented by Survey & Certification (S&C) memoranda.

(Review the S&C memoranda.)

Investigation

You will use the investigative techniques of observing, interviewing, and reviewing records to investigate compliance with the requirements of each regulation.

(For each regulation, have the participants begin to verbalize methods of investigation:

- *What they would observe.*
- *What questions they would ask when interviewing staff and residents.*
- *Documents they may review, if needed.*

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Outline or text of presentation

Assist the participants as needed. Where necessary, refer to the actual regulation and the "Guidance to Surveyors."

Read through Forms CMS-803 and CMS-807. For the Resident Review Worksheet, just read through Section A: Resident room review. It will emphasize information already discussed.)

Documentation

- Form CMS-803 or CMS-807
- Date & time
- Name & title of anyone accompanying you
- Their response & time of response
- Any observations of concern to you

10

Slide 3-F-10

Documentation

Document findings on Form CMS-803 or Form CMS-807, *Surveyor Notes Worksheet*. Document your concerns thoroughly as you identify them. There is a difference between documenting a finding and later citing the facility for noncompliance with a regulation. Document findings as you go along to prevent the need to return to previous areas later.

Always begin by writing:

- The date and time you began this task.
- The name and title of anyone accompanying you.
- Their response(s) and the time of the response(s).
- Any observations of concern to you.
- Anything you show or tell staff, and who you tell.

If you look into a room and there is nothing wrong, you do not have to document anything. If you just list the room, it will show that you did review it for regulations and found nothing. Later, if you have a deficiency and have to determine the number of rooms you observed, it is easier if you have the information on paper rather than in your head.

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Referring Observations

- Teamwork
- Accuracy of documentation

11

Slide 3-F-11

Exercise

- Brainstorm three situations or environmental conditions
- Find applicable regulation
- Write up mock observations for referral
- Present observations & citation(s)

12

Slide 3-F-12

Outline or text of presentation

(Consider doing a mock tour of your office or an available building. Review the building layout before conducting the tour.)

Referring Observations

(Ask the students, "What kinds of concerns would be of interest to the other surveyors?")

The answer should be "all" since the team as a whole needs to determine facility compliance with regulations. Team members who are aware of environmental problems can then observe to see if other findings can strengthen any deficiency citation.

Accuracy of documentation is important in facilitating referral.

(Have the students:

- *Work in small groups to brainstorm three situations (or environmental conditions) surveyors might encounter where a resident's health or safety would actually or potentially be at risk.*
- *Include areas with and without resident access and identify the potential/actual injury or death that could result from the condition/situation observed.*
- *Find the regulation that applies.*
- *Prepare to refer the observation by writing up mock observations and deficiency citation(s).*
- *Appoint someone to be the spokesperson to state the regulation and the deficiency citation.*

Discuss what each group identified, commenting and probing as appropriate.)

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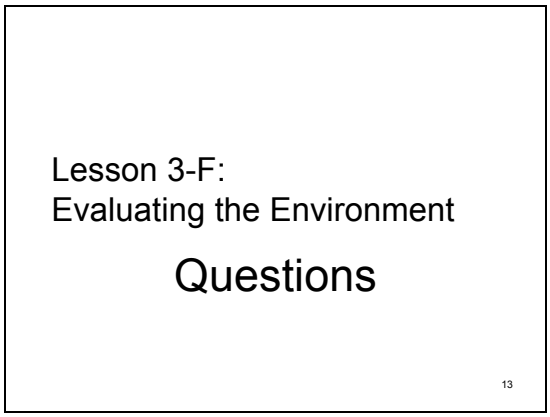
Outline or text of presentation



Slide 3-F-13

Skill Assessment

Evaluating the Environment

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Located environment-related regulations.	
					Identified appropriate observations, interview questions and documents to review.	
					Observed and documented findings relevant to the regulations (using Forms CMS-803, -805 and -807).	
					Evaluated effectiveness of the physical environment in empowering residents, accommodating resident needs and maintaining safety.	
					Identified facility noncompliance with environment-related regulations.	
					Referred specific observations to other team members.	

Comments/Recommendations:

Tour of the Environment

Requirement	Federal Regulation(s)	State Regulation(s)
Resident Rooms		
Not more than 4 beds/room	483.70(d)(l)(i), F457	
80 square feet/multiple–100 square feet/single room	483.70(d)(l)(ii), F458	
Designated/equipped to assure full visual privacy (If originally certified before 3/31/92, the facility can use method other than curtains.)	483.70(d)(l)(iv), F460	
New facility after 3/31/92, ceiling suspended curtains extend around bed	483.70(d)(l)(v), F460	
Bed: proper size and height for individual	483.70(d)(2)(i), F246	
Clean, comfortable mattress	483.70(d)(2)(ii), F246	
Bedding appropriate to weather, climate	483.70(d)(2)(iii), F246	
Clean bed linens in good condition	483.15(h)(3), F254	
Call system present and all parts function	483.70(f), F463	
Functional furniture for needs (e.g., clothing and personal effects accessible, chair for visitors)	483.70(d)(2)(iv), F246	

Requirement	Federal Regulation(s)	State Regulation(s)
Accommodates needs (e.g., everything needed within reach, adapted call system, needs chair with arms, can move around room without difficulty)	483.15(e), F246	
Clean, home-like, without objectionable odors	483.15(h)(l), F252	
Resident care equipment sanitary, properly stored, and labeled with resident's name	483.15(h)(2), F253	
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion	483.15(h)(2), F253	
Everything works (e.g., blinds, drapes, electrical bed, closet door, sink has stopper, heater with controls)	483.15(h)(2), F253	
Closet: private with racks and shelves accessible to resident *(Do not review without the resident's permission.)*	483.15(h)(4), F255	
Lighting adequate, suitable to tasks, comfortable (no glare), controllable by resident	483.15(h)(5), F256	
Temperature comfortable and safe (new facility after 10/1/90, normally 71–81 °F.)	483.15(h)(6), F257	

Requirement	Federal Regulation(s)	State Regulation(s)
Free from accident hazards (e.g., no sharp edges, beds don't move, brakes work, electrical cords intact, no extension cord trip hazards [otherwise a LSC issue], cleaning supplies stored appropriately, floors not slippery, no throw/area rugs that move, water not too hot, no clutter to block movement)	483.25(h)(l), F323	
Sign on door if oxygen used in room	483.25(h)(l), F323	
Bathing and Toilet Areas (Resident and Public)		
Clean, without objectionable odors	483.15(h)(2), F253	
All resident care equipment, toilet, sink, shower and tub are sanitary, properly stored, and labeled with residents' names as appropriate	483.15(h)(2), F253	
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion. Grout in shower area free from mold.	483.15(h)(2), F253	
Everything works (e.g., blinds, drapes, toilets, faucets don't drip)	483.15(h)(2), F253	
Temperature comfortable	483.15(h)(6), F257	
Accessible to the resident without difficulty (including toilet and sink)	483.15(e), F246	

Requirement	Federal Regulation(s)	State Regulation(s)
Free from accident hazards (e.g., no sharp edges; covered wall heater; cleaning supplies secured; razors in locked storage; no electrical extension cord trip hazards [otherwise a LSC issue]; floors not slippery; water not too hot; no clutter; grab bars present and tight; toilet seat tight–doesn't swing back and forth; electrical equipment not stored or used by sink or water)	483.25(h)(l), F323	
Call system present and all parts function	483.70(f), F463	
Visual privacy when appropriate	483.10(e), F164	
Products present to wash and dry hands	483.65(a), F441	
Whirlpool jets and both shower and whirlpool chairs are clean (check underside of chairs)	483.65(a), F441	
Linens		
Bed and bath linens clean, in good condition	483.15(h)(3), F254	
Handled, stored, and transported so as to prevent spread of infection	483.65(c), F445	
Living Room/Lounge Area/Dining Area		
Incontinence pads not automatically placed on furniture	483.15(a), F241	

Requirement	Federal Regulation(s)	State Regulation(s)
Accommodation of resident needs (e.g., television and lighting accessible and controlled by residents, rather than staff)	483.15(e), F246	
Clean (e.g., tables, chairs, carpet free from stains), home-like, without lingering odors	483.15(h)(l), F252	
Ceiling, walls, windows, window frames, screens, floors, furniture, and doors clean and in good repair or repaired in workman-like fashion	483.15(h)(2), F253	
Everything works (e.g., blinds, drapes, doors, lamps, piano)	483.15(h)(2), F253	
Lighting adequate, suitable to tasks, comfortable (no glare), controllable by resident	483.15(h)(5), F256 and 483.70(g)(2), F464	
Temperature comfortable and safe	483.15(h)(6), F257	
Free from accident hazards (e.g., no sharp edges; arms on chairs tight; no frayed wires on electrical cords; floors not slippery; no clutter to prevent safe movement; exit door monitored for wandering residents)	483.25(h)(l), F323	
Comfortable sound levels (consider background noise)	483.15(h)(7), F258	
Well ventilated (good air circulation without drafts, adequate smoke exhaust)	483.70(g)(2), F464 and 483.70(h)(2), F467	

Requirement	Federal Regulation(s)	State Regulation(s)
Adequately furnished to accommodate different resident physical needs (e.g., chairs with arms, tables at appropriate height for eating) and social needs	483.70(g)(3), F465	
Sufficient space to accommodate all activities	483.70(c)(l), F246 483.70(g)(4), F465	
Nourishment Areas		
Refrigerator and freezer maintain appropriate temperature (41 and 0 degrees F., respectively. Thermometers should be placed high in the space)	483.35(h)(2), F371	
Ice container and scoop are clean and covered	483.35(h)(2), F371	
Individual nourishments are covered, canned nourishments are within date (nourishments become outdated the first day of the month of expiration)	483.35(h)(2), F371	
Free from accident hazards (e.g., no sharp edges, floors not slippery, chemicals and knives safely stored)	483.25(h)(l), F323	
Equipment used to store and prepare food is clean and in good condition	483.35(h)(2), F371	
Products present to wash and dry hands, convenient location	483.65(a), F441	

Requirement	Federal Regulation(s)	State Regulation(s)
Activity/Therapy Areas		
Accommodation of resident needs (e.g., resident-use supplies accessible to residents when appropriate)	483.15(e), F246	
Free from accident hazards (e.g., no sharp edges; cleaning supplies and those labeled as a hazard stored properly; no electrical extension cords; floors not slippery; water not too hot; clutter does not pose hazard; grab bars present and tight)	483.25(h)(l), F323	
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion; grout in shower area free from mold	483.15(h)(2), F253	
Clean, home-like, without odors	483.15(h)(l), F252	
Everything works (e.g., blinds, drapes, doors, lamps, piano)	483.15(h)(2), F253	
Lighting adequate, suitable to tasks, comfortable (no glare), controllable by resident	483.15(h)(5), F256 and 483.70(g)(2), F464	
Comfortable sound levels (consider background noise)	483.15(h)(7), F258	
Well ventilated (good air circulation without drafts, adequate smoke exhaust)	483.70(g)(2), F464 and 483.70(h)(2), F467	

Requirement	Federal Regulation(s)	State Regulation(s)
Adequately furnished to accommodate different resident physical needs (e.g., chairs with arms, tables at appropriate height for eating) and social needs	483.70(g)(3), F465	
Sufficient space to accommodate all activities	483.70(c)(l), F246 and 483.70(g)(4), F465	
Products present to wash and dry hands	483.65(a), F441	
Nursing Station		
Call system present and all parts function	483.70(f), F463	
Residents can travel independently through nursing-station area without difficulty	483.15(e), F246	
Medication Room		
Products present to wash and dry hands	483.65(a), F441	
Appropriate drugs (including Schedule 2) and biologics separately locked	483.60(e), F432	
Appropriate drugs and biologics stored under proper temperature controls	483.60(e), F432	
All drugs and biologics are labeled with name of product, cautionary instructions, expiration date (when applicable), and name of patient when used for single patient	483.60(d), F431	

Requirement	Federal Regulation(s)	State Regulation(s)
System in place to permit only authorized personnel to have access to not only the medication room but also to separately locked storage areas	483.60(e), F432	
Needles and syringes safely disposed of	483.25(h)(l) F323 and 483.70(h), F465	
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion	483.70(h), F465	
Clean/Soiled Utility Room		
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion.	483.70(h), F465	
Free from accident hazards (e.g., no sharp edges; cleaning supplies and those labeled as a hazard; stored properly; no electrical extension cords; floors are not slippery; water not too hot; electrical equipment not stored or used by sink or water)	483.25(h)(l), F323	
Products present to wash and dry hands	483.65(a), F441	
In soiled utility room, hopper is clean	483.70(h), F465	
In soiled utility room, hose on hopper has vacuum breaker	483.70(h), F465	

Requirement	Federal Regulation(s)	State Regulation(s)
Halls		
Corridors accessible to residents equipped with firmly secured handrails on each side	483.70(h)(3), F468	
Water fountains accessible and accommodate resident needs	483.15(e), F246	
Clean, home-like, without lingering odors	483.15(h)(l), F252	
Ceiling, walls, windows, window frames, screens, handrail (without splinters), floors, furniture, and doors clean and in good repair or repaired in workman-like fashion	483.15(h)(2), F253	
Everything works (e.g., blinds, drapes, doors, water fountain)	483.15(h)(2), F253	
Lighting adequate	483.15(h)(5), F256	
Exterior Doors		
Exterior doors are monitored to prevent cognitively impaired residents from leaving without permission	483.25(h)(2), F253	
Storage Areas (Inside and Outside)		
Chemicals not stored with or above paper products	483.70(h), F465	
Food items not stored with chemicals	483.25(h)(l), F323	

Requirement	Federal Regulation(s)	State Regulation(s)
Linens stored off the floor and covered if required by storage placement	483.65(c), F445	
When floor is not clean, items should be stored off the floor	483.70(h), F465	
Oxygen tanks anchored	483.25(h)(l), F323	
Janitor's Closet/Area		
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in workman-like fashion	483.70(h), F465	
Vacuum breaker on faucet if hose is attached that extends below edge of sink (if vacuum breaker has holes, they should be free of debris)	483.70(h), F465	
Laundry		
Soiled linens and resident garments should proceed from "dirty" to "clean" area without crossing	483.65(c), F445	
Laundry staff should verbalize procedure to handle laundry for residents isolated because of skin lesions and other appropriate instances	483.65(a), F441 and 483.65(c), F445	
Interview and observe to determine how soiled linens are washed and handled to prevent infection (e.g., hot water temperature, chemical disinfectant)	483.65(c), F445	

Requirement	Federal Regulation(s)	State Regulation(s)
Ceiling, walls, windows, window frames, screens, floors, and doors clean and in good repair or repaired in a workman-like fashion	483.70(h), F465	
Boiler Room		
No flammable materials, reasonably clean and in good repair	483.70(h), F465	
Waste Disposal		
Garbage and refuse (e.g., food, chemical containers, soiled dressings) disposed of in containers that are in good condition and covered to prevent infestation and lingering odors, including dumpsters	483.35(h)(3), F372 and 483.65(a), F441 and 483.70(h), F465	
Miscellaneous		
Effective pest control program/no signs of vermin	483.70(h)(4), F469	
Signs posted: names, addresses, phone numbers of State survey agency, advocacy groups, Ombudsman, Medicaid fraud control, nurse staffing	483.10(b)(7), F156	
Notification: how to apply for and use Medicare/Medicaid benefits and receive refunds for previous payments covered by such benefits	483.10(b)(10), F156	

Requirement	Federal Regulation(s)	State Regulation(s)
Most recent survey results with plan of correction in place readily accessible (i.e., readable form, available without asking staff); results of Health and LSC surveys including all complaint and Federal surveys back to last standard survey	483.10(g)(l), F167	
Telephone: Reasonably accessible (e.g., height for use while seated in wheelchair, adapted for hearing impaired) without being overheard	483.10(k), F174	
Smoking area: sign(s) posted	483.70(g)(2), F464	
Well ventilated (good circulation, adequate smoke exhaust)	483.70(g)(2), F464	
Maintain essential equipment in safe operating condition (e.g., boiler, medication room refrigerator, kitchen refrigerator, range or oven, dish machine, washer, dryer, suction machine, blood glucose monitor—especially small facility with limited equipment)	483.70(c)(2), F456	
Emergency Preparedness		
Interview two staff and a charge nurse to describe what they do in emergencies (include staff from different shifts). Ask regionally appropriate questions. Look for consistent responses. If concerns are identified, review the policies and procedures.	483.75(m), F517, F518	

Requirement	Federal Regulation(s)	State Regulation(s)
Determine if facility has an emergency generator. If so, interview staff regarding location of emergency outlets. (Determine if resident profile requires a generator [life support-dependent residents, for example])	483.70(b)(l), F455	
How to apply for and use Medicare/Medicaid benefits and receive refunds for previous payments covered by such benefits	483.10(b)(10), F156	
Smoking Area: sign(s) posted	483.70(g)(2), F464	
Well ventilated (good circulation, adequate smoke exhaust)	483.70(g)(2), F464	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Ref: S&C-03-03

DATE: **OCTOBER 10, 2002**

FROM: Director
Survey and Certification Group, CMSO

Acting Director
Office of Clinical Standards and Quality

SUBJECT: BIPA 941 Nursing Home Requirement Effective January 1, 2003

TO: Associate Regional Administrator, DMSO
State Survey Agency Directors

The purpose of this memorandum is to alert you to a requirement for skilled nursing facilities and nursing facilities.

Background

Section 941 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires skilled nursing facilities and nursing facilities to post daily for each shift the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This information should be displayed in a clearly visible place. Additionally, BIPA 941 requires the Secretary of Health and Human Services to specify the "uniform manner" in which this information should be displayed.

What State Survey Agencies Need to Know

This information must include the actual number of licensed and unlicensed nursing staff directly responsible for the care of residents for that particular day on each shift. Licensed and unlicensed nursing staff includes: registered nurses, licensed practical nurses, and nurse aides. This information must be prominently displayed where residents, staff, and the public may view it. At this time, surveyors should only verify that the information is posted, not audit it as part of the survey. We will be developing further guidance that will specify the "uniform manner" in which this information should be displayed.

Effective Date

The effective date for this requirement is January 1, 2003.

Page 2 – Associate Regional Administrator, DMSO; State Survey Agency Directors

Training

This policy should be shared with all survey and certification staff, their managers and the State/Regional Office training coordinator.

/s/
Steven A. Pelovitz

/s/
Robert A. Streimer

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-18

DATE: **February 12, 2004**

FROM: Director
Survey and Certification Group

SUBJECT: Impact of the Health Insurance Portability and Accountability Act (HIPAA) on the Nursing Home Requirement for Posting Survey Results - **Clarification**

TO: State Survey Agency Directors

Letter Summary

- This letter replaces S&C-03-26, which was released on June 12, 2003.
- This letter clarifies that nursing homes are required to post survey results in a place readily accessible to residents, family members and legal representatives, and that the state or Secretary is required to make survey results available to the general public.
- The HIPAA Privacy Rule has not altered either the statutory requirement for nursing homes to post results or the requirement for the state/Secretary to make survey results available.

The purpose of this letter is to provide clarification to S&C-03-26, dated June 12, 2003 and its attached suggested template. The statutory mandate for nursing facilities to post survey results can be found at §1919(c)(8) of the Social Security Act (SSA). The statute that requires the state or the Secretary to provide the public with a means of access to survey results is located at §1819(g)(5) and 1919(g)(5). This letter clarifies that the HIPAA Privacy rule has not changed the statutory requirement for nursing homes to post survey results in a place readily accessible to residents, family members and legal representatives. It also notes that the HIPAA Privacy Rule has not altered the state or Secretary's obligation to provide the general public with a means to access these survey results as well. Regulations at 45 C.F.R. §164.512(a) which clarify the Department's HIPAA requirements provide that protected health information (survey results) may be used and disclosed without the authorization of the subject of that information (nursing homes) to the extent a law mandates such use or disclosure.

Page 2 – State Survey Agency Directors

We have attached a suggested template for use by the Centers for Medicare & Medicaid Services' Regional Offices (RO) and State Survey Agencies in response to providers' concerns over making survey results available as mandated by the SSA.

Effective Date: Immediately.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers and the state/RO training coordinator.

/s/
Thomas E. Hamilton

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

Attachment

Mr. X
Administrator
Specific Nursing Home
100 Main Street
City, State 11111

Re: Privacy Concerns about the Posting of Nursing Facility Survey Results

Dear Mr. X:

Thank you for your letter expressing concerns with the posting of federal and state nursing facility survey results in accordance with the statutory and regulatory requirements governing such facilities.

The nursing facility survey process was designed with three interests in mind: to provide surveyors with the information necessary to assess nursing facilities' compliance with federal standards, inform the surveyed facility and the general public about any deficiencies determined and the bases for those deficiencies, and to protect the confidentiality of personal and clinical records of nursing facility residents.

In furthering these goals, every effort is made during the survey process to minimize the use and disclosure of nursing facility residents' health information during the survey process. Deficiency statements, however, need to provide sufficient evidence to support any deficient practice findings as these citations serve as the ultimate basis for the non-compliance finding. While the residents selected as part of the survey sample are referred to by code (rather than by name, social security number, or some other easily identified identifier), it may be possible in rare circumstances to determine the identity of a resident through the documentation of a deficient practice.

While the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Parts 160 and 164; 65 Fed. Reg. 82462 as modified by 67 Fed. Reg. 14776) guarantees certain minimum privacy rights to the subjects of protected health records, those rights have limitations. For example, the HIPAA Privacy Rule provides that protected health information may be used and disclosed without the authorization of the subject of that information to the extent a law mandates such use or disclosure. Such mandates include §1919(c)(8) of the Social Security Act (SSA) that orders nursing facilities to post survey results in a place readily accessible to residents, family members, and legal representatives of the residents. Furthermore, §§1819(g)(5) and 1919(g)(5) of the SSA mandate that the general public must have a means to access these survey results through the State or the Secretary. The HIPAA Privacy Rule provides that protected health information may be used and disclosed without the authorization of the subject of that information for health oversight activities. As such, government regulatory programs that need health information to determine compliance with program standards (including the nursing facility survey program) do not need to obtain an individual's authorization to use that individual's health records for the appropriate oversight of entities subject to that program's regulations.

Page 2 - Privacy Concerns about the Posting of Nursing Facility Survey Results

We share your concerns about the privacy of nursing facility residents' medical records, but we must balance that concern with our statutory duties to regulate the nursing facility industry through the use of surveys and public access to the results of those surveys. We regret that in rare circumstances the statements of deficiencies may inadvertently release information that can be traced to a particular resident of a surveyed facility. While we regret such inadvertent releases, however, we firmly believe that they do not constitute violations of the HIPAA Privacy Rule's spirit or provisions.

If you have any further questions or comments on this matter, please do not hesitate to contact [name of the state or RO contact person], at [phone number or address]. Alternatively, you may wish to contact your State Survey Agency for additional information on this subject.

Lesson 3-G: Resident Review

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the purpose of Form CMS-805 and when the form is to be used.
- State the two pieces of information that should be included with documentation of observations.
- List the four pieces of information that should be included with all interview documentation.
- State the two pieces of information the surveyor adds to copied documents.
- Document resident-specific and facility-wide concerns.
- Use Form CMS-805 in a survey.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
- *Code of Federal Regulations:*
  - 42 CFR 483.25(l)
  - 42 CFR 483.60(c)(2)

State

(Insert State reference[s] here.)

Other

Highlights

- Form CMS-805 overview
- Documentation tips

Training Techniques

- Internet scavenger hunt
- Self-test
- Group discussion
- Lecture

Training Aids

- PowerPoint slides and handouts
- Computer, projector
- Form CMS-805, *Resident Review Worksheet*
- Handout:
  - *Form CMS-805 Self-Test*

Methods of Evaluation

- Effective use of information during a future training session
- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 3-G: Resident Review 1 Slide 3-G-1	*(Preparatory work—Internet scavenger hunt: Have the students find Form CMS-805 at the CMS website, print a copy and bring it with them to training. Tip: Type "CMS-805" in the search box.* *You may use the self-test included with the lesson as a pre-test to help students recall their prior knowledge before the lesson and organize notes during the lesson. Suggestion: If the self-test is used as a pre-test, have pairs of students work together.)*
Learning Objectives At the conclusion of this lesson, you will be able to: • Describe the purpose of Form CMS-805 & when the form is to be used. • State the two pieces of information that should be included with documentation of observations. 2 Slide 3-G-2	*(Inform the students of the objectives.)*
Learning Objectives (cont.) • List the four pieces of information that should be included with all interview documentation. • State the two pieces of information the surveyor adds to copied documents. 3 Slide 3-G-3	

Audiovisual

Outline or text of presentation

Learning Objectives (cont.)

- Document resident-specific & facility-wide concerns.
- Use Form CMS-805 in a survey.

4

Slide 3-G-4

Form CMS-805, *Resident Review Worksheet*

Tool used:

- To gather information
- For every resident
- In comprehensive & focused reviews
- For Phases 1 & 2

5

Slide 3-G-5

Form CMS-805, *Resident Review Worksheet*

The *Resident Review Worksheet* is a tool for gathering information during the survey. Form CMS-805 is to be used for every resident selected, for comprehensive, focused and closed record reviews and during Phase 1 and Phase 2. There is no standard way to complete this form; your State agency or Regional Office can instruct you on their best practices.

Pearls to Remember

Always include date & time of observations & interviews	For photocopied documents, *always* date & initial
Always include name & title of source of information	*Do not* add notes or other markings to copied sheets

6

Slide 3-G-6

In using the *Resident Review Worksheet*, as with all documents used during the survey, there are essentials to remember.

1. Always include the date and time of observations and interviews, as well as the name and title of the source of information.
2. For documents that are copied *always* date and initial each page, but *do not* add additional information or markings to these documents as this may impact their legality if they are needed for a court hearing.

Audiovisual

Form CMS-805

Top two sections:
- Standard identifying information
- Next sections
  - Interviewable or noninterviewable
  - Type of review
  - Focus/care areas

7

Slide 3-G-7

Outline or text of presentation

Top sections
The top two sections ask for standard information such as resident name and identifier (Resident 1, 2, 3 or 4, etc.).

(To help the students get the feel of the documentation process, have the students write hypothetical information on their copy of Form CMS-805 as you discuss the sections.)

The next section asks whether the resident is interviewable, the type of review you will conduct and the focus areas you will look at. The "Focus/Care Areas" are determined based on the concerns identified from the *Roster/Sample Matrix*.

Section A: Resident Room Review

- This section lists prompts for observation of resident room
  - Room should be observed on multiple occasions
  - Review room to ensure it is safe & meets resident's needs

8

Slide 3-G-8

Section A: Resident Room Review
This section lists areas of concern for the observation of the resident room.

The rooms should be observed on multiple occasions to ensure the resident's room is safe and meets his/her needs.

Section B: Resident Daily Life Review

- Prompts for resident observation
  - Multiple observations
  - All residents (except for closed records)

9

Slide 3-G-9

Section B: Resident Daily Life Review
This section lists prompts for the observation of the resident.

Both Sections A and B should be completed (or initialed) as the result of multiple observations and reviewed for all residents, except those chosen for the closed record review.

Audiovisual

Section C: Assessment of Drug Therapies

- Purpose:
  - To review & assess medications taken by resident in prior 7 days
- Suggestions:
  - Photocopy recap of MD orders
  - Photocopy medication administration record (MAR)

10

Slide 3-G-10

Outline or text of presentation

Section C: Assessment of Drug Therapies
The assessment of drug therapies is a means to review the medications the resident is receiving. It evaluates the effectiveness of the therapeutic regime and whether it is being monitored and assessed.

The following procedures are from *SOM* Appendix P. Please refer to page 45 for complete instructions.

General procedures:

1. Assess drug therapies for residents selected for comprehensive and focused reviews. Review and record medications (prescription and nonprescription) the resident has taken for the past seven days.

   Suggestion: An alternative to writing medications in the grid is to photocopy the current recap of physician's orders and any new meds prescribed since the recap. You may also choose to photocopy the medication administration record (MAR), which will show exactly which medications were administered.

2. Evaluate for the presence of any unnecessary drugs. Please refer to 42 CFR 483.25(l) and 42 CFR 483.60(c)(2).

Audiovisual

Review for Unnecessary Drugs
42 CFR 483.25(l) & 42 CFR 483.60(c)(2)

- Indications for use
- Effectiveness
- Dose
- Proper monitoring
- Duplicative therapy
- Presence of adverse side effects

11

Slide 3-G-11

Outline or text of presentation

Review medications for:

- Indications/reason for use.
- Effectiveness of therapeutic goal.
- Dose.
- Presence of monitoring.
- Presence of duplicative therapy.
- Presence of possible adverse drug reactions or side effects.

Adverse Drug Reactions

- High potential for severe adverse drug reactions (ADRs)?
- High potential for less severe ADRs?
- If *yes*, then refer to "Investigative Protocol: Adverse Drug Reactions"

12

Slide 3-G-12

3. Also review for the presence of medications with "High Potential for Severe ADRs" or "High Potential for Less Severe ADRs," as identified in the guidance to surveyors.

4. Correlate the review of the drugs with the resident's clinical condition and any extenuating circumstances, such as recent admission, a change in the resident's environment, hospitalizations, etc.

5. Evaluate how the drugs the resident receives affect his/her quality of care and life through the following methods:
   - Review the clinical record.
   - Observe the resident.
   - Interview the resident or interested parties.

6. Let the facility provide its rationale for use of drugs prescribed contrary to CMS guidelines.

Audiovisual

Concerns?

If there are concerns regarding resident's drug therapy then:

- Look at pharmacist's monthly drug regime review
- Review physician's or nurses' notes regarding medications & those made in response to pharmacist's recommendations

13

Slide 3-G-13

Outline or text of presentation

7. If problems or concerns with drug therapy are noted, review the results of the pharmacist's drug regime review, and the response from the attending physician/director or nurses.

Section D: RAI/Care Review Sheet

- Which records are compared?
- How much information is needed?
- What does comparison show?
  - Do assessments show an improvement or decline?

14

Slide 3-G-14

Section D: RAI/Care Review Sheet
Follow the instructions regarding the time specifications of the MDS records that are to be compared as well as what to look for in a record review.

One of the bullets near the bottom of the page is especially important:

- "If the resident declined or failed to improve relative to expectations, determine if this was avoidable or unavoidable."

Determining whether a resident's decline is unavoidable may lead you to facility culpability and towards a citation.

Remember: If you work for one of the 10 Regional Offices, keep in mind that State Agency surveyors frequently use the standard Form CMS-805. Be sensitive to the fact that this is the official form and therefore documentation should be appropriate. Extensive MDS documentation as sometimes seen on altered forms is not required and is not to be expected for evaluation purposes.

Audiovisual

Outline or text of presentation

Under the "RAI Status/Comparison" column, you must differentiate your notes to identify the different MDS reports you are comparing.

Suggestion: Some people draw a line down the center of the column to simplify the comparison of the two MDS records.

Care Plan Column

- Trigger
  - To check care plan & ensure that identified concerns have been addressed
  - To ensure appropriate interventions are in place

15

Slide 3-G-15

The intent of the Care Plan column is to trigger you to ensure that identified concern areas (from offsite prep, tour, the facility *Roster/Sample Matrix*, etc.) have been identified/acknowledged by the staff, and that appropriate interventions have been implemented.

Concern Areas

- Resident-specific:
  - These are concern areas that were triggered for specific resident
- Facility-wide:
  - These are concerns identified from QI reports that are to be investigated for each resident in sample

16

Slide 3-G-16

Suggestion: On the back page there is room to write down identified concern areas. One technique to use for a comprehensive review would be to list the *resident-specific* concerns at the top of the page going down and the *facility-wide concerns* from the bottom up. Using this method may help to organize and prioritize your investigation.

Audiovisual

Lesson 3-G:
Resident Review

Questions

17

Slide 3-G-17

Outline or text of presentation

Skill Assessment

Resident Review

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described the purpose of the Form CMS-805 and when the form is to be used.	
					Stated the two pieces of information that should be included with documentation of observations.	
					Stated the four pieces of information that should be included with all interview documentation.	
					Described the two pieces of information the surveyor adds to copied documents.	
					Used Form CMS-805 in a survey: A. Resident Room Review.	
					B. Resident Daily Life Review.	
					C. Assessment of Drug Therapies, including use of the "Investigative	

					Protocol: Adverse Drug Reactions.”	
					D: RAI/Care Review Sheet.	
					Documented resident-specific concerns.	
					Documented facility-wide concerns.	

Comments/Recommendations:

Form CMS-805 Self-Test

What is the purpose of Form CMS-805?

When is it used?

What two pieces of information should be included with documentation of observations?

What four pieces of information should be included with all interview documentation?

What two pieces of information are added to copied documents?

Lesson 3-H: Kitchen

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Demonstrate a working knowledge of how to assess facility compliance regarding food storage, preparation and service to prevent food-borne illness.
- Demonstrate knowledge of the requirements of 42 CFR 483.35(h)(1), (2) and (3) in *State Operations Manual (SOM)* Appendix PP, F370, F371 and F372.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I, pages 35–36
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities, pages 208–212
- *Food Code* [On-line]. Available: http://www.cfsan.fda.gov/~dms/foodcode.html#get05

State

(Insert State reference[s] here.)

Other

Highlights

- Investigating principles of food safety
- Procurement, storage, food preparation, food service and distribution
- Sanitizing
- Thermometers
- Cooking temperatures
- Sources of food-borne illness
- Disposal of refuse

Training Techniques

- Lecture
- Group discussion
- Small group exercise

Training Aids

- Forms CMS-804 and CMS-807, one of each per person
- PowerPoint slides and handouts
- Option 1: eight 5” × 8” note cards per student (six for exercise, plus two spares)
- Option 2: Worksheet *The Inside Story* on page 3-H-33
- *SOM* Appendices P and PP
- Handouts:
  - *Worksheet–The Inside Story*
  - *Excerpt from the SOM, Sub-Task 5B–Kitchen/Food Service Observation*
  - *Entering the Institutional Kitchen*

- *Food Storage*
- *Food Preparation*
- *Food Service and Distribution*
- *Sanitization*
- *Thermometers*
- *Thermometer Calibration*
- *Testing Food Temperatures (Bimetal Stem Thermometer)*
- *Cooking Temperatures*
- *Sources of Food-Borne Illness*
- *Excerpt from the SOM, Appendix PP, 483.35(h) Sanitary Conditions*

Methods of Evaluation

- Verbalization/discussion of imaginary survey or survey tips
- Completion of skill assessment

Audiovisual

Lesson 3-H:
Kitchen

1

Slide 3-H-1

Outline or text of presentation

(Option 1: To help the students focus their attention during lecture, you may play "Two Cents' Worth." Have them write survey tips for the kitchen area—their two cents' worth—on a set of eight 5" × 8" note cards, one set per student. Have them label the note cards as follows:

- *Procure.*
- *Store.*
- *Prepare.*
- *Distribute.*
- *Serve.*
- *Dispose.*

There will be two spare cards.

They may write what comes to mind, or get ideas from the handouts—the important thing is to get them thinking. Give them five minutes to come up with at least five tips ***of five words or fewer*** *under any category(ies); they can add or correct items as the lecture progresses. The payoff of this strategy is that they will have a draft set of "cheat sheets.")*

(Option 2: Ask the students to prepare to collaborate on "The Inside Story"[page 3-H-33] of an imaginary survey as they learn about potential issues during the lecture. They may use the worksheet "The Inside Story" or Forms CMS-804 and CMS-807 to jot down imaginary "observations." At the end of the lecture, have groups of three combine their observations to tell the story of a survey. At the end of the story, a group spokesman will indicate whether the facility in the group's imaginary survey had deficient practice and what tags were at issue, if any.)

Audiovisual

Outline or text of presentation

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Demonstrate a working knowledge of how to assess facility compliance regarding food storage, preparation and service to prevent food-borne illness.

2

Slide 3-H-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Demonstrate knowledge of the requirements of 42 CFR 483.35(h)(1), (2) & (3) in Appendix PP, F370, F371 & F372.

3

Slide 3-H-3

Investigation of Kitchen

- F371: 42 CFR 483.35(h)(2):
  - Facilities must store, prepare, distribute & serve food under sanitary conditions

4

Slide 3-H-4

According to 42 CFR 483.35(h)(2), facilities must store, prepare, distribute and serve food under sanitary conditions.

Audiovisual

Survey Context: Sub-Task 5B

- Designed for investigation of facility compliance with regulations for sanitary conditions in food service:
  - Storing
  - Preparing
  - Distributing
  - Serving
- Begins with brief visit to kitchen to observe general cleanliness

5

Slide 3-H-5

Outline or text of presentation

Survey Context

Task 5 of the survey protocol is the information-gathering task. The *SOM* states that 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 is divided into sub-tasks, and Sub-Task 5B is the subject of this lesson. Sub-Task 5B was designed for the investigation of facility compliance with regulations in storing, preparing, distributing and serving food under sanitary conditions. The protocol gives some specific procedures for performing this investigation. You will also become aware of two additional requirements regarding food procurement and the proper disposal of refuse.

Sub-Task 5B overview

This investigation begins during the initial tour. The surveyor assigned to complete this investigation begins with a brief visit to the kitchen to observe general cleanliness. This is a time to make note of any potential sanitation issues, such as meat thawing improperly; perishable foods not labeled, dated and sealed; and staff not wearing hair restraints.

Audiovisual

Documentation

- Use Form CMS-804: *Kitchen/Food Service Observation*
- Include date & time of observation & names of staff

6

Slide 3-H-6

Outline or text of presentation

The *Kitchen/Food Service Observation* worksheet (Form CMS-804) is a guide for completing a thorough investigation of facility kitchen sanitation practices and also is a form to document your observations. If additional writing space is needed, you can use Form CMS-807, *Surveyor Notes Worksheet*.

During the initial tour of the kitchen make observations of potential sanitation issues for further investigation or evident deficient practice. Note significant observations on Form CMS-804, including date, time and the names of staff.

This brief visit will usually not take as much time as all of the initial tour. Generally, you will finish this brief visit and help the team finish other initial-tour responsibilities.

(Refer students to the handout "Excerpt from the SOM, Sub-Task 5B—Kitchen/Food Service Observation" on page 3-H-35.)

The *SOM* directs that if surveyors determine concerns with the quality of the meals, receive complaints regarding taste, texture or foods have an "off" or bad color or there is a high prevalence of weight loss, then the surveyor assigned to Sub-Task 5B will need to conduct some *additional observations*. Please see the *SOM* just above Sub-Task 5C—Resident Review. These observations are not necessary if the above-mentioned circumstances are not occurring at the facility.

Audiovisual

Areas of Institutional Kitchen

- Refrigeration & freezers
- Dry storage
- Food preparation & work areas
- Cleaning & chemical storage
- Areas for washing & sanitizing

7

Slide 3-H-7

Outline or text of presentation

There are some general expectations with regard to the makeup of an institutional kitchen. You will investigate all areas of the kitchen with regard to their different functions of food handling, storage, preparation and service, as well as dish and utensil cleaning and sanitizing. Some main areas of an institutional kitchen are:

- Refrigeration and freezers for the storage of perishable foods or foods to be served chilled.
- Dry storage for foods not requiring refrigeration, as long as they are rotated and used within manufacturer-posted expiration dates and used within appropriate time frames after opening.
- Food preparation and work areas.
- A separate area for cleaning supplies or chemical storage.
- Areas and equipment for washing and sanitizing dishes, utensils, and large pots and pans.

Entering Institutional Kitchen

- Use hair restraint
- Wash hands using good technique
  - Observe trash receptacle use
- Observe staff technique

8

Slide 3-H-8

(Refer students to the handout "Entering the Institutional Kitchen" on page 3-H-37.)

Entering the Institutional Kitchen

- Put on your hair restraint.
- You may have to knock, because kitchens are often locked.
- Introduce yourself and explain why you are there.
- Once inside, the first thing to do is find where employees wash their hands so you can wash yours.
- Wash your hands using good hand-washing technique.
  - Turn the water on, use plenty of soap and hold hands down so that

Audiovisual

Outline or text of presentation

soap and water from your hands run into the sink and not down your arm.
  - Wash approximately 10 seconds, washing between your fingers, around your nails, and the backs of your hands as well as the palms.
  - Rinse your hands, take a clean paper towel and thoroughly dry your hands.
  - Use that paper towel or a clean one to cover the faucet when you turn it off, then throw the towel away without touching the trash receptacle.
- If the employee hand-washing sink is not equipped so that you can employ good hand-washing technique, make a note of that on Form CMS-804 and observe to see how employees are or are not accomplishing the task.

Investigating Food Safety

- Storage
- Preparation
- Service
- Sanitation
- Tip: ask for menu & outline of preparation

9

Slide 3-H-9

Investigating Food Safety

Use Form CMS-804 to guide your investigation. Every question on the form does not have to be answered to have completed a thorough review; however, all areas must be investigated (storage, preparation, service/sanitation). For instance, every facility will not use shell eggs, and it may be that on the days of your investigation, the facility does not thaw any meat because it is serving precooked casseroles. Ask the dietary manager or the cook what foods will be prepared and what preparation will entail. This will help you organize your kitchen investigation with other survey tasks.

Audiovisual

Issues in Technique

- Cross-contamination
- Staff hygiene
- Cleaning & sanitizing
- Time & temperature controls

10

Slide 3-H-10

Outline or text of presentation

Issues in Technique

Common poor techniques associated with food-borne illness include:

1. Cross-contamination: occurs during storage and preparation when pathogens from one food or surface are brought into contact with another food that generally does not require the same temperature controls.
2. Poor staff hygiene: not thoroughly washing hands, working with contagious illness, not washing hands when needed, general lack of personal cleanliness, and not using gloves appropriately.
3. Lack of appropriate cleaning and sanitizing.
4. Lack of adherence to time and temperature controls.

Dry-Storage Issues

- On-floor storage
- Dented or swollen cans
- Signs of infestation
  - Insects
  - Droppings
  - Streaks on walls along shelves
- Lack of first-in, first-out rotation

11

Slide 3-H-11

(Refer students to the handout "Food Storage" on page 3-H-39.)

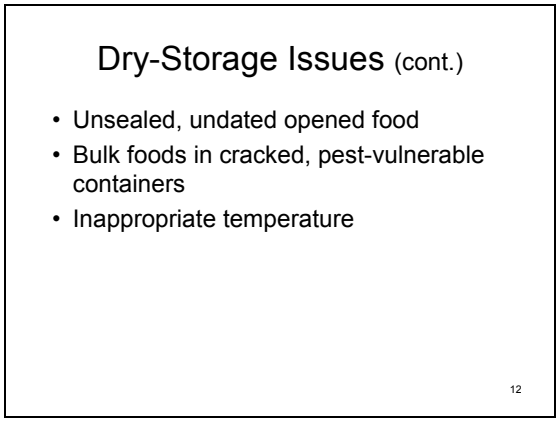
Food Storage

Dry-storage issues

- Food should be stored off the floor (usually on wire racks for cleanliness and visibility, although these are not required.)
- Dented or swollen cans are typically sent back to the vendor. These should be separated from canned foods to be used.
- Check for signs of infestation (insects in the dry-storage bins, rodent droppings, a greasy-looking streak along the lower walls or just above shelf level).
- Dry goods (e.g., boxes of cereal, pasta, rice, instant potatoes) and cans should be rotated so that foods

Audiovisual

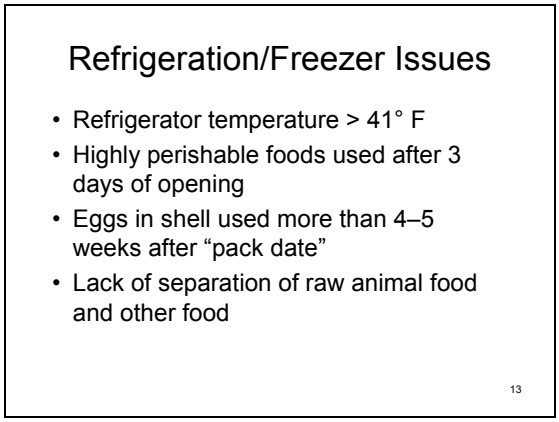
Outline or text of presentation



Slide 3-H-12

delivered more recently go to the back of storage and foods stored the longest are used first. A common acronym for this principle is FIFO (first-in, first-out).

- Opened foods and ingredients should be sealed and dated, denoting when they were opened.
- Bulk dry goods like flour, cornmeal and sugar should be in pest-resistant containers that are well covered and have no cracks.
- Dry-storage areas should also be kept at a temperature generally comfortable for an employee to work in. Higher ambient air temperatures can promote spoilage or bacterial growth even in dry goods.



Slide 3-H-13

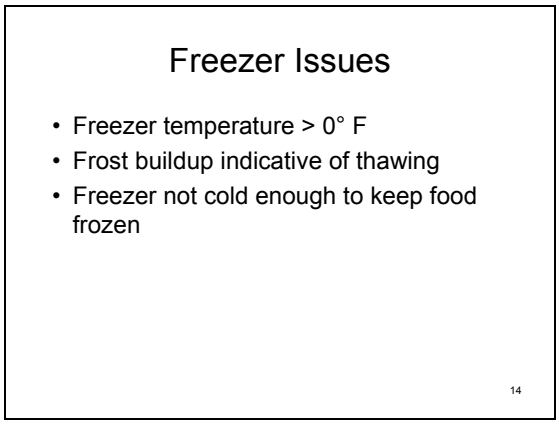
Refrigeration/freezer issues

- Refrigeration/freezer units may include upright "reach-in"-type units or "walk-in"-type units, dairy cases, and deep freezers, all of which you should check for appropriate temperatures for minimizing bacterial growth.
- Refrigeration units should ideally be 41° F but, as Form CMS-804 directs, allow for a two- to three-degree variance and do not expect refrigeration units to hold this temperature when staff are in and out of them during meal preparation. Staff should try to minimize the time that refrigerator doors are open.
- All high-protein foods or products of animal origin are highly perishable, which means they are highly susceptible to bacterial growth that will diminish their safety for consumption. These foods carry an increased risk of causing food-borne

Audiovisual	Outline or text of presentation
	illness if not handled properly. Check the expiration dates. If the items have been opened, check to see if they are sealed, dated and labeled (if the manufacturer label is damaged or absent). Leftovers and opened ready-to-eat foods that require refrigeration should not be kept longer than three days. • Eggs in an unbroken shell can be kept four to five weeks after the "pack date." At that time they will diminish in quality but still may not be spoiled, because the shells on an egg act as a powerful deterrent to microbes. Once the shell is broken, however, eggs become a highly perishable food that should be immediately used in cooking. Furthermore, you may encounter a facility that honors resident food preference for soft-cooked eggs. The facility must use pasteurized eggs if it is serving eggs that are not thoroughly cooked to residents. Pasteurized eggs generally have a stamp of the letter "P" on each egg. • The facility should make every possible effort to keep raw animal products away from other foods, especially foods that will be served without cooking. For example, a worst-case scenario could be finding thawing raw poultry sitting on a rack next to the lettuce that is planned for the chicken salad. Thawing meat should be kept in deep pans and on the bottom shelf of the refrigerator to ensure that gravity does not cause thawing juices to fall onto other foods. More likely, you may find raw meat thawing on the same shelf as an uncut watermelon. Bacteria-laden liquid from the thawing meat can

Audiovisual

Outline or text of presentation



Slide 3-H-14

easily splash or be transferred through staff handling onto the watermelon rind; and when cut, the watermelon could be contaminated.

- Note also that freezers should be 0° F and that freezer temperature will increase very quickly once the door is open. If you do not immediately see the thermometer in a freezer and you have to take time to find it, the reading will no longer be an accurate reflection of the freezer temperature during food storage. If the facility's thermometer is difficult to find or is not present in the unit, ask the dietary manager how he/she monitors to ensure freezers are holding at 0° F.
- *Note:* Although Form CMS-804 states "0 degrees F or below" for freezer temperatures, the freezer temperature provided in *Food Code* (http://www.cfsan.fda.gov/~dms/foodcode.html#get05) was changed to "at any temperature if the food remains frozen."
- Look for frost buildup in the freezer, which is evidence that the freezer may not consistently hold the appropriate temperature. If there is heavy frost buildup, check for evidence that food has thawed and been refrozen. Do this by finding a bag of food in pieces, such as green beans, broccoli, chicken breasts, or fish fillets. If they have not been refrozen you should be able to feel the individual pieces; once refrozen, they will form a clump, and the individual pieces will be less distinguishable. Ask the dietary manager or food service personnel if any of the foods in the freezer have previously been thawed.

Audiovisual

Dairy Case Issues

- Spills
- Lack of first-in, first-out rotation
- Temperature above 41° F

15

Slide 3-H-15

Outline or text of presentation

- Dairy cases should be free from spills, and dairy products should be consistently rotated so that newly delivered products are used after products stored longer. If the contents of the dairy case are very crowded or the thermometer does not register 41° F, consider testing the temperature of one carton of milk. You may ask the dietary manager if you can test the temperature of one carton of milk. Take a carton from the center of the case, test the temperature, record the information, and discard the carton of milk. (Procedures for proper use of a thermometer will be addressed later in the lesson.)

General Food Storage Issues

- Dirty floors
- Dirty shelving & walls
- Crowding

16

Slide 3-H-16

Additional considerations when evaluating food storage are clean floors, clean shelving and walls, and uncrowded storage space.

Audiovisual

Food Preparation Issues

- Thawing meat
- Cooking eggs
- Washing hands
- Using gloves
- Cross-contamination
- Cooling leftovers

17

Slide 3-H-17

Outline or text of presentation

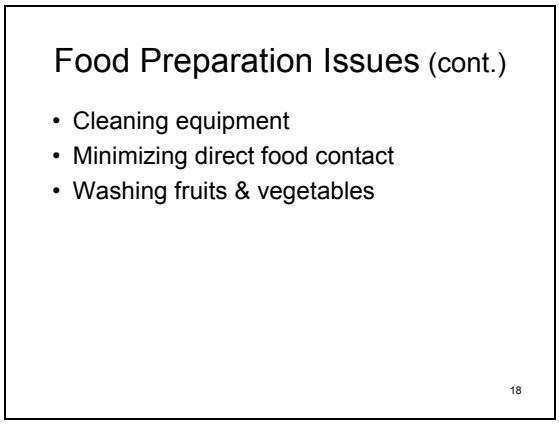
(Refer students to the handout "Food Preparation" on page 3-H-41.)

Food Preparation

- Meat must be thoroughly thawed before it is used for cooking. If it is not, the internal temperature will not reach levels necessary for sanitation before the outside of the meat is overcooked.
  - Acceptable methods of thawing meat include putting it in the refrigerator or putting it under cool running water until thawed.
- Eggs must be cooked firm or used in baked goods or casseroles that are cooked at high temperatures. Pasteurized eggs may be used to honor resident food preferences for "soft-cooked" preparations like "over easy."
- Observe staff preparing the food. Do they wash their hands using good technique at appropriate times? Staff should wash their hands before starting work and before touching clean dishes. Each should also wash after:
  - Using the restroom.
  - Break.
  - Covering their mouth after coughing or sneezing.
  - Eating or drinking.
  - Touching his/her own body (face, hair, nose, etc.).
  - Touching raw meat, trash cans, picking something up off the floor.
  - Using cleaners.
  - Touching dirty dishes.
- Using gloves: Food handlers should always wash their hands before putting on gloves. Gloves should be

Audiovisual

Outline or text of presentation



Slide 3-H-18

changed if torn, when starting a new food preparation procedure, and any of the times one should wash one's hands as mentioned above.

- Watch carefully for signs of staff cross-contaminating the food. An example of cross-contamination would be observing staff cut up raw chicken, wipe off the surface without properly sanitizing the surface where they cut the chicken, and then cut fresh tomato on that surface. Some kitchens may have specific tables used only for raw meat preparation.
- Leftover hot food should always be cooled in a shallow pan. If the stored food is more than two inches in depth after cooking, it may be in the "danger zone" (42° F–139° F) temperature range for too long to be safe. The "danger zone" is the temperature range in which bacteria rapidly multiply.
- You will encounter a variety of institutional food service equipment. Common equipment used in nursing homes besides stovetops, ovens, grills and microwaves is preparation equipment such as mixers, blenders, and meat slicers. Make sure the equipment looks thoroughly cleaned. If staff are using equipment during preparation, observe their technique and the way equipment is cleaned and sanitized after use. If a sanitizer solution is not used after food debris is cleaned from the equipment, ask to see the manufacturer's recommendations for cleaning the equipment and ensure that the instructions are being followed. If there are deviations, make a note of this on Form CMS-804. If your observations are between uses, then

Audiovisual	Outline or text of presentation
	check the equipment for signs of food left on the equipment and not thoroughly cleaned. Make a note of these using good documentation principles so the information can be used in your deficiency determination. • Staff should minimize direct contact with food by using clean utensils in preparation as much as possible. There will be times when staff will touch food, for instance, when making sandwiches or when slicing fruits and vegetables. Do staff wash their hands and use gloves appropriately? • Washing fruits and vegetables: – Fresh produce has a natural protective coating that keeps in moisture and freshness. Staff should wash produce under clean, running water and rub fruits and vegetables briskly with clean hands to remove dirt and surface microorganisms. – Produce is to be washed just before serving—not before storing, as washing will cause produce to spoil faster. – Staff should discard the outer leaves of leafy vegetables such as lettuce and cabbage before washing. – Foods such as squash and melons should always be washed, even if the rind or skin isn't eaten, because when cut, dirt or bacteria that are on the outer surface can be transferred to the inner flesh. – Produce should not be washed with detergent or bleach solutions. Fruits and vegetables are porous and can absorb the detergent or bleach.

Audiovisual

Outline or text of presentation

(Refer students to the handout "Food Service and Distribution" on page 3-H-43.)

Food Service & Distribution Issues

- Hot foods held beyond approximately 30 minutes of readiness
- Cold foods not refrigerated until close to service or put on ice
  - Ice in contact with food

19

Slide 3-H-19

Food Service and Distribution Issues

Most facilities will have a steam table, but some facilities will serve food directly from the stove. Prepared hot food should not be held for longer than approximately 30 minutes before service. Foods served cold should be kept in refrigeration as close to the time of service as is possible or put on ice. The ice should not touch the food directly.

Food Service & Distribution Issues (cont.)

- Hot foods held below 135° F or above 180° F
- Cold foods held above 41° F
  - Meat salad/sandwich treatment
  - Chilling overnight improves temperature control

20

Slide 3-H-20

Observe to see if staff are going to take the temperatures of foods before service. If service is about to begin and staff have not taken temperatures, ask staff how they ensure foods are the proper temperature for service. Record their answers on Form CMS-804. Request that the staff test the temperature of foods so you can investigate the safety of foods served. Hot foods should be held at a minimum of 135° F. Foods can lose quality and moisture when held at temperatures above 180° F. (Consider this in the context of palatability issues at the facility.)

Note: Although Form CMS-804 states "hot foods maintained at 140 degrees F or above," the hot holding temperature in the *Food Code* was changed to "135 degrees F or above."

It can be challenging to serve some cold foods at 41° F. As long as high-protein foods are kept at 41° F until time of

Audiovisual	Outline or text of presentation
	service (e.g., milk, cottage cheese, egg salad), consider this an issue of palatability. For instance, if a menu item for the service you observe is "chilled peaches," opening a can of peaches from dry storage, portioning them into dishes and putting the dishes on ice will not always chill them to 41° F, especially if the ambient air temperature is high in the kitchen. They usually will be about 60° F. Chilling the canned fruit overnight will generally improve this quality outcome. Another scenario you may encounter is the serving of meat salad sandwiches like tuna salad. Does the facility attempt to minimize the preparation, storing, and holding time of high-protein foods that are not going to be cooked? Do staff open the tuna, make the salad, and prepare the sandwiches as they plate and serve them to residents? Do they prepare the sandwiches swiftly, put them in shallow pans and store them in the refrigerator until service time? What you might see instead is that they prepare them slowly, leave the tuna salad sitting out for long periods, then put the sandwiches in deep pans and put them in the refrigerator until service or do not chill them at all. What was the total time the tuna salad was left unrefrigerated before service? Was it greater than two hours from the time a sandwich was being made to the time it was served? Chilling the canned tuna overnight improves temperature control.

Audiovisual

Service Staff Practice Issues

- Lack of hand washing/sanitizing
- Unsanitary utensil use

21

Slide 3-H-21

Outline or text of presentation

Service staff practice issues
Service of food generally involves both dietary and nursing personnel. Do staff serving the food to the residents wash or sanitize their hands? Do they use utensils or do they touch the food when assisting residents with buttering and so on?

Plated Food Issues

- Lack of cover during transportation
- Transportation near floor/shoes

22

Slide 3-H-22

Plated food issues
Plated food should be covered during transport. Food plated and served directly from tray line to residents seated in the dining room adjacent to the kitchen (immediate service) does not have to be covered. However, food transported to another dining area or down a hall must be covered. Food should be transported covered and on the higher shelves away from the floor and staff shoes.

Sanitization

- Definition of sanitization, general requirements:
  - Effective bactericidal treatment
  - By heat or chemical means
  - Acceptable to the permit-issuing official
  - Destroys pathogens on surfaces treated

23

Slide 3-H-23

(Refer the students to the handout "Sanitization" on page 3-H-45.)

Sanitization

Definition
Definition of sanitization, general requirements: Sanitization is effective bactericidal treatment by heat or chemical means that destroys pathogens on surfaces treated.

Audiovisual

Sanitization (cont.)

- Acceptable methods
  - Chemicals
  - Hot water
  - Three-compartment sink
  - Dish machine
- Chemical contamination

24

Slide 3-H-24

Outline or text of presentation

Acceptable methods
(2001 FDA Food Code)

A. If immersion in hot water is used for sanitizing in a manual operation, the temperature of the water shall be maintained at 77° C (171° F) or above.
B. In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90° C (194° F) or less than:
   - 74° C (165° F) for a stationary-rack, single-temperature machine.
   - 82° C (180° F) for all other machines.

   This *does not* apply to the high-pressure and -temperature systems with wand-type, hand-held spraying devices used for the in-place cleaning and sanitizing of equipment such as meat saws.
C. The flow pressure of the fresh hot water sanitizing rinse in a warewashing machine may not be less than 100 kilopascals (15 pounds per square inch) or more than 170 kilopascals (25 pounds per square inch) as measured in the water line immediately downstream or upstream from the fresh hot water sanitizing rinse control valve.
D. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation shall be used in accordance with the Environmental Protection Agency (EPA)–approved manufacturer's label use instructions and shall be used as follows:
   - A chlorine solution shall have a minimum temperature based on the concentration and pH of the

Audiovisual	Outline or text of presentation
	solution (50 parts per million with required temperature of 120° F is typical). • An iodine solution shall have a: – Minimum temperature of 24° C (75° F). – pH of 5.0 or less or a pH no higher than the level for which the manufacturer specifies the solution is effective. – Concentration between 12.5 mg/L and 25 mg/L. • A quaternary ammonium compound solution shall: – Have a minimum temperature of 24° C (75° F). – Have a concentration as specified under and as indicated by the manufacturer's use directions included in the labeling. – Be used only in water with 500 mg/L hardness or less or in water having hardness no greater than specified by the manufacturer's label. • If a chemical sanitizer other than chlorine, iodine, or a quaternary ammonium compound is used, it shall be applied in accordance with the manufacturer's use directions included in the labeling. E. If a detergent-sanitizer is used to sanitize in a cleaning and sanitizing procedure where there is no distinct water rinse between the washing and sanitizing steps, the agent applied in the sanitizing step shall be the same detergent-sanitizer that is used in the washing step. F. Concentration of the sanitizing solution shall be accurately

Audiovisual

Outline or text of presentation

determined by using a test kit or other device.

Typically, facilities use chlorine solutions.

Chemical contamination most often occurs when more than the recommended amount of chemical for sanitizing is used and a chemical residue is left on the dishes, pots, pans and utensils. The facility should use sanitizers according to the manufacturer's instructions.

Sanitization (cont.)

- Check facility's sanitization practices
  - Observe
  - Check congruence of test & chemical
  - Check presence of sanitizer in dish machine
  - Ask for sanitizer maintenance procedure, logs

25

Slide 3-H-25

Checking facilities' sanitization practices

The general sanitizing specifications for the use of a three-compartment sink and a mechanical dish machine are in the guidance for F371. These two methods are the most common.

Some facilities may run all of their pots and pans through the dish machine, while others may use the three-compartment sink method for pots and pans, especially when they are too large for the dish machine.

Observe staff using the two methods:

- The three-compartment sink method will have soap or detergent in the first sink, where food debris is washed from the dishes. The next sink is water for rinsing off the soap. The next sink has the sanitizer in it. There can be too little, too much, or just the right amount of sanitizer. Ask staff to explain the method they are using for sanitization for you, and ask them how they know how much sanitizer to use. They should use a test strip for sanitizer concentration

Audiovisual	Outline or text of presentation
	that is congruent with the sanitizer they are using. Sometimes the test strips and the sanitizer used are from different manufacturers and staff are not using a reliable test method. • Make sure staff are fully immersing dishes in all of the sinks and air-drying the dishes. • You will generally see mechanical dish machines which either use a hot water sanitizing method or a chemical sanitizing method. Ask staff to show you how they ensure the dishes are being sanitized. They should use a test strip to test the amount of sanitizer in the rinse cycle of the dish machine. There may be two or three containers underneath the dish machine. One is detergent and another is the sanitizer. If there is a third, it is probably a drying agent. Look to see how much detergent and especially how much sanitizer is in those containers. You can actually observe the chemical agents feed up through a line and dump a specific amount into the water of the wash and rinse cycles of the machine. Usually a vendor is contracted to come and check the machine and adjust the feed amounts as needed. However, the facility is responsible for ensuring the dishes are being sanitized. Ask staff what system they have for checking the amounts of chemical left in the containers and knowing when a new container is needed. Have staff explain the results of the test strip to you. There should be a guide, usually located on the test strip container, showing what results indicate. Do staff know how to check the amount of sanitizer in the rinse cycle? How often are they checking?

Audiovisual

Outline or text of presentation

Do they keep a log of the results? (The log is not required but may provide evidence of monitoring by the facility.)

Thermometers

- Common types
  - Dial instant-read (bimetal)
  - Digital instant-read (thermistor)
  - Thermocouple
  - Infrared thermometers

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Slide 3-H-26

Thermometers

(Refer the students to the handout "Thermometers" on page 3-H-47.)

Types you may encounter in a nursing home:

- Dial instant-read (bimetal) (most common):
  - Reads in 15–20 seconds.
  - Place 2–2½" deep in thickest part of food.
  - Can be used in roasts, casseroles and soups.
  - Temperature is averaged along probe, from tip to 2–3" up the stem.
  - Cannot measure thin foods unless inserted sideways.
- Digital instant-read (thermistor):
  - Reads in 10 seconds.
  - Place at least ½" deep.
  - Gives fast reading.
  - Can measure temperature in thin and thick foods.
  - Not designed to remain in food while it's cooking.
  - Check internal temperature of food near the end of cooking time.
- Thermocouple:
  - Reads in 2–5 seconds.
  - Place ¼" or deeper, as needed.
  - Gives fastest reading.
  - Good for measuring temperatures of thick and thin foods.
- Infrared thermometers:
  - Do not require contact with the food to get a temperature reading.

Audiovisual

Outline or text of presentation

– Make sure the facility is using the manufacturer's recommendations for when these can be used reliably and the procedure for doing so.

(Refer the students to the handout "Thermometer Calibration" on page 3-H-49.)

Thermometers (cont.)

- Calibration
  - Ice water method
  - Boiling-water method

27

Slide 3-H-27

Calibration

You should have your own thermometer, and it should be calibrated. Also, keep your own thermometer cleaned and sanitized. Allow staff to use facility thermometers when checking food temperatures. If there is concern about the accuracy of their thermometer, use your thermometer to test food temperatures at the same time the staff test with their thermometer, or ask the staff to use yours as well:

- Ice water method: Fill a large glass with finely crushed ice. Add clean water to the top of the ice and stir well. Immerse the thermometer stem a minimum of 2 inches into the mixture. The thermometer should read 32° F after 30 seconds.
- Boiling-water method: Bring water in a deep pan to a full, rolling boil. Immerse the stem of a thermometer 2 inches into the boiling water. The thermometer should read 212° F after 30 seconds.

Thermometers should be checked for accurate calibration periodically. Follow the manufacturer's recommendations. Some dial thermometers have a calibration nut under the dial that can be adjusted. Check the package for instructions.

Audiovisual

Thermometers (cont.)

- When testing food temperatures (bimetal stem thermometer):
  - Use clean, sanitized, dry thermometer
  - Make sure food is stirred
  - Insert 2 inches deep in center or thickest part
  - Wait until reading stabilizes

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Slide 3-H-28

Outline or text of presentation

Testing food temperatures (bimetal stem thermometer)

(Refer students to the handout "Testing Food Temperature (Bimetal Stem Thermometer)" on page 3-H-51.)

- Use a clean, sanitized, dry thermometer.
- Food should be stirred.
- Insert the sensing tip at least 2 inches deep into the center or thickest part of the product.
  - Checking temperatures in the center is good practice because the heat conducts to the metal pans, so the center of the product is most at risk.
- Wait until the thermometer reaches and holds or exceeds 140° F.

Thermometers (cont.)

- Sanitization:
  - Wipe off food
  - Use sanitizing solution per manufacturer or alcohol wipe
  - Include thermometer sheath

29

Slide 3-H-29

Sanitizing thermometers

Staff should:

- Wipe off food particles.
- Put the stem in a sanitizing solution per manufacturer recommendations or wipe the thermometer stem with an alcohol swab.
- Air dry.

How does the facility sanitize the thermometer and thermometer sheath?

Audiovisual

Outline or text of presentation

Cooking Temperatures

- Meats & poultry
- Ham
- Eggs
- Casseroles & leftovers

30

Slide 3-H-30

Cooking Temperatures

(Review the handout "Cooking Temperatures" on page 3-H-53 with the students.)

Sources of Food-Borne Illness

- *Campylobacter jejune*
- *Clostridium botulinum*
- *Clostridium perfringens*
- *Escherichia coli* O157:H7
- *Salmonella*
- *Streptococcus A*
- *Staphylococcus aureus*

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Slide 3-H-31

Sources of Food-Borne Illness

(Review the handout "Sources of Food-Borne Illness" on page 3-H-55 with students.)

F370

- 42 CFR 483.35(h)(1)
  - Facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities

32

Slide 3-H-32

Food Procurement

(Refer students to the handout "Excerpt from the SOM, Appendix PP, 483.35(h) Sanitary Conditions" on page 3-H-57.)

Ask the dietary manager when the deliveries are and what vendor the facility uses. Food that is acquired from sources that are not required to meet inspection codes, such as a community member's home kitchen, garden, or personal farm, should not be served.

Audiovisual

F372

- CFR 42 483.35(h)(3)
  - Facility must dispose of garbage & refuse properly

33

Slide 3-H-33

Outline or text of presentation

Trash Disposal

(Refer students to page 3-H-61 of the handout "Excerpt from the SOM, Appendix PP, 483.35(h) Sanitary Conditions.")

It is sometimes easy to forget to investigate this requirement. Please remember to check the dumpsters!

Lesson 3-H:
Kitchen

Questions

34

Slide 3-H-34

(Summary activities:

For option 1 (Two Cents' Worth) have students pair up for 8–10 minutes and share/refine survey tips gleaned from the lecture and handouts so that they have at least one tip on each of the titled cards. Then reconvene the whole group and get group input to fill in blank cards. Organize the whole group in threes or quartets and have each small group nominate a best tip to share with the whole group.

For option 2 (The Inside Story) have groups of three pool their observations into the story of an imaginary survey. After 10 minutes, have each group present its story. After each story, a group spokesperson is to indicate whether the facility was perfect or had discrepancies and what tags were at issue.)

Skill Assessment

Kitchen

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Correctly performed brief initial tour of the kitchen.	
					Demonstrated understanding of general makeup of an institutional kitchen.	
					Demonstrated correct use of hair restraint and hand washing.	
					Correctly inspected dry-food storage.	
					Correctly inspected refrigeration/freezer units.	
					Demonstrated understanding of safe food procurement and preparation.	
					Made correct decisions regarding observations of the tray line and kitchen according to Sub-Task 5B, pages 35–36 of the *SOM,* Appendix P.	
					Demonstrated understanding of proper food service and distribution.	

					Observed dish sanitization and made correct determinations.	
					Demonstrated correct use, sanitization and calibration of food thermometers.	
					Explained various sources of food-borne illness.	
					Explained correct garbage disposal techniques, including dumpsters.	

Comments/Recommendations:

Worksheet—The Inside Story

Name of the imaginary surveyor:_____

Date and time of the survey:_____

Name of the facility:_____

Part 1: Storage
Observations:

Part 2: Preparation
Observations:

Part 3: Distribution
Observations:

Part 4: Service
Observations:

Part 5: Procurement
Observations:

Part 6: Disposal
Observations

Tag(s) out of compliance, if any:

Excerpt from the *SOM*
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 are 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;
- 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.

Entering the Institutional Kitchen

- Put on your hair restraint.
- You may have to knock, because kitchens are often locked.
- Introduce yourself and explain why you are there.
- Once inside, the first thing to do is find where employees wash their hands so you can wash yours.
- Wash your hands using good hand-washing technique:
  - Turn the water on, use plenty of soap and hold hands down so that soap and water from your hands run into the sink and not down your arm.
  - Wash approximately 10 seconds, washing between your fingers, around your nails, and the backs of your hands as well as the palms.
  - Rinse your hands, take a clean paper towel and thoroughly dry your hands.
  - Use that paper towel or a clean one to cover the faucet when you turn it off, then throw the towel away without touching the trash receptacle.
- If the employee hand-washing sink is not equipped so that you can employ good hand-washing technique, make a note of that on Form CMS-804 and observe to see how employees are or are not accomplishing the task.

Food Storage

Dry Storage

- Food should be stored off the floor (usually on wire racks for cleanliness and visibility, although these are not required).
- Dented or swollen cans are typically sent back to the vendor. These should be separated from canned foods to be used.
- Check for signs of infestation (insects in the dry-storage bins, rodent droppings, a greasy-looking streak along the lower walls or just above shelf level).
- Dry goods (e.g., boxes of cereal, pasta, rice, instant potatoes) and cans should be rotated so that foods delivered more recently go to the back of storage and foods stored the longest are used first. A common acronym for this principle is FIFO (first in, first out).
- Opened foods and ingredients should be sealed and dated, denoting when they were opened.
- Bulk dry goods like flour, cornmeal, and sugar should be in pest-resistant containers that are well covered and have no cracks.
- Dry-storage areas should also be kept at a temperature generally comfortable for an employee to work in. Higher ambient air temperatures can promote spoilage or bacterial growth even in dry goods.

Refrigeration/Freezer Units

- These may include upright "reach-in"-type units, or "walk-in"-type units, dairy cases, and deep freezers, all of which you should check for appropriate temperatures for minimizing bacterial growth.
- Refrigeration units should ideally be 41° F but, as Form CMS-804 directs, allow for a two- to three-degree variance, and do not expect refrigeration units to hold this temperature when staff are in and out of them during meal preparation. Staff should try to minimize the time that refrigerator doors are open.
- All high-protein foods or products of animal origin are highly perishable, which means they are highly susceptible to bacterial growth that will diminish their quality. These foods carry an increased risk of causing food-borne illness if not handled properly. Check the expiration dates. If the items have been opened, check to see if they are sealed, dated and labeled (if the manufacturer label is damaged or absent). Leftovers and opened ready-to-eat foods that require refrigeration should not be kept longer than three days.
- Eggs in an unbroken shell can be kept four to five weeks after the "pack date." At that time they will diminish in quality but still may not be spoiled, because the shells on an egg act as a powerful deterrent to microbes. Once the shell is broken, however, eggs become a highly perishable food that should be immediately used in cooking. Furthermore, you may encounter a facility that honors resident food preference for soft-cooked eggs. The facility must use pasteurized eggs if it is serving eggs that are not thoroughly cooked to residents. Pasteurized eggs generally have a stamp of the letter "P" on each egg.

- The facility should make every possible effort to keep raw animal products away from other foods, especially foods that will be served without cooking. For example, a worst-case scenario could be finding thawing raw poultry sitting on a rack next to the lettuce that is planned for the chicken salad. Thawing meat should be kept in deep pans and on the bottom shelf of the refrigerator to ensure that gravity does not cause thawing juices to fall onto other foods. More likely, you may find raw meat thawing on the same shelf as an uncut watermelon. Bacteria-laden liquid from the thawing meat can easily splash or be transferred through staff handling onto the watermelon rind, and when cut, the watermelon could be contaminated.
- Note also that freezers should be 0° F and that freezer temperature will increase very quickly once the door is open. If you do not immediately see the thermometer in a freezer and you have to take time to find it, the reading will no longer be an accurate reflection of the freezer temperature during food storage. If the facility's thermometer is difficult to find or is not present in the unit, ask the dietary manager how he/she monitors to ensure freezers are holding at 0° F.
- Look for frost buildup in the freezer, which is evidence that the freezer may not consistently hold the appropriate temperature. If there is heavy frost buildup, or dietary staff tell you they have to defrost the unit often and that the frost builds up again within a week, check for evidence that food has thawed and been refrozen. Do this by finding a bag of food in pieces such as green beans, broccoli, chicken breasts, or fish fillets. If they have not been refrozen, you should be able to feel the individual pieces; once refrozen, they will form a clump and the individual pieces will be less distinguishable. Ask the dietary manager or food service personnel if any of the foods in the freezer have previously been thawed.
- Dairy cases should be free from spills, and dairy products should be consistently rotated so that newly delivered products are used after products stored longer. If the contents of the dairy case are very crowded or the thermometer does not register 41° F, consider testing the temperature of one carton of milk. You may ask the dietary manager if you can test the temperature of one carton of milk. Take a carton from the center of the case, test the temperature, record the information, and discard the carton of milk. (Procedures for proper use of a thermometer will be addressed later in the lesson.)
- Additional considerations when evaluating food storage are clean floors, clean shelving and uncrowded walls and storage space.

Food Preparation

- Meat must be thoroughly thawed before it is used for cooking. If it is not, the internal temperature will not reach levels necessary for sanitation before the outside of the meat is overcooked.
  - Acceptable methods of thawing meat include putting it in the refrigerator overnight or putting it under cool running water until thawed.
- Eggs must be cooked firm or used in baked goods or casseroles that are cooked at high temperatures. Pasteurized eggs may be used to honor resident food preferences for "soft-cooked" preparations like "over easy."
- Observe staff preparing the food. Do they wash their hands using good technique at appropriate times? Staff should wash their hands before starting work, and before touching clean dishes. Each should also wash after:
  - Using the restroom.
  - Break.
  - Covering their mouth after coughing or sneezing.
  - Eating or drinking.
  - Touching his/her own body (face, hair, nose, etc.).
  - Touching raw meat, trash cans, or picking something up off the floor.
  - Using cleaners.
  - Touching dirty dishes.
- Using gloves: Food handlers should always wash their hands before putting on gloves. Gloves should be changed if torn, when starting a new food preparation procedure, and any of the times one should wash one's hands as mentioned above.
- Watch carefully for signs of staff cross-contaminating the food. An example of cross-contamination would be observing staff cut up raw chicken, wipe off the surface without properly sanitizing the surface where they cut the chicken, and then cut fresh tomato on that surface. Some kitchens may have specific tables used only for raw meat preparations.
- Leftover food should always be cooled in a shallow pan. If the stored food is more than two inches in depth after cooking, it may be in the "danger zone" (42° F–139° F) temperature range for too long to be safe. The "danger zone" is the temperature range in which bacteria rapidly multiply.
- You will encounter a variety of institutional food service equipment. Common equipment used in nursing homes besides stovetops, ovens, grills and microwaves is preparation equipment such as mixers, blenders, and meat slicers. Make sure the equipment looks thoroughly cleaned. If staff are using equipment during preparation, observe their technique, and the way equipment is cleaned and sanitized after use. If a sanitizer solution is not used after food debris is cleaned from the equipment, ask to see the manufacturer's recommendations for cleaning the equipment and ensure that the instructions are being followed. If there are deviations, make a note of this on Form CMS-804. If your observations are between uses, then check the equipment for signs of food left on the equipment and not thoroughly cleaned. Make a note of these using good documentation principles so the information can be used in your deficiency determination.

- Staff should minimize direct contact with food by using clean utensils in preparation as much as possible. There will be times when staff will touch food; for instance, when making sandwiches or when slicing fruits and vegetables. Do staff wash their hands and use gloves appropriately?
- Washing fruits and vegetables:
  - Fresh produce has a natural protective coating that keeps in moisture and freshness. Staff should wash produce under clean, running water and rub fruits and vegetables briskly with clean hands to remove dirt and surface microorganisms.
  - Produce is to be washed just before serving—not before storing, as washing will cause produce to spoil faster.
  - Staff should discard the outer leaves of leafy vegetables such as lettuce and cabbage before washing.
  - Foods such as squash and melons should always be washed, even if the rind or skin isn't eaten, because when cut, dirt or bacteria that are on the outer surface can be transferred to the inner flesh.
  - Produce should not be washed with detergent or bleach solutions. Fruits and vegetables are porous and can absorb the detergent or bleach.

Food Service and Distribution

Most facilities will have a steam table, but some facilities will serve food directly from the stove. Prepared hot food should not be held for longer than approximately 30 minutes before service. Foods served cold should be kept in refrigeration as close to the time of service as is possible or put on ice. The ice should not touch the food directly.

Observe to see if staff are going to take the temperatures of foods before service. If service is about to begin and staff have not taken temperatures, ask staff how they ensure foods are the proper temperature during preparation (if hot foods) and during service. Record their answers on Form CMS-804. Request that the staff test the temperature of foods so you can ensure foods are the served safely. Hot foods should be held at a minimum of 140° F. Foods can lose their quality when held at temperatures above 180° F. (Consider this in the context of palatability issues at the facility.)

It can be challenging to serve some cold foods at 41° F. As long as high-protein foods are kept at 41° F until time of service (e.g., milk, cottage cheese) consider this an issue of palatability. For instance, if a menu item for the service you observe is "chilled peaches," opening a can of peaches from dry storage, portioning them into dishes and putting the dishes on ice will not always chill them to 41° F, especially if the ambient air temperature is high in the kitchen. They usually will be about 60° F. Chilling the canned fruit over night will generally improve this quality outcome.

Another scenario you may encounter is the serving of meat salad sandwiches like tuna salad. Does the facility attempt to minimize the preparation, storing, and holding time of high-protein foods that are not going to be cooked? Do staff open the tuna, make the salad, and prepare the sandwiches as they plate and serve them to residents? Do they prepare the sandwiches swiftly, put them in shallow pans and store them in the refrigerator until service time? What you might see instead is that they prepare them slowly, leave the tuna salad sitting out for long periods, then put the sandwiches in deep pans and put them in the refrigerator until service or do not chill them at all. What was the total time the tuna salad was left unrefrigerated before service? Was it greater than two hours from the time a sandwich was being made to the time it was served? Chilling the canned tuna overnight improves temperature control.

Service of food generally involves both dietary and nursing personnel. Do staff serving the food to the residents wash or sanitize their hands? Do they use utensils when assisting residents with buttering bread, etc.?

Plated food should be covered during transport. Food plated and served directly from tray line to residents seated in the dining room adjacent to the kitchen (immediate service) does not have to be covered. However, food transported to another dining area or down a hall must be covered. If food is transported in open carts, are plates of food on the lowest shelf close to the floor and staff shoes? Food should be transported covered and on the higher shelves.

Sanitization

Definition
Definition of sanitization, general requirements: Sanitization is effective bactericidal treatment by heat or chemical means acceptable to the permit-issuing official, which destroys pathogens on surfaces treated.

Acceptable Methods (2001 FDA Food Code)
The following are acceptable methods of sanitizing:

A. If immersion in hot water is used for sanitizing in a manual operation, the temperature of the water shall be maintained at 77° C (171° F) or above.
B. In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90° C (194° F) or less than:
   - 74° C (165° F) for a stationary-rack, single-temperature machine.
   - 82° C (180° F) for all other machines.

   This *does not* apply to the high-pressure and -temperature systems with wand-type, hand-held spraying devices used for the in-place cleaning and sanitizing of equipment such as meat saws.
C. The flow pressure of the fresh hot water sanitizing rinse in a warewashing machine may not be less than 100 kilopascals (15 pounds per square inch) or more than 170 kilopascals (25 pounds per square inch) as measured in the water line immediately downstream or upstream from the fresh hot water sanitizing rinse control valve.
D. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation shall be used in accordance with the Environmental Protection Agency (EPA)–approved manufacturer's label use instructions and shall be used as follows:
   - A chlorine solution shall have a minimum temperature based on the concentration and pH of the solution (50 parts per million with required temperature of 120 ° F is typical).
   - An iodine solution shall have a:
     - Minimum temperature of 24° C (75° F).
     - pH of 5.0 or less or a pH no higher than the level for which the manufacturer specifies the solution is effective.
     - Concentration between 12.5 mg/L and 25 mg/L.
   - A quaternary ammonium compound solution shall:
     - Have a minimum temperature of 24° C (75° F).
     - Have a concentration as specified under and as indicated by the manufacturer's use directions included in the labeling.
     - Be used only in water with 500 mg/L hardness or less or in water having hardness no greater than specified by the manufacturer's label.
   - If a chemical sanitizer other than chlorine, iodine, or a quaternary ammonium compound is used, it shall be applied in accordance with the manufacturer's use directions included in the labeling.
E. If a detergent-sanitizer is used to sanitize in a cleaning and sanitizing procedure where there is no distinct water rinse between the washing and sanitizing steps, the agent applied in the sanitizing step shall be the same detergent-sanitizer that is used in the washing step.

F. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.

Typically, facilities use chlorine solutions.

Chemical contamination most often occurs when more than the recommended amount of chemical for sanitizing is used and a chemical residue is left on the dishes, pots, pans and utensils. The facility should use sanitizers according to manufacturer instructions.

Checking Facilities' Sanitization Practices

The general sanitizing specifications for the use of a three-compartment sink and a mechanical dish machine are in the guidance for F371. These two methods are the most common.

Some facilities may run all of their pots and pans through the dish machine, while others may use the three-compartment sink method for pots and pans, especially when they are too large for the dish machine.

Observe staff using the two methods:

- The three-compartment sink method will have soap or detergent in the first sink, where food debris is washed from the dishes. The next sink is water for rinsing off the soap. The next sink has the sanitizer in it. There can be too little, too much or just the right amount of sanitizer. Ask staff to explain the method they are using for sanitization for you, and ask them how they know how much sanitizer to use. They should use a test strip for sanitizer concentration that is congruent with the sanitizer they are using. Sometimes the test strips and the sanitizer are from different manufacturers and staff are not using a reliable test method.
- Make sure staff are fully immersing dishes in all of the sinks and air-drying the dishes.
- You will generally see mechanical dish machines which either use a hot water sanitizing method or a chemical sanitizing method. Ask staff to show you how they ensure the dishes are being sanitized. They should use a test strip to test the amount of sanitizer in the rinse cycle of the dish machine. There may be two or three containers underneath the dish machine. One is detergent and another is the sanitizer. If there is a third, it is probably a drying agent. Look to see how much detergent and especially how much sanitizer is in those containers. You can actually observe the chemical agents feed up through a line and dump a specific amount into the water of the wash and rinse cycles of the machine. Usually a vendor is contracted to come and check the machine and adjust the feed amounts as needed. However, the facility is responsible for ensuring ensure that the dishes are being sanitized. Ask staff what system they have for checking the amounts of chemical left in the containers and knowing when a new container is needed. Have staff explain the results of the test strip to you. There should be a guide, usually located on the test strip container, showing what results indicate. Do staff know how to check the amount of sanitizer in the rinse cycle? How often are they checking? Do they keep a log of the results? (The log is not required but may provide evidence of monitoring by the facility.)

Thermometers

Types you may encounter in a nursing home:

- Dial instant-read (bimetal) (most common):
  - Reads in 15–20 seconds.
  - Place 2–2½" deep in thickest part of food.
  - Can be used in roasts, casseroles and soups.
  - Temperature is averaged along probe, from tip to 2–3" up the stem.
  - Cannot measure thin foods unless inserted sideways.

- Digital instant-read (thermistor):
  - Reads in 10 seconds.
  - Place at least ½" deep.
  - Gives fast reading.
  - Can measure temperature in thin and thick foods.
  - Not designed to remain in food while it's cooking.
  - Check internal temperature of food near the end of cooking time.

- Thermocouple:
  - Reads in 2–5 seconds.
  - Place ¼" or deeper, as needed.
  - Gives fastest reading.
  - Good for measuring temperatures of thick and thin foods.

- Infrared thermometers:
  - Do not require contact with the food to get a temperature reading.
  - Make sure the facility is using the manufacturer's recommendations for when these can be used reliably and the procedure for doing so.

Thermometer Calibration

You should have your own thermometer, and it should be calibrated. Also, keep your own thermometer cleaned and sanitized. Allow staff to use facility thermometers when checking food temperatures. If there is concern about the accuracy of their thermometer, use your thermometer to test food temperatures at the same time the staff test with their thermometers or ask the staff to use yours as well.

Ice water method: Fill a large glass with finely crushed ice. Add clean water to the top of the ice and stir well. Immerse the thermometer stem a minimum of 2 inches into the mixture. The thermometer should read 32° F after 30 seconds.

Boiling-water method: Bring water in a deep pan to a full, rolling boil. Immerse the stem of a thermometer 2 inches into the boiling water. The thermometer should read 212° F after 30 seconds.

Thermometers should be checked for accurate calibration periodically. Follow manufacturer's recommendations. Some dial thermometers have a calibration nut under the dial that can be adjusted. Check the package for instructions.

Testing Food Temperatures (Bimetal Stem Thermometer)

- Use a clean, sanitized, dry thermometer.
- Food should be stirred.
- Insert the sensing tip at least 2 inches deep into the center or thickest part of the product.
  - Checking temperatures in the center is good practice because the heat conducts to the metal pans, so the center of the product is most at risk.
- Wait until the thermometer reaches and holds or exceeds 140° F.

Cooking Temperatures

Ground Meat and Meat Mixtures	
Beef, pork, veal, lamb	160° F
Turkey, chicken	165° F
Fresh Beef, Veal, Lamb	
Medium rare	145° F
Medium	160° F
Well done	170° F
Poultry	
Chicken and turkey, whole	180° F
Poultry breasts, roast	170° F
Poultry thighs, wings, legs	180° F
Duck and goose	180° F
Stuffing (cooked alone or in bird)	165° F
Fresh Pork	
Medium	160° F
Well done	170° F
Ham	
Fresh (raw)	160° F
Precooked (to reheat)	140° F
Eggs and Egg Dishes	
Eggs	Cook until yolk and white are firm
Egg dishes	160° F
Leftovers and Casseroles	165° F

Sources of Food-Borne Illness

Campylobacter jejune

- Found: intestinal tracts of animals and birds, raw milk, untreated water, and sewage sludge.
- Transmission: contaminated water, raw milk, and raw or undercooked meat, poultry, or shellfish.
- Symptoms: fever, headache, and muscle pain followed by diarrhea (sometimes bloody), abdominal pain and nausea that appear 2 to 5 days after eating; may last 7 to 10 days.

Clostridium botulinum

- Found: widely distributed in nature, in soil and water, on plants, and in intestinal tracts of animals and fish. Grows only in little or no oxygen.
- Transmission: improperly canned foods, garlic in oil, and vacuum-packaged and tightly wrapped food.
- Symptoms: bacteria produce a toxin that causes illness. Toxin affects the nervous system. Symptoms usually appear within 18 to 36 hours, but can sometimes appear within as few as 4 hours or as many as 8 days after eating: double vision, droopy eyelids, trouble speaking and swallowing, and difficulty breathing. Fatal in 3 to 10 days if not treated.

Clostridium perfringens

- Found: soil, dust, sewage, and intestinal tracts of animals and humans. Grows only in little or no oxygen.
- Transmission: called “the cafeteria germ” because many outbreaks result from food left for long periods in steam tables or at room temperature. Bacteria destroyed by cooking, but some toxin-producing spores may survive.
- Symptoms: diarrhea and gas pains may appear 8 to 24 hours after eating; usually last about 1 day, but less severe symptoms may persist for 1 to 2 weeks.

Escherichia coli O157:H7

- Found: intestinal tracts of some mammals, raw milk, unchlorinated water; one of several strains of *E. coli* that can cause human illness.
- Symptoms: diarrhea or bloody diarrhea, abdominal cramps, nausea, and malaise; can begin 2 to 5 days after food is eaten, lasting about 8 days. Some, especially the very young, have developed hemolytic uremic syndrome (HUS), which causes acute kidney failure. A similar illness, thrombotic thrombocytopenic purpura (TTP), may occur in older adults.
- Transmission: contaminated water, raw milk, raw or rare ground beef, unpasteurized apple juice or cider, uncooked fruits and vegetables, person-to-person.

Salmonella (over 1,600 types)

- Found: intestinal tract and feces of animals; *Salmonella enteritidis* in raw eggs.
- Transmission: raw or undercooked eggs, poultry, and meat; raw milk and dairy products; seafood.

- Symptoms: stomach pain, diarrhea, nausea, chills, fever, and headache usually appear 6 to 48 hours after eating; may last 1 to 2 days.

Streptococcus A

- Found: noses, throats, pus, sputum, blood, and feces of humans.
- Transmission: people-to-food from poor hygiene, ill food handlers, or improper food handling; outbreaks from raw milk, ice cream, eggs, lobster, salads, custard, and pudding allowed to stand at room temperature for several hours between preparation and eating.
- Symptoms: sore throat, painful swallowing, tonsillitis, high fever, headache, nausea, vomiting, malaise; occur 1 to 3 days after eating, lasting a few days to about a week.

Staphylococcus aureus

- Found: on humans (skin, infected cuts, pimples, noses, and throats).
- Transmission: people-to-food through improper handling. Multiplies rapidly at room temperature to produce a toxin that causes illness.
- Symptoms: severe nausea, abdominal cramps, vomiting and diarrhea occur 1 to 6 hours after eating; recovery within 2 to 3 days—longer if severe dehydration occurs.

Others include *Shigella* and *Listeria* monocytogenes.

Source: www.foodsafety.gov

Excerpt from the *SOM,* Appendix PP, 483.35(h) Sanitary Conditions

The facility must—

F370

§483.35(h)(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities;

F371

§483.35(h)(2) Store, prepare, distribute, and serve food under sanitary conditions; and

Intent §483.35(h)(2)

The intent of this regulation is to prevent the spread of food borne illness and reduce those practices which result in food contamination and compromised food safety in nursing homes. Since food borne illness is often fatal to nursing home residents, it can and must be avoided.

Interpretive Guidelines §483.35(h)(2)

"**Sanitary conditions**" is defined as storing, preparing, distributing, and serving food properly to prevent food borne illness. Potentially hazardous foods must be subject to continuous time/temperature controls in order to prevent either the rapid and progressive growth of infectious or toxigenic micro-organisms such as Salmonella or the slower growth of Clostridium Botulinum. In addition, foods of plant origin become potentially hazardous when the skin, husk, peel, or rind is breached, thereby possibly contaminating the fruit or vegetable with disease causing micro-organisms. Potentially hazardous food tends to focus on animal products, including but not limited to milk, eggs and poultry.

Improper holding temperature is a common contributing factor of food borne illness. The facility must follow proper procedures in cooking, cooling, and storing food according to time, temperatures, and sanitary guidelines. Improper handling of food can cause salmonella and E-Coli contamination. The 1993 FDA Food Code advises the following precautions:

NOTE: The 1993 FDA Food Code is not regulation and cannot be enforced as such. The food temperatures cited that are recommended in the 1993 FDA Food Code are target temperatures and give a margin of safety in temperature ranges and to avoid known harmful temperatures.

Refrigerator storage of food to prevent food borne illness includes storing raw meat away from vegetables and other foods. Raw meat should be separated from cooked foods and other foods when refrigerated on its own tray on a bottom shelf so meat juices do not drip on other

foods. Foods of both plant and animal origin must be cooked, maintained and stored at appropriate temperatures.

- Foods of both plant and animal origin must be cooked, and maintained, and stored at appropriate temperatures. These temperatures are better utilized as food hold temperatures rather than the food temperatures as residents receive the food.

- Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140° F, and cold foods at or below 41° F and freezer temperatures should be at 0° F or below. Refrigerator temperatures should be maintained at 41° F or below. The 1993 FDA Food Code can be used as an authoritative guide to clarify regulatory requirements on how to prepare and serve food to prevent food borne illness. As the public becomes more informed and educated on how to prevent food borne illness, this code will become the standard of practice the same as the 1976 Food Service Sanitation Manual did prior to 1993.

Procedures §483.35(h)(2)

Observe storage, cooling, and cooking of food. Record the time and date of all observations. If a problem is noted, conduct additional observations to verify findings.

Observe that employees are effectively cleaning their hands prior to preparing, serving and distributing food. Observe that food is covered to maintain temperature and protect from other contaminants when transporting meals to residents.

Refrigerated storage:

- Check all refrigerators and freezers for temperatures. Use the facility's or the surveyor's own properly sanitized thermometer to evaluate the internal temperatures of potentially hazardous foods with a focus on the quantity of leftovers and the container sizes in which bulk leftovers are stored.

Food preparation:

- Use a sanitized thermometer to evaluate food temperatures.

In addition, how do kitchen staff process leftovers?

- Are they heated to the appropriate temperatures?

- How is frozen food thawed?

- How is potentially hazardous food handled during multi-step food preparation (e.g., chicken salad, egg salad)?

- Is hand contact with food minimized?

Food service:

- Using a properly sanitized thermometer, check the temperatures of hot and cold food prior to serving.

- How long is milk held without refrigeration prior to distribution?

Food distribution:

- Is the food protected from contamination as it is transported to the dining rooms and residents' rooms?

Pest free:

- Is the area pest free? (See §483.70(h)(4).) Look for signs of pests such as mice, roaches, rates, flies.

Preventing contamination:

- Are hand-washing facilities convenient and properly equipped for dietary services staff Use? (Staff uses good hygienic practices and staff with communicable disease or infected skin lesions do not have contact with food if that contact will transmit the disease.)

Hazard free:

- Are toxic items (such as insecticides, detergent, polishes) properly stored, labeled, and used separate from the food?

Probes: §483.35(h)(2)

Observe food storage rooms and food storage in the kitchen.

- Are containers of food stored off the floor and on clean surfaces in a manner that protects it from contamination?

- Are other areas under storage shelves monitored for cleanliness to reduce attraction of pests.

- Are potentially hazardous foods stored at 41° F or below and frozen foods kept at 0° F or below?

- Do staff handle and cook potentially hazardous foods properly?

- Are potentially hazardous foods kept at an internal temperature of 41° F or below in cold food storage unit, or at an internal temperature of 140° F or above in a hot food storage unit during display and service?

- Is food transported in a way that protects against contamination (i.e., covered containers, wrapped, or packaged)?

- Is there any sign of rodent or insect infestation.

Dishwashing:

- The current 1993 Food Code, DHHS, FDA, PHS recommends the following water temperature and manual washing instructions:

Machine:

1. Hot Water:

    a. 140° F Wash (or according to the manufacturer's specifications or instructions).

    b. 180° F Rinse (180°, 160° or greater at the rack and dish/utensils surfaces).

2. Low Temperature:

    a. 120° F +25 ppm (parts per million) Hypochlorite (household bleach) on dish Surface.

Manual:

1. 3 Compartment Sink (wash, rinse and sanitize): Sanitizing solution used according to manufacturer's instructions.

    a. 75 degrees F–50 ppm Hypochlorite (household bleach) or equivalent, or 12.5 ppm of Iodine.

    b. Hot Water Immersion at 170° F for at least 30 seconds.

Are food preparation equipment, dishes, and utensils effectively sanitized and cleaned to destroy potential disease carrying organisms and stored in a protected manner?

F372

§483.35(h)(3) Dispose of Garbage and Refuse Properly

Interpretive Guidelines §483.35(h)(3)

The intent of this regulation is to assure that garbage and refuse be properly disposed.

Procedures §483.35(h)(3)

Garbage/refuse:

Observe garbage and refuse container construction, and outside storage receptacles.

Probes: §483.35(h)(3)

Are garbage and refuse containers in good condition (no leaks) and is waste properly contained in dumpsters or compactors with lids or otherwise covered?

Are areas such as loading docks, hallways, and elevators used for both garbage disposal and clean food transport kept clean, free of debris and free of foul odors and waste fat?

Is the garbage storage area maintained in a saunter condition to prevent the harborage and feeding of pests?

Are garbage receptacles covered when being removed from the kitchen area to the dumpster?

Lesson 3-I: Nutrition

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Determine whether a facility has ensured that residents maintain acceptable parameters of nutritional status, unless a resident's clinical condition demonstrates that this is not possible.
- Determine whether a facility's residents receive therapeutic nutritional interventions when needed.
- Determine whether a facility has provided each resident with sufficient fluids to maintain proper hydration and health and developed a preventative care plan for residents at high risk for dehydration.
- Determine that residents of a facility who are able to eat alone or with assistance do not have enteral support initiated unless their clinical condition demonstrates that enteral support dependence is unavoidable.
- Determine whether a facility has provided the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills for residents receiving enteral support.

- Determine whether a facility is preparing food using methods that conserve nutritive value and serving food that is palatable, attractive and at the proper temperatures.

- Determine whether a facility has sufficient staff to prepare and serve quality food.

- Determine whether the resident dining services at a facility are homelike.

- Determine whether a facility provides adequate lighting, ventilation, furnishings and space during dining services.

Lesson Plan

References

Federal

- *State Operations Manual (SOM)*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities

State

(Insert State reference[s] here.)

Other

- American Medical Directors Association. (2001). *Clinical practice guideline: Altered nutritional status.* [Online]. Available: http://www.amda.com/info/cpg/nutritionalstatus.htm
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Highlights

- Nutrition and aging
- Nutrition assessment
- Therapeutic diets
- Hydration and compliance
- Issues with tube feedings
- Food palatability
- Menus
- Medications and weight loss

Training Techniques

- Lecture
- Group discussion
- Pair collaboration on summary table of nutrition tags

Training Aids

- PowerPoint slides and handouts
- Examples of thickening agents (if available)
- Assistive devices for meals (if available)
- Enteral support formulary or label from a bottle (if available)
- Handouts:
  - *Nutrition Tags*
  - *Checking Nutritional Parameters*
  - *Laboratory Values*
  - *Etiologies of Unplanned Weight Loss*
  - *Appendix P Investigative Protocol: Unintended Weight Loss*
  - *Appendix P Investigative Protocol: Hydration*
  - *Checking Enteral Support*
  - *Appendix P Investigative Protocol: Dining and Food Service*
  - *Food Exchanges*
  - *Medications Associated with Weight Loss*
- Guidance from *SOM* Appendix PP

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Role-playing potential scenarios between surveyors

Audiovisual

Lesson 3-I:
Nutrition

1

Slide 3-I-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Determine whether a facility has ensured that residents maintain acceptable parameters of nutritional status, unless a resident's clinical condition demonstrates that this is not possible.

2

Slide 3-I-2

Learning Objectives (cont.)

- Determine whether a facility's residents receive therapeutic nutritional interventions when needed.

3

Slide 3-I-3

Outline or text of presentation

(Preparatory work:

- *Have the students obtain copies of Forms CMS-672, CMS-802, CMS-802S, CMS-803, CMS-805, CMS-806A, CMS-806B and CMS-807 from the CMS website (http://www.cms.hhs.gov). Have them highlight the sections pertaining to nutrition.*
- *Refer the students to the worksheet "Nutrition Tags" on page 3-I-47. Have them fill in the worksheet during the lecture, and pair up to fill any gaps after the lecture.)*

(Inform the students of the objectives.)

Audiovisual

Outline or text of presentation

Learning Objectives (cont.)

- Determine whether a facility has provided each resident with sufficient fluids to maintain proper hydration & health & developed a preventative care plan for residents at high risk for dehydration.

4

Slide 3-I-4

Learning Objectives (cont.)

- Determine that residents of a facility who are able to eat alone or with assistance do not have enteral support initiated unless their clinical condition demonstrates that enteral support dependence is unavoidable.

5

Slide 3-I-5

Learning Objectives (cont.)

- Determine whether a facility has provided the appropriate treatment & services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities & nasal-pharyngeal ulcers & to restore, if possible, normal eating skills for residents receiving enteral support.

6

Slide 3-I-6

Audiovisual

Learning Objectives (cont.)

- Determine whether a facility is preparing food using methods that conserve nutritive value & serving food that is palatable, attractive & at the proper temperatures.
- Determine whether a facility has sufficient staff to prepare & serve quality food.

7

Slide 3-I-7

Learning Objectives (cont.)

- Determine whether the resident dining services at a facility are homelike.
- Determine whether a facility provided adequate lighting, ventilation, furnishings & space during dining services.

8

Slide 3-I-8

Outline or text of presentation

Background Information: Basics of Geriatric Nutrition

All residents you encounter will not be past middle age; however, the majority of the nursing home population will be.

Key points:

- As we age some of our nutritional requirements do change.
- Other age-related changes may affect appetite or one's ability to consume adequate nutrition by mouth.
- Nutritional goals also change due to considerations regarding quality of life and the life span.

Audiovisual

Nutrition & Aging

- Caloric needs
- Senses
- Gastrointestinal system
- Dentition
- Restrictive therapeutic diets
- Weight goals
- Physical problems
- Emotional etiologies

9

Slide 3-I-9

Outline or text of presentation

Nutrition and Aging

- Due to a decrease in active cells and a loss of lean tissue, the metabolic rate decreases. Therefore, caloric needs also decrease with age.
- Senses of taste, smell, sight, hearing and touch diminish at individualized rates.
- Changes occur in the gastrointestinal system during the aging process that can affect appetite and the ability to digest and absorb food.
- Periodontal disease, the lack of dentures or ill-fitting dentures can all compromise nutritional status due to pain or embarrassment, leading to decreased meal intakes.
- Recent studies show that restrictive therapeutic diets can be clinically contraindicated in people over the age of 65. Therefore, the efficacy of a restrictive diet must be assessed and each resident's nutritional status and goals individualized.
- Weight goals may be different for the elderly than for other adults. Studies show that losing weight when one is elderly and only moderately overweight may present more clinical risk to one's health than keeping the weight. If an elderly person is not morbidly obese (more on this later in the lesson), and no chronic illness is exacerbated due to the person's weight, a weight loss goal may not be appropriate.
- Common physical problems in the nursing home population that affect nutritional status are poor appetite, weight loss, pressure ulcers, chronic disease, eating dependency, sensory loss and poor oral health. Furthermore, many medications affect appetite and the utilization of nutrients consumed.

Audiovisual

Maintaining Acceptable Nutritional Status

- Nutritional assessment
- Parameters of nutritional status
- Laboratory values
- Quality of care
- Citation references: F325, F326

10

Slide 3-I-10

Outline or text of presentation

- Emotional etiologies, in long-term care, are common during undesirable weight loss and must be a part of the nutrition assessment process.

Maintaining Acceptable Nutrition Status

Nutritional assessment

Nutritional assessment includes, but is not limited to, these areas:

- Subjective: social history and eating habits (e.g., "My mom had diabetes." "My favorite food is fried chicken." "I hate gravy and won't eat anything if it's on my plate.").
- Objective: age, anthropometric data (e.g., weight, height, midarm circumference), weight history or usual body weight (UBW), gender, physical activity levels, presence of infection, wounds, fractures, current exacerbations of illnesses.
- Medical history: diagnoses (physical and psychological), past medical procedures (e.g., gastric bypass would affect ability to metabolize vitamin B-12).
- Factors affecting intake/absorption: recent history of nausea, vomiting, diarrhea, constipation, swallowing problems, chewing problems, usual eating habits, ability to use utensils effectively, pain, cultural considerations, food intolerances/allergies, usual fluid intake, cognitive status, level of independence, medications, emotional status (e.g., depression, adjustment issues, grief).
- Professional estimation of nutritional needs, recommendations, and Care Plan: The dietitian determines the resident's average caloric, protein and fluid needs and any nutrient

Audiovisual	Outline or text of presentation

supplementation that may be indicated based on evidence of a nutrient deficiency or high-risk status.

(Have students turn to the guidance for 483.25(i) in SOM Appendix PP (F325 and F326) and review with class.)

Parameters of nutritional status

Nutritional parameters are used to assess nutritional status. They include, but are not limited to, anthropometric nutritional parameters such as:

- Weight.
- Weight in relation to height (body mass index, ideal body weight):
  - Body mass index (BMI): an indicator used to predict health risk based on the relationship between weight and height:

$$\text{BMI} = \text{weight (kg)}/\text{height (m}^2\text{)}$$
or
$$\text{BMI} = \text{weight (lb.)}/\text{height (in.}^2\text{)} \times 705$$

  - Ideal body weight (IBW):
    - Women: 100 pounds for first 5 feet plus 5 pounds for each inch over 5 feet +/− 10%, depending on frame size.
    - Men: 106 pounds for first 5 feet plus 6 pounds for every inch over 5 feet +/− 10%, depending on frame size.
  - Healthy weight: BMI of 18.5–25.
  - Overweight: BMI of 25–30.
  - Obese: BMI of 30 or greater.
  - Morbidly obese: More than 200% of IBW.
- Paraplegia.
- Quadriplegia.
- Amputations.
- Frame size (wrist circumference, etc.). (USDA, 2000)

Audiovisual	Outline or text of presentation
	(Refer students to the handout "Checking Nutritional Parameters" on page 3-I-49.)
	Laboratory values associated with nutrition *(Refer students to the handout "Laboratory Values" on page 3-I-51.)*
	Examples of laboratory values associated with nutrition include: • Albumin. • Prealbumin. • Alkaline phosphatase. • Blood urea nitrogen. • Chloride. • Cholesterol. • High-density lipoprotein. • Low-density lipoprotein. • Creatinine. • Ferritin. • Glycosylated hemoglobin. • Glucose. • Hematocrit. • Hemoglobin. • Iron. • Mean corpuscular volume. • Mean corpuscular hemoglobin. • Potassium. • Prothrombin time. • Sodium. • Total lymphocyte count. • Thyroid hormones. • Triglycerides. • White blood cells. • Specific serum nutrient levels (e.g., B-12 and folate levels).
	When evaluating laboratory data, use the normal-values reference provided by the laboratory that conducted the laboratory tests. Did the physician, dietitian or pharmacist evaluate abnormal laboratory values and address them?

Audiovisual	Outline or text of presentation
	Your role as a surveyor is to determine if the members of the interdisciplinary team (IDT) assessed the abnormal laboratory results, documented that assessment and made a determination as to whether action was necessary to improve resident outcomes. Also remember that there are physical parameters of nutritional status, such as pale eye membranes (may be an indication of B-12, folate or iron deficiency) and diminished sense of taste (possible indication of a zinc deficiency). **Key point:** The facility dietitian evaluates nutritional parameters and provides recommendations as a consultant to the physician. The interdisciplinary team (may include the dietitian, key nursing personnel, physician, dietary department staff, and social services) and the resident (as much as he/she is able and chooses to participate in his/her care decisions) then develop a nutrition care plan with measurable, realistic goals and determine how to implement nutrition care to meet those goals. The dietary department, the nursing department, and sometimes the social services department and the resident implement the plan. Not all aspects of a nutritional plan require a physician's order; however, therapeutic diets do require a physician's order. If there is a question, investigate the facility policies. **Understand your role:** Your role is not to conduct a nutritional assessment. This assessment, like others requiring specialized skills, should be conducted by a qualified professional working at or consulting with the facility (see F361).

Audiovisual	Outline or text of presentation
	Your role is to gather evidence through record review, interview and observation to determine whether the facility has assessed, planned and provided the needed care so that residents maintain acceptable parameters of nutritional status when at all possible. **Quality of care** Both F325 and F326 pertain to Quality of Care regulations. In its guidance for 42 CFR 483.25 covering the Quality of Care regulations, Appendix PP of the *SOM* states: In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being, may be made only if all of the following are present: • An accurate and complete assessment (see 483.20); • A care plan which is implemented consistently and based on information from the assessment; • Evaluation of the results of the interventions and revising the interventions as necessary. Determine whether the facility is providing the necessary care and services based on the findings of the Resident Assessment Instrument (RAI). If services and care are being provided, determine whether the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine.

Audiovisual

Maintaining Acceptable Nutritional Status (cont.)

- Understanding parameters related to weight loss
- Common etiologies of unplanned weight loss
- Avoidable vs. unavoidable
- Therapeutic diet

11

Slide 3-I-11

Outline or text of presentation

Understanding parameters related to weight loss

- The *SOM* suggests parameters for evaluating significance of unplanned and undesired weight loss. A weight loss of 5% in a month, 7.5% in three months, or 10% in six months is referred to as *significant*. A loss exceeding those parameters is termed *severe.* Also, a gradual, unplanned weight loss can be clinically significant and should be assessed and addressed.
- Once you ascertain that a resident whose care you are reviewing has had significant or severe weight loss, determine whether the weight loss was desirable, intended or planned, or undesirable, unintended or unplanned.
- Desirable/planned/intended weight loss may:
  - Be part of a weight loss regime developed by the dietitian and/or the IDT because the resident is morbidly obese, excessive weight is exacerbating a chronic illness or weight is impairing mobility, etc.
  - Occur because the resident has begun intentionally restricting nutritional intake in order to lose weight. Assessments should include an attempt to communicate with the resident. For example, you may come across a situation in which no one at the facility can figure out why a resident is losing weight because no one has interviewed the resident. You ask the resident if he/she has changed his/her eating habits in any way and explain that you are trying to determine why he/she is losing weight. The resident says, “Well, honey, I was just getting so big. I

Audiovisual	Outline or text of presentation

decided to quit eating those five candy bars I'd been eating every day that my daughter brings me."
  - Result from medically induced diuresis (e.g., diuretics used for congestive heart failure or dialysis in residents with end-stage renal disease).
  - Be a result of amputations.

Look for evidence of a planned weight loss regime in the clinical record. You may find this in the nutrition, nursing or doctor's progress notes, and it should also be reflected in the resident's care plan. If not, consider F279.

- Etiologies of unplanned weight loss: If a review of a resident's clinical record, the resident's clinical condition, and interviews with the resident and staff confirm that the resident's weight loss was not planned, it is not desirable and must be assessed to determine probable etiologies:
  - Has the facility notified the physician, dietitian and responsible party?
  - Has it assessed for etiologies of the weight loss?
  - Establishing a probable etiology of weight loss is key to developing an appropriate clinical approach.

(Refer students to the "Etiologies of Unplanned Weight Loss" handout beginning on page 3-I-53.)

Avoidable versus unavoidable weight loss

Some weight loss may not be planned or desirable but may nevertheless be expected or unavoidable. If a facility has properly assessed a resident, utilized his/her

Audiovisual	Outline or text of presentation
	nutrition consultant (as required at F361), developed an appropriate, individualized Plan of Care that is consistently implemented, and reevaluated and revised the plan, then the resident's weight loss is most likely unavoidable. The existence of clinical conditions generally associated with unavoidable weight loss (end-stage dementia illnesses, some cancers, etc.) does not preclude the facility from providing nutrition care. Conditions causing unavoidable weight loss should be assessed by the IDT and discussed with the resident's family and a Plan of Care developed explaining care approaches and prognosis. You may encounter a situation in which a resident who is or was overweight has had unplanned weight loss. Members of the IDT at the facility may say to you, "Well, she needed to lose weight anyway." This is not appropriate. *All residents, regardless of their baseline weight, need assessment when they experience unplanned weight loss.* For instance, suppose your review reveals that a 73-year-old sampled female resident who weighed 240 pounds lost 20 pounds (~ 9%) in one month. At the time of the survey, two weeks after the weight loss was determined (six weeks after the baseline weight), there has been no facility action: no assessment, no notification to the physician, no notification to the dietitian, no interdisciplinary meeting. You, as a surveyor, interview the lucid resident, and she tells you she does not know why she has lost weight because she has been eating "just like I always do." You interview the director of nursing, and

Audiovisual	Outline or text of presentation
	he states, "We were not worried about her losing weight because she needed to anyway." Did the facility meet the requirement at F325? No. The weight loss could be the sign of an underlying hypermetabolic pathology, and there has been no action. **Therapeutic diet** [*See 42 CFR 483.25 (i)(2).*] Therapeutic diet is defined by the *SOM* as a diet ordered by a physician as part of treatment for a disease or clinical condition to eliminate or decrease certain substances in the diet, to increase certain substances in the diet, or to provide food the resident is able to eat (mechanically altered diet). F326 versus F367: You may notice that a resident has very abnormal laboratory data (such as blood urea nitrogen, creatinine, and high potassium, or high alkaline phosphatase and very low albumin). Did the facility dietitian or physician assess these laboratory values and determine whether the resident might benefit from dietary restrictions or supplementation to slow the progression of disease? If you have strong evidence that a resident may need a therapeutic diet, and the facility has not assessed or developed a Plan of Care to address the resident's abnormal nutritional parameters, consider the Quality of Care tag F326 [42 CFR 483.25(i)]. If a sampled resident's physician has already ordered a therapeutic diet (e.g., no concentrated sweets or no added salt) for him/her, review the facility extended menu to determine what foods were planned according to the parameters of that diet. During observations of meals, note what the resident was served. If there were discrepancies, were they because the

Audiovisual

Outline or text of presentation

resident refused the restrictions that day and requested something not on the planned menu for that diet? The resident has the right to refuse a meal planned on the therapeutic diet and to receive a requested item that is not on the therapeutic diet. If you observe the resident requesting a food item not included on the menu for the therapeutic diet and this is not the first time the resident has done that, then the resident's Care Plan should indicate that he/she chooses not to comply with the limitations of the diet ordered. Is the facility assessing for potential negative outcomes as a result of diet noncompliance? If the facility simply did not follow the therapeutic diet menu, then cite the process tag F367 [42 CFR 483.35 (e)]. More instruction regarding nutrition-related process tags is provided later in the lesson.

Interventions for Nutritional Issues

- Etiology
- Causative factors & approaches
- Investigative protocol for unintended weight loss

12

Slide 3-I-12

Interventions for Nutritional Issues

- Once a probable etiology for a resident's weight loss has been assessed, an individualized, therapeutic approach should be developed based on individualized goals.
- Have you ever heard the saying, "If all you have is a hammer everything looks like a nail?" An issue you may see in facilities is the tendency to treat weight loss with one approach regardless of the etiology. This rarely assists residents in reaching their individualized clinical goals or highest practicable well-being. For example, facilities may give anyone who has unplanned weight loss nutrition supplement drinks, whether their weight loss was from decreased intakes due to depression or a medication causing nausea. Was the resident properly assessed?

Audiovisual	Outline or text of presentation
	• Some examples of causative factors and individualized treatment strategies for undesirable weight loss would be: – For emotional issues affecting intakes: a psychological consultation, a talk with the social worker, planned dining with a close family member or friend, providing comfort or favorite foods. – For pacing behaviors: foods and beverages the resident can hold in his/her hands (finger foods), plus snacks between meals. – For blindness: a careful explanation of the foods that are served and a description of where they are located. Some people with blindness may also prefer foods that are easily held. – For difficulty chewing: regular dental care, daily oral care, and soft foods (some residents will need mechanical alteration of the food). Some edentulous residents will be able to eat a partially modified diet, whereas others may require their food to be pureed. – For dementia illness: during the later stages of these illnesses residents will stop adequately feeding themselves and will require staff assistance to ensure adequate intake. *(Review the "Appendix P Investigative Protocol: Unintended Weight Loss" handout beginning on page 3-I-55 with students.)*

Audiovisual

Hydration

- Investigative protocol for hydration
- Keys to hydration in nursing homes
- Signs & symptoms of dehydration
- Laboratory values
- Risk factors

13

Slide 3-I-13

Outline or text of presentation

Hydration

Investigative protocol
(Review the "Appendix P Investigative Protocol: Hydration" handout beginning on page 3-I-59 with students.)

Keys to hydration in nursing homes

- Hydration is adequate when the body has enough water in the right places and has normal electrolyte levels in needed locations.
- Beverages are not only necessary to support physical well-being and support life; they also enhance the quality of life.
- Fluid and electrolyte imbalance can be the result of organ failure, medication, disease, fluid restrictions *or* a lack of access to adequate fluids or of the assistance necessary to consume them.
- There are different types of dehydration. This is because water is located inside and outside of cells, between tissues and body cavities, and in the bloodstream. Any or all of those locations in the body can become dehydrated and will present a different laboratory picture.
- Most elderly have decreased thirst perception in proportion to their physical need. Many also have diminished functional and cognitive abilities, so they may not tell others they are thirsty or be able to obtain fluids themselves.

Signs and symptoms of dehydration
Signs and symptoms of dehydration may include:

- Dry eyes and/or mouth.
- Change in mental status.
- Fever.
- Vomiting.

Audiovisual	Outline or text of presentation

- Postural hypotension.
- Dark urine and minimal output.
- Urinary tract infections.
- Rapid pulse.
- Dizziness.
- Cracked lips.
- Fatigue.
- Falling.
- Increased confusion and/or combativeness.

Laboratory values

High or low sodium levels can be indications of dehydration. However, low sodium can also indicate overhydration. The ratio between the blood urea nitrogen (BUN) and creatinine levels is considered a good indicator of hydration status; however, a high BUN does not always indicate dehydration. For example, a high BUN and creatinine with a normal ratio is an indication not of dehydration, but rather of renal insufficiency. Of course, severe dehydration can cause acute renal failure with or without the presence of chronic renal failure. Levels of other electrolytes, such as chloride, bicarbonate and potassium, may also be indicators of hydration status.

Risk factors

Some additional risk factors should be considered along with the hydration protocol:

- Draining wounds.
- Excessive sweating.
- Gastrointestinal bleeding.
- History of dehydration.
- Excessive urination.
- Fluid restrictions.
- Use of some specialty beds.
- Inadequate staffing.
- Restraints.
- Institution of thickened liquids.
- Lack of an interdisciplinary approach to hydration promotion.

Audiovisual

Hydration (cont.)

- Surveyor investigation
- Care interventions
- Thickened liquids

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Outline or text of presentation

Surveyor investigation

As a surveyor investigate for:

- Staff knowledge. For example, poorly trained staff may believe that the beverages provided at mealtime are adequate to support residents' hydration needs.
- Amount and variety of beverages at mealtimes.
- The use of hydration protocols or hydration carts at the facility.
- Amounts of fluids offered at medication pass.
- Beverages being provided and encouraged and assistance given as needed between meals regardless of resident location (in room, in outdoor and indoor seating areas, at activities).
- Assessments on high-risk residents and individualized Care Plans that actually address approaches to prevent dehydration.

Care interventions

Poorly developed Care Plans are common. Do the problems, goals and approaches make sense together? For example:

- Care Plan problem: Resident is at high risk for dehydration due to staff dependence and diuretic use.
- Goal: Resident will remain well-hydrated for the next 90 days.
- Plan/approach: Nursing will monitor for signs and symptoms of dehydration.

(Ask: How is the approach going to prevent dehydration?)

Examples of individualized approaches for prevention are (one or more of these could be used for the same individual):

- Provide and assist resident in consuming 6–8 ounces of cold water (resident prefers no ice) between

Audiovisual	Outline or text of presentation
	meals. Document approximate amount consumed or refusal. • Assist the resident in consuming preferred beverage at appropriate activities. This resident prefers apple juice. • Encourage resident to consume liquids at meals and assist in consumption. • Use a 6-ounce cup at medication passes and assist resident in drinking. Is the Care Plan implemented? Observe throughout the survey. Interview resident and family. Interview staff after sufficient observations have been made. Note that there is no regulatory requirement for facilities to keep intake and output records unless ordered by the physician. **Thickened liquids** • As mentioned earlier, when thickened liquids are instituted for a resident due to swallowing problems (dysphagia) and risk for aspiration pneumonia, they can also increase a resident's risk for dehydration. Here are a few reasons why: – Residents often consume less fluid when fluids are thickened because they may not be perceived as palatable. – Facility staff often do not provide fluids to residents who require thickened liquids at the same times or in the same amounts as they do for residents not requiring thickened liquids. (It is not uncommon for staff to assume that another department is providing thickened beverages.) For example, suppose you observe a nurse's aide passing water to residents and ask

Audiovisual	Outline or text of presentation
	him/her if he/she is going to give beverages to the residents receiving thickened fluids, and he/she tells you that the charge nurse does that. You then interview the charge nurse, and she says the dietary department provides the thickened liquids at mealtime. But we already know that beverages at meals are not adequate to support hydration needs. Do residents requiring thickened liquids need less fluid than the general population? Of course not. – Thickened beverages are not as hydrating to the body. There is less water per unit volume than with thin liquids. The thicker liquids are, the less hydrating. • Requiring residents to consume only thickened liquids has its own risk. Thickened liquids are instituted to prevent aspiration pneumonia. However, residents who are dehydrated or malnourished are also at high risk for pneumonia and other infections. If residents do not consume adequate fluids or food because they do not like the thickened beverages, the risk-to-benefit ratio of thickened liquids should be reevaluated by the interdisciplinary team (IDT). • Thickened liquids should be implemented only after a careful and complete assessment by a qualified professional (speech or language pathologist/therapist), and after the IDT has met with the resident and family to discuss the risks and benefits of doing so. Residents have the right to refuse thickened liquids, just as they have the right to refuse any medical treatment.

Audiovisual	Outline or text of presentation
	• Thickened liquids come in three viscosities or consistencies: nectar, honey, and pudding. Honey is the consistency of bee honey, and nectar is a little thinner (e.g., apricot nectar or unstrained tomato juice). Pudding consistency is the consistency of pudding (chocolate, for example, not tapioca). Facility staff must be trained to prepare these consistencies and have a working knowledge of the thickening agent they are using. Some thickening agent preparations become thicker with the passage of time, and others maintain their originally prepared consistency. If you have a resident in your sample that requires thickened liquids, watch staff prepare these liquids to make sure they are not too thin or thick. Are all the resident's beverages thickened to the ordered consistency? Are staff trained on how to use the thickening agent, and is there coordination between different departments? As a surveyor, you will need to read about the thickening agent at the facility when conducting this type of investigation. • The use of thickened liquids is becoming more controversial. There is new evidence that aspirating thin-consistency beverages in small quantities may not present as high a risk for aspiration pneumonia as once thought. The necessity of thickening water has come under particular scrutiny since water is isotonic and is generally absorbed into the body from the lungs. Some facilities may have a policy not to thicken water, whereas others may require thickening of all liquids. Check the policy if there is any question during the survey process.

Audiovisual

Outline or text of presentation

- Another risk factor for aspiration pneumonia besides aspirating beverages is aspirating bacteria. The elderly generally have increased colonization of the nose, mouth and throat with *Staphylococcus aureus, Klebsiella pneumonia* and *Escherichia coli.* Oral hygiene and dental care are generally lacking in the long term care setting. Poor oral care may be a risk factor for aspiration pneumonia even without the presence of swallowing problems, but it is a significant risk factor for those with dysphagia. Deficient practice is present if residents are not provided with adequate supplies for, and individualized assistance with, oral hygiene.

(Allow students to inspect samples of thickening agents, if available.)

Nasogastric Tubes

- Review F321 & F322
- Key points
- Tube feedings & end-of-life decisions
- Care of residents undergoing tube feedings
- Investigation of tube feedings

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Nasogastric Tubes

Relevant tags: F321 and F322
(Review the Appendix P guidance for F321 and F322 [42 CFR 483.25(g)] with the students. Allow students to view the enteral support formulary or bottle label and the assistive devices, if available.)

Key points

- The regulations were written when nasogastric enteral support was more common in long term care. Numerous randomized comparison studies have demonstrated that risks with nasogastric tube feeding exceed those associated with gastrostomy, especially percutaneous endoscopic gastrostomy (PEG).

Audiovisual	Outline or text of presentation
	• Studies have shown that the number of elderly hospitalized patients undergoing PEG placement doubled from 1988 to 1995. The extent of PEG placement and the use of enteral support vary widely by national region. • The placement of a route for enteral support may not be necessary; ensure that the facility adequately or accurately assessed the resident. Has the Care Plan been revised to show that attempts were made to provide nourishment by mouth? For instance, did a speech language pathologist (SLP) evaluate the resident, and did his/her recommendations indicate that eating by mouth was safe for the resident as long as the tolerated consistency was provided? For deficient practice regarding a quality-of-care issue for which there is no specific regulation, consider F309. That is, if you have strong evidence that a gastrostomy tube or PEG was initiated for a resident who could safely and adequately consume food, do not cite that deficient practice at F321, because F321 is specific to nasogastric feedings. Rather, cite the deficient practice at F309, which is the regulatory requirement encompassing quality-of-care deficiencies not specified at other quality of care tags. • Residents who can safely consume adequate nutrition should not be made dependent on enteral means regardless of the route of enteral support or the amount of time needed from staff to feed the resident: – Was a resident, newly dependent on enteral support, eating adequately, however slowly, prior to tube placement?

Audiovisual	Outline or text of presentation
	– Enteral support may sometimes be used for staff convenience especially if a resident eats slowly and takes a while to feed. – You will, on occasion, see residents who both receive enteral support and consume food orally. Is the facility IDT assessing the resident's oral intake to determine whether it is now adequate for healthy nutritional parameters? Is the IDT pursuing therapeutic interventions through various disciplines to reduce tube dependence and gradually restore the resident's ability to consume adequate nutrition orally? Is the tube-feeding schedule supportive of the goal to consume more oral nutrition, or does the schedule interfere with the resident's appetite? (That is, is the tube feeding continuous, or does the resident receive a bolus feeding within two hours of a meal?) • The most common reason for enteral support use in adults is dysphagia due to a cardiovascular accident (CVA). A resident may have had a CVA and have been unable, after the event, to swallow safely, as determined by a trained professional [usually an SLP, and usually through video fluoroscopy minimum barium swallow study (MBSS)]. With proper assessment and therapy, many residents who have had a CVA can improve their ability to swallow safely and return to eating. As the resident improves other functional abilities after the CVA, has the facility reevaluated the resident's swallowing function? Is there still evidence that the tube feeding is necessary?

Audiovisual

Outline or text of presentation

- Residents begin enteral support for other reasons besides CVA-induced dysphagia. They may refuse to consume adequate nutrition orally (due to psychological reasons), or they may eventually refuse to be fed due to confusion as a result of the end stages of dementia. Again, has the facility accurately assessed the situation, developed a Plan of Care to address the resident's needs, and implemented that Plan of Care, revising as needed?
  - If someone refuses to eat because he/she does not have a motivation to live, did he/she receive psychological services prior to implementation of enteral support?
  - Residents have the right to refuse a tube feeding. Are they educated about their rights at the time of admission and about the benefit of advance directives? Does the resident have an advance directive? Was it honored?

Tube feedings and end-of-life decisions
The decision to begin enteral support, regardless of the route, is usually a highly personal and emotional one. It should always be based on a clear clinical picture of the need for the support and the values of the person who will receive the nutritional support. There are many times when a resident will not be cognitively able to make that decision and the IDT, including the resident's physician, has an obligation to provide the family or responsible party with an understanding of the risks and benefits of the decision to begin tube feeding. Once the feeding tube is placed, the decision to remove the tube in the absence of the resident's ability to consume by mouth is especially difficult.

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Outline or text of presentation

There is currently no research to support the use of tube feedings for individuals in the end stages of dementia. Initiating tube feedings for these individuals has not been shown to prevent aspiration pneumonia, prolong life, reduce the risk of infection, restore independence or provide comfort. In fact, if the resident will allow himself/herself to be fed, this normally produces better clinical outcomes. Tube feedings do not increase the survival rates for residents in the end stages of dementia.

There are generally two ethical camps regarding the use of enteral support for residents who have dementia or are no longer conscious. One view is that life is precious and should be preserved regardless of the clinical picture of the resident. The other view is that the quality of life has higher value than the quantity of life and that the use of a medical treatment to maintain nutritional parameters may only prolong suffering.

As surveyors, it is important that we do not impose our own values on facilities, families and residents. For instance, there have been reports of surveyors citing F325 when residents and families chose to forgo nutritional support during an end-of-life process. This is not appropriate. As a surveyor, investigate to determine whether the facility assessed the resident, included social services to assist the family, and developed a palliative care plan when needed. Was the care plan followed? Were the values of the resident honored? Were advance directives followed?

Care of residents undergoing tube feedings

When investigating the care of residents with feeding tubes, check to see whether

Audiovisual	Outline or text of presentation
	the resident has a completed and current nutrition assessment. Be sure to look for nutrition assessments completed by a qualified dietitian, not progress notes or food preferences recorded by the dietary manager. Do the calories, protein, and fluids provided by the tube feeding match the resident's estimated nutritional needs? Is the tube feeding at an adequate rate to meet the resident's daily micronutrient (vitamin and mineral) requirements? *(Refer students to the handout "Checking Enteral Support" beginning on page 3-I-63.)* • All enteral support formulations are unique. The amounts of nutrients in tube feedings vary widely. As a surveyor, observe the type of enteral support the resident is receiving and make notations regarding the amount of calories, protein and fluid provided from each cubic centimeter or milliliter (the information on the bottle may give you this information in liters instead of milliliters): – For instance, the information on the bottle may indicate 1 liter in the bottle with 750 cubic centimeters (cc) of water, 60 grams of protein, and 1,200 calories. – The resident whose care you are reviewing is receiving 55 cc per hour continuously (usually continuously means 22–23 hours divided over a 24-hour period—check facility policy). Since 55 cc times 23 hours is more than 1 bottle, you will need to convert the nutrient provisions to milliliters or convert the total volume to liters to determine how much nutrition the resident is receiving in a day.

Audiovisual	Outline or text of presentation
	– One way is to convert the total volume infused to liters and multiply that factor by the amounts of nutrients provided in 1 liter: o You would simply multiply 55 milliliters × 23 hours (per facility policy) = 1,265 milliliters divided by 1,000 (since there are 1,000 milliliters in a liter) = 1.265. o Now you can use that factor to determine the provision of all nutrients to the resident based on the amounts provided on the bottle (e.g., 1.265 × 60 grams of protein = 75.9 grams provided in 23 hours, 1.265 × 1,200 = 1,518 calories in 23 hours, 1.265 × 750 cc water = 948.75 cc provided in 23 hours). • Does the amount provided match the resident's estimated nutritional needs as determined by the facility dietitian? Did the dietitian make recommendations if there is a discrepancy? If so, were the recommendations communicated to the physician? What system does the facility have for communicating such recommendations, and is it efficient? If the system is not efficient, residents could lose significant weight and become nutritionally compromised before the physician becomes aware that the tube-feeding formula at the ordered rate is not adequate. • If a physician is concerned about total volume becoming too high for the resident due to tolerance issues or fluid volume considerations, more-nutrient-concentrated formulas can be ordered

Audiovisual	Outline or text of presentation
	so that the resident receives adequate calories, protein, and micronutrients without causing fluid overload. • Therefore, as a surveyor, do not accept a facility explanation such as "We could not prevent the weight loss because the rate had to stay low since the resident has congestive heart failure." Be aware, however, that more concentrated formulas can increase the risk of diarrhea. The facility should utilize its nutritional consultant. • As a surveyor investigating the care of residents receiving tube feedings, you will need to determine whether tube feedings are actually administered as ordered. A common problem is that tube feedings are shut off to provide routine care or to provide bowel rest, but the pump is not turned on again. The reason dietitians generally calculate the rate needed to provide adequate nutrition based on 22 or 23 hours and not 24 hours is because tube feedings will need to be shut down periodically for care or bowel rest. However, if a feeding that is ordered to be continuous is left off repeatedly for more than 1–2 hours a day, then the resident's nutritional status could become compromised. **Investigation of tube feedings** When you arrive at the facility and observe a particular resident who is being fed via tube, make a notation of the time of your observation, the time the feeding was started, the rate at which it is being administered, the total volume of the bottle, and the amount that is left in the bottle. There should be a notation on the bottle of the time the feeding was initiated.

Audiovisual	Outline or text of presentation
	If there is not, question facility administration regarding the facility's policy and how the facility ensures that residents receive enteral support as ordered by the physician. If the notation is present, determine how much time has passed since the initiation and your observation. Then, determine whether the correct amount of formula has been administered based on the rate and the amount of time passed. Do this periodically throughout the day. Of course, also document the length of time a feeding is observed to be shut off. This type of investigation is especially important if the resident has lost weight since becoming dependent on enteral support, because then the resident may have been harmed: • During your observations, also always make sure the head of the resident's bed is elevated. Often residents may be in a reclining "geriatric chair," so also make sure the head of the chair is sufficiently elevated (at least 30 degrees). Make note of the resident's posture. Is the facility staff aware of, and trying to reduce, the risk of aspiration? • Also, if the tube feeding interferes with the resident's participation in activities or quality of life, has the facility assessed this and made attempts to reduce the negative psychosocial affects of the enteral support? For example, residents can have bolus feedings throughout the day and not be constantly connected to the pump, or they may prefer to receive their nutritional support at night. • If a resident's condition changes—for example, he/she develops a pressure sore or has excessive vomiting, reflux

Audiovisual

Outline or text of presentation

or diarrhea—then his/her nutritional status is compromised. Residents dependent on enteral support cannot simply eat more when their nutritional needs increase. Did the facility contact the dietitian to reevaluate the resident's nutritional needs when the resident had skin breakdown, a long bone fracture, or recurrent and severe infections? Was the dietitian consulted and the physician notified when the resident showed consistent signs of not tolerating the feeding?

Nutritive Value

- 42 CFR 483.35(d): F364
- Issues affecting nutritive value
- Palatability
- Attractiveness
- Proper serving temperatures
- Test trays

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Nutritive Value

[Refer the students to SOM Appendix PP (F364).]

Issues affecting nutritive value

Conserving reasonable nutritive values in prepared food is not a complicated issue. All methods of cooking or heating food diminish the nutritive value of most foods to some degree. Technically even the preservation of nutrients in food is based on culturally accepted cooking methods. Review the intent of this regulation found in the guidance to surveyors in *SOM* Appendix PP. Issues of prolonged storage, light and air exposure are also issues of inadequate methods of sanitary preparation of food. If food is properly stored (sealed and kept at proper storage temperatures and not kept past expiration or 72 hours for leftovers), is prepared using standardized recipes, and is not "held" (as distinguished from stored in a refrigerator or freezer) after preparation and prior to service for too long (longer than 30 minutes), then the nutritive value should be according to expectation.

Audiovisual

Outline or text of presentation

Palatability
Palatability is defined as food's being acceptable to the taste and sufficiently agreeable in flavor to be eaten. It can be an objective or a subjective issue for surveyor investigation. Many influences affect one's perception of food satisfaction. Food satisfaction is a matter of personal taste, childhood experience, professional training and culture. Food satisfaction can be influenced by medication, appetite and medical symptoms. Menus and standardized recipes, as well as ingredients and amounts used, are highly susceptible to cultural influence.

For example, if a facility is located in the southern part of the United States and "chicken-fried steak" is served without gravy and does not have a batter or coating on it and many residents do not eat it, then the meat for that meal may not have been palatable. Note that if you work as a surveyor in one region of the country, but menus and standardized recipes at a facility were created and approved by a dietitian in another region of the country, the facility's residents may not be satisfied with the food.

Attractiveness
Palatability, attractiveness and proper serving temperatures of the food a facility serves are a matter of resident satisfaction and standards of the community. That is, the palatability of food served does not have to meet your personal standards or satisfaction as a surveyor. What is important is whether or not most residents find the majority of meals at the facility to be palatable. However, if residents do not voice concerns or complain regarding the food quality or preparation, but the food obviously does not meet the standards of the community, then there may still be deficient practice.

Audiovisual

Outline or text of presentation

Test tray

During the survey process, there will be many opportunities to find out the level of food satisfaction of the residents. Some common venues for determining food satisfaction are during initial tour, during review of the resident council minutes and grievance file, during meal observations and during resident, family and group interviews. If there is evidence of resident dissatisfaction with the food, you will need to order and review a "test tray."

The procedure for a sample or test tray in the Investigative Protocol: Dining and Food Service (*SOM,* Appendix P) states:

> If residents complain about the palatability/temperature of food served, the survey team coordinator may request a test meal to obtain quantitative data to assess the complaints. Send the meal to the unit that is the greatest distance from the kitchen or to the affected unit or dining room. Check food temperature and palatability of the test meal at about the time the last resident on the unit is served and begins eating.

A note about test trays:

- You may request a variety of texture-modified foods if there are concerns regarding the texture of foods not being according to resident needs or if residents complain about the texture.
- Even when there are no or few food complaints, you may notice that cognitively impaired residents or residents who cannot voice their dissatisfaction with the food have their meals uncovered for an extended period while they wait for assistance. You may sample one of those trays for palatability provided that you ensure that there is adequate food in the

Audiovisual

Outline or text of presentation

kitchen for the resident to receive another tray.

- Sample all food and beverage items on the test tray and document your impressions with descriptive adjectives in your surveyor notes. It is good practice to have more than one surveyor sample the tray and voice his/her opinion, since food palatability can be subjective.

Staff

- 42 CFR 483.35(b): F362
- Number & training

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Staff

42 CFR 483.35(b) (F362)
(Review the guidance for this regulation with the class.)

If problems have been identified with the palatability of the food or a lack of adherence to the facility food service schedule or professional standards regarding storage, preparation and service of food, then investigate the facility compliance with F362.

Number and training
Are there adequate numbers of staff to prepare quality meals according to scheduled meal times? If so, is the staff adequately trained and competent to conduct food service operations that meet regulatory requirements? Investigate these issues by observing staff working in the kitchen, noting meal service times, and interviewing the dietary staff, food service supervisor and residents who are affected by dietary practices. Document all investigation, noting whom you spoke with in an interview, the time and date and the content of both interviews and observations.

Audiovisual

Dining Services

- Homelike dining environment
  - Individual preferences
  - Light, temperature, ventilation
  - Furnishings, space
  - Medication pass during meal
  - Dining & food service investigative protocol
- 42 CFR 483.5 (h)(1): F252
- 42 CFR 483.70 (g)(1), (2), (3), (4): F464, F465

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Outline or text of presentation

Dining Services

Dining environment
Is the dining environment homelike; that is, does the setting promote a comfortable, relaxed atmosphere for the resident's dining experience?

Individual preferences
Are individual preferences honored or is the dining environment overtly institutionalized? For example, are plate covers stacked in the center of the table? Would residents prefer ceramic plates, rather than the divided plastic trays on which all meal items are placed?

Light, temperature and ventilation
Do residents and staff have enough light for visibility, safety and comfort? Are the temperature and air flow comfortable?

Furnishings
Do the tables and chairs meet individual residents' needs for seeing and reaching their food comfortably? That is, are the tables or chairs too high or too low, so that residents have to reach up or down from the height of their elbows to eat? Make observations, and note your concerns on your surveyor worksheets, then interview residents and staff to determine whether residents are negatively affected and whether the facility has recognized the problems.

Medication pass during a meal
Sometimes a medication pass is conducted during a meal for the convenience of the person conducting the pass (all residents grouped together). This is not appropriate for a variety of reasons. Particular medications, however, may need to be given to certain residents at mealtimes, in which case administration of the medicine during a meal is acceptable.

Audiovisual

Additional Regulatory Requirements Related to Nutrition Services

- F361—Staffing
- F363—Menus & nutritional adequacy
- F365—Food for individual needs
- F366—Substitute items
- F368—Meal frequency

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Outline or text of presentation

(Review "Appendix P Investigative Protocol: Dining and Food Service" beginning on page 3-I-65 with students. Also review SOM Appendix PP tags F252, F464 and F465.)

Additional Regulatory Requirements Related to Nutrition Services

(Review pertinent sections of SOM Appendix PP with the students.)

- 42 CFR 483.35(a) Staffing (F361).
- 42 CFR 483.35(c) Menus and Nutritional Adequacy (F363).
- 42 CFR 483.35(c)(2)–(3) Menus must be prepared in advance and be followed.
- 42 CFR 483.35(d)(3) The facility must provide food prepared in a form designed to meet individual needs (F365).
- 42 CFR 483.35(d)(4) Substitutes offered of similar nutritive value to residents who refuse food served (F366).
- 42 CFR 483.35(f) Frequency of Meals (F368).
- 42 CFR 483.35(i)(1)–(3) Sanitary Conditions (F370, F371, F372) are covered as part of Lesson 3-H, Kitchen, which deals with Sub-Task 5B of the survey process.

Audiovisual

Examples of Food Exchanges

- Starch/breads
- Meat/meat alternatives
- Vegetables
- Fruit
- Milk
- Fat

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Outline or text of presentation

Addition to the Guidance: Food Exchanges

Exchange system
Menus are devised based on standardized "exchange" systems. The U.S. exchange system divides foods for menu and meal planning into six categories: starch/bread; meat/meat alternative; vegetable; fruit; milk; and fats/sugars. The amounts for exchanges of specific foods are based on their approximate nutritional equivalence to foods in the same category. Therefore foods of the same categories can be exchanged in appropriate amounts to meet nutritional needs. As a surveyor, if there are concerns that portions may be too small, check the menu to determine if the facility is serving the correct amounts according to the menu.

(Refer the students to the handout "Food Exchanges" on page 3-I-69.)

Actual nutritional need has nothing to do with the portions we are accustomed to seeing in restaurants. (Note that 4 oz. of cooked meat looks about as big as the palm of a woman's hand or the size of a deck of playing cards.) Most elderly do not need portions as big as those for other adults. Many residents grew up during the Depression era and can become emotionally overwhelmed by large portions. Some facilities may have a "geriatric menu," which may have large portions at breakfast, standard items and portions at lunch, and a "light" supper/dinner (soup, sandwiches, fruit salads, etc.). These can be perfectly adequate nutritionally but should be satisfactory to the residents. The rationale for these menus is that the geriatric population generally prefers eating the

Audiovisual

Outline or text of presentation

bulk of their food earlier in the day and has less appetite in the evening. Regardless, if an underweight resident or nutritionally compromised resident consumes 100% of his/her meal, the facility should offer him/her more food, and individual nutritional preferences should be provided for.

Medications Associated with Weight Loss

Considerations:

- Include medication in investigation of weight loss
- Lesson list is not all-inclusive; other medications may cause weight loss
- Responses to medication are unique; was impact of changes assessed?

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Slide 3-I-21

Medications Associated with Weight Loss

(Review the handout "Medications Associated with Weight Loss" beginning on page 3-I-71 with students and discuss the following considerations.)

- Did the facility review resident medications when assessing for etiologies of weight loss and notify the physician of potential associations? Were changes made according to the resident's clinical needs as determined by risk-benefit analysis?
- This list is not meant to be an all-inclusive list. Review resident medications and check a reliable source when there are potential negative nutritional outcomes from the administration of a medication.
- Remember also that residents can have unique responses to new medications. If meal intakes decreased or weight loss occurred, determine whether the resident was started on a new medication when the nutritional changes began. Did the facility assess this?

Audiovisual

Outline or text of presentation

Summary

- Provision of acceptable nutrition
- Therapeutic nutritional interventions
- Hydration
- Enteral support—initiation & care
- Food value conservation
- Staff considerations
- Homelike, adequate dining services

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Slide 3-I-22

Lesson 3-I:
Nutrition

Questions

23

Slide 3-I-23

Skill Assessment

Nutrition

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Determined whether a facility has ensured that residents maintain acceptable parameters of nutritional status, unless a resident's clinical condition demonstrates that this is not possible.	
					Determined whether a facility's residents receive therapeutic nutritional interventions when needed.	
					Determined whether a facility has provided each resident with sufficient fluids to maintain proper hydration and health and developed a preventative care plan for residents at high risk for dehydration.	
					Determined that residents of a facility who are able to eat alone or with assistance do not have enteral support	

OO	NMSE	PSS	CMS	PI	Skill	Comment
					initiated unless their clinical condition demonstrates that enteral support dependence is unavoidable.	
					Determined whether a facility has provided the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills for residents receiving enteral support.	
					Determined whether a facility is preparing food using methods that conserve nutritive value and serving food that is palatable, attractive and at the proper temperatures.	
					Determined whether a facility has sufficient staff to prepare and serve quality food.	
					Determined whether the resident dining services at a facility are homelike.	
					Determined whether a facility provides adequate lighting, ventilation, furnishings and space during dining services.	

Comments/Recommendations:

Nutrition Tags

Tag	Topic
F325	
F326	
F361	
F279	
F361	
F367	
F321	
F322	
F309	
F364	
F362	
F363	
F365	
F366	
F368	

Checking Nutritional Parameters

- Nutritional parameters are parameters used to assess nutritional status.
- Examples of anthropometric nutritional parameters: weight, weight in relation to height (body mass index, ideal body weight), paraplegia, quadriplegia, amputations, frame size (wrist circumference, etc.) (USDA, 2000).
  - Body mass index (BMI): an indicator used to predict health risk based on the relationship between weight and height.

$$\text{BMI} = \text{weight (kg)}/\text{height (m}^2\text{)}$$
$$\text{or}$$
$$\text{BMI} = \text{weight (lbs.)}/\text{height (in.}^2\text{)} \times 705$$

  - Ideal body weight (IBW):
    - Women: 100 pounds for first 5 feet plus 5 pounds for each inch over 5 feet +/− 10%, depending on frame size.
    - Men: 106 pounds for first 5 feet plus 6 pounds for every inch over 5 feet +/− 10%, depending on frame size.
  - Healthy weight: BMI of 18.5–25.
  - Overweight: BMI of 25–30.
  - Obese: BMI of 30 or greater.
  - Morbidly obese: More than 200% of IBW.

Laboratory Values

Albumin	Hemoglobin
Prealbumin	Iron
Alkaline phosphatase	Mean corpuscular volume
Blood urea nitrogen	Mean corpuscular hemoglobin
Chloride	Potassium
Cholesterol	Prothrombin time
High-density lipoprotein	Sodium
Low-density lipoprotein	Total lymphocyte count
Creatinine	Thyroid hormones
Ferritin	Triglycerides
Glycosylated hemoglobin	White blood cells
Glucose	B-12
Hematocrit	Folate

Etiologies of Unplanned Weight Loss

1) Decreased nutritional intakes.
   a) Decreased appetite.
      i) Dementia.
      ii) Medication (see handout "Medications Associated with Weight Loss").
      iii) Depression.
      iv) Poor food quality.
      v) Food preferences not honored.
      vi) Not allowed to eat at preferred times of day.
      vii) Nausea, emesis, diarrhea, constipation, reflux (other GI discomfort).
      viii) Unpleasant eating environment (socially or physically).
      ix) Pacing behaviors (Often residents with pacing behaviors have a decreased interest in meals. Pacing can be related to dementia or mental illness).
      x) Pain.
   b) Physical limitations.
      i) Paralysis.
      ii) Need for adaptive equipment (plate guard, "built-up" spoon, swivel spoon, etc.).
      iii) Dysphagia (difficulty swallowing).
      iv) Oral pain (infection, sore gums, ill-fitting dentures, edentulous).
      v) Blindness.
2) Increased nutritional needs.
   a) Infections (some common).
      i) Pneumonia.
      ii) Flu.
      iii) Urinary tract.
   b) Fractures (especially long bone).
   c) Wound healing.
      i) Pressure sores.
      ii) Stasis ulcer.
      iii) Healing surgical sites.
      iv) Other.
   d) Hypermetabolic disease states.
      i) Chronic obstructive pulmonary disease.
      ii) Cancer.
      iii) Cardiac cachexia.
      iv) HIV/AIDS.
      v) Hyperthyroidism.
      vi) End-stage-dementia-related illnesses (e.g., Alzheimer's disease, organic brain syndrome, Parkinson's disease) may also increase nutritional needs, and simultaneously decrease one's interest in or ability to consume food by mouth. (Refer to section of this lesson regarding enteral support and end-of-life considerations.)

vii) Malabsorption.
(1) Inflammatory bowel disease (Crohn's/ulcerative colitis).
(2) Celiac disease (gluten intolerance).
(3) Recent bowel or stomach surgery.

e) Physical activity
i) Wandering/pacing.
ii) Repetitive movement disorders.
iii) Exercise.

Appendix P Investigative Protocol: Unintended Weight Loss

Objectives:

- To determine if the identified weight loss is avoidable or unavoidable; and
- To determine the adequacy of the facility's response to the weight loss.

Task 5C: Use:

Utilize this protocol for a sampled resident with unintended weight loss.

Procedures:

- Observations/interviews conducted as part of this procedure should be recorded on the Form CMS-805 if they pertain to a specific sampled resident and on the Form CMS-807 if they relate to general observations of the dining service/dining room.
- Determine if the resident was assessed for conditions that may have put the resident at risk for unintended weight loss such as the following:
  - Cancer, renal disease, diabetes, depression, chronic obstructive pulmonary disease, Parkinson's disease, Alzheimer's disease, malnutrition, infection, dehydration, constipation, diarrhea, Body Mass Index (BMI) below 19, dysphagia, chewing and swallowing problems, edentulous, ill fitting dentures, mouth pain, taste/sensory changes, bedfast, totally dependent for eating, pressure ulcer, abnormal laboratory values (review in accordance with the facility's laboratory norms) associated with malnutrition (serum albumin, plasma transferrin, magnesium, hct/hgb, BUN/creatinine ratio, potassium, cholesterol), and use of medications such as diuretics, laxatives, and cardiovascular agents.

    Note: Amputation of a body part will contribute to a significant decrease in previously targeted weight range. Once the new weight goals are established the resident should be assessed within the parameters of the unintended weight loss investigative protocol.

    Note: Body Mass Index (BMI) estimates total body mass and is highly correlated with the amount of body fat. It provides important information about body composition, making it a useful indicator of nutritional status. BMI is easy to calculate because only information about height and weight are needed.

$$\text{BMI} = \text{weight (Kg)}/\text{height (M}^2\text{)}$$
$$\text{or}$$
$$\text{BMI} = \text{weight (lbs.)}/\text{height (inches}^2\text{)} \times 705$$

- Determine if the facility has assessed the resident's nutritive and fluid requirements, dining assistance needs, such as assistive devices, food cultural/religious preferences, food allergies, and frequency of meals.

- 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.
- Determine if the care plan was developed utilizing the clinical conditions and risk factors identified in the assessment for unintended weight loss. Were the care plan interventions, such as oral supplements, enteral feeding, alternative eating schedule, liberalized diet, nutrient supplements, adaptive utensils, assistance and/or increased time to eat developed to provide an aggressive program of consistent intervention by all appropriate staff?
- Determine if the care plan was evaluated and revised based on the response, outcomes, and needs of the resident.

  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 nutrients are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then the weight loss may be an expected outcome and may not constitute noncompliance with the requirement for maintaining nutritional parameters. 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.

- Observe the delivery of care as described in the care plan, e.g., staff providing assistance and/or encouragement during dining; serving food as planned with attention to portion sizes, preferences, nutritional supplements, and/or between-meal snacks, to determine if the interventions identified in the care plan have been implemented. Use the Dining and Food Service Investigative Protocol to make this determination.

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.25(I), F325, Nutrition:
  - For this resident, the unintended weight loss is unavoidable if the facility properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, the weight loss is avoidable; cite at F325.
- Compliance with 42 CFR 483.25, F309, Quality of Care:
  - For the resident who is in an end-of-life stage and 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, then for this resident, in the area of palliative care, the facility is compliant with this requirement. If not, cite F309.

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

Appendix P 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 flagged for the sentinel event of dehydration on the Resident Level Summary;
- A sampled resident who has one or more QI conditions identified on the Resident Level Summary, such as:
  - #11 - Fecal impaction;
  - #12 - Urinary tract infections;
  - #13 - Weight loss;
  - #14 - Tube feeding;
  - #17 - Decline in ADLs;
  - #24 - Pressure Ulcer
- 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 also 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) × 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:
  - What is the resident's response to the interventions? Do 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?
  - 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?
  - Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?
  - If the resident refuses water, are alternative fluids offered that are tolerable to the resident?
  - Are the resident's beverage preferences identified and honored at meals?
  - Do staff encourage the resident to drink? Are they aware of the resident's fluid needs? Are staff providing fluids during and between meals?
  - 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:
  - 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), F282, 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.

Checking Enteral Support

- All enteral support formulations are unique. The amounts of nutrients in tube feedings vary widely. As a surveyor, observe the type of enteral support the resident is receiving and make notations regarding the amount of calories, protein and fluid provided from each cubic centimeter or milliliter (the information on the bottle may give you this information in liters instead of milliliters):
  - For instance, the information on the bottle may indicate 1 liter in the bottle with 750 cubic centimeters (cc) of water, 60 grams of protein, and 1,200 calories.
  - The resident whose care you are reviewing is receiving 55 cc per hour continuously (usually continuously means 22–23 hours over a 24-hour period—check facility policy). Since 55 cc times 23 hours is more than 1 bottle, you will need to convert the nutrient provisions to milliliters or convert the total volume to liters to determine how much nutrition the resident is receiving in a day.
  - One way is to convert the total volume infused to liters and multiply that factor by the amounts of nutrients provided in 1 liter:
    - You would simply multiply 55 milliliters × 23 hours (per facility policy) = 1,265 milliliters, divided by 1,000 (since there are 1,000 milliliters in a liter) = 1.265.
    - Now you can use that factor to determine the provision of all nutrients to the resident based on the amounts provided on the bottle (e.g., 1.265 × 60 grams of protein = 75.9 grams provided in 23 hours, 1.265 × 1,200 = 1,518 calories in 23 hours, 1.265 × 750 cc water = 948.75 cc provided in 23 hours).
- Does the amount provided match the resident's estimated nutritional needs as determined by the facility dietitian? Did the dietitian make recommendations if there is a discrepancy? If so, were the recommendations communicated to the physician? What system does the facility have for communicating such recommendations, and is it efficient? If the system is not efficient, residents could lose significant weight and become nutritionally compromised before the physician becomes aware that the tube feeding formula at the ordered rate is not adequate.
- If a physician is concerned about total volume becoming too high for the resident due to tolerance issues or fluid volume considerations, more-nutrient-concentrated formulas can be ordered so that the resident receives adequate calories, protein, and micronutrients without causing fluid overload.
- Therefore, as a surveyor, do not accept a facility explanation such as "We could not prevent the weight loss because the rate had to stay low since the resident has congestive heart failure." Be aware, however, that more concentrated formulas can increase the risk of diarrhea. The facility should utilize its nutritional consultant.
- As a surveyor investigating the care of residents receiving tube feedings, you will need to determine whether tube feedings are actually administered as ordered. A common problem is that tube feedings are shut off to provide routine care or to provide bowel rest, but the pump is not turned on again. The reason dietitians generally calculate the rate needed to provide adequate nutrition based on 22 or 23 hours and not 24 hours is because tube feedings will need to be shut down periodically for care or bowel rest. However, if a feeding that is ordered to be continuous is left off repeatedly for more than 1–2 hours a day, then the resident's nutritional status could become compromised.

Investigation of Tube Feedings

When you arrive at the facility and observe a particular resident who is being fed via tube, make a notation of the time of your observation, the time the feeding was started, the rate at which it is being administered, the total volume of the bottle, and the amount that is left in the bottle. There should be a notation on the bottle of the time the feeding was initiated. If there is not, question facility administration regarding the facility's policy and how the facility ensures that residents receive enteral support as ordered by the physician. If the notation is present, determine how much time has passed since the initiation and your observation. Then, determine whether the correct amount of formula has been administered based on the rate and the amount of time passed. Do this periodically throughout the day. Of course, also document the length of time a feeding is observed to be shut off. This type of investigation is especially important if the resident has lost weight since becoming dependent on enteral support, because then the resident may have been harmed:

- During your observations, also always make sure the head of the resident's bed is elevated. Often residents may be in a reclining "geriatric chair," so also make sure the head of the chair is sufficiently elevated (at least 30 degrees). Make note of the resident's posture. Is the facility staff aware of, and trying to reduce, the risk of aspiration?
- Also, if the tube feeding interferes with the resident's participation in activities or quality of life, has the facility assessed this and made attempts to reduce the negative psychosocial affects of the enteral support? For example, residents can have bolus feedings throughout the day and not be constantly connected to the pump, or they may prefer to receive their nutritional support at night.
- If a resident's condition changes—for example he/she develops a pressure sore or has excessive vomiting, reflux or diarrhea—then his/her nutritional status is compromised. Residents dependent on enteral support cannot simply eat more when their nutritional needs increase. Did the facility contact the dietitian to reevaluate the resident's nutritional needs when the resident had skin breakdown, a long bone fracture, or recurrent and severe infections? Was the dietitian consulted and the physician notified when the resident showed consistent signs of not tolerating the feeding?

Appendix P Investigative Protocol: Dining and Food Service

Objectives:

- To determine if each resident is provided with nourishing, palatable, attractive meals that meet the resident's daily nutritional and special dietary needs;
- To determine if each resident is provided services to maintain or improve eating skills; and
- To determine if the dining experience enhances the resident's quality of life and is supportive of the resident's needs, including food service and staff support during dining.

Task 5C: Use:

This protocol will be used for:

- All sampled residents identified with malnutrition, unintended weight loss, mechanically altered diet, pressure sores/ulcers, and hydration concerns; and
- Food complaints received from residents, families and others.

General Considerations:

- Use this protocol at two meals during the survey, preferably the noon and evening meals.
- Record information on the Form CMS-805 if it pertains to a specific sampled resident, or on the Form CMS-807 if it relates to the general observations of the dining service/dining room:
  - Discreetly observe all residents, including sampled residents, during meals keeping questions to a minimum to prevent disruption in the meal service.
- For each sampled resident being observed, identify any special needs and the interventions planned to meet their needs. Using the facility's menu, record in writing what is planned in writing to be served to the resident at the meal observed.
- Conduct observations of food preparation and quality of meals.

Procedures:

1. During the meal service, observe the dining room and/or resident's room for the following:
   - Comfortable sound levels;
   - Adequate illumination, furnishings, ventilation; absence of odors; and sufficient space;
   - Tables adjusted to accommodate wheelchairs, etc.; and
   - Appropriate hygiene provided prior to meals.

2. Observe whether each resident is properly prepared for meals. For example:
   - Resident's eyeglasses, dentures, and/or hearing aids are in place;
   - Proper positioning in chair, wheelchair, gerichair, etc., at an appropriate distance from the table (tray table and bed at appropriate height and position); and
   - Assistive devices/utensils identified in care plans provided and used as planned.

3. Observe the food service for:
   - Appropriateness of dishes and flatware for each resident. Single use disposable dining ware is not used except in an emergency and, other appropriate dining activities. Except those with fluid restriction, each resident has an appropriate place setting with water and napkin;
   - Whether meals are attractive, palatable, served at appropriate temperatures and are delivered to residents in a timely fashion:
     – Did the meals arrive 30 minutes or more past the scheduled mealtime?
     – If a substitute was needed, did it arrive more than 15 minutes after the request for a substitute?
   - Are diet cards, portion sizes, preferences, and condiment requests being honored?

4. Determine whether residents are being promptly assisted to eat or provided necessary assistance/cueing in a timely manner after their meal is served:
   - Note whether residents at the same table, or in resident room's, are being served and assisted concurrently.

5. Determine if the meals served were palatable, attractive, nutritious and met the needs of the resident. Note the following:
   - Whether the resident voiced concerns regarding the taste, temperature, quality, quantity and appearance of the meal served;
   - Whether mechanically altered diets, such as pureed, were prepared and served as separate entree items (except when combined food, e.g., stews, casseroles, etc.);
   - Whether attempts to determine the reason(s) for the refusal and a substitute of equal nutritive value was provided, if the resident refused/rejected food served; and
   - Whether food placement, colors, and textures were in keeping with the resident's needs or deficits, e.g., residents with vision or swallowing deficits.

   Sample Tray Procedure

   If residents complain about the palatability/temperature of food served, the survey team coordinator may request a test meal to obtain quantitative data to assess the complaints. Send the meal to the unit that is the greatest distance from the kitchen or to the affected unit or dining room. Check food temperature and palatability of the test meal at about the time the last resident on the unit is served and begins eating.

6. Observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does not prohibit the administration of medications during meal service for medications that are necessary to be given at a meal, nor does this prohibit a medication to be given during a meal upon request of a resident who is

accustomed to taking the medication with the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

- Has the facility attempted to provide medications at times and in a manner to support the dining experience of the resident, such as:
  - Pain medications being given prior to meals so that meals could be eaten in comfort;
  - Foods served are not routinely or unnecessarily used as a vehicle to administer medications (mixing the medications with potatoes or other entrees).

7. Determine if the sampled resident consumed adequate amounts of food as planned.

   - Determine if the facility is monitoring the foods/fluids consumed. Procedures used by the facility may be used to determine percentage of food consumed, if available; otherwise, determine the percentage of food consumed using the following point system:
     - Each food item served except for water, coffee, tea, or condiments equals one point. Example: Breakfast: juice, cereal, milk, bread and butter, coffee (no points) equals four points. If the resident consumes all four items in the amount served, the resident consumes 100% of breakfast. If the resident consumes two of the four food items served, then 50% of the breakfast would have been consumed. If three-quarters of a food item is consumed, give one point; for one-half consumed, give .5 points; for one- fourth or less, give no points. Total the points consumed × 100 and divide by the number of points given for that meal to give the percentage of meal consumed. Use these measurements when determining the amount of liquids consumed: Liquid measurements: 8 oz. cup = 240 cc, 6 oz. cup = 180 cc, 4 oz. cup = 120 cc, 1 oz. cup = 30 cc.
     - Compare these findings with the facility's documentation to determine if the facility has accurately recorded the intake. Ask the staff if these findings are consistent with the resident's usual intake; and
     - Note whether plates are being returned to the kitchen with 75% or more of food not eaten.

8. If concerns are noted with meal service, preparation, quality of meals, etc., interview the person(s) responsible for dietary services to determine how the staff are assigned and monitored to assure meals are prepared according to the menu, that the meals are delivered to residents in a timely fashion, and at proper temperature, both in the dining rooms/areas and in resident rooms.

   Note: If concerns are identified in providing monitoring by supervisory staff during dining or concerns with assistance for residents to eat, evaluate nursing staffing in accord with 42 CFR 483.30(a), F353, and quality of care at 42 CFR 483.25(a)(2) and (3).

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.35(d)(1)(2), F364, Food:
  - The facility is compliant with this requirement when each resident receives food prepared by methods that conserve nutritive value, palatable, attractive and at the proper temperatures. If not, cite F364.
- Compliance with 42 CFR 483.35(b), F362, Dietary services, sufficient staff:
  - The facility is compliant with this requirement if they have sufficient staff to prepare and serve palatable and attractive, nutritionally adequate meals at proper temperatures. If not, cite F362.

    Note: If serving food is a function of the nursing service rather than dietary, refer to 42 CFR 483.30(a), F353.

- Compliance with 42 CFR 483.15(h)(1), F252, Environment:
  - The facility is compliant with this requirement if they provide a homelike environment during the dining services that enhances the resident's quality of life. If not, cite F252.
- Compliance with 42 CFR 483.70(g)(1)(2)(3)(4), F464, Dining and Resident Activities:
  - The facility is compliant with this requirement if they provide adequate lighting, ventilation, furnishings and space during the dining services. If not, cite F464.

Food Exchanges

- Starches/breads (15 grams carbohydrate, 3 grams protein, 80 calories):
  - ⅓ cup bran cereal.
  - ½ cup cooked cereal.
  - ½ cup grits.
  - ⅓ cup rice.
  - ½ bagel.
  - 1 slice bread.
  - 6 saltine crackers.

- Meat/meat alternatives (7 grams protein, calories and fat vary):
  - 1 oz. of beef, pork, veal, poultry, fish, wild game, lamb.
  - 2 oz. of crab, lobster, scallops, shrimp, clams.
  - Alternatives: exchange according to package, but also:
    - ¼ cup cottage cheese.
    - 1 egg.
    - 3 egg whites.
    - 4 oz. tofu.
    - 1 oz. cheese.
    - 1 tbsp peanut butter.

- Vegetables (5 grams carbohydrate, 2 grams protein, 25 calories):
  - All vegetable exchanges are:
    - ½ cup cooked.
    - 1 cup raw.
    - ½ cup juice.
    - 1 large tomato.

- Fruit (15 grams carbohydrate, 60 calories):
  - Most fruit portions are in ½ cup exchanges:
    - ½ cup fruit juice.
    - ¼ cup dried fruit.
    - 1 whole piece of fruit.
    - ¾ cup berries.
    - 1¼ cup strawberries/watermelon.

- Milk (12 grams carbohydrate, 8 grams protein, total calories/fat varies):
  - 1 cup milk.
  - 8 oz. plain yogurt.

- Fat (5 grams fat, 45 calories):
  - 1 tsp butter, margarine.

Medications Associated with Weight Loss

All have association with decreased appetite and weight loss to varying degrees.

Pharmaceutical name	Brand name	Classification of drug
Acetazolamide	Diamox	K-depleting diuretic, antiglaucoma, anticonvulsant
Acyclovir	Zovirax	Antiviral
Albuterol sulfate	Proventil, Ventolin	Bronchodilator
		Antineoplastics
Alprazolam	Xanax	Antianxiety, antipanic
Amantadine HCL	Symmetrel	Anti-Parkinson's, antiviral
Amiodarone HCL	Cordarone	Antiarrhythmic
Amitriptyline HCL	Elavil	Antidepressant
Amphetamines	Adderall, Dexedrine	Anti-ADHD, antinarcolepsy, appetite depressant
Amphotericin B	Abelcet, AmBisome, Amphotec, Fungizone	Antifungal, antiprotozoal
Azathioprine	Imuran	Immunosuppressant (renal transplant)
Bisacodyl	Dulcolax	Stimulant laxative
Bromocriptine	Parlodel	Anti-Parkinson's, growth hormone
Bupropion HCL	Wellbutrin, Zyban	Antidepressant, smoking cessation
Calcitonin	Calcimar, Miacalcin	Ca regulator, antiosteoporosis
Calcitriol	Rocaltrol	Ca regulator
Calcium acetate	Phoslo	Phosphate binder
Captopril	Capoten	Antihypertensive, anti-CHF
Carbamazepine	Tegretol	Anticonvulsant
Cephalexin HCL	Keftab, Keflex	Antibiotic
Cholestyramine	Questran	Antihyperlipidemic, antidiarrheal
Citalopram HBr	Celexa	Antidepressant, SSRI
Clemastine fumarate		Antihistamine
Clindamycin	Cleocin	Antibiotic
Clomipramine HCL	Anafranil	Anti-OCD, antidepressant
Clonazepam	Klonopin	Anticonvulsant, antipanic
Colchicine		Antigout
Digitalis	Digitoxin, Digoxin, Lanoxin,	Cardiotonic,

Pharmaceutical name	Brand name	Classification of drug
	Digitek	antiarrhythmic, anti-CHF
Donepezil	Aricept	Anti-Alzheimer's
Ethosuximide	Zarontin	Anticonvulsant
Ferrous salts	--	Hematinic, antianemic
Flouxetine	Prozac	Antidepressant, anti-OCD, antibulimia nervosa, SSRI
Fluvoxamide maleate	Luvox	Anti-OCD, SSRI
Galantamide	Reminyl	Anti-Alzheimer's
Gentamicin sulfate	Garamycin	Antibiotic
Hydralazine HCL	Apresoline	Antihypertensive
Hydroxychloroquine sulfate	Plaquenil	Antimalarial, antiarthritic
Lamotrigine	Lamictal	Anticonvulsant
Levodopa	Dopar, Larodopa	Anti-Parkinson's
Lithium carbonate	Eskalith, Lithobid, Lithotabs	Antimanic
Mesalamine	Asacol, Pentasa, Canasa, Rowasa	Anti-inflammatory
Metformin	Glucophage	Oral hypoglycemic
Methotrexate	Rheumatrex	Antineoplastic, antipsoriatric, antiarthritic
Methylphenidate HCL	Ritalin, Concerta	Anti-ADHD, anti-narcolepsy, stimulant
Naltrexone HCL	ReVia	Alcohol abuse deterrent, narcotic antagonist
Orlistat	Xenical	Weight control
Paroxetine	Paxil	Antidepressant, anti-OCD, antipanic disorder, social anxiety
Phentermine HCL	Adipex-P	Appetite suppressant
Pramipexole	Mirapex	Anti-Parkinson's, dopamine agonist
Quinidine gluconate	Quinaglute Dura-tabs, Quinidex extentabs, Quinora	Antiarrhythmic
Rivastigmine	Exelon	Anti-Alzheimer's, cholinesterase inhibitor
Ropinirole HCL	Requip	Anti-Parkinson's, dopamine agonist
Sertraline HCL	Zoloft	Antidepressant, anti-OCD, anti–panic disorder, anti-PTSD, SSRI
Sotalol	Betapace	Antiarrhythmic
Topiramate	Topamax	Anticonvulsant
Trazodone HCL	Desyrel	Antidepressant

Pharmaceutical name	Brand name	Classification of drug
Valproic acid	Depakene	Anticonvulsant, antimanic, anticonvulsant
Venlafaxine	Effexor	Antidepressant, Antianxiety

Lesson 3-J: Introduction to the Resident Assessment Instrument

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the components of the Resident Assessment Instrument (RAI).
- Recognize the elements of the Resident Assessment Protocol (RAP) review and required documentation.
- Review the care plan and identify whether the facility used the RAPs to make effective care plan decisions.

Lesson Plan

References

Federal

- State *Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix R, Resident Assessment Instrument for Long Term Care Facilities
- *Revised Long-Term Care Facility Resident Assessment Instrument User's Manual* at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage
- Minimum Data Set (MDS) forms
- *Code of Federal Regulations:*
  - 42 CFR 483.20, Resident Assessment and Care Plans
  - 42 CFR 483.25, Quality of Care

State

(Insert State reference[s] here.)

Other

Highlights

- Overview of the RAI process
- Using the RAI
- MDS items
- Procedure for completing the RAPs

Training Techniques

- Lecture
- Group discussion
- Small group exercise
- Gallery walk

Training Aids

- PowerPoint slides and handouts
- Pens or pencils—one per student
- Masking tape or tacks to post 8½" x 11" sheets of paper on the wall
- *State Operations Manual,* Appendix R
- *Revised Long Term Care Resident Assessment Instrument User's Manual*
- 42 CFR 483.20
- 42 CFR 483.25
- Form CMS-805, *Resident Review Worksheet*

- Handouts:
  - *Appendix R*
  - *MDS Manuals and Forms*
  - *OBRA Assessment Schedules*
  - *Significant Change*
  - *PPS Assessment Schedule*
  - *RAP Summary Sheet*
  - *Care Plan*
  - *MDS Balance*
  - *MDS Continence*
  - *RAP Process*
  - *Decision Making Documentation*
  - *Urinary Incontinence RAP*
  - *Care Planning*
  - *Self-Test*
- MDS forms

Methods of Evaluation

- Completion of skill assessment
- Observation of trainee performance
- Return demonstration

Audiovisual

Outline or text of presentation

(Preparatory work: have the students conduct an Internet scavenger hunt on the CMS website for, and print a copy of, SOM Appendix R, the Revised Long-Term Care Resident Assessment Instrument User's Manual, 42 CFR 483.20 and 25, Form CMS-805 (Resident Review Worksheet) and the MDS forms. Have them become familiar with the links to all segments of the Revised Long-Term Care Resident Assessment Instrument User's Manual (RAI Manual).)

Lesson 3-J:
Introduction to the Resident Assessment Instrument

1

Slide 3-J-1

Knowledge of the Resident Assessment Instrument (RAI) is essential to understanding and application of the long-term care survey process. This lesson introduces key concepts regarding the RAI.

The RAI is the tool used to assess the condition of nursing home residents in order to identify care needs and develop a plan of care.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the components of the Resident Assessment Instrument (RAI).
- Recognize the elements of the Resident Assessment Protocol (RAP) review & required documentation.
- Review the care plan & identify whether the facility used the RAPs to make effective care plan decisions.

2

Slide 3-J-2

(Inform the students of the objectives.)

Audiovisual

The RAI Manual

- Location: www.cms.hhs.gov/medicaid/mds20
- Related links
- Table of contents

3

Slide 3-J-3

Outline or text of presentation

Appendix R of the *SOM* introduces the RAI concept.

(Refer the students to the handouts "Appendix R" and "MDS Manuals and Forms" on pages 3-J-19 to 3-J-21. Review the table of contents of the RAI Manual, giving a brief overview of the manual.)

Chapter 1: RAI

- Overview of RAI
- Three basic elements
- Use of RAI
- Manual
- Basis for RAI
- State designation

4

Slide 3-J-4

Chapter One of the RAI Manual

(Have the students turn to Chapter One of the RAI Manual. Review and discuss each section.)

Let's start by reading and discussing information regarding the RAI. It is important to have a good understanding of the process the facility follows.

1.1 "Overview of the RAI"
The problem identification model is central to the RAI.

1.2 "Content of the RAI for Nursing Facilities"
The RAI consists of three basic elements:
1. Minimum Data Set (MDS).
2. Resident Assessment Protocols (RAPs).
3. Utilization Guidelines.

1.3 "Additional Uses of the MDS"
Information from the MDS is used for payment purposes and is gathered into a national database. Lesson 3-B introduces the use of this information in the survey process. MDS data is also used to generate information posted on *Nursing Home Compare*, a CMS website.

Audiovisual

Chapter 1: RAI (cont.)

- Privacy of data
- MDS components
- Applicability to residents
- Facility responsibility
- Completing RAI
- Information sources for MDS

5

Slide 3-J-5

Outline or text of presentation

1.4 "Suggestions for the Use of This Manual"
The RAI Manual was prepared for the use of nursing home staff. Because the RAI information is so important to the survey process, the surveyors must have a working knowledge of the RAI.

1.5 "Clarifications and Revisions to the Manual"
Surveyors should be aware of the CMS website that provides updates and answers to frequently asked questions regarding RAI:
http://www.cms.gov/medicaid/mds20.

1.6 "Statutory and Regulatory Basis for the RAI in Nursing Facilities"
The Social Security Act, amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 97), required the establishment of a system of resident assessment. The Federal regulations are found at 42 CFR 483.20.

1.7 "State Designation of the RAI for Nursing Facilities"
CMS must approve each State's RAI. The three basic elements must be included.

1.8 "Protecting the Privacy of MDS Data"
The RAI is part of the clinical record and must be protected as such. Because the RAI information is to be used during the survey process, the surveyors do have access to this personal, resident-specific data.

1.9 "The Components of the MDS"
Refer to the sample MDS as you read all of this section.

Audiovisual

Outline or text of presentation

1.10 "Applicability of RAI to Facility Residents"
The long-term care facility must use the RAI for any resident who occupies a bed that is *certified* by either Medicare or Medicaid. The RAI must be used regardless of the payment method for the resident's stay in the facility.

1.11 "Facility Responsibilities for Completing Assessments"
This section has specific information for newly-certified facilities, change in ownership and transfers of residents.

1.12 "Completion of the RAI"
Appropriate health professionals, as determined by the facility, should participate in the completion of the RAI. The registered nurse (RN) who signs and certifies the assessment must coordinate the process.

1.13 "Sources of Information for Completion of the MDS"
The facility must use various sources to gather information for the MDS. Usually this includes the clinical record, observation of the resident, and communication with the resident, caregivers, family, health-care professionals and the physician.

Chapter 1: RAI (cont.)

- Documentation
- Time frames
- Attestation
- Corrections
- Maintenance

6

Slide 3-J-6

1.14 "CMS Clarification Regarding Documentation Requirements"
The resident's clinical record should support information in the MDS.

1.15 "RAI Completion Time Frames"
Each person who completes a portion of the MDS must sign and date the MDS, designating the section completed. This must be done prior to the date the certifying RN signs the MDS.

Audiovisual

Outline or text of presentation

1.16 "Attestation Statement of Accuracy"
In signing the MDS, each person is certifying the accuracy of his/her noted sections. Each person is subject to penalties for falsifying information.

1.17 "Correcting the MDS"
Errors in the MDS input may be corrected following specific procedures. These corrections are not made as a result of changes in a resident's status.

1.18 "Reproduction and Maintenance of the Assessments"
A copy of an MDS completed during the last 15 months must be kept in the clinical record.

Chapter 2: Using RAI

Assessment:
- Assessment reference date (ARD)
- MDS time frames

7

Slide 3-J-7

Chapter Two of the RAI Manual, "Using the RAI"

(Refer to pages 2-1 and 2-2 of the RAI Manual (handout "OBRA Assessment Schedule" on pages 3-J-25 and 3-J-26).)

Assessment reference date (ARD)
The staff person or persons who coordinate the RAI process first determine the assessment reference date. This is the last date of the time period that individuals use to assess the resident. Everyone completing portions of the MDS must use the same time period for observation of that specific resident. Thus the information on the MDS relates to the resident's status at a particular point in time.

MDS time frames
Most residents must have an admission MDS completed within 14 days of admission. Then a briefer MDS is completed quarterly. On an annual basis, the facility completes a full MDS.

Audiovisual	Outline or text of presentation
	The complete RAI must also be conducted for a significant change in the resident's condition, or a significant correction of a full assessment. *(Refer students to pages 2-7 through 2-9 of the RAI manual (regarding significant change). Read the box on page 2-7 and the guidelines on page 2-8 (handout "Significant Change" on page 3-J-27).)* When Medicare pays for a resident's stay, more complex time frames are followed when completing the MDS. The Prospective Payment System (PPS) currently followed by Medicare for skilled nursing facilities uses MDS data to calculate payment structures. The facility must generally complete a full MDS on the resident's 5th, 14th, 30th, 60th and 90th day after admission, so several MDSs should be available for the surveyor to review. Consider choosing one that had accompanying RAPs, as this RAI may provide more information. *(Refer students to page 2-27 of the RAI Manual (handout "PPS Assessment Schedule" on page 3-J-31).)* The RAI Manual contains much more information about timing of the MDS (see chapter six of the manual), but our purpose is a general overview.

Audiovisual

Chapter 2: Using RAI (cont.)

RAPs & care plan:
- RAP summary
- Care plan

8

Slide 3-J-8

Outline or text of presentation

The RAPs and Care Plan

(Refer students to section V of the MDS (handout "RAP Summary Sheet" on page 3-J-33).)

RAP summary
Once the MDS is completed, the facility can either manually complete the RAP summary or have a computer do it. Information at the top of the form requires the facility to provide supporting documentation for the RAI.

(Refer the students to the information regarding documentation on the RAP Summary.)

Certain items in the MDS will "trigger" a RAP problem area. These 18 areas are listed along the left side of the form. Each RAP has been identified as potentially significant for a large number of long-term care residents.

(Refer the students to each RAP listed.)

Care plan
In order to complete the RAP Summary, the facility team must decide whether or not to develop a care plan for a triggered area.

(Refer the students to pages 2-19 and 2-20 of the RAI Manual (handout "Care Plan" beginning on page 3-J-35).)

Audiovisual

Chapter 3: MDS Items

- Each section is:
  - Named
  - Lettered
- Each section has subparts that are numbered & lettered
- Each box is completed based on directions or information provided for box

9

Slide 3-J-9

Discussion

- Balance
- Incontinence

10

Slide 3-J-10

Outline or text of presentation

Chapter Three of the RAI Manual, "MDS Items"

Each section of the MDS addresses a major area.

(Refer the students to the MDS items in their printout of the MDS Manual that would be used for a full assessment, pointing out the following:

- *Each section is:*
  - *Named.*
  - *Lettered (A., B., etc.).*
- *Each section has subparts that are numbered and lettered.*
- *Each box is completed based on directions or information provided for the box.)*

This chapter of the RAI Manual includes very specific instructions for completing each item. For example, the manual has an explanation for how to assess the resident's balance.

(Refer the students to the balance portion of section G on the MDS (RAI Manual starting page 3-102 and Appendix R). (The section of the RAI Manual is included as handout "MDS Balance" on page 3-J-37). Have the students practice assessing balance, using the RAI instructions.)

As a surveyor, you use the information in the MDS to direct much of your activity and decisions. You should become familiar with each MDS section. In order to avoid false assumptions regarding this data, know what the information means.

Audiovisual

Outline or text of presentation

(Refer students to Section H, "Continence in Last 14 Days," on page 3-119 of the manual (handout "MDS Continence" beginning on page 3-J-43). Discuss how our assumptions could be misleading. For example, refer to the top of page 3-120 for the discussion of what an episode of incontinence is.)

Chapter 4: Procedures for Completing RAPs

- Page 4-5, summary of RAP process
- Page 4-10, documentation of decision making
- Page C-39, sample triggers and guidelines
- Care plans—Sections 4-11 & 4-12

11

Slide 3-J-11

Chapter Four of the RAI Manual, "Procedures for Completing RAPs"

This chapter presents detailed information about the RAPs and the care planning process.

Page 4-5 *(handout "RAP Process" on page 3-J-51)* includes a summary of the RAP process. The RAP is one method the facility is required to use to comprehensively assess the resident in particular areas. RAP documentation is required for all areas triggered from the MDS. However, a RAP is written only for selected areas and may not include all the areas where the facility must comprehensively assess the resident's needs.

In your review of a resident's RAI, look for the facility's documentation of its decision-making process. Section 6 of Chapter Four addresses this issue in depth and includes some examples. Key elements are listed on page 4-10 *(handout "Decision Making Documentation" on pages 3-J-53)*.

Each protocol has lists of background information; items from the MDS that trigger the use of the RAP; and information on factors that can cause, contribute to or exacerbate the triggered condition.

Audiovisual	Outline or text of presentation
	Let's discuss the Urinary Incontinence RAP. *(Refer to page C-39 (handout "Urinary Incontinence RAP" on page 3-J-55). Review the triggers and guidelines, referring the students to the indicated sections of the MDS.* *Discuss the RAP, emphasizing an individualized approach to a specific resident's condition and full consideration of each causal factor for the resident.)* Care planning is a key step in the RAI process. The care plan should reflect the resident's needs as determined by other steps in the RAI process. Sections 4-11 and 4-12 include detailed information regarding care planning. *(Review these sections (handout "Care Planning" beginning on page 3-J-57).)* The surveyor should become familiar with the resident's care plan. During the information-gathering portion of the survey process, validate the accuracy of that information through observations and interviews. Does the resident's care plan effectively address the issues identified by the RAI process? If you find problems with the RAI, interview the RAI coordinator regarding the facility's system for conducting the RAI assessment or process and any specific issues you have identified. Provide examples of the issues.

Audiovisual

Lesson 3-J:
Introduction to the Resident Assessment Instrument

Questions

12

Slide 3-J-12

Outline or text of presentation

(To check understanding and allow students to practice:

- *Have the students use the handout Self-Test on page 3-J-67. Have them work individually, then pair up and compare answers for questions A and B.*
- *Have students post their answers for question C of the self-test on the wall and give the students time for a "gallery walk" to view others' approaches.*
- *Have the students retrieve their papers and discuss answers for question C as a class.)*

Skill Assessment

Introduction to the Resident Assessment Instrument

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described the components of the Resident Assessment Instrument.	
					Recognized the elements of the Resident Assessment Protocol (RAP) review and required documentation.	
					Reviewed the care plan and determined whether the facility used the RAPs to make effective care plan decisions.	

Comments/Recommendations:

Appendix R

State Operations Manual

Appendix R - Resident Assessment Instrument for Long-Term Care Facilities - (Rev. 1, 05-21-04)

Introduction

Sections 1819(f)(6) and 1919(f)(6) of the Social Security Act (the Act) require that the Secretary specify a minimum data set (MDS) of core elements and common definitions for use by long-term care facilities in conducting comprehensive assessments of residents residing in long-term care facilities. These sections also require the Secretary to establish guidelines for the use of these data elements. These utilization guidelines consist of instructions for using the Resident Assessment Instrument (RAI) and include the resident assessment protocols (RAPs). Furthermore, the Secretary is required to designate one or more RAIs that are consistent with the MDS and common definitions. A State may specify the RAI designated by the Secretary for use in conducting assessments, or it may develop an alternate RAI provided it is approved by the Secretary as being consistent with the MDS of core elements, common definitions and utilization guidelines. CMS' original RAI was published in 1990 and implemented in all States by 1991. CMS subsequently undertook a collaborative process to revise the RAI, which culminated in the release of version 2.0 of the RAI.

CMS requires the use of the September 2000 update of version 2.0 of the RAI (or an approved alternate) by all States. Each State's RAI must consist of at least CMS' September, 2000 RAI. Any State-specific items are included in an optional Section S; States may also specify the standardized, optional sections T and U as part of their RAI.

CMS' RAI consists of:

- MDS Version 2.0 (with or without optional Sections S, T, U)
  - Resident Assessment Protocols (RAPs)
- Utilization Guidelines

Under the SNF PPS requirements, facilities must complete Section T for residents in a Medicare Part A covered stay each time an MDS is required for Medicare payment purposes.

The revised Long-Term Care Resident Assessment Instrument User's Manual , Version 2.0, December 2002 including the August 2003 updates is located on the CMS website. http://www.cms.hhs.gov/medicaid/mds20.

MDS Manuals and Forms

U.S. Department of Health & Human Services www.hhs.gov

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Nursing Home Quality Initiatives

Overview
Highlights
Quality Measures
MDS 2.0
MDS 3.0

MDS 2.0

MDS 2.0 Manuals and Forms

December 2002 Revised Long Term Care Resident Assessment Instrument (RAI) User's Manual for the Minimum Data Set (MDS) Version 2.0

Highlights

1. **January 2006 revisions to the MDS 2.0 RAI User's Manual** are available below in the **Downloads** section.
2. **Satellite Broadcast & Webcast on Nursing Home Immunization**: Thank you to everyone who participated in and viewed our CMS live webcast/broadcast shown on September 8, 2005! If you missed this very important program you can still view it at: http://cms.internetstreaming.com until August 31, 2006.

Description of MDS 2.0 RAI User's Manual: The December 2002 Revised Long Term Care RAI User's Manual for the Minimum Data Set (MDS) Version 2.0 replaced CMS's original Long Term Care RAI User's Manual Version 2.0 published in October 1995.

This version and subsequent updates of the RAI\MDS manual incorporate clarifications to existing coding and transmission policy, integrate previously published Questions and Answers (Q&As) into the appropriate sections and address requested clarifications and scenarios concerning problem areas.

Please note that InterRAI holds the copyright to Version 2.0 of the RAI for long term care outside of the US. Therefore, this revised Version 2.0 of the RAI/MDS manual should not be reproduced outside of the United States without permission of InterRAI. Within the US, Version 2.0 is in the public domain.

The **updated files** for the **RAI User's Manual for MDS 2.0**, listed in the **Downloads** section below, include only the pages from the RAI manual with the affected changes and can be placed directly into your manual. If you wish to download an **entire updated chapter**, scroll down to the list of chapters below the updated files and **select the appropriate chapter**.

EFFECTIVE DATES: will be communicated to providers, state, regional offices and others as needed, through an e-mail notification.

Browse By Audience

Provider Center
Partner Center
More ...

Browse By Subject

Medicare Coverage
Intergovernmental Relations
More ...

MPAF Form with Section W Supplemental Items added

The new MDS Medicare PPS Assessment Form (see below in the Downloads section) will provide facilities with options concerning the form used for Medicare PPS assessments. To allow reduction in assessment burden, facilities can choose to complete and submit the shorter MPAF form rather than a full MDS assessment for Medicare PPS assessments.

The OBRA assessment requirements supercede the use of the abbreviated form. When assessments are completed for both OBRA reasons and PPS reasons, then all OBRA-required items, all PPS-required items, and any state-specific items (Section S) must all be submitted, with all required items being stored in the state MDS database. When assessments are PPS-only (no OBRA reason present), only the MPAF items and any state-specific items (Section S) will be active and stored in the state MDS database. If a facility submits a full assessment for PPS reasons only, the extra MDS items (that are not on the MPAF form) will not be edited and will not be stored in the state database.

A document providing more specific detail regarding submission issues (see below in the Downloads section) has been included. This is version 10 of this document (5/21/02). The only changes with version 10 are to correct the Medicare PPS reason for assessment values (AA8b) associated with Record-Type OM (bottom of page 1) and Record-Type AM (middle of page 2). For OM records, the appropriate values of AA8b are 1, 2, 3, 4, 5, 7, or 8. For AM records, the appropriate values of AA8b are 1, 5, 7, or 8.

Long Term Care Facilities User's Manual

The "**Long Term Care Facility User's Manual**", see below in the Downloads section , dated April 2000, is now available to download.

Downloads

January Update 2006 [PDF 654 KB]
December Update 2005 [PDF 219 KB]
November Update 2005 [PDF 1.7 MB]

MDS All Forms [PDF 1.1 MB]
RAI User's Manual Title Pages and Table of Contents [PDF 106 KB]
Chapter 1- Resident Assessment Instrument [PDF 217 KB]
Chapter 2 - The Assessment Schedule for the RAI [PDF 491 KB]
Chapter 3 - Item-by-Item Guide to the MDS [PDF 1.86 MB]
Chapter 4 - Procedures for Completing the RAP & Linking the Assessment to the Care Plan [PDF 524 KB]
Chapter 5 - Submission and Correction of the MDS Assessment [PDF 365 KB]
Chapter 6 - Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) [PDF 1.9 MB]
Appendices & Index [ZIP 2 MB]

Long Term Care Facility User's Manual [ZIP 3 MB]

MDS Medicare PPS Assesment Form [PDF 128 KB]
MPAF Submission Issues [PDF 105 KB]
Satellite Broadcast & Webcast on NH Immunization Agenda & Handouts [PDF 60 KB]

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OBRA Assessment Schedule

CHAPTER 2: THE ASSESSMENT SCHEDULE FOR THE RAI

This chapter presents the instructions for the completion of the mandated clinical and Medicare assessments in nursing facilities.

2.1 Introduction to the OBRA Assessment Schedule for the MDS

INTRODUCTION TO THE OBRA ASSESSMENT SCHEDULE

The OBRA regulations have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. These are known as "OBRA assessments." MDS assessments are also required for Medicare payment purposes and are discussed in detail in Section 2.6.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. It is important for facility staff to fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort.

OBRA ASSESSMENTS

When the resident is first admitted to a facility, the RN Assessment Coordinator (RNAC) and the interdisciplinary team will agree on a period known as the observation period for the Admission assessment. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified time periods such as 7, 14, or 30 days, the ARD is the common endpoint of these "look back" periods. This concept of setting the ARD is used for all assessment types. When completing the MDS, only those items that occurred during the look back period will be captured. In other words, if it did not occur during the look back period, it should not be coded on the MDS.

When all members of the team have completed their portions of the assessment and the assessment is complete, the RN Assessment Coordinator (RNAC) will sign Item R2a and will date Item R2b with the date that R2a was signed. The R2b date is the completion date for all assessment types that do not require RAPs, and is the date used to determine when the next OBRA assessment is to be completed. An OBRA assessment is due no less frequently than every 92 days.

Resident Assessment Protocols (RAPs) are reviewed following the completion of the MDS portion of the RAI for comprehensive assessments in order to identify the resident's strengths, problems, and

needs. This decision-making process is documented on the Resident Assessment Protocol Summary, which is detailed in Chapter 4.

The timing requirements for a comprehensive assessment apply to both completion of the MDS (R2b) and the completion of the RAPs (VB2). For example, an Admission assessment must be completed within 14 days of admission. This means that both the MDS and the RAPs (R2b and VB2 dates) must be completed by day 14. The MDS Completion Date (R2b) may be earlier than or the same as the RAPs Completion Date (VB2), and neither can be later than day 14.

The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (VB2). The care plan must be completed by the end of the 7th day following completion of the RAI assessment. In other words, 7 days following the VB2 date.

Assuming the resident does not have any significant changes in status or is not discharged from the facility, the next assessment in the OBRA assessment schedule is the Quarterly assessment. The Quarterly assessment is to be completed within 92 days of the R2b date of the Admission assessment. The OBRA schedule would continue with another Quarterly assessment to be completed within 92 days of the R2b of the previous Quarterly. A third Quarterly is completed within 92 days of the completion (R2b) of the previous Quarterly.

Following the third Quarterly, and within a year of the Admission assessment, an Annual assessment is completed. This is a comprehensive assessment that requires a full MDS with RAPs and care plan review.

This cycle (comprehensive assessment – Quarterly – Quarterly - Quarterly assessment - comprehensive assessment) would repeat itself annually for a resident who never experienced a significant change or discharge.

However, residents do experience significant changes, are discharged and are readmitted to facilities. Therefore, OBRA regulations have defined a comprehensive assessment that a facility completes in the event of a significant change in status that includes RAP review and care plan revision. When a resident is discharged from a facility, a Discharge Tracking form may be required. When a resident who was discharged returns to a facility, a Reentry Tracking form may be required. When a resident is readmitted to the hospital and an OBRA-required assessment is due during the resident's absence, the facility has up to 14 days after the resident's readmission to complete the assessment. If the assessment that was due during the resident's absence was the initial Admission assessment, see page 2-4. If a significant change is identified on readmission, the significant change assessment would replace the assessment that was due while the resident was in the hospital. (Error messages will result from the late assessment but can be ignored.) The Significant Change in Status assessment, and the Discharge and Reentry Tracking forms, including their impact on the assessment schedule are discussed in more detail later in this chapter.

A comprehensive assessment is also required when the facility has identified a major error in a previously submitted comprehensive assessment. A Significant Correction of a Prior Full assessment (SCPA) must be completed within 14 days of the identification of the error. A major error is one where the resident's overall clinical status is not accurately represented on the MDS, has not been addressed in a subsequent assessment, nor addressed in the resident's care plan. Because this is a comprehensive assessment, completion of the full MDS, RAPs and the RAPs Summary is required.

Significant Change

SIGNIFICANT CHANGE IN STATUS ASSESSMENTS (SCSA)-Comprehensive Assessment

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident's condition they should share this information with the resident's physician, who they may consult about the permanency of the change. The facility's medical director may also be consulted when differences of opinion about a resident's status occur among team members.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. A Significant Change in Status (SCSA) assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred.

An SCSA can be performed at any time after the completion of the Admission assessment. If a significant change in status is identified in the process of completing a Quarterly assessment, code the assessment as a SCSA and complete a comprehensive assessment. Do not code it as a Quarterly assessment. The SCSA restarts the schedule and the next Quarterly assessment would be due no more than 92 days from R2b of the SCSA. Similarly, if an SCSA is identified in the process of completing an Annual assessment, it should be coded as an SCSA.

A "**significant change**" is a decline or improvement in a resident's status that:

1. **Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting"**
2. **Impacts more than one area of the resident's health status; and**
3. **Requires interdisciplinary review and/or revision of the care plan.**

A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a "significant change" reassessment. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff should begin a comprehensive RAI assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a significant change reassessment, unless a second area of decline accompanies it. Note that this answer assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and if the problem persists or worsens, a comprehensive RAI reassessment may be clinically indicated.

If there is only one change, however, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique and the interdisciplinary treatment team must make the decision as to whether or not the resident will benefit from an RAI.

Other conditions may not be permanent but would have such an impact on the resident's overall status that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through the RAI reassessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent," but a change does not necessarily need to be both major and permanent.

An SCSA is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement). Any determination about whether or not a resident has experienced a significant change in status is a clinical decision. When a SCSA is completed, the facility must review all of the RAPs because they are interrelated. If there are no changes in a RAP, they can then document that there were no changes and bring that RAP forward and specify where the supporting documentation can be located in the medical record.

GUIDELINES FOR DETERMINING SIGNIFICANT CHANGE IN RESIDENT STATUS (Please note this is not an exhaustive list.)

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the clinical staff and the guidelines shown below.

Decline in two or more of the following:

- Resident's decision-making changes from 0 or 1 to 2 or 3 for Item B4;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2);
- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1"s for Item E4B);

- Any decline in an ADL physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) for Item G1A;
- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 (Item H1a or b), or there was placement of an indwelling catheter (Item H3d);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (Item K3a);
- Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher (Item M2a);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (Items P4c and e);
- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making) (Item Q2 = 2);
- Emergence of a condition or disease in which a resident is judged to be unstable (Item J5a).

EXAMPLE

Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change and reassessment is required since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Mr. T's behavioral symptoms could have many causes, and reassessment will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (Item G1A);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (Items E2 and E4B);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (Item B4);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (Item H1a or b);
- Overall improvement of resident's condition; resident receives fewer supports (Item Q2 = 1).

PPS Assessment Schedule

2.5 The SNF Medicare Prospective Payment System Assessment Schedule

Nursing facilities will assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care. The MDS must be completed in compliance with the Medicare schedule as shown in the chart below.

Medicare MDS Assessment Type	Reason for Assessment (AA8b code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 Day	1	Days 1-5*	6 - 8	14	1 through 14
14 Day	7	Days 11-14	15 - 19	16	15 through 30
30 Day	2	Days 21-29	30 - 34	30	31 through 60
60 Day	3	Days 50-59	60 - 64	30	61 through 90
90 Day	4	Days 80-89	90 - 94	10	91 through 100

*If a resident expires or transfers to another facility before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. Otherwise, the days will be paid at the default rate. The Assessment Reference Date must also be adjusted to no later than the date of discharge.

+Grace Days: A specific number of grace days (i.e., days that can be added to the Medicare assessment schedule without penalty) are allowed for setting the Assessment Reference Date (ARD) for each scheduled Medicare assessment.

The Medicare assessment schedule includes a 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessment. The first day of Medicare Part A coverage is considered Day 1. In most cases, the first day of Medicare Part A eligibility is also the date of admission. However, there are situations where the Medicare beneficiary may only become eligible for Part A services at a later date. See Section 2.9 for more detailed information.

Assessments must also be completed whenever there is a significant change in clinical status or when all therapies are discontinued for a beneficiary who is classified in a RUG-III Rehabilitation group, and that beneficiary continues to require skilled services.

A Readmission/Return assessment must be completed when a beneficiary who was receiving Part A SNF-level services is hospitalized and returns to the SNF and continues to receive Part A SNF-level services.

Assessments performed solely for Medicare payment purposes must be completed within 14 days of the Assessment Reference Date (ARD). The Assessment Reference Date establishes a common reference end-point for all items. The Assessment Reference Date is described in detail in Chapter 3. Nursing facility staff should make every effort to complete assessments in a timely

RAP Summary Sheet

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier _____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     — Complications and risk factors that affect your decision to proceed to care planning.
     — Factors that must be considered in developing individualized care plan interventions.
     — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ – ☐☐ – ☐☐☐☐ (Month Day Year)

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ – ☐☐ – ☐☐☐☐ (Month Day Year)

MDS 2.0 September, 2000

Care Plan

FORMULATION OF THE CARE PLAN

For an Admission assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The MDS and RAPs provide the clinician with additional information to assist in this preliminary care planning process. The MDS ensures that staff has timely access to a wide range of assessment data. The RAPs provide criteria that trigger review of possible problem conditions to ensure that staff identifies problems in a consistent and systematic manner. Use of the RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission MDS is not completed until the last date possible (i.e., at the end of calendar day 14 of the residency period), interventions will already have been implemented to address priority problems. Many of the appropriate RAP problems will have been identified, causes will have been considered, and a preliminary care plan initiated. The final care plan is then required no later than 7 days after the RAI assessment is completed.

For triggered problems that have already resulted in a care plan intervention, the final RAP review will ensure that all causal factors have been considered. For RAP conditions for which facility staff has not yet initiated a care program, the RAP review will focus on whether or not these conditions are, in fact, problems that require facility intervention. For any triggered problem, staff will apply the RAP Guidelines to evaluate the resident's status and determine whether or not a situation exists that warrants care planning. If it does, the RAP Guidelines will next be used to help identify the factors that should be considered for developing the care plan.

For an Annual reassessment or a Significant Change in Status assessment, the process is basically the same as that described for newly admitted residents. In these cases, however, the care plan will already be in place, and staff is unlikely to be actively instituting a new approach to care as they simultaneously complete the MDS and RAPs. Here, review of the RAPs when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the RAP may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

Clarification: ◆ The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" at MDS

Item K1a. Although the resident might have a chewing problem, checking this problem does not trigger a RAP. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered RAPs. Another example of this is "side rails" at MDS Item P4. Although the resident may use side rails, this item does not automatically trigger a RAP.

CARE PLAN COMPLETION

Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident's care plan. The RN coordinator should sign and date the RAP Summary form after all triggered RAPs have been reviewed to certify completion of the comprehensive assessment (RAPs Completion Date, VB1 and VB2). Facilities should use this date to determine the date by which the care plan must be completed.

The 7-day requirement for completion or modification of the care plan applies to the Admission, Significant Change in Status, Significant Correction of a Prior Full assessment, or Annual RAI assessment. A new care plan does not need to be developed after each SCSA, Significant Correction of a Prior Full assessment, or Annual reassessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each Quarterly assessment and modify the care plan if necessary. (See Chapter 4 for more information on care planning.)

Clarification:

- The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool. Review 42 CFR 483.20(d), Comprehensive Care Plans. The comprehensive care plan must include measurable objectives and time frames, and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care. Refer to the SOM Transmittal #274, (F Tag 279), "The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care."

MDS Balance

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bathing		
Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely.	3	2
Resident afraid of mechanical lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.	3	2
For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. ***Rationale:*** The coding directions for bathing state, "code for most dependent in self performance and support."	4	2

G3. Test for Balance (7-day look back)

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

Intent: To record the resident's capacity of **a.** Balance while standing (not walking) without an assistive device or assistance of a person, and **b.** Balance while sitting **without using the back or arms of the chair for support.**

Process **a. Balance While Standing**

Preparation:

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later. In approaching a resident for a balance test, staff should provide privacy and an explanation. The resident may, of course, decline the test, but the

- facility should attempt to determine why the resident is refusing. Since this would affect the MDS response, it seems worthy of a short notation, which may be written directly on the MDS form. Surveyors will accept individual residents declining to participate, but will probably be suspicious if an untoward number of residents decline participation in this test.

- Place a chair directly behind the resident in case the resident needs to sit down.

- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.

- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the tests:

- **DO** each of the following tests (10 seconds each) on residents who are able to stand without physical help.

- **DO NOT** attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.

- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

Position 1 -

"I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]

"Do not move your feet until I say stop. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 2. **If the resident is NOT ABLE to maintain this position for 10 seconds, stop testing here.** Do not proceed with Position 2 for balance testing.

Position 2 -

"Now I would like you to stand with one foot halfway in front of the other like this" (demonstrate as illustrated).

"You may use either foot, whichever is more comfortable for you. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 3. **If the resident is NOT ABLE to do this, stop testing here.**

Position 3 -

"Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin."

Coding:

0. **Maintained Position as Required in Test** - Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.

1. **Unsteady, but Able to Rebalance Self Without Physical Support** - Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2. **Partial Physical Support During Test, or Stands but Does Not Follow Directions for Test** - While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to stand without physical help from another person or an assistive device.

Examples of Balance Testing

Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin."

Results: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

How to proceed: Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

Coding: "1", Unsteady, but able to rebalance self without physical support.
Rationale: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if her were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

Results: During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

How to proceed: STOP the test.

Coding: "2", Partial physical support during test or stands, but does not follow directions for test.

Rationale: This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

How to proceed: DO NOT perform any standing balance tests. Ms. M cannot stand.

Coding: "3", Not able to attempt test without physical help.

Process: **b. Balance while sitting - position, trunk control**

Preparation:

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test:

- DO NOT attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

Coding:

0. **Maintained Position as Required in Test** - Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.

1. **Unsteady, but Able to Rebalance Self Without Physical Support** - Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.

2. **Partial Physical Support by Others During Test or Sits but Does Not Follow Directions for Test** - While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support from other(s) or from touching the backs or sides of the chair for support. This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support." You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

How to proceed: Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

Coding: "0", Maintained position as required in test.

G4. Functional Limitation in Range of Motion (7-day look back)

(A) Limitation in Range of Motion.

Intent: **Limitation in the Range of Motion**: To record the presence of (A) functional limitation in range of joint motion or (B) loss of voluntary movement.

Definition: Limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

Process: **Assessing for Functional Limitations:** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

MDS Continence

SECTION H.
CONTINENCE IN LAST 14 DAYS

H1. Continence Self-Control Categories (14-day look back)

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days. The 14-day period allows many opportunities for assessment, but it is acceptable to establish voiding patterns in shorter periods of time.

Intent: To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

Definition: **(a.) Bowel Continence** and **(b.) Bladder Continence**

Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self - e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in Item G1Ai.

Process: Review the resident's clinical record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private. Control of bladder function and bowel function are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

- Determination of whether or not to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown. According to Dr. Courtney Lyder, Ph.D. a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure

needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure may be required to develop an ulcer." Coding incontinence is a matter of acknowledging and recording a resident's incontinence problem on the assessment, and ensuring that the care plan derived from the assessment addresses the problem. If the resident's skin gets wet with urine, or if whatever is next to the skin (i.e., pad, brief, underwear) gets wet, it should be counted as an episode of incontinence - even if it's just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care plan. In addition, since incontinence is a problem that many residents are sensitive about, intervention involves maintaining dignity and life-style.

- Validate continence patterns with people who know the resident well (e.g., primary family caregiver of newly admitted resident; direct care staff).

- Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information as a basis for coding decisions and, ultimately, care planning.

- The keys to obtaining, tracking and recording accurate information in this section are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

  - Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.

  - Focus your assessment over the last 14 days. When getting information about continence from CNAs, start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code "0" (Continent). If the resident is always wet, and has no control, code "4" (Incontinent). If incontinence occurs only once a week or less, code "1" (Usually continent). The difference between code "2" (Occasionally incontinent), and code "3" (Frequently incontinent) is that for code "3", the resident is incontinent at least daily or multiple times a day.

Coding: A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more

episodes of urination per day and week, whereas bowel movements typically occur less often.

0. **Continent** - Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

1. **Usually Continent** - Bladder, incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.

2. **Occasionally Incontinent** - Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.

3. **Frequently Incontinent** - Bladder incontinent episodes tend to occur daily, but some control is present (e.g., on day shift); Bowel incontinent episodes occur two to three times per week.

4. **Incontinent** - Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern - i.e., the frequency with which the resident is wet and dry during the 14-Day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

To ensure accurate coding in H1a and H1b, assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

Examples of Bladder Continence Coding

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent" - Bladder.**

Mr. R had an indwelling catheter in place during the entire 14-Day assessment period. He was never found wet and is considered continent. **Code a "0" for "Continent" - Bladder.**

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent" - Bladder.**

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent" - Bladder.**

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent" - Bladder.**

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. **Code "4" for "Incontinent" - Bladder.**

H2. Bowel Elimination Pattern (14-day look back)

Intent: To record the effectiveness of resident's bowel function.

Definition:

a. **Bowel Elimination Pattern Regular** - Resident has at least one movement every three days.

b. **Constipation** - Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

c. **Diarrhea** - Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

d. **Fecal Impaction** - The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on an abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

e. ***NONE OF ABOVE***

Process: Ask the resident and examine the resident, if necessary; review the clinical record, particularly any documentation on flow sheets of bowel elimination patterns; and consult with direct care staff (e.g., nurse assistants from all shifts).

Coding: Check all that apply in the last 14 days. If no items apply, check *NONE OF ABOVE*.

Clarification:

- The distinction between constipation and fecal impaction has usually been the effort it takes for the resident to have a bowel movement. Most constipation will pass without manual extraction through the use of laxatives, enemas, high fiber diets, and other remedies. In constipated residents, many times just doing a digital exam will stimulate the bowel enough to move the stool.

  On the other hand, fecal impaction may require a digital rectal exam to physically break the hard stool mass into smaller parts and remove them manually. Follow-up enemas may be given to move stool higher in the bowel. Residents with fecal impactions may present with other symptoms such as fever, acute abdomen (pain, cramping, swollen abdomen), nausea, vomiting, and thin watery discharge from the rectum (a sign liquid stool is passing around the hard mass of stool).

  According to Dr. Peter Toth, MD, Ph.D. in an article entitled "Gastroenterology: Constipation and Fecal Impaction" in the University of Iowa Family Practice Handbook, 4th Edition, Chapter 5, a fecal impaction is "a firm, immobile mass of stool most often in the rectum but may also occur in the sigmoid or descending colon." It is also possible for stools to pass around an impaction. Item H2d must be checked whenever a fecal impaction was present during the 14-Day assessment period, regardless of how the determination was made (e.g., digital rectal examination, x-ray, CAT scan or other method). In the presence of symptoms of fecal impaction, the facility is obligated to determine whether or not the resident is, in fact, impacted, and to provide appropriate treatment. Information regarding the article can be found at: **http://www.vh.org/providers/clinref/FPhandbook/outline.html**.

H3. Appliances and Programs (14-day look back)

Definition:

a. **Any Scheduled Toileting Plan** - A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

b. **Bladder Retraining Program** - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

c. **External (Condom) Catheter** - A urinary collection appliance worn over the penis.

d. **Indwelling Catheter** - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

e. **Intermittent Catheter** - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder-emptying program (e.g., every shift in a resident with an under active or a contractile bladder muscle).

f. **Did Not Use Toilet Room/Commode/Urinal** - Resident never used any of these items during the last 14 days, nor used a bedpan.

g. **Pads/Brief Used** - Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

h. **Enemas/Irrigation** - Any type of enema or bowel irrigation, including ostomy irrigations.

i. **Ostomy Present** - Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.

j. ***NONE OF ABOVE (Not Used on the MPAF)***

Process: Check the clinical record. Consult with the nurse assistant and the resident. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).

Coding: Check all that apply. These items should be coded if a resident has, or has had any of the items during the 14-day observation period. Items that were in use during the observation period but were discontinued should be included. For example, if the resident had an indwelling catheter at the beginning of the observation period and it was later discontinued, the indwelling catheter would be coded. If none of the items apply, check *NONE OF ABOVE*.

Clarifications:

- There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void.

  If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

  For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting program.

  Feeding tubes/gastrostomies are coded in Sections K and P. Only appliances used for elimination are coded here.

H4. Change in Urinary Continence (90 days ago)

Intent: To document changes in the resident's urinary continence status as compared to 90 days ago (or since the last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. This item asks for a snapshot of "today" as compared to that of 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

Coding: Code "**0**" for No change, "**1**" for Improvement, or "**2**" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. A resident who was continent 90 days ago is on a bladder retraining program, but is leaking urine during the new observation period would be coded deteriorated (2).

Examples of Change in Urinary Continence

During an outbreak of gastroenteritis at the nursing facility six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.** ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

RAP Process

Rather, facility staff should be creative and experiment until they find "what works" most efficiently and effectively for them in achieving the desired outcome (i.e., a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident).

The RAP process includes the following steps:

1. Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary form.

2. Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information, including items not automatically triggered, as needed, to determine the nature of the problem and understand the causes specific to the resident.

3. Staff documents key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:

   - Nature of the condition (may include presence or lack of objective data and subjective complaints).

   - Complications and risk factors that affect the staff's decision to proceed to care planning.

   - Factors that must be considered in developing individualized care plan interventions. Include appropriate documentation to justify the decision to care plan or not to care plan for the individual resident.

   - Need for referrals or further evaluation by appropriate health professionals.

   Documentation about the resident's condition should support clinical decision-making regarding whether or not to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

   The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

4. Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention.

5. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

Decision Making Documentation

4.6 Decision-Making and Documentation of the RAP Findings (RAP Process - Steps 3 and 4)

It is recommended that staff who have participated in the assessment and who have documented information about the resident's status for triggered RAPs be a part of the interdisciplinary team that develops the resident's care plan. The team, including the resident, family or resident representative, makes the final decision to proceed to address the "triggered" condition on the care plan.

In order to provide continuity of care for the resident and good communication to all persons involved in the resident's care, it is important that information from the assessment that led the team to their care planning decision be clearly documented.

It is not necessary to record all of the items referred to in the RAP Guidelines, listing all factors that do and do not apply. Rather, documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident's daily functioning?
- Why did you decide the resident is at risk, or that improvement is possible, or that decline can be minimized?
- How could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

Or, for triggered conditions that do not warrant care planning:

- Why did you determine that the triggered condition is not a problem for the resident?

Written documentation of the RAP findings and decision-making process may appear anywhere in the resident's record. It can be written in discipline specific flowsheets, progress notes, in the care plan summary notes, in a RAP summary narrative, on a RAP questionnaire, etc. Facilities should use a format that provides the information as outlined in SOM #272. If it is not clear that a facility's documentation provides this information, surveyors should ask facility staff to provide such evidence. As stated in 482.20(b)(1)(xvii), "Documentation of participation in assessment: The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed staff members on all shifts."

No matter where the information is recorded, use the "Location and Date of RAP Assessment Documentation" column on the RAP Summary form to note where the RAP review and decision-making documentation can be found in the resident's record. Also indicate in the column "Care Plan Decision" if the triggered problem is addressed in the care plan.

Clarification: ◆ The RAP documentation requires information from the resident's assessment and staff's decision-making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired caregiver for this resident, will I be able to find and understand the assessment and decision-making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note.

While interpretations of CMS's requirements have varied, the RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed--RAPs guide further assessment of residents who have or are at risk of developing problems (triggered areas). This assessment is supposed to lend further insight into the problems identified by the MDS. RAP "documentation" involves only what should already be taking place, such as clearly written assessments, decision-making by staff knowledgeable about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.

What does clear documentation and decision-making mean? Decision-making is a written account of the team's clinical thought processes about the resident assessment findings. To accomplish this process, many people have searched for "user friendly" alternatives to RAP documentation. As a result, an industry of workbooks, flow sheets, checklists and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and made the process more complicated than necessary. Each facility should establish a documentation process that "works" for them and incorporate additional tools only if they are deemed of clear benefit in facilitating documentation and clinical decision-making.

Examples of Resident Assessment Documentation Using RAP Guidelines as a Framework:

The following examples illustrate different ways to document resident status information that the assessor(s) gleaned using RAP Guidelines. This documentation would be referenced by facility staff on the RAP Summary form under the "Location of Information" column, or it could be referenced in a RAP Summary note. Please note that these examples are not related to any particular resident or case example. Also, they are not related to one another. They merely depict samples of written notes.

EXAMPLE #1: This is an example of a note that substantiates the initiation of problem evaluation using RAP Guidelines.

Urinary Incontinence RAP

6. URINARY INCONTINENCE AND INDWELLING CATHETER RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Incontinence care plan suggested if one or more of following present:

Incontinent 2+ Times a Week
[**H1b = 2, 3 or 4**]
Use of External (Condom) Catheter
[**H3c = checked**]
Use of Indwelling Catheter
[**H3d = checked**]
Use of Intermittent Catheter
[**H3e = checked**]
Use of Pads/Briefs
[**H3g = checked**]

GUIDELINES

Possible reversible problems to be reviewed in evaluating incontinence or need for catheter:

- **Conditions:** Delirium [**B5**], Fecal Impactions [**H2d**], Depression [**I1ee**], UTI [**I2j**], Edema [**J1g**].
- **Environment:** Locomotion [**G1c,d,e,f**], Lack of access to toilet, Barriers [**observation**], Restraints [**P4**].
- **Diagnoses:** Diabetes [**I1a**], CHF [**I1f**], CVA [**I1t**], Parkinson's [**I1y**].
- **Medications:** Diuretics [**O4e**], Parkinson's meds, Disopyramide, Antispasmodics, Antihistamines, Drugs that stimulate or block sympathetic nervous system, Calcium channel blockers (verapamil, nifedipine, diltiazem), Narcotics [**from record**].
- **Psychoactive Medications:** Anti-psychotics, Antianxiety, Anti-depressants, Hypnotics, [**O4a,b,c,d**].

Other potential factors contributing to incontinence or use of catheter:

- **Conditions:** Pain [**J2**]; Excessive or inadequate urine output, Atrophic vaginitis, Cancer of bladder, prostate, brain, or spine, tabes dorsalis [**from record or exam**].
- **Abnormal Lab Values:** High blood calcium, High blood glucose, Low B_{12}, High BUN or Creatinine [**P9; from record**].

Final evaluation if incontinence persists:

- **Specific Tests:** Post Void Residual, bladder stress test for females, reflux test (kidney ultrasound for males with PVR>100 ml.) [**Note:** Tests not indicated when Comatose [**B1**] or when No memory recall [**B3e**] AND Dependent in Transfer, Locomotion [**G1b,c,d,e,f**] are both present].

Final evaluation for residents with indwelling catheters: If indwelling catheter [**H3d**], do Voiding Trial unless Untreatable urethral blockage [**I3**], terminal illness [**J5c**], or stage 3 or 4 pressure ulcer [**M2a**] present.

Care Planning

4.11 Overview of the RAI and Care Planning

Assessment (MDS/other) → Decision-Making (RAPs/other) → Care Plan Development → Care Plan Implementation → Evaluation

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This section provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review, which is carried out utilizing the Guidelines that have been developed for each RAP. Staff uses RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. After using the RAP Guidelines to assess the resident, the staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan. Conversely, the staff may decide that items that were not triggered do affect the resident's functioning or well-being and therefore should be addressed on the care plan.

The care planning process in long-term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident

by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well-being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision-making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.
2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.
3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.
4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Documentation may be done by

individual staff members who have completed assessments using the RAP Guidelines or who participated in care planning, or as a joint note by members of the interdisciplinary team.

5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.

6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of well-being. The resident's wishes should be documented in the clinical record.

7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

EXAMPLES

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.

9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.

10. The parts of the goal statement should include:

    The **Subject** - the **Verb** - **Modifiers** - the **Time frame**. See following example.

EXAMPLE

Subject	*Verb*	*Modifiers*	*Time frame*
Mr. Jones	will walk	up and down 5 stairs with the help of one nursing assistant	daily for the next 30 days.

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.

12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.

13. The final care plan should be discussed with the resident or the resident's representative.

14. The goals and their accompanying approaches are to be communicated to all direct care staff who were not directly involved in the development of the care plan.

15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

4.12 The Care Planning Process

The care planning process is based on good clinical practice and specified in the interpretive guideline probes for the care planning requirements at 42 CFR 483.20(k)(1) and (2). The appropriate **F Tags** have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in **Appendix P** of the State Operations Manual (SOM). The SOM can be found at the following web site: **http://www.cms.gov/manuals/pub%5F07.asp**.

The care plan must be oriented toward preventing avoidable declines in functioning or functional levels - F 279

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

Managing risk factors in the care plan - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

Addressing resident strengths in the care planning process - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

Utilizing current standards of practice in the care plan - F 281

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

Evaluating treatment objectives and outcomes of care in the care planning process - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline-in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

Respecting the resident's right to refuse treatment - F 279 and F280

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether or not they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how

a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

Offering alternative treatments - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff that has regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

Utilizing an interdisciplinary approach to care plan development to improve resident's functional abilities - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff is usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each member's contribution should be sought and valued.

Family and other resident representatives involvement in care planning - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality

of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this fact and that individual should be given the opportunity to participate in the assessment and care planning process.

Assessment and care planning sufficient for meeting the care needs of new admissions - F 281

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20(a) Tag F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident were incontinent of urine at the first admission, or newly incontinent at re-admission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

Involving the direct care staff with the care planning process relating to the resident's expected outcomes - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff has the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff

to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether or not specific program variations might be useful.

Additional care planning areas that could be considered in the long-term care setting - F 280

The following are six general care planning areas that are useful in the long-term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

1. **Functional Status**

   Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

2. **Rehabilitation/Restorative Nursing**

   A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative-nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

3. **Health Maintenance**

   Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

   The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

   Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

4. **Discharge Potential**

   Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before

the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

5. **Medications**

The facility must conduct initially and periodically a comprehensive assessment of a resident's needs including medications **(See 483.20(b)(1)(xiv))**. This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facility staff on a monthly basis.

It is the interdisciplinary team's decision whether or not medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications that may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

Many medications have been identified that are judged to place a person over the age of 65 at greater risk of adverse drug outcomes. These were identified in a paper published in the *Archives of Internal Medicine*, Vol. 157, July 28, 1997 entitled "Explicit Criteria for Determining Inappropriate Medication Use by the Elderly" by Mark H. Beers, M.D., and are outlined in the State Operations Manual, Appendix PP, Guidance to Surveyors, Tag F329, 42 CFR 483.25(1)(1). The interdisciplinary team will want to carefully review the use of any of these medications and care plan for possible side effects.

6. **Daily Care Needs**

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

Clarifications: ◆ For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. In most nursing facilities, the timing of such routines is fairly standardized. If that is not the case, then specific times should be noted. Good clinical practice dictates that any care plan be periodically evaluated

and revised as necessary, which would include documentation of the resident's response to the program.

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- The plan of care should present a true picture of the resident's status. It should therefore be revised with any major change of condition (decline or improvement), as well as completing a Significant Change in Status assessment. Refer to Chapter 2 for guidelines for Significant Change in Status assessment.

Self-Test

A. What are the three components of the Resident Assessment Instrument?
   1.
   2.
   3.

B. Which of the following are elements of the Resident Assessment Protocol review? (Circle the number.)
   1. Delirium
   2. Cognitive loss
   3. Visual function
   4. Hearing function
   5. Dentition
   6. Communication
   7. Kidney function
   8. ADL functional/rehabilitation potential
   9. Urinary incontinence and indwelling catheter
   10. Psychosocial well-being
   11. Mood state
   12. Behavioral symptoms
   13. Cardiac symptoms
   14. Activities
   15. Falls
   16. Nutritional status
   17. Feeding tubes
   18. Postural support
   19. Dehydration maintenance
   20. Dental care
   21. Pressure ulcers
   22. Psychotropic drug use
   23. Physical restraints

C. Suppose a resident has a care plan for hearing loss. Using the guidelines in Sections 4.11 and 4.12 of the *Revised Long-Term Care Resident Assessment User's Manual*, what would you look for to identify whether the facility used the RAP to make effective care plan decisions? (**Use the back of this sheet, and don't sign it—you will be posting your answers for a gallery walk.)**

Lesson 3-K: Quality of Life

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Recognize the Quality of Life (QOL) and Resident Behavior and Facility Practices regulations.
- Discuss QOL expectations for people who live in nursing facilities.
- Utilize the *Quality of Life Assessment Interview* information to evaluate QOL issues.
- Describe various interviewing techniques.
- Identify note-taking and documentation strategies.
- Discuss methods for investigating and evaluating QOL issues.
- Identify resident outcomes to evaluate QOL.
- Describe decision-making factors for QOL issues.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Task 5D, P-55 through P-59
  - Appendix PP, Quality of Life regulations 483.15 and Resident Behavior and Facility Practices regulations 483.13
- For additional information on interviewing, view the CMS webcast or video *Interviewing Skills for Surveyors,* broadcast May 21, 2004; handouts available.
- For additional information on activity programs, view the CMS webcast video *Surveying Activities Requirements for Nursing Homes,* broadcast September 29, 2000; handouts available.
- For additional information on efforts to improve the quality of life in nursing homes, view the CMS webcast video *Innovations in the Quality of Life—Pioneer Network Broadcast,* broadcast September 27, 2002.
- For additional information on abuse and neglect, please see the *CMS Training Manual for Detection and Prevention of Abuse and Neglect.*

State

(Insert State reference[s] here.)

Other

Highlights

- Introduction: exercise and discussion
- Investigation using the survey process
- Discussion of interviewing techniques, effective listening, note taking
- Interviewing small group activity using *Quality of Life Assessment Interview* forms
- Review of Quality of Life and Resident Behavior and Facility Practice regulations
- Exercise—"Why All of These Questions?"—using the abbreviated F-tag list and *Quality of Life Assessment Interview* forms

Training Techniques

- Lecture
- Group discussions
- Small group exercises

Training Aids

- *Quality of Life Assessment Interview* (Forms CMS-806A, -806B, -806C)
- *Resident Review Worksheet* (Form CMS-805)

- *General Observations of the Facility* (Form CMS-803)
- PowerPoint slides and handouts
- Handouts:
  - *Quality of Life Assessment Interview* forms
  - *Recreating Our Nursing Homes through Culture Change: Pioneer Network*
  - *Role-Play Scenario 1: Resident*
  - *Role-Play Scenario 1: Surveyor*
  - *Role-Play Scenario 1 Discussion Sheet: Observer*
  - *Role-Play Scenario 2: Family Member*
  - *Role-Play Scenario 2: Surveyor*
  - *Role-Play Scenario 2 Discussion Sheet: Observer*
  - *Role-Play Scenario 3: Resident*
  - *Role-Play Scenario 3: Surveyor*
  - *Role-Play Scenario 3 Discussion Sheet: Observer*
  - *Interviewing Skills for Surveyors*
  - *Activities 101*
  - *Population Assessment Tool*
  - *Formula for Population Assessment Tool*
  - *111 Activities for Alzheimer's Residents*
  - *Surveying the LTC Activities Requirements*
  - *Abbreviated F-Tags List*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Outline or text of presentation

(Preparatory work: have the students conduct an Internet scavenger hunt for and print Forms CMS-803, -805 and -806A, -B and -C. Have them view the webcasts "Innovations in the Quality of Life: Pioneer Network," "Interviewing Skills for Surveyors" and "Surveying Activities Requirements for Nursing Homes.")

Lesson 3-K:
Quality of Life

1

Slide 3-K-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Recognize the Quality of Life (QOL) & Resident Behavior & Facility Practices regulations.
- Discuss QOL expectations for people who live in nursing facilities.
- Utilize the *Quality of Life Assessment Interview* information to evaluate QOL issues.

2

Slide 3-K-2

(Inform the students of the objectives.)

Audiovisual

Learning Objectives (cont.)

- Describe various interviewing techniques.
- Identify note-taking & documentation strategies.
- Discuss methods for investigating & evaluating QOL issues.
- Identify resident outcomes to evaluate QOL.
- Describe decision-making factors for QOL issues.

3

Slide 3-K-3

Quality of Life (QOL)

- 42 CFR 483.15—facility must care for its residents in manner & in environment that promotes maintenance or enhancement of each resident's quality of life
- What is quality of life?

4

Slide 3-K-4

Outline or text of presentation

Introduction

What does it mean to care for residents "in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life"? How is quality of life defined?

How does a facility create and sustain "an environment that humanizes and individualizes each resident"?

(Exercise and discussion: Quality of Life

Tell the students: "Close your eyes. See yourself comfortably sitting in your living room or family room doing what you like to do. Now hear someone opening your front door. See a neighbor you do not know walking into your house past you into your bedroom. Now see your neighbor rummaging through your underwear drawer and taking some of your underwear. Then imagine your neighbor walking out the front door carrying your underwear.

How do you feel about this uninvited person in your home handling and taking your personal belongings? What would

Audiovisual	Outline or text of presentation
	you do about this? When someone moves to a nursing facility, do the rights and privileges of citizenship, personal property, respectful treatment, and privacy change?" *Engage surveyors in discussion. Have them suggest other examples of concerns about the quality of life in a nursing home.)* The people who reside in nursing facilities live closely together, share space with other residents, and have staff care for them twenty-four hours a day, seven days a week; consequently, many other people influence a resident's quality of life on a daily basis. This affects each resident's individuality, choices, personal possessions, activities, rights as a citizen, and feelings of self-worth and dignity. Before nursing-facility residents required the care and assistance provided in such facilities because of illness and incapacity, these residents raised families, contributed to their communities in many ways and retired from productive jobs. They moved from their houses, mobile homes and apartments into one-half of a room they share with a stranger. The Quality of Life regulations were written to ensure that each resident lives in an environment that humanizes and individualizes each person and promotes self-worth and dignity. In addition to fellow residents' behaving in an invasive manner, facility staff may also walk into residents' rooms unannounced, call them "Honey" and "Sweetie" instead of their names, discuss personal

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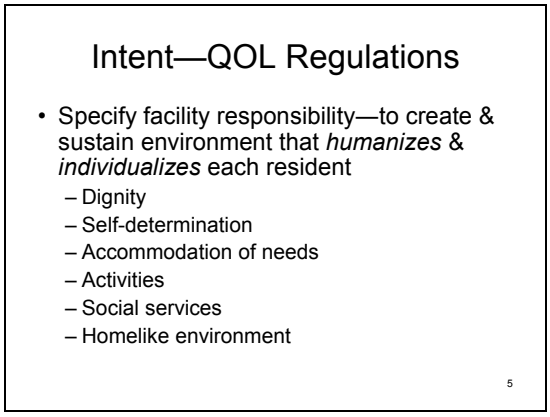
Outline or text of presentation



Slide 3-K-5

information in front of other residents and visitors (or write such information in a location within plain sight of visitors) without considering confidentiality, and make life and care decisions without resident input or choice.

Although each resident has a vision of what "home" is, the facility is where he/she lives for the present. The expectation of quality of life and individual rights should not disappear when the resident enters a nursing facility. Statutes and regulations require facility staff and the survey agency to ensure quality of life and individual rights.

The federally mandated Long Term Care Ombudsman program in each State offers additional protection for resident quality of life. It provides a network of program and volunteer staff who act as resident advocates and work to improve the quality of life in nursing facilities.

Other groups are also working through innovative projects to change the nursing home culture and improve the quality of life of residents. These topics were addressed in the CMS webcast *Innovations in the Quality of Life: Pioneer Network Broadcast*.

(Refer students to the handout "Recreating Our Nursing Homes through Culture Change: Pioneer Network" on page 3-K-39.)

CMS funds other agencies in each State to serve as quality improvement organizations that provide long term care facilities with additional training on quality-of-life and quality-of-care issues.

Audiovisual

Outline or text of presentation

Family members, friends, other visitors and facility staff report perceived quality-of-life and residents' rights issues to the survey staff during the survey and to the Complaint Hot Line for investigation and necessary action.

Associated Regulations

- Quality of Life
  - 42 CFR 483.15: F241–F258
- Resident Behavior & Facility Practices
  - 42 CFR 483.13: F221–F226
- Resident Rights
  - 42 CFR 483.10: F151–F177
- Admission, Transfer & Discharge
  - 42 CFR 483.12: F201–F208

6

Slide 3-K-6

Associated Regulations

Regulations outside the Quality of Life regulatory grouping also have an impact on the nursing-facility resident's life.

42 CFR 483.13, Resident Behavior and Facility Practices (F221–F226)
This section addresses:

- 42 CFR 483.13(a): physical (F221) and chemical (F222) restraints.
- 42 CFR 483.13 (b) and (c): abuse (F223), staff treatment of residents (F224), and development and implementation of policies and procedures for abuse detection and prevention (F226).
- 42 CFR 483.13 (c)(1): employment of abusive staff (F225).

42 CFR 483.10, Resident Rights (F151–F177)
Lesson 3-L, Resident Rights, covers resident rights.

42 CFR 483.12, Admission, Transfer, and Discharge Rights (F201–F208)
Lesson 3-L addresses admission, transfer and discharge rights.

Audiovisual

Survey Process for QOL

- Task 1—Offsite Survey Preparation
  - Quality indicators:
    - Activities
    - Restraint use
  - Complaint issues

7

Slide 3-K-7

Survey Process for QOL (cont.)

- Task 3—Initial Tour
  - On-site observations & interviews identify QOL issues to investigate
  - Identify interviewable residents & families
- Observations
  - Staff supervision & interaction with residents
  - Resident responses to staff
  - Activities
  - Confidentiality of resident information
  - Resident injuries, use of restraints

8

Slide 3-K-8

Outline or text of presentation

Survey Process for QOL

Surveyors use observation, interview and record review throughout the survey to gather evidence regarding resident quality of life. Since quality of life and care are closely interrelated, the survey process holistically integrates the quality-of-life assessment into the resident review and general observations.

Offsite Survey Preparation

During Task 1, Offsite Survey Preparation, surveyors evaluate the quality indicators regarding activities and restraint usage and any complaints involving quality-of-life issues as possible areas for focus during the survey.

Initial Tour

During Task 3, initial tour, surveyors note staff and resident interactions, resident behaviors and injuries, facility environment (i.e., whether or not it is "homelike"), restraint use and activities. Quality-of-life issues are often identified during observation and interview in the initial tour and information-gathering tasks. Input from facility staff, surveyor observations and interactions with residents determine which residents can be interviewed and which residents who cannot be interviewed have family members available for interviews. Surveyors may observe:

- Confused residents: unsupervised outside the facility, wandering in and out of other resident rooms; other residents' reactions to these actions.
- Resident grooming: appropriate for the season, resident choice, labeled clothing.
- Staff choice of language, tone of voice, redirection of residents, confinement.

Audiovisual

Outline or text of presentation

- Resident response to staff: verbal, body language, eye contact.
- Residents and staff engaged in individual and group activities.
- Privacy of resident rooms.
- Confidentiality of resident information (written and spoken).
- Resident injuries: bruising, skin tears, fractures.
- Use of restraints.

Survey Process for QOL (cont.)

- Task 4—Sample Selection
  - Select residents & families for resident & family interviews
  - Discuss any tour issues to include in group interview

9

Slide 3-K-9

Sample selection

During Task 4, Sample Selection, surveyors select a sample of residents to be interviewed, choose noninterviewable residents with available families for family interviews and plan the group interview. Residents identified in quality-of-life complaint issues should be included in the sample of residents to be interviewed.

Survey Process for QOL (cont.)

- Sub-Task 5D—information gathering
  - Observation, interview, record review
  - Direction from structured CMS forms
    - *Resident Review Worksheet*
    - *QOL Assessment Interview* forms
      - Resident, family, & group
    - *General Observations of the Facility* form

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Slide 3-K-10

Information gathering

The QOL assessment is Sub-Task 5D, part of the information-gathering task. Evaluating a resident's QOL involves using direction and questions from the *Resident Review Worksheet, Quality of Life Assessment Interview* forms, and *General Observations of the Facility* form. Surveyors interview residents, families, facility staff, physicians, therapists and many others to evaluate how the facility promotes the resident's QOL experience.

Audiovisual

Survey Process for QOL (cont.)

- Sub-Task 5D—information gathering
  - Document date, time, staff member name & title for:
    - Observations of resident condition & care
    - Resident & staff interactions
    - Requests for documentation & staff responses if staff are unavailable
  - Review MDS, care plan

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Slide 3-K-11

Survey Process for QOL (cont.)

- Task 6—information analysis
  - Team discussions throughout survey
  - Consider "sum of staff actions &/or decisions for individual"
  - Severe single incident
  - Scope & severity determination
    - Decision of substandard quality of care & extended survey

12

Slide 3-K-12

Outline or text of presentation

Observation of staff interaction with each other and with residents is crucial, as are observations of resident condition and care. Specific documentation of observations, interviews and record review serves as evidence of facility compliance or noncompliance with these regulations. Remember to record the date and time of the observation or interview, as well as the full name and title of staff you are observing or interviewing. Record this same information for all documentation requests and staff responses if staff are unavailable.

Information analysis

Survey team discussion of facility compliance with the QOL regulations during Task 6, Information Analysis for Deficiency Determination, helps clarify individual staff versus systematic facility noncompliance with the regulations. As stated in *SOM* Appendix PP, "For some requirements, especially those in the regulatory grouping of Quality of Life (42 CFR 483.15), the team will evaluate the sum of the staff actions and/or decisions for an individual resident to determine if the requirement is met for that individual. Quality of Life requirements are best evaluated comprehensively, rather than in terms of a single incident. However, a single incident which is considered severe enough may result in a deficiency" (p. 66).

If noncompliance is determined, the scope and severity of the noncompliance may lead to a determination of substandard quality of care with regard to any of the Quality of Life regulations (42 CFR 483.15 F241–F258). Such a determination requires an extended survey and notification of facility staff.

Audiovisual

Survey Process for QOL (cont.)

- Task 7—Exit Conference
  - Present preliminary findings
  - Discuss facility clarifying information

13

Slide 3-K-13

Outline or text of presentation

Exit Conference

Any evidence of noncompliance with the QOL regulations is presented to the facility's representatives during Task 7, Exit Conference. The facility may supply additional clarifying information in response to the surveyor's findings.

Interviewing

- Definition—form of communication conducted to accomplish specific task-related purpose
- Purpose—to gather information
- Structured or unstructured
  - Interview forms plus additional questions

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Slide 3-K-14

Interviewing

Understanding some basic interviewing techniques and developing good interviewing and note-taking skills are essential to gathering pertinent information for compliance determinations.

An interview is a form of communication conducted to accomplish a specific purpose: to gather information. Interviews may be structured or unstructured. The *QOL Assessment Interview* forms provide a structured format for conducting interviews with residents, families and groups. The surveyor may use questions from each section and then add specific questions based on issues that have surfaced during the investigation.

Surveyors use an unstructured interview format to investigate specific issues encountered during survey and complaint investigation. Taking time to develop a list of pertinent questions before conducting the interview will assist the surveyor in obtaining the needed information and prevent his/her being sidetracked by the interviewee.

Audiovisual

Four Interview Stages

- Preparation
- Opening
- Questioning
- Conclusion

15

Slide 3-K-15

Outline or text of presentation

Interview stages

There are four phases or stages to an interview:

- Preparation.
- Opening.
- Questioning.
- Conclusion.

Four Interview Stages (cont.)

- Preparation
  - Familiarize yourself with structured interview questions
  - Develop specific questions
  - Plan environment
  - Establish relationship with interviewee

16

Slide 3-K-16

Preparation

Preparation for a QOL interview should include familiarizing yourself with the questions on the structured form used for the interview as well as developing a list of your own questions you plan to ask. Decide where to conduct the interview and make provisions for any special circumstances. The *QOL Assessment Interview* forms provide space to ask additional focus questions as your observations, interviews and record reviews uncover specific concerns. Prior to an interview with a resident, the surveyor has usually met the resident either during the initial tour or in other interactions during the survey process. This helps the surveyor begin a relationship with the resident.

Audiovisual

Four Interview Stages (cont.)

- Opening—see interview forms
  - Greet politely
  - Introduce yourself
  - State your role
  - Identify how information will be used
  - Build rapport—interests, family
  - Take time to listen
  - Show respect & propriety

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Slide 3-K-17

Outline or text of presentation

Opening

The opening of the interview is important. First impressions are developed and solidified within the first 30 seconds to two minutes of an encounter with a person. Surveyors should have a positive attitude and take time to listen. The goal of the opening is to establish rapport and develop trust with the interviewee. Maintaining respect and propriety are important. Survey staff should knock on resident doors and wait for permission to enter the resident's room. Once inside, they should ask if it is all right before turning down radios or making any other arrangements for the interview. The *QOL Assessment Interview* forms offer other suggestions for opening the interview.

Four Interview Stages (cont.)

Questioning:

- Open questions
  - Obtain more information
  - Build better rapport
  - Time-consuming
  - May be difficult to remember answers
- Closed questions
  - Obtain specific information
  - Restrict answers
  - May be valuable for clarification

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Slide 3-K-18

Questioning

The questioning phase uses open and closed questions to probe for information. It is often helpful to start the interview with open-ended questions.

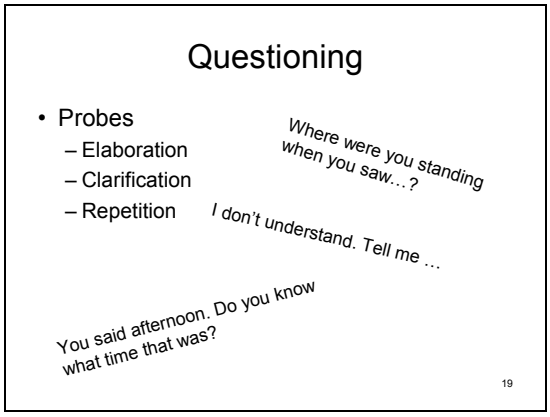
Open-ended questions generally yield more information and build rapport, but they are time-consuming, and it is sometimes difficult to follow the answers to these types of questions.

Examples:

- "Tell me about what you do for Mr. Jones."
- "How is the food?"

Closed questions obtain specific information and are valuable for clarification. They are good follow-up questions when specific information is needed, but they may restrict the answer or suggest the "right" answer or "correct" procedure.

Audiovisual



Slide 3-K-19

Outline or text of presentation

Examples:

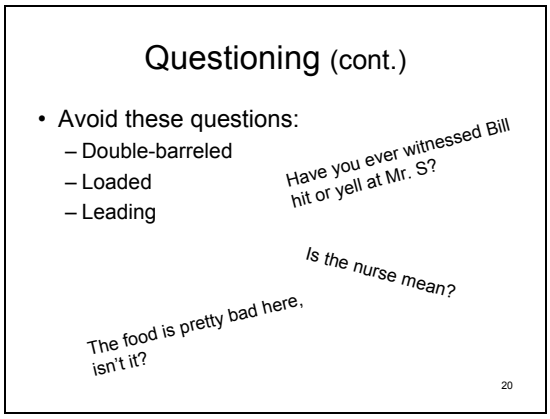
- "What time did you see Mr. Jones?"
- "Was he in the merry walker?"
- "Do you change Mr. Jones every two hours?"
- "Is the food served hot?"

Probes are used to obtain more information.

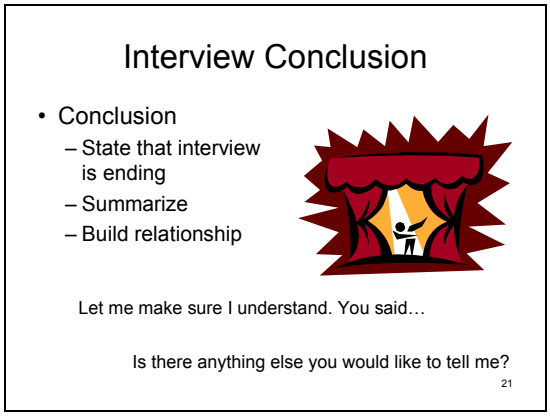
Examples:

- Elaboration
  - "I don't understand . . . could you tell me more or give an example?"
- Clarification
  - "You said afternoon. Do you know what time that was? Was it after lunch or closer to suppertime?"
  - "Where were you standing when you saw . . . ?"
- Repetition
  - If a resident seems not to have understood a question, find words the resident can understand and ask the question again. First attempt: "Have you ever had an accident with your urine while waiting for staff to answer your call light?" Repetition: "Have you ever passed your water while waiting for the girls here to help you to the toilet?"

Audiovisual



Slide 3-K-20



Slide 3-K-21

Outline or text of presentation

Avoid:

- Asking two questions at once: "Have you ever witnessed Bill hitting or yelling at Mr. S?"
  - The interviewee will answer one question—often the question that is the easiest or least incriminating.
  - Ask the questions separately: "Have you ever witnessed Bill hitting Mr. S?" Then, "Have you ever seen Bill yell at Mr. S?"
- Loaded questions: "Is the nurse mean?"
  - Let the interviewee describe the nurse's actions and anything else he/she has witnessed.
- Leading questions: "The food's pretty bad here, isn't it?"
  - A leading question suggests the answer in the question.

Conclusion

The conclusion of the interview includes an opportunity for the interviewee to add to or elaborate on the topics discussed. It also lets the surveyor summarize the information he/she has obtained, ask whether it is correct and seek clarifying information if necessary. It helps to build the relationship between surveyor and interviewee, which is invaluable if further information is needed from the interviewee.

Examples:

- "Is there anything else you would like to tell me?"
- "Let me make sure I understood what you told me about . . ."

Audiovisual

Interviewing Skills

- Good eye contact
- Attentive posture
- Consistent body language
  - Are you listening or are you waiting for your turn to talk?
- Interest
- Empathy
- Accurate notes

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Slide 3-K-22

Outline or text of presentation

Interviewing Skills

General interviewing practices

- Maintain good eye contact and an attentive posture (sit up, with feet on the floor if possible).
- Make sure your nonverbal communication mirrors what you say.
- Be aware of body language—yours and the interviewee's.
- Arrange the environment (with resident permission) to limit distractions.
- Listen to what the interviewee is saying.
- Do not interrupt and do not assume.
- Ask for clarification.
- Demonstrate interest and empathy.
- Seek specificity and concreteness: What did the interviewee see, hear, smell, say, write?
- Take notes; do not rely on memory.
- Write while maintaining eye contact (this takes practice).
- Place quotation marks around any direct quotes in your notes if you plan to use them in the statement of deficiency.
- Use quotes sparingly and make sure they are accurate and appropriate.

Interviewing Skills (cont.)

- Facility staff
  - Be professional
  - Be considerate of time
  - Find appropriate staff
  - Talk to workers before supervisors, if possible
  - Document name & title
  - Ask for names of other witnesses
- Residents & families
  - Offer to speak privately
  - Allow plenty of time
  - Decrease distractions
  - Interpret body language
  - Accommodate special conditions

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Slide 3-K-23

Interviewing facility staff

- Remember that staff are also professionals or experienced paraprofessionals.
- Be considerate of their time: they have work to do and residents to care for.
- Interview one staff member at a time in a convenient place.
- Talk to the person who knows the information.

Audiovisual

Outline or text of presentation

- Interview nurse's aides and kitchen aides before the charge nurse, director of nursing, or kitchen supervisor (if possible).
- When an interviewee relates a particular incident, ask if other persons saw or heard the incident or have additional information about it.

Special Populations

- Allow plenty of time
- Make sure environment is suitable
- Do not try too many things at once
- Do not expect memory to work quickly

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Slide 3-K-24

Interviewing residents and families

- Remember that residents and their families have the right to speak to surveyors in private without facility staff present.
- Allow plenty of time for the interview.
- Make sure the environment is free of distractions and affords privacy.
- Do not expect the interviewee's memory to work quickly.
- Interpret body language—tiredness, agitation, breaking of eye contact—that suggests the resident cannot continue, needs to use the toilet, is in pain, etc.
- Determine any special resident conditions and make provisions to accommodate them.
  - Hearing impairments.
    - Lower your pitch.
    - Talk at a moderate rate.
    - Speak clearly.
    - Maintain an even speaking volume.
    - Change the subject slowly.
    - Face the interviewee.
    - Associate names with people's roles.
    - Talk to the person's better ear.
    - Use gestures.

Hard of Hearing

DO

- Lower pitch
- Talk at moderate rate
- Speak clearly
- Keep even volume
- Slow change of subject
- Face interviewee
- Associate names with person's role
- Talk to person's better ear
- Use gestures

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Slide 3-K-25

Audiovisual

Blind or Sight Impaired

DO
- Identify yourself
- Announce departure
- Speak naturally
- Identify in group
- Speak prior to giving person object
- Describe surroundings

DO NOT
- Rearrange familiar objects
- Answer with gestures
- Answer with nod

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Slide 3-K-26

Aphasia—Speech Impaired

DO
- Regard as adult
- Use environmental cues
- Use gestures & facial expressions
- Stand on functional side when talking
- Keep short & simple
- Speak in natural tone
- Give adequate time to respond
- Be alert to delayed responses
- Communicate when you don't understand
- Be supportive

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Slide 3-K-27

Outline or text of presentation

– Blindness or sight impairments.
  - Identify yourself.
  - Announce your departure.
  - Speak naturally.
  - Identify in group.
  - Speak prior to giving the person an object.
  - Describe the surroundings in which the interview is being conducted.
  - Don't rearrange familiar objects.
  - Don't answer with gestures (including facial gestures, such as nods).

– Aphasia (speech impairments)
  - Regard the person as an adult.
  - Use environmental cues.
  - Use gestures and facial expressions.
  - Stand on the person's functional side when talking.
  - Keep speech short and simple.
  - Speak in a natural tone.
  - Give the person adequate time to respond.
  - Be alert to delayed responses.
  - Communicate when you don't understand.
  - Be supportive.

Audiovisual

Aphasia—Speech Impaired (cont.)

DO NOT

- Bombard with too many words
- Rush response
- Talk about person in his/her presence
- Assume person cannot understand
- Correct errors
- Be uneasy with periods of silence

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Slide 3-K-28

Outline or text of presentation

- Don't bombard the person with too many words.
- Don't rush the person's response.
- Don't talk about the person in his/her presence.
- Don't assume the person cannot understand.
- Don't correct the person's errors.
- Don't show discomfort with periods of silence.

Residents with Alzheimer's Dementia

DO

- Stand in line of vision
- Keep communication simple & clear
- Discuss concrete action & objects
- Reduce noise
- Use same words if you repeat
- Use visual cues & gestures
- Listen
- Be patient

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– Alzheimer's dementia
  - Stand in the person's line of vision.
  - Keep communication simple and clear.
  - Discuss concrete action and objects.
  - Reduce noise.
  - Use the same words if you repeat information.
  - Use visual cues and gestures.
  - Listen.
  - Be patient.

Interviewing Exercise

- Work in group of three
  - Roles
    - Surveyor
    - Resident or family member
    - Observer
- Review only information for your role
- Surveyor—utilize appropriate QOL interview form to interview resident or family
- Observer—use discussion sheet as you watch interview

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Slide 3-K-30

Interviewing Exercise

(There are three different role-play scenarios, labeled 1, 2 and 3, beginning on page 3-K-41. Each scenario involves three individual role assignments: resident or family, surveyor (interviewer) and observer. One page has information about the resident or family, a second has information the interviewer knows about the resident and the third has discussion questions to use for observing the interview between the other two. Assign a scenario to a group of three people, and

Audiovisual

Outline or text of presentation

give each member ***only the page with information for his/her role.***

The interviewer will use the appropriate "QOL Assessment Interview" form to interview the resident or family member. The observer will read the discussion sheet and think about the questions as he/she observes the interview.

A final, large-group wrap-up will include positive observations of how the interviewer used the interview skills discussed in the lecture and any comments from the interviewer and resident or family member about the forms, getting specific information, and other challenges.

For additional information on interviewing, have the students view the CMS webcast or video "Interviewing Skills for Surveyors." Refer students to the handout "Interviewing Skills for Surveyors" that begins on page 3-K-59.)

Quality of Life Regulations

- Dignity
- Self-determination
- Participation in groups
- Accommodation of needs
- Activities
- Medically related social services
- Environment

May be substandard quality of care

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Slide 3-K-31

Regulations

42 CFR 483.15 and its associated quality-of-life tags (F241–F258) address a combination of regulations regarding dignity, self-determination, participation in groups, accommodation of needs, activities, medically related social service needs, qualifications of the social worker (if one is required in the facility) and the facility's environment. All are areas that can directly impact a resident's QOL on a day-to-day basis.

The QOL regulations are discussed here sequentially, with examples of compliance issues for each.

Audiovisual

483.15(a) F241—Dignity

- Observe how staff treat residents
  - Resident reactions
- Ask residents, "How does that make you feel?"
- Use "reasonable person" standard
- Investigate staff actions
  - Not using resident names
  - Not intervening when residents are naked or incontinent
  - Discussing or posting private care information where others can hear or see

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Outline or text of presentation

Tags F221–226, associated with 42 CFR 483.13, Resident Behavior and Facility Practice, are also briefly included in the discussion here.

42 CFR 483.15(a), Dignity (F241)

42 CFR 483.15(a) concerns how staff treat the resident during the resident's daily life in the facility. QOL observations in regard to this regulation continue throughout the survey.

Further investigation would be indicated if surveyors observe or interviews indicate evidence of staff:

- Pulling a resident backward through the hall.
- Talking about a resident in front of him or her without involving the resident in the conversation.
- Putting a resident's name on the outside of his/her clothing.
- Putting personal care information on the wall in the resident's room where everyone (visitors, clergy, various other people) can see it.
- Speaking to a resident as if the resident were a child and/or not addressing him/her by name.
- Not recognizing that resident rooms are personal space and not knocking on doors to enter the room.
- Not intervening to cover a resident who has exposed private body areas.

When evaluating resident outcomes for these issues, consider how a "reasonable person" would feel under similar circumstances. This is especially important when a resident cannot tell you how he/she feels. Look also for body language: poor eye contact with staff, avoidance of staff, expressions of fear or anger, or striking out.

Audiovisual

Outline or text of presentation

Document your observations with the date, time and full name and title of staff and/or residents involved. Follow up with questions to corroborate your information: "Tell me about staff assignments. If you see someone other than your assigned resident who needs assistance, what do you do? I noticed you walked by Ms. Jones in the hall just now. How was she sitting? Is that usual for her? What else did you see?" Then ask the charge nurse or director of nursing what the expectation for staff is, for instance, when they notice a resident who has exposed private body areas.

If a resident can talk to you, ask, for example, "How do you feel when a staff member calls you 'Sweetie'?" Document the response. If you plan to use a direct quotation in your report, make sure you record the interviewee's words accurately. (Note that such direct quotations should be used sparingly and where they will have the most effect.)

483.15(b) F242—
Self-Determination/Participation

- Do staff make adjustments for resident preferences & choices?
  - Food choices, table mates, room trays
  - Activity choices, pets
  - Dress—choice & availability of clothes, shower schedule
  - Quiet versus noise
  - Time to get up & to retire

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Slide 3-K-33

42 CFR 483.15(b), Self-Determination and Participation (F242)

When residents feel they can control their lives, they feel better about their lives.

Think about all the decisions and choices you make each day:

- The time you get up in the morning, during the week and on weekends.
- When you take a shower or a bath.
- The clothing, jewelry and perfume you will wear.
- What you are going to do and with whom you are going to do it.

Audiovisual	Outline or text of presentation
	Through your investigation, find out what is important to a particular resident. If it seems reasonable, is the facility doing it, and if not, why not? 42 CFR 483.15(b) requires the facility to assess and plan a resident's care, accommodating his/her preferences and choices. Evaluate whether this has been done. A choice significant to the resident can relate to any department in the facility. You have to determine through interviews and record review what is or was important to the resident and then determine whether it is being done. Examples: • Food and meals (special food at a meal, time of meal, eating with certain people). • Activities (watching certain television shows, staff assistance to get to a particular activity, supplies to do an activity, participating in individual versus group activities). • Dress (special clothing for church/weekends, makeup, jewelry). • Quiet (in the room, building, dining room). • Timing of meals (residents taken to the dining room at 6 a.m. and sleeping through breakfast served at 8 a.m.).

Audiovisual

483.15(c) F243—Groups

- Does facility have resident or family group?
- How does facility assist?
- Review resident council minutes for:
  - Recurring issues
  - How facility resolves issues & provides feedback to residents
- Conduct group interview

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Slide 3-K-34

Outline or text of presentation

42 CFR 483.15(c), Participation in Resident and Family Groups (F243)

A facility is not required to have a resident group (resident council), nor must such a group, if one exists, necessarily elect officers. If residents and their families wish to organize such a group, however, the facility must not interfere and must provide private space for the group to meet and staff to assist with the meetings.

If the facility has a resident council, review the minutes of council meetings before conducting the group meeting. Look not only for problems that tend to recur, but for what the facility tried to do to correct each problem. For recurring problems and for any that appear to have gone unaddressed, ask yourself whether it is reasonable for the facility *not* to have solved the problem.

Interview the facility staff person who assists the group and determine whether he/she verbally responds to the group regarding facility actions to resolve the problems the group identifies. If the facility is not able to resolve a particular issue the group has raised or to implement a reasonable suggestion by the group for doing so, check to see how the facility staff informed the group and what explanation, if any, was provided. If no such explanation was provided, during the quality assurance task, you may wish to ask whether the facility's quality assurance committee addressed the particular issue.

Do not confuse 42 CFR 483.15(c), which is a regulation concerning group recommendations and grievances, with the regulation regarding individual grievances,

Audiovisual

483.15(e) F246—
Accommodation of Needs

- Individualize resident's environment for independence, dignity & preferences
  - Table & chair height & position
  - Adaptive utensils & dishes
  - Adaptive call lights
  - Bathroom accommodates resident wheelchair
  - Supportive equipment for wheelchairs, beds

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Outline or text of presentation

which are covered under 42 CFR 483.10(f), Resident Rights.

42 CFR 483.15(d), Participation in Other Activities (F245)
Interview the resident, family and staff about how the facility accommodates resident participation in social, religious and community groups inside and outside the facility.

42 CFR 483.15(e), Accommodation of Needs (F246)
42 CFR 483.15(e) is concerned with the facility's efforts to individualize the resident's environment to maintain and promote independence, dignity and the resident's preferences.

The following are examples of surveyor observations and interview and record review information that would indicate that further investigation is warranted:

- Residents having difficulty reaching food during mealtime, spilling food when eating, unable to lift water glass or use utensils.
- A resident who is unable to support his/her head when in the wheelchair.
- A resident who is unable to move his/her hand to use the call button.

The following are examples of situations in which changes to the physical environment or staff behaviors could accommodate a resident's need:

- Hanging clothing at a level at which the resident can independently reach it.
- Hanging a mirror so the resident can see when combing his/her hair.
- Hanging a clock where the resident can see it from where the resident spends time in the room.

Audiovisual	Outline or text of presentation
	• Adjusting the height of the bed so the resident can safely and independently get in and out. • Having half bed rails rather than full bed rails for residents who can get in and out of bed alone, but want them for repositioning. • Placing a commode at bedside where a resident who cannot walk more that two steps alone does not need to seek staff assistance. • Placing beverages of choice within reach in a size and type of container the resident can use independently. • Providing snacks throughout the day for residents who wander and won't sit to eat. • Adapting light switches and call light switches for the resident. • Adjusting the height of dining tables to accommodate resident chair and wheelchair height to enable residents to feed themselves. Consider soiled clothing, sleeping through meals, weight loss, dehydration, resident pain and resistance to getting in the wheelchair as possible negative accommodation-of-needs outcomes. Questions for residents, staff and families to corroborate findings should include resident preferences, facility schedules and staffing during specific times, and facility equipment and policies.

Audiovisual

483.15(f) F248—Activities

- Activity program for *each individual based on resident capabilities & interests*
- Quality Indicator (QI)—little or no activity

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Slide 3-K-36

Outline or text of presentation

42 CFR 483.15(f)(1), Activities (F248)
The time required to provide care for residents fills a small portion of a resident's 24-hour day in the facility. That leaves many hours of boredom and loneliness unless the facility provides activities geared to each resident's capabilities, needs and interests.

The presence of little or no activity is a quality indicator used to determine focus areas for the survey.

42 CFR 483.15(f)(1) requires that the facility staff provide an activity program within each resident's capabilities based on the resident's Comprehensive Assessment (Resident Assessment Instrument) and Care Plan. The program should be meaningful to the resident, promote well-being and meet physical, mental and psychosocial needs. Facility staff are required to assess each *individual* and develop appropriate activities for residents with different physical and mental abilities and psychosocial needs.

The regulation requires that the facility provide an ongoing program of activities. It does not require that only the activity staff plan and conduct activities. Rather, the activity staff can secure the assistance of nursing staff, housekeepers, and laundry and dietary staff in conducting activities. For example, a housekeeper can turn the TV on to a resident's favorite program if information about the program (time, channel, day of the week) is posted on the side of the TV.

Audiovisual

483.15(f) F248—Activities (cont.)

- Investigation
  - Review MDS, interests, care plan & activity participation documentation
  - Interview resident, family & staff
  - Observe activities, resident responses to daily life & activities & resident improvement or decline

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Slide 3-K-37

Outline or text of presentation

Observe sampled residents and group activities throughout the survey:

- Are staff other than activity staff involved with activities, transportation and one-on-one activity?
- Are there scheduled activities? Are they occurring?
- Are the activities appropriate for the resident?
- Are residents actively participating? If not, how many are just observing and how many are asleep?
- Are staff encouraging the more passive residents to participate more actively?
- Are there individual and small group activities for the cognitively impaired?
- What activities and interventions are staff providing for wandering residents?
- What are the residents' responses to the activities or lack of activities?
  - Look for resistive and acting-out behaviors.

Review the activities documentation for residents' assessments, interests, Care Plan and participation. Review MDS Section N to determine whether residents' activity choices are being accommodated.

Interview residents, family and staff regarding your observations, resident responses to daily life and activity, and resident improvement or decline.

(Refer the students to the handouts "Activities 101" on page 3-K-65 and "Surveying the LTC Activities Requirements" on page 3-K-77 (from the "Surveying Activities Requirements for Nursing Homes" webcast).)

Audiovisual

483.15(g) F250—Social Services

- Medically related social services
  - To manage everyday physical, mental & psychosocial needs
  - Guidance to surveyors outlines services & conditions
    - Working with families, care planning
    - Advocate for reduction of psychotropic drug & restraints
- See F251—Qualified social worker
  - Greater than 120 residents

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Outline or text of presentation

Deficient activity programs may produce resident outcomes such as persistent aimless wandering, infringement of other residents' rights by wandering into others' personal space and rooms, wandering individuals' being harmed by other residents, residents' leaving the building without supervision, resistive and acting-out behaviors, statements of not liking the available activities, boredom and depression.

42 CFR 483.15(g), Social Services (F250)
Several regulations are associated with medically related social services (services to assist residents in managing their everyday physical, mental and psychosocial needs). 42 CFR 483.15(g) outlines many of the services and conditions requiring social services intervention.

Please refer to the surveyors' guidance at F250 for specific information to consider when identifying a number of unmet social services needs.

Examples of matters that may require investigation:

- Are staff working with families, including notifying them of resident changes of condition and including them in resident care planning?
- Are staff fostering understanding of resident behaviors and acting as advocates for reductions in psychotropic drug and restraint use?

Audiovisual

483.25(f) F319 & F320—Mental & Psychosocial Functioning

- Resident with behaviors
  - F319—Use if assessed for psychosocial adjustment issues
  - F320—Use if not assessed for these issues

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Slide 3-K-39

Outline or text of presentation

42 CFR 483.15(g)(2) and (3), Qualified Social Worker (F251)
A facility with more than 120 beds must employ a qualified social worker on a full-time basis. Qualifications are listed in the regulation.

42 CFR 483.25(f), Mental and Psychosocial Functioning (F319, F320)
42 CFR 483.25(f)(1) and (2) pertaining to mental and psychosocial functioning are included in the investigation of the provision of medically related social services. If there are issues with provision of services, refer to all three and evaluate which regulations have not been met.

Consider the issues discussed at 42 CFR 483.25(f)(1) and (2) when a resident is displaying abnormal behaviors. Evaluate as follows:

1. Decide which regulation is appropriate to the resident, based on your review of the Comprehensive Assessment.

   The regulations at 42 CFR 483.25(f)(1) and (2) begin by stating, "Based on the comprehensive assessment of a resident. . . ." Therefore, review the resident's Comprehensive Assessment. If the resident was assessed for a mental or psychosocial adjustment problem, look at F319. If the assessment does not show anything about such a problem, but the resident is displaying problems and has the behaviors listed, look at F320.

2. Read the guidance to surveyors to help you determine whether the facility did what was expected.

Audiovisual	Outline or text of presentation
	3. Review what the facility did. Did the facility begin psychotropic medication? If so, when? Was it effective? Review the date the medication or medications were ordered and the dosages. If regulations require the facility to keep behavior sheets, review them. Note what behaviors the facility staff are tracking, the days of the week and the time of day different behaviors occurred, what staff did to redirect the resident and the effectiveness of the redirection. Stop and ask yourself some questions: • "Based on other information in the medical record, is this a behavior I would expect from a resident with these diagnoses or are these *normal* behaviors for a person with these diagnoses?" After all, no one is calm all the time, for example. Everyone can get agitated and act out. Many people would get upset too if staff did not talk to them before trying to provide care, especially incontinence care. • "Is there a pattern?" If so, what did the facility do about it? 4. Evaluate whether a change in the medication or the dosage resulted in a change in behaviors. 5. Evaluate whether the facility should have or could have tried something different. Interview not only nursing management, but also direct-care staff.

Audiovisual

483.15(h) F252–F258—Environment

- F252—Homelike environment
- F253—Housekeeping/maintenance
- F254—Linens
- F255—Private closet
- F256—Lighting
- F257—Facility temperature
- F258—Sound levels

Impact quality of life

May be substandard quality of care

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Slide 3-K-40

Outline or text of presentation

42 CFR 483.15(h), Environment (F252—F258)

The condition of the physical environment affects resident quality of life on a daily basis and may be cited as evidence of substandard quality of care, requiring an extended survey. Multiple questions on the *Quality of Life Assessment Interview* form for residents direct your investigation of this aspect of the resident's quality of life.

Regulations in this area are 42 CFR 483.15:

- (h)(1), Homelike Environment (F252).
- (h)(2), Housekeeping and Maintenance (F253).
- (h)(3), Linens (F254).
- (h)(4), Private Closet Space (F255).
- (h)(5), Lighting (F256).
- (h)(6), Facility Temperature (F257).
- (h)(7), Sound Levels (F258).

(Have the students brainstorm environmental quality-of-life issues and discuss them.

Additional information related to the physical environment of the facility is presented in Lesson 3-F, Evaluating the Environment.)

Several regulations outside the Quality of Life regulatory grouping also have an impact on the resident's quality of life.

Audiovisual

483.13—Resident Behavior & Facility Practices

- F221—Physical restraints
- F222—Chemical restraints
- F223—Abuse
- F224—Mistreatment, neglect, misappropriation of property
- F225—Employment of abusive staff
- F226—Development & implementation of policies & procedures for abuse detection & prevention

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Outline or text of presentation

42 CFR 483.13, Resident Behavior and Facility Practices (F221–F226)
42 CFR 483.13(a) addresses physical (F221) and chemical (F222) restraints, 42 CFR 483.13(b) and (c) deal with abuse (F223) and staff treatment of residents (F224) and development and implementation of policies and procedures for abuse detection and prevention (F226) and 42 CFR 483.13(c)(1) covers employment of abusive staff (F225).

Abuse & Neglect

- When do dignity issues such as:
  - Staff member's raising his/her voice when addressing resident
  - Choice of words
  - Posture
  - Speed & force of care

…change from possible dignity issues or standards of care to possible abuse?

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Slide 3-K 42

(Discuss with class: When do issues such as a staff member's raising his/her voice when addressing a resident, choice of words, posture, speed and force of care change from possible dignity or standard-of-care issues to issues of possible abuse? Refer to the "CMS Training Manual for Detection and Prevention of Abuse and Neglect" for additional information.)

Lesson 3-R, Abuse Prohibition Review, contains additional information on abuse and neglect issues.

Exercise: Why All of These Questions?

- Take handouts:
  - *Quality of Life Assessment Interview* forms A, B & C
  - *Abbreviated F-tag list*
- Use three colored markers or symbols (lines, dots, checks) to make legend on F-tag list indicating resident, family & group
- Review questions & F-tags on interview forms
- Code F-tags on list using color or symbol

43

Slide 3-K-43

(Exercise:

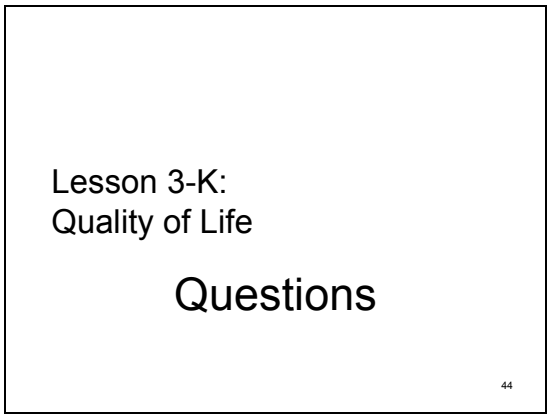
- *Refer the students to the abbreviated F-tag list beginning on page 3-K-83 and the three "CMS Quality of Life Assessment Interview" forms (806A, 806B and 806C).*
- *Have them select three different symbols (for example, lines, dots, check marks) or three different-colored highlighters and make a legend on the bottom left-hand side of the first page that shows which symbols or colors they will use to indicate F-tags found*

Audiovisual

Outline or text of presentation

on the resident, family and group interview forms.

- *Have them review the questions on each interview form and the F-tags listed for each group of questions or observations (observations of noninterviewable residents) and mark the F-tags on the list with the appropriate color or symbol, according to the legend they have created.*
- *When they have finished, discuss the F-tags targeted by these structured interview/observation forms.)*



Slide 3-K-44

Skill Assessment

Quality of Life

Trainee Name _____

Preceptor Name _____

Date _____

OO Observation Only
NMSE Needs More Supervised Experience
PSS Performed with Some Supervision
CMS Competent with Minimal Supervision
PI Performed Independently
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed quality of life expectations for people who live in nursing facilities.	
					Recognized the Quality of Life (QOL) and Resident Behavior and Facility Practices regulations.	
					Utilized the *Quality of Life Assessment Interview* worksheet information to evaluate QOL issues.	
					Described various interviewing techniques.	
					Identified note-taking and documentation strategies.	
					Discussed methods to investigate and evaluate QOL issues.	
					Identified resident outcomes to evaluate QOL.	
					Described factors for decision making for QOL issues.	
					Verbalized the intent of the QOL regulations.	

					For resident dignity: • Verbalized the significance of the issue. • Demonstrated throughout the survey process the ability to identify issues that impact negatively on a resident's dignity.	
					Identified when facility staff has not accommodated the resident's needs.	

Comments/Recommendations:

Elders with Illness

Recreating Our Nursing Homes through Culture Change

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As more Americans live longer, concerns about the quality of life in our nation's nursing homes is growing. In spite of the fact that good progress has been made in the physical care of residents, a recent national survey of seriously ill older adults found 70 percent unwilling to go into a long term care facility. Thirty percent stated they would rather die than enter one.

Good people work in and administer nursing homes. The problem is not the people; it is the culture. According to psychological research, certain minimal needs must be met in order for human beings to thrive throughout the entire course of their lives. These include 1) maintaining a sense of control over one's daily life. 2) maintaining the integrity of one's identity. 3) Sustaining meaningful relationships with others, and 4) having at least a minimal degree of daily variety and diversity. Unfortunately, the conventional policies and practices of nursing home often. thwart these needs, both for residents and staff.

Concerns about traditional nursing home practices and culture is the impetus for the national Pioneer Nursing Home Culture Change movement. Monroe County has become the national center for that movement.

Since their inception, nursing homes have been modeled after acute hospital care. Routines are inflexible. The focus is on residents as dependent. "patients with problems." Residents are known for their conditions rather than for their strengths. They are isolated from the normal rhythms and interactions of everyday life. Staff usually make daily routine lifestyle decisions for residents: when to get up, go to bed, what and when to eat, when to bathe. Staffs have heavy workloads, and neither residents nor staff has much say in how they live and work together. In general, nursing homes based on the medical model are nothing like the homes from which residents come.

The result for residents is that nursing homes are too often places of loneliness, depression and decline. The result for staff is high turnover and, for both staff and residents, difficulty in really knowing and caring about each other,

In 1987, Congress passed the Nursing Home Reform Law. Among other provisions, the law mandates restraint-free care, resident rights. a holistic approach to care (mind, body and spirit) and a homelike environment, Unfortunately, the traditional medical model that is the standard for most nursing homes makes it

When we transform our nursing homes into human communities, places for living and growing, we will ultimately change the very nature of aging in America.

experts in long term care. [People]across the country are actively working to transform nursing homes, implementing Pioneer approaches to culture change, such as The Regenerative Community, Resident-Directed Care, Individualized Care and the Eden Alternative.

The central belief of Pioneer approaches is striking in its simplicity, "residents first." The goal is to recreate nursing homes as places for living, with good medical and nursing care supporting, rather than dominating, a daily life that is meaningful to each resident. Nursing homes undergoing culture change **aim** to restore control to the resident and to those closest to the resident, the Certified Nursing Assistants. Residents can continue to grow even in the last years of their lives. A sense of "home" characterizes the environment, and a community is built that connects residents, staff arid families to one another.

Monroe County became part of the nursing home culture change movement in 1992. That year. LIFESPAN of Greater Rochester started the Long Term Care Community Forum. The Forum, which grew out of LIFESPAN'S Long Term Care Ombudsman Program, brings together providers, regulators, advocates, family members and residents to explore pioneer approaches. The Long Term Care Community Forum organizes programs and conferences featuring national leaders in the

culture change movement.

From these beginnings, and with funding from the NYS Department of Health and the van Ameringen Foundation. in 1998 LIFESPAN formed a three-year collaborative with Fairport Baptist Homes and The Jewish Home of Rochester to help them implement pioneer approaches in their facilities. The University of Rochester, as part of this collaborative, is studying and evaluating the process and the outcomes. The goal of the collaborative is to show that changing the culture of a nursing home will result in positive mental health changes for residents. including those with dementia. Expectations are that resident's physical health and well being will also improve. Positive outcomes will encourage more facilities to transform their own culture. The evaluation report for the first two years of the project has recently been submitted to the Department of Health, and preliminary outcomes are encouraging.

Since the formation of the collaborative, nine other county long term care facilities, including an adult care home. have become part of a group, *Practicing Organizations on the Path to Culture Change*. to exchange ideas, share experiences and support each other as they seek to transform their environments and practices. Also, 35 Certified Nursing Assistants from area nursing homes have formed an organization as a preliminary to a state Certified Caregiver Association. Their goal is to increase respect for their profession and to have the opportunity to impact public policy related to long term care.

This past fall, Rochester hosted the first ever conference for nursing home Pioneers and those interested in the movement. The "Frustration to Pride" Conference attracted 350 participants from 23 states.

Nursing Home culture change is not the "new wallpaper and the bird in the lobby," it means systemic change throughout a facility. Culture change is a continuing process of growth, not a program to be installed once and for all. When we transform our nursing homes into human communities, places for living and growing, we will ultimately change the very nature of aging in America.

Fagan is the director of the Nursing Home Culture Change Project for Lifespan of Greater Rochester.

Role-Play Scenario 1: Resident

You are a 62-year-old resident at Happy Haven Care Center. You have lived in the facility for two weeks and plan to return home. You had a stroke two months ago, and as a result you have little use of your right arm and leg. You are able to talk but sometimes have difficulty saying the right word or phrase, which you find very frustrating. You were in the rehabilitation section of the hospital for six weeks before you moved to the nursing home. You received several hours of occupational therapy, physical therapy and speech therapy while in the hospital. You are currently receiving three hours of therapy each week, which you do not feel is enough. You are able to partially dress yourself, and you want to do as much as you can for yourself, but the facility staff want to do it for you because it takes you so long to do anything.

You are not involved in activities in the facility. Your spouse comes to help you with your lunch and supper every day. You do not know much about residents' rights.

Role-Play Scenario 1: Surveyor

You are interviewing a 62-year-old resident who plans to return home. The resident had a stroke two months ago, and as a result has little use of his/her right arm and leg. The resident also has difficulty with some words and phrases. The resident's chart indicates that the resident does not participate in activities.

Role-Play Scenario 1 Discussion Sheet: Observer

1. Did the surveyor obtain all of the information from the resident? If not, what other information was needed?

2. What about the resident's action or response made it difficult to obtain the information?

3. Did the surveyor establish rapport with the resident? If so, how?

4. What nonverbal communication did the surveyor and resident use during the interview?

5. Did the surveyor use open or closed questions?

6. Did the surveyor use leading or suggestive questions?

7. Did the surveyor use any of the suggestions that were discussed during this training session? If so, what suggestions? Were they effective?

8. Could anything else have been done?

Role-Play Scenario 2: Family Member

You are the son/daughter of an 82-year-old resident at ABC Care Center. Your father has lived in the facility for six months, and you do not feel the facility is meeting his needs. He has an Alzheimer's disease diagnosis and was cared for by your mother at home until he was placed in the facility because he is incontinent of bladder and falls several times a week. He is taking 2 mg of Navane twice a day and .5 mg of Ativan twice a day. He sleeps a total of 13 hours in a 24-hour period and may go to sleep before he finishes his breakfast.

You are also concerned about how the facility staff treat your father. You usually find him wet when you go to the facility. Several times he has been physically restrained. You have heard staff yell at him as you arrive, and they often call him by a nickname. You have talked to the charge nurse several times about your concerns.

Role-Play Scenario 2: Surveyor

You are interviewing the son or daughter of an 82-year-old male resident who has an Alzheimer's disease diagnosis. He has been in the facility for six months, and the family does not feel the facility is meeting his needs. He is incontinent of bladder at times. The family decided to place him in the facility because he was incontinent and had fallen several times.

Role-Play Scenario 2 Discussion Sheet: Observer

1. Did the surveyor obtain all of the information from the resident's family member? If not, what other information was needed?

2. What about the family member's action or response made it difficult to obtain the information?

3. Did the surveyor establish rapport with the family member? If so, how?

4. What nonverbal communication did the surveyor and family member use during the interview?

5. Did the surveyor use open or closed questions?

6. Did the surveyor use leading or suggestive questions?

7. Did the surveyor use any of the suggestions that were discussed during this training session? If so, what suggestions? Were they effective?

8. Could anything else have been done?

Role-Play Scenario 3: Resident

You are an 82-year-old resident at ABC Care Center. You have lived in the facility for six months and *want* to return home. You are on a regular diet and think the food you like is OK but are not aware you can ask for something else to eat if you do not like what is served. You have difficulty eating some of the food because your dentures do not fit. You have arthritis in your hands, knees and hips, and you use a walker. You are able to dress yourself if someone helps button some of your clothes. You want to dress yourself, but sometimes the staff do it because you take so long. You have poor vision, are hard-of-hearing and do not have a hearing aid. You are not involved in activities in the facility.

Prior to coming to the facility, you lived at home alone. You fell, and the in-home service provider found you on the floor. You were sent to the hospital. Your doctor and niece felt you could no longer live at home alone, so they arranged for placement in the facility. Your niece comes to see you, but you are angry with her because she will not let you return home.

There is an order for bed rails to be used at night, which you do not like because you have to wait for help to get out of bed to go to the bathroom.

You do not know much about residents' rights.

Role-Play Scenario 3: Surveyor

You are interviewing an 82-year-old resident who does not want to be in the facility. The resident is hard-of-hearing, has poor vision, has arthritis in his/her hands, hips and knees and uses a walker. There is an order for bed rails for safety. The resident's chart indicates that the resident does not participate in activities.

Role-Play Scenario 3 Discussion Sheet: Observer

1. Did the surveyor obtain all of the information from the resident? If not, what other information was needed?

2. What about the resident's action or response made it difficult to obtain the information?

3. Did the surveyor establish rapport with the resident? If so, how?

4. What nonverbal communication did the surveyor and resident use during the interview?

5. Did the surveyor use open or closed questions?

6. Did the surveyor use leading or suggestive questions?

7. Did the surveyor use any of the suggestions that were discussed during this training session? If so, what suggestions? Were they effective?

8. Could anything else have been done?

Interviewing Skills for Surveyors

Slide 1

Interviewing Skills for Surveyors

- A skill you already have and use
  - Example: talk with friends about something fun
    - You listen
    - You pay attention
    - You enjoy each other
    - You're a "team" without being one
  - Purpose of this session:
    - To give you tools to help you apply your skills in a variety of work situations

Slide 2

Before You Leave

- Clear your mind of distractions, e.g., home and work environments.
- If you have distracting or distorted sentences in your head, change them to rational thoughts.

No one is more important than anyone else.

Examples of distorted thinking patterns that get in the way of effective interviewing: "I should be perfect. If the interviewee speaks English as a second language and I don't understand her accent I'll fake it." Rational thinking pattern would be to say, "I'm sorry, I didn't get what you said. Would you repeat it, please?" Communicate to the interviewee that your lack of understanding is *your problem*, not the interviewee's.

Slide 3

Onsite

- Overall: establish and nurture a relationship with the interviewee
- Explain why you're there
- Purpose of the survey: to get a picture of facility
- Establish a respectful stance
  - I'll ask you questions
  - You ask me, too

Slide 4

Be Real

- Demonstrate genuineness, courtesy, respect, empathy
- Encourage the interviewee to tell his/her story
- Balance story listening with focusing on your goal
- Use a protocol to keep you focused (e.g., nursing home interview protocol)

Slide 5

Adapt to the Interviewee

- Let the interviewee dictate the environment
- Ask permission to enter the interviewee's space
- Keep societal/cultural differences in mind
- Engage the person from the face on out—eye contact
- Eye contact seen as a threat for some Native Americans
- Know when to hold 'em and when to fold 'em

Hold 'em and fold 'em. Stop exploring an area if the interviewee becomes increasingly agitated and has difficulty continuing with the interview. Return to the topic at another time, either later in the interview, or come back later. Acknowledge the issue of time management. But use your strengths.

Slide 6

Individuals with Speech Impediments

- Your issue
  - Individuals who use communications devices
  - Individuals with dementia
  - Individuals who have English as a second language

Slide 7

Delivery

- Speak clearly
- Ask one question at a time
- Know the interview protocol well enough to refer to it without reading it verbatim
- Control your volume and pace
- As much as possible, interview in a quiet place

Slide 8

Note Taking

- Tell interviewee if you're going to take notes and why
- Encourage interviewee to read your notes

If it's an agency requirement that you have to take notes, say so. If, instead, it's your wish to be accurate and the interviewee doesn't want you to take notes, don't. But write your notes down as soon as you've finished.

Slide 9

Clarity

- Use language that the interviewee understands
- Clarify as you go, make sure the interviewee is with you
- Be honest about any difficulties you have understanding
- Make sure you understand an interviewee's question before giving an answer
- If you don't know an answer, get back to interviewee ASAP with appropriate information

Key in to the person you're interviewing so you are aware when they're missing a point.
Make sure you understand the question: an issue if you're the last person on the team, it's the last afternoon of the survey and everyone else is finished. Don't get distracted.

Slide 10

Rapport

- Avoid "role-playing"
- Make sure you speak the same language
- Keep in mind age, education, values, vocabulary
- Both parties carry personal values, attitudes, needs, culture, and experience

Role-playing: "I'm a nurse, and I know that . . ." Be a person with a name, such as Ginny or Steve, rather than a discipline.

Slide 11

Body Language

- Make sure there's consistency between verbal and nonverbal elements of your conversation
- If there's a distraction (e.g., a noise), comment on that, rather than making believe it's not there

Slide 12

Confidentiality

- Cannot promise and do not
- If there's something against the law, abuse and neglect, inform the interviewee that it will be reported—"We're here for your safety"
- Focus on the interviewee's benefit—make it concrete

Slide 13

Techniques (1)

- Make sure you and your interviewee are on the same page. How?
- *Check facts*
  - "This is what I'm getting from our conversation."
  - "How does that compare with what you understand?"
- *Paraphrase implications*
  - "Sounds like you might be worried that the same thing might happen to you. Is that right?"

Slide 14

Techniques (2)

- *Focus*
  - Bring the subject back to the matter at hand
  - Useful when an interviewee would like to monopolize the conversation
  - Use checking to get back to the point
- *Genuine Empathy*
  - Acknowledge if there's a real difficulty in relating to an embarrassing area (e.g., abuse)
  - "It looks like you might be having difficulty getting around, but you're still working at it. That's great. Now what was your question about insurance?"

Genuine empathy, as opposed to role-playing; not genuine condescension.

Slide 15

Techniques (3)

- *Mix closed and open questions*
  - Closed—yes or no, and facts
    - "Are you currently receiving Social Security?"
    - "What is your address?"
  - Open—room for a complex answer. Useful if an interviewee is reluctant to talk, or to get information about a complex matter
    - "What do you think about your care? How is it for you?"

Slide 16

Techniques (4)

- Be ready to hear what you never wanted to know
- Be a slow reacter—if necessary, work at it

The "thanks for sharing" reaction—never make it public. The "Oh my God! Oh, be real!"

It is important especially in abuse situations that we listen in a manner that invites the interviewee to continue telling us what we need to know.

Slide 17

Closing

- Summarize the interview
- Don't promise what you can't deliver
- Paraphrase what you've learned
- Ask if what you've said is an accurate picture
- Give the interviewee the opportunity to ask questions as well
- Tell the interviewee the next steps
- Thank the interviewee for his/her time

Activities 101

Activities are:
Activities refer to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success and financial or emotional independence. Activities should also provide stimulation or solace; spiritual well being; promote physical, cognitive and/or emotional health. They also enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice.

Some examples of activity needs are:
- Continuation of life-long roles.
- Improvement or maintenance of muscle strength and tolerance.
- Improvement or maintenance gross hand coordination.
- Improvement of maintenance of cognitive functioning.
- Opportunities for movement.
- Reality assurance.
- Enhancement of self-esteem.
- Independence through empowerment and choice.
- Stimulation of procedural memory.
- Improvement or maintenance of joint range of motion.
- Maintenance of a "normalized" atmosphere.
- Improvement or maintenance of concentration.
- Improvement of "alertness" level through focused stimulation.
- Socialization.
- Sensory stimulation.
- Reminiscence.
- Opportunities for nurturing and expressing affection.
- Opportunities for pleasure.
- Opportunities for caring touch and physical contact.
- Opportunities for self-expression.
- Opportunities to express emotions.
- Opportunities for family/significant other involvement.
- Opportunities to give something to others.
- Opportunities for nonverbal communication.
- Opportunities for relaxation and alleviation of stress.
- Outlet for restless energy.
- Leadership roles.

Activity progress notes:
- Are completed on a quarterly or as needed basis.
- Are written when significant changes occur.
- Are written more frequently for residents with higher levels of acuity (e.g., respite and short-term care).
- Should reflect how the resident spends their day at the facility.
- Should reflect the implementation of the activity Care Plan, and the resident's involvement and response to that plan.

Note that the activity calendar is being widely utilized as an attendance record that works well for tracking participation. Each resident's attendance is tracked on their calendar by highlighting programs attended, designate a color code for level of involvement, etc. This form can be inserted in the medical record for a clear, easy to follow accounting of what the resident has done. Residents who need more individualized involvement can have an additional form that tracks this participation.

The following are good examples of therapeutic outcomes for activities:
- Customary routine or continuation of the resident's previous lifestyle.
- Fewer symptoms of depression.
- Reinforcement of self-worth.
- Resident comments and feedback.
- Increased socialization.
- Improvement in mental status and memory recall.
- Gain in strength, dexterity and movement in muscles and joints.
- Regain of lost skills and/or abilities.
- Reduction in behavioral symptoms.

A population profile/assessment or facility/company form should assist in identifying residents whom:
- Attend activities independently when offered.
- Have special physical and cognitive needs and participate optimally in smaller groups designed to address these special needs.
- Have their own independent daily schedule of activities that do not include those offered by the facility.
- Always refuse participation.
- Require 1:1 programming, etc.
- Need gender-specific activities.

See attachment 1 for a sample population assessment tool and formula (page 3-K-71).

Often men may prefer:
- Fishing, hunting or other outdoor hobbies.
- Sports, especially baseball.
- Talking about or "reliving" past travel, especially if it was done during the War.
- Westerns (movies and TV).
- Reading the daily newspaper.
- Gardening.
- Barbecues and picnics.
- Competitive games.
- Animals.

The following should be considered when planning activities for men:
1. Most men were used to having their social lives planned by their wives.
2. Most of their socialization occurred in the homes of friends and family—not in large groups.
3. Most men like to win in sports or games and be recognized, either through awards/ trophies or at banquets. It is important for the activity/game to be as close to what the man was accustomed to doing in a normal lifestyle. Attention needs to be given to age-appropriateness, as well as dignity.

Examples of clusters:

Cluster 1—strong social skills, expresses self well verbally, good social skills, recognizes familiar faces, interacts well, attention span is approximately an hour.

Cluster 2—less social skills, may need some staff intervention when conflicts arise, some verbal skills, increased energy level, needs something to do with hands, attention span from a few minutes to 15.

Cluster 3—less social skills with others focuses on a few familiar people, more energy and need to be on the move, highly distractible, visual/spatial perception and balance are concerns, major assistance is needed for care.

Cluster 4—low energy level, non-verbal communication is the best, can respond if given enough time but rarely initiates contact, distracted easily.

Effective activities for the cognitively impaired resident share some of the following characteristics:

1. Normality and naturalness are essential.
2. Opportunities are provided for manageable choice.
3. Parallel presentation where the resident can follow the leader.

4. Immediate positive feedback is necessary.
5. Focus on individual strengths as opposed to limitations.
6. Activity should have a purpose or goal for participants—maintenance of existing abilities for as long as possible is an example of one such goal.
7. Categories of activities that are often beneficial to the cognitively impaired resident include:
   - Appearance/self-image activities.
   - Food related activities.
   - Intergenerational activities.
   - Movement and exercise activities.
   - Horticulture/gardening activities.
   - Handicraft/craft activities.
   - Pet therapy activities.
   - Music Therapy activities.
   - Reminiscence activities.

See attachment 2 for a list of possible activities for the resident who is cognitively impaired (page 3-K-75).

Activity kits and supplies that could be available for individualized programming:
Sensory-stimulating items like snow, fall leaves, bread baking, flowers from the garden and freshly picked apples are examples of every day items that could stimulate one's senses. It is highly recommended to look for opportunities to use the "real thing" vs. imitation props.

Reminiscing kits to include a wide array of topics like school days, weddings, babies, holidays, fishing, wartime, etc.

Lotions, perfumes and nail polish are all items that can be used to enhance self-esteem and also stimulate one's senses.

Board games, magazines, books, video tapes, hand held video games, word searches, crossword puzzles, jigsaw puzzles, craft supplies for quilting, crocheting, knitting, woodworking, musical tapes, writing materials often appeal to the resident who independently participates in activities structured by self.

Nutritious snacks can provide sensory stimulation, hydration and increased caloric intake—juice carts, ice cream wagons and fruit bowls taken right to the room can be popular.

Trivia questions, reminiscing topics, poetry, books to read aloud, popular musical tapes, old movies and exercise challenge courses can assist non-activity staff with materials needed to comfortably lead a group activity or 1:1 visit.

Adaptive equipment and supplies:
Large-print reading material, cards, hymnals, books and music on tape, pocket talkers for the hearing impaired, non-skid mats with consideration of color for appropriate contrast, built up items like paint brushes, pens, balls in a variety of weights, clamps and easels for art projects,

book holders, computer with specialized software for the visually impaired, magnifying glasses, card holders.

Surveyor *red flags*:

1. The activity area for group activities is too noisy or too small or does not exist.

2. Insufficient supplies to meet resident needs or no adaptive equipment/supplies/ materials available.

3. Long periods of time with no scheduled activities.

4. Residents appear bored, sleep through activities or don't attend activities. The surveyor should always determine the cause if possible:
   - Resident choice.
   - Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement.
   - Lack of assistance with ambulation.
   - Lack of sufficient supplies and/or staff to facilitate attendance and participation.
   - Program design that fails to reflect the interests or ability levels of residents such as activities being too complex, too simple, age inappropriate, beyond mental or physical capabilities, etc.

5. Resident interview and observation of activities indicate that some activities insult the intelligence, age and dignity of residents.

6. Activities are canceled on a regular basis or activity schedule is not followed. Frequent changes are made or evidence exists that there have been no changes to the calendar month after month.

7. No observation or documentation of specialized programming for room-confined/bedfast residents.

8. Residents not being invited or taken to activities by facility staff and unable to create their own activity stimulation or interaction with other residents.

9. Insufficient staff to meet resident needs and interests.
   - What percentage of the population is bed-confined or room-confined?
   - What percentage of the resident population is cognitively impaired has dementia or Alzheimer's?
   - How much time per day does the activity professional require to complete documentation, assess new admissions, participate in care conferences, solicit volunteers and schedule/format an activity program? Staff adequate to meet those requirements and needs? Are there negative outcomes?

10. Activity staff are the only individuals involved with activities or providing assistance to and from activities.

Questions about this portion of the presentation or the handout should be directed to: Cat Selman, ACC, at 601-853-4211 or HealthcareComm@aol.com. Karen Land, ACC/CTRS, at 757-456-5295 or landkaren@aol.com.

Population Assessment Tool

I. GENERAL

Residents who *are* your most frequent attendees of activities and are active participants. Considered to be higher-functioning. This group meets the facility goals for attendance.

II. LOW FUNCTIONING

Residents who have moderate levels of abilities, both physical and cognitive. Residents who presently participate *passively in* large group activities, are seen one to one, in general, have a Jaw level of participation. When asked to attend these residents are often incapable of making the decision and go along with anything you suggest.

III. ONE TO ONE

A. True one to ones—residents who are either too sick, too disruptive, or too agitated for group/structured activities. Often these residents are in need of sensory stimulation or the awareness activities.

B. Active Isolates—residents who refuse scheduled group activities. This particular group uses their leisure time constructively and consistently with their former lifestyle. This must be carefully and completely documented in the assessment and progress notes.

C. Inactive Isolates—residents who refuse regularly scheduled group activities as well. This group of residents fail to use their leisure time constructively and/or it is not consistent with their former lifestyle. While no residents can be forced to participate, every attempt must be made and documented on efforts to facilitate involvement.

D. Transportation/Reminders—residents who can successfully participate in scheduled activities but need assistance to the site or just a casual reminder.

E. In-Betweens—residents who alternate between the above categories. This group of residents has swing periods. This group of residents must be monitored constantly to assure their involvement in activities.

FORMULA FOR POPULATION ASSESSMENT TOOL

This tool is based on information gathered from the assessment and progress notes.

1. Group residents in three categories as defined.
2. Tally number in each category.
3. Determine how many programs will be offered daily—set a goal.
4. Daily number of programs x 7 = number of programs to be offered weekly.
5. Total number of programs x population % = number that should be offered to this category weekly.

EXAMPLE

Tally:	120-bed facility:	General	30 residents
		Low functioning	55 residents
		One to one	35 residents
% each category is of overall population:		General	30 of 120 = 25%
		Low functioning	55 of l20 = 46%
		One to one	35 of 120 = 29%
Weekly goal of programs:		This facility mandates 4 programs a day 7 days x 4 = 28	
No. that should be offered to each category weekly:		General	28 x .25 = 7 per week
		Low functioning	28 x .46 = 13 per week
		One to one	28 x .29 = 8 per week
Total programs offered a week:		7 + 13 + 8 = 28 total programs a week	

Of the 28 programs offered in a week, 7 should be for the general population, 13 should be for the low functioning and 8 should be for one-to-one.

111 ACTIVITIES FOR ALZHEIMER'S RESIDENTS

1. Clip coupons.
2. Sort poker chips.
3. Count tickets.
4. Rake leaves.
5. Use the carpet sweeper.
6. Polish silver.
7. Bake cookies.
8. Look up names in the phone book.
9. Read the daily paper out loud.
10. Ask a friend, neighbor or church acquaintance who has a baby or young child to visit.
11. Listen to polka music.
12. Plant seeds indoors or out.
13. Look at family photos.
14. Toss a ball.
15. Color pictures.
16. Make homemade lemonade.
17. Make cream cheese mints:
    2 lbs powdered sugar
    8 oz. cream cheese
    2 drops peppermint extract
18. Have a spelling bee.
19. Read from Reader's Digest.
20. Play kickball.
21. Have a pet visit.
22. Cut greeting cards into pictures.
23. Wash silverware.
24. Bake homemade bread.
25. Sort objects, such as beads, by shape or color.
26. Sing Christmas carols.
27. Say "tell me more" when they start talking about memories.
28. Put silverware away.
29. Play favorite songs together.
30. Make a valentine collage.
31. Take a ride.
32. Make a cherry pie.
33. Read aloud, from Ideals Book, P0 Box 1101, Milwaukee, WS 53201.
34. Dye Easter eggs.
35. Match a basket of socks.
36. Take a walk.
37. Reminiscence about the first day of school.
38. String Cheerios to hang outside for the birds.
39. Make a fresh fruit salad.
40. Sweep the patio.
41. Paint a picture.
42. Color paper shamrocks green.
43. Fold towels or pillow cases.
44. Have an afternoon tea.
45. Remember great inventions.
46. Play Pictionary.
47. Paint a sheet.
48. Cut out paper dolls.
49. Identify states and capitols.
50. Make a family tree poster.
51. Color a picture of our flag.
52. Cook hot dogs outside.
53. Grow magic rocks.
54. Water house plants.
55. Talk about first of kin.
56. Play horseshoes.
57. Dance.
58. Sing favorite hymns.
59. Make homemade ice cream.
60. Force winter bulbs to bloom.
61. Make Christmas cards.
62. Sort playing cards by color.
63. Write to a family member.
64. Dress in local team colors on game day.
65. Pop popcorn.
66. Name the U.S. Presidents.
67. Give a manicure.
68. Make paper butterflies.

69. Plant a tree.
70. Make a May basket.
71. Make homemade applesauce.
72. Finish famous sayings.
73. Feed the animals.
74. Mold with play dough.
75. Look at pictures in a National Geographic magazine.
76. Put a simple puzzle together.
77. Sand wood.
78. Rub on scented hand lotion.
79. Decorate paper placemats.
80. Arrange fresh flowers.
81. Remember famous people.
82. Straighten clothes drawers.
83. Finish nursery rhymes.
84. Make peanut butter sandwiches.
85. Fold diapers.
86. Sort and fold children's clothes.
87. Set the table.
88. Rinse off the dinner plates.
89. Wipe down the table after a meal.
90. Finish Bible quotes.
91. Paint with string.
92. Cut pictures from magazines.
93. Read classic short stories.
94. Put coins in a jar.
95. Sew sewing cards.
96. Put out birdseed.
97. Give a neck message.
98. Take care of a fish tank.
99. Trace and cut out leaves.
100. Roll yarn into a ball.
101. Have a day care class visit.
102. Recite the Lord's Prayer or 23rd Psalm (if appropriate).
103. Read a daily devotional.
104. Sort coins and put in coin wrappers.
105. Build with Lincoln logs or wooden blocks.
106. Dust furniture.
107. Sort buttons by color and size.
108. Arrange dominoes.
109. Change beds with help.
110. Remove and put back shoe strings from old shoes.
111. Fill large-mouth salt and pepper shakers.

Source: Unknown.

Surveying the LTC Activities Requirements

HCFA Satellite Broadcast
September 29, 2000

Presented by Carmen S. Bowman, MHS, ACC,
SMQT Health Compliance Surveyor
Health Facilities Division, Colorado Department of Public Health and Environment

Offsite Survey Preparation

- History of Facility/OSCAR Reports: Past activity deficiencies?
- Ombudsman report: Any activity concerns?
- Facility QI Profile: What is percentile rank of QI 23 - Prevalence of little or no activity?
- Resident Level Summary: Any residents trigger for this QI?

Initial Tour:

- Interviews: Interview residents and/or family members, if present, regarding satisfaction with the activity program: If not satisfied with activity program, why?
    - How does dissatisfaction affect resident?
    - What activities do they desire or would they suggest?
    - Ask resident if they could do anything, what would it be. Adapted?

- Observations: Scheduled activities occurring?
    - At occurring activities, are residents engaged?
    - Residents sitting around or wandering with no interaction or engagement?

Trigger Considerations for Sample Inclusion:

- Group activities not being conducted at all or as planned according to activity calendar.
- Residents sitting around or wandering with no interaction or engagement for lengths of time.
- Concerns/dissatisfaction from residents, family members, staff, or ombudsmen.
- Social isolation, residents observed in rooms without stimulation provided.
- Residents not invited to activities by any staff and unable to create their own activity stimulation.

Observation/Record Review/Interviews regarding Sample Residents:

- Interviews of resident and/or family per interview form.
- Care planned activities taking place/offered? Groups? 1:1's?
- Are residents invited to activities identified on Care Plan?
- Does documentation reflect residents invited/attending care planned activities?
- Are activities attended, appropriate for residents' functional level?

- When attending an activity, are residents engaged, involved and encouraged to participate?
- For residents who spend most time in their rooms, are there activities, projects, or items for stimulation?
- When residents are not interested in, or refuse activities, have alternatives been explored?
- If problems triggered, what information do activity staff offer?

Resident Review

Assessment for Activities Potential for Sample Residents (F272):

- MDS triggered? Section N-Activities Triggers are:
  - N1 Morning time awake AND N20 Most time involved in activities
  - N2 Little time involved in activities
  - N3 None - time involved in activities
  - N5 Slight or major change in 1) type of activities in which resident is currently involved, or 2) extent of resident involvement in activities
- RAP utilized appropriately? If indicated to proceed with care planning, was it? Are all RAP considerations reviewed as to their affect on resident activity participation?
- Is there a comprehensive assessment of activities potential interests and needs, which includes past and current activity interests? Social History may have additional activity interest information.
- Were MDS identified preferences further assessed? If music and sports were identified on the MDS, were the kinds of music or sports assessed and was is assessed how the resident prefers to enjoy that kind of music or sport, i.e. passively listen or watch, or actively play an instrument or sport, reminisce, etc.
- Even if not triggered by the MDS, if activity concerns arise, need to be followed up.
- Does assessment match interview information? Has resident expressed interests not included in the activity assessment or Care Plan? Did staff know of these interests?
- Does assessment accurately reflect resident's needs/interests and current abilities to participate?

Care Plan (F279):

- Activities are interest-based, not necessarily problem-based. A resident may have an interest in water color painting and express a desire to do so; this is not necessarily a problem. Instead, it is a presented need and interest, which becomes staff's responsibility to meet in as much as is possible.
- Are Care Plans individualized (beyond "invite to activities") to both resident activity interests as well as needs?
- Address activities appropriate for each resident, based on Comprehensive Assessment?
- Include services that are to be furnished to meet *highest practicable* level of functioning?
- Does activity plan include/reflect past and present interests or simply reflect the generic calendar?
- Written with input from resident and/or family?

- Are Care Plan goals appropriate? Are 3 1:1 activities per week for 15 minutes each enough? 45 minutes of planned activity? Depends upon rest of resident week.
- Are Care Plan goals meaningful to individual resident? Are goals measurable? Beyond a number of activities to attend per week? For example:
  - Resident will accept bead toy to fiddle with when offered daily.
  - Will stay at an activity at least 3 times per week
- If a need for one-to-one activities is determined, is there a goal established for the one-to-one interactions beyond one-to-one visits 3 times a week?
  - For example, a Resident will make eye contact during 1:1 activities 5 times per week.
- Are care planned activities reflected on the activity schedule?

Documentation:

- Activity attendance records, including one-to-one records, may assist in determining the types of activities residents attend and to determine if care planned activities are attended.
- Decipher activity attendance codes; what is the resident really engaged in? Match Care Plan?
- When activity attendance codes show non-attendance such as sleeping, bed rest, refused, ill, has facility noticed and made changes in activity plan accordingly?
- Care Plan goals met? If not, why? What is staff explanation?
- One-to-one records: Is the content of the visit indicated? Is resident response indicated? Is it evident that the goal is being pursued? Made eye contact, sang, answered questions, smiled. Successful one-to-one activities are numerous: play cards, checkers, write letters, read to resident, have resident read, sensory stimulation, reminiscing, massage, aromatherapy, pets, children, etc.

Progress Notes:

- Reflect outcomes to goals and responses to care planned activity interventions?
- Reflect progress? (Not just a summary) Met goals? If not, are new ones developed?
- If there are changes in condition, are changes made to the plan of care regarding activities?

Highest Practical Level of Functioning:

- If residents are not observed invited to care planned activities or care planned approaches are not observed; 1) ask staff if they know what the approaches are, and 2) consider asking staff to try those approaches so that you can observe resident reaction.
- While interviewing residents, try to establish resident's highest level of functioning per your observations and per information stated by resident.
- While interviewing family members, try to establish resident's highest level of functioning.
- Ask staff why care planned approaches are not known or are not carried out.
- Ask residents who are not attending occurring activities, if they were invited and if they would have liked to attend those activities.
- Utilize the family member interview protocol to establish what activity interests the resident has ever had. Are these interests known by staff? Were they assessed, care planned, and adapted to residents current level of functioning?

- Is the context of each resident's day considered, i.e. are baths rescheduled if resident prefers attending an activity? Is facility working together for the optimum of the resident? May trigger whether choices are respected (F242)

Note: Just because a resident can no longer do a certain activity, it does not mean that they no longer have a desire to pursue that interest in different ways. Regardless of whether a resident can perform a favorite activity, every activity can be adapted. If an activity interest can no longer be carried out physically, such as horseback riding, it can be adapted, altered or in some way expressed, i.e. by utilizing reminiscence, books, movies, documentaries, slide shows, magazines, photographs, photo albums, visiting a farm or ranch, etc.

Ongoing Activities Program (F248):

- Meets needs of each sample resident?
  - Determined through assessment, Care Plan, observation and interviews.
- Any comments regarding activity dissatisfaction from group interview?
- Are staff, both activity staff and non-activity staff, knowledgeable of resident's preferences and care planned activities? Do both activity and non-activity staff invite and/or escort residents to activities of choice? It is the facility's responsibility, not only the activity staff's to provide an ongoing program of activities.
- Are there activities when activity staff are off-duty?
- Because activities are interest-based and not necessarily problem-based, is staffing adequate to meet interests of residents?
- When there is transition of staff, i.e. activity staff resigned and a replacement has not been hired, what systems are in place to ensure that the activity program is indeed ongoing?

Activity Interview (Group, Resident, Family) Probes:

- Ask what the resident's favorite things to do are/have been.
  - Do they get to participate in that activity, in any adapted fashion?
  - Ask what activity a resident would do if s/he could do whatever s/he wanted?
  - Could this conceivably be provided? Brainstorm during interview; Would you try...? Would you enjoy...?

Activity Calendar Probes:

- Review the activity calendar in relation to interests of sample residents and any comments residents share from group interview. Reflect schedules, choices, and rights?
- Available to residents? Posted for residents to see and be able to read?
- Multi-faceted? Low and high functioning activities? Reflect cultural and religious interests? Appeal to men and women? Appeal to all age groups of residents?
- Evening activities? Determined by resident interest.
- Weekend activities? Also determined by resident interest.
- Outings? Community involvement?
- Does the activity calendar match residents or are residents simply fit into the already established activity calendar?

Secured Unit Probes:

- Are activities designed to meet needs of unit residents, i.e. for short attention spans, more frequently, activities to expend energy for wanderers, etc.?
- Supplies available according to resident wishes and needs? Or are supplies locked up after activity staff leave the unit?
- Are activities only offered when activity staff are present? Are activities available in evenings, early mornings, or during the night if residents are unable to sleep?

Transitional Care Unit/Extended Care Facility/Sub-Acute Unit/Swing Bed Unit Probes:

- Are there staff assigned to activities? Are CNAs assigned to activities? Are they able to conduct both activities and CNA duties?
- Are activities observed being conducted or offered?
- Are activities planned/is there an activities calendar?
- Because residents may be fatigued, are activities offered/provided in room?
- Because residents are in rehabilitation with the goal of discharge, are residents also encouraged to get out of their rooms? For example, for activities or meals? Or are they simply served meals in their rooms and not given a choice? May involve Choices (F242)
- Do residents know about activities available, supplies available, the activity calendar, and an activity room?
- Although residents may experience occasional pain, are they offered activities for when they feel up to it?
- Are residents assessed regarding level of pain or fatigue, times of day available, i.e. not preoccupied with therapy, etc.?
- Are televisions in a comfortable viewing position in rooms? Are they placed too high?
- May involve Accommodation of Needs (F246).

F249 Activity Director Qualifications:

- Often triggered if problems exist with activities program or during an initial cert. survey.
- Qualified therapeutic recreation specialist or an activities professional, who is licensed, registered, or certified.
- Or 2 yrs experience in a social/recreational program within past 5 yrs, 1 full time in activities.
- Or qualified occupational therapist (OT) or occupational therapist assistant (COTA).
- Or has completed a training course approved by the State.

(There may be additional possible AD qualifications per individual State regulations.)

Writing Activity Deficiencies:

- Deficiency Components.
- Record information: MDS, RAPs, Activity assessment, Care Plan, activity attendance records including one-to-one records.
- Resident/Family Interview information.
- Observations of sample resident's routines as well as activities as conducted.
- Care Plan carried out?
- Staff interview information and feedback to surveyor concerns.
- Failure summary statements.

- Did the facility provide an ongoing program of activities which met assessed and care planned activity needs and interests of sample residents?

Other Considerations:

- When activities not occurring, the number of potential or care planned activities were missed by how many residents who were assessed for that type of activity can be calculated.
- Observe how many residents at certain times are wandering aimlessly, sitting around without engagement, etc. If observe residents agitated or fidgety and no interventions offered, state your observation. This could possibly be a general observation and/or an observation of sample residents. Compare with plan of care.
- If care planned approaches are not observed nor documented but staff state they do occur, state this. Although staff stated that pet visits occur regularly, none were observed and there was no documentation indicating regular pet visits. Interview resident/family members.
- Observe activities while being conducted to determine whether residents are engaged.
- Determine by observation and documentation whether care planned activities occurred or were offered. Did care planned activities occur and the resident was not observed invited?
- If there has been a change in condition, did facility re-assess activity needs and interests?
- If documentation indicates that resident refused or was unavailable, why? Are scheduled activities changed or adapted to times convenient to the resident? Do staff go back later, i.e. for 1:1's?
- When there is no documentation and resident is not attending/being invited to activities, may consider stating that there was no indication that the resident was refusing activities or any other information regarding why the resident was not attending activities.
- When interviewing staff for feedback regarding activity issues/problems, asking why may help in discovering the heart of the matter.

For any additional activity/survey questions or if I can be a resource for you,
feel free to contact me at: carmen.bowman@state.co.us or 303-692-2859.
(Cbowman:surveyingactltcHCFA.wpd)

Abbreviated F-Tags List

Resident Rights

F151 Exercise Rights/Free of Reprisal
F152 Rights if Adjudged/Not Adjudged Incompetent
F153 Access Records
F154 Informed of Medical Condition
F155 Refuse Treatment
F156 Inform of Medicaid Services
Inform of Facility Services/Charges
Inform Medicaid Eligibility
Comply with Advance Directives
Inform How to Contact MD
How to Apply for Medicaid
F157 Notify Accidents, Significant Change
F158 Resident Manage Personal Funds
F159 Facility Manage Personal Funds
Deposit of Funds
Accounting of Funds
Notice of Balances
F160 Funds Conveyed Upon Death
F161 Surety Bond
F162 Limits on Facility Charges
F163 Free Choice—MD
F164 Privacy/Confidentiality
F165 Voice Grievances
F166 Facility Resolve Grievances
F167 Examine Survey Results
F168 Receive Information From Advocates
F169 Refuse to Work/Right to Work
F170 Mail – Send/Receive Unopened
F171 Access to Stationery
F172 Access for Visitors
F173 Ombudsman Can Examine Records
F174 Access to Telephone – Private
F175 Share Room with Spouse
F176 Self – Administration of Drugs
F177 Refusal of Transfers

Admission, Transfer and Discharge Rights

F201 Transfer for 6 Reasons
F202 Document Transfer
F203 Notice Before Transfer
Timing of Notice
Content of Notice
F204 Orientation for Transfer/Discharge
F205 Bedhold, Prior Notice
Bedhold, Notice at Transfer
F206 Permit Resident to Return
F207 Equal Access to Care Policies
F208 Admissions Policy
Not Require 3rd Party Pay
Not Solicit Money for Admission

Resident Behavior and Facility Practices

F221 Physical Restraints
F222 Chemical Restraints
F223 Free from Abuse
F224 Free from Mistreatment, Neglect, Stolen Property
F225 Not Employ Guilty Employees
Report Court Actions
Abuse Reported to Administrator
Investigate Abuse
Report Investigation Results
F226 Abuse Policies and Procedures – Written and Implemented

Quality Of Life

F240 Promote Quality of Life
F241 Dignity
F242 Choose Activities, Schedules, Healthcare
Interact with Community
Make Choices Significant to Resident
F243 Organize Resident Groups
Family Groups
Facility Provide Group Space
Staff May Attend Group
Facility Must Assist Group
F244 Facility Must Listen to Group
F245 Participate in Community Activities
F246 Accommodation of Needs
F247 Notice Before Room Change
F248 Activities Program
F249 Activities Directed by a Professional
F250 Social Services
F251 Qualified Social Worker
SW Degree and Experience
F252 Safe, Clean, Comfortable, Homelike Environment
F253 Housekeeping and Maintenance
F254 Clean Linens
F255 Closet Space
F256 Adequate Lighting
F257 Comfortable and Safe Temperatures
F258 Comfortable Sound

Resident Assessment

F271 Admission Orders
F272 Comprehensive Assessment – RAI Process
F273 14 Days after Admission
F274 After Significant Change
F275 12 Months
F276 Review of Assessment—Quarterly
F278 Accuracy of Assessment
Participation of Professionals
RN Sign It
Everybody Signs It
F279 Comprehensive Care Plan
F280 Develop Care Plan within 7 Days
By Interdisciplinary Team
Periodically Revised
F281 Services meet Professional Standards
F282 By Qualified Persons
F283 Discharge Summary— Recap
Final Summary of Status
F284 Post Discharge Plan of Care
F285 ASARR—MI and MR
F286 Maintain 15 months in active record
F287 Automated Required Data

Quality Of Care

F309 Highest Practicable Well Being
F310 ADLs Do Not Diminish
Bathe
Transfer
Toilet
Eat
Use Language
F311 Abilities Maintain/Improve
F312 Dependent Residents Get Care
F313 Vision/Hearing
F314 Pressure Sore Prevention and Treatment
F315 Do Not Use Catheter
Restore Bladder Function
Prevent Infection
F317 No Reduction in ROM
F318 ROM Treatment
F319 Treatment of Psychosocial Adjustment
F320 No Development of Mental Problems
F321 No Nasogastric (NG) Tubes
F322 NG Treatment
F323 Environment Free of Hazards
F324 Supervision to Prevent Accidents
F325 Maintain Nutrition
F326 Therapeutic Diet
F327 Hydration
F328 Special Needs
Injections
Parenteral & Enteral Fluids
Colostomy
Tracheostomy
Tracheostomy Suctioning
Respiratory Care
Foot Care
Prostheses
F329 Unnecessary Drugs
Excessive Dose
Excessive Duration
Without Monitoring
Without Indications
Adverse Consequences
Any Combinations of Above
Beers List
F330 Not Use Antipsychotic Drugs
F331 Antipsychotic Dose Reductions
F332 5% Medication Error
F333 Significant Medication Error

Nursing Services

F353 Sufficient Nursing Staff
F354 Registered Nurse (RN)
Licensed Nurse
F355 RN Waiver

Dietary Services

F360 Good Diet
F361 Qualified Dietitian
F362 Sufficient Dietary Staff

F363 Menus Meet Nutritional Needs
Menus Prepared in Advance
Menus Followed
F364 Food Flavor, Appearance, Nutrition, Temperature
F365 Food Form
F366 Substitutes
F367 Therapeutic Diets
F368 Meal Frequency
Three Meals a Day
14 Hours Between Supper and Breakfast
Bedtime Snacks
16 Hours With Snacks
F369 Assistive Devices
F370 Procure Food
F371 Store, Prepare, Distribute Food
F372 Dispose Garbage

Physician Services

F385 Physician Supervises Care/Provides Substitute
F386 Physician Review Plan of Care
Write Progress Notes
Sign, Date Orders
F387 Physician Visits
F388 Physician Must Personally Visit
Physician Assistant, Nurse Practitioner
F389 Physician Emergency Availability
F390 Delegate to Nurse Practitioner
When not to Delegate

Specialized Rehabilitative Services

F406 Provide or Obtain Services
F407 Qualified Providers

Dental Services

F411 SNF Assist to get Dental Care
F412 Routine Dental NF – Assist to get Dental Care

Pharmacy Services

F425 Provide Drugs
F426 Pharmacy Procedures
F427 Licensed Pharmacist Consults on Pharmacy Services
System of Records
Drug Records are in Order
F428 Drug Regimen Review Monthly
F429 Report Irregularities
Beers List
F430 Act upon Reports
F431 Labeling of Drugs
F432 Store Drugs—Locked
Controlled Drugs—Locked

Infection Control

F441 Program Prevents Infection
Isolation Procedures
Record Incidents of Infection
F442 Isolate Residents
F443 Prohibit Employee Contact
F444 Wash Hands
F445 Handle Linens

Physical Environment

F454 Designed, Equipped, Maintained
Life Safety from Fire
F455 Emergency Power
Power for Life Support
F456 Space/Equipment Maintenance
F457 Resident Rooms
F458 Square Footage
F459 Access to Exit Corridor
F460 Visual Privacy
Ceiling Suspended Curtains
F461 Have a Window
Floor At/Above Grade Level
F462 Have a Toilet
F463 Call System in Resident Rooms
Call System in Toilets/Bath Facilities
F464 Provide Dining and Activity Rooms
Well Lighted
Ventilated
Furnished
Sufficient Space For All Activities
F465 Other Environment Conditions
F466 Water Supply
F467 Outside Ventilation
F468 Handrails
F469 Pest Control

Administration

F490 Administered Effectively
F491 Be Licensed
F492 Compliance with Laws
F493 Governing Body
Appoints Administrator/Licensed
Appoints Administrator Who is Responsible
F494 Nurse Aides Competent and Trained
Nurse Aide Temporary
F495 Nurse Aide Competency
F496 Nurse Aide Registry Verification
Nurse Aide Multistate Verification
F497 Nurse Aide In-Services
F498 Nurse Aide Proficiency
F499 Employ Professionals
Professionals be Licensed
F500 Use Outside Professionals
Outside Services meet Standards
Outside Services are Timely
F501 Designate a Medical Director
Medical Director Implements Policies
Medical Director Coordinates

Medical Care

F502 Provide or Obtain Lab Services
F503 Lab Services meet Requirements
Blood Bank meets Requirements
Referral Labs are Certified
Agreement to Obtain Lab Offsite
F504 Labs Only When Ordered
F505 Notifies MD of Findings
F506 Facility Assists Transportation to Lab
F507 File Lab Reports in Record
F508 Provide/Obtain Radiology
F509 Radiology meets Regulations
Agreement for Radiology
F510 Radiology Only Upon MD Order
F511 Notifies MD of Findings
F512 Transport to Radiology
F513 File Radiology Reports in Record
F514 Clinical Records Complete
F515 Retention of Records
F516 Safeguard Records
F517 Emergency Plan
F518 Train Employees in Plan
Periodic Review with Staff
Unannounced Staff Drills
F519 Transfer Agreement with Hospital
F520 Quality Assurance Committee
F521 QA Committee Meets Quarterly
QA Committee Develops Plans
F522 Ownership Disclosure
Notice to State of Changes
Notice Contents

Lesson 3-L: Resident Rights

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe how a facility protects and promotes resident rights.
- Explain how facility promotion of resident rights empowers residents to achieve and maintain their highest practicable well-being.
- Identify resident rights investigative methods.
- Discuss examples of resident outcomes.
- Describe a facility's steps for making equal access to quality care available to all, regardless of payment source.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Sub-Task 5D, pp. 55–59
  - Appendix PP
  - 42 CFR 483.10, Resident Rights
  - 42 CFR 483.12, Admission, Transfer, and Discharge Rights
- *Quality of Life Assessment* interview forms
  - Forms CMS-806A, CMS-806B and CMS-806C

State

(Insert State reference[s] here.)

Other

Highlights

- *Flying in an Airplane* exercise and discussion
- Investigation using the survey process
- Concept of the "reasonable person"
- Review of resident rights regulations and suggestions for investigation
- *Staff Fantasy* exercise and discussion

Training Techniques

- Internet scavenger hunt (optional)
- Lecture
- Group discussion
- Small group exercises
- Self-test

Training Aids

- PowerPoint slides and handouts
- *Quality of Life Assessment* interview forms
- Handouts:
  - *Flying in an Airplane*
  - *Airplane Analogy Instructor Information*
  - *Survey Process*
  - *Notes on Resident Rights Regulations—1*
  - *Notes on Resident Rights Regulations—2*
  - *Instructor's Guide to Staff Fantasy Exercise*

- *Staff Fantasy Exercise*
- *Resident Rights Self-Test*

Methods of Evaluation

- Verbalization/discussion of understanding
- Effective use of information during a future training session
- Completion of skill assessment

Audiovisual	Outline or text of presentation
Lesson 3-L: Resident Rights 1 Slide 3-L-1	*(Optional preparatory work: Have the students conduct an Internet scavenger hunt for Forms CMS-806A, CMS-806B and CMS-806C.)*
Learning Objectives At the conclusion of this lesson, you will be able to: • Describe how a facility protects & promotes resident rights. • Explain how facility promotion of resident rights empowers residents to achieve & maintain their highest practicable well-being. 2 Slide 3-L-2	*(Inform the students of the objectives.)*
Learning Objectives (cont.) • Identify resident rights investigative methods. • Discuss examples of resident outcomes. • Describe a facility's steps for making equal access to quality care available to all, regardless of payment source. 3 Slide 3-L-3	

Audiovisual

Resident Rights

- 42 CFR 483.10: "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident."

4

Slide 3-L-4

Outline or text of presentation

Resident Rights

42 CFR 483.10 states that "the resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident."

Resident rights and issues that affect quality of life are important for residents who live in long term care facilities.

Determining facility compliance with the regulations regarding resident rights and quality of life is often challenging. Investigation of quality-of-care issues often relies on more concrete outcomes that are determined by observations of care or lack of care, deterioration of wounds and functional ability and inaccurate or absent records. Often, resident care needs are emphasized over resident rights and quality-of-life needs. Federal regulations require that the facility provide certain services or care to ensure that each resident can exercise his/her rights and has the quality of life he/she desires.

Flying in Airplane—Discussion

This is your home

This is your chair

This is food we are serving

We don't want you to fall

5

Slide 3-L-5

Exercise and discussion: Flying in an Airplane

(The Flying in an Airplane exercise compares the experience of being a passenger on an airplane to the experience of living in a long term care facility.

Use the student handout "Flying in an Airplane" on page 3-L-17 and the Instructor handout "Airplane Analogy Instructor Information" on page 3-L-19.

Audiovisual

Outline or text of presentation

Hand out the participant "Flying in an Airplane" worksheet. In the group discussion, ask the surveyors how each of the listed issues is handled on an airplane. Use the "Airplane Analogy Instructor Information" to guide the discussion as it applies to resident rights in a nursing home. Invite participants to talk about the similarities and differences.)

Examples of resident rights ensured by the regulations include:

- Written notification of rights as a resident and citizen.
- Access to health status and records.
- Advance notification of facility policies.
- Notification of changes in condition.
- Management of personal funds.
- Privacy and confidentiality.
- Communication inside and outside facility.
- Admission, transfer and discharge rights.

Survey Process

- Evidence facility protects & promotes resident rights
- Interview, observation, record review
- "Reasonable-person" concept

6

Slide 3-L-6

Survey Process

(Refer the students to the handout "Survey Process" beginning on page 3-L-21.)

Surveyors use observation and interviews to look for evidence that the facility protects and promotes the rights of residents.

Many residents in long term care facilities may become resigned to their circumstances. That does not mean that they like or prefer their lives the way they are. They may speak out about an issue only when it means a lot to them or they become angry and frustrated. Other

Audiovisual

Outline or text of presentation

residents may be physically or cognitively unable to voice their reaction to loss of their rights, such as lack of privacy of their bodies during personal care.

Surveyors frequently use the "reasonable-person" concept when evaluating compliance with resident rights and Quality of Life regulations.

(See Lesson 3-A, Introduction to the Outcome-Oriented Survey Process.)

How would a reasonable person feel about someone:

- Changing a cognitively impaired resident's wound dressing in a public place such as the TV room?
- Saying, "Just pee in your bed," or putting an adult diaper on a resident instead of helping the resident to the toilet?
- Making care decisions for a resident who could make his/her own informed decisions?
- Not telling or indicating to a resident (whether cognitively intact or impaired) what he/she was going to do (bathe, turn, transfer the resident, etc.)?

Survey Process (cont.)

- Task 2—Entrance Conference/Onsite Preparatory Activities
  - Request copy of resident admission packet
    - Resident rights notification
    - Resident policies
    - Advance directive information
    - Facility charges

7

Slide 3-L-7

During Task 2—Entrance Conference/Onsite Preparatory Activities, surveyors request a copy of a resident admission packet. They later review it to ensure that facility staff provided notification of resident rights, resident policies (e.g., about smoking privileges and pets), advance directives information and various charges.

Audiovisual

Survey Process (cont.)

- Task 3—Initial Tour
  - Onsite observations & interviews identify issues to investigate
  - Identify interviewable residents & families
  - Observations
    - Display of resident rights information
    - Access to most recent survey results
    - Staff provision of privacy for resident personal care
    - Provision of privacy with visitors & telephone
    - Privacy of resident personal care information & medical records

8

Slide 3-L-8

Outline or text of presentation

During Task 3—Initial Tour, surveyors observe other facility methods of notifying residents of their rights, such as by displaying a large poster listing resident rights. Additionally, surveyors look for how the facility provides resident and visitor access to the most recent survey findings. Surveyors also look for how the facility staff provides privacy for personal care and treatment and with personal visitors and telephone access.

Survey Process (cont.)

- Task 4—Sample Selection
  - Select residents & families for resident & family interviews
  - Discuss any tour issues to include in group interview

9

Slide 3-L-9

During Task 4—Sample Selection, surveyors include in the sample interviewable residents and families and residents named in any complaints. (Information gathering directed by Sub-Task 5D—Quality of Life Assessment includes evaluation of resident rights.)

The surveyor investigates how the facility promotes resident rights using a *Quality of Life Assessment* interview form (Form CMS-806A, *Resident Interview,* Form CMS-806B, *Group Interview* and Form CMS-806C, *Family Interview*). (Lesson 3-K, Quality of Life, contains additional information on interviewing techniques and use of these interview forms.) Information gathering verifies, validates and investigates concerns identified in these interviews through observation of life and care in the facility, further interviews with staff, other residents, physicians, etc. and record review.

The surveyor:

- Determines whether the resident, group, or family wants certain information kept confidential.

Audiovisual	Outline or text of presentation
	• Investigates the issue(s) while maintaining confidentiality. In a timely manner, shares concerns from interviews with the team and determines the approach(es) for further investigation. • Provides an opportunity for all interested parties, including facility staff, to give pertinent information. For all interviews, the surveyor is to: • Interview in private unless interviewee prefers otherwise. • Establish rapport at beginning of the interview. • Use open-ended questions as much as possible (e.g., "Tell me about . . . ," "What if . . . ?" and "How would that make you feel?"). • Notify the ombudsman of relevant concerns (with interviewee's permission). • Include questions from the protocol to cover all areas. • Offer to summarize his/her notes at the end of the interview. In this way, if there was miscommunication, it can be clarified. • Respect confidentiality of information and the interviewee unless he/she receives permission from the interviewee to share information. • Accurately document responses on the appropriate form (resident and family quotes lend credence to deficiencies and can have a real impact). • Conduct the required number of interviews. • Probe for further information when answers were incomplete, unclear or nonspecific. • For all problems identified, try to determine whether there was an actual, or just a potential, negative outcome.

Audiovisual

Outline or text of presentation

Resident interviews (Form CMS-806A)
The surveyor should look at the Minimum Data Set (MDS) to determine how the facility assessed the resident's cognitive status and behaviors. Introducing himself/herself to the resident, the surveyor should determine whether the resident is indeed interviewable by talking with the resident and assessing the validity of the information the resident provides. (Do the statements corroborate what was seen in the facility? Are the answers consistent with what the resident said earlier? Does the resident answer the question he/she was asked? Are the answers plausible? As the interview continues and leads to more specific questions, do the answers become more vague and not make sense?) Orientation questions such as the date, year and name of the current president often have no relevance to the nursing home resident and do not necessarily indicate reliability of the information gained from him/her in an interview about life in the facility. Sometimes the resident cannot physically participate in the interview (shortness of breath or acute illness).

The surveyor should:

- Ask if he/she can interview the resident *privately* regarding his/her opinion on a variety of issues that surveyors look into when in the facility.
- If the resident refuses to be interviewed, select another resident to interview.
- Conduct some resident interviews before the group interview is held.

Audiovisual

Outline or text of presentation

Group interview (Form CMS-806B)
If the surveyor identifies problems through the resident interviews, the group interview provides an opportunity to find out how many additional residents have the same problems. Quantification will add further credibility to a deficiency and refine the scope of each problem.

The surveyor should determine from team members whether there are identified concerns not listed on the interview form that the team would like to ask the group about.

Survey Process (cont.)

- Sub-Task 5D—Information Gathering
  - Interview, observation, record review
  - Direction from structured CMS forms
    - *Quality of Life Assessment* interview forms
      - Resident, family & group
  - Resident funds review

10

Slide 3-L-10

Information-gathering suggestions

- Resident-staff interactions and outcomes:
  - Do residents know their rights and have input into their daily lives and care?
  - Do resident-staff interactions demonstrate staff implementation of resident rights?
- Interviews with residents, group, families, staff:
  - Does the facility address resident grievances and provide notification of results?
  - Discussion with team members may reveal many isolated incidents.
  - Review Resident Council minutes and follow up during the group meeting.
- Observations of privacy of personal care and medical and personal care information:
  - Use the reasonable-person standard.
- Closed record review of discharge notices and return of personal funds.

Survey Process (cont.)

- Sub-Task 5D—Information Gathering (cont.)
  - Document date, time, staff name, title:
    - Resident/staff interactions & outcomes
    - Interviews with residents, group, families, staff
    - Observations of privacy of personal care & medical & personal care information
    - Closed record review of discharge notices & return of personal funds
    - Resident funds review & observation of purchase of items

11

Slide 3-L-11

Audiovisual

Survey Process (cont.)

- Task 6—Information Analysis
  - Team discussions
  - Sum of actions
  - Severity & scope
- Task 7—Exit Conference
  - Present preliminary findings
  - Discuss facility clarifying information

12

Slide 3-L-12

Resident Rights—1

- Citizen
- Resident
- Decision making
- Notice of rules, policies
- Inform of health status
- Access to records
- Choose physician
- Inform of Medicare & Medicaid services & charges
- Notification of changes
- Resident funds
- Participation in Care Plan & treatment decisions
- Privacy & confidentiality
- Grievances

13

Slide 3-L-13

Outline or text of presentation

- Resident funds review and observation of purchase of items:
  - Observe residents trying to access their petty cash for treats or to purchase clothing.

Survey team discussion of facility compliance with resident rights regulations continues throughout the survey and during Task 6—Information Analysis for Deficiency Determination. The regulations at 42 CFR 483.10 Resident Rights (F151–177) and 42 CFR 483.12 Admission, Transfer, and Discharge Rights (F201–208) are not included in the regulations for determining substandard quality of care and do not have the potential to lead to an extended survey.

Presenting evidence of noncompliance with resident rights regulations during Task 7—Exit Conference provides opportunities for the facility to submit additional information.

(There are two handouts containing notes on resident rights regulations. The slide at left corresponds to the first handout.

For the slide at left, refer students to the handout "Notes on Resident Rights Regulations—1" beginning on page 3-L-25 and review the handout with them.)

Audiovisual	Outline or text of presentation
Resident Rights—2 • Survey results • Advocate information • Work • Mail • Visitors • Ombudsman • Telephone • Use personal property • Share room with spouse • Administer meds • Admission • Transfer • Discharge 14	*(Refer students to the handout "Notes on Resident Rights Regulations—2" beginning on page 3-L-31 and review the handout with them.)*
Slide 3-L-14	
What to keep? How do I decide? Staff Fantasy Exercise What can I give up? Choices 15	*(Conduct the Staff Fantasy Exercise using the "Instructor's Guide to Staff Fantasy Exercise" on page 3-L-35 and the "Staff Fantasy Exercise" student handout on page 3-L-37.)*
Slide 3-L-15	
Lesson 3-L: Resident Rights Questions 16	
Slide 3-L-16	*(Refer students to the "Resident Rights Self-Test" on page 3-L-39. Have them complete the test using their notes and handouts. Collect the tests for use as an indication of student learning.)*

Skill Assessment

Resident Rights

Trainee Name _____

Preceptor Name _____

Date _____

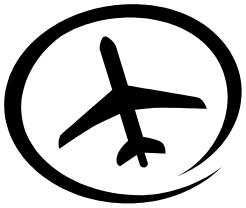
OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described how a facility protects and promotes resident rights.	
					Explained how facility promotion of resident rights empowers residents to achieve and maintain their highest practicable well-being.	
					Identified resident rights investigative methods.	
					Discussed examples of resident outcomes.	
					Described a facility's steps for making equal access to quality care available to all, regardless of payment source.	

Comments/Recommendations:

Flying in an Airplane



Personal belongings

Seating

Seatmates

Access to bathroom

Access to food and water

Seatbelts

Movement

Activities

Dependence on attendants

Trust

Airplane Analogy Instructor Information

The following compares the experience of being a passenger on an airplane to the experience of living in a long term care facility. Invite participants to talk about the similarities and differences. The list below can help you lead the discussion.

1. **Personal belongings—very limited**
   - Moving from a private residence into a long term care facility, choosing which personal items to take and which must be stored or discarded.

   Related rights: dignity and respect, freedom of choice.

2. **Assigned seating—limited choice of location**
   - Having your room assigned at the long term care facility.

   Related rights: freedom of choice, accommodation of needs.

3. **Assigned seatmates**
   - Being assigned a roommate, having a change of roommate.

   Related rights: freedom of choice, accommodation of needs.

4. **Access to bathroom restricted**
   - Having to wait until an aide is available to assist you to the toilet.

   Related rights: accommodation of needs.

5. **Eat what and when served**
   - Meals served at regimented times, special diets (low-salt, pureed, diabetic) strictly enforced.

   Related rights: freedom of choice.

6. **Restraints are used**
   - Chemical or physical restraints inappropriately used.

   Related rights: accommodation needs, freedom of choice.

7. **No place to go**
   - Lack of transportation to outside events/activities, not enough activities scheduled.

   Related rights: participation in activities.

8. **Dependence on attendants**
   - Reliance on staff for care needs as well as socialization.

   Related rights: participation in activities, freedom of choice, dignity and respect.

9. **Must trust pilots**
   - Must trust staff and administration of health care facility.

   Related rights: freedom of choice, accommodation of needs.

Developed by: Carol Scott, State Ombudsman, Department of Health & Senior Services, P. O. Box 570, Jefferson City, MO 65102

Survey Process

Surveyors use observation and interviews to look for evidence that the facility protects and promotes the rights of residents.

Many residents in long term care facilities may become resigned to their circumstances. That does not mean that they like or prefer their lives the way they are. They may speak out about an issue only when it means a lot to them or they become angry and frustrated. Other residents may be physically or cognitively unable to voice their reaction to loss of their rights, such as lack of privacy of their bodies during personal care.

Surveyors frequently use the "reasonable-person" concept when evaluating compliance with resident rights and Quality of Life regulations. (See Lesson 3-A, Introduction to the Outcome-Oriented Survey Process.)

How would a "reasonable" person feel about someone:

- Changing a cognitively impaired resident's wound dressing in a public place such as the TV room?
- Saying, "Just pee in your bed," or putting an adult diaper on a resident instead of helping the resident to the toilet?
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During Task 2—Entrance Conference/Onsite Preparatory Activities, surveyors request a copy of a resident admission packet. They later review it to ensure that facility staff provided notification of resident rights, resident policies (such as smoking privileges and pets), advance directives information and various charges.

During Task 3—Initial Tour, surveyors observe for other facility methods of notifying residents of their rights, such as by displaying a large poster listing resident rights. Additionally, surveyors look for how the facility provides resident and visitor access to the most recent survey findings. Surveyors also look for how the facility staff provides privacy for personal care and treatment and with personal visitors and telephone access.

During Task 4—Sample Selection, surveyors include interviewable residents and families and residents named in any complaints in the sample. Information gathering directed by Sub-Task 5D—Quality of Life Assessment includes evaluation of resident rights.

The surveyor investigates how the facility promotes resident rights using the *Quality of Life Assessment* interview forms (Forms CMS-806A, *Resident Interview,* CMS-806B, *Group Interview* and CMS-806C, *Family Interview.* Lesson 3-K, Quality of Life, contains additional information on interviewing techniques and use of these interview forms.) Information gathering verifies, validates and investigates concerns identified in these interviews through

observation of life and care in the facility, further interviews with staff, other residents, physicians, etc. and record review.

The surveyor:

- Determines whether the resident, group or family wants certain information kept confidential.
- Investigates the issue(s) while maintaining confidentiality. In a timely manner, shares concerns from interviews with the team and determines the approach(es) for further investigation.
- Provides an opportunity for all interested parties, including facility staff, to give pertinent information.

For all interviews, the surveyor is to:

- Interview in private unless interviewee prefers otherwise.
- Establish rapport at beginning of the interview.
- Use open-ended questions as much as possible (e.g., "Tell me about . . . ," "What if . . . ?" and "How would that make you feel?").
- Notify the ombudsman of relevant concerns (with interviewee's permission).
- Include questions from the protocol to cover all areas.
- Offer to summarize his/her notes at the end of the interview. In this way, if there was miscommunication, it can be clarified.
- Respect confidentiality of information and the interviewee unless he/she receives permission from the interviewee to share information.
- Accurately document responses on the appropriate form (resident and family quotes lend credence to deficiencies and can have a real impact).
- Conduct the required number of interviews.
- Probe for further information when answers were incomplete, unclear or nonspecific.
- For all problems identified, try to determine whether there was an actual, or just a potential, negative outcome.

Resident Interviews (Form CMS-806A)

The surveyor should look at the MDS to determine how the facility assessed the resident's cognitive status and behaviors. Introducing himself/herself to the resident, the surveyor should determine whether the resident is indeed interviewable by talking with the resident and assessing the validity of the information the resident provides. (Do the statements corroborate what was seen in the facility? Are the answers consistent with what the resident said earlier? Does the resident answer the question he/she was asked? Are the answers plausible? As the interview continues and leads to more specific questions, do the answers become more vague and not make sense?) Orientation questions such as the date, year and name of the president often have no relevance to the nursing home resident and do not necessarily indicate reliability of the information gained in an interview about life in the facility. Sometimes the resident cannot physically participate in the interview (shortness of breath or acute illness).

The surveyor should:

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- If the resident refuses to be interviewed, select another resident to interview.
- Conduct some resident interviews before the group meeting is held.

Group Interview (Form CMS-806B)

If the surveyor identifies problems through the resident interviews, the group interview provides an opportunity to find out how many additional residents have the same problem. Quantification will add further credibility to a deficiency and refine the scope of each problem.

The surveyor should determine from team members whether there are identified concerns not listed on the interview form that the team would like to ask the group about.

Information-Gathering Suggestions

- Resident-staff interactions and outcomes:
  - Do residents know their rights and have input into their daily lives and care?
  - Do resident-staff interactions demonstrate staff implementation of resident rights?
- Interviews with residents, group, families, staff:
  - Does the facility address resident grievances and provide notification of results?
  - Discussion with team members may reveal many isolated incidents.
  - Review Resident Council minutes and follow up during the group meeting.
- Observations of privacy of personal care and medical and personal care information:
  - Use the reasonable-person standard.
- Closed record review of discharge notices, return of personal funds.
- Resident funds review and observation of purchase of items:
  - Observe residents trying to access their petty cash for treats or to purchase clothing.

Survey team discussion of facility compliance with resident rights regulations continues throughout the survey and during Task 6—Information Analysis for Deficiency Determination. The regulations at 42 CFR 483.10 Resident Rights (F151–177) and 42 CFR 483.12 Admission, Transfer, and Discharge Rights (F201–208) are not included in the regulations for determining substandard quality of care and do not have the potential to lead to an extended survey.

Presenting evidence of noncompliance with resident rights regulations during Task 7—Exit Conference provides opportunities for the facility to submit additional information.

Notes on Resident Rights Regulations—1

All residents in long term care facilities have rights guaranteed under Federal and State law. The requirements at 42 CFR 483.10 include the following regulations. The examples below may only address a part of the regulatory statement.

42 CFR 483.10(a) Exercise of rights as a resident and a citizen (F151)
(1) Right to vote, make decisions common to any citizen.
(2) Be free of discrimination and reprisal for trying to exercise a right.

- What is the facility's system for assisting residents in voting in an election?
- Did residents mention difficulty during the group meeting?
- Were residents talking openly about staff responses to their requests?

42 CFR 483.10(a) Incompetent/competent resident (F152)
(3) Person who has legal authority is making decisions for a resident judged legally incompetent under State law.
(4) A competent resident may designate a surrogate to make some decisions. The facility listens and responds to the surrogate, although the resident can still make decisions.

- The MDS requires the facility to assess the cognitive status of a resident. If the facility has identified problems and you disagree, be sure to document information in your notes that shows why you think the individual is *not* cognitively impaired and is providing valid information regarding a specific issue.
- How has the facility resolved the resident's wishes when in conflict with the family's?
- Has the facility involved the ombudsman or other resources to help resolve these conflicts?

42 CFR 483.10(b)(1) Resident notifications of rules and responsibilities (F156)

The admission packet should contain information regarding all of the facility's rules: for example, smoking restrictions and diet/menu restrictions (e.g., serve kosher only):

- Investigate by reviewing the entire admission packet provided to residents when they enter the facility. Read all of it to make sure this and other regulations are met.
- Interview the resident and family.

42 CFR 483.10(b)(2) Access to records and photocopying (F153)

- To determine a valid community standard for a charge to photocopy, consider the charge to photocopy at the post office, grocery store or a business that copies documents.

42 CFR 483.10(b)(3) Information on total health status (F154)

- Total health status also includes psychotropic medications and diet restrictions.

42 CFR 483.10(b)(4) Refusal of treatment and participation in research (F155)

- As part of the procedure for this section, surveyors may check for whether the facility participates in experimental research. (Consider emphasizing the right to refuse treatment over the issue of experimental research.)
- Determine the facility policy for refusal of treatment and creation of advance directives. Are residents aware of this?

42 CFR 483.10(b)(5)–(6) Initially and periodically informed of Medicaid services and charges (F156)

42 CFR 483.10(b)(7) Written statement of legal rights (F156)

- Although this information often is provided verbally, many facilities do *not* provide a *written* statement explaining:
  - The facility's manner of protecting personal funds.
  - The requirements and procedures for establishing eligibility for Medical.
  - The requirements and procedures for an assessment to determine the extent of a couple's nonexempt resources.
  - Where to file a complaint with the State agency.
  - All required information regarding advance directives. (This may be a regional issue.)
- Review the complete admission packet for this information.
- If needed, interview the staff person who usually admits residents and provides the written information.

42 CFR 483.10(b)(8) Written statement of the facility's policies to implement advance directives and applicable State law (F156)

- Many facilities do not provide such a statement in writing. It should address if the facility will or will not implement certain advance directives. For example, many facilities will not provide intravenous therapy. Others may not have the capacity to care for a person on a ventilator. The written statement of the facility policy should provide this information.
- The law allows a facility, based on concerns, *not* to follow a person's advance directive. For example, the facility staff could then resuscitate all residents even though there were

advance directives that stated *not* to. (Guidance to Surveyors: "The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and state law allows the provider to conscientiously object.") Again, if you have any questions, request a copy of the written information provided and interview additional residents and staff regarding your concern.

42 CFR 483.10(b)(9) Information about physician responsible for their care (name, specialty, and means available to them for contacting) (F159)

- Attempt to elicit this information from residents and facility staff during interviews.
- Do the resident's and family's responses match the information provided by the facility?

42 CFR 483.10(b)(10) Information on applying for Medicaid and Medicare (F156)

- This is the regulation that addresses "demand bill" or, as the regulation states, "how to receive refunds for previous payments covered by such benefits."
- If a resident is receiving skilled care services and occupies a bed that is certified for Medicare, Medicare will pay only for a certain number of days. When the Medicare runs out, the facility must give the resident a written notice that Medicare will no longer pay for the care. At this point the nursing home begins to bill the resident rather than Medicare. However, the notice must also state that the *resident can appeal or "demand" that the bill be submitted to Medicare* to see if it *will* pay the bill. That's why it is known as "demand" bill.

42 CFR 483.10(b)(11) Notification to resident, physician, legal representative or family of changes (see the following) (F157)

42 CFR 483.10(b)(11)(A) Notification of accidents resulting in injury and having potential for requiring physician intervention

- Facility policies may vary on reporting falls or other accidents without apparent injuries.
- For example, a resident fell and there were no obvious injuries. The initial assessment showed neurological checks and vital signs were normal. Because injuries may not manifest themselves immediately, it would be prudent for the facility staff to monitor the resident's condition to be sure that there was no injury.
- Complaint investigations often include facility failure to notify the physician and/or family of an injury that deteriorates and results in hospitalization and/or death.
- Review the medical record for documentation of the initial assessment, physician notification and monitoring of the resident's condition. If needed, interview staff that completed the assessment.
- Interview staff about their knowledge and implementation of facility policies and procedures for care, monitoring and physician notification following falls and other accidents.

42 CFR 483.10(b)(11)(i)(B)–(C) Notification of significant change

The facility is responsible for notifying the resident, the resident's physician and the resident's legal representative (if known) of significant changes in the resident's status (physical, mental or psychosocial) as well as alternatives in treatment:

- There are various methods of detecting, documenting and interviewing that surveyors may use for this regulation. For example:
  - Reviewing the MDS, Care Plan, medication and treatment records, physician orders and progress notes for changes in status, assistance, medications and treatments.
  - Observing resident care and interactions for comparison to facility documentation.
- Interview the resident, family and staff regarding resident status and any changes.

42 CFR 483.10(b)(11)(ii)(A) Notification of a change in roommates.

- If the resident has concerns about such a change, look at the regulations regarding individual grievances [42 CFR 483.10(f)] and medically related social service needs [43 CFR 483.18(g)(1)].

42 CFR 483.10(c)(1)–(8) Resident funds

All personal funds of any resident held by the facility. If requested in writing, the facility must manage resident personal funds. The following Federal regulations apply. However, State regulations for managing resident funds vary. Include those regulations in addition to the following:

42 CFR 483.10(c)(1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility (F158)

42 CFR 483.10(c)(2) Facility will manage resident personal funds (F159)

42 CFR 483.10(c)(3) Deposit personal funds greater than $50 in interest-bearing account (F159)

42 CFR 483.10(c)(4) Accounting system based on accounting principles (F159)

42 CFR 483.10(c)(5) Notification of certain balances (F159)

42 CFR 483.10(c)(6) Funds conveyed on death (review in closed record) (F160)

42 CFR 483.10(c)(7) Surety bond (F161)

- Ask to see a copy of the surety bond and compare to the balance of resident funds.

42 CFR 483.10(c)(8) Limits on facility charges (Medicaid/Medicare covered items) (F162)

- Interview residents and family members regarding the bill.
- Ask each interviewee whether he/she understands all the charges on the bill. Since you have already reviewed the medical record for the current pay status of the resident, you will know whether this regulation is appropriate or not.
- Follow up on resident and family concerns.

Example questions for investigating handling of resident funds:

1. Who is responsible for handling resident funds within the facility?
2. How many residents have requested that the facility handle their personal funds? This should be the same number as in question 4.
3. Does the facility maintain individual accounts or are resident accounts pooled? If resident accounts are pooled, is the account separate from any facility operating account?
4. Are individual records maintained for each account? If yes, select a sample of residents and ask to see the record for each. Make a list of the name of each individual and the dollar amount currently in each account. If the dollar amount is high, ask what the Supplementary Security Income (SSI) resource limit is for the State and compare it to the dollar amount.
5. Does each resident account maintained by the facility have a written authorization? If yes, for sampled residents, review the written authorization for each account, checking it against the ledger card list from question 3.
6. How frequently is each resident's account reconciled?
7. How frequently does the facility deposit resident funds into the bank?
8. Does the facility maintain a resident accounts petty cash fund? If yes, how often is this fund reconciled? Is there any limit to the amount of money a resident may get from petty cash? Where is the petty cash kept? Do residents have access on weekends?
9. What does the facility do with the funds of residents who no longer reside at the facility? Are any being held at the moment?
10. What is the amount of the surety bond covering resident accounts? Review the surety bond. It should be at least equal to the total amount from all ledger cards.
11. How are expenditures authorized and documented?
12. How frequently is a written account provided to the resident, conservator or both?

Surveyor Red Flags for Resident Funds

- Petty cash is kept in the drug box; there is no record of ownership or disbursements.
- Residents deny receiving quarterly statements of their account balance.
- A resident says that he/she cannot get his/her spending money.
- Discharged residents' funds remain in the account.
- A resident has a negative balance on his account. (Whose money did he spend?)
- A resident's account shows multiple purchases (TVs, VCR, clothing) and you do not see the items purchased in the resident's possession.

Your State may have a form that must be used for resident funds.

42 CFR 483.10(d)(1) Choice of a personal attending physician (F163)

- Investigation of this choice is included on the *Resident Interview* (Form CMS-806A).

42 CFR 483.10(d)(3) Participation in care planning and treatment (F280)

Many residents see the Care Plan meeting as something they attend only if they have a complaint. Individuals in nursing facilities rarely complain aloud. Rather, they may say that they wished staff could do something differently, but then say, "They work so hard, and I really don't want to cause a problem."

Ask the resident:

- Do you meet with staff to discuss what staff do to assist you (Care Plan meeting)? If the answer is "no," follow up by asking about the resident's knowledge of specifics on the Care Plan and whether the resident agrees or would like something changed.
- Do staff want you to walk? How far?
- How often do they want you to walk that far?
- Did anyone ask you if you thought you could walk that far that frequently?
- Give me an example of something you asked staff to do differently. Do they do that now?
- For residents who receive a psychotropic medication: Do you get any pills to help you feel better about things? What pills do you get before you go to sleep? What are they for?

42 CFR 483.10(e) Privacy and confidentiality (F164)

- Observe staff during resident care in regard to providing privacy through closing doors, pulling privacy curtains and performing treatments in private.
- Observe how staff protect confidentiality in regard to resident records, faxes and staff discussions of confidential resident issues.
- Privacy can also mean private, uninterrupted time with a visiting spouse or significant other for an intimate relationship.
- As a representative of the Federal government, you have a right to review any record for any resident who receives either Medicare or Medicaid assistance. Neither the facility nor the resident can deny you immediate access to such records. If you are ever denied this access, immediately call your supervisor.

42 CFR 483.10(f) Voice grievances without reprisal (F165) and resolve grievances (F166)

- These regulations are for *individual* grievances. Grievances and recommendations from a group of residents are covered under Quality of Life at 42 CFR 483.15(c).
- The facility should respond promptly and *reasonably* to any *reasonable* grievance.
- Request and review the Resident Council minutes for evidence of how the facility resolves grievances.
- Ask residents to whom they go if they have a concern about issues (care, lost items, other residents, staff, conditions in the shower room).
- Ask residents how their concerns were resolved.

Notes on Resident Rights Regulations—2

42 CFR 483.10(g)(1) Accessible survey results and Plan of Correction (F167)

- Observe to see that survey results are posted or otherwise accessible to residents without asking staff.

42 CFR 483.10(g)(2) Receive information from advocates (F168)

- Ask residents whether they have seen or talked to an ombudsman.

42 CFR 483.10(h) Refuse to work/right to work (F169)

- If you observe residents working in the facility, check their Care Plans.
- Ask these residents, "Have you ever been unable to work?" "What happened?"
- As needed, interview and review records for compensation.

42 CFR 483.10(i)(1) Send and promptly receive unopened mail (F170)

42 CFR 483.10(i)(2) Access to writing materials (F171)

- If mail is delivered on Saturday in the general community, it should be delivered to residents in the nursing home.

42 CFR 483.10(j)(1–2) Access to resident and visitation rights (F172)

- A family member who does not have legal authority over the resident cannot restrict access to a resident.
- The facility cannot restrict access to residents.
- Discuss flu season. The facility may post a sign suggesting or requesting that individuals from the community not visit but cannot prevent anyone from actually doing so.

42 CFR 483.10(j)(3) Ombudsman examination of records with resident permission (F173)

- If possible, ask the ombudsman if he/she is allowed to review the resident's clinical records with the permission of the resident and to the extent allowed by State law.

42 CFR 483.10(k) Access to telephone (F174)

- If residents use a telephone in an office, do staff leave the office when the resident is using the phone?
- Is the office available on weekends?
- Has the telephone been adapted for special needs if needed?

42 CFR 483.10(l) Use personal property (F252)

- All residents' possessions must be treated as valuable to the resident.
- Residents have the right to retain and use personal possessions that make the environment more homelike and may increase residents' feelings of control. Environmental safety considerations (clutter) may balance the residents' right to use of these items.
- How has the facility dealt with resident hoarding of items?

42 CFR 483.10(m) Share room with spouse (F175)

- Although they have a right to share a room, married couples may be assigned different rooms if one continues to try to take care of the other and is at risk of becoming ill in the process.
- Spouses have also been separated when one abused the other.
- Investigate the circumstances when separated spouses verbalize that they would like to live together. How and why was the decision made to separate them?

42 CFR 483.10(n) Self-administration of drugs (F176)

- Few residents self-administer medications. However, self-administration of medication may actually be beneficial if the resident will be discharged to home or transferred to a lower level of care. In that case, the facility may want to ensure that the resident can take medications as ordered. See also 42 CFR 483.12(a)(7).

42 CFR 483.10(o) Refusal of certain transfers (F177)

- These are the regulations for transfers *within* the facility, from one part to another, when residents require skilled versus nonskilled care.
- Investigate whether the bed the resident occupies is certified as a skilled nursing facility (SNF) bed or a nursing facility (NF) bed. If it is certified as both, the resident does *not* have to move to another room.

Admission, Transfer and Discharge Rights (F201–F208)

42 CFR 483.12(a)(1–6) Reasons and requirements for discharge (F201)

- Six reasons (F201).
- Requirements of timing and contents of written notice (F202 and F203).
- These are regulations that require "paper" compliance that you will review during your closed record review.

42 CFR 483.12(a)(7) Orientation for transfer or discharge (F204)

- The emphasis is on "sufficient preparation and orientation [for a] safe and orderly transfer or discharge."
- For example, if a resident is returning home, has the home been evaluated for safety before the resident goes?
- If the resident will walk up and down stairs at home, have facility staff observed the resident doing it safely in the facility?
- Even if the resident receives Meals on Wheels, the resident will have to prepare a simple breakfast and evening meal. What is the facility doing to ensure a safe discharge from the facility in this regard?
- Does the Care Plan address that the resident will demonstrate simple meal preparation?
- Home health staff will not be there to ensure that the resident takes medications at specific times and in specific amounts during the day. Can the resident take his/her medications as the physician has ordered?
- What is the facility doing to ensure a safe discharge?

42 CFR 483.12(b)(1–2) Notice of bed hold policy and readmission (F205)

- Did the facility provide notice in advance of any transfer and at the time of transfer?
- You will review compliance with this regulation when you review closed records.
- This may also be an issue reported by a resident or family member.

42 CFR 483.12(b)(3) Permit resident to return (F206)

- This regulation does not require the facility to provide the *same* bed, just *a* bed.
- 42 CFR 483.12(b)(1) requires the holding of *a* bed.

42 CFR 483.12(c) Equal access to care policies and practices (F207)

- If the facility has most private-pay residents in one area, is staffing or care different? How about the foods served or variety of activities offered?

42 CFR 483.12(d)(1) Facilities policies for payment (F208)

- The facility may not make residents waive Medicare/Medicaid rights or require third-party payment or solicit other money for admission.
- Surveyors request the admission contract during the entrance conference. Review it for third-party guarantee of payment before you interview family members:
  1. Look at the beginning and near the end. If you see the word "guarantor," it is likely there is a problem. Likewise, if you see the words "responsible party," look for a definition of the term within the contract. If you are in a hospital-based nursing home, ask for a facility policy regarding who is a "responsible party" or "guarantor."

2. If you see the words “jointly and severally,” these are legal terms meaning “together and separately.” Therefore, if a person signs as the “guarantor” or “responsible party” for his/her parent, and the contract holds him/her “jointly and severally” responsible for the bill, not only must he/she pay the parent’s bill from the parent’s available money, but he/she is also liable personally for the bill.

If you find a problem with the bill, interview residents, family members and facility staff.

Instructor's Guide to Staff Fantasy Exercise

The purpose of this exercise is to think about how difficult it is to change lifelong habits and give up daily routines. Each participant will individually select seven items from the list of privileges, participate in a group discussion, then select items with roommates and again participate in a group discussion.

Script:

"Welcome to Happy Days Nursing Home. Due to space limitations and the fact that lots of people live in the building, things that you were used to doing in the past must now be chosen from the provided list. We have allowed one 'Other' choice, in case there is something missing from the list that is very important to you."

"Mark the boxes for seven of the listed items that you want to make sure you can continue to do. Additionally, specify which two items are the first and second most important to you."

Discussion:

After giving everyone 10 minutes to pick the seven items they want to "keep," begin the discussion:

- "How hard was it to choose just seven?"
- "What is your number-one item and why is it important to you?"

Script:

"The facility does not have enough single rooms to accommodate everyone . . . so everyone will now have one or more roommates. For this exercise, gender does not matter."

Divide the room into groups of two or three. Now the assignment is for the "roommates" to come up with their group list of seven items.

(Don't tell them how to do this . . . we hope that different groups will use different methods. Some will look for items in common; others will start with what was most important to each person. Some of the groups will not be successful.)

Discussion:

After giving 7–10 minutes for this activity, begin the discussion:

- "How hard was it to choose just seven?"
- "Did everyone get to keep his/her number one and two choices?"
- "How did you go about coming up with the seven items?"
- "Was there something that you had not 'kept' in the beginning that after discussing it with your roommate(s), you decided was very important? Did everyone get the assignment completed?" (If there is a group that did not come to agreement, this is a

great time to talk about incompatibilities of individuals. Not everyone can live together in harmony. Sometimes residents will have to be moved to find the right harmony. Do facilities have a method of "matching" residents upon admission?)

Summary:

"Of course, for you, this is just an exercise. We often take these rights and privileges for granted in our everyday lives. All residents in long term care facilities have rights guaranteed to them under Federal and State law. These are specified in the regulations."

Staff Fantasy Exercise

You are an 80-year-old person and you have come to live in a nursing home. It was difficult for you to leave your home, but you and your doctor, your family and your friends have come to believe that you really need the help you can get from a skilled nursing facility. Your safety, social, nutritional and housekeeping needs are being taken care of in your present residence. You have pretty much the same likes and dislikes as you have always had.

For purposes of this exercise, you can keep only seven of the privileges listed below. Place a check mark in front of the seven that are most important to you. If the most important things to your happiness are not listed, you may add one choice by writing it in the space marked "Other." It will be included in your final list of seven. You will have 10 minutes to complete this task.

- ☐ The privilege of maintaining a special morning or evening ritual (e.g., an early morning walk or coffee and chocolate each evening).
- ☐ The privilege of taking frequent trips and visiting with friends and family outside the nursing home.
- ☐ The privilege of engaging in some gainful activity every day, similar to what you did in your home or apartment.
- ☐ The privilege of keeping pictures of your family and small, treasured mementos close to you.
- ☐ The privilege of defining your own schedule (e.g., making noise, staying up late, not getting dressed in the morning) without consultation with others.
- ☐ The privilege of being considered a sexual being and being able to be intimate in sufficient space and privacy.
- ☐ The privilege of keeping and preparing food any way you please.
- ☐ The privilege of bringing favorite pieces of furniture from your own home or apartment and of having your living space be a reflection of your personality (including not being particularly neat).
- ☐ The privilege of having a pet.
- ☐ The privilege of living in a diverse community where you regularly come into contact with people of different races and ages, including children.

- ☐ The privilege of monitoring your own health: to keep, take or refuse to take medications.
- ☐ The privilege of making totally independent decisions, with yourself and your close family and friends as the only ones whose opinions you need to consider.
- ☐ The privilege of choosing how you will spend your time.
- ☐ The privilege of having space and supplies to work on your hobby.
- ☐ The privilege of being alone and having absolute peace and quiet for as long as you want.
- ☐ The privilege of grieving for loss of home and independent living status.
- ☐ The privilege of receiving considerate, respectful care, with your privacy and need for independence recognized.
- ☐ The privilege of living in an environment where it is okay to talk about and discuss your fears and feelings about aging, life and death.
- ☐ Other:

[Modified from the *Resident Council Resource Kit* from the Minnesota Alliance of Health Care Consumers, 5609 Lyndale Avenue South, Minneapolis, MN 55419, (612) 866-4373.]

Resident Rights Self-Test

Describe how a facility protects and promotes resident rights.
Explain how facility promotion of resident rights empowers residents to achieve and maintain their highest practicable well-being.
Resident rights investigative methods are *(circle the letters)*: A. Audit B. Fact-finding C. Investigation D. Observation
What are three examples of resident outcomes related to resident rights? 1. 2. 3. What tags are related to these outcomes? How would you as a team member survey for information on these outcomes? Task 1: Task 2: Task 3: Task 4: Task 5: Task 6: Task 7:
Describe a facility's steps for making equal access to quality care available to all, regardless of payment source.

Lesson 3-M: Psychopharmacological Medications and Pharmacological Services Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify high risk medications.
- Identify the potential for adverse drug reaction (ADR).
- Identify the components of medication review by the pharmacist.
- Perform the medication pass task.
- Calculate medication error and expand the survey sample when necessary.
- Determine whether the facility has demonstrated a significant medication error and determine severity and scope.
- Present findings concerning psychopharmacological medications and services in clear, concise language on Form CMS-2567.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities
    - 42 CFR 483.10(n) Self Administration of Drugs
    - 42 CFR 483.13(a) Restraints
    - 42 CFR 483.25(l)(1) Unnecessary Drugs—General
    - 42 CFR 483.25(l)(2) Antipsychotropic Drugs
    - 42 CFR 483.25(m) Medication Errors
    - 42 CFR 483.25(m)(2) Residents Are Free of Any Significant Drug Error
    - 42 CFR 483.60 Pharmacy Services

State

(Insert State reference[s] here.)

Other

- Beers, M. H., Ouslander, J. G., Rollingher, I., Reuben, D. B., Brooks, J., Beck, J. C. (1991). Explicit criteria for determining inappropriate medication use in nursing home residents. *Archives of Internal Medicine*, *151*:1825-32.
- Beers, M. H. (1997). Explicit criteria for determining potentially inappropriate medication use by the elderly: an update. *Archives of Internal Medicine*, *157*:1531-6.

Highlights

- Definition and guidance regarding negative outcomes of drug therapies
- Presentation and review of Beers' lists
- Definition and guidance regarding adverse drug reaction (ADR)
- Principles of medication review
- Explanation of what constitutes a significant drug error
- Principles of effective pain management
- Presentation of the concept of pharmacy consultant reviews

Training Techniques

- Lecture
- Group discussion
- Introduction to Internet or other electronic sources utilized by the State agency
- Small group exercise—use of case studies developed by the State trainer

Training Aids

- Videos:
  - *Surveyors' Guide to Chemical and Physical Restraints* (if available)
  - *Chemical and Physical Restraints* (archived video from satellite broadcast, if available)
  - *Alzheimer's and Related Dementia in the Elderly I* and *II*
- PowerPoint slides and handouts
- Chart pad with colored markers
- Forms CMS-805 and CMS-677
- Handouts:
  - *Beers' List 1991*
  - *Beers' List 1997*
  - *Medications to Avoid or Use Within Specified Dose and Duration Ranges In Elderly Patients—Beers' List 1991*
  - *Medications to Avoid in Elderly Patients with Specific Concomitant Diseases—Beers' List 1997*
  - *Medications Commonly Used in Long Term Care*
  - *Answers to Beers' List 1991*
  - *Answers to Beers' List 1997*
  - *Unnecessary/Antipsychotic Drug Algorithm*
  - *Pharmacological Survey Case Study—Student's Notes*
  - *Pharmacological Survey Case Study—Instructor's Notes*
  - Sections of the *SOM* pertaining to medication review

Methods of Evaluation

- Verbalization/discussion of understanding of medication use and impact on the elderly
- Observation of trainee performing the medication pass observation and reconciliation task
- Completion of skill assessment
- Effective use of information and feedback during a future training session

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Lesson 3-M:
Psychopharmacological Medications & Pharmacological Services Survey Process

1

Slide 3-M-1

Outline or text of presentation

(Preparatory work—students will:

- *View the video "Surveyors' Guide to Chemical and Physical Restraints."*
- *View the archived video from the CMS satellite broadcast "Chemical and Physical Restraints."*
- *View the video "Alzheimer's and Related Dementia in the Elderly" parts I and II.*
- *Read the Appendix PP sections pertaining to medication.*
- *Work on the crossword puzzles "Beers' List 1991" and "Beers' List 1997" on pages 3-M-19 and 3-M-21, respectively.*

Provide the students the handouts "Medications to Avoid or Use Within Specified Dose and Duration Ranges in Elderly Patients—Beers' List 1991" and "Medications to Avoid in Elderly Patients with Specific Concomitant Diseases—Beers' List 1997" on pages 3-M-23 through 3-M-29 for reference in completing the puzzles.)

(Inform the students of the objectives.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify high risk medications.
- Identify the potential for adverse drug reaction (ADR).
- Identify the components of medication review by the pharmacist.
- Perform the medication pass task.

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Slide 3-M-2

Audiovisual

Learning Objectives (cont.)

- Calculate medication error & expand the survey sample when necessary.
- Determine whether the facility has demonstrated a significant medication error & determine severity & scope.
- Present findings concerning psychopharmacological medications & services in clear, concise language on Form CMS-2567.

3

Slide 3-M-3

Outline or text of presentation

(Throughout this lesson the student should have the SOM open to the area addressing 42 CFR 483.25.)

Negative Outcome of Drug Therapy

- Definition
  - Undesired side effects or interaction with other drugs
- Guidance
  - F332 at 42 CFR 483.25 (m)(1)
  - F333 at 42 CFR 483.25 (m)(2)

4

Slide 3-M-4

Negative Outcome of Drug Therapy

Negative outcome is the undesired side effects of drugs or interaction with other drugs.

Example
Amlodipine besylate (Norvasac) 5/10, one capsule, p.o., ordered daily. Suppose the resident experienced the following symptoms: headache, edema, nausea and muscle pain. All are signs of adverse drug reaction (ADR) or negative outcome of drug therapy. The nursing staff would need to contact the attending physician and the drug should no longer be given to the resident.

Refer to the *SOM*—surveyor guidance for F332 can be found at 42 CFR 483.25(m)(1) and for F333 at 42 CFR 483.25(m)(2).

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Commonly Used Medications/ Cautions

- Drugs listed in regulations
- Beers' lists

5

Slide 3-M-5

Outline or text of presentation

Commonly Used Medications

Effective review of the psychopharmacological medication regime begins with a basic knowledge of the most commonly used medications in the long term care population.

(Refer the students to the handout "Medications Commonly Used in Long Term Care" on page 3-M-31.)

Beers' Lists

The Beers' lists are used as a national guideline and reference guide for pharmacists and physicians to improve the use of medication in the elderly. For several years, Mark H. Beers, MD, gerontologist, has been advocating the use of explicit criteria—developed through consensus panels—for identifying inappropriate use of medications. In a 1991 paper that looked at the nursing facility population, he and his colleagues wrote that these explicit criteria were "based on the risk-benefit definition of appropriateness, i.e., that the use of a medication is appropriate if its use has potential benefits that outweigh potential risks." Beers' first set of criteria was developed specifically with the frail, elderly nursing facility resident in mind.

In 1997, Beers updated his criteria to include medication therapy inappropriate in all patients over 65 years old. Consultant pharmacists can use both sets of criteria in prescription processing and drug regimen review to improve the pharmacotherapeutic regimens of their elderly patients.

(Provide the handouts "Answers to Beers' List 1991" and "Answers to Beers' List 1997" on pages 3-M-45 and 3-M-47, respectively.

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Outline or text of presentation

Refer the students to the handout "Medications to Avoid or Use Within Specified Dose and Duration Ranges in Elderly Patients—Beers' List 1991" on page 3-M-23.

Refer the students to the handout "Medications to Avoid in Elderly Patients with Specific Concomitant Diseases—Beers' List 1997" on page 3-M-27.)

Adverse Drug Reaction

Definition:
- Secondary effect of drug that is usually undesirable & different from therapeutic & helpful effects of drug

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Slide 3-M-6

Adverse Drug Reaction

An ADR is defined as a secondary effect of a drug that is usually undesirable and different from the therapeutic and helpful effects of the drug.

Survey Process

- Principles of medication review
  - Correct & most effective medications for diagnoses
    - Evidence should exist in clinical record

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Slide 3-M-7

Survey Process

(Refer the students to the handout "Unnecessary/Antipsychotic Drug Algorithm" on page 3-M-49.)

Principles of medication review

Look for:

- Correct and most effective medications for the diagnoses.
  - Evidence should exist in the clinical record for need and expected outcome of therapy.

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Survey Process (cont.)

– Timely consulting pharmacist review
– Pharmacist comments related to:
  • Excessive dose?
  • Excessive duration?
  • Clinical indication for use?

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Slide 3-M-8

Outline or text of presentation

- Timely consulting pharmacist review.
  – Monthly.
  – Were comments acted upon by attending physician?
- Pharmacist comments related to:
  – Excessive dose.
    o Dilantin 600 mg QID.
  – Excessive duration.
    o Antibiotic eye ointment therapy ordered for 10 days and administered for 30 days.
  – Clinical indication for use.
    o Xanax without documentation of clinical indication.

Survey Process (cont.)

Look to see that:
• Pharmacist reviews comments acted or commented upon by attending physician
  – Evidence to support continued use of medication

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Slide 3-M-9

- Evidence existing in both pharmacy notes and physician notes for continued use of medication ordered.

Survey Process (cont.)

• Nursing staff monitors for effective drug action with targeted behaviors
  – Evidence of monitoring for ADR
  – Evidence of physician notification in event of ADR

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Slide 3-M-10

- Nurses' notes documenting behaviors, change in condition or resident's cognitive status.

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Survey Process (cont.)

Look for evidence of nurses' monitoring for:
- Drug interaction
- ADR
  - Side effects
  - Tardive dyskinesia
  - Orthostatic hypotension
  - Cognitive or behavioral impairment
  - Akathisia
  - Pseudoparkinsonism

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Slide 3-M-11

Outline or text of presentation

Look for evidence of nurses' monitoring for:
- Drug interaction.
- ADR.
  - Side effects.
  - Tardive dyskinesia.
  - Orthostatic hypotension.
  - Cognitive or behavioral impairment.
  - Akathisia.
  - Pseudoparkinsonism.

Regulations & Guidelines

- 42 CFR 483.10(n) Self medication
- 42 CFR 483.13(a) Chemical restraints
- 42 CFR 483.25(l)(1) Psychopharmacological drugs
- 42 CFR 483.25(l)(2) Antipsychotropic drugs

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Slide 3-M-12

Regulations and Guidelines

- Review of regulations and guidelines:
  - 42 CFR 483.10(n) Self medication.
  - 42 CFR 483.13(a) Chemical restraints.
  - 42 CFR 483.25(l)(1) Unnecessary drugs—General.
  - 42 CFR 483.25(l)(2) Antipsychotropic drugs.
  - 42 CFR 483.25(m) Medication error.
  - 42 CFR 483.25(m)(2) Residents are free of any significant drug error.
  - 42 CFR 483.60 Pharmacy services.

Regulations & Guidelines (cont.)

- 42 CFR 483.25(m) Medication error
- 42 CFR 483.25(m)(2) Residents free of any significant drug error
- 42 CFR 483.60 Pharmacy services

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Slide 3-M-13

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Survey Tasks

- Purpose
  - Task 5C: relationship of drug regimen & resident condition
    - Form CMS-805
    - Investigative protocol: ADRs
  - Task 5E: medication pass
    - Form CMS-677

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Slide 3-M-14

Outline or text of presentation

Survey Tasks

- The purpose of Tasks 5C and 5E is to review use of long- and short-acting psychotropic drugs and documentation in clinical record.
- Task 5C: relationship of drug regimen and resident condition.
  - Form CMS-805.
  - Investigative protocol: ADRs.
- Task 5E: medication pass.
  - Form CMS-677.

Medication Errors

- Observe medication administration
  - Monitoring of pulse or blood pressure prior to administration, when appropriate
  - Observance of 5 patient rights
    - Right resident
    - Right time
    - Right drug
    - Right dosage
    - Right route of administration
  - Appropriate technique

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Slide 3-M-15

Medication Errors

The following are standards of practice, and certain medications have built-in or physician-ordered parameters.

- Observe medication administration.
  - Monitoring of pulse or blood pressure prior to administration, when appropriate.
  - Observance of the five patient rights (Nursing 101).
    - Right Resident.
    - Right time.
    - Right drug.
    - Right dosage.
    - Right route of administration.
  - Appropriate technique.

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Medication Errors (cont.)

- Reconcile observed medication & physician's orders
- Determine whether facility followed manufacturer's specifications regarding preparation & storage
- See that professional Standards of Practice followed during medication administration

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Slide 3-M-16

Outline or text of presentation

- Reconcile observed medication and physician's orders.
- Determine whether the facility followed manufacturer's specifications regarding preparation and storage.
- See that professional standards of practice are followed during medication administration.

Significant Medication Error

- Causes resident discomfort or jeopardizes his/her health
  - Example: constipation
    - Caused by ordered medication unresolved for 3 days
    - Resulting in resident discomfort & risk of obstruction or fecal impaction

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Slide 3-M-17

Significant medication error

- Causes the resident discomfort or jeopardizes his/her health.
  - For example: constipation caused by an ordered medication that is unresolved for three days, causing resident discomfort and risk of obstruction or fecal impaction.

Significance Guidelines

- Resident condition:
  - Lasix 40 mg administered though not ordered or continued even when resident demonstrated clinical signs of dehydration
  - Prednisone 60 mg ordered twice daily but given 3 times daily for 2 days, after which resident suddenly experienced signs & symptoms of delirium & hallucinations

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Slide 3-M-18

Significance Guidelines

- Resident condition:
  - Lasix 40 mg administered though not ordered or continued even when resident demonstrated clinical signs of dehydration.
  - Prednisone 60 mg ordered twice daily but given three times daily for two days, after which the resident suddenly experienced signs and symptoms of delirium and hallucinations.

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Significance Guidelines (cont.)

- Drug category
  - Drugs that require titrating or monitoring for toxic potential (e.g., Dilantin, Digoxin, Warfarin or TheoDur)

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Slide 3-M-19

Outline or text of presentation

- Drug category:
  - Be alert to drugs that require titrating or monitoring for toxic potential (e.g., Dilantin, Digoxin, Warfarin or TheoDur).

Significance Guidelines (cont.)

- Frequency of error
  - Omissions or administration of medication too often for most effective use of drug
  - Error occurring over more than 1 day or multiple shifts

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Slide 3-M-20

- Frequency of error:
  - Omissions or administration of medication too often for most effective use of drug.
  - Determine whether the error occurred over more than one day or multiple shifts.

Medication Error Rate

- Determine by calculating percentage of errors after reconciliation
  - Medication error rate:
    - Number of errors observed ÷ number of opportunities for error (doses given) X 100
  - Deficient practice documented when percentage is 5% or greater
    - Rounding off of rate is not permitted

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Slide 3-M-21

Medication Error Rate

This is determined by calculating the percentage of errors after reconciliation.

- Medication error rate:
  - Number of errors observed ÷ number of opportunities for error (doses given) X 100.
- Deficient practice is documented when the percentage is 5% or greater.
  - Rounding off of rate is not permitted.

Audiovisual

Effective Pain Management

Goal of effective pain management is for resident to be pain-free & maintain functional level of activity

- Can still carry on conversation, participate in desired activities & visit with friends & family

22

Slide 3-M-22

Outline or text of presentation

Effective Pain Management

The goal of effective pain management is for resident to be pain-free and maintain a functional level of activity.

- Can still carry on a conversation, participate in desired activities and visit with friends and family.

Case Study

(Refer the students to the "Pharmacological Survey Case Study—Student's Notes" handout on page 3-M-53.)

- *Observe surveyors simulating performance of the medication review for a clinical record and reconciliation.*
- *Observe surveyors simulating performance of the medication pass observation task.*
- *Give an example of expanding the sample if the error rate is 5% or greater.*
  - *Guide deficiency determination (severity and scope) if error rate is 5% or greater.*
  - *Guide deficiency writing for significant error and error rate of 5% or greater.*
- *Observe surveyor simulating use of Adverse Drug Reaction Protocol.*

Instructor notes are provided in the handout "Pharmacological Survey Case Study—Instructor's Notes" on page 3-M-55.)

Audiovisual

Lesson 3-M:
Psychopharmacological
Medications & Pharmacological
Services Survey Process

Questions

23

Slide 3-M-23

Outline or text of presentation

Skill Assessment

Psychopharmacological Medications and Pharmacological Services Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified high risk medications.	
					Identified the potential for adverse drug reaction.	
					Identified the components of medication review by the pharmacist.	
					Performed the medication pass task.	
					Calculated medication error and expanded the survey sample when necessary.	
					Determined whether the facility has demonstrated a significant medication error and determined severity and scope.	
					Demonstrated the ability to present findings concerning psychopharmacological medications and services in clear, concise language on Form CMS-2567.	

Comments/Recommendations:

Beers' List 1991

Across

3. One of the least effective antiemetic agents; produces extrapyramidal side effects. Low severity.

8. Causes depression, impotence, sedation and orthostatic hypotension. Low severity.

10. Doses greater than 3 mg/day should be avoided; residents with psychotic disorders may require higher doses.

15. Few advantages over acetominophen. Low severity.

18. Highly addictive and sedating. Avoid unless patient is already addicted to it. High severity.

21. More toxic than aspirin, yet no more effective. High severity.

22. Causes orthostatic hypotension. Beneficial only in patients with artificial heart valves. Low severity.

24. Can cause prolonged and serious hypoglycemia. Also can cause syndrome of inappropriate antidiuretic hormone. High severity.

25. Avoid doses greater than 30 mg/day; residents with psychotic disorders may require higher doses. Low severity.

26. Avoid doses greater than 300 mg/day and therapy for greater than 12 weeks.

27. Total daily doses should not exceed these amounts; for the nursing facility resident avoid any single dose of oxazepam greater than 30 mg or triazolam greater than 0.25 mg.

Down

1. Long half-life; risk of sedation and increased falls. High severity.

2. Poorly tolerated by the elderly; causes anticholinergic side effects, sedation and weakness. Effectiveness at tolerated doses questionable. Low severity.

4. Avoid doses greater than 50 mg/day.

5. Avoid doses greater than 900 mg/day and therapy for greater than 12 weeks.

6. Not proven effective at doses studied. Low severity.

7. May induce heart failure because of strong negative inotropic activity. Also has strong anticholinergic activity. High severity.

9. Most control nervous system (CNS) side effects of any nonsteroidal anti-inflammatory drug. Low severity.

11. Avoid therapy for greater than four weeks except when treating osteomyelitis, prostatis, tuberculosis or endocarditis.

12. Strong anticholinergic and sedating properties. High severity.

13. Long half-life, risk of sedation and increased falls. High severity.

14. Doses of ferrous sulfate greater than 325 mg are no more effective but cause constipation. Low severity.

16. Strong anticholinergic activity and questionable efficacy as antispasmodic agents. Avoid long-term use; other use is questionable. High severity.

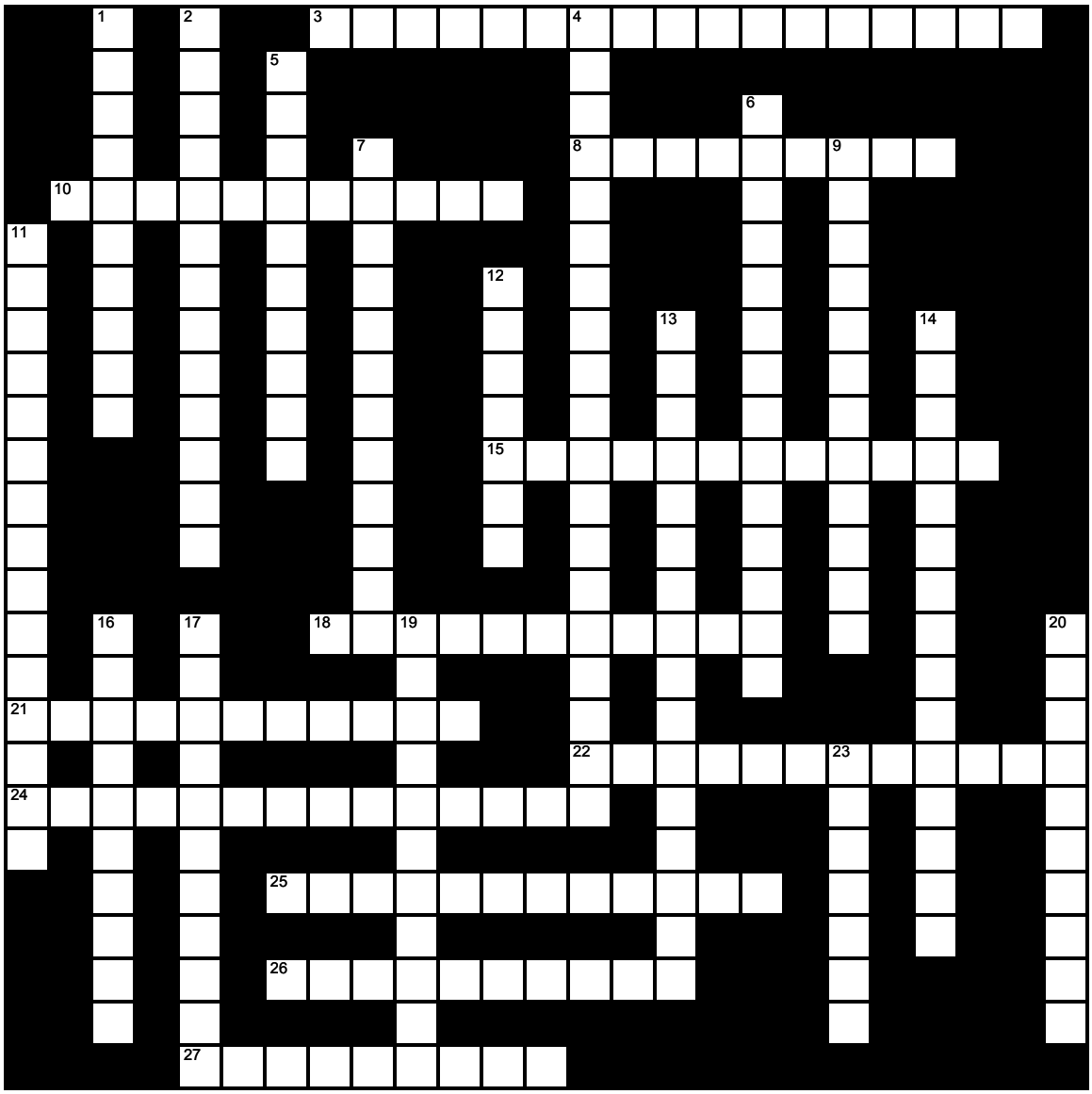
17. Avoid except when used to treat violent behaviors; other beta blockers offer less CNS penetration or more beta-receptor selectivity.

19. Has more CNS side effects, including confusion and hallucinations; is a mixed agonist-antagonist. High severity.

20. Not effective orally and has disadvantages compared with other narcotic analgesics. High severity.

23. Except for treatment of atrial arrhythmias, doses should rarely be greater than 0.125 mg in the elderly.

Beers' List 1991



Beers' List 1997

Across

2. Relaxes the external bladder sphincter in incontinence.

7. May increase blood pressure in cases of hypertension.

8. May worsen heart failure because of negative inotropic action.

10. Lowers seizure threshold in cases of epilepsy.

11. May cause obstruction when used to treat benign prostatic hypertrophy.

12. May cause or worsen insomnia.

Down

1. May slow respirations and increase carbon dioxide retention in chronic obstructive pulmonary disease.

3. Lowers seizure threshold in cases of epilepsy.

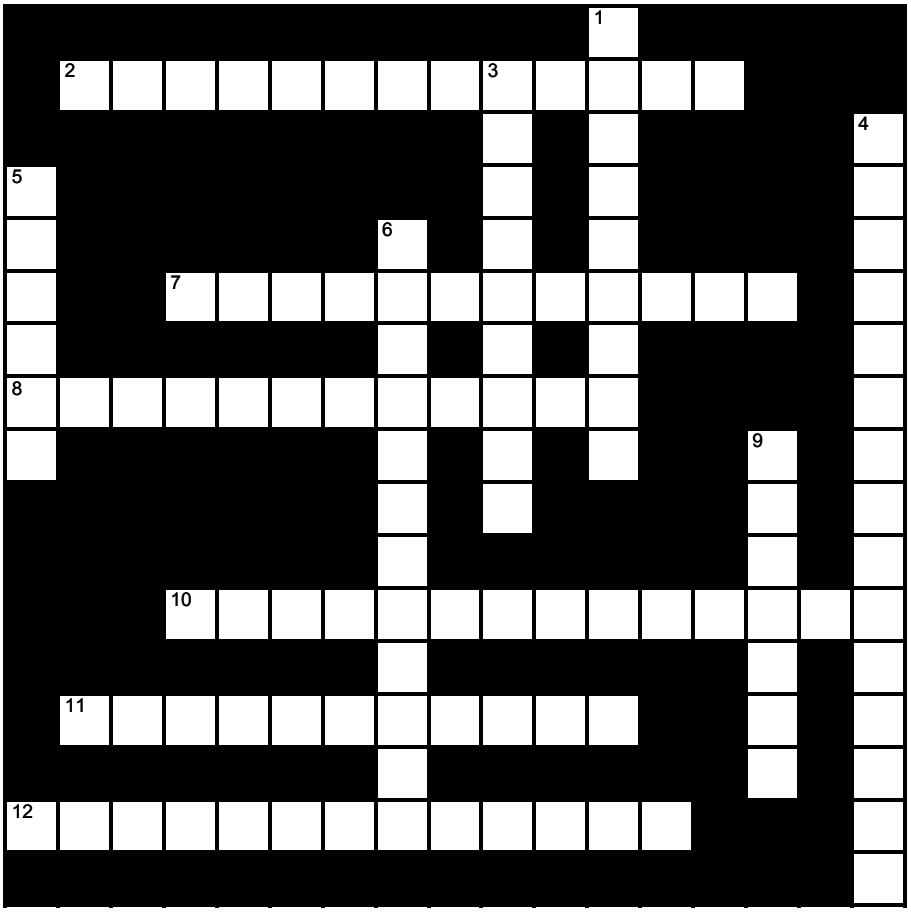
4. Will worsen constipation.

5. May exacerbate ulcer disease, gastritis, gastroesophageal reflux disease.

6. In people being treated with insulin or oral agents, these may worsen symptoms. May worsen respiratory function in cases of asthma.

9. May cause bleeding in cases of blood-clotting disorders being treated with anticoagulants.

Beers' List 1997



Medications to Avoid or Use Within Specified Dose and Duration Ranges in Elderly Patients—Beers' List 1991[a]

MEDICATION(S)[b]	EXPLANATION OF PROBLEM	SEVERITY
PSYCHOTROPIC MEDICATIONS		
Amitriptyline, alone or in combination products	Strong anticholinergic and sedating properties	High
Barbiturates (other than phenobarbital)	Side effects and addictive properties	High
Chlordiazepoxide (alone or in combination) or diazepam	Long half-lives, risk of sedation and increased falls	High
Doxepin	Strong anticholinergic and sedating properties	High
Ergot mesylates, cyclandelate isoxsuprine[c]	Not proven effective at doses studied	Low
Flurazepam	Long half-life; risk of sedation and increased falls	High
Haloperidol[c]	Doses >3mg/day should be avoided; residents with psychotic disorders may require higher doses	High
Lorazepam 3 mg Oxazepam 60 mg Alprazolam 2 mg Temazepam 15 mg Zolpidem 5 mg Triazolam 0.25 mg	Total daily doses should not exceed these amounts; in the nursing facility resident, avoid any single dose of oxazepam >30 mg or triazolam >0.25 mg	Low
Meperidine	Not effective orally and has disadvantages compared with other narcotic analgesics	High
Meprobamate	Highly addictive and sedating; avoid unless patient is already addicted to it	High
Pentazocine	Has more CNS side effects, including confusion and hallucinations; is a mixed agonist-antagonist	High

MEDICATION(S)[b]	EXPLANATION OF PROBLEM	SEVERITY
Propoxyphene	Few advantages over acetaminophen	Low
Thiordiazine[c]	Avoid doses >30 mg/day; residents with known psychotic disorders may require higher doses	High
EENT AGENTS		
Antihistamines (alone or in combination, including chlorapheniramine, diphenhydramine, hydroxyzine, cyproheptadine, promethazine and dexchlorpheniramine)	Strong anticholinergic activity; substitute cough and cold products without these antihistamines	Low
Decongestants (oxymetazoline, phenylephrine, pseudoephedrine)[c]	Avoid daily use for >two weeks	High
Diphenhydramine	Do not use as a hypnotic; for allergies, use the lowest possible dose	Low
GASTROINTESTINAL AGENTS		
Cimetidine[c]	Avoid doses >900 mg/day and therapy for >12 weeks	High
Dicyclomine, hysoscyamine, propantheline, belladonna alkaloids, clidinium, chlordiazepoxide	Strong anticholinergic activity and questionable efficacy as antispasmodic agents; avoid long-term use; other use is questionable.	High
Ranitidine[c]	Avoid doses >300 mg/day and therapy for >12 weeks	High
Trimethobenzamide[c]	One of the least effective antiemetic agents; produces extrapyramidal side effects	Low

MEDICATION(S)[b]	EXPLANATION OF PROBLEM	SEVERITY
ENDOCRINE AGENTS		
Chlorpropamide	Can cause prolonged and serious hypoglycemia; also can cause syndrome of inappropriate antidiuretic hormone	High
CARDIAC AGENTS		
Digoxin	Except for treatment of atrial arrhythmias, doses should rarely exceed >0.125 mg in the elderly	High
Disopyramide	May induce heart failure because of strong negative inotropic activity; also has strong anticholinergic activity	High
VASCULAR AGENTS		
Dipyridamole	Causes orthostatic hypotension; beneficial only in patients with artificial heart valves	Low
Hydrochlorothiazide[c]	Avoid doses >50 mg/day	High
Methyldopa (alone or in combination)	Causes bradycardia and exacerbates depression	High
Propranolol[c]	Avoid except when used to treat violent behaviors; other beta blockers offer less CNS penetration or more beta-receptor selectivity	High
Reserpine (alone or in combination)	Causes depression, impotence, sedation and orthostatic hypotension	Low
Ticlopidine	More toxic than aspirin, yet no more effective	High
MUSCULOSKELETAL AGENTS		
Indomethacin	Most CNS side effects of any NSAID	Low

MEDICATION(S)[b]	EXPLANATION OF PROBLEM	SEVERITY
Methocarbamol, carisoprodol, oxybutynin, chlorzoxazone, metaxalone, cyclobenzaprine, orphenidrate[c]	Poorly tolerated by the elderly; cause anticholinergic side effects, sedation and weakness; effectiveness at tolerated doses questionable	Low
Phenylbutazone (off US market)	Serious hematologic side effects	Low
HEMATOPOIETIC AGENTS		
Iron supplements exceeding 325 mg of ferrous sulfate	Higher doses no more effective but cause constipation	Low
ANTI-INFECTIVE AGENTS		
Oral antibiotics[c]	Avoid therapy for >four weeks except when treating osteomyelitis, prostatis, tuberculosis or endocarditis	High

[a] Abbreviations: CNS, central nervous system; EENT, eyes, ears, nose and throat; NSAID, nonsteroidal anti-inflammatory drugs.
[b] Unless otherwise stated in the "Explanation of Problems" column, use of these medications should be avoided completely in all patients 65 years and older.
[c] These criteria were developed specifically for the frail, elderly patient, especially those who are residents of nursing facilities. Use in other elderly patients may be acceptable.

Medications to Avoid in Elderly Patients with Specific Concomitant Diseases—Beers' List 1997

Disease	Medication(s)	Problem	Severity
	Neurologic Disorders		
Epilepsy	Clozapine, chlorpromazine, thioridazine, chlorprothixene	Agents lower seizure threshold	Low
	Metoclopramide	Agents lower seizure threshold	High
	Psychiatric Disorders		
Insomnia	Decongestants	May cause or worsen insomnia	Low
	Theophylline	May cause or worsen insomnia	Low
	Desirpramine, serotonin selective reuptake inhibitors and monoamine oxidase inhibitors	May cause or worsen insomnia	Low
	Beta agonists	May cause or worsen insomnia	Low
	Gastrointestinal Disorders		
Constipation	Anticholinergics	Will worsen constipation	Low
	Narcotics	Will worsen constipation	Low
	Tricyclic antidepressants	Will worsen constipation	High
Ulcers	NSAIDs	May exacerbate ulcer disease, gastritis, GERD	High
	Aspirin	May exacerbate ulcer disease, gastritis, GERD	Low
	Potassium supplements	May exacerbate ulcer disease, gastritis, GERD	Low

Disease	Medication(s)	Problem	Severity
Endocrine Disorders			
Diabetes	Beta blockers	In people being treated with insulin or oral agents, beta blockers may worsen symptoms	Low
	Corticosteroids (started recently)	May worsen diabetic control	Low
Respiratory Disorders			
Asthma	Beta blockers	May worsen respiratory function	High
Chronic obstructive pulmonary disease	Beta blockers	May worsen respiratory function	High
	Sedative-hypnotics	May slow respirations and increase carbon dioxide retention	High
Cardiac Disorders			
Arrhythmias	Tricyclic antidepressants	May induce arrhythmias	High if started recently
Heart failure	Disopyramide	May worsen heart failure because of negative inotropic action	High
	Drugs with high sodium content	Large sodium load may lead to fluid retention and thereby worsen heart failure	Low

Disease	Medication(s)	Problem	Severity
Vascular Disorders			
Blood-clotting disorders being treated with anticoagulants	Aspirin	May cause bleeding	High
Hypertension	Amphetamines and other weight-control agents	May increase blood pressure	High
Peripheral vascular disease	Beta blockers	Negative chronotropic and inotropic activity	Low
Syncope	Beta blockers	Negative chronotropic and inotropic activity	Low
	Long-acting benzodiazepines	May contribute to falls	High
Urologic Disorders			
Benign prostatic hypertropy	Anticholinergic antihistamines	May impair micturation and cause obstruction	High
	Gastrointestinal antispasmodics	May impair micturation and cause obstruction	High
	Muscle relaxants	May impair micturation and cause obstruction	Low
	Narcotic drugs (including propoxyphene)	May impair micturation and cause obstruction	Low
	Flavoxate, oxybutyin	May cause obstruction	Low
	Bethanechol	May cause obstruction	Low
	Anticholinergic antidepressants	May impair micturation and cause obstruction	High
Incontinence	Alpha blockers	Relaxes the external bladder sphincter	High

Adapted from various references. These criteria apply to all elderly patients, not just nursing facility residents. Abbreviations: NSAID, nonsteroidal anti-inflammatory drugs; GERD, gastroesophageal reflux disease.

Medications Commonly Used in Long Term Care

This list is only intended to be a quick reference to determine whether a drug is mentioned in *SOM* Appendix PP, Guidance to Surveyors for Long Term Care Facilities.

It is not an all-inclusive list. There may be other drugs that should be reviewed in the survey process.

The categories include only those referred to in *SOM* Appendix PP, and the drugs may be used for other indications.

The list is alphabetical and includes drugs listed for tag numbers:

- F329 Unnecessary Drugs
- F330 Antipsychotic Drugs
- F331 Antipsychotic Drugs
- F429 Drug Regimen Review

It does NOT include examples given in F333 Medication Errors.

The first column is an alphabetical list of both generic (begin with lowercase letter) and brand (begin with uppercase letter) names. The second column is the alternate brand or generic name for the corresponding drug in the first column. The third column is the category of use. The categories are adapted from *SOM* Appendix PP and other long term care references.

Drug Name	Alternate Name	Category
Abilify	aripiprazole	Antipsychotic
acetophenazine	Tindal	Antipsychotic
Advil	ibuprofen	NSAID
Akineton	biperidin	Anticholinergic anti-Parkinson
albuterol	Proventil	Beta agonist
Aldoril	methyldopa	Antihypertensive
Aldomet	methyldopa	Antihypertensive
Ambien	zolpidem	Hypnotic

Drug Name	Alternate Name	Category
amitriptyline	Elavil, Limbitrol, Triavil	Tricyclic anticholinergic antidepressant
amobarbital	Amytal	Barbiturate, hypnotic/anxiolytic/sedative
amobarbital/secobarbital	Tuinal	Barbiturate, hypnotic/anxiolytic/sedative
amoxapine	Asendin	Tricyclic anticholinergic antidepressant
Amytal	amobarbital	Barbiturate, hypnotic/anxiolytic/sedative
Anafranil	clomipramine	Tricyclic, anticholinergic antidepressant
Anaprox	naproxen	NSAID
alprazolam	Xanax	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
aripiprazole	Abilify	Antipsychotic
Artane	trihexyphenidyl	Anticholinergic anti-Parkinson
Asendin	amoxapine	Tricyclic anticholinergic antidepressant
aspirin		NSAID
Atarax	hydroxyzine	Traditional anticholinergic antihistamine, hypnotic/anxiolytic/sedative
Ativan	lorazepam	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
Aventyl	nortriptyline	Tricyclic anticholinergic antidepressant
beclomethasone	Beclovent	Corticosteroid
Beclovent	beclomethasone	Corticosteroid
belladonna alkaloids	Donnatal	GI antispasmodic
Benadryl	diphenhydramine	Traditional anticholinergic antihistamine, hypnotic/anxiolytic/sedative
Bentyl	dicyclomine	GI antispasmodic
benztropine	Cogentin	Anticholinergic anti-Parkinson
betamethasone	Celestone	Corticosteroid
bethanechol	Urecholine	Bladder relaxant
biperidin	Akineton	Anticholinergic anti-Parkinson

Drug Name	Alternate Name	Category
bitolterol	Tornalate	Beta agonist
Brethine	terbutaline	Beta agonist
bupropion	Wellbutrin	Antidepressant
butabarbital	Butisol	Barbiturate, hypnotic/anxiolytic/sedative
butalbital	Fiorinal	Barbiturate
Butazolidin	phenylbutazone	NSAID
Butisol	butabarbital	Barbiturate, hypnotic/anxiolytic/sedative
carisoprodol	Soma	Skeletal muscle relaxant
Cataflam	diclofenac	NSAID
Celestone	betamethasone	Corticosteroid
Celexa	citalopram	SSRI antidepressant
chloral hydrate	Noctec, Somnos	Anxiolytic/sedative/hypnotic
chlordiazepoxide	Librium, Librax	Long-acting benzodiazepine
chlorpheniramine	Chlor-Trimeton	Traditional anticholinergic antihistamine
chlorpromazine	Thorazine	Antipsychotic
chlorpropamide	Diabinese	Antidiabetic
chlorprothixene	Taractan	Antipsychotic
Chlor-Trimeton	chlorpheniramine	Traditional anticholinergic antihistamine
chlorzoxazone	Paraflex	Skeletal muscle relaxant
citalopram	Celexa	SSRI antidepressant
clidinium/ chlordiazepoxide	Librax	GI antispasmodic
Clinoril	sulindac	NSAID
clomipramine	Anafranil	Tricyclic anticholinergic antidepressant
clonazepam	Klonopin	Long-acting benzodiazepine
clorazepate	Tranxene	Long-acting benzodiazepine
clozapine	Clozaril	Antipsychotic

Drug Name	Alternate Name	Category
Clozaril	clozapine	Antipsychotic
codeine	Tylenol w/codeine, Empirin w/codeine	Narcotic analgesic
Cogentin	benztropine	Anticholinergic anti-Parkinson
Compazine	prochlorperazine	Antipsychotic
Cortef	hydrocortisone	Corticosteroid
cortisone	Cortone	Corticosteroid
Cortone	cortisone	Corticosteroid
cyclandelate	Cyclospasmol	Cerebrovascular insufficiency
cyclobenzaprine	Flexeril	Skeletal muscle relaxant
Cyclospasmol	cyclandelate	Cerebrovascular insufficiency
cyproheptadine	Periactin	Traditional anticholinergic antihistamine
Dalmane	flurazepam	Long-acting benzodiazepine
Dantrium	dantrolene	Skeletal muscle relaxant
dantrolene	Dantrium	Skeletal muscle relaxant
Darvocet-N	propoxyphene	Narcotic analgesic
Darvon	propoxyphene	Narcotic analgesic
Daypro	oxaprozin	NSAID
Decadron	dexamethasone	Corticosteroid
Demerol	meperidine	Narcotic analgesic
desipramine	Norpramin, Pertofrane	Tricyclic anticholinergic antidepressant
Desyrel	trazodone	Antidepressant
dexamethasone	Decadron	Corticosteroid
dexchlorpheniramine	Polaramine	Traditional anticholinergic antihistamine
Diabinese	chlorpropamide	Antidiabetic
diazepam	Valium	Long-acting benzodiazepine
diclofenac	Voltaren, Cataflam	NSAID

Drug Name	Alternate Name	Category
dicyclomine	Bentyl	GI antispasmodic
diflunisal	Dolobid	NSAID
digoxin	Lanoxin	Antiarrythmic
Dilaudid	hydromorphone	Narcotic analgesic
diphenhydramine	Benadryl	Traditional anticholinergic antihistamine, hypnotic/anxiolytic/sedative
dipyridamole	Persantine	Antiplatelet, coronary vasodilator
disopyramide	Norpace	Antiarrythmic
Ditropan	oxybutynin	Bladder relaxant
Dolobid	diflunisal	NSAID
Donnatal	belladonna alkaloids	GI antispasmodic
Doral	quazepam	Long-acting benzodiazepine
Doriden	glutethimide	Hypnotic/anxiolytic/sedative
doxepin	Sinequan	Tricyclic anticholinergic antidepressant
DuoMedihaler	phenylephrine	Decongestant
Duragesic	fentanyl	Narcotic analgesic
Effexor	venlafaxine	Antidepressant
Elavil	amitriptyline	Tricyclic anticholinergic antidepressant
Elixophyllin	theophylline	Bronchodilator
Empirin with codeine	codeine	Narcotic analgesic
Equanil	meprobamate	Hypnotic/anxiolytic/sedative
ergot mesyloids	Hydergine	Cerebrovascular insufficiency
estazolam	ProSom	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
ethchlorvynol	Placidyl	Hypnotic/anxiolytic/sedative
etodolac	Lodine	NSAID
Feldene	piroxicam	NSAID
fenoprofen	Nalfon	NSAID

Drug Name	Alternate Name	Category
fentanyl	Duragesic	Narcotic analgesic
Fiorinal	butalbital	Barbiturate, hypnotic/anxiolytic/sedative
flavoxate	Urispas	Bladder relaxant
Flexeril	cyclobenzaprine	Skeletal muscle relaxant
fluoxetine	Prozac	SSRI antidepressant
fluphenazine	Prolixin, Permitil	Antipsychotic
flurazepam	Dalmane	Long-acting benzodiazepine
fluvoxamine	Luvox	Antidepressant
Genex	phenylpropanolamine	Decongestant
Geodon	ziprasidone	Antipsychotic
glutethimide	Doriden	Anxiolytic/sedative/hypnotic
halazepam	Paxipam	Long-acting benzodiazepine
Halcion	triazolam	Hypnotic
Haldol	haloperidol	Antipsychotic
haloperidol	Haldol	Antipsychotic
Hydergine	ergot mesyloids	Cerebrovascular insufficiency
hydrocortisone	Cortef	Corticosteroid
hydromorphone	Dilaudid	Narcotic analgesic
hydroxyzine	Atarax/Vistaril	Traditional anticholinergic antihistamine, hypnotic/anxiolytic/sedative
hyoscyamine	Levsin/Levsinex	GI antispasmodic
ibuprofen	Motrin, Advil	NSAID
imipramine	Tofranil	Tricyclic anticholinergic antidepressant
Indocin	indomethacin	NSAID
indomethacin	Indocin	NSAID
isocarboxazid	Marplan	Antidepressant
isoproterenol	Isuprel	Beta agonist

Drug Name	Alternate Name	Category
Isuprel	isoproterenol	Beta agonist
Kemadren	procyclidine	Anticholinergic anti-Parkinson
ketoprofen	Orudis	NSAID
Klonopin	clonazepam	Long-acting benzodiazepine
Lanoxin	digoxin	Antiarrythmic
Levsin/Levsinex	hyoscyamine	GI antispasmodic
Librax	clidinium/chlordiazepoxide	GI antispasmodic
Librium	chlordiazepoxide	Long-acting benzodiazepine
Limbitrol	amitriptyline	Tricyclic anticholinergic antidepressant
Lodine	etodolac	NSAID
lorazepam	Ativan	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
loxapine	Loxitane	Antipsychotic
Loxitane	loxapine	Antipsychotic
Ludiomil	maprotiline	Tricyclic anticholinergic antidepressant
Luvox	fluvoxamine	Antidepressant
maprotiline	Ludiomil	Tricyclic anticholinergic antidepressant
Marplan	isocarboxazid	Antidepressant
Medrol	methylprednisolone	Corticosteroid
Mellaril	thioridazine	Antipsychotic
meperidine	Demerol	Narcotic analgesic
meprobamate	Equanil, Miltown	Hypnotic/anxiolytic/sedative
mesoridazine	Serentil	Antipsychotic
metaxalone	Skelaxin	Skeletal muscle relaxant
methocarbamol	Robaxin	Skeletal muscle relaxant
methyldopa	Aldomet, Aldoril	Antihypertensive
methylphenidate	Ritalin	CNS stimulant

Drug Name	Alternate Name	Category
methylprednisolone	Medrol	Corticosteroid
methyprylon	Noludar	Anxiolytic/sedative/hypnotic
metoclopramide	Reglan	Antiemetic
Miltown	meprobamate	Anxiolytic/sedative/hypnotic
Moban	molindone	Antipsychotic
molindone	Moban	Antipsychotic
Morphine		Narcotic analgesic
Motrin	ibuprofen	NSAID
nabumetone	Relafen	NSAID
Nalfon	fenoprofen	NSAID
Naprosyn	naproxen	NSAID
naproxen	Naprosyn	NSAID
Nardil	phenelzine	MAOI antidepressant
Navane	thiothixene	Antipsychotic
Nembutal	pentobarbital	Barbiturate, hypnotic/anxiolytic/sedative
nefazodone	Serzone	Antidepressant
Noctec	chloral hydrate	Anxiolytic/sedative/hypnotic
Noludar	methyprylon	Anxiolytic/sedative/hypnotic
Norflex	orphenadrine	Skeletal muscle relaxant
Norpace	disopyramide	Antiarrythmic
Norpramin	desipramine	Tricyclic anticholinergic antidepressant
nortriptyline	Aventyl, Pamelor	Tricyclic anticholinergic antidepressant
Novafed	pseudoephedrine	Decongestant
olanzapine	Zyprexa	Antipsychotic
Orap	pimozide	Antipsychotic
orphenadrine	Norflex	Skeletal muscle relaxant
Orudis	ketoprofen	NSAID

Drug Name	Alternate Name	Category
oxaprozin	Daypro	NSAID
oxazepam	Serax	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
oxybutynin	Ditropan	Bladder relaxant
oxycodone	Roxicodone, Percocet, OxyContin	Narcotic analgesic
OxyContin	oxycodone	Narcotic analgesic
Pamelor	nortriptyline	Tricyclic anticholinergic antidepressant
Paraflex	chlorzoxazone	Skeletal muscle relaxant
paraldehyde		Anxiolytic/sedative/hypnotic
Parnate	tranylcypromine	MAOI antidepressant
paroxetine	Paxil	SSRI antidepressant
Paxil	paroxetine	SSRI antidepressant
Paxipam	halazepam	Long-acting benzodiazepine
pentazocine	Talwin	Narcotic analgesic
pentobarbital	Nembutal	Barbiturate, hypnotic/anxiolytic/sedative
Percocet	oxycodone	Narcotic analgesic
Periactin	cyproheptadine	Traditional anticholinergic antihistamine
Permitil	fluphenazine	Antipsychotic
perphenazine	Trilafon	Antipsychotic
Persantine	dipryidamole	Antiplatelet, coronary vasodilator
Pertofrane	desipramine	Tricyclic anticholinergic antidepressant
phenelzine	Nardil	MAOI antidepressant
Phenergan	promethazine	Traditional anticholinergic antihistamine
phenobarbital		Barbiturate, hypnotic/anxiolytic/sedative
phenylbutazone	Butazolidin	NSAID
phenylephrine	DuoMedihaler	Decongestant
phenylpropanolamine	Genex	Decongestant

Drug Name	Alternate Name	Category
pimozide	Orap	Antipsychotic
piroxicam	Feldene	NSAID
Placidyl	ethchlorvynol	Hynotic/anxiolytic/sedative
Polaramine	dexchlorpheniramine	Traditional anticholinergic antihistamine
potassium supplements		Potassium replacement/supplement
prednisolone		Corticosteroid
prednisone		Corticosteroid
ProBanthine	propantheline	GI antispasmodic
prochlorperazine	Compazine	Antipsychotic
procyclidine	Kemadren	Anticholinergic anti-Parkinson
Prolixin	fluphenazine	Antipsychotic
promazine	Sparine	Antipsychotic
promethazine	Phenergan	Traditional anticholinergic antihistamine
propantheline	ProBanthine	GI antispasmodic
propoxyphene	Darvon, Darvocet N	Narcotic analgesic
ProSom	estazolam	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
protriptyline	Vivactil	Tricyclic anticholinergic antidepressant
Proventil	albuterol	Beta agonist
Prozac	fluoxetine	SSRI antidepressant
pseudoephedrine	Sudafed, Novafed, Triaminic AM	Decongestant
Pyribenzamine	tripelennamine	Traditional anticholinergic antihistamine
quazepam	Doral	Long-acting benzodiazepine
quetiapine	Seroquel	Antipsychotic
Reglan	metoclopramide	Antiemetic
Relafen	nabumetone	NSAID
Restoril	temazepam	Hypnotic

Drug Name	Alternate Name	Category
Risperdal	risperidone	Antipsychotic
risperidone	Risperdal	Antipsychotic
Ritalin	methylphenidate	Central nervous system stimulant
Robaxin	methocarbamol	Skeletal muscle relaxant
Roxicodone	oxycodone	Narcotic analgesic
secobarbital	Seconal	Barbiturate, hypnotic/anxiolytic/sedative
Seconal	secobarbital	Barbiturate, hypnotic/anxiolytic/sedative
Serax	oxazepam	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
Serentil	mesoridazine	Antipsychotic
Seroquel	quetiapine	Antipsychotic
sertraline	Zoloft	SSRI antidepressant
Serzone	nefazodone	Antidepressant
Sinequan	doxepin	Tricyclic anticholinergic antidepressant
Skelaxin	metaxalone	Skeletal muscle relaxant
Slo-Bid	theophylline	Bronchodilator
Soma	carisoprodol	Skeletal muscle relaxant
Somnos	chloral hydrate	Hypnotic/anxiolytic/sedative
Sparine	promazine	Antipsychotic
Stelazine	trifluoperazine	Antipsychotic
Sudafed	pseudoephedrine	Decongestant
sulindac	Clinoril	NSAID
Surmontil	trimipramine	Tricyclic anticholinergic antidepressant
Talwin	pentazocine	Narcotic analgesic
Taractan	chlorprothixene	Antipsychotic
temazepam	Restoril	Hypnotic
terbutaline	Brethine	Beta agonist

Drug Name	Alternate Name	Category
TheoDur	theophylline	Bronchodilator
theophylline	TheoDur, Slo-Bid, Uniphyl, Elixophyllin	Bronchodilator
thioridazine	Mellaril	Antipsychotic
thiothixene	Navane	Antipsychotic
Thorazine	chlorpromazine	Antipsychotic
Ticlid	ticlopidine	Antiplatelet
ticlopidine	Ticlid	Antiplatelet
Tigan	trimethobenzamide	Antiemetic
Tindal	acetophenazine	Antipsychotic
Tofranil	imipramine	Tricyclic anticholinergic antidepressant
Tolectin	tolmetin	NSAID
tolmetin	Tolectin	NSAID
Tornalate	bitolterol	Beta agonist
Tranxene	clorazepate	Long-acting benzodiazepine
tranylcypromine	Parnate	MAOI antidepressant
trazodone	Desyrel	Antidepressant
Triaminic AM	pseudoephedrine	Decongestant
Triavil	amitriptyline	Tricyclic anticholinergic antidepressant
triazolam	Halcion	Hypnotic
trifluoperazine	Stelazine	Antipsychotic
triflupromazine	Vesprin	Antipsychotic
trihexyphenidyl	Artane	Anticholinergic anti-Parkinson
Trilafon	perphenazine	Antipsychotic
trimethobenzamide	Tigan	Antiemetic
trimipramine	Surmontil	Tricyclic anticholinergic antidepressant
tripelennamine	Pyribenzamine	Traditional anticholinergic antihistamine

Drug Name	Alternate Name	Category
Tuinal	amobarbital/secobarbital	Barbiturate, hypnotic/anxiolytic/sedative
Tylenol w/codeine	codeine	Narcotic analgesic
Uniphyl	theophylline	Bronchodilator
Urecholine	bethanechol	Bladder relaxant
Urispas	flavoxate	Bladder relaxant
Valium	diazepam	Long-acting benzodiazepine
venlafaxine	Effexor	Antidepressant
Vesprin	triflupromazine	Antipsychotic
Vistaril	hydroxyzine	Traditional anticholinergic antihistamine, hypnotic/anxiolytic/sedative
Vivactil	protriptyline	Tricyclic anticholinergic antidepressant
Voltaren	diclofenac	NSAID
Wellbutrin	bupropion	Antidepressant
Xanax	alprazolam	Short-acting benzodiazepine, hypnotic/anxiolytic/sedative
ziprasidone	Geodon	Anitpsychotic
Zoloft	sertraline	SSRI antidepressant
zolpidem	Ambien	Hypnotic
Zyprexa	olanzapine	Antipsychotic

Abbreviations: NSAID, nonsteroidal anti-inflammatory drugs; GI, gastrointestinal; SSRI, selective serotonin reuptake inhibitor; MAOI, monoamine oxidase inhibitor; CNS, central nervous system.

Answers to Beers' List 1991

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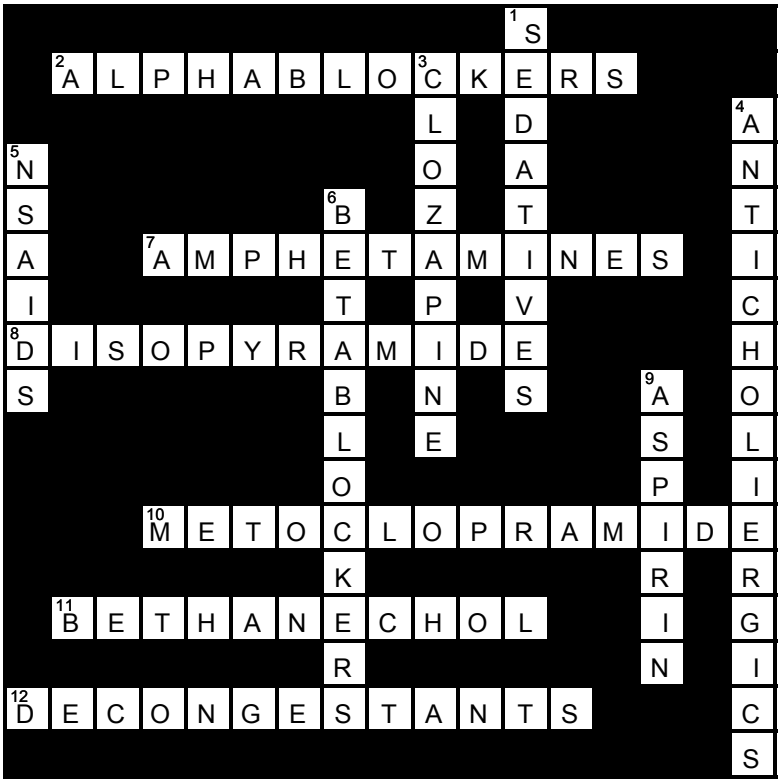
Across: 3. Trimethobenzamide, **8.** Reserpine, **10.** Haloperidol, **15.** Propoxyphene, **18.** Meprobamate, **21.** Ticlopidine, **22.** Dipyridamole, **24.** Chlorpropamide, **25.** Thiordiazine, **26.** Ranitidine, **27.** Lorazepam.

Down: 1. Flurazepam, **2.** Methocarbamol, **4.** Hydrochlorothiazide, **5.** Cimetidine, **6.** Ergot mesylates, **7.** Disopyramide, **9.** Indomethacin, **11.** Oral antibiotics, **12.** Doxypin, **13.** Chlordiazepoxide, **14.** Iron supplements, **16.** Dicylomine, **17.** Propranolol, **19.** Pentazocine, **20.** Meperidine, **23.** Digoxin.

Answers to Beers' List 1997



Across: 2. Alpha blockers, **7.** Amphetamines, **8.** Disopyramide, **10.** Metoclopramide, **11.** Bethanechol, **12.** Decongestants.

Down: 1. Sedatives, **3.** Clozapine, **4.** Anticholiergics, **5.** NSAIDS, **6.** Beta blockers, **9.** Aspirin.

Unnecessary/Antipsychotic Drug Algorithm

During Task 5C identify the drug then proceed to the listed page. Hypnotic and anxiolytic dosage differ.

Long-Acting Benzodiazepines–Page 2

Chlordiazepoxide	(Librium)	20mg
Clonazepam	(Klonopin)	1.5mg
Clorazepate	(Traxene)	15mg
Diazepam	(Valium)	5mg
Flurazepam	(Dalmane)	15mg
Halazepam	(Paxipam)	40mg
Quazepam	(Doral)	7.5mg

Anxiolytic drugs–Page 2

Alprazolam	(Xanax)	0.75mg
Chloral Hydrate	(many brands)	750mg
Diphenhydramine	(Benadryl)	50mg
Estazolam	(ProSom)	0.5mg
Hydroxyzine	(Vistaril, Atarax)	50mg
Lorazepam	(Ativan)	2mg
Oxazepam	(Serax)	30mg

Hypnotic Drugs–Page 2

Alprazolam	(Xanax)	0.25mg
Chloral Hydrate	(Many brands)	500mg
Diphenhydramine	(Benadryl)	25mg
Estazolam	(ProSom)	0.5mg
Hydroxyzine	(Vistaril, Atarax)	50mg
Lorazepam	(Ativan)	2mg
Oxazepam	(Serax)	15mg
Temazepam	(Restoril)	7.5mg
Triazolam	(Halcion)	0.125mg
Zolpidem	(Ambien)	5mg

Academy Approved Job Aid September 24, 2002

Barbiturates–Page 4

Amobarbital-Secobarbital	(Tuinal, Amytal)
Barbiturates w/other drugs	(e.g., Florinal)
Butabarbital	(Butisol, others)
Pentobarbital	(Nembutal)
Phenobarbital	(Many Brands)
Secobarbital	(Seconal)

Miscellaneous Hypnotic/Anxiolytic drugs–Page 4

Glutethimide	(Doriden)
Ethchlorvynol	(Placidyl)
Meprobamate	(Equanil, Miltown)
Methprylon	(Noludar)
Paraldehyde	(Many Brands)

Antipsychotic drugs–Page 3

Acetophenzine	(Tindal)	20mg
Chlorpromazine	(Thorazine)	75mg
Chlorprothixene	(Taractan)	75mg
Clozapine	(Clozaril)	50mg
Fluphenazine	(Prolixin, Permitil)	4mg
Haloperidol	(Haldol)	4mg
Loxapine	(Loxitane)	10mg
Mesoridazine	(Serentil)	25mg
Molindone	(Moban)	10mg
Olanzapine	(Zyprexa)	10mg
Perhpenazine	(Trilafon)	8mg
Prochlorperazine	(Compazine)	10mg
Promazine	(Sparine)	150mg
Quetiapine	(Seroquel)	200mg
Risperidone	(Risperdal)	2mg
Thioridazine	(Mellaril)	75mg
Thiothixene	(Navane)	7mg
Trifluoperazine	(Stelazine)	8mg
Triflupromazine	(Vesprin)	20mg

2

Anxiolytic and Hypnotic Drugs

(for this group of drugs start at item D)

Other reasons for insomnia has been considered and ruled out

Yes — No → **Inadequate indications(F329)**

Results in the maintenance or improvement of resident's functional status

Yes — No → **Inadequate indications (F329)**

Use is less than 10 consecutive days

Yes — No

attempted gradual dose reduction (3x/6mos)

Yes — No → **Excessive Duration (F329)**

Total daily dose is less than amounts listed on Page 1

Yes — No

No Deficiency — Documentation is present to prove why it's necessary

Yes — No → **Excessive Dose (F329**

Long-Acting Benzodiazepine LABZD

The LABZD is being used for one of the following

A. Diazepam for neuromuscular syndromes (seizures, cerebral palsy, tardive dyskinesia)
B. To withdraw from a short acting benzodiazepine
C. Clonazepam for bipolar disorders, tardive dyskinesia, seizures or nocturnal myoclonus
D. For single use prior to dental or medical procedure

No — Yes → **No deficiency**

For use in sleep induction (hypnotic drug)

Yes — No

The anxiolytic is being used for one of the following;

A. Generalized anxiety disorder
B. Dementia with agitation WHICH the facility has
   1) documented the behaviors quantitatively & objectively PRIOR to the use of the drug AND
   2) demonstrated that the behaviors are:
      - Persistent AND
      - Not due to preventable reasons AND
      - Which constitute sources of distress OR dysfunction to the resident OR represents danger to the resident or others
C. Panic disorder
D. Symptomatic anxiety associated with a psychiatric disorder (e.g. depression)

Yes — No → **Inadequate indications (F329)**

Evidence exists that other possible reasons for the resident's distress were ruled out

Yes — No → **Inadequate indications (F329)**

Use results in the maintenance or improvement in the resident's functional status

Yes — No → **Inadequate indications (F329**

Daily Use is less than 4 consecutive months

Yes — No → attempted gradual dosage reduction(2x/yr)

Yes — No → **Excessive Duration (F329)**

Total daily dose is less than amount listed on page 1

Yes — No → Documentation to prove its necessary

No deficiency ← Yes — No → **Excessive Dose (F329)**

3

Antipsychotics

Resident with dementia and associated psychotic and/or agitated behaviors

No

Is one of the following specific conditions present?

-Schizophrenia
-Schizoaffective disorder
-Delusional disorder
-Psychotic mood disorder
-Schizophreniform disorder
-Acute or Brief reactive psych
-Tourette's
-Huntington's disease
-Symptomatic treatment of hiccups, N/V, pruritis

No → **Inadequate indications (F329 or F330)**

Yes → **No Deficiency**

Yes

The behaviors exhibited by the resident MUST:

1. Be quantitatively & objectively documented prior to use of the drug AND
2. Be persistent, AND
3. Not caused by preventable reasons, AND
4. Be causing the resident to;
   a. Present a danger to himself or others OR
   b. Continuously scream, yell or pace—which causes an impairment in functional capacity, OR
   c. Experience psychotic symptoms which causes the resident distress or impairment in functional capacity

No to any of items 1-4 may be **F330 or F329 (Inadequate indications)**

Yes to all of items 1-4 then indication = okay

The facility must continue to monitor the behaviors in a quantitative and objective manner (i.e. no clumping)

Yes

No → **Inadequate monitoring (F329)**

Total daily dose is less than amount listed on Page 1

Yes

No → Justification for higher dose?

Yes

No → **Excessive Dose (F329)**

Side effects are monitored; tardive dyskinesia, postural hypotension, akathisia, Parkinsonism, cognitive/behavior impairments

Yes

No → **Inadequate monitoring &/or In the presence of adverse Consequences (F329)**

Does the resident receive a dosage reduction twice in 12 months?

Yes

No → Does the facility document that dosage reduction is clinically contraindication?

Yes → **No Deficiency**

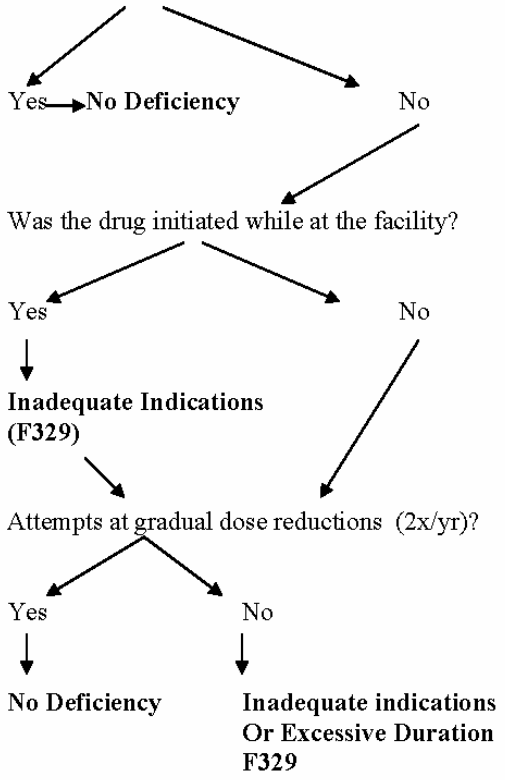
No → **F331 or F329 (Excessive duration)**

4

Barbiturates & Miscellaneous Hypnotics/Anxiolytics

Indications

1. For single dose use as a sedative for dental or medical procedures.
2. Phenobarbital for seizures



The algorithm is only a guide, your professional judgment & Task 6 process will dictate whether to cite the facility and the appropriate F tag to utilize

The algorithm doesn't address violations of F329 – In the presence of adverse consequences the drug dosage should be reduced or discontinued.

If there is any confusion please consult with your pharmaceutical consultant

General Notes

Pharmacological Survey Case Study—Student's Notes

Mrs. Williams was started on a new medication for her hypertension. The drug, Lotrel, is one of the new combination products which contain amlodipine 2.5 mg and benazepril hydrochloride 10 mg. The medication was ordered for once a day and started on January 14.

The surveyor was reviewing the medical record on January 22. Nursing notes referenced the following:
1/16 2 p.m. Res. c/o headache, medicated with Tylenol as ordered.
1/16 8 p.m. Res. c/o headache, medicated with Tylenol as ordered.
1/17 10 a.m. Res. c/o muscle aches and headache, medicated with Tylenol as ordered. Dr. called.
1/18 3 a.m. Res. c/o headache and muscle aches and slight nausea. Medicated with Tylenol and Maalox.
1/20 10 a.m. Res. c/o "flu-like muscle pains." Medicated with Tylenol.
1/21 1 p.m. Res. weight up 10#, face flushed, edema of hands noted and Res. unable to remove rings due to same. Still c/o muscle pains, dizziness and headache. Said she feels like her tongue is numb.
1/21 4 p.m. Res. c/o flu-like symptoms, flushed and short of breath. VS 99-98-32 98/64. Oxygen started at 3 L/min via nasal canula, Dr. notified and 911 called. Res. trans to hospital for eval at 3:45 p.m.

Pharmacological Survey Case Study—Instructor's Notes

Mrs. Williams was admitted for heart failure due to an adverse drug reaction.
First symptoms of adverse drug reaction were noted on 1/16 and not followed up on by nursing staff.
Adverse reaction to Lotrel:

- Central nervous system: Headache, somnolence, fatigue, dizziness, paresthesia.
- Cardiovascular: edema, flushing and palpitations.
- Gastrointestinal: nausea and abdominal pain.
- Musculoskeletal: muscle pain.
- Respiratory: dyspnea.
- Skin: rash, pruritis.

Lesson 3-N: Dialysis in Long Term Care

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Demonstrate a general knowledge of dialysis care for a long term care facility resident.
- Recognize various methods for the provision of dialysis in the long term care setting.
- Apply the long term care survey protocols for the resident who is receiving dialysis.
- Evaluate the significance of laboratory values, specific medications and dietary recommendations for residents receiving dialysis.
- Evaluate specific considerations for home dialysis treatment in the long term care setting.

Lesson Plan

References

Federal

- *State Operations Manual (SOM)*:
  - Appendix P, Survey Protocol for Long Term Care Facilities, pages 54–55
- CMS Survey & Certification letter S&C-04-24, *Clarification of Certification Requirements and Coordination of Care for Residents of Long-Term Care (LTC) Facilities Who Receive End Stage Renal Disease (ESRD) Services*
- *Code of Federal Regulations (CFR):*
  - 42 CFR 405.2137(a) and 405.2137(b), Condition: Patient long term program and patient care plan (2004)

State

(Insert State reference[s] here.)

Other

American Nephrology Nurses' Association website (www.annanurse.org)

Amgen Inc. (2001). *Core Curriculum for the Dialysis Technician* (2nd ed.). Thousand Oaks, CA: Author.

Highlights

- Definition of chronic kidney disease and end stage renal disease (ESRD)
- Types of dialysis and common settings
- Factors influencing morbidity and mortality relative to ESRD
- Implications for the long term care survey process
- Assessment and care planning
- Pertinent resident rights and social service needs
- Infection control and dialysis-related infections
- Drug therapy, laboratory values and nutritional needs
- Physician notification
- Regulatory considerations
- Concept of home dialysis provided onsite at the long term care facility

Training Techniques

- Lecture
- Group discussion
- Crossword
- Self-test

Training Aids

- PowerPoint slides and handouts
- Handouts:
  - CMS Survey and Certification letter S&C-04-24, *Clarification of Certification Requirements and Coordination of Care for Residents of Long-Term Care (LTC) Facilities Who Receive End Stage Renal Disease (ESRD) Services*
  - *Condition: Patient Long Term Program and Patient Care Plan*, *42 CFR 405.2137 (a) and (b)*
  - *Drug Therapy for ESRD*
  - *Laboratory Values for ESRD*
  - *Dietary Requirements for ESRD*
  - *Chronic Kidney Disease: What Is It?*
  - *Peritoneal Dialysis Fact Sheet*
  - *Checklist: Long Term Care Residents Receiving Dialysis*
  - *Considerations and Regulations for Dialysis*
  - *Dialysis in LTC*
  - *Self-Test for Dialysis*
  - *Solution for Dialysis in LTC*
- Easel pad with colored markers

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of self-test
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Outline or text of presentation

Lesson 3-N:
Dialysis in Long Term Care

1

Slide 3-N-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Demonstrate a general knowledge of dialysis care for a long term care facility resident.
- Recognize various methods for provision of dialysis in the long term care setting.

2

Slide 3-N-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Apply the long term care survey protocols for the resident who is receiving dialysis.
- Evaluate the significance of laboratory values, specific medications & dietary recommendations for residents receiving dialysis.
- Evaluate specific considerations for home dialysis treatment in the long term care setting.

3

Slide 3-N-3

Audiovisual

Functions of Kidneys

- Removal of waste—urea & creatinine
- Regulation of fluid balance
- Regulation of blood pressure through water & salt balance
- Production of substances which are important to formation of red blood cells (erythropoietin)
- Control of calcium & phosphorus

4

Slide 3-N-4

Outline or text of presentation

Functions of the Kidneys

- Removal of waste: urea and creatinine.
- Regulation of fluid balance.
- Regulation of blood pressure through water and salt balance.
- Production of substances that are important to the formation of red blood cells (erythropoietin).
- Control of calcium and phosphorus.

Dialysis in Long Term Care Facilities

- Stage 1—Kidney Damage (normal or GFR > 90)
- Stage 2—Mild Kidney Damage (GFR < 60–89)
- Stage 3—Moderate Kidney Damage (GFR < 30–59)

5

Slide 3-N-5

Chronic Kidney Disease

The glomerulofiltration rate (GFR) is a measure of kidney function. GFR is used to define the stages of chronic kidney disease (CKD):

- Stage 1—Kidney damage (normal or GFR > 90).
- Stage 2—Mild kidney damage (GFR < 60–89).
- Stage 3—Moderate kidney damage (GFR < 30–59).
- Stage 4—Severe kidney damage (GFR < 15–29).
- Stage 5—Kidney failure (GFR < 15).

Dialysis in Long Term Care Facilities (cont.)

- Stage 4—Severe Kidney Damage (GFR < 15–29)
- Stage 5—Kidney Failure (GFR < 15)

6

Slide 3-N-6

Audiovisual

End Stage Renal Disease (ESRD)

Stage of kidney disease or injury that appears irreversible & permanent, requiring routine, repetitive dialysis or kidney transplantation to sustain life.

7

Slide 3-N-7

Outline or text of presentation

End Stage Renal Disease

End stage renal disease (ESRD) is defined as the stage of kidney disease or injury that appears irreversible and permanent, requiring routine, repetitive dialysis or kidney transplantation to sustain life.

Primary Causes of End Stage Renal Disease

- Diabetes
- Hypertension
- Glomerulonephritis
- Other

8

Slide 3-N-8

Primary Causes of End Stage Renal Disease

- Diabetes.
- Hypertension.
- Glomerulonephritis.
- Other.

Treatment Modalities

- Transplantation—receipt of organ from either living or deceased donor
- Dialysis—process by which dissolved substances & waste such as urea & creatinine are removed from body by diffusion & osmosis from one fluid compartment to another across semipermeable membrane

9

Slide 3-N-9

Treatment Modalities

- Transplantation: receipt of an organ from either a living or deceased donor.
- Dialysis: process by which dissolved substances and waste such as urea and creatinine are removed from the body by diffusion and osmosis from one fluid compartment to another across a semipermeable membrane.

Audiovisual

Two Types of Dialysis

- Hemodialysis (HD)
- Peritoneal dialysis (PD)

10

Slide 3-N-10

Outline or text of presentation

Types of Dialysis

Two types of dialysis are hemodialysis (HD) and peritoneal dialysis (PD):

- "Hemodialysis is a process that cleans the blood of waste products by passing the blood through an artificial kidney, or dialyzer. Blood and dialysate are separated by the semipermeable dialyzer membrane. Excess water and wastes move out of the patient's blood through the membrane, and into the dialysate, according to the principles of diffusion and osmosis. HD is the most commonly chosen treatment modality for patients with ESRD" (Amgen, 2001, pp. II-34–35).
- "Peritoneal dialysis is a type of dialysis that uses the peritoneal membrane (a blood-vessel-rich sac surrounding the abdominal organs) as a filter. A catheter is surgically inserted into the abdominal cavity to allow sterile dialysate to fill the abdomen, dwell, and drain out. During the dwell time, wastes and excess fluid move from the blood across the peritoneum and into the dialysate by diffusion and osmosis" (Amgen, 2001, p. II-32).

Settings for Dialysis

- Most common: certified dialysis unit (CDU)
- Other settings:
  - In SNF, dialyzed by CDU staff
  - By durable medical equipment monitored by CDU staff
  - By SNF staff under CDU supervision
  - By CDU staff in SNF

11

Slide 3-N-11

Settings for Dialysis

Most commonly, residents of long term care facilities are dialyzed in a certified dialysis facility. However, a resident may also be dialyzed in a skilled nursing facility (SNF) by certified dialysis unit staff, by use of durable medical equipment (DME) monitored by staff in a certified unit, by SNF staff under supervision of a certified dialysis unit, or by unit staff in the SNF.

Audiovisual

Outline or text of presentation

(Refer the students to handout "Surveyor and Certification Letter S&C-04-24" on page 3-N-27.)

If a resident of a long term care facility is dialyzed in an SNF, the SNF's nursing staff must be trained and monitored by a certified dialysis facility.

Factors Influencing Morbidity (Illness)

- Infection
- Dialysis dose
- Quality of water
- Intradialytic hypotension
- Vascular access problems
- Anemia
- Peritonitis (with PD)
- Depression
- Lack of education
- Lack of adherence to treatment plan

12

Slide 3-N-12

Factors Influencing Morbidity (Illness) for Residents with ESRD

- Infection.
- Dialysis dose.
- Quality of the water used in dialysis treatment.
- Hypotension during dialysis (too much water being removed or being removed faster than intracellular fluid shifts can refill the vascular space).
- Vascular access clotting, low flow or infection.
- Anemia.
- Peritonitis (with PD).
- Depression.
- Failure to educate the resident and family.
- Resident's lack of adherence to the treatment plan.

Factors Influencing Mortality

- Cardiovascular disease
- Infection
- Age
- Low albumin
- Diabetes mellitus
- Anemia
- Left ventricular mass load

13

Slide 3-N-13

Factors Influencing Mortality for Residents with ESRD

- Cardiovascular disease.
- Infection: Vascular access is the most frequent site.
- Age: Morbidity among dialysis recipients is higher the older they are and the longer they have been on dialysis (especially those who have been receiving dialysis for more than 10 years).

Audiovisual

Outline or text of presentation

- Low albumin (a blood protein that is a measure of nutritional status).
- Diabetes mellitus.
- Anemia.
- Left ventricular mass load.

Leading causes of death among dialysis recipients are cardiovascular disease and infection.

Survey Protocol

- Entrance conference
- Sample selection
- Resident review

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Slide 3-N-14

Survey Protocol

(Refer the students to "Review of a Resident Receiving Dialysis Services" on pages 54–55 of Appendix P of the State Operations Manual.)

During the entrance conference, ask the administrator to complete the Roster/Sample Matrix (Form CMS-802) and the Resident Census and Conditions of Residents (Form CMS-672); each identifies the number of residents receiving dialysis. Ask the administrator to describe the setting for provision of dialysis.

(Refer to "Home Dialysis Treatment in the Long Term Care Setting" section later in this lesson.)

During sample selection, you may decide to include residents with end stage renal disease. Sample selection criteria include considering, but do not require choosing, a resident who is receiving dialysis services.

(Refer to Lesson 3-E, Sample Selection.)

If there is a sampled resident who is receiving dialysis care, evaluate the following, in addition to the standard resident review protocol:

Audiovisual

Outline or text of presentation

- Whether medication is given at times at which it will have the maximum effect.
- Whether staff know how to manage emergencies and complications, including equipment failure and alarm systems (if any), bleeding/hemorrhaging, and infection/bacteremia/septic shock.
- Whether facility staff are aware of the care of the vascular access, infection control, waste handling, nature and management of end stage renal disease (including nutritional needs, emotional and social well-being, and aspects to monitor).
- Whether the treatment for this (these) resident(s) affects the quality of life, rights or quality of care for other residents (e.g., restricting access to their own spaces, risk of infections).

If you have concerns regarding the care provided, you can request to see a copy of the agreement with the certified dialysis unit to see if it includes these provisions.

Dialysis Agreement

- Should include all aspects of how resident's care is to be managed, including:
  - Medical & nonmedical emergencies
  - Development & implementation of resident's Care Plan
  - Interchange of information useful & necessary for care of resident
  - Responsibility for waste handling, sterilization & disinfection of equipment (refer to SOM, Appendix P, page 54)

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Slide 3-N-15

Dialysis Agreement

When dialysis is provided in the facility by an outside entity or the resident leaves the facility to obtain dialysis, the facility must have an agreement or arrangement with the entity in accordance with 42 CFR 483.75(h). This agreement/arrangement should include all aspects of how the resident's care is to be managed, including:

- Medical and nonmedical emergencies.

Audiovisual

Outline or text of presentation

- Development and implementation of the resident's Care Plan.
- Interchange of information useful/necessary for the care of the resident.
- Responsibility for waste handling, sterilization, and disinfection of equipment (refer to *SOM*, Appendix P, page 54).

Care Teams

ESRD Unit
- Physician
- RN
- Dietitian
- Social worker

LTC Facility
- Physician
- Nursing staff
- Dietary staff
- Social service designee

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Slide 3-N-16

Care Teams

Dialysis Facility:	**LTC Facility:**
Physician	Physician
RN	Nursing staff
Dietitian	Dietitian, dietary staff
Social worker	Social service designee

The dialysis facility's dietitian must be eligible for registry with the American Dietetic Association with at least one year of clinical experience.

The dialysis unit's social worker must hold a master's degree in social work.

For each resident receiving dialysis, the ESRD unit and the LTC facility teams must exchange information regarding:
- Medical issues.
- Nursing issues.
- Dietary concerns.
- Psychosocial concerns.
- Laboratory values.

Audiovisual

Minimum Data Set

- Every section of MDS may be affected because of effects that resident may experience related to disease process. Specific areas include:
  - Diseases/diagnoses: renal failure
  - Oral/nutritional status: therapeutic diet
  - Special treatments: dialysis

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Slide 3-N-17

Outline or text of presentation

Minimum Data Set

Every section of the Minimum Data Set (MDS) may be affected by the disease process. Specific areas include:

- Diseases/diagnoses: renal failure.
- Oral/nutritional status: therapeutic diet.
- Special treatments: dialysis.

Care Plan

- ESRD unit's long term program
- LTC facility's resident care plan:
  - Dialysis order
  - Dialysis center information
  - Transportation plan & contact information
  - Dialysis days & times
  - Nutritional requirements
  - Fluid allowance
  - Laboratory values
  - Vascular access care
  - Emotional & social well-being

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Slide 3-N-18

Care Plan

The ESRD unit is required to send the LTC facility the long term program and patient Care Plan within one working day.

(Refer students to the handout "Condition: Patient Long Term Program and Patient Care Plan" on page 3-N-57.)

The long term program (LTP) is completed on admission to dialysis and revised annually by the ESRD unit. The LTP includes the patient's choices regarding type of dialysis, location of the service and transplantation. Information exchanged should be integrated with the LTC facility's resident Care Plan.

The LTC facility's resident Care Plan should address the following for residents receiving dialysis services:

- Dialysis order.
- Dialysis center name, phone number and contact person.
- Transportation plan and contact information.

Audiovisual

Outline or text of presentation

- Dialysis days and times.
- Nutritional requirements.
- Fluid allowance.
- Laboratory values.
- Vascular-access care.
- Emotional and social well-being.

Resident Rights

- Evaluate LTC facility's provisions for rights & choices of resident receiving dialysis

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Slide 3-N-19

Resident Rights

Evaluate the LTC facility's provisions for the rights and choices of the resident receiving dialysis. For example:

- Does the facility address issues related to a resident's noncompliance with care?
- How does the facility assist a resident who chooses to discontinue dialysis? Both the facility and the resident should understand and consider the risks of noncompliance with dialysis care.
- Referrals for hospice care often follow a patient's choice to discontinue dialysis. Evaluate whether the treatment for the resident receiving dialysis affects the quality of life, rights or quality of care for other LTC facility residents. For example:
  - Does the care of the resident receiving dialysis restrict other residents' access to their own living or activity space?
  - Does the condition or care of the resident receiving dialysis place other facility residents at risk of infection?

Audiovisual

Social Services

- Evaluate LTC facility's efforts to address social needs of resident receiving dialysis

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Slide 3-N-20

Outline or text of presentation

Social Services

Evaluate the LTC facility's efforts to address the social needs of the resident receiving dialysis. For example:

- Does the facility arrange transportation for the dialysis care?
- Does the facility make alternative plans for the resident's meals to ensure the resident does not miss a meal if the resident leaves the facility before regular meal service or is away during meal service?

Medicare Coverage for Dialysis

- Medicare ESRD benefit pays for dialysis or transplantation regardless of resident's age
  - 90-day waiting period for Medicare eligibility
    - Waived if patient chooses home dialysis treatment or transplant
  - If patient has private insurance at start of dialysis care Medicare is secondary payer for first 18 months after 90-day waiting period

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Medicare Coverage for Dialysis

In order to assist residents, the LTC facility should be familiar with Medicare benefits for dialysis services provided once the diagnosis of ESRD is established. The Medicare ESRD benefit pays for dialysis or transplantation regardless of the resident's age. There is a 90-day waiting period for Medicare eligibility; this is waived if the patient chooses home dialysis treatment or transplant. If the patient has private insurance at the start of dialysis care, Medicare is the secondary payer for the first 30 months after the 90-day waiting period.

Assessment of Vascular Access

- Licensed nurse should assess resident both before & after dialysis, noting resident's overall condition
  - Includes lung sounds, vascular access site & vital signs, including weight
  - If resident is transported by stretcher, nursing home may need to measure pre- & postdialysis weight

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Slide 3-N-22

Assessment of the Vascular Access

A licensed nurse should assess the resident both before and after dialysis, noting the resident's overall condition. This includes lung sounds, vascular-access site and vital signs, including weight. If the resident is transported by stretcher, the nursing home may need to measure the pre- and postdialysis weight.

Audiovisual

Types of Vascular Access

- Fistula
- Graft
- Central catheter

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Outline or text of presentation

The types of vascular access are:

- *Fistula*—this is the preferred vascular access for dialysis. The patient's own artery and vein are connected end to end, end to side or side to side, allowing increased blood flow through the vein. The vein then develops thicker walls, allowing for insertion of large needles and for a high blood flow rate through the blood lines to the dialysis machine.
- *Graft*—an artificial material is used to connect the patient's artery and vein. Needles are then inserted into the graft for dialysis.
- *Central catheter*—large catheters are inserted in a central vein for dialysis access. This carries a high risk of infection but may be the only available route for immediate treatment.

In assessing a fistula or graft, the nurse should:

- Listen via stethoscope for a *bruit*, a sound created when blood flows through a narrowed space.
- Note any *thrill*, a vibration that is felt when blood flows through a narrowed space.
- Observe skin condition over the vascular access, checking for color, warmth, edema, drainage or bleeding.
- Check any dressing over the site and remove the dressing after 4–6 hours.
- Observe the positioning of the extremity in order to avoid pressure on the access, which would decrease blood flow.

Audiovisual

Outline or text of presentation

The LTC facility staff should be aware of precautions regarding the extremity with the vascular access to protect it from injury: no blood pressure measurements, no injections, no IVs and no restraint should be applied to the extremity with the vascular access.

Infection Risk Factors

- Severe underlying disease process
- Immunosuppression inherent in kidney disease
- Invasive procedures, performed three times a week
- Multiple facility stays, hospitalizations
- Foreign objects in vascular system (catheters/grafts)

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Slide 3-N-24

Infection Risk Factors

- Severe underlying disease process.
- Immunosuppression (inherent in kidney disease).
- Invasive procedures performed three times a week.
- Multiple facility stays, hospitalizations.
- Foreign objects in vascular system (catheters/grafts).

Dialysis-Associated Infections

- Blood-borne pathogens
  - Hepatitis B
  - Hepatitis C
- Drug-resistant microorganisms
  - VRE
  - MRSA
- Bacteremia & pyrogenic reactions

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Slide 3-N-25

Dialysis-Associated Infections

- Blood-borne pathogens.
  - Hepatitis B.
  - Hepatitis C.
- Drug-resistant microorganisms.
  - Vancomycin-resistant *enterococci.*
  - Methicillin-resistant *Staphylococcus aureus*.
- Bacteremia and pyrogenic reactions.

Audiovisual

Drug Therapy

- Epogen
- Heparin
- Phosphate binders
- Cardio-active medications
- Others

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Slide 3-N-26

Outline or text of presentation

(Refer students to the handout "Drug Therapy for ESRD" on page 3-N-59.)

Laboratory Values

- Urea reduction ration
- Kinetic modeling
- Hemoglobin & hematocrit
- Potassium
- Sodium
- Phosphorus

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Slide 3-N-27

(Refer students to the handout "Laboratory Values for ESRD" on page 3-N-61.)

Dietary Requirements

- Role of RD at ESRD unit
- Individualized resident diet
- Foods high in certain nutrients
- Weight changes
- Fluid allowance

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Slide 3-N-28

(Refer students to the handout "Dietary Requirements for ESRD" on page 3-N-63.)

Audiovisual

Physician Notification

- LTC facility should report following to physician of resident receiving dialysis care:
  - No bruit or thrill in vascular access (fistula or graft)
  - Symptoms of infection
  - Abnormal lab values
  - Fluid imbalance, especially fluid overload

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Physician Notification (cont.)

- Bleeding at access site
- Hypertension
- Anything that may interrupt or interfere with scheduled treatment

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Slide 3-N-30

Regulatory References

- Notification of changes
- Resident rights
- Social services
- Accommodation of needs
- Assessment
- Care planning
- Nutritional status
- Therapeutic diet
- Hydration
- Physician visits
- Laboratory services

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Slide 3-N-31

Outline or text of presentation

Physician Notification

The LTC facility should report the following to the physician of the resident receiving dialysis care:

- No bruit or thrill in the vascular access (fistula or graft). This indicates clotting and needs to be addressed promptly.
- Symptoms of infection.
- Abnormal lab values. (Remember—"Normal" lab values will be different for the resident with CKD.)
- Fluid imbalance, especially fluid overload.
- Bleeding at the access site.
- Hypertension.
- Anything that may interrupt or interfere with scheduled treatment.

Regulatory References

The LTC survey team should consider regulations related to the following areas in making deficiency determinations related to care of the resident receiving dialysis:

- Notification of changes.
- Resident rights.
- Social services.
- Accommodation of needs.
- Assessment.
- Care planning.

Audiovisual

Outline or text of presentation

- Nutritional status.
- Therapeutic diet.
- Pressure sores.
- Hydration.
- Physician visits.
- Laboratory services.

Surveyor Checklist and References

The LTC survey team should consider regulations related to the following areas in making deficiency.

(*Review:*
- *"Chronic Kidney Disease: What Is It?" on page 3-N-65.*
- *"Peritoneal Dialysis Fact Sheet" on page 3-N-67.*
- *"Checklist: Long Term Care Resident Receiving Dialysis" on page 3-N-69).*

Home Dialysis Treatment in Long Term Care Setting

- Provision of home dialysis in LTC facility is responsibility of ESRD provider
- LTC facility is responsible for resident's care leading up to & following provision of services by home dialysis team

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Slide 3-N-32

Home Dialysis Treatment in the Long Term Care Setting

Long term care residents may receive dialysis services at the facility, that is, onsite at the LTC facility.

The provision of home dialysis in the LTC facility is the responsibility of the ESRD provider. The LTC facility is responsible for the resident's care leading up to and following the provision of services by the home dialysis team.

Audiovisual

Entrance Conference

- Interview staff regarding dialysis provided
- If home dialysis is provided, request list of residents
- Ask about coordination of care
- If home dialysis occurs onsite in facility, identify as area of concern for survey

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Slide 3-N-33

Outline or text of presentation

Entrance Conference

During the entrance conference, interview staff to determine whether:

- The Skilled Nursing Facility or Nursing Facility is Medicare-approved as an ESRD provider, has a designated area in the facility that is Medicare-approved as an ESRD provider, and/or has home dialysis services onsite. If home dialysis occurs onsite in the facility, identify this as an area of concern for the survey. (This direction is in addition to Appendix P of the *SOM*, which directs the survey team to select offsite dialysis as a concern area only under certain circumstances.)
- There are residents in the facility who are receiving home dialysis. If so, have the facility provide a list of the residents' names and room numbers, the name of the ESRD-assigned caregiver/technician (and identify whether this caregiver is provided by the ESRD facility, the DME supplier, or the LTC facility) and the days and times when each resident will receive his/her dialysis treatment.
- The care is coordinated for residents who receive home dialysis, if provided. Ask the administrator to explain how the coordination of care is developed, implemented and monitored. Obtain a copy of the written contract, agreement, or arrangement, policies/procedures and/or Plan of Care, specifying how care is coordinated, to assist with the evaluation of care. Review the documents as described in the LTC survey protocol (Appendix P, page

Audiovisual

Outline or text of presentation

P-54). Alert the State agency's ESRD survey team that dialysis is being provided within this LTC facility and to any concerns identified with this service during the LTC survey.

Initial Tour

- Make observations & interview residents, staff &/or family to determine if home dialysis is being provided in facility & document any facility practices that appear questionable
- Observe locations for storage of dialysis equipment

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Slide 3-N-34

Initial Tour

During the tour and observation of the facility, observe and interview residents, staff, and/or family to determine if home dialysis is being provided in the facility and document any facility practices that appear questionable. Observe locations for the storage of dialysis equipment (in resident's room or on the unit). Dialysis may be performed in a resident's room or in a common room designated for dialysis, in which one or more residents may dialyze at the same time.

For identified concerns, share information with team members and add selected residents to the sample.

During the LTC survey, if residents, family or staff voice concerns about the provision of care to residents during the home dialysis procedure, or if you identify concerns through your investigations related to the care of the resident during dialysis, identify the involved resident(s) and specific issues and copy pertinent documents in each resident's record pertaining to the concerns. *Notify the State agency and file a complaint against the ESRD facility for review by the ESRD survey team.*

Audiovisual

Outline or text of presentation

Survey Protocol

Existing survey procedures and guidance are to be followed during the LTC survey. Also consider the following regarding home dialysis for residents of the LTC facility if a concern is identified:

(Refer students to the handout "Considerations and Regulations for Dialysis" on page 3-N-71.)

Considerations & Regulations

- Resident rights
- Coordination of care
- Provision of care
- Infection control
- Equipment maintenance
- Medical records
- Quality assurance

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Lesson 3-N:
Dialysis in Long Term Care

Questions

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Slide 3-N-36

(As a review, have the students work the crossword "Dialysis in LTC" on page 3-N-75 using their handouts. The solution is on 3-N-81.)

(Have the students check their knowledge with the "Self-Test for Dialysis" on page 3-N-77.)

Skill Assessment

Dialysis in Long Term Care

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Defined CKD and ESRD.	
					Described factors influencing morbidity and mortality relative to ESRD.	
					Explained implications of the LTC survey process for dialysis patients.	
					Demonstrated understanding of assessment and care planning for the LTC resident receiving dialysis.	
					Described pertinent resident rights and social service needs.	
					Explained infection control and dialysis-related infections.	
					Assessed drug therapy, laboratory values and nutritional needs.	
					Described physician notification issues relative to the LTC resident receiving dialysis.	

					Demonstrated understanding of regulatory considerations.	
					Explained the concept of home dialysis provided onsite at the long term care facility.	

Comments/Recommendations:

Survey and Certification Letter S&C-04-24

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C: 04-24

DATE: **March 19, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Certification Requirements and Coordination of Care for Residents of Long-Term Care (LTC) Facilities Who Receive End Stage Renal Disease (ESRD) Services.

Letter Summary

- Regardless of the type of ESRD services provided, all Medicare-approved ESRD facilities must meet the Conditions for Coverage (CfCs) at 42 CFR §405.2130 through §405.2163 unless otherwise specified by the regulations.
- With respect to the provision of home dialysis training and support in LTC facilities, the Centers for Medicare & Medicaid Services (CMS) will approve only those ESRD applications that meet the specifications put forth in this memorandum and attachments. Applicants seeking approval must file the Form CMS-3427 or CMS-3427A as specified in this memorandum and may be subject to an on-site survey prior to approval.
- Attachments: Survey protocols for ESRD facilities and LTC facilities where residents qualify for and receive home dialysis. These protocols reflect currently existing requirements found in either the ESRD or LTC regulations.

This memorandum describes the steps CMS is taking to ensure that necessary safeguards are in place for residents of LTC facilities who receive dialysis. To that end, we are providing clarifications regarding the approval process for facilities that intend to provide dialysis to LTC residents.

We recognize that many residents of LTC facilities (skilled nursing facilities (SNFs), and nursing facilities (NFs)) who require dialysis would prefer the convenience of receiving dialysis in the LTC facility. And there has been a great deal of interest in the provision of home dialysis training and support in the LTC setting. While CMS regulations do not preclude this type of arrangement under certain circumstances, CMS has been holding all initial applications to provide home dialysis and training within LTC facilities pending assessment of their ability to provide home dialysis in a way that ensures the provision of adequate safeguards, clear lines of responsibility and accountability between the ESRD facility and the LTC facility, and quality care.

The purpose of this memorandum is to ensure that there are necessary safeguards and coordination of care for Medicare-approved facilities that provide home dialysis services for residents of LTC facilities. Specifically, this memorandum intends to: 1) clarify the applicable certification requirements and approval processes for Medicare-certified ESRD facilities; 2) specify the conditions under which home dialysis and training may be provided; and 3) augment CMS surveyor guidance to ensure that there is coordination of care, with defined lines of accountability and responsibility for quality safeguards for ESRD facilities providing home dialysis and training for LTC patients.

Certification Requirements

Part 42 of the Code of Federal Regulations (CFR), §405.2102, defines an ESRD facility as a Renal Transplantation Center, a Renal Dialysis Center, a Renal Dialysis Facility, a Self-Dialysis Unit, or a Special Purpose Facility. This section further defines an ESRD facility as "a facility which is approved to furnish at least one specific ESRD service." These services are: transplantation service; dialysis service; and self-dialysis and home dialysis training. While an ESRD facility may opt to provide all, or only one of the above services, Medicare-certified ESRD facilities must meet all of the ESRD Conditions for Coverage (CfC) unless otherwise provided by the regulations. For example, all ESRD facilities must meet the CfCs at Sections 405.2130 through 405.2163. However, sections 405.2161, 405.2162, and 405.2163 apply only to Renal Dialysis Centers and Renal Dialysis Facilities. Similarly, section 404.2164 exempts special purpose facilities from certain CfCs, but also applies additional standards. Therefore, while an ESRD "facility" may opt to offer home dialysis training as its only service, it must comply with all applicable CfCs, which include all ESRD CfCs except those specifically applicable to renal transplant centers (405.2170 and 405.2171) and special purpose dialysis facilities (405.2164).

The State Operations Manual (SOM) at §2274 states that an ESRD facility must file an application with its State Survey Agency (SA) to establish eligibility for a change, expansion, or initial provision of an ESRD service. Therefore, prior to providing home dialysis training and support for LTC residents, a facility must seek Medicare approval. This memorandum is intended to provide guidance for facilities, states, and regions regarding determinations of approval for this service. Where this ESRD service already exists, states and regions will use this memorandum to determine compliance with the current regulations through the ongoing recertification process.

Page 3 – State Survey Agency Directors

The SA will work with the relevant Regional Office (RO) to determine whether an on-site survey will be required before approval of an ESRD home dialysis training and support program. According to section 2278 of the State Operations Manual (SOM), a SA survey is required if the facility has not been surveyed in more than six months, or if substantial changes have been made. If a survey is not required, the RO includes the rationale for not surveying the ESRD facility.

If the SA determines a survey is needed to add the "training and support" services or if an initial certification survey is required, the SA visits the ESRD facility that is requesting approval for the service and the LTC facilities with which the ESRD facility has an agreement to provide "training and support" services.

Upon receipt of the survey report from the SA, the RO reviews all material and approves or disapproves the ESRD facility's request for "Patient Dialysis Training." The RO, in accordance with SOM 2278, forwards a copy of the notice to the SA and other required information to the fiscal intermediary.

ESRD facilities approved for training and support services for LTC residents are required to meet applicable regulations at 42 CFR 405.2130-405.2163. During a recertification visit, the SA surveys the facility using the guidance presented in this Memorandum. If the SA determines the ESRD facility's "training and support program" for LTC residents does not meet applicable requirements, the SA issues a CMS-2567, Statement of Deficiencies. The ESRD facility may have an opportunity to submit an acceptable plan of correction and regain compliance with required regulations.

Home Dialysis and Self/Home Dialysis Training in LTC Facilities

Part 42 CFR §405.2102 defines home dialysis as dialysis performed by an appropriately trained patient at home. CMS has considered LTC facilities as the patient's home for purposes of this benefit. This section further defines self-dialysis and home dialysis training as programs that train ESRD patients to perform self-dialysis or home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis or home dialysis. In order for Medicare payment of home dialysis to be made, the patient must have actively elected to become a home dialysis patient and have completed a training program provided by an approved ESRD facility. Home dialysis is intended to be self-dialysis performed by the patient and/or with the assistance of other individuals, (i.e., a designated family member or caregiver). However, there is the recognition that some Medicare beneficiaries may have physical, developmental, or cognitive limitations that would preclude the patient from completing the required home dialysis training without significant involvement and assistance from other individuals. As a result, for purposes of payment CMS permits the patient to play a secondary or limited role in the dialysis training and service provision in instances where a designated family member or caregiver is present to actively participate.

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Coordination of Services and Clarification of Responsibility and Accountability

While this model of care provides greater flexibility for dialysis patients, it also creates additional programmatic vulnerabilities that we believe can be minimized by adherence to the CfCs and active and ongoing care coordination between LTC and ESRD facilities. CMS will only approve applications of ESRD facilities to provide home training and support for LTC residents if the ESRD facility can assure CMS that the applicable facilities have a documented coordination agreement that outlines clear lines of responsibility and accountability.

Both the ESRD facility and the LTC facility will be held accountable for the coordination and quality of dialysis services delivered to LTC facility residents. The ESRD facility is responsible for providing the dialysis treatments, including training the patient and caregiver, monitoring the patient and patient's home, dietary and nutritional consultations, assuring continuity of care, installing and maintaining equipment, testing and treating the water, and ordering supplies. The LTC facility remains responsible for the overall care delivered to the resident including monitoring after completion of the dialysis treatment.

Under the ESRD regulations at 42 CFR §405.2136(b), 405.2136(c), 405.2136(d), and 405.2136(e) written documentation is required which specifies the terms and responsibilities of various providers of services. Therefore, to ensure that there is adequate coordination of care to effectively provide home dialysis training and support services to residents of LTC facilities, the ESRD facility will enter into a written coordination agreement with each LTC facility in which home dialysis patients reside. The purpose of this agreement is to coordinate the provision of such specific services to maximize patient safety and program efficiency. However, in no case may the ESRD facility or the LTC facility transfer responsibility for matters that each are otherwise required by law or regulation to provide.

Identify the Provision of Home Dialysis in LTC Facilities

Consistent with section 2274 of the SOM, in order to establish eligibility to provide ESRD services under Medicare, an applicant must complete Part I of the ESRD Application and Survey and Certification Report, Form CMS-3427/CMS-3427A. The Form CMS 3427/CMS-3427A is required when requesting initial approval, expansion or addition of stations, and a change in location, ownership, and/or in services provided. Any ESRD facility that plans to perform home dialysis and/or training as part of its initial application or as a part of an expansion of its services must request CMS approval. Part I of Form CMS-3427 must be submitted for an Initial Application. Part I of Form CMS-3427A must be submitted to request the "Addition of Services." Item 27 of CMS-3427 must identify those ESRD facilities that plan to provide or are providing training and support services to residents in a SNF and/or NF in lieu of transporting those patients to an ESRD facility to be dialyzed. Item 27 should include a list of the LTC facilities that are participants in the ESRD facilities' home training and support program. Item 27 does not need to reference those situations in which the dialysis is being furnished by a Medicare-approved ESRD outpatient facility.

Page 5 – State Survey Agency Directors

ESRD surveyors should ensure that Item 27 of CMS-3427/CMS-3427A is appropriately completed to identify the provision of home dialysis in LTC facilities. LTC surveyors should report to the SA which LTC facilities provide home dialysis to residents and any concerns that they have about the provision of dialysis services in a specific facility. The appropriate CMS RO will then ensure this information is entered into QIES/OSCAR in a timely manner so that these arrangements may be appropriately monitored.

Protocols

To assist with consistent application of the guidance in this memorandum, we are attaching two survey protocols that provide guidance in regard to the application of specific regulatory requirements. Attachment A provides guidance to qualified ESRD surveyors who survey ESRD facilities that provide home dialysis to residents of LTC facilities. Attachment B includes guidance to qualified LTC surveyors who survey facilities having residents who receive dialysis. These protocols reflect already existing requirements found in either the ESRD or the LTC regulations. These protocols are not all inclusive, but rather they are intended to assist facilities and surveyors in determining compliance with current requirements.

Contact: Judith Kari (jkari@cms.hhs.gov), 410-786-6829

Effective Date: This guidance is effective immediately for all recertifications, complaint surveys or initial application reviews. Nothing in this Memorandum should be construed to require the rescheduling of a recertification review.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers and ESRD Networks.

/s/
Thomas E. Hamilton

Attachments:
A – Survey Protocol for the Medicare-approved ESRD Facilities
B – Survey Protocol for Long-Term Care Facilities

5

Attachment A

Survey Protocol for Medicare-Approved ESRD Facilities

The Medicare-approved ESRD facility must monitor the dialysis care of Long-Term Care (LTC) facility residents for whom they are providing care, whether the care is provided in an ESRD facility or in a LTC facility. The survey process must include a review for compliance with ESRD requirements at both the residents' LTC facility and the Medicare-approved ESRD training and support facility.

This survey protocol includes references to potential regulatory citations for ESRD facilities by V-Tag numbers to assist the survey team in determining the facility's compliance or non-compliance with Conditions for Coverage. These references are provided after each highlighted protocol.

Pre-Survey Preparation or Entrance Conference Information

All home dialysis in a LTC facility requires that a Medicare-approved ESRD facility be responsible for all aspects of the dialysis care, whether the care is provided by Method I (i.e., supplies, equipment, training, and support care delivered by a Medicare-approved ESRD facility) or by Method II (i.e., supplies and equipment provided by a Durable Medical Equipment [DME] supplier with support care and training delivered by a Medicare-approved ESRD facility). Determine either prior to the survey or during the entrance conference the type and extent of ESRD services provided to LTC residents who participate in home dialysis. When the ESRD facility provides home dialysis services onsite in a LTC facility, the survey team must make a visit to the LTC facility to conduct additional investigations.

Interview staff and conduct record review to determine:

- The contractual arrangements related to both financial aspects and patient care responsibilities between the ESRD training and support facility, the LTC facility, and the DME supplier.
- The number of LTC facility residents who are dialyzing in the LTC facility. Are they dialyzing as a skilled nursing facility's (SNF) or nursing facility's (NF) residents? How long have they been residents of the LTC facility? Are they on hemodialysis or peritoneal dialysis? Identify the number of LTC facility patients on Method I or Method II. If on Method II, what DME supplier is used? Review of the ESRD beneficiary selection form, CMS 382, will indicate which patients selected each method. For patients on Method II, determine if there is a backup agreement between the ESRD facility and the DME supplier.
- Whether residents in the LTC facility are dialyzed in a common room or in their bedrooms. During which days/hours is dialysis performed? Ideally, the surveyor will visit during a dialysis treatment.

NOTE: This protocol is to be used with existing survey procedures and interpretive guidelines found in the State Operations Manual, Appendix H. The following investigative components are added to address the home dialysis component of the survey. The Medicare-approved ESRD facility must meet the Conditions for Coverage at 42 CFR §405.2130-405.2163.

Coordination Agreement and Governance

The ESRD facility shall have a written coordination agreement, signed by the ESRD facility and each LTC facility in which home dialysis patients reside. The agreement needs to ensure that there is adequate coordination of care to provide home dialysis training and services to residents of LTC facilities. The ESRD facility assumes responsibility for appropriately delivering ESRD care, even if the care is delivered outside of the venue of the ESRD facility, i.e. the LTC facility.

If the ESRD facility provides home dialysis on the premises of the LTC facility, conduct an onsite visit to determine if:

- There is a written coordination agreement, signed by the ESRD facility and the applicable LTC facilities, which delineates respective responsibilities and accountability for routine and emergency care, care planning, and communication. The coordination agreement must include information on financial aspects and patient care responsibilities among the ESRD training and support facility, the LTC facility, and the DME supplier (if applicable).
- The coordination agreement is reviewed at least annually.
- The written coordination agreement clearly delineates where patients will be sent in the event of an emergency situation.
- There are clear lines of responsibility and accountability between the ESRD facility and the LTC facility that safeguard the health and safety of LTC patients who receive dialysis treatments.
- The ESRD facility staff communicates patient care issues with LTC facility staff.

§405.2136 Governing Body and Management

V110 Condition: Governing Body and Management. The ESRD facility is under the control of an identifiable governing body, or designated person(s) so functioning, with full legal authority and responsibility for the governance and operation of the facility.

V121 Operational Objectives Established. The operational objectives of the ESRD facility, including the services that it provides, are established by the governing body and delineated in writing. The governing body adopts effective administrative rules and regulations that are designed to safeguard the health and safety of patients and to govern the general operations of the facility, in accordance with legal requirements.

V122 Operational Objectives in Writing. Such rules and regulations are in writing and dated.

V123 Revised Operational Objectives. The governing body ensures that they are operational, and that they are reviewed at least annually and revised as necessary.

V135 CEO: Administrative Function and Accountability. Organizing and coordinating the administrative functions of the facility, re-delegating duties as authorized, and establishing formal means of accountability for those involved in patient care.

V156 Use of Outside Resources. If the ESRD facility makes arrangements for the provision of a specific service as authorized in this subpart, the responsibilities, functions, objectives, and the terms of each arrangement, including financial provisions and charges, are delineated in a document signed by an authorized representative of the facility and the person or agency providing the service. The chief executive officer when utilizing outside resources, as a consultant, assures that he is apprised of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the chief executive officer for follow-up action and evaluation of performance.

V157 Patient Care Policies. The ESRD facility has written policies, approved by the governing body, concerning the provision of dialysis and other ESRD services to patients.

V165 Patient Care Policies: Emergencies. Care of patients in medical and other emergencies.

V175 Medical Supervision and Emergency Coverage. The governing body of the ESRD dialysis and/or transplant facility ensures that the health care of every patient is under the continuing supervision of a physician.

V176 Medical Emergency Coverage. That a physician is available in emergency situations.

V177 Medical Supervision: Orders. The physician responsible for the patient's medical supervision evaluates the patient's immediate and long-term needs and on this basis prescribes a planned regimen of care which covers indicated dialysis and other ESRD treatments, services, medication, diet, special procedures recommended for the health and safety of the patient, and plans for continuing care and discharge.

V179 Medical Supervision: Emergency Roster. The governing body ensures that there is always available medical care for emergencies, 24 hours a day, 7 days a week. There is posted at the nursing/monitoring station a roster with the names of the physicians to be called, when they are available for emergencies, and how they can be reached.

§405.2140 Physical Environment

V276 Emergency preparedness. Written policies and procedures specifically define the handling of emergencies that may threaten the health or safety of patients. Such emergencies would exist during a fire or natural disaster or during functional failures in equipment. Specific emergency preparedness procedures exist for different kinds of emergencies.

§405.2160 Affiliation Agreement/Arrangement

V411 Affiliation Agreement: Pts Accepted in Emergencies. The affiliation agreement or arrangement provides the basis for effective working relationships under which inpatient hospital care or other hospital services are available promptly to the dialysis facility's patients when needed. The dialysis facility has in its file documentation from the renal dialysis center to the effect that patients from the dialysis facility will be accepted and treated in emergencies.

Infection Control

Because of the extracorporeal blood exchanges in dialysis treatments, there is a risk of transmission of blood-borne infections/diseases.

Determine through observations, interviews, and record reviews if:

- There is evidence of collaboration between the ESRD facility and the LTC facility to investigate, control and prevent infections. Infection control policies of the LTC facility and ESRD facility are to be reviewed by the Medical Director of the Medicare-approved ESRD facility.
- The staff providing dialysis follows appropriate hand washing and gloving procedures.
- Items used for dialysis are either dedicated to single use or appropriately cleaned and disinfected.
- The multiple-use of single-use vials of Epoetin Alfa (EPO) is performed according to the Centers for Disease Control and Prevention (CDC) guidance.
- Clean and contaminated areas for dialysis are clearly separated and used appropriately.
- External transducer protectors are changed between patients and not reused.
- Dialysis stations and machines are disinfected between uses.
- Waste is managed and disposed of appropriately.

§405.2140 Physical Environment

V265 Functional, Sanitary, & Comfortable. The facility is maintained and equipped to provide a functional, sanitary, and comfortable environment with an adequate amount of well-lighted space for the service provided.

V266 Infection Control. There are written policies and procedures in effect for preventing and controlling hepatitis and other infections. These policies include, but are not limited to, appropriate procedures for surveillance and reporting of infections, housekeeping, handling and disposal of waste and contaminants, and sterilization and disinfection, including the sterilization and maintenance of equipment. Where dialysis supplies are reused, there are written policies and procedures covering the rinsing, cleaning, disinfection, preparation, and storage of reused items that conform to requirements for reuse.

V274 Contamination Prevention: Policies/Functions. The written patient care policies specify the functions that are carried out by facility personnel and by the self-dialysis patients with respect to contamination prevention.

§405.2150 Reuse

V388 Transducer filters. To control the spread of hepatitis, transducer filters are cleaned after each dialysis treatment and are not reused.

Water Treatment

For health and safety reasons, it is critical that the water used to reprocess dialyzers and to mix with concentrates to make dialysate is appropriately treated and monitored.

Determine through observations, interview and record review if the ESRD facility assures the following standards are met:

- The LTC location has equipment that ensures water used in dialysis treatments will meet the AAMI minimum standards for chemical contaminants and bacteriology.
- The LTC location ensures on a daily basis the water in the facility used for dialysis meets the AAMI minimum standards for the following: total chlorine less than 0.5 ppm and chloramines less than 0.1 ppm. Does the long-term care location test chlorines/chloramines daily prior to patient treatments?
- The water is cultured at least monthly. Are the results either less than 200 cfu/ml by culture for bacteria or less than 5 eu/ml by LAL for endotoxins?
- The dialysate is cultured monthly. Are the results less than 2000 cfu/ml for bacteria?
- The chemical analysis of the water done at least annually. Do the results meet AAMI standards?
- The person responsible for water treatment has an appropriate understanding of the water treatment equipment, testing, and procedures.

§405.2140 Physical Environment

V261 Water Treatment. The ESRD facility must employ the water quality requirements listed in paragraph (a)(5)(ii) of this section developed by the Association for the Advancement of Medical Instrumentation (AAMI) and published in "Hemodialysis Systems," second edition, which is incorporated by reference. **(ii)** Required water quality requirements are those listed in sections 3.2.1, Water Bacteriology; 3.2.2 Maximum Level of chemical contaminants; and in Appendix B: Guideline for Monitoring Purity of Water Used for Hemodialysis as B1 through B5.

V262 AAMI: Water Bacteriology. Total viable microbial count should not exceed 200/ml. A method of cleaning the equipment so that the equipment is capable of meeting this requirement shall be recommended by the manufacturer or supplier.

V263 AAMI: Dialysate Bacteriology. Total viable microbial count for the dialysate should not exceed 2000/ml.

V264 AAMI: Maximum Chemical Contaminants. The water used to prepare dialysate shall not contain chemical contaminants at concentrations in excess of those in Table 2, AAMI.

§405.2161 Physician Director

V423 Responsibility for Training Staff. Assuring adequate training of nurses and technicians in dialysis techniques.

Reuse

If a home dialysis program in a LTC facility reuses dialyzers, the reuse process must conform to Federal standards for reuse per **42 CFR §405.2150 (V300-V392).**

Equipment Installation and Maintenance

If a DME supplier provides equipment for home dialysis in a LTC facility under Method II, the Medicare-approved ESRD support facility remains responsible for overall management and oversight of equipment maintenance and installation.

Determine through observations, interview and record review if:

- There is an emergency tray, including emergency drugs, medical supplies, and emergency equipment available and accessible at all times at the ESRD facility's LTC location. Emergency equipment and supplies should be comparable to those located in an outpatient ESRD facility.
- Staff/caregivers are appropriately monitoring machine safety alarms as needed and continuously monitoring machine-derived blood pressure and fluid status.
- Equipment records show that preventive maintenance and repairs were done in a timely manner.
- A system is in place to monitor equipment function, identify equipment problems, and to ensure updates on preventive maintenance.

§405.2140 Physical Environment

V258 Equipment Preventive Maintenance. All electrical and other equipment used in the facility is maintained free of defects, which could be a potential hazard to patients and personnel. There is established a planned program of preventive maintenance of equipment used in dialysis and related procedures in the facility.

V281 Emergencies: Drugs and Supplies. There is available at all times on the premises a fully equipped emergency tray, including emergency drugs, medical supplies, and equipment.

V283 Emergencies: Staff Trained in Procedures. The staff is familiar with the use of all dialysis equipment and procedures to handle medical emergencies.

§405.2150 Reuse

V305 Equipment Maintenance Record**.** A log must be maintained of the date of preventive maintenance procedures and the date of results of scheduled testing in order to ensure the proper functioning of reprocessing equipment, environmental-control equipment, safety equipment, or other equipment.

§405.2161 Physician Director

V423 Responsibilities: Training Staff. Assuring adequate training of nurses and technicians in dialysis techniques.

V424 Responsibilities: Monitoring Process. Assuring adequate monitoring of the patient and the dialysis process, including, for self-dialysis patients, assuring periodic assessment of patient performance of dialysis tasks.

§405.2162 Staff

V434 Staff Numbers Meet Patient Needs. An adequate number of personnel are readily available to meet medical needs.

Staffing, Staff Training and Patient Monitoring During Treatment

In reviewing staffing and staff training, the survey process needs to determine that either the LTC facility resident or the resident's assistant (i.e., "caregiver") has the required knowledge and skills to perform required dialysis tasks. The surveyors also must determine if the staff in the LTC facility is trained to handle medical emergencies while residents are dialyzing and whether ongoing care is appropriate for dialysis patients. The LTC facility resident needs to be observed during dialysis treatment to ensure that treatments are delivered appropriately.

Determine through observation, interview and record review if:

- A "qualified" nurse, who has at least 3 months of his/her ESRD experience in training patients in self-care, is in charge of all training for "home" dialysis in a LTC facility, including caregivers and LTC facility staff.
- The training curriculum is appropriate for the type of dialysis provided and covers medical emergencies. Medical emergencies can include the administration of CPR and intravenous medication, and the treatment of air emboli, blood loss, and severe hypotension.
- There is an appropriately trained caregiver providing adequate monitoring while patients are dialyzing in the ESRD facility's LTC locations.

- For purposes of home dialysis in a LTC facility, the ESRD facility must ensure either through direct employment or other contractual arrangement with the LTC facility that one or more currently licensed health professionals experienced in rendering ESRD care is on duty to oversee ESRD patient care whenever patients are undergoing dialysis. The licensed health professional must have practical experience in or be trained by the ESRD facility to perform assessments, observe the patients pre and post dialysis, respond to emergency situations relative to dialysis treatments, and administer any necessary intravenous, intradialytic and intramuscular medications in accordance with all Federal and State requirements.
- A "qualified" renal dietitian monitors the dialysis patient's nutritional and dietary needs.
- A "qualified" renal social worker monitors the social service needs and services provided to the dialysis patient.
- The Physician Director of the ESRD facility assumes responsibility for ensuring adequate training of the staff and the availability of patient teaching materials.
- Trained personnel (staff/caregiver) are responsible for treatments.
- There are patient care policies, which are specific to care provided in the LTC setting, that cover the care of patients in medical and other emergencies.
- The treatment being received match the orders for treatment, and blood pressure and fluid status are continuously being monitored.
- Staff/caregiver is appropriately trained in preparing the dialysate bath, dialysis machine, dialyzer, and priming the machine with initial settings.
- Staff/caregiver is appropriately trained to handle equipment emergencies.

§405.2136 Governing Body

V144 Personnel Policies/Procedures: Staff Qualified. These policies and procedures ensure that: **(1)** All members of the facility's staff are qualified to perform the duties and responsibilities assigned to them and meet such Federal, State, and local professional requirements as may apply.

V170 Patient Care Policies: Consultants. Consultant qualifications, functions, and responsibilities.

§405.2140 Physical Environment

V282 Emergencies: Staff Trained in Equipment. There is available at all times on the premises a fully equipped emergency tray, including emergency drugs, medical supplies, and equipment, and staff are trained in its use.

V283 Emergencies: Staff Trained in Procedures. The staff is familiar with the use of all dialysis equipment and procedures to handle medical emergencies.

§405.2161 Physician Director

V421 Qualifications. The director of a dialysis facility is a qualified physician director.

V423 Responsibilities: Training Staff. Assuring adequate training of nurses and technicians in dialysis techniques.

V424 Responsibilities: Monitoring Process. Assuring adequate monitoring of the patient and the dialysis process, including, for self-dialysis patients, assuring periodic assessment of patient performance of dialysis tasks.

V426 Responsibilities: Self Care. When self-dialysis training is offered, assuring that patient teaching materials are available for the use of all trainees during training and at times other than during the dialysis procedure.

§405.2162 Staff

V430 Condition: Staff of a Renal Dialysis Facility or Renal Dialysis Center. Properly trained personnel are present in adequate numbers to meet the needs of the patients, including those arising from medical and nonmedical emergencies.

V431 Registered Nurse. The dialysis facility employs at least one full time qualified nurse responsible for nursing service.

V432 On-duty personnel: Licensend Person. Whenever patients are undergoing dialysis: (1) one currently licensed health professional (e.g. physician, registered nurse, or licensed practical nurse) experienced in rendering ESRD care is on duty to oversee ESRD patient care.

V433 Staff Ratios Meet Patient Needs. An adequate number of personnel are present so that the patient/staff ratio is appropriate to the level of dialysis care being given and meets the needs of patients.

V434 Staff Numbers Meet Patient Needs. An adequate number of personnel are readily available to meet medical needs.

V436 Self-care dialysis training personnel. If the facility offers self-care dialysis training, a qualified nurse is in charge of such training.

§405.2163 Minimal Service Requirements

V446 Social Worker Qualified. Social services are furnished by a qualified social worker who has an employment or contractual relationship with the facility.

V448 (d) Dietetian Qualified. Each patient is evaluated as to his nutritional needs by the attending physician and by a qualified dietician who has an employment or contractual relationship with the facility.

Patient Care Plans and Long-Term Program

Coordination of care and communication between the ESRD facility staff and the LTC facility staff should be clearly documented in the patients' medical records at the ESRD facility and at the LTC location.

Determine through observation, record review and interview if:

- There is a multidisciplinary, written, individualized patient care plan that is updated as required.
- The LTC staff and ESRD facility staff communicates and coordinates the development and implementation of the individualized patient care plan.
- There is a long-term program that is updated annually.
- The ESRD renal dietitian and social worker participate in long-term care plans and patient care planning, and communicate and coordinate with the long-term care facility staff to address individual patient needs.
- The Physician Director of the ESRD facility assumes responsibility for participating in the long-term program.
- The physician responsible for the patient's dialysis treatments work with a professional ESRD team to develop and review the individualized patient care plans.

§405.2136 Governing Body

V174 Patient Care Policies. The governing body adopts policies to ensure there is evaluation of the progress each patient is making towards the goals stated in the patient's long-term program and patient's care plan. Such evaluations are carried out through regularly scheduled conferences, with participation by the staff involved in the patient's care.

§405.2137 Long Term Program and Patient Care Plan

V187 Patient Long-Term Program: Written There is a written long-term program representing the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient.

V188 LTP: Team Members. The program is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker.

V189 LTP: Reviewed by Team. The program is formally reviewed and revised in writing as necessary by a team which includes but is not limited to the physician director of the dialysis facility or center where the patient is presently being treated, in addition to the other personnel listed in paragraph (a)(1) of this section at least every 12 months or more often as indicated by the patient's response to treatment.

V192 Patient Care Plan: Written, Assessed. There is a written patient care plan for each patient of an ESRD facility (including home dialysis patients under the supervision of the ESRD facility), based upon the nature of the patient's illness, the treatment prescribed, and an assessment of the patient's needs.

V193 PCP: Individualized. The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well as the individualized modifications in approach necessary to achieve the long-term and short term goals.

V194 PCP: Team. The plan is developed by a professional team consisting of at least the physician responsible for the patient's ESRD care, a qualified nurse responsible for nursing services, a qualified social worker, and a qualified dietitian.

V195 PCP: Patient Involved**.** The patient, parent, or legal guardian, as appropriate, is involved in the development of the care plan, and due consideration is given to his preferences.

V196 PCP: Frequency. The care plan for patients whose medical condition has not become stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patients' ongoing needs.

V197 PCP: Copy with Transfer**.** If the patient is transferred to another facility, the care plan is sent with the patient or within 1 working day.

V198 PCP: Home Patients**.** For a home-dialysis patient whose care is under the supervision of the ESRD facility, the care plan provides for periodic monitoring of the patient's home adaptation, including provisions for visits to the home by qualified facility personnel to the extent appropriate.

V199 PCP: EPO at Home. Beginning July 1, 1991, for a home dialysis patient, and beginning January 1, 1994, for any dialysis patient who uses EPO in the home, the plan must provide for monitoring home use of EPO that includes the following: (i) Review of diet and fluid intake for indiscretions as indicated by hyperkalemia and elevated blood pressure secondary to volume overload.

§405.2138 Patient Rights

V222 Participation in Planning. All patients treated in the facility are afforded the opportunity to participate in the planning of their medical treatment and to refuse to participate in experimental research.

Patient Rights and Responsibilities

Determine through interview with patients and families if:

- The patient/family was fully informed of options, including options for different modalities and settings. Form CMS-382, ESRD Beneficiary Selection, may be reviewed to verify patient election of Method I or Method II.
- Patients' rights are being observed, including the rights to privacy and respect.

- The patient/family is fully informed of services available in the facility and of related charges for services not covered under Medicare.
- If the patient/family is aware that there are grievance/complaint procedures.

§405.2138 Patients Rights and Responsibilities

V215 Condition: Patients' Rights and Responsibilities. The governing body of the ESRD facility adopts written policies regarding the rights and responsibilities of patients and, through the chief executive officer, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients and any guardians, next of kin, sponsoring agency (ies), representative payees, and to the public.

V217 Informed of Rights/Responsibilities. All Patients in the Facility: (1) Are fully informed of these rights and responsibilities, and of all the rules and regulations governing patient conduct and responsibilities.

V218 Informed of Services/Charges. Are fully informed of services available in the facility and of related charges including any charges for services not covered under title XVIII of the Social Security Act;

V219 Informed of Medical Condition. Are fully informed by a physician of their medical condition unless medically contraindicated (as documented in their medical records).

V220 Informed of Reuse. Are fully informed regarding the facility's reuse of dialysis supplies, including hemodialyzers. If printed materials such as brochures are utilized to describe a facility and its services, they must contain a statement with respect to reuse; and

V221 Informed of Modalities. Are fully informed regarding their suitability for transplantation and home dialysis.

V224 Respect, Dignity, and Privacy. All patients are treated with consideration, respect, and full recognition of their individuality and personal needs, including the need for privacy in treatment.

V225 Translators. Provision is made for translators where a significant number of patients exhibit language barriers.

V226 Confidentiality. All patients are ensured confidential treatment of their personal and medical records, and may approve or refuse release of such records to any individual outside the facility, except in case of their transfer to another health care institution or as required by Federal, State, or local law and the Secretary for proper administration of the program.

Medical Records

Patient records (electronic or paper) must be accessible at both the ESRD facility and the ESRD facility's LTC location.

Determine if:

- The medical records are complete and maintained both at the LTC facility and at the Medicare-approved ESRD facility.
- The records document the operation, disinfection and preventive maintenance and repair of dialysis, water treatment, and reuse equipment.
- The results of testing and cultures are consistently documented and reviewed.
- Affiliation agreements are appropriate and complete.

§405.2139 Medical Records

V230 Condition: Medical Records. The ESRD facility maintains complete medical records on all patients (including self-dialysis patients within the self-dialysis unit and home dialysis patients whose care is under the supervision of the facility) in accordance with accepted professional standards and practices. A member of the facility's staff is designated to serve as supervisor of medical records services, and ensures that all records are properly documented, completed, and preserved. The medical records are completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information.

V231 Medical Records: Identify, Justify, Document. Each patient's medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately.

V232 Patient Assessments. All medical records contain the following general categories of information. Documented evidence of assessment of the needs of the patient,

V233 Reuse Information. Whether the patient is treated with a reprocessed hemodialyzer,

V234 LTP and PCP. Establishment of an appropriate plan of treatment, and of the care and services provided.

V235 Patient Involvement in LTP/PCP. Evidence that the patient was informed of the results of the assessment.

V236 ID and Social Data. Identification and social data.

V237 Consents. Signed consent forms, referral information with authentication of diagnosis.

V238 Medical & Nursing History. Medical and nursing history of patient.

V239 Physician Exams. Report(s) of physician examination(s).

V240 Orders. Diagnostic and therapeutic orders.

V241 Progress Notes. Observations and progress notes.

V242 Treatments and Findings. Reports of treatments and clinical findings.

V243 Lab Reports. Reports of laboratory and other diagnostic tests and procedures.

V244 Discharge Summary. Discharge summary including final diagnosis and prognosis.

V245 Protection of Medical Record Information. The ESRD facility safeguards medical record information against loss, destruction, or unauthorized use. The ESRD facility has written policies and procedures which govern the use and release of information contained in medical records. Written consent of the patient, or of an authorized person acting in behalf of the patient, is required for release of information not provided by law. Medical records are made available under stipulation of confidentiality for inspection by authorized agents of the Secretary, as required for administration of the ESRD program under Medicare.

V246 Medical Records Supervisor. A member of the ESRD facility's staff is designated to serve as supervisor of the facility's medical records service. The functions of the medical records supervisor include, but are not limited to, the following: Ensuring that the records are documented, completed, and maintained in accordance with accepted professional standards and practices; safeguarding the confidentiality of the records in accordance with established policy and legal requirements; ensuring that the records contain pertinent medical information and are filed for easy retrieval. When necessary, consultation is secured from a qualified medical record practitioner.

V247 Completion of Medical Records and Centralization of Clinical Information. Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient is centralized in the patient's medical record.

V248 Self Care/Home Patients. Provision is made for collecting and including in the medical record medical information generated by self-dialysis patients. Entries concerning the daily dialysis process may either be completed by staff, or be completed by trained self-dialysis patients, trained home dialysis patients or trained assistants and countersigned by staff.

V249 Retention and Preservation of Records. Medical records are retained for a period of time not less than that determined by the State statute governing records retention or statute of limitations; or in the absence of a State statute, 5 years from the date of discharge; or, in the case of a minor, 3 years after the patient becomes of age under State law, whichever is longest.

V250 Location and Facilities. The facility maintains adequate facilities, equipment, and space conveniently located, to provide efficient processing of medical records (e.g., reviewing, filing, and prompt retrieval) and statistical medical information (e.g., required abstracts, reports, etc.).

V251 Transfer of Medical Information. The facility provides for the interchange of medical and other information necessary or useful in the care and treatment of patients transferred between treating facilities, or in determining whether such patients can be adequately cared for otherwise than in either of such facilities.

Quality Assurance/Quality Improvement

The Medicare-approved ESRD facility must monitor the care of LTC facility residents who are receiving dialysis treatments, whether in an ESRD facility or in a LTC facility.

Determine through record review and interview if:

- The dialysis care, including patient outcomes, is monitored, reviewed, and identified problems are corrected.
- The ESRD staff report and review incidents and accidents regarding dialysis care in LTC facilities to both the LTC facility and the ESRD support facility.

§405.2136 Governing Body

V112 Governing Body: Health and Safety. And to the health care and safety of patients,

V146 Incidents Reviewed. Reports of incidents and accidents to patients and personnel are reviewed to identify health and safety hazards.

§405.2150 Reuse

V387 Surveillance of Patient Reactions. In order to detect bacteremia and to maintain patient safety when unexplained events occur, the facility- (i) Takes appropriate blood cultures at the time of a febrile response in a patient; and

§405.2161 Physician Director

V424 Responsibilities: Monitoring Process. Assuring adequate monitoring of the patient and the dialysis process, including, for self-dialysis patients, assuring periodic assessment of patient performance of dialysis tasks;

Laboratory Services

The laboratory services may either be performed by the ESRD facility that is Clinical Laboratory Improvement Amendments (CLIA) certified or by arrangements with a CLIA-certified laboratory. Determine through record review and interview if the facility has systems in place to ensure laboratory services are provided to the patients.

§405.2163 Minimal Service Requirements

V443 Laboratory Services: In-house. The dialysis facility makes available laboratory services (other than the specialty of tissue pathology and histocompatibility testing), to meet the needs of the ESRD patient. All laboratory services must be performed by an appropriately certified laboratory in accordance with part 493 of this chapter. If the renal dialysis facility furnishes its own laboratory services, it must meet the applicable requirements established for certification of laboratories found in part 493 of this chapter.

V444 Laboratory Services: Outside. If the facility does not provide laboratory services, it must make arrangements to obtain these services from a laboratory certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

Attachment B

Survey Protocol for Long Term Care Facilities

The provision of home dialysis treatments in a Long Term Care (LTC) facility place an increased burden on the LTC facility staff and may place the resident population at increased risk for negative outcomes. To protect the residents and ensure adherence to and compliance with Federal regulatory requirements and current standards of quality, it is critical for survey teams to recognize situations where home dialysis is occurring in the LTC setting and to understand the roles and responsibilities of both the LTC and the End-Stage Renal Disease (ESRD) facilities.

This survey protocol includes references to potential regulatory citations for LTC Facilities by F-Tag numbers, though not all-inclusive, to assist the survey team in determining the facility's compliance or non-compliance with regulatory requirements. These references are provided after each highlighted protocol.

Survey Preparation and Procedures for Long Term Care Facilities (SNF/NF)

The provision of home dialysis in the LTC facility is the responsibility of the Medicare-approved ESRD facility. The LTC survey teams are to survey the LTC facility with the existing regulations for all residents who receive dialysis whether in an outpatient treatment setting or onsite in the LTC facility. For all residents who receive dialysis, the LTC facility is responsible for the delivery of care and services to residents before transferring the resident to the ESRD facility or onsite team and after the resident has received dialysis and is assessed as stable for transfer back to the LTC facility team. When the ESRD facility is providing the home dialysis procedure on the premises of the LTC facility and the facility allows their staff to contract with the ESRD facility to provide aspects of the dialysis care, the LTC surveyors must be more astute to issues surrounding this hybrid model of care. To evaluate the LTC facility's compliance with current regulations and standards of quality, the LTC survey team uses current survey procedures. The survey team must use the skills of observation, record review, and interview to validate or invalidate the facility's compliance.

Entrance Conference:

During the entrance conference, interview staff to determine if:

- The Skilled Nursing Facility (SNF) or Nursing Facility (NF) is Medicare-approved as an ESRD provider, has a designated area in the facility that is Medicare-approved as an ESRD provider, and/or has home dialysis services onsite. If home dialysis occurs onsite in the facility, identify this as an area of concern for the survey.
- There are residents in the facility who are receiving home dialysis. If so, have the facility provide a list of the residents' names, room numbers, the name of the ESRD assigned caregiver/technician (and identify if this caregiver is provided by the ESRD facility, the DME supplier, or the LTC facility), and the days and times when each resident will receive his/her dialysis treatment.

- The care is coordinated for residents who receive dialysis. Ask the Administrator to explain how the coordination of care is developed, implemented, and monitored. Obtain a copy of the written contract, agreement, arrangement, polices/procedures and/or plan of care, specifying how care is coordinated, to assist with the evaluation of care. Review the documents as described in the LTC survey protocol (Appendix P, page P-54). Alert the State Survey Agency's (SA) ESRD survey team that dialysis is being provided within this LTC facility and to any concerns identified during the survey of the LTC facility.

Initial Tour:

During the tour and observation of the facility, observe and interview residents, staff, and/or family to determine if home dialysis is being provided in the facility and document any facility practices that appear questionable. Observe locations for the storage of dialysis equipment (in resident's room or on the unit). For identified concerns, share information with team members and add selected residents to the sample.

During the LTC survey, if residents, family, or staff voice concerns about the provision of care to residents during the home dialysis procedure, or if you identify concerns through your investigations related to the care of the resident during dialysis, identify the involved resident(s), specific issues, and copy pertinent documents in the resident(s) record pertaining to the concerns. **Notify the SA and file a complaint against the ESRD facility for review by the ESRD survey team.**

> **NOTE:** This protocol is to be used with existing survey procedures and guidance to surveyors found in the State Operations Manual, Appendix P and PP. The following investigative components are added to address the home dialysis component of the survey.

Resident Rights

Many residents in the LTC facility will not be able to independently participate in the dialysis process and will require the ESRD facility/DME supplier to assign a caregiver/technician. Determine through interview with residents, families/responsible party, LTC facility staff and medical record review if:

- The LTC and ESRD/DME provider coordinated the home dialysis care to ensure that the resident and/or family was informed of the resident's suitability for home dialysis and the role of the ESRD facility staff including the assigned caregiver/technician; and
- The ESRD facility staff documented that the resident or family/responsible party was given explanations of the benefits, reasonable risks of the home dialysis treatment, and any related charges for services not covered by Medicare.

483.10 Resident Rights (b) Notice of rights and services and (d) Free Choice

F154 (3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; **(d) (2)** Be fully informed in advance about care and treatment and of any changes in that care for treatment that may affect the resident's well being.

F155 (4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section

F156 (5) The facility must—**(i)(b)** inform each resident of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; **(6)** The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and or charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. **(9)** The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

483.75 Administration

514 (l) Clinical Records **(1)** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are **(i)** Complete; **(ii)** Accurately documented; **(iii)** Readily accessible; and **(iv)** Systematically organized.

Coordination of Care

The LTC and ESRD facilities' staff are to coordinate the assessment and care planning to ensure that the ESRD and LTC interdisciplinary teams appropriately assessed the resident's suitability for home dialysis and meet to develop and revise the plan of care, in accordance with the LTC facility regulatory requirements and the individual resident's needs and preferences.

Determine through observation, record review, and interview with residents, family/responsible party, and LTC facility staff if:

- The comprehensive care plan was developed by the interdisciplinary teams from both the ESRD and LTC facilities including the physicians, registered nurses, dieticians, social workers, ESRD social worker, ESRD dietician, the resident, ESRD home dialysis assigned caregiver/technician (if applicable), and family member, or responsible party.
- The care plan is implemented by qualified staff and the services implemented meet professional standards of quality.
- The care plan was reviewed and revised based on the resident's response to home dialysis and outpatient dialysis in accordance with regulatory requirements.
- The LTC facility staff communicates identified concerns with the resident's nutritional status or psychosocial needs to the ESRD social worker and/or dietitian.

483.20 Resident Assessment

F272 (b) Comprehensive Assessments. **(1)** Resident Assessment Instrument (RAI). A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State.

F274 (ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.

F279 (k) Comprehensive Care Plans. **(1)** The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: **(i)** The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being as required under 483.25.

F280 (k)(2)(ii) A comprehensive care plan must be prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and **(iii)** Periodically reviewed and revised by a team of qualified persons after each assessment.

F281 (k)(3) The services provided or arranged by the facility must **(i)** Meet professional standards of quality.

F282(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

483.75 Administration

514 (l) Clinical Records **(1)** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are **(i)** Complete; **(ii)** Accurately documented; **(iii)** Readily accessible; and **(iv)** Systematically organized.

Provision of Care

The ESRD/ DME assigned caregiver/technician and licensed health professional designated by the ESRD facility is responsible for the surveillance of the resident(s) during the dialysis treatment and documentation of the resident's response to dialysis. During the LTC survey process, determine if:

- The LTC facility ensures the availability of sufficient staffing for other residents in the facility when home dialysis is provided onsite.
- The LTC facility ensures physician supervision of the care for the resident who receives dialysis treatments, physician availability during emergencies and how this is accomplished.

- The Medical Director has reviewed the policies and procedures for care of the residents receiving dialysis.
- The resident is receiving EPO. Investigate to determine if:
  a) the ESRD and LTC facility staff coordinated how hemoglobin and hematocrit lab values are ordered, monitored, and results reported to the physician;
  b) the LTC facility pharmacist or consultant pharmacist reports irregularities of EPO administration and potential drug interaction concerns; and
  c) the ESRD and LTC facility staff have established policies and procedures for the dispensing and storage of EPO.
- The LTC facility staff ensures that the resident's room or area used for dialysis has a functioning resident call system or other device to summon help in the event of an emergency.
- The resident's room or designated area in the LTC facility is set up and equipped to afford personal privacy and respect during the home dialysis treatment.
- Through observation and interview with LTC facility staff and review of training records if the LTC facility staff demonstrates competency in the:
  a) Clinical monitoring and care of the resident's vascular access (fistula, graft or central venous catheter) and post dialysis complications;
  b) Clinical monitoring for residents who receive EPO;
  c) Clinical monitoring and reporting of medication side effects and adverse drug reactions; and
  d) Identification, monitoring and reporting of nutritional and hydration complications.

483.10 Resident Rights

F157 (b) (11) Notification of changes. **(i)** A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is **(B)** A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) **(C)** A need to alter treatments significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or **(D)** A decision to transfer or discharge the resident from the facility as specified in 483.12(a).

F164 (e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. **(1)** Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

483.15 Quality of Life

F241 (a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

483.20 Resident Assessment

F282 (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

483.25 Quality of Care

F309 Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.

F312 (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

F316 (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

F326 The resident **(i) (2)** Receives a therapeutic diet when there is a nutritional problem.

F327 (j) Hydration**.** The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

F329 (l) (1) Unnecessary drugs. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
(iii) without adequate monitoring; or
(v) in the presence of adverse consequences, which indicate, the dose should be reduced or discontinued.

483.30 Nursing Services

F353 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

483.40 Physician Services

F385 (a) Physician supervision. The facility must ensure that (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician in unavailable.

F389 (d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.

483.60 Pharmacy services.

F425 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in section 483.75 (h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

F428 (c) Drug regimen review. **(1)** The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

F429 (c) (2) The pharmacist must report any irregularities to the attending physician, and the director of nursing.

F432 (e) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

483.70 Physical Environment

F457 (i) Accommodate no more than four residents.

F463 (f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from – **(1)** Resident rooms; and **(2)** Toilet and bathing facilities.

483.75 Administration

F501 (i) Medical Director. **(2)** The medical director is responsible for –
(i) implementation of resident care policies; and
(ii) the coordination of medical care in the facility.

F502 (3) Laboratory services. **(1)** The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

F505 (ii) Promptly notify the attending physician of the findings.

F507 (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

F514 (l) Clinical Records. **(1)** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are **(i)** Complete; **(ii)** Accurately documented; **(iii)** Readily accessible; and **(iv)** Systematically organized.

Infection Control:

The LTC facility staff ensures that disposal of biohazardous waste is done in accordance with LTC facility infection control regulatory requirements and practices. Determine if:

- The LTC and ESRD facilities staff have coordinated policies related to infection control practices for the resident receiving home dialysis treatment.
- These policies and procedures have been reviewed and approved by the LTC Medical Director.
- The LTC facility staff ensures that the ESRD facility staff disposes of biohazardous waste in accordance with the LTC infection control practices and regulatory requirements.

483.65 Infection Control

F441 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
(a) Infection control program. The facility must establish an infection control program under which it --
(1) Investigates, controls, and prevents infections in the facility;
(3) Maintains a record of incidents and corrective actions related to infections.

Equipment Maintenance

The ESRD facility is responsible for the maintenance of all dialysis equipment for the resident. Determine if the LTC facility ensures that there is an emergency electrical system available in the rooms used for dialysis; and that the plan for an emergency water supply addresses provision of additional water for dialysis treatments.

483.70 Physical Environment

F455 (b) Emergency Power. **(1)** An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. **(2)** When life support systems are used, the facility must provide emergency electrical power with an emergency generator.

F466 (h)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

Medical Records

Determine if the LTC facility ensures that the resident's medical record is complete, accurate, and reflects the resident's care during dialysis treatment as well as his/her response to the dialysis process. This includes documentation of complications and notifications to physicians, families/responsible party, and ESRD personnel.

483.75 Administration

F514 (1) Clinical Records. **(1)** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are **(i)** Complete; **(ii)** Accurately documented; **(iii)** Readily accessible; and **(iv)** Systematically organized. **(5)** The clinical record must contain— **(i)** Sufficient information to identify the resident; **(ii)** A record of the resident's assessments; **(iii)** The plan of care and services provided; **(iv)** The results of any preadmission screening conducted by the State; and **(v)** Progress notes.

F515 (2) clinical records must be retained for – **(i)** The period of time required by State law; or **(ii)** Five years from the date of discharge when there is not a requirement in State law; or **(iii)** For a minor, three years after a resident reaches legal age under State law.

F516 (3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

Quality Assurance

Determine if the LTC facility has identified problems with dialysis treatment and care through the Quality Assessment and Assurance Program. If so, interview LTC facility staff to determine if corrective actions have been implemented to ensure the quality and continuity of care, minimization of infections and injuries, and coordination of the plan of care.

483.75 Administration

(o) Quality assessment and assurance. **F521 (ii)** Develops and implements appropriate plans of action to correct identified quality deficiencies.

Condition: Patient Long Term Program and Patient Care Plan 42 CFR 405.2137(a) and (b)

and termination of appointments to the medical staff.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, and amended at 43 FR 48952, Oct. 19, 1978; 51 FR 30362, Aug. 26, 1986; 52 FR 36934, Oct. 2, 1987]

§ 405.2137 Condition: Patient long-term program and patient care plan.

Each facility maintains for each patient a written long-term program and a written patient care plan to ensure that each patient receives the appropriate modality of care and the appropriate care within that modality. The patient, or where appropriate, parent or legal guardian is involved with the health team in the planning of care. A copy of the current program and plan accompany the patient on interfacility transfer.

(a) *Standard: patient long-term program.* There is a written long-term program representing the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient.

(1) The program is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker.

(2) The program is formally reviewed and revised in writing as necessary by a team which includes but is not limited to the physician director of the dialysis facility or center where the patient is presently being treated, in addition to the other personnel listed in paragraph (a)(1) of this section at least every 12 months or more often as indicated by the patient's response to treatment (see §405.2161(b)(1) and §405.2170(a)).

(3) The patient, parent, or legal guardian, as appropriate, is involved in the development of the patient's long-term program, and due consideration is given to his preferences.

(4) A copy of the patient's long-term program accompanies the patient on interfacility transfer or is sent within 1 working day.

(b) *Standard: patient care plan.* There is a written patient care plan for each patient of an ESRD facility (including home dialysis patients under the supervision of the ESRD facility; see §405.2163(e)), based upon the nature of the patient's illness, the treatment prescribed, and an assessment of the patient's needs.

(1) The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well as the individualized modifications in approach necessary to achieve the long-term and short-term goals.

(2) The plan is developed by a professional team consisting of at least the physician responsible for the patient's ESRD care, a qualified nurse responsible for nursing services, a qualified social worker, and a qualified dietitian.

(3) The patient, parent, or legal guardian, as appropriate, is involved in the development of the care plan, and due consideration is given to his preferences.

(4) The care plan for patients whose medical condition has not become stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patients ongoing needs.

(5) If the patient is transferred to another facility, the care plan is sent with the patient or within 1 working day.

(6) For a home-dialysis patient whose care is under the supervision of the ESRD facility, the care plan provides for periodic monitoring of the patient's home adaptation, including provisions for visits to the home by qualified facility personnel to the extent appropriate. (See §405.2163(e).)

(7) Beginning July 1, 1991, for a home dialysis patient, and beginning January 1, 1994, for any dialysis patient, who uses EPO in the home, the plan

must provide for monitoring home use of EPO that includes the following:

(i) Review of diet and fluid intake for indiscretions as indicated by hyperkalemia and elevated blood pressure secondary to volume overload.

(ii) Review of medications to ensure adequate provision of supplemental iron.

(iii) Ongoing evaluations of hematocrit and iron stores.

(iv) A reevaluation of the dialysis prescription taking into account the patient's increased appetite and red blood cell volume.

(v) A method for physician followup on blood tests and a mechanism (such as a patient log) for keeping the physician informed of the results.

(vi) Training of the patient to identify the signs and symptoms of hypotension and hypertension.

(vii) The decrease or discontinuance of EPO if hypertension is uncontrollable.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 43 FR 48952, Oct. 19, 1978; 59 FR 1284, Jan. 10, 1994; 59 FR 26958, May 25, 1994]

§ 405.2138 Condition: Patients' rights and responsibilities.

The governing body of the ESRD facility adopts written policies regarding the rights and responsibilities of patients and, through the chief executive officer, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients and any guardians, next of kin, sponsoring agency(ies), representative payees (selected pursuant to section 205(j) of the Social Security Act and subpart Q of 20 CFR part 404), and to the public. The staff of the facility is trained and involved in the execution of such policies and procedures. The patients' rights policies and procedures ensure at least the following:

(a) *Standard: informed patients.* All patients in the facility:

(1) Are fully informed of these rights and responsibilities, and of all rules and regulations governing patient conduct and responsibilities;

(2) Are fully informed of services available in the facility and of related charges including any charges for services not covered under title XVIII of the Social Security Act;

(3) Are fully informed by a physician of their medical condition unless medically contraindicated (as documented in their medical records);

(4) Are fully informed regarding the facility's reuse of dialysis supplies, including hemodialyzers. If printed materials such as brochures are utilized to describe a facility and its services, they must contain a statement with respect to reuse; and

(5) Are fully informed regarding their suitability for transplantation and home dialysis.

(b) *Standard: participation in planning.* All patients treated in the facility:

(1) Are afforded the opportunity to participate in the planning of their medical treatment and to refuse to participate in experimental research;

(2) Are transferred or discharged only for medical reasons or for the patient's welfare or that of other patients, or for nonpayment of fees (except as prohibited by title XVIII of the Social Security Act), and are given advance notice to ensure orderly transfer or discharge.

(c) *Standard: respect and dignity.* All patients are treated with consideration, respect, and full recognition of their individuality and personal needs, including the need for privacy in treatment. Provision is made for translators where a significant number of patients exhibit language barriers.

(d) *Standard: confidentiality.* All patients are ensured confidential treatment of their personal and medical records, and may approve or refuse release of such records to any individual outside the facility, except in case of their transfer to another health care institution or as required by Federal, State, or local law and the Secretary for proper administration of the program.

(e) *Standard: grievance mechanism.* All patients are encouraged and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the network organization, and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's

Drug Therapy for ESRD

Some drugs commonly used for patients receiving dialysis are:

- Epogen
  - Stimulates red blood cell production.
  - Is given to most patients.
  - Is used to treat anemia.
  - May require iron replacement therapy to be effective.
  - Monitors hematocrit (Hct) and hemoglobin (Hgb) levels and blood pressure.
  - Expected target for Hct is 33–36 and for Hgb is 11.
  - Adverse reaction: uncontrolled hypertension.
- Heparin
  - Prevents clotting during dialysis.
  - Is given to all patients.
  - Usually do not need to monitor partial thromboplastin time unless administered outside of dialysis treatment, such as via continuous infusion.
  - Adverse reaction: excessive bleeding.
- Phosphate binders
  - Prevent phosphorus absorption from foods.
  - Protect patients from loss of calcium from bone.
  - Are given to all patients.
  - Calcium carbonates: Tums, Os-cal, Florical, Nephro-cal.
  - Calcium acetates: Phos-lo.
  - Renalgel.
  - Must be given with meals.
  - Work by binding with phosphorus in the gut, preventing absorption, so should be taken with all food: snacks, meals, etc.
  - Must not give any other calcium supplements when on Phos-lo.
- Cardioactive medications
  - Are given to many patients.
  - May become toxic rapidly.
  - Examples:
    - Digoxin.
    - Hypertensive medications.
    - Anti-arrhythmics.
- Others
  - Many patients receive vitamin D replacement.
  - Some patients receive intravenous iron.

Caution: If dialysis is performed in the LTC facility, heparin and lidocaine may be drawn up at the same time. Ensure that these drugs are separate and identifiable. Lidocaine should not be routinely used long term. It is administered subcutaneously to anesthetize sites of needle insertion. It may cause scarring over time, making needle insertion difficult. At times, it is necessary to hold some drugs prior to dialysis.

Laboratory Values for ESRD

Adequacy of dialysis is determined by how well the dialysis treatment has filtered out toxins:

- Urea reduction ration (URR) should be equal to or greater than 65%.
- Kinetic modeling (KT/V) should be equal to or greater than 1.2 for HD and 2.0 for PD.

The normal hematocrit value is 45–52% for males and 37–48% for females. The target for dialysis patients is 33–36%. The hemoglobin target is 11%.

The kidneys regulate the body's *potassium* level, the normal value of which is 3.5–5.0 meq/l. If this level rises to 5.0–6.5, exercise caution. If this level is greater than 6.5 or less than 3.0, alert the dialysis staff to make changes in the patient's treatment. High levels will lead to muscle breakdown, irregular heartbeats and possibly death by cardiac arrest. Low levels will lead to muscle weakness, shaking and possibly death by cardiac arrest.

Sodium is needed by the body to maintain water balance. The normal value is 135–145 meq/l. Limiting sodium in the diet of the resident receiving dialysis can control thirst, fluid gain, increased blood pressure and discomfort during dialysis.

Phosphorus pulls calcium from the bones, causing the bones to weaken. The normal value is 3.0–5.0 mg/100 ml. For a resident receiving dialysis, the goal is to keep the phosphorus level below 6.0 mg/100 ml. Dialysis removes some of the phosphorus, but not very effectively, and levels build between treatments. The phosphorus level may become high if the resident does not take phosphate binders with meals or if the resident has a high intake of dairy foods. The outcome could be broken bones and hardened blood vessels and muscles, including the heart.

Dietary Requirements for ESRD

In reviewing the LTC facility's care of the resident receiving dialysis, the surveyor should evaluate how the facility meets the resident's dietary needs. The surveyor should identify how the facility receives and integrates information from the ESRD unit regarding the resident's food and fluid needs.

The dietitian (RD) at the ESRD unit routinely monitors the resident's lab values and modifies the diet accordingly. Each resident receiving dialysis services must be provided an individualized diet. Communication between the ESRD unit, the RD and the LTC facility's dietary department is the key to success in meeting the resident's dietary needs.

The RD will consider the lab values of sodium, phosphorus and potassium, and values indicative of visceral protein status (e.g., albumin, pre-albumin). Prior to the initiation of dialysis, residents with renal failure receive diets with limited protein. However, after dialysis has begun, almost all of these residents need more grams of protein per kilogram of body weight per day than a resident without renal problems.

It is essential that the surveyor remember that the RD individualizes the resident's diet after assessment and careful review of the current status of various nutrients. There are no definite rules for limits on these nutrients, but the surveyor should be aware of examples of high sources of nutrients:

- Protein—Meat, fish, eggs, cheese, milk.
- Sodium—Ham, bacon, sauerkraut, salted crackers, regular canned soup, table salt.
- Potassium—Bananas, oranges, prunes, tomatoes, potatoes, milk, beans.
- Phosphorus—Milk, cheese, dried beans, meats.

The facility's inclusion of these foods in the diet of a resident receiving dialysis is not necessarily inappropriate—the individualized diet is the key!

Vitamin requirements vary depending on dietary restrictions, the type of dialysis and the stage of the disease. The ESRD unit staff will establish a plan to meet these needs.

The resident's weight may vary up to 5% after each dialysis session. If the postdialysis weight (or "dry" weight) increases or decreases more than 5% over three months, this should be addressed. This weight change should be considered only over a period of time, as the weight can fluctuate with each dialysis treatment.

It is important not to make assessment determinations regarding weight by comparing predialysis weights to postdialysis weights. Those comparisons are used for measure of fluid balance.

If fluid gain between treatments is too great, the resident has an increased risk of high blood pressure, respiratory failure, cardiac damage or stroke. Most HD patients produce

little or no urine, so monitoring of output is not useful. Of note: Constipation is a frequent problem for uremic residents.

The ESRD unit establishes the fluid allowance for each resident receiving dialysis services. Again, communication between the ESRD unit and the LTC facility is essential. The surveyor should see evidence in the resident's Care Plan that the facility collaborates with the ESRD unit staff regarding the resident's needs.

ANNA's Mission Statement

ANNA will advance nephrology nursing practice and positively influence outcomes for patients with kidney or other disease processes requiring replacement therapies through advocacy, scholarship, and excellence.

ANNA
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CHRONIC KIDNEY DISEASE: WHAT IS IT?

Chronic Kidney Disease (CKD) may become a progressive loss of renal function leading to *End Stage Renal Disease (ESRD)* requiring *replacement therapy* or replacement of kidney function. The etiology of ESRD can be from a variety of diseases, most notably:

- Diabetes mellitus
- Glomerular disease
- Chronic pyelonephritis
- Obstructive disorders
- Hypertension
- Interstitial nephritis
- Cystic/hereditary/congenital diseases
- Drugs/toxins

Regardless of the etiology, many body systems depend upon an environment in which normal kidney function exists. ESRD affects virtually every system. These alterations can include:

- Cardiovascular disease
- Bone disease
- Anemia
- Hypertension

These alterations are manifested by:

- Decreased or no urine output
- Fluid retention/edema – hands, feet, face
- Nausea/vomiting
- Thirst
- Shortness of breath
- Sleep interruption
- Restlessness ("restless legs syndrome")

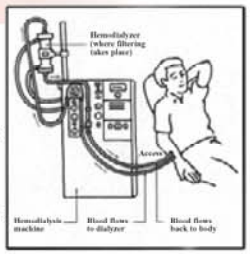
Replacement Therapy can take several forms: kidney transplantation, peritoneal dialysis, and the most common form of therapy: hemodialysis.

HEMODIALYSIS

Kidney function is necessary for homeostasis, but replacement therapies, e.g. hemodialysis, can replace some of these kidney functions.

Hemodialysis is the most common therapy for patients with ESRD because it:

- Removes waste products and excess fluid directly from the vascular system by passing the blood through the artificial kidney. dialyzer (filter).
- Usually requires 3-5 hours, 3 times a week.
- Corrects the pH, electrolytes and chemical levels of the blood.



The dialysis process:

- Blood is separated from the dialysate (the fluid that passes through the dialyzer and causes the removal of toxins) by a thin semipermeable membrane.
- Uremic toxins and excess levels of chemicals like potassium are removed from the artificial kidney through diffusion.
- Pressure in the dialyzer is used to remove excess fluid. The blood and the dialysate do not come in direct contact with each other.

VASCULAR ACCESS FOR HEMODIALYSIS: ***The patient's lifeline***

- Three types of access to circulation can provide adequate blood flow for a thorough dialysis.
- Two types of internal accesses require cannulation with two large bore fistula needles for every dialysis session. One needle will pull the blood into the tubing and dialyzer, while the other is used to return the blood. The needles are removed after the treatment is completed.

Arterio-venous Fistula

- Created by surgically connecting an artery to a vein.
- It is the access of preference.
- Should not be used until it is determined to be ready for use, usually 6-12 weeks after its creation.

Arterio-venous Graft:

- Created by attaching a special synthetic tubing to an artery at one end and a vein at the other.
- Ready for use in 2-3 weeks.

Central Vein Catheter :

- Is an external access and may be used for hemodialysis immediately.
- Is placed in a large vein through the neck or upper chest.
- The ports to access the catheter remain outside the body.
- Does not require cannulation.
- Connects directly to the blood tubing of the dialysis machine.

NOTE: DO NOT USE any of these forms of vascular access for anything other than hemodialysis!

NUTRITIONAL MANAGEMENT: TYPICAL RECOMMENDATIONS

- **Protein** 1.0-1.2 g/kg/day 50% high biologic value protein
- **Potassium** 40-70 mEq (1,500-2,500 mg)/day (avoid high potassium foods and salt substitute that is potassium chloride)
- **Sodium** 750-1,000 mg/day (avoid high sodium foods and do not use added salt)
- **Phosphorus** 600-1,200 mg/day (limit dairy products)
- **Calories** >35 kcal/kg/day, less for obese patients (25-30 kcal/kg), and more with stress or malnutrition (40-45 kcal/day)
- **Fluids** limited to 1-1.5 liters plus urine output per day

Diabetes Mellitus: same meal plan but limit concentrated sweets

TYPICAL MEDICATIONS

- **Multivitamins without minerals or vitamin D** to replace excess loss during hemodialysis (folic acid 1 mg/day)
- **Phosphate binders** to limit GI absorption of phosphorous and prevent renal bone disease or hyperparathyroidism (e.g. PhosLo™, Renagel™, Tums™)
- **Erythropoietin** for anemia (Aranesp™, Epogen™, Procrit™)
- **Iron** for anemia management (oral or IV – e.g. Ferrlecit®, iron dextran, Venofer™)
- **Vitamin D** (1,25 vitamin D_3) to prevent/treat renal bone disease (Hectorol™, Rocaltrol Zemplar™)
- **Antihypertensives** for blood pressure management (ACE inhibitors, angiotensin receptor blockers, beta blockers, diuretics [especially for CKD], calcium channel blockers, central alpha-2 agonist, alpha-1 blockers, and vasodilators)

ACTIVITY AND LIMITATIONS: EXERCISE BENEFITS FOR DIALYSIS PATIENTS

- Increased strength and energy
- Improved muscle strength and stronger bones
- Better BP control
- Better sleep
- Better control of body weight
- Lowered level of blood fats (cholesterol & triglycerides)

GUIDELINES FOR EXERCISE

- Advise patients to:
  a. check with their health care professional,
  b. follow the treatment plan,
  c. take any appropriate medications, and
  d. follow their diet.
- Emphasize that individual health, fitness level, interest, and available time will vary.

TYPE OF EXERCISE

- Recommend *continuous exercises* that will move large muscle groups, such as walking, swimming, bicycling, skiing, and aerobic dancing.
- Recommend *low level strength exercises*, such as low weights and high repetitions.
- Emphasize that there is to be *no* heavy lifting, and that a slow, relaxed pace of exercise can still yield positive benefits!

TIME TO EXERCISE

- Recommend a minimum of 3 days per week of exercise.
- Advise patients to work toward exercising 30 minutes/session.
- Emphasize that a patient's endurance will be better on nondialysis days.

PARTNERING WITH THE HEALTH CARE TEAM

- Patients can be confident that health care professionals will listen, offer education, continuity of care, and encouragement, as well as information on support groups and rehabilitation.
- Patients who are active participants in their care may have a greater sense of control of their disease.
- Health care professionals (doctors, nurses, social workers, dieticians, and case managers) are invaluable resources to patients.
- Worldwide web is also available and offers numerous informative sites, but beware of misinformation.
- Patients can be confident that support is available for lifestyle changes.
- **Remember: Health care team + patient = The Winning Team!**

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continued

- fibrin formation
- bloody effluent
- constipation
- obstruction of flow
- tunnel infection
- peritonitis
- catheter related pain

Caring for the PD Patient

The Role of the PD Nurse
The role of the PD nurse provides a unique opportunity to be an autonomous, innovative, and resourceful professional.

The PD nurse functions in several capacities:

- Educator
- Clinician
- Care coordinator
- Leader of health care team
- Patient advocate

- The most consistent member of the health care team who is involved with the PD patient is the nurse. The relationship that develops is crucial for the well being of the patient and family and the success of PD for the patient.
- As a responsible professional, the PD nurse is pivotal in coordinating a consistent and clear plan of care for the patient.
- Using professional competency and communication skills, the PD nurse can establish a trusting relationship with the patient and the entire health care team.
- This commitment is crucial in empowering the PD patient.

Other Questions:
For questions and/or concerns please contact us at _____.
For more information about nephrology nursing, dialysis, transplantation or other renal disorders check out the American Nephrology Nurses' Association (ANNA) Web site at annanurse.org.

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Peritoneal Dialysis
Fact Sheet

Developed by:
ANNA Peritoneal Dialysis Special Interest Group

ANNA's Mission Statement

ANNA will advance nephrology nursing practice and positively influence outcomes for patients with kidney or other disease processes requiring replacement therapies through advocacy, scholarship, and excellence.

www.annanurse.org

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What is Peritoneal Dialysis?

Peritoneal dialysis (PD) is a dialysis option for patients with chronic kidney disease (CKD). An alternative treatment to hemodialysis, this form of dialysis is usually performed by the patient at home. PD occurs inside the body using the peritoneal membrane (the lining of the abdomen) as a filter. This membrane also covers the organs that lie within the abdominal cavity. The peritoneal membrane is semipermeable, allowing certain size substances to pass through it.

How Peritoneal Dialysis Works

A soft tube, known as a catheter, is surgically placed through the abdominal wall. The catheter can generally be used 2 weeks after it is inserted. Sterile dialysis solution (2-3 liters) will flow into the peritoneum through the catheter. The volume of solution used depends upon the size of the patient. Through the process of diffusion, waste products are removed from the blood. Excess fluid is removed by the process of osmosis using a hypertonic glucose solution. Both waste products and excess fluid are transported across the peritoneal membrane into the dialysis solution. The used dialysis solution is drained from the peritoneal cavity and replaced with new solution.

Types of Peritoneal Dialysis

There are two types of PD. One is **CAPD** (continuous ambulatory peritoneal dialysis). The other is **CCPD** (continuous cycling peritoneal dialysis).

CAPD. This type of self-dialysis is done 7 days a week. Four to five exchanges of new solution are done each day. During an exchange, which takes about 30 minutes, the solution that was inside the peritoneal cavity is drained and new solution is instilled. The new solution remains in the cavity for 4 to 6 hours; this is called the **dwell** time. The last evening's exchange dwells overnight to allow for an uninterrupted night's sleep.

CCPD. During this type of dialysis, the exchange of dialysis solution is performed by a machine while the patient sleeps. Each exchange is referred to as a "cycle." Patients are taught how to set up the machine and generally connect to the cycler at bedtime, 7 days a week, for 8 to 10 hours each night. The machine controls the three phases of the cycle: draining used solution, re-filling with new solution, and monitoring the dwell time. In the morning, the machine does a "final fill," which remains in the patient throughout the day.

Advantages and Disadvantages of Peritoneal Dialysis

Advantages	Disadvantages
Patient involved in self-care	Four exchanges per day (CAPD)
Control over schedule/freedom	Nightly cycles with machine (CCPD)
Less restricted diet	Permanent external catheter
Typically, once a month clinic visits	Some risks of infections
No needles	Potential weight gain
More steady blood levels	Storage space at home is needed
Preservation of kidney function	Body image changes

PD as a Dialysis Option

What the Patient Needs to Know

- Options for renal replacement therapy (hemodialysis, PD, and transplantation) should be presented by a knowledgeable professional who can address issues and questions about each option.
- The option of PD can be presented in either an individual or group setting, and should include family members and significant others.
- A description of PD should include:
  - Introduction to the supplies (bags, tubing and catheter).
  - Demonstration of exchange.
  - Examples of exchange schedule and daily routines.
- Prospective patients should be offered the opportunity to network with established PD patients.

PD Patients: Who are Likely Candidates?

The success of PD depends on the patient's motivation, physical and mental capability to complete procedures, and the desire for independence. If there are any clinical or psychological contraindications, the nephrologist and PD nurse will discuss these concerns with the patient and family.

- Potential candidates are patients who:
  - Choose PD.
  - Desire self-care and independence.
  - Have cardiovascular disease.
  - Have diabetes.
  - Are pediatric patients.
  - Are pre-transplant candidates.

Home PD: What the Patient Needs to Know

- Location and function of the peritoneal membrane
- Short and long-term complications of uremia
- Aseptic technique in the home
- Catheter care
- Dialysis solution exchange procedure
- Fluid balance guidelines
- Addition of medication
- Self-monitoring of vital signs (B/P and wt.) and maintaining home dialysis records
- Monthly clinic visits and review of current medications, procedures, and techniques
- Individual activity and exercise regimen
- Nutritional needs assessed and modified by renal dietitian
- Social and emotional needs assessed by renal social worker
- Incorporating the patient's need for relationships and sexual identity in plan of care
- Monitoring and inventory of supplies
- Understanding and recognizing complications of PD:
  - fluid overload
  - dehydration
  - exit site infection
  - exit site leak

continued →

Checklist: Long Term Care Resident Receiving Dialysis

Resident Name	**Date**

Type of Dialysis:	__ Hemodialysis	__Peritoneal Dialysis

MDS:
Section I.1.qq: Disease Diagnosis—Renal Failure
Section K.5.e: Oral/Nutritional Status—Therapeutic Diet
Section P.1.a.b: Special Treatments and Procedures—Dialysis

Facility Assessment:
Pre- and postdialysis by nurse.
Resident's overall condition.
Lung sounds.
Vital signs.
Weight—pre- and postdialysis.
Vascular access:

- Bruit and thrill.
- Color, warmth, redness, edema, drainage.
- Bleeding.
- Dressing (remove ~4 hours after treatment).
- Positioning to avoid pressure.

Care Plan:
Dialysis facility's long term program integrated with LTC facility Care Plan.
LTC facility Care Plan includes:

- Dialysis order.
- Dialysis facility contact information.
- Transportation plan and contact information.
- Dialysis days and times.
- Nutritional requirements.
- Fluid allowance.
- Laboratory values.
- Vascular-access care.
- Emotional and social well-being.

Resident Rights:
Choices of treatment.
Effect of dialysis on rights.
Effect of dialysis on quality of life.
Effect of dialysis on other residents.

Social Services:
Coordination with dialysis social worker.
Accommodation of needs.
Transportation.
Noncompliance.
Coordination of Medicare benefits.

Care:
Evaluate staff knowledge regarding:

- Vascular access.
- Precautions: No BP, IM injection, IV or restraint on extremity of vascular access.
- Emergencies or complications.
- Equipment.
- Alarm systems.
- Bleeding or hemorrhaging.
- Infection, bacteremia, septic shock.
- Infection control, waste handling.
- Nutritional needs and risks.
- Emotional and social well being.

Drug Therapy:
Epogen—Hematocrit monitored.
Epogen—Blood pressure monitored.
Phosphate binders—Given with meals.
Phos-lo—No other calcium supplements.
Cardioactive medications monitored.

Nutrition:
Individualized diet.
Staff aware of dietary requirements and restrictions.
Fluid allowance.

Lab Values:
URR ≥ 0.65%
KT/V ≥ 1.2 for HD or 2.0 for PD
Hematocrit 33–36; hemoglobin 11–12
Potassium > 3.0 and < 6.5 meq/l
Sodium 135–145 meq/l
Phosphorus < 6.0 mg/100 ml

Notification of Physician:
No bruit or thrill in access.
Abnormal lab values.
Fluid imbalance.
Bleeding at vascular access.
Interruption of scheduled dialysis.

Considerations and Regulations for Dialysis

1. Resident Rights

Many residents in the LTC facility will not be able to independently participate in the dialysis process and will require the ESRD facility/DME supplier to assign a caregiver or technician. Determine through interview with residents, families/responsible party, LTC facility staff and medical record review whether:

- The LTC and ESRD/DME provider coordinated the home dialysis care to ensure that the resident and/or family was informed of:
  - The resident's suitability for home dialysis.
  - The role of the ESRD facility staff, including the assigned caregiver/technician.
- The ESRD facility staff documented that the resident or family/responsible party was given explanations of the benefits, reasonable risks of the home dialysis treatment, and any related charges for services not covered by Medicare.

If deficient practice is identified, consider citing at:

- 483.10 Resident Rights (b) Notice of rights and services and (d) Free Choice; F154, F155 or F156.
- 483.75 Administration; F514.

2. Coordination of Care

The LTC and ESRD facilities' staff are to coordinate assessment and care planning to ensure that the ESRD and LTC interdisciplinary teams appropriately assess the resident's suitability for home dialysis and meet to develop and revise the resident's Plan of Care, in accordance with the LTC facility regulatory requirements and the resident's needs and preferences.

Determine through observation, record review and interview with residents, family/responsible party, and LTC facility staff whether:

- The comprehensive Care Plan was developed by the interdisciplinary teams from both the ESRD and LTC facilities, including the physicians, registered nurses, dietitians, social workers, ESRD social worker, ESRD dietitian, the resident, ESRD home dialysis assigned caregiver/technician (if applicable), and family member or responsible party.
- The Care Plan has been implemented by qualified staff and the services implemented meet professional standards of quality.
- The Care Plan was reviewed and revised based on the resident's response to home dialysis and outpatient dialysis in accordance with regulatory requirements.

- The LTC facility staff has communicated identified concerns regarding the resident's nutritional status or psychosocial needs to the ESRD social worker and/or dietitian.

If deficient practice is identified, consider citing at:

- 483.20 Resident Assessment; F272, F274, F279, F280, F281 or F282.
- 483.75 Administration; F514.

3. Provision of Care

The ESRD/DME assigned caregiver/technician and licensed health professional designated by the ESRD facility is responsible for the surveillance of the resident during the dialysis treatment and documentation of the resident's response to dialysis. During the LTC facility survey process, determine whether:

- The LTC facility ensures the availability of sufficient staffing for other residents in the facility when home dialysis is provided onsite.
- The LTC facility ensures physician supervision of care for the resident who receives dialysis treatments, physician availability during emergencies and how this is accomplished.
- The medical director has reviewed the policies and procedures for care of the residents receiving dialysis.
- The resident is receiving epoetin (EPO). Investigate to determine whether:
    - The ESRD and LTC facility staff have coordinated how hemoglobin and hematocrit lab values are ordered and monitored and how results are reported to the physician.
    - The LTC facility pharmacist or consultant pharmacist reports irregularities in EPO administration and potential drug interaction concerns.
    - The ESRD and LTC facility staff have established policies and procedures for the dispensing and storage of EPO.

- The LTC facility staff ensures that the resident's room or the area used for dialysis has a functioning resident call system or other device to summon help in the event of an emergency.
- The resident's room or designated area in the LTC facility is set up and equipped to afford personal privacy and respect during the home dialysis treatment.
- Through observation and interview with LTC facility staff and review of training records the LTC facility staff demonstrates competency in the:
    - Clinical monitoring and care of the resident's vascular access (fistula, graft or central venous catheter) and postdialysis complications.
    - Clinical monitoring for residents who receive EPO.
    - Clinical monitoring and reporting of medication side effects and adverse drug reactions.
    - Identification, monitoring and reporting of nutritional and hydration complications.

If deficient practice is identified, consider citing at:

- 483.10 Resident Rights; F157 or F164.
- 483.15 Quality of Life; F241.
- 483.20 Resident Assessment; F282.
- 483.25 Quality of Care; F309, F312, F316, F326, F327 or F329.
- 483.30 Nursing Services; F353.
- 483.40 Physician Services; F385 or F389.
- 483.60 Pharmacy Services; F428, F429 or F432.
- 483.70 Physical Environment; F457 or F463.
- 483.75 Administration; F501, F502, F507 or F514.

4. Infection Control
The LTC facility staff ensures that biohazardous waste is disposed of in accordance with LTC facility infection control regulatory requirements and practices. Determine whether:

- The LTC and ESRD facilities' staff have coordinated policies related to infection control practices for the resident receiving home dialysis treatment.
- These policies and procedures have been reviewed and approved by the LTC medical director.
- The LTC facility staff ensures that the ESRD facility staff disposes of biohazardous waste in accordance with the LTC infection control practices and regulatory requirements.

If deficient practice is identified, consider citing at:

- 483.65 Infection Control; F441.

5. Equipment Maintenance
The ESRD facility is responsible for the maintenance of all dialysis equipment for the resident. Determine whether the LTC facility ensures that there is an emergency electrical system available in the rooms used for dialysis and that the plan for an emergency water supply addresses provision of additional water for dialysis treatment.

If deficient practice is identified, consider citing at:

- 483.70 Physical Environment; F455 or F466.

6. Medical Records
Determine whether the LTC facility ensures that the resident's medical record is complete and accurate and reflects the resident's care during dialysis treatment as well as his/her response to the dialysis process. This includes documentation of complications and notifications to physicians, families/responsible party, and ESRD personnel.

If deficient practice is identified, consider citing at:

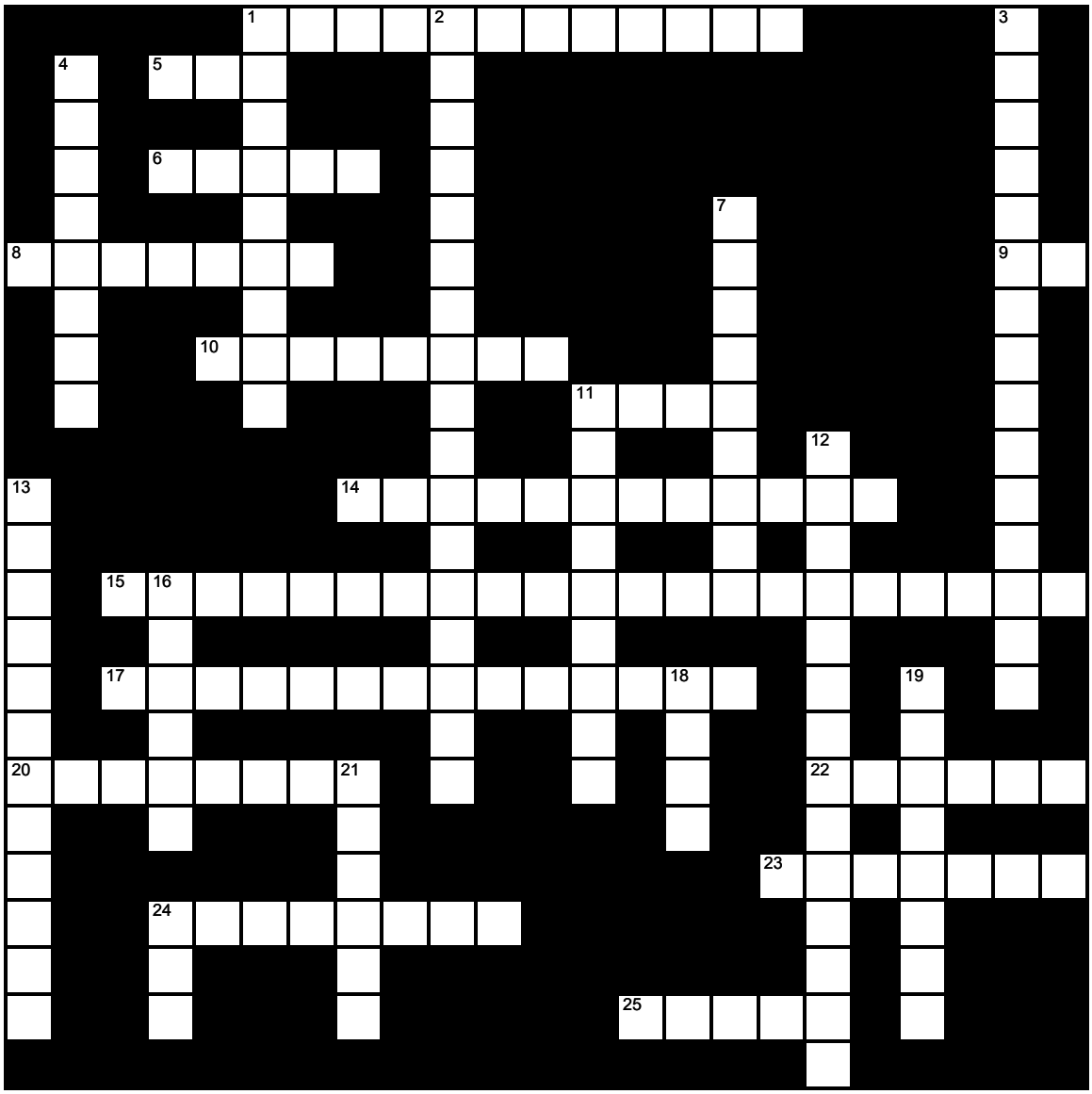
- 483.75 Administration; F514, F515 or F516.

7. Quality Assurance
Determine if the LTC facility has identified problems with dialysis treatment and care through quality assessment and assurance program. If so, interview LTC facility staff to determine whether corrective actions have been implemented to ensure quality and continuity of care, minimization of infections and injuries, and coordination of the Plan of Care.

If deficient practice is identified, consider citing at:

- 483.75 Administration (o) Quality Assessment and Assurance; F521.

Dialysis in LTC



Across

1. A process of cleaning the blood of waste products by passing the blood through an artificial kidney.

5. A drug-resistant microorganism.

6. A _____ is made of artificial material and is used to connect a resident's artery and vein.

8. A drug associated with dialysis.

9. A type of dialysis that uses the peritoneal membrane as a filter.

10. A process by which dissolved substances and waste such as urea and creatinine are removed from the body by diffusion and osmosis from one fluid compartment to another across a semipermeable membrane.

11. A drug-resistant microorganism.

14. Provision of home dialysis is the responsibility of the ____ _____.

15. The most common type of facility where dialysis takes place.

17. A _____ _____ issue might be whether the facility makes sure a resident does not miss a meal when scheduled for dialysis.

20. The resident _____ _____ should contain the following: dialysis order, dialysis center name and contact information, transportation plan, dialysis days and times, nutritional requirements fluid allowance, laboratory values, vascular-access care, and information on emotional and social well-being.

22. A vibration that is felt when blood flows through a narrowed space.

23. A _____ is where a resident's own artery and vein are connected to allow increased blood flow through a vein.

24. A central _____ may be inserted in a central vein for dialysis access. This carries a high risk of infection but provides immediate dialysis access.

25. A sound created when blood flows through a narrowed space.

Down

1. A dialysis-associated infection.

2. When the resident leaves the nursing home to receive dialysis, the nursing home must have this, which describes patient care.

3. A treatment modality for end stage renal disease.

4. A primary cause of end stage renal disease.

7. Cardiovascular disease, infection, age, low albumin, diabetes, anemia and left ventricular mass load influence this.

11. Infection, dialysis dose, quality of water, anemia, and lack of adherence to a treatment plan influence this.

12. A _____ _____ issue might be whether the facility addresses noncompliance with care or assistance to a resident who chooses to discontinue dialysis.

13. Physician _____ should occur if there is no bruit or thrill in the vascular access (fistula or graft), symptoms of infection, abnormal lab values, fluid imbalance, bleeding at the access site, hypertension, or anything that may interrupt scheduled treatment.

16. A drug used in dialysis.

18. Acronym for end stage renal disease.

19. Composed of a physician, RN, dietitian, and social worker in a dialysis facility. In an LTC facility, composed of a physician, nursing staff, dietitian, dietary staff, and social service designee.

21. The waiting period for Medicare eligibility for dialysis or transplantation is _____ days.

24. Acronym for chronic kidney disease.

Self-Test for Dialysis

1. Define the following:

CKD:

ESRD:

2. Describe factors influencing morbidity and mortality relative to ESRD.

3. Explain considerations of the LTC survey process for dialysis patients.

What are the implications of this process for dialysis patients?

4. What are important considerations of assessment and care planning for LTC patients receiving dialysis?

5. What are the pertinent resident rights and social service needs for LTC residents receiving dialysis?

6. Explain infection control for dialysis patients and describe dialysis-related infections.

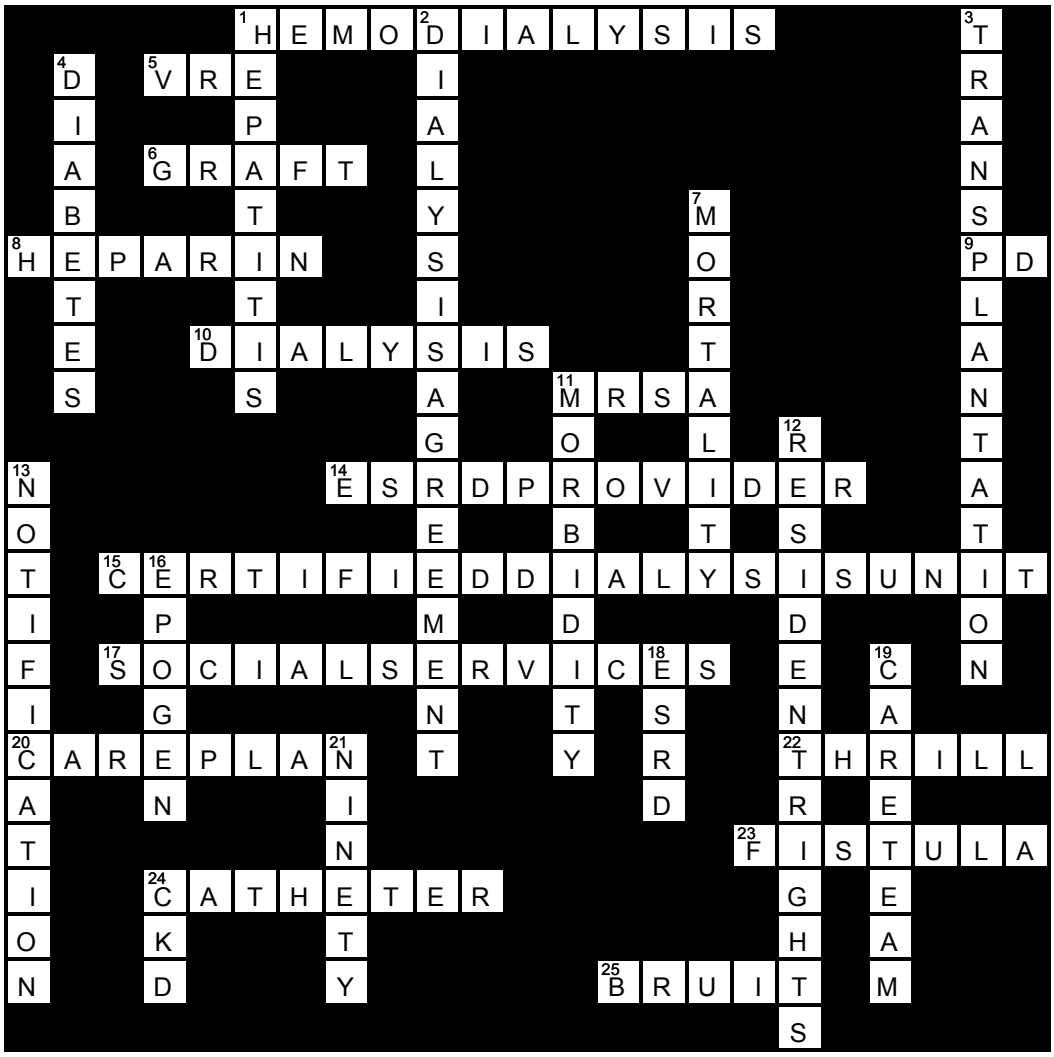
7. How would you assess laboratory values and nutritional needs for LTC patients on dialysis?

8. Describe factors indicating the need for physician notification in the case of an LTC resident receiving dialysis.

9. What regulatory topics are pertinent for dialysis surveys?

10. Explain the concept of home dialysis provided onsite at the LTC facility.

Solution for Dialysis Crossword



Across: 1. Hemodialysis, **5.** VRE, **6.** Graft, **8.** Heparin, **9.** PD, **10.** Dialysis, **11.** MRSA, **14.** ESRD provider, **15.** Certified dialysis unit, **17.** Social services, **20.** Care Plan, **22.** Thrill, **23.** Fistula, **24.** Catheter, **25.** Bruit.

Down: 1. Hepatitis, **2.** Dialysis agreement, **3.** Transplantation, **4.** Diabetes, **7.** Mortality, **11.** Morbidity, **12.** Resident rights, **13.** Notification, **16.** Epogen, **18.** ESRD, **19.** Care team, **21.** Ninety, **24.** CKD.

Lesson 3-O: Hospice Review as Part of the Long Term Care Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the principles of hospice management in the long term care setting.
- Identify the components of effective pain management.
- Identify and demonstrate knowledge of the principles of hospice management in clinical record review.
- Determine whether the facility demonstrates and utilizes hospice services to the benefit of the resident.

Lesson Plan

References

Federal

- *Code of Federal Regulations (CFR):*
  - 42 CFR 418, Hospice Care
  - 42 CFR 483.13, Resident Behavior and Facility Practices
  - 42 CFR 483.15, Quality of Life
  - 42 CFR 483.25, Quality of Care
- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I, Transmittal 274, pages 14 and 31
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Transmittal 274, pages 14 and 31

State

(Insert State reference[s] here.)

Other

Highlights

- What hospice care is
- Core hospice services—how the interdisciplinary hospice team provides
  - Nursing services
  - Pain management
  - Spiritual and emotional support to both the resident and the resident's family
  - Social services consultation as needed
- Survey of hospice care
  - Hospice physician and nurse interaction with the attending physician
  - Attending physician responsibilities
  - Followup notes by the physician or certified registered nurse practitioner
- Plan of Care
  - Focus on integrated plan for resident
    - Pain management
    - Nutritional care
    - Resident support
    - Resident family support
- Long term care regulations to consider
  - F224 Staff treatment of resident—neglect, failure to provide pain medication as ordered
  - F240 Quality of Life—enhance quality of life
  - F241 Quality of Life
  - F242 Quality of Life—resident decision making
  - F278 Resident Assessment—accurately reflect the resident status

  - F279 Resident Assessment—use of the assessment to develop a Plan of Care
  - F309 Quality of Care—includes pain management and assessment
  - F360 Dietary Services—diet
  - F363 Dietary Services—food in a form to meet the resident's needs

Training Techniques

- Lecture
- Group discussion
- PowerPoint presentation and discussion
- Videos:
  - *Residents Rights*
  - *Interviewing Technique*
- CD-ROM:
  - Hospice Basic Training—optional choice at State agency trainer level
- Small group exercise using case study
  - Sample case study provided

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Case study
- Handout:
  - *Hospice Survey Case Study*

Methods of Evaluation

- Observation and review of trainee surveyor during survey
  - Review of Form CMS-2567 and review of any State deficiencies related to care
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 3-O:
Hospice Review as Part of the Long Term Care Survey Process

1

Slide 3-O-1

Learning Objectives

- At the conclusion of this lesson, the student will be able to:
  - Identify the principles of hospice management in the long term care (LTC) setting.
  - Identify the components of effective pain management.

2

Slide 3-O-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Identify & demonstrate knowledge of the principles of hospice management in clinical record review.
- Determine whether the facility demonstrates & utilizes hospice services to the benefit of the resident.

3

Slide 3-O-3

Audiovisual

Topics to Be Incorporated into Standard Survey

- Core hospice services
- Interaction of hospice physician/nurse with attending physician
- Integrated Plan of Care
- Resident's representative
- Advance directive
- DNR order
- Staffing & resuscitation
- Hospice election & resuscitation
- Diagnosis of terminal illness

4

Slide 3-O-4

Outline or text of presentation

Topics to Be Incorporated into the Standard Survey

- Core hospice services.
- Interaction of hospice physician/nurse with the attending physician.
- Integrated Plan of Care (PoC).
- Resident's representative.
- Advance directive.
- Do not resuscitate (DNR) order.
- Staffing and resuscitation.
- Hospice election and resuscitation.
- Diagnosis of terminal illness.

What Is Hospice Care?

Core hospice services provided to those with diagnosis of terminal illness:

- Pain management
- Symptom management
- Spiritual support

5

Slide 3-O-5

Hospice Care

The core services of hospice care are the management of the resident's pain, the management of symptoms and the provision of spiritual support for the resident.

Interaction with LTC Care Review

- Hospice physician & nurse interaction with the attending physician & facility staff nurses
- Attending physician responsibilities
  - Continues to monitor & manage clinical issues
  - Consults with hospice physician/nurse for most effective pain & symptom management

6

Slide 3-O-6

Interaction with the LTC Care Review

- Hospice physician and nurse interaction with the attending physician and facility staff nurses.
- Attending physician responsibilities.
  - Continues to monitor and manage the clinical issues.
  - Consults with the hospice physician/nurse for the most effective pain and symptom management.

Audiovisual

Plan of Care

Based on a comprehensive assessment:
- See MDS—admission & quarterly reports
- Review of State-required assessment for LTC
- Review of hospice nurse's assessment & notes

7

Slide 3-O-7

Outline or text of presentation

Hospice and Plan of Care

The PoC is based on a comprehensive assessment through Minimum Data Set (MDS) admission and quarterly reports, review of State-required assessment for LTC and review of the hospice nurse's assessment and notes.

Goal of Integrated Plan of Care

- Pain management
- Nutritional care
- Resident spiritual support
- Resident family support

8

Slide 3-O-8

Goal of an Integrated Plan of Care

Focus on how the plan handles pain management, nutritional care, resident spiritual support and resident family support.

Resident's Representative

- Representative's authority may come from articles in State regulations as to:
  - Guardian of person & property
  - Surrogate decision maker
  - Power of attorney

9

Slide 3-O-9

Resident's Representative

The representative's authority may come from articles in the State regulations as to:
- Guardian of person and property.
- Surrogate decision maker.
- Power of attorney.

Audiovisual

Resident's Representative (cont.)

- Hospice must recognize authority of any person designated by resident or legal system when resident or representative has provided hospice with documentation of designation
- Documentation must be in resident's clinical record
  - Both hospice & LTC facility

10

Slide 3-O-10

Outline or text of presentation

- A hospice must recognize the authority of any person designated by a resident or the legal system when the resident or representative has provided the hospice with documentation of the designation.
- The documentation must be in the resident's clinical record in both the hospice and the LTC facility.

Advance Directives & DNR Orders

- Hospice care program must recognize authority of resident's advance directive
  - Copy of advance directives should be in clinical record

11

Slide 3-O-11

Advance Directives and DNR Orders

The hospice care program must recognize the authority of the resident's advance directive.

- A copy of any advance directives should be in the resident's clinical record.

Election of Hospice Care & Resuscitation

- Hospice:
  - Is required to furnish advance directive information when resident elects hospice care
  - Must counsel resident on its philosophy on resuscitation at time of election of hospice benefit
- Residents whose views differ from hospice philosophy may elect to receive care from another hospice or source

12

Slide 3-O-12

Election of Hospice Care and Resuscitation

Hospice:

- Is required to furnish advance directive information when the resident elects hospice care.
- Must counsel the resident on its philosophy on resuscitation at time of election of hospice benefit.

Residents whose views differ from the hospice philosophy may elect to receive care from another hospice or source.

Audiovisual

Hospice Care in Licensed Health Care Facility

- Federal regulations refer to hospice care in any licensed facility including:
  - Long term care facilities
  - Assisted living facilities
  - Intermediate care facilities for persons with mental retardation
  - Group homes for persons with developmental disabilities

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Slide 3-O-13

Outline or text of presentation

Hospice Care in a Licensed Health Care Facility

Federal regulations refer to hospice care in any licensed facility including:

- Long term care facilities.
- Assisted living facilities.
- Intermediate care facilities for persons with mental retardation.
- Group homes for persons with developmental disabilities.

Hospice Care in Licensed Health Care Facility (cont.)

- Written agreement between hospice & facility must define their respective roles & responsibilities
  - Surveyors may request to see this when there are concerns about care issues

14

Slide 3-O-14

- A written agreement between the hospice and the facility must define their respective roles and responsibilities.
  - Surveyors may request to see this document when there are concerns about care issues.

Interdisciplinary Team Plan of Care

- Jointly developed by:
  - Resident
  - Resident's family
  - Hospice
  - Facility
- Must identify services to be provided by hospice & facility

15

Slide 3-O-15

Interdisciplinary Team Plan of Care

- An interdisciplinary team (IDT) Plan of Care should be jointly developed by the resident, the resident's family, the hospice and the facility.
- The IDT Plan of Care must identify the services to be provided by the hospice and the facility.

Audiovisual

Interdisciplinary Team Plan of Care (cont.)

- Must be:
  - Included in medical record at hospice & facility
  - Reviewed at predetermined intervals
  - Updated to reflect resident's current status

16

Slide 3-O-16

Outline or text of presentation

- The IDT Plan of Care must be:
  - Included in the medical record at the hospice and at the facility.
  - Reviewed at predetermined intervals.
  - Updated to reflect the resident's current status.

Hospice Care Management

- Hospice:
  - Retains management responsibility for resident's hospice care
  - Must identify professional to coordinate activities of IDT & facility staff

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Slide 3-O-17

Hospice Care Management

The hospice:

- Retains management responsibility for the resident's hospice care.
- Must identify a professional to coordinate activities of the IDT and the facility staff.

Hospice Care Management (cont.)

- All core hospice services identified in PoC must be provided directly by hospice employees or volunteers & *may not be delegated to health care facility*
- Core services are:
  - Physician care
  - Nursing case management
  - Social work
  - Counseling

18

Slide 3-O-18

All core hospice services identified in the Plan of Care must be provided directly by the hospice employees or volunteers and *may not be delegated to the health care facility.*

- Core services are, specifically:
  - Physician care.
  - Nursing case management.
  - Social work.
  - Counseling.

Audiovisual

Surveying Hospice Care

- Diagnosis
- PoC
- Pain assessment/management
- Psychosocial needs
- Physical needs
- Spiritual needs

19

Slide 3-O-19

Outline or text of presentation

Surveying Hospice Care

Review of:

- Diagnosis.
- PoC.
- Pain assessment/management.
- Psychosocial needs.
- Physical needs.
- Spiritual needs.

Diagnosis

- Inclusion in:
  - Progress notes?
  - Doctor order sheet?
- MDS:
  - Coded as 6 months or less to live & hospice service checked off?
  - Used to develop a basic PoC for LTC facility?

20

Slide 3-O-20

Diagnosis

- Inclusion in:
  - Progress notes?
  - Doctor order sheet?
- MDS:
  - Coded as 6 months or less to live and hospice service is checked off?
  - Used to develop a basic PoC for LTC facility?

Integrated PoC

- Has hospice been involved in care planning?
  - If so, does LTC facility follow plan?
  - Who makes revisions?
  - Made after primary physician or hospice physician notification?
  - Are revisions of approaches timely?

21

Slide 3-O-21

Integrated PoC

- Has the hospice been involved in care planning?
  - If so, does the LTC facility follow the plan?
  - Who makes revisions?
  - Is this done after the primary physician or the hospice physician notification?
  - Are revisions of approaches timely?

Audiovisual

Pain Assessment/ Management

- 63% of LTC residents experience pain in some debilitating form even without being terminal
  - 21% of those do not have effective pain management
- Is pain assessed consistently?
  - If so, who is responsible?
  - Is assessment in notes of LTC nurses?

22

Slide 3-O-22

Outline or text of presentation

Pain assessment/management

- 63% of LTC residents experience pain in some debilitating form even without being terminal.
  - 21% of those individuals do not have effective pain management.
- Is pain assessed consistently?
  - If so, who is responsible for the assessment?
  - Is the assessment included in the notes of the LTC nurses?

Pain Assessment/ Management (cont.)

- Does LTC facility document effectiveness or ineffectiveness of pain regimen?
  - Does LTC staff contact hospice in timely manner for revisions of medications?
  - Does LTC primary physician follow recommendations of hospice physician or does he/she countermand hospice orders?

23

Slide 3-O-23

- Does the LTC facility document the effectiveness or ineffectiveness of the pain regimen?
  - Does the LTC staff contact the hospice in a timely manner for revisions of medications?
  - Does the LTC primary physician follow recommendations of hospice physician or does he/she countermand hospice orders?

Psychosocial Needs

- Are hospice staff involved?
  - Nurses
  - Nursing assistants
- Is resident's anxiety addressed?
- Has LTC facility offered services that social worker identified as needed?
- Does resident participate in meaningful activities involving his/her preferences?

24

Slide 3-O-24

Psychosocial needs

- Are hospice staff involved?
  - Nurses.
  - Nursing assistants.
- Is the resident's anxiety addressed?
- Has the LTC facility offered services that the social worker identified as needed?
- Does the resident participate in meaningful activities involving his/her preferences?

Audiovisual

Physical Care Needs

- Are hospice nurses, nursing assistants & adjunct care providers involved?
  - Important since LTC facility has insufficient staff to spend quality time with resident
- Are LTC staff following plan?
  - Pain medications?
  - Positioning & assistive devices used when recommended?

25

Slide 3-O-25

Outline or text of presentation

Physical care needs

- Are hospice nurses, nursing assistants and adjunct care providers involved?
  - Important part of the plan since there are insufficient LTC staff to spend quality time with resident.
- Are LTC staff following the plan?
  - Pain medications?
  - Positioning and assistive devices used when recommended?

Physical Care Needs (cont.)

- Are alternative therapies performed?
  - Permitted provided they are performed by licensed/certified practitioner

26

Slide 3-O-26

- Are alternative therapies performed?
  - May be utilized provided they are performed by a licensed/certified practitioner.

Physical Care Needs (cont.)

- Nutritional needs considered?
  - Diet restrictions removed?
  - Preferences honored?
  - Monthly weights may be waived
    - Look for doctor's order

27

Slide 3-O-27

- Nutritional needs considered?
  - Diet restrictions removed?
  - Preferences honored?
  - Monthly weights may be waived.
    - Look for a doctor's order.

Audiovisual

Spiritual Needs

Resident visited by:
- Clergy, from either hospice or facility?
  - Who makes sure this happens?
- Friendly visitors?
  - If no family, arranged for by facility activities & social services directors?
  - Hospice volunteers?
- Family?

28

Slide 3-O-28

Outline or text of presentation

Spiritual needs

Resident visited by:
- Clergy, from either hospice or facility?
  - Who makes sure this happens?
- Friendly visitors?
  - If no family, arranged for by the facility activities and social services directors?
  - Hospice volunteers?
- Family?

Case Study

- What are three areas of concern in this scenario?
- Is there anyone else who should be interviewed?
- What regulations cover this scenario?
- On what tags might facility be out of compliance?

29

Slide 3-O-29

Case Study

(Refer students to the handout "Hospice Survey Case Study" on page 3-O-17. Review the following questions with students.)

- What are three areas of concern in this scenario?
- Is there anyone else who should be interviewed?
- What regulations cover this scenario?
- On what tags might the facility be out of compliance?

Lesson 3-O:
Hospice Review as Part of the Long Term Care Survey Process

Questions

30

Slide 3-O-30

Skill Assessment

Hospice Review as Part of the Long Term Care Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies, and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					1. Identified the principles of hospice management in the long term care setting.	
					2. Identified the components of effective pain management.	
					3. Identified and demonstrated knowledge of the principles of hospice management in clinical record review.	
					4. Determined whether the facility demonstrated and utilized hospice services to the benefit of the resident.	

Comments/Recommendations:

Hospice Survey Case Study

Read the following case study and answer the questions that follow.

Surveyors selected Mrs. G after receiving information at the entrance conference that she was currently being managed by Gate of Heaven Hospice.

Mrs. G was interviewable and a surveyor assigned to review her care set up a time after lunch on the third day of survey to speak with her. When the surveyor arrived in Mrs. G's room at 1 p.m., she noticed that the resident was tearful and restless and had not touched her lunch tray.

When the surveyor stated that she would come back at a more convenient time, Mrs. G asked her to "please stay" because she needed to talk to someone about her pain. She stated that it was so bad she wished that someone would just put her out of her misery like that doctor she saw on TV. "I can't eat, I can't sleep and I just want to die soon so I can be out of all this terrible pain. I told the nurses I needed something and they ignore me."

When the surveyor asked when the nurses had last asked Mrs. G about her pain, the response was, "I'm never asked about my pain. All they do is just give me the same pill and tell me to wait four hours until the next one."

Review of Mrs. G's orders revealed she had orders for Roxanol 10 mg., one tablet q4h as needed for pain, Duragesic 50 mcg transdermal patch q48 hours and Ativan 0.5 mg BID. The hospice consultant nurse and hospice physician had recommended these medications. The facility consultant pharmacist had noted this recommendation after reviewing the resident's frequent requests for more pain medication. The pharmacist made a recommendation to the attending physician to add the Duragesic patch in the monthly review completed the day before the interview.

The surveyor's interview with the nurses on the unit assigned to Mrs. G revealed that they thought she was demonstrating "drug-seeking behavior since her pain can't be that bad." When asked if they had a method to have Mrs. G assign a severity to her pain, such as on a 1–10 scale, the nurses stated that they "just kept an eye on her and made sure she gets her meds when we think she needs it."

Further investigation revealed that Mrs. G's attending physician had failed to order the Duragesic patch. The note in the physician's progress notes stated, "I see no reason to add the transdermal patch at this time. I don't want this resident hooked on pain medications."

1. What are three areas of concern in this scenario?

2. Is there anyone else who should be interviewed?

3. What regulations cover this scenario?

4. On what tags might the facility be out of compliance?

Lesson 3-P: Closed Record Review

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Determine the number of closed records to review based on the facility census.
- Describe the selection criteria for a closed record.
- Access the proper documentation: Form CMS-805, *Resident Review Worksheet*.
- Describe the regulations applicable to the closed record review.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Task 4—Sample Selection and Table 1, Survey Procedures for Long Term Care Facilities—Resident Sample Selection
  - Appendix PP

State

(Insert State reference[s] here.)

Other

Highlights

- Presentation of the concept of closed record review
- Instruction regarding items to be filled out on Form CMS-805, *Resident Review Worksheet*
- Discussion of the selection criteria for a closed record

Training Techniques

- Lecture
- Group discussion

Training Aids

- PowerPoint slides and handouts
- *SOM,* Appendices P and PP
- Form CMS-805, *Resident Review Worksheet*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Outline or text of presentation

Lesson 3-P:
Closed Record Review

1

Slide 3-P-1

Learning Objectives

- Determine the number of closed records to review based on the facility census.
- Describe the selection criteria for a closed record.
- Access the proper documentation: Form CMS-805, *Resident Review Worksheet*.
- Describe the regulations applicable to the closed record review.

2

Slide 3-P-2

(Inform the students of the objectives.)

Components of Closed Record Review

- Resident care issues
- Phase 2 concerns
- Transfer & discharge requirements

3

Slide 3-P-3

Components of Closed Record Review

Review of a closed record includes reviewing the resident's care, the selected Phase 2 concerns and the transfer and discharge requirements. You may use records of residents chosen for the offsite sample if once onsite you discover these residents have been discharged or are deceased.

Audiovisual

Record Selection

- Phase 2
  - Unresolved issues from Phase 1 or 2
- Offsite sample
  - Discharged or deceased residents chosen during offsite preparation

4

Slide 3-P-4

Outline or text of presentation

Record Selection

Closed records are most commonly chosen as part of Phase 2 sample selection. In that case, record selection is based on unresolved issues from Phase 1 or Phase 2 such as:

- Assessment and care of infections.
- Pressure sores.
- Significant weight loss.
- Restraints.
- Multiple falls or injuries.

If there is a care area that is an identified concern, try to obtain the closed records of residents who had the same care needs before death, discharge or transfer.

Record Review

Focus on:

- Events leading up to transfer or discharge
- Care & treatment surrounding resident's transfer or discharge
- Conveyance by facility of resident's personal funds & final accounting within 30 days of death

5

Slide 3-P-5

Record Review

Focus on:

- Events leading up to the transfer or discharge.
- Appropriateness of care and treatment surrounding the resident's discharge or transfer.
- Conveyance by the facility of the deceased resident's personal funds and final accounting within 30 days of death.

Audiovisual

Outline or text of presentation

Number of Closed Records

- Refer to Appendix P in *SOM*
  - Table 1, Survey Procedures for Long Term Care Facilities—Resident Sample Selection

6

Slide 3-P-6

Number of Closed Records

Refer to Table 1, Survey Procedures for Long Term Care Facilities—Resident Sample Selection, in Appendix P of the *SOM*. This table shows the quantity of records that are to be selected for closed record review.

Group Exercise

- How many closed records must be selected for review for resident census of:
  - 45?
  - 85?
  - 130?
  - 175?

7

Slide 3-P-7

(Have surveyors open Appendix P to Table 1 and practice determining the number of closed records to complete based on facility censuses of 45, 85, 130 and 175.)

Form CMS-805

- Skip Sections A & B—these are not applicable for closed record review
- Complete Sections C & D
  - For Section D, pay special attention to triggered concern areas

8

Slide 3-P-8

Form CMS-805

As in Phase 1 and 2, use Form CMS-805 for completion of the closed record review.

- Skip Sections A, Resident Room Review, and B, Resident Daily Life Review.
- Complete Section C, Assessment of Drug Therapies, as appropriate.
- Complete Section D, RAI/Care Review Sheet, as appropriate. Review the closed records for care areas that were selected as concerns for Phase 2 survey.

Audiovisual

Relevant Regulations

- 42 CFR 483.10(b)(4–10) Advance directives
- 42 CFR 483.10(b)(11) Notice of significant change
- 42 CFR 483.10(c)(6) Conveyance of funds upon death

9

Slide 3-P-9

Outline or text of presentation

Relevant Regulations

42 CFR 483.10(b)(4–10) Advance directives
The resident has the right to "formulate an advance directive."

- An advance directive is defined to be written instructions such as a will or durable power of attorney (DPOA) applicable when the individual is incapacitated.
- An individual cannot be treated against his/her wishes or, when incapacitated, against the wishes of his/her representative.
- A facility cannot transfer or discharge a resident refusing treatment unless the criteria to transfer or discharge are met.

See tag F155.

42 CFR 483.10(b)(11) Notice of significant change
The facility must immediately inform the resident, his/her physician and legal representative or interested family member when there is:

- An accident resulting in injury and the potential for physician intervention.
- A significant change in the resident's physical, mental or psychosocial status.
- A need to alter treatment significantly.
- A decision to transfer or discharge the resident from the facility as specified in 483.12(a).

See tag F157.

42 CFR 483.10(c)(6) Conveyance of funds upon death
Upon the death of a resident having personal funds deposited with the facility, the facility must convey the resident's funds and make final accounting of those

Audiovisual

Relevant Regulations (cont.)

- 42 CFR 483.10(d)(3) Participation in planning care & treatment
- 42 CFR 483.10(o) Refusal of transfer from a distinct part
- 42 CFR 483.12 Admission, transfer & discharge rights

10

Slide 3-P-10

Outline or text of presentation

funds to the individual or probate jurisdiction administering the resident's estate within 30 days.

See tag F160.

42 CFR 483.10(d)(3) Participation in planning care and treatment
The resident has the right to:

- "Participate in planning care and treatment."
- Select from alternative treatments.

See tag F163.

42 CFR 483.10(o) Refusal of transfer from a distinct part
The resident's right to refuse certain transfers applies to transfer within a physical plant. Examples include transfers:

- From one room to another.
- From a skilled nursing facility (SNF) area to a different part of the facility that is not an SNF.

See tag F177.

42 CFR 483.12 Admission, transfer and discharge rights
Transfer or discharge is defined as the movement of a resident to a bed outside of the certified facility, regardless of whether that bed is in the same building or not. This does not refer to movement within the facility. The regulation applies to transfers or discharges initiated by the facility regardless of whether the resident agrees to the transfer or discharge.

- The facility may not transfer or discharge a resident unless the transfer or discharge is:
  1. Necessary for the resident's welfare when the resident's needs cannot be met in the facility.

Audiovisual	Outline or text of presentation
	2. Appropriate because the resident's health has improved sufficiently that he/she no longer needs the services of the facility. 3. Necessary because the safety and/or health of other individuals in the facility is endangered. 4. Necessary due to resident's failure to pay for a stay after reasonable and appropriate notices. • The resident's physician must document in the resident's record that the resident's welfare cannot be ensured in the facility or that discharge or transfer is appropriate because he/she no longer needs the services of the facility. • When the transfer or discharge is necessary because the safety and/or health of other individuals in the facility is endangered, any physician may make the documentation in the resident's record. • Prior to discharge, the facility must notify the resident, family member or representative of the reasons for the transfer and document them in the resident's record. • The notice must include an explanation of the right to appeal the transfer to the State, as well as the name, address and phone number of the State long term care ombudsman. • The discharge notice must be provided 30 days prior to the transfer except when: – Other residents are endangered. – The resident's condition has improved, allowing for more immediate transfer. – A resident's urgent medical need requires immediate transfer. – A resident has not resided in the facility 30 days.

Audiovisual

Outline or text of presentation

- The facility must ensure sufficient preparation and orientation for residents to result in a safe and orderly discharge.
- Under Medicaid, the facility must provide notice to a resident of the facility's bed hold and readmission policies prior to transfer of that resident for hospitalization or therapeutic leave. A written notice to the resident and representative must specify the duration of any bed hold.
- A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed hold period is readmitted immediately upon the first availability of a bed in a semiprivate room.

See tags F201, F202, F203, F204, F205 and F206.

Relevant Regulations (cont.)

- 42 CFR 483.20(l) Discharge summary & planning
- 42 CFR 483.15(g)(1) Medically related social service needs
- 42 CFR 483.25 Acute changes in condition

11

Slide 3-P-11

42 CFR 483.20(l) Discharge summary and planning

When the facility anticipates discharge, a resident must have a discharge summary that includes:

1. A recapitulation of the resident's stay.
2. A final summary of the resident's status that is available for release to authorized persons and agencies with the consent of the resident or legal representative.

A postdischarge plan of care must be developed with the participation of the resident and his/her family to assist the resident in his/her new environment.

See tags F283 and F251.

Audiovisual

Outline or text of presentation

42 CFR 483.15(g)(1) Medically related social service needs
The facility must provide medically related social services aimed at attaining or maintaining the highest practicable physical, mental and psychosocial well-being for each resident.

Social services are to:

- Assist in discharge planning services:
  - Get a resident placed on a waiting list for a different facility.
  - Arrange intake for home care services for a resident returning home.
  - Assist with transfer arrangements to other facilities.
- Assist staff in informing residents, and those whom residents designate, about health status and health-care choices.
- Assist residents with financial and legal matters such as referrals to funeral homes for preplanning arrangements.

See tags F250 and F251.

42 CFR 483.25 Acute changes in condition
According to the guidance for surveyors in the *SOM,* "the facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process." When there has been a lack of improvement or a decline, the survey team must determine whether this was unavoidable or avoidable.

A determination of unavoidable decline or failure to reach the highest practicable well-being can be made only when the following are present:

Audiovisual

Outline or text of presentation

- An accurate and complete assessment.
- A Care Plan that is implemented and based on information from the assessment.
- Evaluation of the results of the interventions and revision of the interventions as necessary.

Determine whether the facility was providing the necessary care and services based on the assessment findings of the Resident Assessment Instrument (RAI). Potential quality-of-care issues include:

- Activities of daily living (ADLs):
  - Vision and hearing.
  - Pressure ulcers.
  - Incontinence.
  - Range of motion.
  - Mental and psychosocial condition.
  - Tube feeding.
  - Accidents.
  - Nutrition.
  - Hydration.
  - Therapeutic diet.
  - Special needs.
  - Unnecessary drugs.
  - Antipsychotic drugs.

See tags F309–F333.

Categories of Closed Records

- Hospital transfer
- Death
- Discharge
  - Different facility
  - Less-skilled environment
    - Assisted living
    - Home

12

Slide 3-P-12

Categories of Closed Records

- Hospital transfer.
- Death.
- Discharge.
  - Different facility.
  - Less-skilled environment.
    - Assisted living.
    - Home.

Audiovisual

Hospital Transfer

Review:
- Physicians' orders & nurses' notes
- Appropriateness of care & treatment surrounding resident's transfer, as well as events leading up to transfer
- Bed hold information

13

Slide 3-P-13

Death

- Review events & care or lack of care prior to resident's death
- Review physicians' orders & nurses' notes
- Determine whether resident's advance directives were followed

14

Slide 3-P-14

Outline or text of presentation

Hospital transfer

If an individual was transferred to the hospital, review at a minimum:

- Physicians' orders and nurses' notes.
- Appropriateness of care and treatment surrounding the resident's transfer, as well as the events leading up to the transfer.

If there was a decline in the resident's condition, determine whether:

- The decline was avoidable.
- The resident's physician and family member were notified.
- The family member was notified of hospitalization.
- The resident's advance directives were followed.

Review the bed hold information for hospital transfer.

Death

Review the events and care or lack of care prior to the resident's death. At a minimum, review physicians' orders and nurses' notes:

- Was the death sudden or was the decline gradual and expected?
- Did the facility respond appropriately to changes in the resident's condition?
- If there was a sudden decline in condition prior to the resident's death, were the physician and family member notified?
- Were the resident's advance directives followed?
- What should have happened but didn't?

Audiovisual

Discharge

- Review MDS for resident limitations that may need to be addressed before &/or at time of discharge
- Review Care Plan for resident-specific issues & plans for discharge that addressed those issues
- Review discharge plan &/or social service notes

15

Slide 3-P-15

Outline or text of presentation

Discharge

If the individual was discharged to a more independent environment:

- Review the MDS for the expectation of discharge and resident limitations that needed to be addressed before and/or at the time of discharge.
- Review the Care Plan for resident-specific issues and plans for discharge that addressed those issues:
  - Did the individual have to climb steps?
  - Did the individual take medication independently?
  - Did the individual prepare simple meals?
  - Did the individual perform activities of daily living independently or with minimal assistance?
  - How did the facility ensure the resident was capable of functioning in these areas before discharge?
- Review the discharge plan and/or social services notes:
  - When did the facility staff begin to work to prepare the resident and others for discharge?

Lesson 3-P:
Closed Record Review

Questions

16

Slide 3-P-16

Skill Assessment

Closed Record Review

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Determined the number of closed records to review based on the facility census.	
					Accessed the proper documentation: Form CMS-805, *Resident Review Worksheet*.	
					Described the selection criteria for a closed record.	
					Described the regulations for the review of closed records under 42 CFR 483.10(b)(4–10).	
					Described the regulations for the review of closed records under 42 CFR 483.12, 483.15, 483.20 and 483.25.	

Comments/Recommendations:

Lesson 3-Q: Quality Assessment and Assurance Review

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the differences between quality assurance (QA) and quality improvement.
- Identify the six components of any QA program.
- Identify and demonstrate application of knowledge of the long term care QA regulations.
- Determine whether a facility has a functioning QA process currently in place.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
- *Code of Federal Regulations (CFR):*
  - 42 CFR 483.75(o)

State

(Insert State reference[s] here.)

Other

Highlights

- Presentation of the concepts of quality improvement and quality assurance
- Definitions
- Key concepts about quality

Training Techniques

- Lecture
- Group discussion
- Small group exercise

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - *Group Activity Worksheet*
  - *Group Activity: Instructor's Summary*
  - *Quality Assessment and Assurance for Long Term Care Facilities*
- Online Survey Certification & Reporting (System) (OSCAR) Reports 3 and 4 for sampled facilities
- Quality Indicator Reports
  - The Facility Characteristics Report (Report 1)
  - The Facility Quality Indicator Profile (Report 2)
  - The Resident Level Summary (Report 3)

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

Audiovisual

Outline or text of presentation

Lesson 3-Q:
Quality Assessment &
Assurance Review

1

Slide 3-Q-1

Learning Objectives

- Identify the differences between quality assurance (QA) & quality improvement.
- Identify the 6 components of any QA program.
- Identify & demonstrate application of knowledge of the long term care QA regulations.
- Determine whether a facility has a functioning QA process currently in place.

2

Slide 3-Q-2

(Inform the students of the objectives.)

Key Point of
Accountability

3

Slide 3-Q-3

Quality assessment and assurance committees represent a key point of accountability for ensuring both quality of care and quality of life in nursing homes.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires nursing homes to maintain quality assessment and assurance committees that meet at least quarterly to identify and correct quality deficiencies and improve care.

Audiovisual

Assurance versus Improvement

- Act of assuring
- Providing confidence
- Certainty of quality
- Increase in excellence
- Additions or changes that improve something
- To make something more valuable

4

Slide 3-Q-4

Outline or text of presentation

The Concept

The concept or general idea of quality assurance (QA) is the act of assuring: providing confidence and certainty of quality.

Quality improvement is the act of increasing excellence or quality by making additions or changes that improve something or make it more valuable.

System Perspective of Quality

5

Slide 3-Q-5

QA Systems from the Perspective of the State Agency

Survey:

- Is primarily a snapshot and a baseline for all providers.
- Can use enforcement to gain compliance with quality standards.

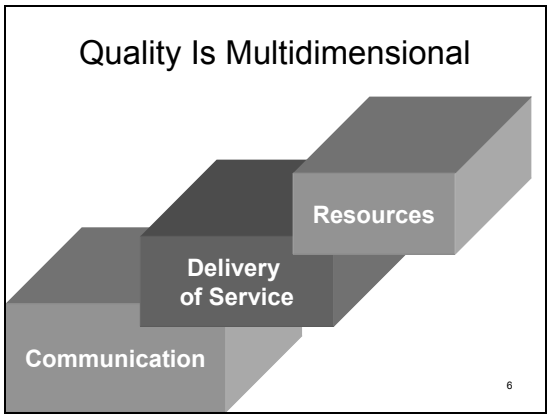
Complaint investigations (abbreviated surveys) are:

- Most responsive part of the system.
- Most direct link to the public.
- Usually where resident care concerns will show up first.

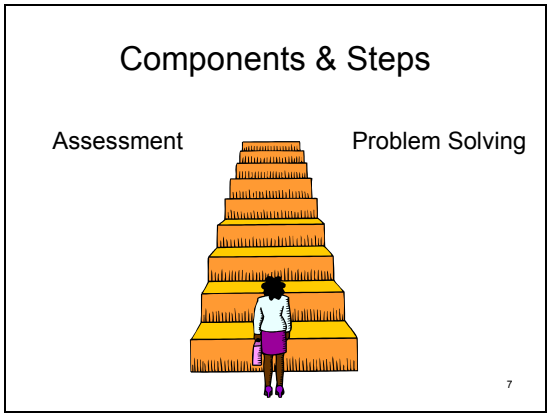
Quality assessment and assurance committees:

- Are internal to the provider.
- Are focused on prevention or early intervention.
- Are focused on ongoing improvement in the provision of care and services.
- Are focused on a facility system rather than on a specific person or point of view.
- Maintain the facility's focus on continuous attention and problem solving from a systems perspective.

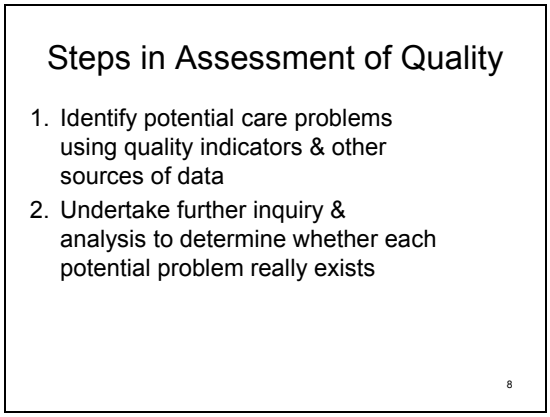
Audiovisual



Slide 3-Q-6



Slide 3-Q-7



Slide 3-Q-8

Outline or text of presentation

How Does "Quality" Affect Facilities?

Quality is multidimensional
The nature, relative importance and expectations pertaining to quality dimensions are dynamic, from resident to resident and over time.

Quality encompasses:
- Resources used to deliver care.
- The actual delivery of service to the resident.
- Resident-caregiver communication.

QA Components and Steps

QA forces the facility's quality assessment and assurance committee to ask the question: Were the right things done for the resident, and were they done with adequate skill?

From a surveyor's perspective, a red flag that a facility's quality assessment and assurance committee is not working well—or is not meeting—would be *multiple negative issues resulting in negative outcomes in multiple residents*.

QA process
QA is a two-step process:
1. Identify potential care problems using quality indicators and other sources of data that reflect potential problems for residents.
2. Undertake further inquiry and analysis to determine whether each potential problem really exists.

Audiovisual

Components of Problem Solving in Quality Assurance

- Collection of meaningful data
- Identification of root causes of problems
- Development of appropriate solutions
- Evaluation of results
- Making necessary corrections until goals are reached
- Working to maintain level of goal

9

Slide 3-Q-9

Outline or text of presentation

Basic Components

Problem-solving processes are not really new to health-care providers.

Components in basic QA problem solving
The components of basic QA problem solving are:

- Collection of meaningful data.
- Identification of root causes of problems.
- Development of appropriate solutions.
- Evaluation of results.
- Making necessary corrections until goals are reached.
- Working to maintain the level of the goal.

Nursing facilities are drowning in data. Most often facilities fail to use and analyze the data they collect or that are provided through the quality indicator system.

Assessment Activity—Part 1

- Using quality indicator reports & OSCAR reports, identify 3 areas/concerns that could be addressed in facility's quality assurance program
- Identify where facility could gather additional data or information to assess these areas/concerns

10

Slide 3-Q-10

(Have the students form groups and complete "Group Activity, Part 1" of the handout "Group Activity Worksheet" on page 3-Q-17.

1. *Provide participants with OSCAR Reports 3 and 4 and Quality Indicator Reports 1, 2 and 3. Have them identify three areas for quality improvement from these reports. Record these areas on a chart pad.*

Audiovisual

Assessment Activity—Part 1 (cont.)

- Choose 1 area/concern & develop plan with assessment & problem solving steps you have learned

11

Slide 3-Q-11

Additional Activity Questions

If facility is failing to meet standards, following concerns must be addressed:

- Which system or systems are involved with this issue?
- What are possible root causes of problems that have led to issue?
- What solutions can be developed for 2 of these root causes?

12

Slide 3-Q-12

Additional Activity Questions (cont.)

- How can success of dealing with this issue be evaluated?
- Are there further corrections that can be implemented to assure that goals are reached & maintained?

13

Slide 3-Q-13

Outline or text of presentation

2. *Have each group choose one of the areas and try to develop the answers to questions listed on the worksheet for the area of concern they have identified.*
3. *Each group should have a spokesperson and be prepared to discuss their program with the entire group.*

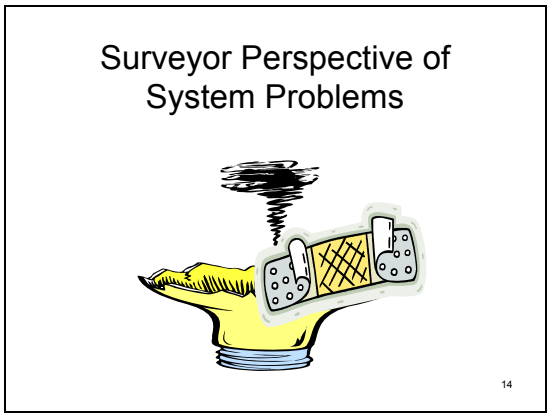
See the handout "Group Activity: Instructor's Summary" on page 3-Q-21 for an outline of both group activities in this lesson.

Call attention to the following activity questions.

If a facility is failing to meet standards, the following concerns must be addressed:

- *Which system or systems are involved with this issue?*
- *What are the possible root causes of the problems that have led to the issue?*
- *What solutions can be developed for two of these root causes?*
- *How can the success of dealing with this issue be evaluated?*
- *Are there further corrections that can be implemented to assure that goals are reached and maintained?)*

Audiovisual



Slide 3-Q-14

Slide 3-Q-15

Outline or text of presentation

Systems Perspectives

From a surveyor's point of view, a "band-aid" approach is often what we see facilities doing, fixing the symptoms of a problem rather than fundamentally changing the system that caused the problem.

Systems thinking requires examination of interrelationships rather than of linear cause-effect chains.

Facilities must focus on prevention of problems, or else expend time and energy responding to short-term crises or reacting to negative resident outcomes.

Facility Responsibility

Each facility has the primary responsibility for undertaking activities to improve its facility-specific systems.

Annual and abbreviated surveys are not intended to act as the facility's QA program. Effective QA programs are driven internally by focusing on the organizational performance as a whole. Again, such programs require a systems perspective.

Surveys represent an externally imposed set of standards. The intent of surveying is QA from a public policy and accountability perspective, not the perspective of the individual facility.

QA that is external to the facility ensures that residents are receiving the care and services they need and validates that health-care dollars are being expended appropriately.

Audiovisual

Purpose of Review during Survey

- Does facility have quality assessment & assurance committee that meets in accordance with requirements?
- Does committee have method to routinely identify, respond to & evaluate its responses to issues that require quality assessment & assurance activity?

Now let's review protocol

16

Slide 3-Q-16

Outline or text of presentation

Purpose of Reviewing the QA System during the Survey

There are two main purposes for reviewing QA within the facility:

1. Does the facility have a quality assessment and assurance committee that meets in accordance with the regulatory requirements?
2. Does the committee have a method for routinely identifying, responding to and evaluating its responses to issues that require quality assessment and assurance activity?

QA review of a facility is conducted after Phase 2 (sampling) to ensure that the survey team does not use the facility's QA activity to identify deficiencies.

Survey Protocols

(Refer the students to the handout "Quality Assessment and Assurance for Long Term Care Facilities" on page 3-Q-23.)

Part 1

- Applicable to all facilities.
- Information is obtained through interviews with the appropriate staff.

Questions

1. Does the facility have a quality assessment and assurance committee?
2. Does the committee meet the membership requirements (i.e., the director of nursing, a physician and three members of the facility staff)?
3. Does the committee include individuals who are not on the staff?
4. How often does the committee meet?
5. What data sources does the facility use to target problem areas?

Audiovisual	Outline or text of presentation
	6. How does the facility use the data from these sources to initiate improvement projects? Committee minutes that address actual quality deficiencies should not be included in this part of the review. **Part 2** • The survey team identified actual or probable quality deficiencies during Phase 1 of the survey. The survey team goal during this portion of the review is to determine whether the facility has an effective method of identifying quality deficiencies and dealing with them. **Questions** 1. Has the facility identified any quality deficiencies? 2. Does the facility have a plan for addressing the deficiencies? 3. Does it have a method of evaluating the effectiveness of the implementation of its improvement plan? 4. Do direct-care staff know how to access the QA committee? 5. Do direct-care staff and the members of the committee know how the committee functions? 6. Does the committee respond to concerns submitted by staff? 7. Can staff describe an example of a quality deficiency that the committee identified, worked on and resolved?

Audiovisual

Assessment Activity—Part 2

Since surveyors are not to review quality assessment & assurance committee's notes, interviewing staff & key personnel is 1 of most important aspects of determining compliance:

- Write down specific interview questions that can help you as surveyor obtain information regarding quality assessment & assurance committee

17

Slide 3-Q-17

Outline or text of presentation

(Have the students form groups and complete "Group Activity, Part 2" of the handout "Group Activity Worksheet" on page 3-Q-17.)

Key Concepts

- Quality assurance versus quality improvement
- Components of quality program
- Task & regulations
- Interview questions

18

Slide 3-Q-18

Key Concepts

- QA versus quality improvement.
- Components of a quality program.
- Task and regulations.
- Interview questions.

Lesson 3-Q:
Quality Assessment &
Assurance Review

Questions

19

Slide 3-Q-19

Skill Assessment

Quality Assessment and Assurance Review

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified the differences between QA and quality improvement.	
					Identified the six components of any QA program.	
					Identified and demonstrated application of knowledge of the long term care QA regulations.	
					Determined whether a facility has a functioning QA process currently in place (interview questions).	

Comments/Recommendations:

Group Activity Worksheet

Group Activity, Part 1
Choose a group leader and answer the following questions. Be prepared to share your answers with the rest of the groups.

1. Identify three areas/concerns that, in your experience, have been addressed in a facility's QA program or that you believe could be addressed in such a program.

   a.

   b.

   c.

2. Identify where the facility could gather data to assess these areas. Compare this list with the results of the other groups when you are finished. For each data resource identified, answer the following questions: Should the data from these sources be meaningful to the facility? What other data would be meaningful?

   More considerations:
   a. Describe what the QA process might be.

   b. What might the direct caregivers believe is the process?

c. Might there be anything identified on the Care Plans for residents who have these areas/concerns or have the potential for them?

d. What might the internal policies and procedures direct for these areas/concerns?

e. What are the current best practices surrounding these areas/concerns?

3. Using OSCAR Reports 3 and 4 and Quality Indicator Reports 1, 2 and 3, identify three areas for quality improvement. Record these areas below. Choose one area and develop answers for the questions listed above to discuss with other groups.

   a.

   b.

   c.

   d.

   e.

4. Identify the system or systems within the facility that may be involved in this area.

5. Identify the possible root causes of the problem(s) in this area. For example: poor pain management causing residents to refuse turning or repositioning, thereby impacting the skin system, medication management system, communication system between direct caregivers and licensed staff, etc.

6. Choose two root causes and develop appropriate ways of addressing them.

7. How could the facility evaluate its success in dealing with the issue(s) in this problem area?

8. What other corrections could be implemented to assure that its goals were reached and maintained?

Group Activity, Part 2

Write down specific interview questions that would help a surveyor to answer the following question:

1. Does the facility have a quality assessment and assurance committee?

2. Does the committee meet the membership requirements (i.e., the director of nursing, a physician and three members of the facility staff)?

3. Does the committee include individuals who are not on the staff?

4. How often does the committee meet?

5. What data sources does the facility use to target problem areas?

6. How does the facility use the data from these sources to initiate improvement projects?

Group Activity: Instructor's Summary

Group Activity, Part 1
Have each group choose a group leader to act as a spokesperson.

1. Have groups identify three areas/concerns that, in their experience, have been addressed in a facility's QA program or that they believe could be addressed in such a program.
2. Have groups identify where a facility could gather data to assess these areas. Have groups compare lists. Ask the following questions: should the data from these sources be meaningful to the facility? What other data would be meaningful? More questions to ask:
   - What might the current QA process be?
   - What might the direct caregivers believe is the process?
   - Might there be anything identified on the Care Plans for residents who have this issue or have the potential for this issue?
   - What might the internal policies and procedures direct for this issue?
   - What are the current "best practices" surrounding this issue?
3. Provide participants with OSCAR Reports 3 and 4 and Quality Indicator Reports 1, 2 and 3. Have them identify three areas for quality improvement from these reports. Record these areas on a sheet of chart pad paper. Have each group choose one area and develop the answers to some of the questions above.
4. Ask the groups to identify the system or systems within the facility that may be involved in this area.
5. Have each group identify the possible root causes of the problem(s) in this area. For example: poor pain management causing residents to refuse turning or repositioning, thereby impacting the skin system, medication management system, communication system between direct caregivers and licensed staff, etc.
6. Have groups choose two root causes and develop appropriate solutions.
7. Ask the following question: How could the facility evaluate its success in dealing with the issue(s) in this area?
8. What other corrections could be implemented to assure that its goals were reached and maintained?

Group Activity, Part 2
Have each group write down specific interview questions that would help the surveyor to answer the following questions:

1. Does the facility have a quality assessment and assurance committee?
2. Does the committee meet the membership requirements (i.e., the director of nursing, a physician and three members of the facility staff)?
3. Does the committee include individuals who are not on the staff?
4. How often does the committee meet?
5. What data sources does the facility use to target problem areas?
6. How does the facility use the data from these sources to initiate improvement projects?

Quality Assessment and Assurance for Long Term Care Facilities

Never review records or minutes regarding any specific QA issue, whether it was resolved or currently being addressed.

Part 1
Following 42 CFR 483.75(o), interview administrative staff and committee members to determine the following:

1. Does a quality assessment and assurance committee exist at the facility?

2. Who are the members of the committee? (It must include, at a minimum, the director of nursing, a physician who attends and three members of the staff.)

3. What are the dates on which the committee has met since the last survey? (It must meet at least quarterly.)

4. Describe the method or system used to identify issues pertinent to the quality of care and quality of life of facility residents that require assessment and assurance activities.

5. Describe the method used to provide information regarding a QA issue to facility staff and to implement changes.

6. Describe the method used to evaluate the effectiveness of the implemented changes.

Request and review a written description of the committee's process or protocol for identifying quality problems.

Part 2
Conduct this portion of the task after Phase 2 sample selection if actual or probable quality deficiencies were identified. The goal is to determine the *effectiveness* of the method used by the facility to identify quality problems and deal with them.

Interview committee members to determine the following:

1. Describe a sample of the types of quality problems the facility has identified and how they were addressed and resolved.

2. If the plan described by the committee for addressing the problems is not being followed, is there a justifiable reason?

Interview direct-care staff to determine the following:

1. Do they know how to access the QA process and committee?

2. How does the committee function?

3. Is the committee responsive to QA concerns submitted to it?

4. Describe problems that were addressed. (Determine whether direct-care staff can describe interventions that are or were planned by QA staff.)

Lesson 3-R:
Abuse Prohibition Review

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the various forms of abuse and neglect.
- Explain possible indicators of abuse and neglect.
- Determine whether a provider has developed and implemented policies and procedures to prohibit abuse, neglect, mistreatment, involuntary seclusion and misappropriation of resident property.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities, Sub-Task 5G, Abuse Prohibition Review: Investigative Protocol, Abuse Prohibition
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities
- *Code of Federal Regulations:*
  - 42 CFR 483.13(b), Abuse, and (c), Staff treatment of residents
  - 42 CFR 488.301, Definitions
- Centers for Medicare & Medicaid Services. *Abuse and Neglect Detection and Prevention Training Manual*, Instructor and Participant Guides
- CMS Survey & Certification letter S&C 02-20, Subject: Review of Time Frames for Reporting Abuse; Reporting Abuse to Law Enforcement; Displaying Telephone Numbers; and Clarification on Defining and Citing Abuse
- CMS Survey & Certification letter S&C 05-09, Subject: Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property

State

(Insert State reference[s] and specific regulations here.)

Other

- Pillemer, K. and Moore, D. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *Gerontologist, 29,* 314–320.
- McCartney, J. R. and Campbell, V. A. (1998). Confirmed abuse cases in public residential facilities for persons with mental retardation: A multi-state study. *Mental Retardation, 36(6),* 465–473.

Highlights

- Obtaining and reviewing abuse policies and procedures to determine if the seven key components are included
- Requesting written evidence of alleged violations (if any) and selecting two or three for review
- Interviewing individual(s) responsible for coordinating policies/procedures
- Interviewing at least three front-line supervisors
- Interviewing at least five direct-care staff
- Obtaining a list of all employees hired within the previous four months and reviewing five to determine whether prescreening was completed prior to hiring
- Interviewing staff, residents and families during survey process

Training Techniques

- Lecture
- Group discussion
- Group exercise

Training Aids

- *SOM,* Appendix P and Appendix PP
- CMS Survey & Certification letters S&C 02-20 and S&C 05-09
- PowerPoint slides and handouts
- Handout:
  - *Exercise for Abuse Prohibition Review*
- Video: *At the End of the Day*, Center for Advocacy for the Rights and Interests of the Elderly (CARIE), 1999 (A copy of the video can be obtained directly from CARIE, 100 North 17th Street, Suite 600, Philadelphia, PA 19103, phone: (215) 545-5128.

Methods of Evaluation

- Verbalization/discussion of understanding of this part of the survey process
- Completion of exercise
- Completion of skill assessment
- Evaluation completed by State agency trainer in format developed by the State

Audiovisual	Outline or text of presentation
Lesson 3-R: Abuse Prohibition Review 1	
Slide 3-R-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Describe the various forms of abuse & neglect. • Explain possible indicators of abuse & neglect. 2	*(Inform the students of the objectives.)*
Slide 3-R-2	
Learning Objectives (cont.) • Determine whether a provider has developed & implemented policies & procedures to prohibit abuse, neglect, mistreatment, involuntary seclusion & misappropriation of resident property. 3	
Slide 3-R-3	

Audiovisual

Regulations

- "The resident has the right to be free from verbal, sexual, physical, mental abuse, corporal punishment & involuntary seclusion"
- "The facility must develop & implement written policies & procedures that prohibit mistreatment, neglect & abuse of residents & misappropriation of resident property"

4

Slide 3-R-4

Outline or text of presentation

Regulations

The regulations state:

- "The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion." [42 CFR 483.13(b)]
- "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property." [42 CFR 483.13(c)]

(Review definitions found in the SOM, Appendix PP, Guidance to Surveyors for Long Term Care Facilities.)

Abuse

- Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish
- Defined at 42 CFR 488.301

5

Slide 3-R-5

Abuse

This is defined by 42 CFR 488.301. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical, verbal, mental and sexual abuse are defined in the *SOM* (F223).

Audiovisual

Outline or text of presentation

Physical Abuse

Use of physical force that may result in bodily injury, physical pain or impairment

6

Slide 3-R-6

Physical Abuse

Physical abuse is the use of physical force that may result in bodily injury, physical pain or impairment.

Examples of Physical Abuse

- Pinching
- Shaking
- Striking
- Shoving
- Burning
- Pushing
- Slapping
- Hitting
- Kicking

or controlling behavior through corporal punishment

7

Slide 3-R-7

Examples of Physical Abuse

- Pushing, slapping, hitting.
- Shoving, shaking, striking.
- Pinching, kicking, burning.
- Controlling behavior through corporal punishment.

Verbal Abuse

Use of oral, written or gestured language that willfully includes disparaging & derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability

8

Slide 3-R-8

Verbal Abuse

This is defined in the *SOM* (F223). Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend or disability:

- Threats of harm, saying things to frighten a resident, such as telling a resident he/she will never be able to see his/her family again.

Audiovisual

Outline or text of presentation

Mental Abuse

Includes but is not limited to:
- Humiliation
- Harassment
- Threats of punishment
- Threats of deprivation

9

Slide 3-R-9

Mental Abuse

This is defined in the *SOM* (F223). Mental abuse includes but is not limited to:
- Humiliation.
- Harassment.
- Threats of punishment.
- Threats of deprivation.

Sexual Abuse

Includes, but is not limited to:
- Sexual harassment
- Sexual coercion
- Sexual assault

10

Slide 3-R-10

Sexual Abuse

This is defined in the *SOM* (F223). Sexual abuse includes but is not limited to:
- Sexual harassment.
- Sexual coercion.
- Sexual assault.

Neglect

- Failure to provide goods & services necessary to avoid physical harm, mental anguish or mental illness
- Defined at 42 CFR 488.301

11

Slide 3-R-11

Neglect

Neglect constitutes a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. This is defined by 42 CFR 488.301.

Audiovisual

Outline or text of presentation

Involuntary Seclusion

Separation of resident from other residents or from his/her room or confinement to his/her room against resident's will or will of resident's legal representative

12

Slide 3-R-12

Involuntary Seclusion

Separating a resident from other residents or from his/her room, or confinement to his/her room against the resident's will (or the will of the resident's legal representative) constitutes involuntary seclusion. This is defined in the *SOM* (F223).

Possible Signs & Symptoms of Abuse

- Bruises, black eyes, welts, lacerations, skin tears, rope marks & imprint injuries
- Fractures, open wounds, cuts, punctures, sprains & dislocations
- Unexplained venereal disease or infections
- Unexplained vaginal or rectal bleeding

13

Slide 3-R-13

Possible Signs and Symptoms of Abuse

- Bruises, black eyes, welts, lacerations, skin tears, rope marks and imprint injuries.
- Fractures, open wounds, cuts and punctures.
- Sprains and dislocations.
- Unexplainable venereal disease or infections.
- Unexplainable vaginal or rectal bleeding.

Psychosocial Behaviors That May Indicate Abuse

- Unexplained restlessness
- Inexplicable timidity, shyness, reticence or withdrawn behavior
- Nervousness or exhibition of aimless wandering without provocation
- Lack of interaction between residents & staff

14

Slide 3-R-14

Psychosocial Behaviors That May Indicate Abuse

- Unexplained restlessness.
- Inexplicable timidity, shyness, reticence or withdrawn demeanor.
- Nervousness or exhibition of aimless wandering without provocation.
- Lack of interaction between residents and staff.

Audiovisual

Psychosocial Behaviors That May Indicate Abuse (cont.)

- Avoidance of staff attention with appearance of fear, anger, stress, defensiveness or anxiety
- Tearfulness or crying

15

Slide 3-R-15

Outline or text of presentation

- Avoidance of staff attention with the appearance of fear, anger, stress, defensiveness or anxiety.
- Tearfulness or crying.

Note: These signs alone would not constitute abuse, but would warrant further investigation.

Injury of Unknown Source

- Defined in CMS S&C 5-09
- Both of following conditions must be met:
  - Source is unobserved or unexplained by resident
  - Injury is suspicious because of 1 or more of following:
    - Extent
    - Number of injuries at one point in time
    - Location
    - Incidence of injuries over time

16

Slide 3-R-16

Definition of Injury of Unknown Source

An injury should be classified as an "injury of unknown source" when both of the following conditions are met:

- The source of the injury was not observed by any person or could not be explained by the resident.
- The injury is suspicious because of one or more of the following:
  - Extent of the injury.
  - Location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).
  - Number of injuries observed at one particular point in time.
  - Incidence of injuries over time.

(Refer to CMS Survey & Certification letter S&C 05-09.)

Audiovisual

Characteristics Associated with Abuse

Typical abusers are:
- Caregivers (nurse's aides & orderlies)
- Lowest-paid employees
- Staff who work in most understaffed areas
- Frequently males, new hires & individuals working second shift

17

Slide 3-R-17

Factors Contributing to Abuse & Neglect

- Job burnout
- Inability to manage conflict & stress
- Insufficient training
- Challenging personal life
- Economic burden
- Different cultural, racial, ethnic & class backgrounds

18

Slide 3-R-18

Factors Contributing to Abuse & Neglect (cont.)

- Staffing issues
- Lack of supervision of staff &/or residents

19

Slide 3-R-19

Outline or text of presentation

Characteristics Associated with Abuse

Research has been conducted on abuse in nursing homes and other institutional settings. In the institutional setting, Pillemer and Moore (1989) and McCartney and Campbell (1998) have shown that typical abusers are direct caregivers (nurse's aides and orderlies). They are also the lowest-paid employees and work in the most understaffed areas of the facilities. Some of the factors that lead to abuse and neglect include job burnout, inability to manage conflict, stress and insufficient training. In their study of abuse in intermediate care facilities for those with mental retardation (ICF/MRs) in six States, McCartney and Campbell (1998) found that perpetrators were frequently males, new hires and those working the second shift. Additional factors include a challenging personal life, economic burden and different cultural, racial, ethnic and class backgrounds.

Other factors include staffing issues and lack of supervision of staff and/or residents.

Audiovisual

Characteristics of Residents at Risk

- Dependence
- Frailty
- Mental or physical incapacitation
- Chronic illness
- Impaired vision, hearing, mobility

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Slide 3-R-20

Characteristics of Residents at Risk (cont.)

- Physical disability
- Maladaptive behaviors, including verbal or physical aggression
- Inadequate social supports

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Slide 3-R-21

Abuse Prohibition Review

The objectives of this task are to:

- Determine whether facility has developed & implemented policies & procedures for screening & training employees
- Verify facility's policies for protection of residents

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Slide 3-R-22

Outline or text of presentation

Characteristics of Residents at Risk

Characteristics of those receiving services who are at an increased risk for abuse and neglect include:

- Dependence.
- Frailty.
- Mental or physical incapacitation.
- Chronic illness.
- Impaired vision, hearing or mobility.
- Physical disability.
- Maladaptive behaviors, including verbal or physical aggression.
- Inadequate social supports.

(If applicable, review the State definitions and requirements and discuss any discrepancies or differences.)

Abuse Prohibition Review

The purpose of the abuse prohibition review is to ensure that the facility has done everything within its control to prevent these types of adverse occurrences. The objectives of the review are to:

- Determine whether the facility has developed and implemented policies and procedures for screening and training employees.
- Verify the facility's policies for protection of residents.

Audiovisual

Abuse Prohibition Review (cont.)

- Identify prevention, identification, investigation & reporting of abuse, neglect, mistreatment & misappropriation of property

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Slide 3-R-23

Outline or text of presentation

- Identify the prevention, identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of property.

How do you, as the surveyor, complete this portion of the survey process?

Reporting Abuse & Neglect

- Mandatory
- Often underreported:
  - Lack of awareness of reporting duties
  - Fear of recrimination for whistle-blowing
  - Lack of sanctions for failing to report
  - Fear of retaliation against victim or person making allegation
  - Lack of knowledge of what constitutes abuse or neglect

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Slide 3-R-24

Abuse Prohibition Protocol

- Specific protocol for evaluating abuse prohibition
- Should be used on every standard survey & complaint investigation in which violations of 42 CFR 483.13(b) are substantiated

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Slide 3-R-25

Abuse Prohibition Protocol

There is a specific protocol to follow when evaluating abuse prohibition. The protocol must be used on every standard survey and every complaint investigation in which violations of 42 CFR 483.13(b) are substantiated.

One surveyor should be assigned to conduct the review of abuse prohibition at the facility. However, during the survey process, the survey team can and should assist with interviews to evaluate the facility's abuse prohibition and prevention.

Audiovisual

Abuse Prohibition Protocol (cont.)

- Obtain & review facility's abuse prohibition policies & procedures
  - Do not have to be maintained in 1 document or manual
- Ask facility staff to identify policies & procedures for you

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Slide 3-R-26

7 Mandatory Components in Abuse Prevention Policies & Procedures

- Screening
- Training
- Prevention
- Identification

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Slide 3-R-27

7 Mandatory Components in Abuse Prevention Policies & Procedures (cont.)

- Investigation
- Protection
- Reporting/response

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Slide 3-R-28

Outline or text of presentation

The procedure is as follows:

- Obtain and review the facility's abuse prohibition policies and procedures to determine whether they include the seven mandatory components (see Guidance to Surveyors at F226).
  - These policies and procedures do not have to be collected in one document or manual.
- If you have problems identifying how the facility has developed and operationalized policies and procedures in accordance with abuse prohibition, ask facility staff to identify the policies and procedures for you.

Seven Mandatory Components in Abuse Prevention Policies and Procedures

- Screening.
- Training.
- Prevention.
- Identification.
- Investigation.
- Protection.
- Reporting/response.

Audiovisual

Screening

Verify that facility screened prospective employees for history of abuse, neglect, mistreatment, etc.

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Slide 3-R-29

Outline or text of presentation

Screening

Verify that the facility screened prospective employees for history of abuse, neglect, mistreatment, etc.

Examples of Screening

- Attempting to obtain information from previous employers, such as reference checks
- Checking with licensing boards or registries such as checking nurse licenses & nurse's aide certifications

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Slide 3-R-30

Examples of Screening

- Attempting to obtain information from previous employers, such as reference checks.
- Checking with licensing boards or registries such as checking nurse licenses and nurse's aide certifications.

Training

- For *all* staff
- Orientation & ongoing sessions
- Should cover:
  - Dealing with aggressive behaviors
  - Reporting allegations
  - Recognizing signs (burnout, frustration, stress) that may lead to abuse
  - Recognizing signs of abuse, neglect & misappropriation of resident property

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Slide 3-R-31

Training

The facility's policies should address the training of all employees, through orientation and ongoing sessions, about:

- Appropriate interventions to deal with aggressive behaviors.
- How staff should report allegations without fear of reprisal or retaliation.
- How to recognize signs of burnout, frustration and stress that may lead to abuse.
- How to recognize signs of abuse, neglect and misappropriation of property.

Audiovisual

Prevention

Procedures should cover:
- Reporting concerns, incidents, grievances:
  - How
  - To whom
- Providing feedback to those who make reports:
  - Residents
  - Families
  - Staff

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Slide 3-R-32

Prevention (cont.)

Policies should address:
- Provision of information to residents, families & staff on how & to whom to report concerns, incidents or grievances
- Deployment of staff
- Supervision of staff

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Slide 3-R-33

Prevention (cont.)

- Monitoring of residents
- Ongoing monitoring by facility of implementation of policies & procedures for preventing abuse, neglect, etc.
  - Possibly thorough quality assurance committee

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Slide 3-R-34

Outline or text of presentation

Prevention

The facility's procedures should provide residents, families and staff with information on how to and to whom they may report concerns, incidents and grievances and provide feedback to them regarding these issues.

Audiovisual

Identification

Facility procedures should be proactive to identify events such as:
- Suspicious bruising/injuries of unknown origin
- Unexplained occurrences
- Patterns & trends that may constitute abuse

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Slide 3-R-35

Outline or text of presentation

Identification

The facility's procedures should be proactive in order to identify events, to determine the direction of the investigation.
- Suspicious bruising/injuries of unknown origin.
- Unexplained occurrences.
- Patterns and trends that may constitute abuse.

Investigation

Procedures should:
- Include measures for investigating different types of incidents
- Identify staff members responsible for initial reporting & investigation
- Include information regarding reporting results to proper authorities
- Ensure timely, thorough & objective investigation of all allegations of abuse, neglect or mistreatment

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Slide 3-R-36

Investigation

The facility's procedures should:
- Include measures to investigate different types of incidents.
- Identify staff members responsible for the initial reporting and investigation.
- Include information regarding reporting results to the proper authorities.
- Ensure a timely, thorough and objective investigation of all allegations of abuse, neglect or mistreatment.

Protection

Procedures should address protection of residents from harm & retaliation during investigation of allegation of abuse, neglect or mistreatment

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Slide 3-R-37

Protection

The facility should have procedures to protect residents from harm and retaliation during the investigation of an allegation of abuse, neglect or mistreatment.

Audiovisual

Reporting/Response

- Facility should have procedures requiring that all alleged violations of abuse & neglect be reported to administrator, including:
  - Injuries of unknown origin
  - Misappropriation of resident property

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Slide 3-R-38

Outline or text of presentation

Reporting/Response

The facility should have procedures to report all alleged violations of abuse and neglect to the administrator including:

- Injuries of unknown origin.
- Misappropriation of resident property.

Reporting/Response (cont.)

- Facility must immediately report:
  - All alleged violations involving mistreatment, neglect or abuse
  - Injuries of unknown source
  - Misappropriation of resident property
- Report must be made to:
  - Facility administrator
  - Other officials in accordance with State law through established procedures
    - Including State survey & certification agency

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Slide 3-R-39

The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey & certification agency).

Reporting/Response (cont.)

- Reports of all investigations must be made within 5 working days of incident to:
  - Administrator or his/her designated representative
  - Other officials in accordance with State law
- Appropriate action must be taken if alleged violation is verified

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Slide 3-R-40

Reports of all investigations must be made within five working days of the incident to the administrator or his/her designated representative and to other officials, including the State survey & certification agency, in accordance with State law. If the alleged violation is verified, the facility must take appropriate action to safeguard the residents.

- See 42 CFR 483.13(c)(2) and (4).
- Refer to CMS Survey & Certification letters S&C 05-09 and S&C 02-20.

Audiovisual

Reporting Abuse to Law Enforcement

- When SA or RO *substantiates* finding of abuse, SA or RO must report *substantiated findings* to local law enforcement &, if appropriate, Medicaid Fraud Control Unit

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Slide 3-R-41

Outline or text of presentation

Reporting Abuse to Law Enforcement

When the State agency or Regional Office *substantiates* a finding of abuse, the State agency or Regional Office must report the *substantiated findings* to local law enforcement and, if appropriate, the Medicaid Fraud Control Unit.

Interview with Policy Coordinator

Determine:

- How abuse prohibition policies are instituted
- How staff are monitored to ensure care is provided

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Slide 3-R-42

Interview with Policy Coordinator

Interview the individual(s) identified by the facility as responsible for coordinating the facility's abuse prohibition policies and procedures to evaluate how each component of the policies and procedures is instituted. If the policies and procedures seem unclear, ask the following questions:

- How is each component of the policies and procedures instituted?
- How does the facility monitor the staff providing and/or supervising the delivery of resident care and services to ensure that care is provided as needed?
- How does the facility ensure that residents, families and staff feel free to communicate concerns and allegations of abuse without fear of reprisal?

Interview with Policy Coordinator (cont.)

- How facility ensures that residents, families & staff feel free to communicate concerns & allegations without fear of reprisal

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Slide 3-R-43

Audiovisual

Reviewing Abuse Investigations

- Review 2 or 3 alleged violations since last survey
  - Request written evidence of how allegation was handled
  - Review facility's investigations for adequacy

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Slide 3-R-44

Outline or text of presentation

Reviewing Abuse Investigations

- Request written evidence of how the facility has handled alleged violations of abuse prohibition policies.
- Select two or three alleged violations of these policies (if the facility has this many) since the previous State review of the facility's abuse prohibition.
- Review the facility's investigations of these alleged violations.

Investigating Facility's Policy

Compare the facility's policy to the investigations and regulatory requirements (F225) to determine whether the facility has implemented adequate procedures:

- Reporting and thoroughly investigating.
- Protection of the resident during the investigation.
- Provision of corrective action.

Determine whether the facility has reevaluated and revised applicable procedures as necessary.

The reporting requirements at 42 CFR 483.13(c)(2), (3) and (4) specify that both a report of every alleged violation of the facility's abuse prohibition policies and a report of the results of the facility's investigation of the alleged violation must be made to the State survey agency.

Audiovisual

Outline or text of presentation

Investigation of Allegations of Abuse or Neglect

Aimed at determining:
- Whether abuse or neglect has occurred
- Extent of abuse &/or neglect
- Causative factors
- Interventions to prevent further injury

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Slide 3-R-45

Critical Components of Internal Investigation

- Initial evaluation & interview
- Conducting:
  - Observation
  - Interviews
  - Record review
- Acquiring relevant history of past abuse & neglect incidents

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Slide 3-R-46

Critical Components of an Internal Investigation

- Initial evaluation and interview.
- Conducting:
  - Observation.
  - Interviews.
  - Record review.
- Acquiring relevant history of past abuse and neglect incidents.

Initial Evaluation & Interview

Facility's procedures must ensure:
- Identification of all persons involved:
  - Alleged victim
  - Alleged perpetrator
  - Witnesses
  - Others with relevant knowledge

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Slide 3-R-47

Initial Evaluation and Interview

- All involved persons should be identified, including the alleged victim, perpetrator, witnesses and others with knowledge of the allegation.
- A thorough examination should be conducted.
- Witnesses should be interviewed as soon as possible with results documented in the individual's words.

Audiovisual

Outline or text of presentation

Initial Evaluation
& Interview (cont.)

- Thoroughness of examination
- Interviewing of witnesses as soon as possible after incident
- Documentation of interviews in individual's own words

48

Slide 3-R-48

Reporting Results

- Facility's procedures must ensure timely reporting of allegation & results of investigation to local & State authorities
- Report must:
  - Identify specific problem
  - Detail findings of investigation
  - Facilitate corrective action

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Slide 3-R-49

Reporting the Results of the Investigation

- After the allegation has been thoroughly investigated, the provider must ensure proper and timely reporting of the incident to local and State authorities.
- The report must identify the specific problem, inform those concerned of the investigation findings and facilitate corrective action.

Interviewing Residents & Families

- Do residents & their families know *how* to:
  - File allegations?
  - Report incidents?
  - Make complaints?
- Do residents & their families know *to whom* they should address these matters?

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Slide 3-R-50

Interviewing Residents and Families

Interview several residents and families regarding:

- Awareness of to whom and how to report allegations, incidents and/or complaints (see F156 and CMS Survey & Certification letter S&C 02-20).
- This information can be obtained through the resident, group and family interviews at Sub-Task 5D.

Audiovisual

Outline or text of presentation

Interviewing Residents & Families (cont.)

- Information can be obtained through resident, group & family interviews

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Slide 3-R-51

Interviewing Direct-Care Staff

- At least 5
- All 3 shifts
- Include activity staff & nurse's assistants

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Slide 3-R-52

Interviewing Direct-Care Staff (cont.)

- Do they know:
  - How to intervene if residents have aggressive or catastrophic reactions?
  - What to report, when & to whom?
  - How to recognize forms of abuse & neglect & indicators of them?

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Slide 3-R-53

Interviewing Direct-Care Staff

Interview at least five direct-care staff representing all three shifts, including the activity staff and nurse's assistants, to determine:

- Whether staff have been trained in and are knowledgeable about how to appropriately intervene in situations involving residents who have aggressive or catastrophic reactions. (A catastrophic reaction is an extraordinary reaction by a resident to an ordinary stimulus, such as the attempt to provide care. There is a more definitive explanation in Appendix P of the *SOM*.)
- Whether staff are knowledgeable regarding what, when and to whom to report according to facility policies.
- Whether staff are able to recognize various forms of abuse and neglect and able to recognize potential indicators of abuse and neglect.

Audiovisual

Interviewing
Front-Line Supervisors

- Select supervisors of staff with direct resident interaction:
  - Nursing
  - Dietary
  - Housekeeping
  - Activities
  - Social services

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Slide 3-R-54

Outline or text of presentation

Interviewing Front-Line Supervisors

- Interview at least three front-line supervisors of staff who interact with residents (nursing, dietary, housekeeping, activities, social services).

Interviewing
Front-Line Supervisors (cont.)

- How do supervisors monitor:
  - Provision of care & services?
  - Staff-resident interactions?
  - Deployment of staff to meet residents' needs?
  - Potential for staff burnout?

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Slide 3-R-55

- Determine how they monitor the provision of care and services, the staff/resident interactions, deployment of staff to meet the residents' needs and the potential for staff burnout, which could lead to residential abuse.

Reviewing Recent Hiring

Determine whether facility conducted adequate prescreening prior to hiring:

- Reference checks
- Licenses & certifications
- Evidence that employee does not have previous history of abuse, neglect or mistreatment

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Slide 3-R-56

Reviewing Recent Hiring

Obtain a list of all staff the facility has hired within the previous five months. Select five individuals from this list and ask the facility to provide written evidence of prescreening conducted based on the regulatory requirements at 42 CFR 483.13(c). Determine whether the following prescreening occurred:

- Reference checks.
- Licenses and certifications.
- Evidence that the employee does not have a previous history of abuse, neglect or mistreatment.

Audiovisual

Outline or text of presentation

Conclusion of Investigation

Once you have completed all the requirements of the survey task, you and the rest of the team must determine whether or not the facility is in compliance with the regulatory requirements at 42 CFR 483.13(c).

The facility is in compliance when it has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of their property. If it has not, a citation must be written.

Determine whether or not the facility has taken appropriate actions in the areas of:

- Screening.
- Training.
- Prevention.
- Identification.
- Investigation
- Protection.
- Reporting/response.

If it has not, it is not in compliance with requirements at 42 CFR 483.13(c)(1), (2) and (3) and a citation must be written at that number.

(Have students watch the video "At the End of the Day," record their reactions on the copy of the handout "Exercise for Abuse Prohibition Review" on page 3-R-29 and discuss their responses.)

Audiovisual

Lesson 3-R:
Abuse Prohibition Review

Questions

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Slide 3-R-57

Outline or text of presentation

Skill Assessment

Abuse Prohibition Review

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Described the various forms of abuse and neglect.	
					Explained the possible indicators of abuse and neglect.	
					Determined whether a provider developed and implemented policies and procedures to prohibit abuse, neglect, mistreatment, involuntary seclusion, and misappropriation of resident property.	
					Collected and reviewed appropriate information from facility staff: • Policies and procedures (reviewed for adequacy). • Alleged violations of abuse prohibition policies (reviewed to determine whether appropriate conclusions obtained).	

					• List of employees hired within past four months (reviewed for prescreening measures).	
					Conducted interviews with residents, families and staff.	

Comments/Recommendations:

Exercise for Abuse Prohibition Review

Watch *At the End of the Day*, an award-winning video illustrating an abusive situation that occurs in a nursing home. Although the scenario takes place in a specific long term care setting, the issues are applicable to all settings. Use the following questions as a basis for discussion of the video:

1. What are your general reactions to the video?

2. Does the video present a realistic scenario?

3. How do each of the seven key components of abuse prohibition policies and procedures apply to the scenario?

4. How would you respond to the incident presented in the video if you were called to investigate?

5. What could have been done differently to prevent this scenario from occurring?

6. What are the facility's failures?

7. Do you think abuse has occurred? If so, what evidence do you have?

8. Is there deficient practice? If so, what tag(s) could be considered and why?

Lesson 3-S: Nursing Services Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the evaluation of a facility's nursing services.
- Apply the concept of surveying for nursing services to situations commonly encountered during the survey process.
- Describe the concept of surveying for nursing services compliance:
  - Determine whether nursing staff is sufficient for the facility.
  - Determine whether qualifications for all nursing staff are in accord with Federal and State regulations.
  - Determine whether agency staff employed at the facility meet the Federal and State regulations.
- Demonstrate:
  - Correct procedure for review of licensed and registered staff information/files.
  - Correct use of nursing services protocol.

Lesson Plan

References

Federal

- *Code of Federal Regulations:*
  - 42 CFR 483.30, Nursing Services

State

(Insert State reference[s] here.)

Other

Highlights

- Presentation of the concept of "sufficient nursing staff"
- The concept of the appropriate credentials for each level of nursing services
- Definition and guidance regarding negative outcomes

Training Techniques

- Lecture
- Group discussion
- Small group exercise using case study example developed by the SAT

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Videos:
  - *Surveying for Long Term Care Nursing Services*
  - *Chemical and Physical Restraints*
- Webcasts, and video or CD-ROM:
  - *Basic Medications in Nursing Homes*
  - *Pressure Ulcers and Nutritional Implications*
  - *Enteral Feeding*
  - *Fall Prevention*
  - *Standards of Care and Strategies for Immunizing Nursing Home Residents*
  - *Incontinence*
  - *Urinary Incontinence*
  - *Pain Management*
  - *Forensic Wound Identification and Documentation*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during an actual survey

Audiovisual

Outline or text of presentation

Lesson 3-S:
Nursing Services
Survey Process

1

Slide 3-S-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the evaluation of a facility's nursing services.
- Apply the concept of surveying for nursing services to situations commonly encountered during the survey process.

2

Slide 3-S-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Describe the concept of surveying for nursing services compliance:
  - Determine whether nursing staff is sufficient for the facility.
  - Determine whether qualifications for all nursing staff are in accord with Federal & State regulations.
  - Determine whether agency staff employed at the facility meet the Federal & State regulations.

3

Slide 3-S-3

Audiovisual

Learning Objectives (cont.)

- Demonstrate:
  - Correct procedure for review of licensed & registered staff information/files.
  - Correct use of nursing services protocol.

4

Slide 3-S-4

Evaluation of Facility's Nursing Services

- At minimum, "staff" is defined as licensed nurses (RNs &/or LPNs/LVNs) & nurse's aides
- Nurse's aides must meet training & competency requirements described in 42 CFR 483.75(e)

5

Slide 3-S-5

Staffing Sufficiency

Determine nurse staffing sufficiency for each unit:

- Is there adequate staff to meet direct-care needs, assessments, planning, evaluation & supervision?
- Are direct-care staff able to complete work assignments within allotted time?
- Do residents, family & ombudsmen report insufficient staff to meet resident needs?

6

Slide 3-S-6

Outline or text of presentation

Evaluation of Facility's Nursing Services

- At a minimum, "staff" is defined as licensed nurses (RNs and/or LPNs/LVNs) and nurse's aides.
- Nurse's aides must meet the training and competency requirements described in 42 CFR 483.75(e).

Staffing Sufficiency

Determine nurse staffing sufficiency for each unit:

- Is there adequate staff to meet direct-care needs, assessments, planning, evaluation and supervision?
- Are the direct-care staff able to complete work assignments within the allotted time?
- Do residents, family and ombudsmen report insufficient staff to meet resident needs?

Audiovisual

Staffing Sufficiency (cont.)

- Are staff responding to & servicing residents' requests for assistance? Are call bells answered within 5 minutes?
- Do residents call out repeatedly for assistance without response from nursing staff?

7

Slide 3-S-7

Outline or text of presentation

- Are staff responding to and servicing residents' requests for assistance? Are call bells answered within five minutes?
- Do residents call out repeatedly for assistance without response from nursing staff?

Staffing Sufficiency (cont.)

- Are residents who are unable to call for help checked frequently (e.g., each half hour) for safety, comfort & positioning & to offer fluids & provision of care?
- Are identified care problems associated with specific unit or tour of duty?

8

Slide 3-S-8

- Are residents who are unable to call for help checked frequently (e.g., each half hour) for safety, comfort and positioning and to offer fluids and provision of care?
- Are identified care problems associated with a specific unit or tour of duty?

Staffing Sufficiency (cont.)

- Is there licensed nurse who serves as charge nurse (e.g., supervises provision of residential care) on each tour of duty (if not, does facility have official waiver for this requirement)?
- What does charge nurse do to remedy problems in nurse staff performance?

9

Slide 3-S-9

- Is there a licensed nurse who serves as a charge nurse (e.g., supervises the provision of residential care) on each tour of duty (if not, does the facility have an official waiver for this requirement)?
- What does the charge nurse do to remedy problems in nurse staff performance?

Audiovisual

Staffing Sufficiency (cont.)

- Does facility have services of RN available 8 consecutive hours per day, 7 days per week (if not, does facility have official waiver for this requirement)?

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Slide 3-S-10

Outline or text of presentation

- Does the facility have the services of an RN available eight consecutive hours per day, seven days per week (if not, does the facility have an official waiver for this requirement)?

Staffing Sufficiency (cont.)

- How does facility ensure that each resident receives nursing care in accordance with his/her needs & Care Plan on weekends, nights & holidays?

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Slide 3-S-11

- How does the facility ensure that each resident receives nursing care in accordance with his/her needs and Care Plan on weekends, nights and holidays?

Staffing Sufficiency (cont.)

- How does sufficiency (numbers & categories) of nursing staff affect facility's ability to identify problems & implement interventions related to quality of care, resident rights, quality of life or facility practices?

12

Slide 3-S-12

- How does the sufficiency (numbers and categories) of nursing staff affect the facility's ability to identify problems and implement interventions related to quality of care, resident rights, quality of life or facility practices?

Audiovisual

Investigative Protocol

- Determine whether facility has sufficient staff available to meet residents' needs
  - List of staff on duty at time of entrance conference

13

Slide 3-S-13

Investigative Protocol (cont.)

- Determine whether facility has licensed & registered nursing staff to provide & monitor care
  - Review nursing staff personnel files for active & current license verification

14

Slide 3-S-14

Investigative Protocol (cont.)

- Determine whether registered/licensed nursing staff are available to:
  - Supervise & monitor delivery of care by nursing assistants according to residents' needs & Care Plans
  - Assess residents' condition changes & implement interventions as indicated
  - Monitor mealtime activities to identify concerns or changes in residents' needs

15

Slide 3-S-15

Outline or text of presentation

Investigative Protocol

- Determine whether the facility has sufficient staff available to meet the residents' needs.
  - List of staff on duty at the time of the entrance conference.
- Determine whether the facility has licensed and registered nursing staff to provide and monitor care.
  - Review nursing staff personnel files for active and current license verification.

- Determine whether the registered/ licensed nursing staff is available to:
  - Supervise and monitor the delivery of care by nursing assistants according to residents' needs and care plans.
  - Assess residents' condition changes and implement interventions as indicated.
  - Monitor mealtime activities to identify concerns or changes in residents' needs.

Audiovisual

Investigative Protocol (cont.)

– Respond to nurse's aides' requests for assistance & assist as appropriate
– Remedy inappropriate or unsafe nursing assistants' techniques
– Identify training needs for nursing assistants
– Implement interventions to address any identified training needs

16

Slide 3-S-16

Outline or text of presentation

– Respond to nurse's aides' requests for assistance and assist as appropriate.
– Remedy inappropriate or unsafe nursing assistants' techniques.
– Identify training needs for the nursing assistants.
– Implement interventions to address any identified training needs.

Credentials

• Facility must employ on full-time, part-time or consultant basis those professionals necessary to carry out provision of services

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Slide 3-S-17

Credentials

- The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provision of services.
- Professional staff must be licensed, certified or registered in accordance with applicable State laws.
  – Verification of current and active license status must be confirmed with the appropriate State licensing agency or board.

Credentials (cont.)

• Professional staff must be licensed, certified or registered in accordance with applicable State laws
  – Verification of current & active license status must be confirmed with appropriate State licensing agency or board

18

Slide 3-S-18

Audiovisual

Nurse's Aide Qualifications

- Facilities may use, as nurse's aides:
  - Individuals who have successfully completed either accredited nurse's aide training or accredited competency evaluation program

19

Slide 3-S-19

Outline or text of presentation

Nurse's Aide Qualifications

- Facilities may use, as nurse's aides:
  - Individuals who have successfully completed either accredited nurse's aide training or an accredited competency evaluation program.

Nurse's Aide Qualifications (cont.)

- Facility must ensure that nurse's aides are able to demonstrate competency in skills & techniques necessary to care for residents' needs, as identified through resident assessments & described in Plan of Care
  - Include, when available, any accident or incident reports to identify that substandard care contributed to injury or harmed resident

20

Slide 3-S-20

- The facility must ensure that nurse's aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the Plan of Care.
  - Include, when available, any accident or incident reports to identify that substandard care contributed to the injury or harmed the resident.

Nurse's Aide Qualifications (cont.)

- If individual has not completed program at time of employment, facility may use individual as nurse's aide only if:
  - Individual is in nurse's aide training & competency evaluation program (not competency evaluation program alone) & individual is permanent employee in his/her first 4 months of employment in facility

21

Slide 3-S-21

- If an individual has not completed a program at the time of employment, a facility may use that individual as a nurse's aide only if:
  - The individual is in a nurse's aide training *and* competency evaluation program (not a competency evaluation program alone) *and* that individual is a permanent employee in his/her first four months of employment in the facility.

Audiovisual

Nurse's Aide Qualifications (cont.)

- Facility must receive registry verification that individual has met competency evaluation requirements unless:
  - Individual is full-time employee in training & competency evaluation program approved by State

22

Slide 3-S-22

Outline or text of presentation

- A facility must receive registry verification that the individual has met competency evaluation requirements unless:
  - The individual is a full-time employee in a training *and* competency evaluation program approved by the State.

Review Agency Staff

- It is responsibility of facility to confirm current & active license or registration status of any individual working in capacity of nursing staff for facility, including but not limited to agency staff
- Each facility is responsible for comprehensive orientation of individual to facility & unit

23

Slide 3-S-23

Review Agency Staff

- It is the responsibility of the facility to confirm current and active license or registration status of any individual working in the capacity of nursing staff for the facility, including but not limited to agency staff.
- Each facility is responsible for the comprehensive orientation of the individual to the facility and unit.

Survey Process

- Observe both licensed & unlicensed staff performing their duties during various times of day during survey
- Do nursing assistants:
  - Observe & describe resident behavior & status & report to charge nurse?
  - Follow instructions?
  - Carry out appropriate infection control precautions & safety procedures?

24

Slide 3-S-24

The Survey Process

Observe both licensed and unlicensed staff performing their duties during various times of the day during the survey. Do the nursing assistants:

- Observe and describe resident behavior and status and report to charge nurse?
- Follow instructions?
- Carry out appropriate infection control precautions and safety procedures?

Audiovisual

Interview of Residents

Discuss treatment & conditions of facility with residents:

- Are residents treated with dignity & respect?
- Are accommodations made for special needs or preferences?
- Are call lights answered promptly & do staff intervene appropriately to address residents' reasons for calls?

25

Slide 3-S-25

Outline or text of presentation

Interview of Residents

Discuss the treatment and conditions of the facility with residents:

- Are residents treated with dignity and respect?
- Are accommodations made for special needs or preferences?
- Are call lights answered promptly and do staff intervene appropriately to address the residents' reasons for the calls?

Interview of Residents (cont.)

- Are baths provided in accordance with residents' individual preferences?
- Are residents assisted with meals when needed?

26

Slide 3-S-26

- Are baths provided in accordance with the residents' individual preferences?
- Are residents assisted with meals when needed?
- Are staff assessing residents' feeding assistance needs for changes on a daily basis and providing timely assistance when indicated?
- Are residents who need assistance fed in a timely manner?

Interview of Residents (cont.)

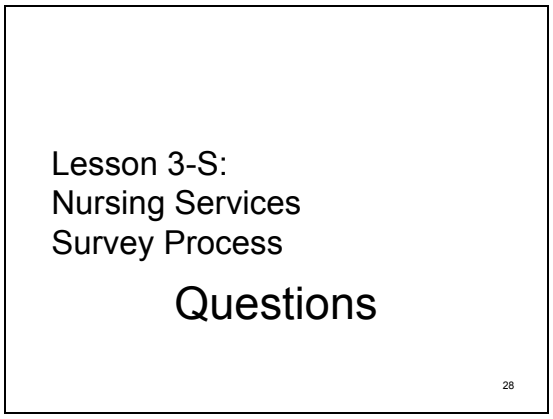
- Are staff assessing residents' feeding assistance needs for changes on daily basis & providing timely assistance when indicated?
- Are residents who need assistance fed in timely manner?

27

Slide 3-S-27

Audiovisual

Outline or text of presentation



Slide 3-S-28

Skill Assessment

Nursing Services Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified the objectives of this survey task.	
					Described the nursing services survey process.	
					Described the concept of surveying for nursing services in terms of situations encountered during the survey process.	
					Collected and reviewed appropriate information from the facility: • Determined whether the nursing staff is sufficient for the needs of the residents. • Determined whether nursing staff credentials are appropriate to the facility. • Determined whether residents are receiving proper care and treatment.	

					• Demonstrated: – Correct procedure for review of licensed and registered staff information/files. – Correct use of nursing services protocol.	

Comments/Recommendations:

Lesson 3-T: Infection Control Survey Component for Long Term Care

This lesson builds upon the infection control information in Lesson 2-H, Infection Control, and focuses on long term care survey issues.

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Investigate infection control issues in long term care correctly, using observation, interview and review.
- Make appropriate compliance decisions regarding infection control issues.
- Identify and demonstrate the ability to document noncompliance with Centers for Disease Control (CDC) infection control guidelines.
- Identify and demonstrate the ability to document noncompliance with infection control standards of practice.

Lesson Plan

References

Federal

- *Code of Federal Regulations:*
  - 42 CFR 483.65, Infection Control
- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities

State

(Insert State reference[s] here.)

Other

Highlights

- Explanation of infection control issues for surveyors
- Definition of and guidance regarding negative outcomes
- Definition of the surveyor's role in investigating infection prevention

Training Techniques

- Lecture
- Group discussion
- Small group exercise using State-developed scenarios

Training Aids

- PowerPoint slides and handouts
- Website: http://www.cdc.gov/
- Webcasts available from http://cms.internetstreaming.com:
  - *Flu and Pneumonia Immunization in Nursing Homes*
  - *Preventing the Spread of SARS*
- CMS videos:
  - *Wound Care*
  - *Pressure Ulcers*
- Chart pad with colored markers
- Calibrated thermometer to measure food and water temperatures
- Handouts:
  - *Tips for Surveying Infection Control*
  - *Infection Control Scenarios*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Outline or text of presentation

Lesson 3-T:
Infection Control Survey
Component for Long Term Care

1

Slide 3-T-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Investigate infection control issues in long term care correctly, using observation, interview & review.
- Make appropriate compliance decisions regarding infection control issues.

2

Slide 3-T-2

(Inform the students of the objectives.)

Learning Objectives (cont.)

- Identify & demonstrate the ability to document noncompliance with Centers for Disease Control (CDC) infection control guidelines.
- Identify & demonstrate the ability to document noncompliance with infection control standards of practice.

3

Slide 3-T-3

Audiovisual

Surveying Infection Control

- Determine whether facility has effective program to identify, investigate, control & prevent infection
- Identify regulations & interpretive guidelines pertaining to infection control (IC) in the *State Operations Manual*

4

Slide 3-T-4

Outline or text of presentation

Surveying Infection Control

Surveying infection control (IC) involves:

- Determining whether the facility has an effective program to identify, investigate, control and prevent infection.
- Identifying regulations and interpretive guidelines pertaining to IC in the *State Operations Manual*.

Surveying Infection Control (cont.)

- Apply current IC standards & practices to determine causes & means of transmission for infections or potential infections

5

Slide 3-T-5

- Applying current IC standards and practices to determine causes and means of transmission for infections or potential infections.

What General IC Standards Address

- Hand washing
- Respiratory protection
- Linen handling
- Housekeeping
- Needle & hazardous waste disposal
- Proper use of disinfectants, antiseptics & germicides, in accordance with manufacturer's instructions
- Other IC strategies

6

Slide 3-T-6

General IC Standards

A negative IC outcome is one that is avoidable and preventable if staff comply with basic rules of infection control practice. Examples of such rules include:

- Hand washing between services provided to residents.
- Using gloves and protective clothing as required by CDC guidelines:
  - Gloving is not a substitute for hand washing.

Audiovisual

Outline or text of presentation

- Hand washing between removing soiled dressings and applying new dressings:
  - Double gloving is not an acceptable technique for wound treatments and dressing changes.
- Correct linen handling.
- Correct linen disposal and laundry handling.
- Storing, holding and serving food at the correct holding temperatures.
- Storing medications at the correct temperatures and preparing them in a clean environment.

Surveying Standard IC Practices

- How does facility control spread of infection by visitors?
- What are IC policies for those with tuberculosis (TB), AIDS, hepatitis B or hepatitis C?

7

Slide 3-T-7

Surveying Standard IC Practices

Elements of surveying standard IC practices include:

- Facility control of the spread of infection by visitors.
- IC policies for those with tuberculosis, AIDS, hepatitis B or hepatitis C.

Surveying Standard IC Practices (cont.)

- Are residents isolated only to degree needed, in least restrictive way possible?
- Do staff know & follow facility policy & protocol on hand washing?

8

Slide 3-T-8

- Resident isolation only to the degree needed, in the least restrictive way.
- Hand-washing protocol.

Audiovisual

LTC Standards for IC

- Risk assessment for occurrence of communicable disease for residents & staff
- Measures to prevent communicable disease outbreaks (TB, scabies, flu, methycillin-resistant *Staphylococcus aureus*, etc.)

9

Slide 3-T-9

Outline or text of presentation

Long Term Care Standards for Infection Control

Long term care standards for IC include:

- Assessment of risk of occurrence of communicable disease for residents and staff.
- Measures to prevent communicable disease outbreaks: tuberculosis, scabies, flu, methicillin-resistant *Staphylococcus aureus* (MRSA), etc.

LTC Standards for IC (cont.)

- Procedures to inform & involve local or State epidemiologist as necessary
- Authority, indications & procedures for obtaining cultures & isolating residents

10

Slide 3-T-10

- Procedures to inform and involve a local or State epidemiologist as necessary.
- Authority, indications and procedures for obtaining cultures and isolating residents.

General Tour of Facility

- Cleanliness & environment
- Use of personal protective equipment
- Hand washing
  - Stations include soap & towels
- Linen handling
  - Clean: covered storage
  - Soiled: closed containers, off floor

11

Slide 3-T-11

General Tour of Facility

For infection control issues, observe:

- Cleanliness and environment.
- Use of personal protective equipment.
- Hand washing:
  - Stations include soap and towels.
- Linen handling:
  - Clean: covered storage.
  - Soiled: closed containers, off floor.

Audiovisual

General Tour of Facility (cont.)

- Appropriate storage of supplies:
  - Clean: utility room separate from soiled utility room, with no direct connection
  - Clean: hand-washing station & work counter
  - Soiled: clinical sink, hand-washing station, work counter, separate covered containers for soiled linen & waste
- Isolation technique, as necessary
- Correct handling of infectious waste

12

Slide 3-T-12

Outline or text of presentation

- Appropriate storage of supplies:
  - Clean: utility room separate from soiled utility room, with no direct connection.
  - Clean: hand-washing station and work counter.
  - Soiled: clinical sink, hand-washing station, work counter, separate covered containers for soiled linen and waste.
- Isolation technique, as necessary.
- Correct handling of infectious waste.

Errors in IC Technique

During LTC facility tour:

- If failures to follow standard technique noted, verify system in place to monitor staff IC practices
- Ask direct caregiver staff what they do & whom they notify when signs of infection are noted (see 42 CFR 483.65)

13

Slide 3-T-13

Errors in IC Technique

During the LTC facility tour:

- If failures to follow standard technique are noted, verify that there is a system in place to monitor staff IC practices. Some examples of failure to follow standard techniques are:
  - When donning gloves, contaminating the outside of the glove with the ungloved hand (i.e., putting on the glove in the same way you would put on a winter glove, without concern for the clean outside surface).
  - Failing to remove gloves and wash hands between glove changes or when double gloving.
  - Using the same cleaning gauze on more than one wound site when the first site is infected and draining and the second is not.
  - Continuing with a dressing change and treatment to the sacral or ischial area when the resident has become incontinent of stool and the field is soiled.

Audiovisual

Outline or text of presentation

– Other nontreatment examples:
  - Nursing assistant observed walking down the hall with soiled linen clutched to his/her chest area and not in a bag.
  - Isolation linen not noted as such.
- Ask direct caregiver staff what they do and whom they notify when signs of infection are noted (see 42 CFR 483.65).

Long Term Care Challenges

Current standards address measures for prevention of infections associated with:

- Intravenous therapy
- Indwelling catheters
- Tracheostomy care
- Stoma care
- Respiratory care
- Immunosuppression
- Pressure sores
- Bladder & bowel incontinence
- Factors compromising resident's resistance to infection

14

Slide 3-T-14

Long Term Care Challenges

Current standards for LTC address measures for prevention of infections associated with:

- Intravenous therapy.
- Indwelling catheters.
- Tracheostomy care.
- Stoma care.
- Respiratory care.
- Immunosuppression.
- Pressure sores.
- Bladder and bowel incontinence.
- Factors compromising a resident's resistance to infection.

Flu & Pneumonia Immunizations

- Ask whether immunizations have been offered to all residents & staff
- Interview:
  - Administrator
  - Director of nursing
  - Medical director
- Review clinical record to determine compliance

15

Slide 3-T-15

Flu and Pneumonia Immunizations

- Ask whether immunizations have been offered to all residents and staff.
- Interview:
  - Administrator.
  - Director of nursing.
  - Medical director.
- Review clinical record to determine compliance.

Audiovisual

Outline or text of presentation

Air Movement

- Air flow should be from "clean to less clean" using "tissue test":
  - Does vacuum in air exhaust in bath & utility rooms have sufficient strength to hold 2 pieces of toilet tissue against ceiling vent?
- Air flow from rooms with contamination or odor problems exhausted to outside
- Vents clean & free from dust & soil

16

Slide 3-T-16

Air Movement

- Air flow should be from "clean to less clean"—use the "tissue test":
  - Does the vacuum in the air exhaust in bath and utility rooms have sufficient strength to hold two pieces of toilet tissue against the ceiling vent?
- Air flow from rooms with contamination or odor problems should be exhausted to the outside.
- Vents should be clean and free from dust and soil.

Pressure Ulcer

- Was standard of practice technique used during dressing changes?
  - Hand washing?
  - Correct disposal of soiled dressing?

17

Slide 3-T-17

Pressure Ulcer

- Was standard of practice technique used during dressing changes?
  - Hand washing?
  - Correct disposal of soiled dressing?

Pressure Ulcer (cont.)

- Was treatment current?
  - Did staff technique follow standard of practice?
    - Potential for cross-contamination present?
  - Was drainage present?
    - Color
    - Odor
    - Amount

18

Slide 3-T-18

- Was treatment current?
  - Did the staff technique follow standard of practice?
    - Potential for cross-contamination present?
  - Was drainage present?
    - Color.
    - Odor.
    - Amount.

Audiovisual

Urinary Tract Infection

- Do staff provide:
  - Proper peri-care?
    - Requires interview & observation
  - Linen changes to prevent residents' sitting or lying in soiled linens?
    - Requires surveyor observation & resident interview

19

Slide 3-T-19

Outline or text of presentation

Urinary Tract Infection

- Do staff provide proper peri-care?
  - Requires interview and observation.
- Are linen changes made to prevent residents' sitting or lying in soiled linens?
  - Requires surveyor observation and resident interview.

Urinary Tract Infection (cont.)

- Catheter care & handling—observation & interview:
  - Standards of practice followed in transfer to prevent backflow of urine?
  - Catheter necessary by medical diagnosis?

20

Slide 3-T-20

- Catheter care and handling—observation and interview:
  - Standards of practice followed in transfer to prevent backflow of urine?
  - Catheter necessary by medical diagnosis?

Therapy Department IC Issues

Verify:

- Written procedures for hand washing & cleanliness of whirlpools, paraffin baths, moist hot pack units
- Procedures for soiled linen removal & storage
- Pest control program
- Electrical checks regularly performed on equipment

21

Slide 3-T-21

Therapy Department IC Issues

Verify:

- Written procedures for hand washing and cleanliness of whirlpools, paraffin baths and moist hot pack units.
- Procedures for soiled linen removal and storage.
- Pest control program.
- Electrical checks regularly performed on equipment.

Audiovisual

Kitchen & Food Service

- Food handling:
  - Safety precautions
- Food preparation:
  - Area cleanliness maintained?
  - Pest management systems in place?

22

Slide 3-T-22

Outline or text of presentation

Kitchen and Food Service

- Food handling:
  - Safety precautions.
- Food preparation:
  - Area cleanliness maintained?
  - Pest management systems in place?

Kitchen & Food Service (cont.)

- Food storage:
  - Correct holding temperatures?
- Hazard analysis & critical control point:
  - Observed?
- Dishwasher:
  - Correct water temperature maintained?
- Wash & rinse sinks:
  - Correct wash & sanitizing agents?

23

Slide 3-T-23

- Food storage:
  - Correct holding temperatures?
- Hazard analysis and critical control point:
  - Observed?
- Dishwasher:
  - Correct water temperature maintained?
- Wash and rinse sinks:
  - Correct wash and sanitizing agents?

Infection through Linens

- Do staff know & follow facility policy for handling linen?
- Linens processed, transported, stored & handled properly?
- Contact between clean & soiled linen?

24

Slide 3-T-24

Infection through Linens

- Do staff know and follow the facility policy for handling linen?
- Are linens processed, transported, stored and handled properly?
- Is there contact between clean and soiled linen?

Audiovisual

Infection through Linens (cont.)

- Soiled linen storage areas well ventilated & maintained under relative negative air pressure?
- Staff understand isolation linen handling precautions?

25

Slide 3-T-25

Outline or text of presentation

- Are soiled linen storage areas well ventilated and maintained under relative negative air pressure?
- Do staff understand isolation linen handling precautions?

Linen Handling by Staff

- Surveyor observations should include:
  - Hand washing when required?
  - Linens held away from clothing?
  - Linen bags closed?
  - Linen hampers covered?
  - Clean linens covered?

26

Slide 3-T-26

Linen Handling by Staff

Surveyor observations should include:

- Hand washing when required?
- Linens held away from clothing?
- Linen bags closed?
- Linen hampers covered?
- Clean linens covered?

Linen Handling by Laundry

- Surveyor observations should include:
  - Is hazardous waste identified?
  - Do staff wear protective clothing?
  - Is water temperature or bleach rinse sufficient to provide disinfection?
  - Do staff understand standard precautions?

27

Slide 3-T-27

Linen Handling by Laundry

Surveyor observations should include:

- Is hazardous waste identified?
- Do staff wear protective clothing?
- Is the water temperature or bleach rinse sufficient to provide disinfection?
- Do staff understand standard precautions?

Audiovisual

IC in Respiratory Care

- Do respiratory staff process any patient care equipment?
  - Where?
  - How?
- Who does electrical checks on equipment?
- Do respiratory practitioners follow standard infection control practices, approved by committee that includes IC practitioner?

28

Slide 3-T-28

Outline or text of presentation

IC in Respiratory Care

- Do respiratory staff process any patient care equipment?
  - Where?
  - How?
- Who does the electrical checks on equipment?
- Do respiratory practitioners follow standard infection control practices, approved by a committee that includes an infection control practitioner?

(Review the handout "Tips for Surveying Infection Control" on page 3-T-19 with the students. Then allow them to silently read and underline areas of infection control concern in the handout "Infection Control Scenarios" on page 3-T-21. Discuss the scenarios with the class.)

Lesson 3-T:
Infection Control Survey
Component for Long Term Care

Questions

29

Slide 3-T-29

Skill Assessment

Infection Control Survey Component for Long Term Care

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Investigated infection control issues correctly, using observation, interview and review.	
					Made appropriate compliance decisions regarding infection control issues.	
					Identified and demonstrated the ability to document noncompliance with CDC infection control guidelines.	
					Identified and demonstrated the ability to document noncompliance with infection control standards of practice.	

Comments/Recommendations:

Tips for Surveying Infection Control

What to observe:

- Medication passes.
- Wound care.
- Hand-washing technique.
- Use of personal protective equipment.
- Gowning and gloving for isolation.
- Instrument processing.

Whom to interview:

- IC practitioner or person responsible for IC policy.
- Medical director.
- Quality assurance coordinator or risk manager.
- Nurse managers.
- Director of housekeeping.

What documents to review:

- Infection control log.
- Minutes of IC committee meeting.
- Laboratory results.
- Medical records.
- In-service records.
- Employee health records.
- Policies and procedures:
  - Hand washing.
  - Housekeeping.
  - Linen handling.
  - Infectious waste.
  - Isolation.
  - Aseptic technique.

Infection Control Scenarios

Underline and prepare to discuss with the class the areas of infection control concern in the following scenarios.

Surveyors have been completing the tour phase of a survey. They have observed the following:

- A container of warm milk is on the window ledge in Resident 16's room at 10:15 a.m. Upon interviewing the resident, the surveyor learns that the milk is left over from breakfast the day before. The resident tells the surveyor, "The nursing assistant always puts it there in case I want it at lunch." When questioned, the resident states that she has been routinely drinking the milk after dinner as her late-night snack. The expiration date on the milk carton is June 12, which is 10 days before the surveyor sees the milk. When the surveyor asks the resident's permission to test the temperature of the milk, it is found to be 76° F. Further interview reveals that the resident has been experiencing some "off-and-on bouts of diarrhea," for which no one could find a cause. This has interfered with her attending many of her favorite activities.
- During the tour of the skilled short stay unit, the surveyor sees five residents' rooms (234, 235, 236, 241 and 243) noted as having contact isolation precautions. The surveyor observes the nursing assistant carrying soiled laundry from one of the rooms (235). This linen is in a pillowcase being held against the uniform of the nursing assistant and not contained in an isolation linen bag. Upon questioning, the nursing assistant informs the surveyor that she does not know why the resident is on isolation. An interview with the charge nurse reveals the resident in question is isolated for an MRSA wound that is draining and requires frequent dressing changes. The interview also reveals that the facility has had a number of residents with new MRSA issues.
- The surveyor observes the nursing assistant deposit the soiled linen from room 235 in the regular linen hamper, leave the lid open, and, without washing her hands, go to answer another resident's call light (244). The second resident is assisted on the bedpan. The nursing assistant then returns to room 235 and feeds that resident without washing her hands. The second resident (19) in room 244 is a new admission for rehabilitation after total hip replacement. This resident is not on contact isolation and has a healing surgical wound.
- Surveyor observation of the medication room reveals:
  - The countertop is soiled with spilled medications.
  - The medication refrigerator has a temperature of 58° F. Along with injectable antibiotics and various insulins, it contains residents' snacks, some of which are dated from the week before.
- The temperature in the walk-in refrigerator is 56° F. Uncovered chicken for the dinner meal is defrosting in a shallow pan, from which the water is dripping on the uncovered salad to be served at lunch. There are no deliveries being made at the time of the surveyor observation, and the refrigerator door has been closed since tray line service started 30 minutes prior, according to the food service manager.

- Observation of the breakfast tray line reveals that:
  - The turkey sausage is being held at 120° F (per surveyor temperature measurement).
  - The scrambled eggs are being held at 100° F (per surveyor temperature measurement).
  - The toast is not being held in a warming oven.
  - The milk is out on a tray, unchilled. Milk temperature taken at the time of observation is 58° F (per surveyor temperature measurement).

Lesson 3-U: Information Analysis for the Survey Process

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Define a deficiency.
- Determine whether substandard quality of care exists.
- Demonstrate knowledge of tools used to determine severity and scope.

Lesson Plan

References

Federal

- *Code of Federal Regulations:*
  - 42 CFR 483
- *State Operations Manual (SOM):*
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I, Deficiency Categorization
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities

State

(Insert State reference[s] here.)

Other

- Klein Associates Inc. (2003, September 30; revised 2004, March 16). *Understanding the Cognitive Challenges of Surveying Long-Term Care Facilities* (Order # CMS 02-00284). Fairborn, OH: Author.
- Morrison, R. & Siu, A. (2000). Survival in end-stage dementia following acute illness. *Journal of the American Medical Association, 284,* 47–52.

Highlights

- Presentation of the concept of what constitutes a deficiency
- Definition of and guidance regarding negative outcomes

Training Techniques

- Lecture
- Group discussion
- Case studies
- Small group exercise using State-developed 2567 reports

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Video:
  - *Decision Making*
- Handouts:
  - *Immediate Jeopardy Issues and Triggers*
  - *Deficiency Categorization Instructions*
  - *Advance Health-Care Decisions: Case Study*
  - *Understanding the Cognitive Challenges of Surveying Long-Term Care Facilities*

- *State-Developed Statements of Deficiency*
- *Pharmacological Survey Case Study—Student's Notes from Lesson 3-M, Psychopharmacological Medications and Pharmacological Services Survey Process*
- *Pharmacological Survey Case Study—Instructor's Notes from Lesson 3-M, Psychopharmacological Medications and Pharmacological Services Survey Process*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Outline or text of presentation

Lesson 3-U:
Information Analysis for the Survey Process

1

Slide 3-U-1

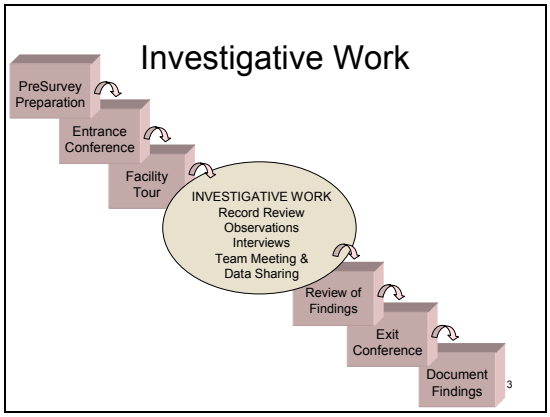
Learning Objectives

- Define a deficiency.
- Determine whether substandard quality of care exists.
- Demonstrate knowledge of tools used to determine severity & scope.

2

Slide 3-U-2

(Inform the students of the objectives.)



Slide 3-U-3

Investigative Work

Investigative work consists of:

- Record review.
- Observations.
- Interviews.
- Team meeting and data sharing.

Audiovisual

Investigative Work (cont.)

Information-gathering portions of survey focused on:
- Resident
- Delivery of services by facility using:
  - Observation
  - Interview
  - Record review

4

Slide 3-U-4

Outline or text of presentation

The information-gathering portions of the survey have focused on:
- The resident.
- The delivery of services by the facility using:
  - Observation.
  - Interview.
  - Record review.

Investigative Work (cont.)

Information analysis & decision-making portion of survey focuses on determinations about whether facility meets requirements

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Slide 3-U-5

The information analysis and decision-making portion of the survey focuses on making determinations about whether the facility meets requirements.

Decision Making

- Builds on discussion from daily team meetings
- Should include discussions of:
  - Observed problems
  - Areas of concern
  - Facility's possible failure to meet requirements

6

Slide 3-U-6

Decision Making

- Decision making builds on the discussion from the daily team meetings.
- Should include discussions of:
  - Observed problems.
  - Areas of concern.
  - The facility's possible failure to meet requirements.

Audiovisual

Outline or text of presentation

Definition of Deficiency

- Failure to meet participation requirement as specified in 42 CFR 483.5 through 42 CFR 483.75.

7

Slide 3-U-7

Definition of Deficiency

- A facility's failure to meet a participation requirement as specified in 42 CFR 483.5 through 42 CFR 483.75.

Use of Worksheets

Worksheets & procedures CMS provides for survey designed to:

- Assist in gathering information
- Assist in investigation
- Organize & analyze information about quality of services provided by facility

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Slide 3-U-8

Use of Worksheets

The worksheets and procedures CMS provides for survey are designed to:

- Assist in gathering information.
- Assist in the investigation.
- Organize and analyze information about the quality of services provided by the facility.

Use of Worksheets (cont.)

Worksheets should:

- Help identify concerns & specific evidence relating to requirements facility potentially failed to meet
- Reflect source of evidence
- Summarize concerns on relevant data tags

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Slide 3-U-9

Worksheets should:

- Help identify concerns and specific evidence relating to requirements that the facility has potentially failed to meet.
- Reflect the source of the evidence.
- Summarize the concerns on relevant data tags.

Audiovisual

Use of Worksheets (cont.)

Surveyors should:
- Review worksheets on tag-by-tag basis
- Prioritize review of worksheets so first information team discusses relates to requirements facility has potentially failed to meet
- Look for information that supports or does not support regulatory noncompliance

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Slide 3-U-10

Outline or text of presentation

Surveyors should:
- Review the worksheets on an individual tag-by-tag basis.
- Prioritize your review of worksheets so that the first information the team discusses relates to those requirements that the facility has potentially failed to meet.
- Look for information that supports or does not support a regulatory noncompliance.

Use of Worksheets (cont.)

If:	Then team should:
Resident primary information source	• Conduct further information gathering & analysis • Hold additional interviews with family or staff • Perform record reviews

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Slide 3-U-11

If the resident is the primary source of information, the team should conduct further information gathering and analysis by holding additional interviews with family or staff and performing record reviews to supplement or corroborate the resident's report.

Interview As Part of Information Analysis

- Document:
  - Date, time & location
  - Who was present during interview
- Quote accurately
  - Repeat wording back to individual to ensure accuracy

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Slide 3-U-12

Interview As Part of Information Analysis

- Document:
  - Date, time and location.
  - Who was present during the interview.
- Quote accurately.
  - Repeat wording back to the individual to ensure accuracy.

Audiovisual

25 Signs That Someone Is Lying to You

1. Touching chin or rubbing brow
2. Crossing arms or legs
3. Playing with hair
4. Perspiring on brow if it isn't warm day
5. Saying "no" several times
6. Continually denying accusations
7. Being extremely defensive

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Slide 3-U-13

Outline or text of presentation

25 Signs That Someone Is Lying to You

1. Touching the chin or rubbing the brow.
2. Crossing arms or legs.
3. Playing with hair.
4. Perspiring on the brow if it isn't a warm day.
5. Saying "no" several times.
6. Continually denying accusations.
7. Being extremely defensive.

25 Signs That Someone Is Lying to You (cont.)

8. Providing more information & specifics than necessary
9. Being inconsistent in what is being shared
10. Body language & facial expressions not matching what is being said, such as saying "no," but nodding head up & down
11. Being smug

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Slide 3-U-14

8. Providing more information and specifics than necessary.
9. Being inconsistent in what is being shared.
10. Body language and facial expressions not matching what is being said, such as saying "no," but nodding the head up and down.
11. Being smug.

25 Signs That Someone Is Lying to You (cont.)

12. Placing barrier such as desk or chair in front of self
13. Being uncommonly calm
14. Being unwilling to touch spouse or significant other during conversation
15. Being hesitant
16. Slouching
17. Being rigid or fidgeting

15

Slide 3-U-15

12. Placing a barrier such as a desk or chair in front of self.
13. Being uncommonly calm.
14. Being unwilling to touch spouse or significant other during conversation.
15. Being hesitant.
16. Slouching.
17. Being rigid or fidgeting.

Audiovisual

25 Signs That Someone Is Lying to You (cont.)

18. Changing behaviors; not acting in usual fashion
19. Making unnatural or limited arm & hand movements
20. Making partial shrug
21. Not pointing fingers
22. Showing unusual voice fluctuations, word choice & sentence structure

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Slide 3-U-16

Outline or text of presentation

18. Changing behaviors; not acting in a usual fashion.
19. Making unnatural or limited arm and hand movements.
20. Making a partial shrug.
21. Not pointing fingers.
22. Showing unusual voice fluctuations, word choice and sentence structure.

25 Signs That Someone Is Lying to You (cont.)

23. Stalling conversation by repetitive use of pauses & comments like “um” or “you know”
24. Not using contractions; emphasizing “not” when talking
25. Avoiding eye contact, eyes glancing to right, staring past you or turning away from you when talking

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Slide 3-U-17

23. Stalling the conversation by repetitive use of pauses and comments like “um” or “you know.”
24. Not using contractions; emphasizing “not” when talking.
25. Avoiding eye contact, eyes glancing to the right, staring past you or turning away from you when talking.

Deficiency Determination

Trainee & preceptor, along with team, should come to consensus on each requirement for which team identified problems

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Slide 3-U-18

Deficiency Determination

The trainee and preceptor, along with the team, should come to consensus on each requirement for which the team identified problems.

Audiovisual

Outline or text of presentation

Data Evaluation

- Evaluate specifics of regulatory language & specific data gathered:
  - Observation
  - Resident, family & staff interview information
  - Record review

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Slide 3-U-19

Data evaluation

- Evaluate the specifics of the regulatory language and the specific data gathered through:
  - Observation.
  - Resident, family and staff interview information.
  - Record review.

Key Regulatory Groupings

- At minimum, focus on:
  - 42 CFR 483.10, Resident Rights
  - 42 CFR 483.13, Resident Behavior & Facility Practice
  - 42 CFR 483.15, Quality of Life
  - 42 CFR 483.20, Resident Assessment
  - 42 CFR 483.25, Quality of Care

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Slide 3-U-20

Key regulatory groupings

- At a minimum, focus on the regulatory groupings:
  - 42 CFR 483.10, Resident Rights.
  - 42 CFR 483.13, Resident Behavior and Facility Practice.
  - 42 CFR 483.15, Quality of Life.
  - 42 CFR 483.20, Resident Assessment.
  - 42 CFR 483.25, Quality of Care.

Consideration of Regulatory Language

- To help determine whether deficiency exists, look at language of requirement
  - Some requirements need to be met for each resident
  - Any violation of these requirements, even for one resident, is deficiency

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Slide 3-U-21

Consideration of regulatory language

- To help determine whether a deficiency exists, look at the language of the requirement.
  - Some requirements need to be met for each resident.
  - Any violation of these requirements, even for one resident, is a deficiency.

Audiovisual

General Categories of Deficiency

Note that failure to meet requirements related to quality of care, resident rights & quality of life generally falls into two categories:

1. Potential or actual physical, mental or psychosocial injury or deterioration of resident including violation of resident rights

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Slide 3-U-22

Outline or text of presentation

General categories of deficiency

Note that failure to meet requirements related to quality of care, resident rights and quality of life generally falls into two categories:

1. Potential or actual physical, mental or psychosocial injury or deterioration of a resident including violation of resident rights.

General Categories of Deficiency (cont.)

2. Failure to meet expectations of a "reasonable person"
   - In cases in which residents are unable to speak for themselves, survey team should assess how most people would react to situation in question
   - Quality of Life & Resident Rights requirements most often evaluated using this type of analysis

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Slide 3-U-23

2. Failure to meet expectations of a "reasonable person."
   - In cases in which residents are unable to speak for themselves, the survey team should assess how most people would react to the situation in question.
   - Quality of Life and Resident Rights requirements are most often evaluated using this type of analysis.

Requirements Regarding Facility Systems

- Certain facility systems requirements must be met in absolute sense
- Facility must have:
  - RN on duty 7 days/week unless it has received waiver
  - Administrator
  - Medical director
  - Food services
  - Pharmacy services
  - Lab services

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Slide 3-U-24

Requirements regarding facility systems

- Certain facility systems requirements must be met in an absolute sense.
- A facility must have:
  - Registered nurse (RN) on duty seven days per week unless it has received a waiver.
  - Administrator.
  - Medical director.
  - Food services.
  - Pharmacy services.
  - Lab services.

Audiovisual

Avoidable or Unavoidable Decline

If:	Then:
Surveyor states facility is noncompliant: – Avoidable harm – Severity G or above	Deficiency must show harm was avoidable

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Slide 3-U-25

Outline or text of presentation

Avoidable or unavoidable decline

If the surveyor is stating that the facility is noncompliant because avoidable harm has occurred and is indicating this through a possible severity rating of G or above, then the deficiency needs to clearly show that the harm was avoidable.

Well-Written Deficiency

- Good documentation & well-written deficiency include:
  - Who
    - Resident?
    - Facility?
    - Staff?
    - Interviews with whom?
  - What
    - Not met as evidenced by. . .

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Slide 3-U-26

Well-Written Deficiency

- Good documentation and the well-written deficiency include:
  - Who
    - The resident?
    - The facility?
    - The staff?
    - Interviews with whom?
  - What
    - Not met as evidenced by. . .

Well-Written Deficiency (cont.)

- When
  - Dates & duration
  - Observation & interview date & time
- Where
  - Specific location in resident's environment when appropriate
  - Critical when citing food prep & environmental issues
- How & why
  - May be needed to clarify technical issue for general public

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Slide 3-U-27

  - When
    - Dates and duration.
    - Observation and interview date and time.
  - Where
    - The specific location in the resident's environment when appropriate.
    - Critical when citing food prep and environmental issues.
  - How and why
    - This may be needed to clarify a technical issue for the general public.

Audiovisual

Examples of Deficiency Language

- Some examples of how to describe harm or potential harm:
  - The (service being cited)
    - . . .failed to deliver necessary care & services to . . .which resulted in. . .
    - . . .failed to treat. . .which resulted in. . .
    - . . .failed to provide. . .which resulted in. . .
    - . . .administered overdose of. . .which resulted in . . .
    - . . .denied resident his/her right to. . .which resulted in. . .

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Outline or text of presentation

Examples of deficiency language

- Some examples of how to describe harm or potential harm:
  - The (service being cited)
    - . . .failed to deliver necessary care and services to. . .which resulted in. . .
    - . . .failed to treat. . .which resulted in. . .
    - . . .failed to provide. . .which resulted in. . .
    - . . .administered an overdose of. . .which resulted in. . .
    - . . .denied the resident his/her right to. . .which resulted in. . .

Severity & Scope

Immediate Jeopardy to resident health or safety	J PoC required	K PoC required	L PoC required
Actual harm that is not immediate jeopardy	G PoC required	H PoC required	I PoC required
No actual harm-potential for more than minimal harm	D PoC required	E PoC required	F PoC required
No actual harm-potential for minimal harm	A No PoC required, but to be corrected by the facility	B PoC required	C PoC required
	Isolated	Pattern	Widespread

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Slide 3-U-29

Severity and Scope

(Refer students to the related handouts "Immediate Jeopardy Issues and Triggers" on page 3-U-19 and "Deficiency Categorization Instructions" on page 3-U-21. Review these with the students.)

Severity & Scope Exercises

- Case Study, Lesson 3-M
  - Determine severity & scope
- Case Study
  - Determine severity & scope
- Review State-generated statements of deficiency

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Slide 3-U-30

Severity and scope exercises

(Refer students to the handout "Pharmacological Survey Case Study" from Lesson 3-M, Psychopharmacological Medications and Pharmacological Services Survey Process, and have them determine severity and scope.)

(Refer students to the handout "Advance Health-Care Decisions: Case Study" on page 3-U-23 and have them determine severity and scope.)

Audiovisual

Outline or text of presentation

(Refer students to a State-generated Statement of Deficiency and have them assess the severity and scope.)

Followup to Determination of Severity & Scope

If actual harm determined regarding:	Then:
– 42 CFR 483.13 Resident Behavior & Facility Practice – 42 CFR 483.15 Quality of Life – 42 CFR 483.25 Quality of Care	Perform extended or partial extended survey (Lesson 3-V)

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Slide 3-U-31

Followup to determination of severity and scope

- If determination of actual harm has been made in:
  - 42 CFR 483.13, Resident Behavior and Facility Practice.
  - 42 CFR 483.15, Quality of Life.
  - 42 CFR 483.25, Quality of Care.
    - An extended or partial extended survey will be indicated (see Lesson 3-V, Extended and Partial Extended Survey, for guidance).

Followup to Determination of Severity & Scope (cont.)

If:	Then team leader must:
• Immediate jeopardy identified	• Notify facility administrator • Notify as applicable: – Director of nurses – Medical director – Food services director – Director of environmental services

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Slide 3-U-32

- If an immediate jeopardy situation has been identified at any time during the survey, the team leader must notify the facility administrator and as applicable:
  - Director of nurses.
  - Medical director.
  - Food services director.
  - Director of environmental services.

Lesson 3-U:
Information Analysis for the Survey Process

Questions

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Slide 3-U-33

Skill Assessment

Information Analysis for the Survey Process

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Defined a deficiency.	
					Determined whether substandard quality of care existed.	
					Demonstrated knowledge of tools used to determine severity and scope of deficiency.	

Comments/Recommendations:

Immediate Jeopardy Issues and Triggers

The following are triggers or situations that surveyors should further investigate to determine whether immediate jeopardy exists. The listed triggers do not automatically equal immediate jeopardy. The team must investigate and use professional judgment to determine whether the situation has caused or is likely to cause serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive. Serious harm, injury, impairment or death does not have to occur before the surveyors consider a finding of immediate jeopardy. Consider both potential and actual harm when reviewing the triggers.

A Failure to Protect from Abuse

1. Serious injuries such as head trauma or fractures.
2. Nonconsensual sexual interactions (e.g., sexual harassment, sexual coercion or sexual assault).
3. Unexplained serious injuries that have not been investigated.
4. Staff striking or roughly handling a resident.
5. Staff yelling, swearing, gesturing or calling an individual derogatory names.
6. Bruises around the breast or genital area.
7. Suspicious injuries (e.g., black eyes, rope marks, cigarette burns and unexplained bruising).

B Failure to Protect from Psychological Harm

1. Application of chemical or physical restraints without clinical indications.
2. Presence of behaviors by staff that are threatening or demeaning, resulting in displays of fear, unwillingness to communicate and recent or sudden changes in behavior by individuals.
3. Lack of intervention to prevent individuals from creating an environment of fear.

C Failure to Protect from Undue Adverse Medication Consequences and/or Failure to Provide Medications as Prescribed

1. Administration of medication to an individual with a known history of allergic reaction to that medication.
2. Lack of monitoring and identification of potential serious drug interaction, side effects and adverse reactions.
3. Administration of contraindicated medications.
4. Pattern of repeated medication errors without intervention.
5. Lack of diabetic monitoring, resulting or likely to result in serious hypoglycemic or hyperglycemic reaction.
6. Lack of timely and appropriate monitoring required for drug titration.

D Failure to Prevent Neglect

1. Lack of timely assessment of individuals after injury.
2. Lack of supervision for individuals with known special needs.
3. Failure to carry out doctor's orders.
4. Repeated occurrences such as falls that place the individual at risk of harm without intervention.
5. Access to chemical and physical hazards by individuals who are at risk.
6. Access to hot water of sufficient temperature to cause tissue injury.
7. Nonfunctioning call system without compensatory measures.
8. Unsupervised smoking by an individual with a known safety risk.
9. Lack of supervision of cognitively impaired individuals with known elopement risk.
10. Failure to adequately monitor individuals with known severe self-injurious behavior.
11. Failure to adequately monitor and intervene for serious medical or surgical conditions.
12. Use of chemical or physical restraints without adequate monitoring.
13. Lack of security to prevent abduction of infants.
14. Improper feeding or positioning of individual with known aspiration risk.
15. Inadequate supervision to prevent physical altercations.

E Failure to Provide Adequate Nutrition and Hydration to Support and Maintain Health

1. Food supply inadequate to meet the nutritional needs of the individual.
2. Failure to provide adequate nutrition and hydration resulting in malnutrition (e.g., severe weight loss and abnormal laboratory values).
3. Absence of nutrition and hydration without advance directive.
4. Lack of potable water supply.

Immediate jeopardy: A situation in which the providers' noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death to a resident. *Only one individual* needs to be at risk. Identification of immediate jeopardy for one individual will prevent risk to other individuals in similar situations.

F Failure to Protect from Widespread Nosocomial infections (e.g., Failure to Practice Standard Precautions, Failure to Maintain Sterile Techniques During Invasive Procedures and/or Failure to Identify and Treat Nosocomial Infections)

1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease.
2. High number of infections or contagious diseases without appropriate reporting, intervention and care.
3. Pattern of ineffective infection control precautions.
4. High number of nosocomial infections caused by cross-contamination from staff and/or equipment or supplies.

G Failure to Correctly Identify Individuals

1. Blood products given to the wrong individual.
2. Surgical procedure or treatment performed on the wrong individual or wrong body part.
3. Administration of medication or treatments to the wrong individual.
4. Discharge of an infant to the wrong individual.

H Failure to Safely Administer Blood Products and Safely Monitor Organ Transplantation

1. Wrong blood type transfused.
2. Improper storage of blood and blood products.
3. High number of serious blood reactions.
4. Incorrect cross-match and utilization of blood products or transplantation organs.
5. Lack of monitoring for reactions during transfusions.

I Determine:

1. Who was involved?
2. What harm has occurred?
3. When did the situation first occur?
4. Where did the potential or actual harm occur?
5. Why did the potential or actual harm occur?

J Failure to Provide Initial Medical Screening, Stabilization of Emergency Medical Conditions and Safe Transfer of Individuals and Women in Active Labor Seeking Emergency Treatment (Emergency Medical Treatment and Active Labor Act)

1. Individuals turned away from emergency room (ER) without medical screening exam.
2. Women with contractions not medically screened for their status of labor.
3. Absence of ER and obstetrics medical screening records.
4. Failure to stabilize an emergency medical condition.
5. Failure to appropriately transfer an individual with an unstabilized emergency medical condition.

K Failure to Provide Safety from Fire, Smoke and Environmental Hazards and/or Failure to Educate Staff in Handling Emergency Situations

1. Nonfunctioning equipment or lack of emergency equipment and/or power source.
2. Smoking in high-risk areas.
3. Incidents such as electrical shock or fires.
4. Ungrounded or unsafe electrical equipment.
5. Widespread lack of knowledge of emergency procedures by staff.
6. Widespread infestation by insects or rodents.
7. Lack of functioning ventilation, heating or cooling system.
8. Use of non-approved space heaters, such as kerosene or electrical heaters, in resident or patient areas.
9. Improper handling or disposal of hazardous materials, chemicals and waste.
10. Locking exit doors in a manner that does not comply with NFPA 101 (Life Safety Code).
11. Obstructed hallways and exits, preventing egress.
12. Lack of maintenance of fire or life safety systems.
13. Unsafe dietary practices, resulting in high potential for food-borne illnesses.

Note: Harm does *not* have to occur before considering immediate jeopardy. Consider both potential and actual harm when reviewing the triggers.

Deficiency Categorization Instructions

(Excerpt from the *State Operations Manual*, Appendix P, part V, Deficiency Categorization.)

A. General Objective. After the survey team determines that a deficiency(ies) exists, assess the effect on resident outcome (severity level) and determine the number of residents potentially or actually affected (scope level). Use the results of this assessment to determine whether the facility is in substantial compliance or is noncompliant. When a facility is noncompliant, consider how the deficient practice is classified according to severity and scope levels in selecting an appropriate remedy (see Section 7400 for discussion of remedies).

B. Guidance on Severity Levels. There are four severity levels:

- Level 1—no actual harm with potential for minimal harm.
- Level 2—no actual harm with potential for more than minimal harm that is not immediate jeopardy.
- Level 3—actual harm that is not immediate jeopardy.
- Level 4—immediate jeopardy to resident health or safety.

These four levels are defined accordingly:

1. Level 1 is a deficiency that has the potential for causing no more than a minor negative impact on the resident(s).
2. Level 2 is noncompliance that results in minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well being as defined by an accurate and comprehensive resident assessment, Plan of Care and provision of services.
3. Level 3 is noncompliance that results in a negative outcome (see Appendix P, Task 6, for discussion of negative outcomes) that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well being as defined by an accurate and comprehensive resident assessment, Plan of Care and provision of services. This does not include a deficient practice that only has limited consequence for the resident and would be included in Level 2 or in Level 1.
4. Level 4 is immediate jeopardy, a situation in which immediate corrective action is necessary, because the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, serious harm, impairment or death to a resident receiving care in a facility (see Appendix Q).

C. Guidance on Scope Levels. The levels of scope are as follows:

- Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved and/or the situation has occurred only occasionally or in a very limited number of locations.

- Scope is a pattern when more than a very limited number of residents are affected and/or more than a very limited number of staff are involved and/or the situation has occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.

- Scope is widespread when the problems causing the deficiencies are pervasive in the facility or represent systemic failure that affected or has the potential to affect a large portion of the facility's residents.

D. General Procedures. After the team makes a decision to cite a deficiency(ies), evaluate the deficient practice(s)' impact on the resident(s) and the prevalence of the deficient practice. Review deficiency practice. Review deficiency statements, worksheets and results of team discussions for evidence on which to base these determinations. The team may base evidence of the impact or prevalence for residents of the deficient practices on record reviews, interviews and/or observations. Whatever the source, the evidence must be credible.

After determining the severity level of a deficient practice, determine scope and evaluate the cause of the deficiency. If the facility lacks a system or policy (or has an inadequate system) to meet the requirements and this failure has the potential to affect a large number of residents in the facility, then the deficient practice is likely to be widespread. If an adequate system or policy is in place but is being inadequately implemented in certain instances, or if there is an inadequate system with the potential to impact only a subset of the facility's population, then the deficient practice is likely to be pattern. If the deficiency affects or has the potential to affect one or a very limited number of residents, then the scope is isolated.

If the evidence gathered during the survey for a particular requirement includes examples of various severity or scope levels, surveyors should generally classify the deficiency at the highest level of severity, even if most of the evidence corresponds to a lower severity level. For example, if there is a deficiency in which one resident suffered a Level 3 while there were widespread findings of the same deficiency at Level 2, then the deficiency would be classified as Level 3, isolated.

Advance Health-Care Decisions: Case Study

"We have no simple problems or easy decisions after kindergarten."

—*John Turk*

The right of a patient to accept or refuse medical intervention is a well-established principle in health care. In a setting that involves an alert, oriented and clearly competent individual, the process by which medical decisions are made is relatively straightforward. However, when disease or injury precludes the patient from actively participating in health-care decisions, the situation becomes increasingly more complex. At these times, advance health-care decisions are pivotal in preserving a patient's ability to direct his/her own care.

Advance health-care decisions generally involve choices made by competent individuals concerning their own desired end of life care if they should become terminally ill, have an end stage condition or be in a persistent vegetative state. The individual determines, while fully able, whether he/she wishes such interventions as the insertion or continued use of a feeding tube, the initial or continued use of a ventilator, the initiation or continuation of renal dialysis and/or the administration of antibiotics. Although occasionally difficult for families and even those health-care workers caring for patients to accept, these "advance directives" should be followed in the same manner that one would in the case of a competent and communicative patient speaking directly to them.

The following occurred in an area nursing home and hospital during 2001 and is an example of one such situation:

Jane Doe was an 83-year-old female when she was admitted to [a local nursing home] on February 26, 1998. Almost a year prior to her admission, while still living in the community, this resident wrote certain instructions related to her health care. These instructions were contained in a document entitled "Advance Health-care Directive for [resident's name]." The resident signed this document on March 19, 1997, and two individuals witnessed this signing.

The creation of an advance directive is an important and proactive step in preserving one's autonomy as it relates to health care. An advance directive "speaks" for a resident at a time when she is unable, due to her medical condition, to communicate her wishes. End of life issues, such as withholding or removing life-sustaining interventions, are often the focus of advance directives.

Mrs. Doe's advance directive instructed her health-care providers to withhold or withdraw life-sustaining procedures if she met any one of the following criteria:

1. *"If I am suffering from a terminal condition and if my death is imminent. . ."*
2. *"If I am in a persistent vegetative state. . ."*
3. *"If I have an end stage condition. . ."*

Mrs. Doe, in her advance directive, specifically addressed the issue of artificial nutrition as follows:

Continued

> *"I direct that no nutrition or sustenance be administered to me artificially, such as the insertion of a feeding tube, and I direct that upon finding that I am as described [as terminal, in a persistent vegetative state or in an end-stage condition] that any such artificial administration be terminated immediately. . ."*

Mrs. Doe had been at [a local nursing home] for 18 months when, on August 23 and September 20, 1999, two physicians certified that her medical condition was end-stage due to dementia. On July 17, 2000, two physicians again certified that her condition was end-stage secondary to dementia. At that time, the physicians also noted that tube feeding this resident (i.e., providing nutrition via a tube placed into the stomach) would be "medically ineffective."

Mrs. Doe experienced a gradual decline in her overall condition, and during the first several months of 2001, it became apparent that her oral intake of food and fluids was becoming inadequate. Her capacity to make medical decisions and her ability to communicate had become severely impaired, and she was no longer able to participate in decisions related to her health care due to her dementia. On April 5, 2001, she was admitted to (a local hospital) for the third time in six months due to dehydration. Despite Mrs. Doe's clear advance directives to the contrary, a feeding tube was surgically placed into her stomach during this hospitalization at the insistence of her son. Fluids and tube feeding formula were then administered to her at the hospital.

She returned to [a local nursing home] on April 13, 2001. The clinical staff at the nursing center, including the attending physician, medical director, numerous members of the nursing staff, the administrator, the social worker and a corporate nurse who was a member of the facility's patient care advisory committee, all agreed that administering tube feeding to this resident would be against her wishes. Therefore, Mrs. Doe received only water and medications through the feeding tube. The facility's decision not to administer nutritional tube feeding per the resident's advance directive was communicated to the resident's family.

On April 14, 2001, the attending physician visited the resident and wrote the following progress note:
". . .G tube [feeding tube] is placed against living will. . ."

The attending physician next visited Mrs. Doe on April 16, 2001 and wrote: *"Pt [patient] had PEG [feeding tube] placed for nutritional purposes against the wishes of the patient. I personally [sic] do not recommend G tube [feeding tube] placement; I want to respect patient's wishes. . .continue G-tube [feeding tube] flushes [water only]. . ."*

Three days later, on April 19, 2001, the attending physician again came to the nursing facility and wrote:
"Tried for family discussion with her son and daughter-in-law. Looks like they have contacted the attorney and made the decision if patient is not fed they will sue us. . ."

From the time Mrs. Doe was readmitted to the nursing facility on April 13, 2001, until the physician wrote her last note on April 19, 2001, all the resident had received was water and medications through her feeding tube. As she had on two previous occasions been declared in an end stage condition (due to dementia) and her own physician had deemed that providing nutrition via a feeding tube would be "medically ineffective," the decision to withhold nutrition was completely in accordance with her advance directive. However, after the resident's family made threats of legal action, the physician, on April 20, 2001, ordered the nursing staff to begin administering nutrition via Mrs. Doe's feeding tube. The nursing staff of the facility complied with this order, and from April 20, 2001, through May 2, 2001, the resident was administered tube feeding formula daily. On May 2, 2001, the resident became acutely ill, was hospitalized and did not return to the facility.

In summary, it is clear that the staff at the nursing facility was not responsible for the placement of the feeding tube. That act, in direct contrast to the expressed wishes of the resident, was performed at the hospital. The staff at the nursing facility was, however, required to honor the instructions set forth by Mrs. Doe in her advance directive. Those instructions carried the same weight as if Mrs. Doe had spoken them herself during April and May of 2001. Despite clear misgivings on the part of the nursing and clinical staff, who were personally familiar with Mrs. Doe's wishes, the facility failed to allow this resident to exercise her right to refuse treatment, specifically the right to reject the artificial administration of sustenance. Instead of honoring the very clear and concise directives of Mrs. Doe, the facility inappropriately followed the wishes of the family, which were in absolute contradiction to the expressed wishes of the resident.

A hospital investigation was also conducted into the care Mrs. Doe received at the hospital where the feeding tube was inserted. The hospital was seemingly unaware that a feeding tube had been placed in this patient against her will. The State agency wrote and forwarded the following deficiency to the hospital.

A76 482.13(b)(3) Exercise of Rights.

The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with 489.100 of this part (Definition), 489.102 of this part (Requirements for providers) and 489.104 of this part (Effective dates). Based on a review of Jane Doe's medical record, the patient's advance directives and the hospital's policies and procedures, it was determined that the hospital failed to comply with the patient's advance directives that clearly indicated her desire to not be fed by artificial means.

Jane Doe was an 83-year-old female who had lived at a nursing home for about 4 years. She was diagnosed with advanced dementia, with severe brain atrophy. While still capable of making her own decisions, Jane Doe had executed an advance health-care directive in March of 1997. Her son was appointed her health-care agent, and she also spelled out detailed health-care instructions.

Per the patient's instructions in her advance directives, which were to be acted upon when she was "incapable of making an informed decision," two physicians certified (July 17, 2000)

that the patient had become "end stage." The certifications specified that CPR (cardiopulmonary resuscitation) and G-tube feeding would not change patient's deteriorating health or prevent impending death. The patient's advance health-care directive instructed *"that no nutrition or sustenance be administered to me artificially, such as by the insertion of a feeding tube. . ."* and upon finding that she has an end stage condition *". . .that any such artificial administration be terminated immediately."* Finally, she had directed, *". . .that such life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally."* The patient's son was appointed as health-care agent but only to the extent the patient's wishes were unknown or unclear.

On April 4, 2001, Jane Doe was found to be unresponsive at the nursing home, and intravenous fluids were started. She was sent from the nursing home to this hospital for dehydration with related abnormal laboratory findings. At the time of admission to the hospital, the patient's medical record indicated that she underwent testing and observation to rule out a heart attack. "Aggressive intravenous hydration" was started to address her dehydration. The patient did not recover sufficiently to take food or liquids by mouth. The attending physician had stated in his admitting history and physical for Jane Doe, dated April 5, 2001, that *"The patient is do not resuscitate with no ventilator or tube feedings. Orders are already in place."*

On April 7, 2001, the patient's attending physician wrote a progress note in the patient's chart saying, *"Discussed options with patient's son (who had medical power of attorney) and daughter-in-law. They have agreed to placement of a feeding tube. Reiterated patient is DNR/DNI (do not resuscitate/do not intubate). Will insert NG-tube and start feeds today. Cardiac arrhythmias noted, am hesitant to treat in view of hypotension (low blood pressure); will monitor. Dr. _ _ called for GI (gastroenterology) consult."*

On April 9, 2001, the GI surgeon wrote his/her signature on the patient's informed consent, for placement of the G-tube. The son's name is printed, not signed, in the space for (Patient, Nearest Relative, Legal Guardian) signature. The surgeon's signature attests that the physician has explained to the son the surgical procedure, the alternatives and possible complications and risks.

On April 10, 2001, surgery to insert a feeding tube (G-tube) into Jane Doe's stomach was performed. Fluids and food were administered first through the NG-tube then through the G-tube for approximately a week, until her discharge on April 13, 2001, despite the patient's written directive that she should not be fed by artificial means. The attending physician stated in Jane Doe's hospital "Transfer Summary—AMENDED REPORT" dated April 13, 2001, that *"However, after discussion with the patient's daughter-in-law, she agreed to a placement at discharge of a feeding tube."*

The patient was discharged from this hospital to her previous nursing home placement, then to another acute care hospital and finally to a new nursing home placement. About one month after discharge from this hospital, the patient died with possible aspiration pneumonia, infections in her urinary tract, several decubitus ulcers and hypotension. The patient's attending physician and her daughter-in-law are the documented decision makers for the patient. The attending and the patient's daughter-in-law chose to institute treatments that

would be medically ineffective as previously determined by the two physician certifications, (i.e., treatment that would not alter the patient's deteriorating health status nor prevent her impending death).

A review of hospital policies revealed that Hospital Policy Number RI10 was enacted to *"foster respect for the inherent dignity of each person."* This policy defines medically ineffective treatment and end stage condition and allows a health-care provider to withhold or withdraw life-sustaining procedures provided that the patient's attending and a second physician have certified the patient as having a terminal condition. The certifications (noted above) predated this hospital admission by nearly one year and certified that the patient's condition was *"severe and permanent deterioration indicated by incompetence and complete physical dependency. . .[and] treatment of the irreversible condition would be medically ineffective."* Despite this fact, the G-tube was inserted.

A review of Hospital Policy Number RI8 revealed that this hospital policy states to *"Avoid conflicts of interest and/or the appearance of conflict."* This policy stated that the hospital *"assure that the care provided each patient is appropriate"* and *"ensure the integrity of clinical decision making. . ."* This policy states that it is in place to *"promote employee and medical staff sensitivity to the full range of such needs and practices (physical, psychological, social and spiritual needs and cultural beliefs and practices)."* There was no documentation to indicate that the physician, surgeon, anesthesiologist or other health-care providers or administrative staff voiced the conflict between the patient's advance directive and the insertion of a feeding tube by invoking the hospital's "specific mechanisms or procedures to resolve conflicting values and ethical dilemmas among patients, their families, medical staff, employees, the institution and the community" as identified in Policy RI8.

A review of the hospital's Ethics Committee meeting minutes revealed that the hospital has a functioning system for the review of cases where there are conflicts regarding a patient's treatment, family wishes or advance directives. However, there was no documented evidence that the conflict among this family, the provider and the patient's advance directives had been referred to the hospital's Ethics Committee or for an ethics consult. Hospital staff interviewed on October 10, 2001, indicated that neither the physician nor the family referred this patient's case for an Ethics Consult.

In response, the hospital revised its policies and implemented staff training to ensure that advance directives are followed.

Discussion:

Researchers Morrison and Siu compared the treatment of patients with acute illness and end stage dementia to another group with acute illness and without end stage dementia. They found that patients with end stage dementia received as many burdensome procedures as cognitively intact patients and that only 7% had a documented decision made to forego a life-sustaining treatment other than cardiopulmonary resuscitation. In the case of Jane Doe, even though she had clearly indicated her desires through advance directives to forego life-sustaining treatment, she was unable to avoid the imposition of unwanted and medically ineffective therapy.

For additional information, please read:

Morrison, R. & Siu, A. (2000). Survival in end-stage dementia following acute illness. *Journal of the American Medical Association, 284*; 47–52.

Understanding the Cognitive Challenges of Surveying Long-Term Care Facilities

FINAL REPORT

Order #CMS 02-00284

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September 30, 2003
Revised March 16, 2004

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Understanding the Cognitive Challenges of Surveying Long-Term Care Facilities

Introduction

Surveying long-term care facilities involves more than simply marking the right box in a series of checklists or mindlessly following procedures. Because regulations are not black and white, violations are not always obvious. Skilled surveyors have learned to make accurate assessments and good decisions despite the complexities of their job. They rely on lessons learned from past experience to assess the extent to which the facilities are in compliance with Medicare and Medicaid standards. Their experience enables them to accurately assess difficult situations and make sound decisions when patient safety and welfare are at risk.

High turnover rates for long-term care facility surveyors (ranging from 8–15% a year) result in thousands of new and inexperienced surveyors each year in need of effective training that will prepare them to handle the array of demands associated with this job. Many of these demands are cognitive in nature and therefore nontrivial to train. The Division of Quality Improvement and Training of the Centers for Medicare and Medicaid Services (CMS) is making a concerted effort to re-evaluate its current training. CMS believes that existing training addresses the procedural aspects of the job, but not the cognitive components that influence the quality of surveyors' assessments and decisions. This belief is supported by a large number of surveyors who feel their training has not adequately prepared them for the complexities of the surveying environment and the decision-making challenges inherent to the task.

The goal of this study was to uncover the cognitive components involved in conducting an accurate survey, so that these elements can be better incorporated into training. Our approach to tackling this challenge was to identify what it means to be an expert surveyor. For example, what do expert surveyors notice that their less-experienced counterparts do not? How do they make sense of the environment in a given facility? How do they make judgments, assessments and decisions within a survey? By answering these questions and uncovering aspects of surveying expertise, we can help CMS better understand the cognitive subtleties of the surveying task that should be addressed in training for new surveyors.

Methodology

Researchers from Klein Associates interviewed 15 long-term health care facility surveyors from five different district offices in Ohio (Akron, Cambridge, Columbus, Dayton and Toledo) Three interviews were conducted at each of the five district offices (see Table 1). The surveyors' experience ranged from 2 years to 12 years, with a mean of 7.5 years. Thirteen of the surveyors were Registered Nurses (RNs), one was a Registered Dietician (RD) and one was a Licensed Practitioner Nurse (LPN). Surveyors' pre-CMS backgrounds varied from long-term care experience to hospital experience.

Table 1
Overview of the Surveyors Interviewed

Region	Years as a Surveyor
Akron	11 years 4 years 3 years
Toledo	11 years 4 years 12 years *
Dayton	4 years 12 years 10 years
Cambridge	12 years 12 years ^ 2 years
Columbus	10 years 4 years 3 years
Avg. # of years as a surveyor	***7.6 years***

Note: All the surveyors identified in this table are RNs, except for those otherwise noted.
* RD, ^ LPN

Cognitive Task Analysis

In order to understand the cognitive elements of performance and how surveyors actually think and function on a survey, it is necessary to access the specific situations in which judgments and decisions are made. Only recently have methods for identifying cognitive task demands and skills evolved. The method we have adopted to identify these cognitive skills is a technique called Cognitive Task Analysis (CTA). (For reviews of CTA, see Schraagen, Chipman, & Shalin (2000) and Cooke (1994)). Cognitive Task Analysis enables the researcher to identify the often tacit cognitive skills possessed by experts within a particular domain. It goes beyond the procedural knowledge and the behavioral aspects of a task. Data acquired through CTA techniques provide a framework for training developers to address human thought processes explicitly and to incorporate them as an integral part of the training product (e.g., Jonassen, Tessmer, & Hannum (1999); Miller, Phillips, Battaglia, Wiggins, Baxter, Mills, et al. (2003); Phillips, McCloskey, McDermott, Wiggins, Battaglia, & Klein (2001).

Cognitive Task Analysis comprises a series of techniques for knowledge elicitation and knowledge representation. We have found that no single method works well in all cases and that the methods must be adapted to suit the needs of each domain. The methods that are most effective in each domain depend on the characteristics of the task, the characteristics of

the decision makers and the conditions under which they must perform the task. For the task of surveying, we chose to use the Critical Decision Method (CDM).

Critical Decision Method

Critical Decision Method interviews, based on Flanagan's (1954) critical incident technique, are organized around an account of a specific incident (Hoffman, Crandall, & Shadbolt, 1998). The incident must be the participant's own. That is, it must come from his or her own, lived experience. The specific episode carries context with it and reveals how particular aspects and events in the environment impel the decision maker to action. A CDM interview requires an initial step to guide the participant to recall and recount a relevant incident. Once that step has been accomplished, the interviewer conducts three information-gathering sweeps through the incident. These sweeps are: (1) timeline verification and decision point identification, to structure and organize the account into ordered segments; (2) progressive deepening, to develop a comprehensive, detailed and context-specific account of the incident from the perspective of the decision maker; and (3) what-if queries, in which the decision maker discusses the incident in terms of potential errors and expert-novice differences. A CDM interview allows the interviewer to elicit goals, options that were generated, cues that were utilized, factors that influenced the decision(s) and strategies that were used to make decisions. Typical CDM interviews are two-hour sessions.

Although recall of specific events cannot be assumed to be perfectly reliable, the method has been highly successful in eliciting perceptual cues and details of judgment and decision strategies that are generally not captured with traditional reporting methods (Crandall, 1989). Moreover, CDM provides this information from the perspective of the person performing a task and can be particularly useful in identifying cognitive elements that are central to its proficient performance.

In this effort, we elicited critical incidents from each surveyor we interviewed by asking for a specific survey that would have turned out very differently if he/she had conducted it as a new and inexperienced surveyor. Once an incident was identified, we proceeded with the "sweeps" in order to uncover the critical judgments, assessments and decisions that were involved in their particular surveying task.

Findings

In the remainder of this report, we will describe our findings. We begin with an overview of the long-term care *surveying process*. Our purpose for giving an overview of the survey process is so that subsequent discussions of cognitive challenges can be framed within an appropriate context. The survey process overview will be followed by a guide to the *pre-requisite declarative knowledge* necessary to complete the mechanics of the various stages of the process. The main portion of the report contains a description of our findings pertaining to the *principle cognitive demands* that surveyors face—the challenging judgments, assessments and decisions that surveyors are consistently met with when conducting long-term care facility surveys. Within each cognitive demand section, we provide some suggestions for how new surveyors could be *trained* to handle that particular cognitive

demand. After each of the cognitive demands and associated training recommendations are described, we will present information about *additional factors* that can complicate the decisions and judgments of surveyors. We conclude with a *summary of training recommendations* for preparing new surveyors to manage the key cognitive challenges of surveying.

It is critical to emphasize that our findings are based upon interviews with surveyors from one geographical region. There are likely to be important differences that exist between regions and these must be identified in future research. However, it is our belief that the principal cognitive demands of surveying identified in this report are faced by all surveyors, regardless of region.

The Survey Process

Based upon analysis of our interview data, we constructed a representation of the general surveying process (see Figure 1). While key differences exist between complaint and annual surveys (see Appendix A), the basic stages and associated cognitive demands are encountered in both types. We will describe the basic survey process and then highlight any differences between annuals and complaints within the descriptions of the stages.

As an overview, an annual survey usually takes about 4–5 days and is conducted by a team of surveyors. Each facility undergoes an annual survey every 9 to 12 months on average. The State offices determine when and where the annual surveys will take place and the survey team arrives unannounced at the facility to begin its inspection. Annual surveys ensure a facility's compliance across a wide range of issues and incorporate a broad assessment of a facility's compliance with State and Federal regulations.

In contrast, a complaint survey typically takes about 1 day and is conducted by one or occasionally two, surveyors. The State office notifies the appropriate regional offices of potential problems at specific facilities in their territories. Depending on the nature of the complaint and the scope and severity of the potential problem at the facility, complaint surveys are required to be conducted within a certain window of time. A survey must take place within 2 days of a complaint regarding a death or serious injury, within 10 days for allegations of harm and within 30 days for something less serious (e.g., complaints about cold food).

The following section will provide a description of the various stages of the survey process that are diagrammed in Figure 1.

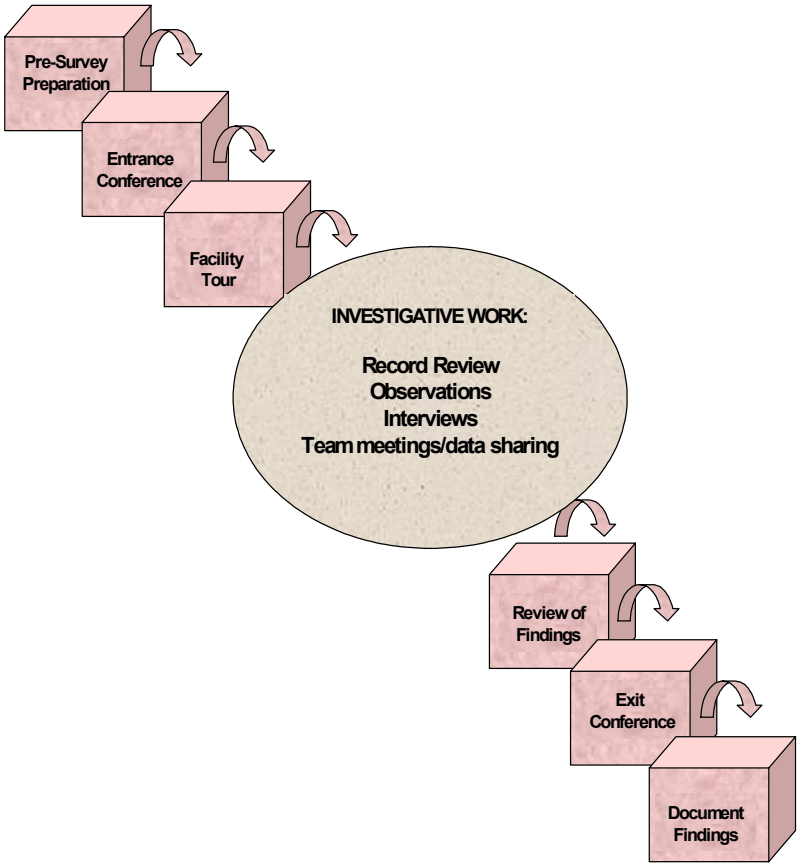


Figure 1—*The general survey process for long-term care facilities.*

Stage 1—Pre-Survey Preparation

This stage encompasses the preparatory work that takes place before a team or individual heads out to conduct a survey. Preparation can involve reviewing previous survey documentation and a facility's quality indicators (QI) matrix and involves selecting an initial sample. The QI matrix contains statistical information across residents about areas of interest that may prove to be problem areas (e.g., falls, pressure sores, depression, activity, weight loss, etc.). This matrix is useful in determining what sample to select for investigation during the survey.

The *Pre-Survey Preparation* typically involves talking to people in the office who have surveyed the facility in the past and also communicating with team members prior to entering the facility. It is important to note that the surveyors do not always go into the field with the same team and several interviewees noted that it takes some time to understand the team members' individual work styles. This indicates that the *Pre-Survey Preparation* phase for

annual surveys is also important for developing the shared team perspective on how to tackle the task ahead of them.

A complaint survey can vary from an annual survey in this stage because usually the preparatory work is conducted by one surveyor and involves only reviewing the actual complaint. If there is time, the surveyor will review the documents described above as well. However, with more serious complaints sometimes there is not time to review much more than the complaint.

Stage 2—Entrance Conference

The surveyors enter the facility unannounced and request a meeting with the Director of Nursing (DON) and the administrator. During the entrance conference, the surveyor gives the DON and administrator a broad description of why they are there and what they will be doing. At this time the surveyor also requests any initial paperwork that will be needed by the survey team.

In a complaint survey, the surveyor conducts the entrance conference immediately upon arrival. If the DON and the administrator are not on duty at the time of arrival, the surveyors often instruct the nurse on duty to take certain steps (e.g., "call your administrator and tell him/her that I am here to investigate a complaint") and they begin the tour (Stage III) right away. In annual surveys, the team leader conducts the entrance conference while the rest of the team starts immediately on the tour. In both cases the purpose of getting to the tour as quickly as possible is so that the surveyors can conduct observations of the facility under "normal" conditions before the staff has a chance to fix or cover up any blatant problems.

Stage 3—Facility Tour

The tour allows the surveyors to get a practical overview of the establishment (layout, exits, facilities, etc.) as well as to look for indications of possible problems and locate members of the staff or residents that they will be interviewing later in the process. Many surveyors use the tour to see if there is anyone they would like to add to their sample. In annual surveys, often the team will split up to cover the facility more quickly. Many times the facility will have someone escort each surveyor and these staff members will "lead" the surveyor through the facility. Experienced surveyors are careful, however, to not let a tour guide dictate where they do and do not go.

In complaint surveys, the surveyor usually covers the entire facility alone and it becomes much more difficult to ensure that the facility staff or administration do not cover up any potential areas of concern. The one advantage surveyors have in complaint surveys is that the facility is not always aware of the issue being investigated, making it less likely that they can cover up the problem in question.

Stage 4—Investigative Work

This stage consists of Record Review, Observations, Interviews and Team Meetings/Data Sharing. It is the heart of the surveying process and it is filled with cognitive challenges. Surveyors in this stage play detective and gather key information to support or deny the complaint or problem areas identified prior to the survey and during the tour. The four tasks contained within this stage do not progress in a strict linear fashion. Rather, they are iterative and vary for each survey and surveyor. Surveyors may cycle back and forth between records, observations, interviews and data sharing as information is unearthed.

An annual survey consists of two main investigative phases. The initial sample (Phase I) is identified during the *Pre-Survey Preparation* and *Tour* and the second sample (Phase II), which is more focused and in-depth, is based upon information gathered from the Phase I sample. Both phases involve record review, observations, interview and data sharing.

Record Review—This component of the Investigative stage entails examining records of the residents chosen for the sample. Although there are standard items in the records that surveyors review during every survey, they also direct their attention based on the particular problems under investigation. Sometimes while looking for one thing, surveyors will spot something else that alerts them to a potential problem. The ultimate goal is to use the information contained in the records, in combination with observations and interviews, to determine whether or not there are deficiencies or violations in the facility.

Observations—Observations are essential components of the investigation that help surveyors put together pieces of the puzzle and identify areas that may need further investigation. Observations, however, involve more than just looking to see what is there; they also involve looking to see what is not there. As one surveyor noted, “The expertise of this job lies in seeing what isn’t happening.”

Interviews—Talking to residents, staff and family members usually provides surveyors with supplemental information that cannot be obtained through record reviews or observations. Staff members or residents, however, are sometimes hesitant to talk. Staff members may provide false information in an attempt to cover up problems and residents may fear being reprimanded for providing revealing information about the facility and its staff to the surveyors. Ultimately, if a surveyor can identify individuals who are willing and able to share information, it is usually highly useful in filling in any gaps in their assessments.

A complicating factor in complaint surveys is the need to ensure confidentiality of the complainant. As a result, the surveyor may select a variety of residents for interviews and record review to mask the purpose of the survey and help to prevent any negative repercussions on those with information surrounding the complaint.

Team Meetings/Data Sharing—Team meetings are held throughout the annual survey and provide a means for surveyors to discuss their findings and observations. Surveyors use this time together to get a better sense of the overall picture and make initial hypotheses about whether certain problems exist and what information is needed to corroborate those concerns.

Team meetings are also a way for surveyors to determine how to focus their findings and gather more evidence to substantiate any hunches that they have about the facility's level of compliance. Team meetings occur much more frequently in annual surveys than complaint surveys and will consist of scheduled meetings throughout the survey in addition to impromptu data sharing meetings. In lieu of a team meeting, a surveyor who is conducting a complaint survey alone will call the office to discuss specific issues with his/her supervisor. Whether surveyors are talking with teammates or their supervisor, this data sharing enables them to make sense of all the information gathered.

Stage 5—Review of Findings

During the *Review of Findings*, the surveyor(s) involved have to determine where they should cite the facility. This review is usually conducted by a team in the annual survey and by an individual in complaint surveys. In both cases, surveyors may request assistance from their home office. Surveyors try to choose the "tags" that best reflect what they believe are the root causes of the problems identified in the facility, as opposed to the symptoms of the problems. In addition to determining citations, surveyors also determine the scope and severity of each of the citations. It is essential for surveyors to double-check that they hold all the necessary documentation to support the citation they choose and the level of scope and severity they assign. Once they have left the facility it becomes very difficult to obtain information not documented while in the facility.

Stage 6—Exit Conference

During the *Exit Conference*, the surveyor provides general descriptions about the nature of the deficiencies or problems found during the survey. Our interviewees said that this meeting should still be somewhat general because the decision on how to cite the facility can change. The surveyors will explain the citations but usually refrain from revealing the specific scope and severity. In addition to reporting which citations the facility will receive, they sometimes recommend how the facility can improve the deficient areas.

Stage 7—Documentation of Findings

The final stage of the survey process involves assembling the citations and their supporting evidence into a cohesive document. One interviewee explained this stage as "*trying to paint a picture with words*." It is important to gather the right evidence to support the scope and severity for each citation. When the surveyor fails to make his/her case with the evidence available and the data support a different "grade" than what is cited, the citation will not hold up. The State office will adjust the scope and severity to match the evidence provided, thereby resolving the mismatch.

Prerequisite Knowledge for Survey Stages

While our goal was to identify the cognitive components of proficient surveying, we learned that certain declarative and procedural knowledge is required in order to develop expertise for each cognitive component. We refer to this knowledge as "prerequisite knowledge."

Distinct prerequisites are associated with each stage of the survey process. They pertain to the goals, procedures and basic mechanics of the stages. Although much of this information may seem obvious to an experienced surveyor, it is likely to be unknown to a novice. Prerequisite knowledge is a critical foundation for mastery of the higher order cognitive demands, which will be discussed throughout the remainder of the report. For example, a surveyor cannot possibly spot inconsistencies in records if he or she does not know what records are available for comparison or the type of information contained in each source. Table 2, organized by survey stages, outlines prerequisite declarative knowledge identified in our analysis.

Table 2—*Stage-Specific Prerequisite Knowledge Requirements*

Stage	Prerequisite Knowledge Requirements
Pre-Survey Prep	• Purpose of the pre-survey preparation • Type of information one should have when finished with preparation • Relative amount of time one should spend in this stage • Standard amount of time in between this stage and the beginning of the survey • What sources should be used to gather information • How to read the particular documents used in pre-survey prep (e.g., QI matrix, resident list, etc.) • The history of the documents (e.g., who wrote the last QI? Where does it come from? How old is it?) • How the team is formed and when the team begins working together • Time available to conduct the survey and whether that changes or is constant • Whether one should give the facility any kind of notice and whether one needs appointments to see specific people in the facility
Entrance Conference	• Whether there are timing considerations for entering a facility and whether they vary • The purpose of the entrance conference • What type of information one should have when finished with the meeting • The relative amount of time one should spend in the entrance conference • Who should be involved in the meeting • What type of information, documents or records one should request • What information the surveyor should provide to the DON and administrators
Facility Tour	• The purpose of the tour • What type of information one should collect on the tour • The relative amount of time one should spend on the tour • The mechanics or steps of a tour • Who "leads" the tour (from the survey team and facility standpoint) • What is the appropriate level of granularity at this stage—looking for surface indicators of problems, just getting the "lay of the land" or general feel of the place, etc.
Investigative Work (data collection) • Record Review • Observations • Interviews	• The purpose of the investigation stage • The relative amount of time to spend in the investigation stage Record Review: • What records are available

Stage	Prerequisite Knowledge Requirements
• Team meetings/data sharing	• Which records should be reviewed • What is contained in each record • Where to find the records • How to read the records Observations: • The appropriate level of depth to observe • The degree of latitude available for "testing" the environment or creating hypothetical situations (e.g., opening a door with an alarm to see when and how staff respond) Interviews: • Whether there is a standard list of questions to ask people or whether it is up to the surveyor's discretion • Whether it is the surveyor's job to assess and interpret the reliability of the information the interviewee provides
	Team meetings/data sharing: • How frequently these should occur • Who should be included in the meetings • The type of information that should be shared
Review of Findings (Final Team Meeting)	• The purpose of the reviewing findings stage • The relative amount of time one should spend in this stage • Who on the team gets the final "say" • Where there is a standard procedure to follow when reviewing findings
Exit Conference	• The purpose of the exit conference • What type of information one should have when finished • The relative amount of time one should spend in the exit conference • Who should be in the exit conference • What should be given to the participants • Timing of the conference
Documentation	• The purpose of documentation • The relative amount of time that should be spent in the documentation stage • What information needs to be included in the documentation • Whether there is a standard format for documentation findings

This table provides a reference to show the stage-specific *declarative knowledge* required in order to develop skill in conducting each stage. This information can be used to supplement current or future training tools or as a checklist for lead surveyors or preceptors to address with new or inexperienced members of their survey team in the context of a particular survey. The latter use is likely to enhance new surveyors' understanding of the survey process, since they will have the opportunity to apply the knowledge in context.

The next section will present the focus of our effort—identification of the cognitive demands encountered during a survey.

Principal Cognitive Demands of Long-Term Care Facility Surveying

The overarching goal of both an annual and a complaint survey is to determine whether there is a problem or deficiency—*Is the facility in compliance with the regulations or not*? Determining whether the facility is in compliance with State and Federal regulations is the cognitive thread that weaves through every stage of the survey process. It involves making sense of the environment and building the big picture of all the information accumulated through a variety of senses. There are several cognitively demanding tasks that feed into this ultimate determination that surveyors consistently find challenging. Although experienced surveyors have developed strategies or "tricks of the trade" to deal with these cognitive challenges, these are the areas in which new and inexperienced surveyors are likely to experience substantial difficulty. These principal cognitive demands are presented in Table 3 below.

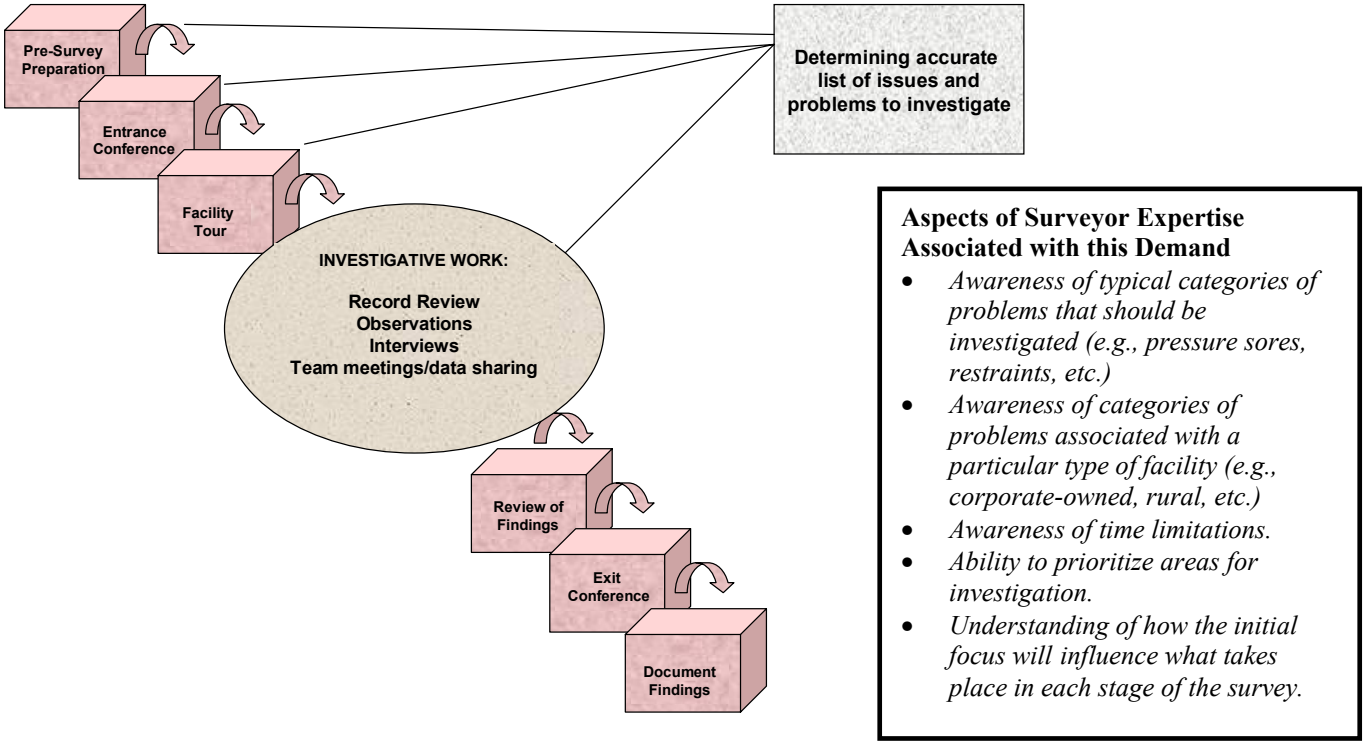
Table 3
Key Cognitive Demands of Conducting a Survey

➢ Determining an accurate set of problems and issues to investigate
➢ Identifying a representative sample to investigate the issues
➢ Determining what to look for and where to find it
➢ Interpreting rules and regulations
➢ Noticing "red flags" (detecting indicators of potentials problems)
➢ Uncovering the root cause of the problem
➢ Determining what to cite and what tags to assign
➢ Determining scope and severity of the problems
➢ Documenting the findings: Painting a picture with words

While these cognitive demands are discussed separately, this should *not* be taken to indicate that these decisions, judgments and assessments occur in isolation. They are all *highly interrelated* and feed into one another, often in an iterative fashion. Successfully managing certain demands is highly dependent on being able to effectively manage others. For example, determining what to cite and what tags to assign is largely dependent upon the ability to notice red flags and uncover the root cause of the problem.

In the following section, each cognitive demand is presented separately. A diagram is presented for each cognitive demand that illustrates the primary stages in which that particular demand is experienced, in addition to a list of key aspects of surveyor expertise associated with that demand. This diagram is followed by a description of the cognitive demand and examples of how that demand is experienced while conducting a survey. Any associated training recommendations for providing surveyors with practice in handling these demands are then presented.

Determining an Accurate Set of Problems and Issues to Investigate



Experienced surveyors know that the ability to quickly and accurately generate a focus for their investigation enables maximization of time once in the facility. A good first estimate of the problems at hand enables surveyors to get the most out of the survey. Determining how to scope the issues and decide what to investigate can seem daunting and may even feel like premature closure (or fixation) on what issues to probe without having spent time in the facility. However, an initial hypothesis or "frame" for what could be happening in a facility is a powerful strategy to help the surveyors to generate questions and expectancies for the situation and conduct effective tests (Klein, Phillips, Rall, & Battaglia, 2003; Rudolph, 2003) to see if those expectancies hold in the wake of actual data.

In our investigation, we identified some basic aspects of surveyor expertise that new surveyors need in order to quickly generate and adapt a list of potential problems to investigate. One major demand placed on surveyors is the fact that one surveyor or team cannot possibly investigate compliance with every single regulation. To deal with this challenge, many of the surveyors interviewed had categories or mental models of problems to look for in the facility. These pre-indexed, abstract "packets of knowledge" are developed over an individual's range of experiences (Ross, Battaglia, Phillips, Domeshek, & Lussier, 2003). Mental models help people manage their attention and know what to expect in situations so that they can make sense of information from the environment. Some examples of these typical categories of problems or mental models include knowing about pressure sore development and care, restraints used with patients, facility security, nutrition, sanitation and cleanliness.

Some of the interviewees described how they used knowledge about a particular type of facility to help focus issues for investigation. For example, typical problem areas in corporate-owned facilities might be different than those facilities located in rural areas. Another way surveyors use mental models is in knowing how the hundreds of regulations break down into major groupings for investigation. Grouping the regulations in a particular way helps to better guide their investigation as opposed to trying to remember every individual regulation. New surveyors need help in breaking these down into manageable categories.

Experienced surveyors know how crunched they are for time once in a facility. They don't want to squander opportunities, yet they know they cannot possibly chase down every little indicator of a potential problem. Having an initial focus for investigation helps in sorting through all the information coming to them once they walk through the doors of the facility. Tools to help surveyors estimate how long to spend on a particular phase, interview, meeting, etc. would help them see how to put little bits of time to great use.

The strategy of prioritization and narrowing down critical focus areas is directly related to time management. Surveys can be overwhelming with so many things to look at, people to interview, meetings to conduct and records to review. Experienced surveyors understand *which areas are more critical* to spend time on than others. An example of prioritization was a surveyor choosing to investigate deeper into potential pressure sore problems versus looking into some complaints of lukewarm food. The skill of prioritization can be developed by learning what issues may supersede other issues and knowing what problems may connect to even larger problems. The key aspect of expertise involves creating a plan of attack for uncovering the biggest issues without getting sidetracked into documenting smaller symptoms of those big issues.

Just as surveyors need to *develop* initial foci for their investigation, they also should learn how to *use and adapt* it since they will inevitably notice things on the tour that weren't originally in their plan to investigate. The following excerpt highlights this need:

"The nature of the complaint determines what you are looking for... If the complaint is that folks are getting beat up, then you look for bruises. If its incontinence, then you

are trying to be aware of smells… But if there is something important, I'll jot it down as something to look at."

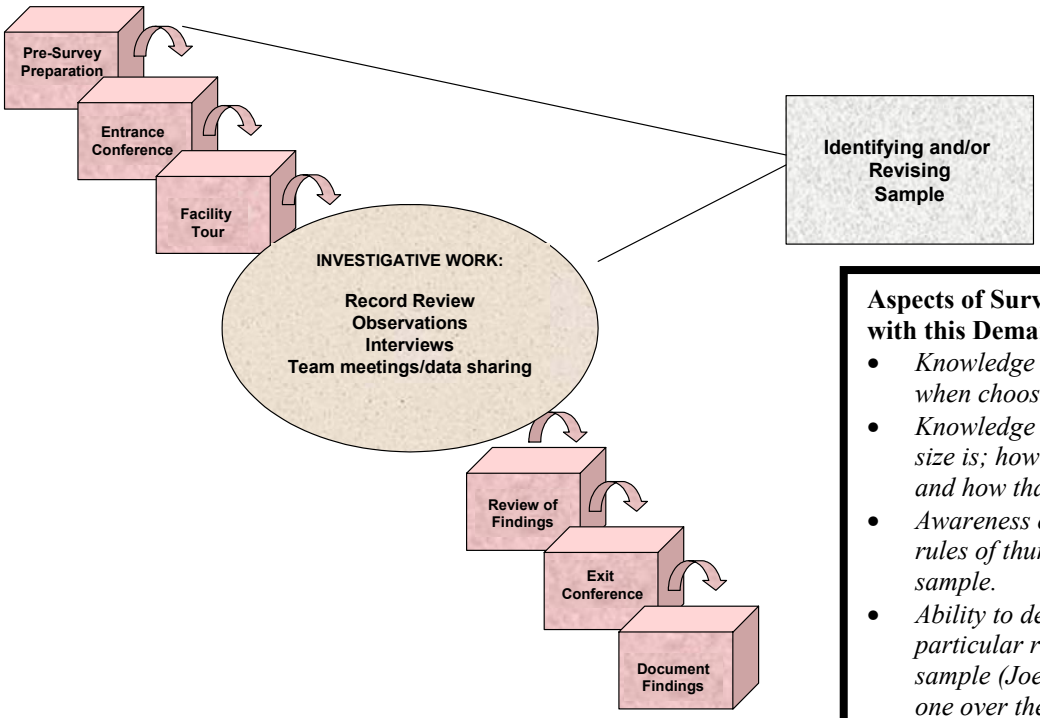
So how should the surveyor react? Abandon the plan and chase down the new lead? Strictly adhere to the original plan no matter what? The training challenge is to strike a balance between teaching surveyors how to develop a list of problems, which typically happens during pre-survey preparation and learning how to modify those foci as one gathers more information.

Training Recommendations—Teaching surveyors techniques for creating, managing and updating a list of issues for investigation is one of our key training recommendations that, if successfully trained, will help the surveyor get the most out of their time in the facility. There are several methods that could help surveyors develop this key skill.

One method for training surveyors to develop an appropriate set of issues to investigate is through the use of a workbook and paper-and-pencil exercises that the surveyor works through prior to beginning a survey. The exercises could be based on both fictitious case studies and upcoming surveys in which the trainee will be participating. Based on case studies and other supporting documents (e.g., QI matrices, facility history, accounts from surveyors who had visited in the past), trainees would answer questions about what focus areas they would identify as critical to the investigation, their game plan for investigating those items and their expectations of what they will find to either confirm or disconfirm that an area is indeed a problem.

Ideally, this workbook would also serve as a mechanism for communication and knowledge sharing between a preceptor and trainee. The trainee could use the exercises to guide his/her thinking about each upcoming survey in which he or she will participate. Then, the preceptor could provide feedback on the plan the trainee devised and together they would make modifications. A critical step in this learning activity would be to review the original plan after the conclusion of the survey. This would allow the preceptor and the trainee to retrace their thought processes and reflect on why the emphases may or may not have changed. The workbook tool would include a job aid to help the surveyor remember the critical categories for investigation, major groupings of the regulations and how different kinds of facilities might exhibit different problems. This job aid could be provided as an appendix to the workbook in CD-ROM format so that it could be populated with expertise of the local surveyors, such as tricks of the trade, checklists and rules of thumb that others have picked up in their experiences.

Identify (and Revise) Representative Sample



Aspects of Surveyor Expertise Associated with this Demand

- *Knowledge of what factors to consider when choosing a sample.*
- *Knowledge of what a typical sample size is; how many residents is enough; and how that number is determined.*
- *Awareness of standard procedures or rules of thumb for determining a sample.*
- *Ability to determine whether a particular resident is good for the sample (Joe vs. Jane) – how to choose one over the other.*

The sample is the survey team's best guess for what portion of the resident population they wish to observe, interview and review their records. Determining who to include in the sample is often informed by the initial list of issues that the surveyors decide to focus on (as discussed in the previous section). While the original sample is identified in the pre-survey preparation, often it is necessary to revise this initial list to reflect information gathered after entering the facility. Similarly, sample revisions may occur following the tour during the team meeting, when the surveyors have a chance to meet and discuss their initial impressions of how the facility is holding up against the regulations.

Identifying and revising the sample is not a trivial task. Surveyors are not able to talk to every staff member or resident, nor are they able to look into records for every resident in the facility. Instead they need to target a sample that will enable them to investigate the most critical areas. Sometimes they need to revise it because residents originally picked from the sample may not still be at the facility or there may be additional problem areas that stick out to the surveyors on the tour—and they want to revise their sample to better enable them to investigate those issues. This was one topic that many of the interviewees handled in a different way. Some surveyors were taught in their training that it is inappropriate or unacceptable to change the sample during the initial investigation. As one surveyor reported, *"It is CMS protocol to stick with the same sample you pre-selected.* "Hence, any changes to the kinds of records to pull or the people to interview happen formally during another section of the survey known as "Phase II."

Other surveyors we interviewed were much more liberal in their views on how to use the sample as an instrument for their investigation. *"The pre-selected (Phase I) sample is examined to make sure that the issues addressed in the sample are still pertinent after the tour."* Still those surveyors who felt comfortable with revising the sample sometimes met with resistance from their team. One interviewee recalled a particular incident where the team was reluctant to expand the sample because of feeling overwhelmed by all the issues that needed to be investigated. "*The team was reluctant to expand the sample during this survey. They were still reacting. It was like taking the lid off of Pandora's box."*

There were certain aspects of surveyor expertise pertaining to selecting and revising a sample that we pulled from the data set. One of these items included knowing what factors to consider when choosing a sample. This is very similar in nature to the cognitive demand discussed earlier about how to select initial areas for investigation. Another basic piece of knowledge that new surveyors need is knowing typical sample sizes and how to determine those numbers.

New surveyors should also have a basic understanding of protocol or procedures for how to determine a sample. Any written guidance that can help them monitor the task would be helpful. Just as discussed, different surveyors have different ideas about when to select a sample, how many samples to identify over the course of the survey and how often one can change those samples. Just as there may be formal guidelines for determining the sample, the experienced surveyors also have rules of thumb for how to select their sample. One surveyor described how *"the sample in Phase I is supposed to correlate with the pre-selected sample chosen prior to the survey."* To help contain this investigation, each team member *"examined 3 records in depth looking for anything that stood out"* and that would support the initial list of ideas. Another strategy offered was to spend time talking to staff, especially nurse assistants, who can be *"a really good source of information, sometimes better than the nurses."* This same surveyor suggested *"there are lots of things to look for in Phase I so you don't want to get too caught up in records until you make some initial observations and talk to people."*

The task of revising the sample for subsequent investigation can get very complicated quickly. By this time the surveyor has an initial idea of where the problems may be in the facility and he or she has to make judgments about how to utilize the remaining time in the facility to ferret out any last concerns. It can also get very detailed, where the surveyor has to make a decision about who to specifically investigate. This was referred to as the "Joe versus Jane" dilemma. The following describes this problem:

There may be too many people with the same problem. When should you look at Jane and not Joe? A lot depends on how forthcoming the facility is with you. Do they give you correct information? For example, the staff tells you that Joe is violent towards staff and they have difficulty getting him to go to bed. On the converse, Jane is very cooperative but dependent on the staff to do everything for her.

This scenario might lead a surveyor to pick Jane because she is very dependent and it would give the investigator a chance to see how the staff manages someone in her situation.

However, considering Joe again, what if the reason why he won't go to bed is because he has a pressure sore? And he has the pressure sore because the staff haven't changed his brace in weeks and don't check his skin? For Joe, it hurts to lie in bed and so he prefers to sit. However, the staff also don't feed him on time and so he is malnourished. This won't help his pressure sore heal and therefore he becomes angry at the staff for not caring for him.

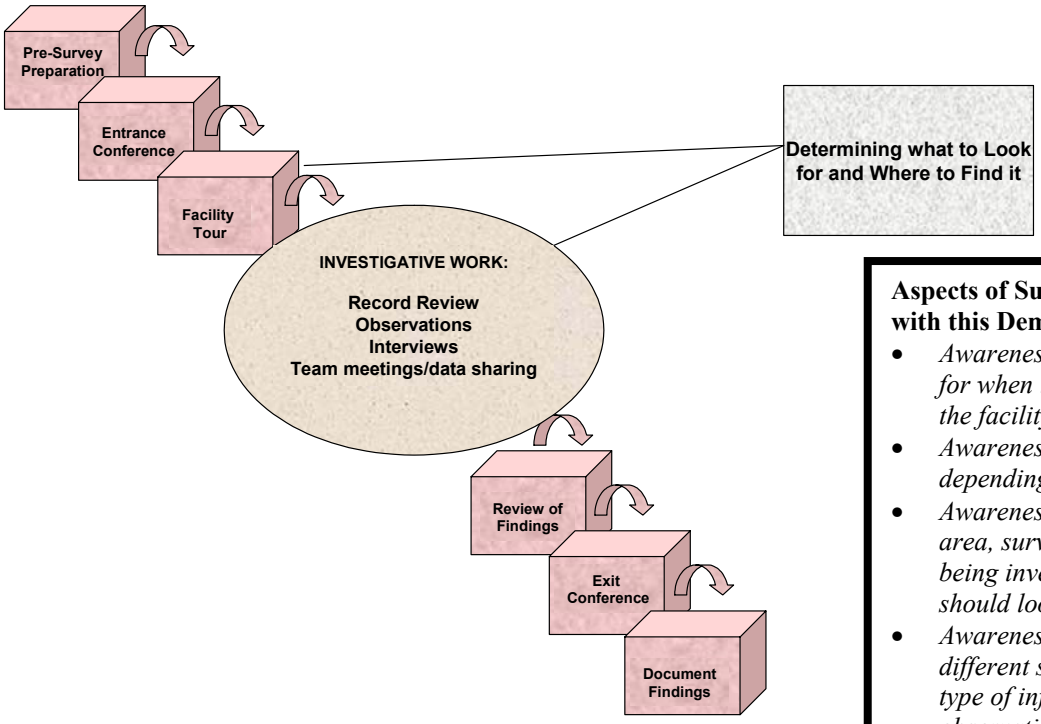
In this hypothetical case, if the surveyors had selected Joe, they may have unearthed a whole series of issues that otherwise would not have been discovered. Either resident could provide clues to help the surveyor piece together what is really going on in a facility. The surveyor needs to understand these potential trade-offs and make the best educated guess possible at decision time.

Training Recommendations—One basic training recommendation for enabling new surveyors to manage this cognitive demand is to provide guidance or "how to's" for sample selection. One recommendation is to develop a video of an expert surveyor who is selecting and revising the initial sample. This could be produced documentary style with commentary from the surveyor about what he or she is thinking and using to make this decision. The training medium could also be as simple as a PowerPoint slide show presentation that offers basic tips and rules of thumb for accomplishing this task.

Another powerful training technique would be developing a hands-on training module in which surveyors work either in teams or individually in a mock sample selection task. Depending on the learning objectives either approach would be beneficial. Working as a team would allow the surveyors to benefit from each others' insights during the process. However, working as an individual would replicate the surveyor preparing and conducting a complaint investigation. In the mock sample selection, trainees could be provided with, for example, a QI inventory, a residents list, any previous survey documentation, pictures of the facility, etc. They would then practice choosing a sample. A debriefing session led by a facilitator would probe the trainees on their thought processes for determining the sample.

To further exercise the skill of revising the sample, a short narrative or video showcasing a facility tour, conversations with staff members and residents and some initial record review could be presented. Again, the trainees would be tasked with making any changes to their sample and developing a game plan for what to investigate next. This technique would allow the trainee to think about a cognitive demand (identifying and revising a sample) as it naturally occurs over several stages of the survey. Thus, it is a good way to practice reinforcing the lessons of each stage as well.

Determining What to Look for and Where to Find It



Aspects of Surveyor Expertise Associated with this Demand

- *Awareness of the types of things to look for when investigating a particular area in the facility, or a particular problem.*
- *Awareness of what depth to look for things depending upon the* stage *of the survey.*
- *Awareness that the interaction of facility area, survey stage, and problem area being investigated affects what things one should look for.*
- *Awareness of the type of information different sources will provide (e.g., what type of info can be obtained from observations, versus records, versus interviews).*
- *Knowledge of what information is contained in which record or document, and how those records or documents can be obtained.*
- *Awareness of the type of information that particular members of the staff are likely to have (e.g., the types of information that could be obtained from the DON, versus the nurses, versus the nurse aids, versus the administrator).*

Surveyors are faced with this demand in nearly every stage of the survey process, but it is most predominant during the facility tour and the *Investigative Work*. It was evident from our interviews that this particular cognitive demand is not addressed in training and is usually left up to the surveyors to learn through experience. As one surveyor noted, *"The training teaches you how to fill out paperwork, but not what to look for in the investigation*."

One factor that contributes to what surveyors look for is the *stage* of the survey process that they are in. Experienced surveyors possess mental models of what is appropriate to look for during the various stages and these help direct their attention. What surveyors look for during the tour, for example, differs from what they look for during the record review, interviews and observations. During the tour, surveyors get an overview of the facility and try to identify anomalies and situations that stand out as potential problems. They look for general conditions of the environment and try to get a feel of how "homey" a place feels—whether it is a place you would want to be or a place you would be comfortable having your loved one

live. Initial tour observations are done primarily to get the lay of the land and to figure out what to investigate further.

What surveyors look for during the investigative stage is more specific and in-depth and frequently involves some "digging." What they decide to look for is dependent upon factors including the area of the facility that is being examined, as well as the category of problem being investigated. Clearly, what surveyors look for in the kitchen is going to be different than what they look for in the residents' bedrooms. Experienced surveyors have mental models of the types of things they should look for depending on the area of the facility that they are in. Those new to the surveying profession need help in developing these mental models. In Table 4 we provide *some* examples of what constitutes these mental models.

The actual problem area being investigated also contributes to the determination of what to look for. Experienced surveyors possess mental models of the types of things they should be observing when investigating a particular problem area. If you are investigating allegations of abuse, for example, you look for bruises and other injuries on the residents. If you are investigating problems with incontinent care, you try to be aware of smells. If the issue is privacy, you look to see if you can readily peek into people's rooms.

One surveyor described what she looked for when investigating a potential problem of inadequate hydration:

"…You look to see if there is water within reach of the patients' beds. On the Alzheimer's unit, you would want to make sure they are being offered fluids, because they forget to drink. You also want to make sure that patients' membranes are moist—you do this by trying to talk to the residents, looking at their lips, tongue, etc. Are their lips cracked, dried, chapped? Are their eyes sunken in? If the patient has a history of dehydration, are they identified as a risk (i.e., do they have a plan with interventions in place, such as measuring intake/output and are those being implemented?). If they are supposed to be getting a health shake, then that should be documented. Another thing you look for is how often is the patient going to the bathroom? If their urine smells really strong, that's also a cue for dehydration. Also looking to see if water pitchers are in place, making sure residents are not seated for a long time in the dining room without being offered fluids, etc."

Table 4—*Some Examples of What to Look for Based on Area of the Facility Being Investigated*

Kitchen:
• Whether containers are sealed properly
• If storage is off the floor and not touching the ceilings so there is air flow
• If clean and dirty laundry is separated
• Whether the area is sanitized
• Whether the area is free from things like cockroaches, mouse droppings and "big dirty fans blowing over clean dishes"
• Whether workers are monitoring the temperature of the freezer and dishwasher
• If everything in the kitchen is dated

- Whether food is being rotated
- Whether the food manager has good credentials
- Whether the kitchen staff is wearing hair nets
- Whether the silverware is stacked the way it's supposed to be (so that you don't grab the top part that goes in the mouth)
- Whether there are measurement labels
- If there is a six week menu plan

Resident's bedrooms:

- Whether bed rails are up or down
- Whether the rails are padded
- Whether there are gaps between the bed mattresses and rails
- Whether urine odors are present
- Whether the bed linens are clean or soiled
- Whether the floor is sticky or not

In contrast, when investigating potential pressure sore problems the surveyors look for:

- Whether residents are being turned or whether they're lying in the same position all day.
- Whether residents had sores when they were admitted versus whether they developed them while at the facility.
- Whether sores have increased in severity since the residents were admitted to the facility.
- Whether preventative measures are in place.
- Whether it is documented in the records that pressure sores are present.
- Whether treatment is underway for pressure sores that are present.
- Whether residents who have pressure sores were identified in the 802 matrix as having them.

One of the reasons why the survey is so complex is because what a surveyor looks for is dependent upon the *interaction* of mental models pertaining to the problem being investigated, the area of the facility and the stage of the survey they are in. We have attempted to illustrate some of these interactions in Figure 2. The stages of the survey are shown as the first leg of the triangle. As surveyors move through the process, they must have good mental models of the kinds of general issues that typically plague facilities (shown in green). Depending on where they are in the survey process, the depth and breadth in which they investigate these issues varies considerably. Thirdly, surveyors must have good mental models of what to expect while considering different areas or locations around the facility (shown in purple). For example, expectations for what to find in the kitchen varies whether one is thinking about sanitation issues (how is the food handled, how is the kitchen cleaned) or resident care issues (are the staff preparing meals according to dietary needs) or staff training (are the staff delivering meals on time, are they at the right temperature, etc). It is the intersection of these three dimensions that helps the surveyor set expectations for what to look for and to what extent during any one part of the survey.

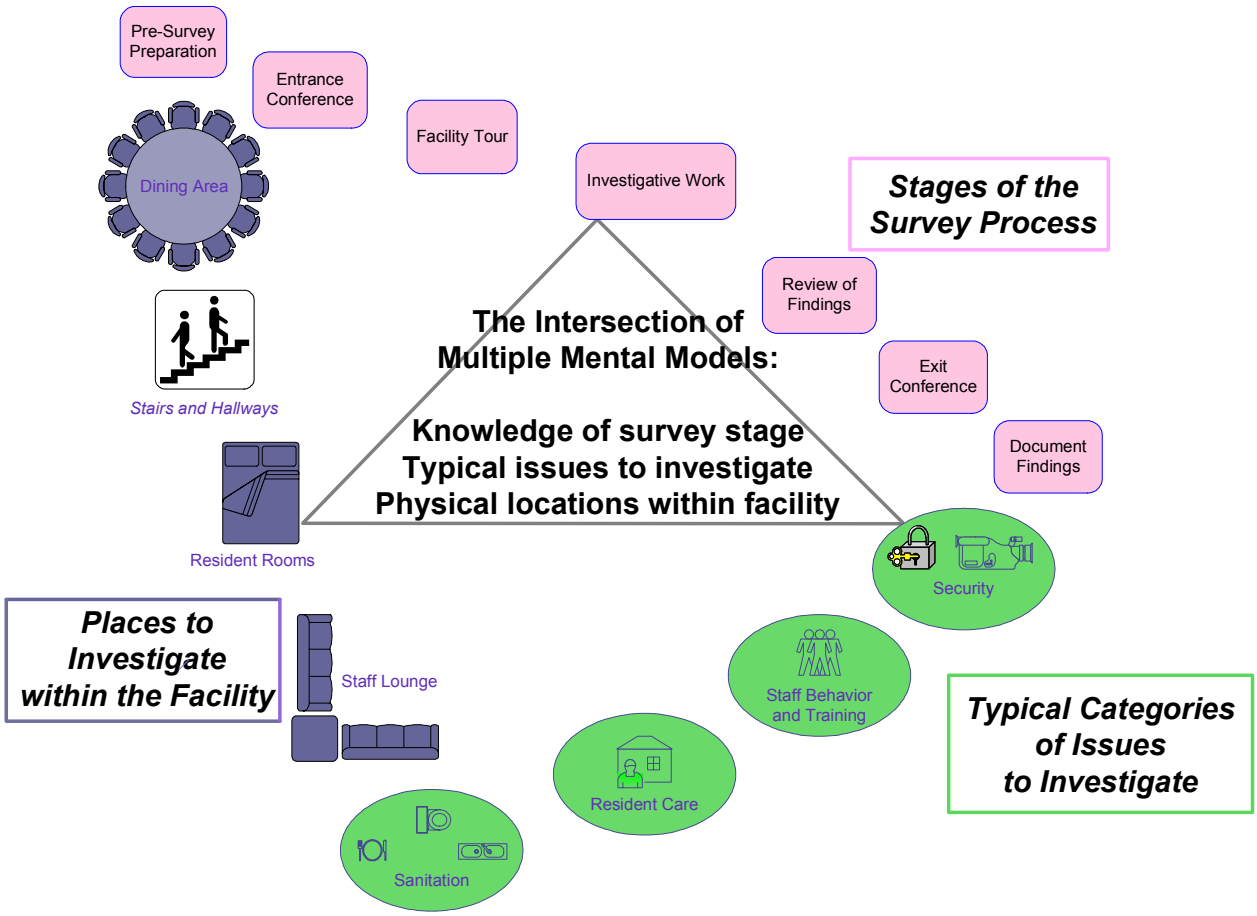


Figure 2—The intersection of mental models for determining what to look for.

It is important to note that experienced surveyors not only look for what is there, they also look for what is *not* there. As one interviewee explained, *"the expertise of this job lies in seeing what isn't happening. You have to see the invisible, not just what's there. Often things that aren't visible are the serious problems."* For example, a surveyor may find that a resident's records indicate that a particular device should be in place. But when they make an observation, they find that the device is actually not in place. Sometimes the fact that nothing is being done is a sign that something is wrong.

Knowing where to *find* certain information is challenging for surveyors. Sometimes the information that you need is in a record or chart. This can be tricky for surveyors who do not have a background in nursing or for inexperienced surveyors who do not know what is contained in particular records. Experienced surveyors note that sometimes you can only find the information you need by speaking with a nurse, nurse aid, another resident or a family member. Many of our interviewees emphasized the importance of talking to the staff to get information: *"Talking to the staff is one of the best ways to get information. The staff can tell you more than what is usually written down."* One can learn a lot, for example by asking the staff "What does Jane or Joe need?" By asking questions such as this, surveyors "*learn a lot about what the staff knows or more importantly what the staff doesn't know. If they don't know a particular resident is dependent and needs to be turned or fed, for example, this is a*

serious lack of knowledge." Knowing who is likely to have what information, however, is not always obvious.

Training Recommendations—It is critical that new surveyors receive training in determining what to look for and where to find it. If they are able to manage this cognitive demand effectively, surveyors will be much better able to focus their attention on what is important in an otherwise overwhelming sea of sights, sounds and smells. There are a variety of ways in which surveyors could be trained to manage this cognitive demand. We recommend a few different methods that can build off of one another.

One training method is to provide new surveyors with checklists or rules of thumb for investigating general problem areas or particular areas of the facility. For example, general categories of problems could be presented such as pressure sores, falls or restraints, followed by checklists of things that surveyors should examine when trying to determine if problems exist in those areas. This checklist could also include guidance for where those things can be found (e.g., from observing a particular area, from a specific record or chart or from a particular member of the staff or administration). These checklists could be presented through a variety of modalities including workbooks, in-classroom PowerPoint presentations or web-based modules. The goal of this approach would be to provide surveyors with some guidance on what they should be looking for when investigating a particular problem area or a particular area of the facility and where those things can be found. This type of training will help to develop new surveyors' mental models of what to look for and where to find it.

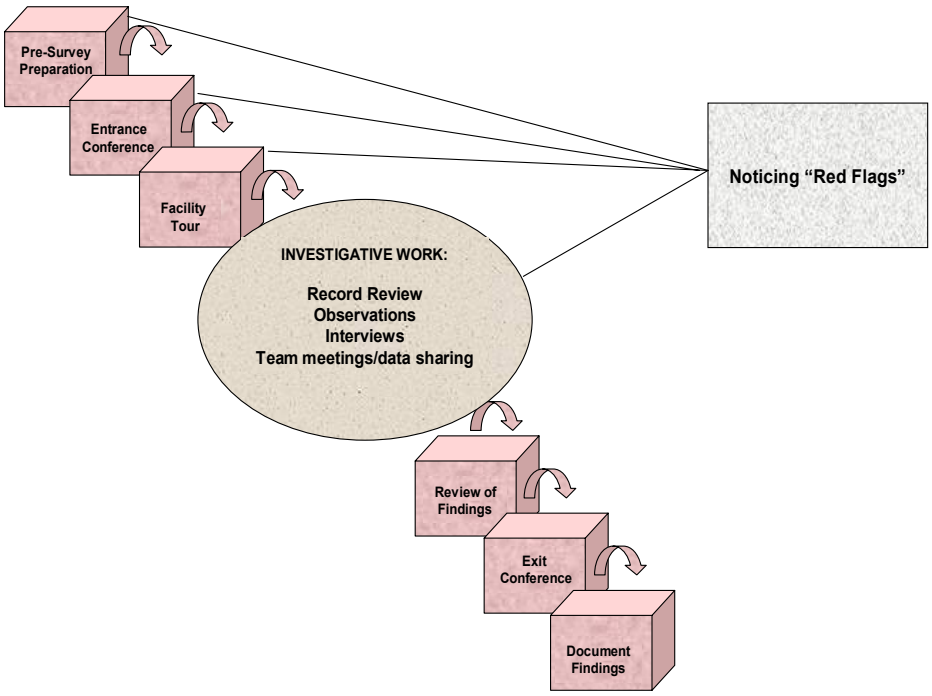
A second method that we recommend is to provide case studies. These case studies would illustrate examples of situations where expert surveyors investigated particular issues or areas in the facility and what they looked for to help them make an assessment about whether or not the facility was in compliance with regulations. These case studies could be provided in a written format. But there are other options as well. Given that many of the things surveyors look for are very perceptual in nature, we believe this could be done effectively with video clips. An experienced surveyor (or actor) could describe a particular problem area they are investigating and do a talk-aloud walk-through of the types of things they are looking for and where they are going to find them.

In order to gain practice in actually making the determination of what to look for, we recommend decision making exercises (DMXs). Decision Making Exercises are context-rich scenarios that require the trainee to make decisions, judgments or assessments in response to the situation described. Decision Making Exercises are based on the Tactical Decision Games originally conceived by Maj. John Schmitt (USMCR) (Schmitt, 1994; 1996). The purpose of the DMX is to provide trainees with the opportunity to practice assessing and responding to a situation, to reflect on the decisions that they and others have made and to receive feedback regarding those decisions.

For purposes of providing new surveyors with practice in determining what to look for and where to find it, the DMXs could be created based upon incidents elicited from experienced surveyors. We currently have some incidents that could be used based upon our set of interviews, but more could be obtained in future interviews. The scenarios created from these

incidents would place the trainees in a particular context (e.g., you have noticed some things on your tour that lead you to believe that there could be a possible issue of non-compliance in the area of restraints.) The trainee would then be asked questions such as, What are you going to look into during your *Investigative Work*? and Where or from whom are you going to obtain that information? This could be an individual exercise or it could be conducted within a group. It could involve group discussion—ideally small groups led by expert surveyors. This training method could be distributed if necessary and could be either paper-and-pencil or web-based. The ultimate goal of these DMXs would be to give the surveyors practice in determining what they need to look for and where they need to go to find it.

Noticing "Red Flags" (Detecting Indicators of Potential Problems)



Aspects of Surveyor Expertise Associated with this Demand

- *Awareness of singular cues that should alert a surveyor to investigate something further.*
- *Understanding of combinations/patterns of cues that should alert them and what they might suggest.*
- *Awareness of what cues to watch out for within each of the general problem areas (i.e., What things should alert you to pressure sores? What things should alert you to potential problems with security? etc.)*
- *An understanding of what is typical or normal, so that one can more easily identify abnormality (red flags).*
- *Awareness that certain members of the team might notice different things depending on their background.*

In order to ultimately make an accurate assessment about a facility's level of compliance with regulations, surveyors must be able to detect problems or "red flags." There are certain things that are very obvious and "smack you in the face," as one of our interviewees noted. For example, there is no doubt that there is a problem when you see a resident in a wheelchair entering a stairwell or when you see someone getting strangled by his bed sheets. In some ways, glaring problems such as these result in easier surveys because the problems are so apparent. The surveys that really pose challenges to surveyors are those in which the problems or the signals for the problems are more subtle.

One of the differences between experienced and novice surveyors is the ability to pick up on some of the more subtle or "covert" cues that indicate that a particular area should be

investigated more thoroughly. Surveyors must be aware of and able to detect these subtle cues in order to make an accurate assessment of the facility's compliance with regulations. A sample of the types of cues that experienced surveyors may view as potential "red flags" are presented in Table 5 below.

Table 5—*Cues That Might Raise a "Red Flag"*

• Inconsistencies in records
• Urine odors
• A lack of staff present in a given area
• Residents crying because they're hungry
• Problems with the environment, such as holes in the walls
• Filthy toilets
• Discrepancies between records and what the staff is saying
• Residents that look exceptionally thin
• Residents that appear to be afraid of the staff
• Residents that are inactive or look bored
• Staff who cannot answer a question about a resident without flipping through a record
• Staff not able to produce records of showers or skin checks
• Resident's skin red and mushy
• Call lights not being answered
• Residents appearing bored and slouched over
• Dried stool in resident's diapers

In certain cases, it is a single cue by itself that will alert a surveyor. But other times it is a combination of cues within a particular context that indicates a potential problem. For example, consider a situation where a meal is brought to a resident, but the staff does not help to feed him. This by itself may not raise a red flag because many residents eat without assistance. Upon further observation and record review, however, let's say you find that the resident is dependent and cannot eat by himself. Now, the fact that the staff did not feed the resident, in combination with the finding that he is dependent, suggests a serious problem. In this case, it is the combination of cues that raises the red flag.

As another example, sometimes a combination of behaviors of the staff and administration might signal that they are being dishonest or intentionally trying to cover up serious problems. Some of these cues are provided in Table 6 below.

Table 6—*Cues That Might Raise a "Red Flag" About the Honesty of Staff and Administration*

• If they are being very talkative and it's preventing you from doing what you're there to do
• If it seems to be taking a long time to get the information and documents that you are requesting

• If the staff offers you a drink and a magazine and asks you to sit down for awhile before beginning the tour
• If you have to ask them several times for a particular record that you need
• If the staff members are telling you conflicting stories

By themselves, some of the cues listed above might appear innocuous to an outside observer or a new surveyor. For example, a talkative staff member may be seen as just that: talkative. An administrator who offers you a drink may simply be seen as friendly and hospitable. A staff member may take a long time to retrieve a particular record for you simply because he/she was sidetracked with a more pressing concern. However, experienced surveyors know that if there is a pattern of these behaviors, it could indicate a serious problem of cover-up. Surveyors must be alert to such cues given that staff and administration cooperation is critical to the outcome of the survey. Unfortunately, due to many reasons including fear, embarrassment and the severe penalties associated with the citation, staff and administrators sometimes deliberately deceive or hide information from surveyors.

An important finding to highlight is that the way in which a surveyor interprets or attaches meaning to a cue (i.e., whether or not he/she views it as a "red flag") might be influenced by his/her professional background. One surveyor we interviewed described for us a survey in which members of her team with different backgrounds interpreted a cue quite differently:

"*…during the tour, a member of my team who was a very experienced surveyor (and a social worker) walked into a room where there was a blood stain on the carpet outside the bathroom. But since there were no residents in the room, she disregarded it. Another surveyor (who was an R.N. with nursing home experience) walked by the room and saw the spot on the floor. She decided to ask the cleaning woman what happened. The woman told her that she couldn't get the blood stain out of the carpet, which was caused by the resident falling and cracking her head open. The 2nd surveyor found the resident and examined her only to see her face badly bruised and a cut down the middle of her forehead…"*

In this particular case, one surveyor saw the blood stain as a red flag while the other did not. The social worker needed the resident in the room to put the cues together that there was a problem. The RN just needed the stain to wonder what really happened and investigate further. Given that surveys (particularly annual surveys) are often conducted within teams, it is essential that surveyors are aware that a person's background can influence how he/she interprets certain cues. Although this can be a complicating factor in a survey, it can also provide added value to the team. Noticing different cues and bringing that to the table when it is time for the team to make decisions can add to the completeness and accuracy of the final assessment.

Training Recommendations—There are several training recommendations that we suggest to prepare surveyors to detect potential problems in facilities. One training approach involves exposing surveyors to cue inventories. These inventories would include singular cues or patterns of cues that expert surveyors have identified as indicators of potential problems. We have examples of these cue inventories included above (see Tables 5 and 6). However,

further interviews would enable us to elicit cues for more categories. The cue inventories could also be expanded to include descriptions of what the cues might suggest or potential problem areas to which they might be linked. For example, the cue of staff members being extremely talkative might be followed by a description such as: this could suggest an effort to stall a surveyor in time to cover up problems in the facility. A cue of urine odors might be followed by a description such as: this could suggest problems with incontinent care. There are multiple options for how these inventories could be presented to surveyors, including in workbooks, during classroom presentations or online. The goal of this training would be to make surveyors aware of some of the more subtle cues that might indicate potential problems within the facility and to aid in the development of their mental models so that they are primed to take notice of such cues when they are present.

A second option would be to use DMXs, which would provide surveyors with practice in picking up on subtle indicators of potential problems. These DMXs would include scenarios that describe a particular incident, such as an interaction between a staff member and a resident during mealtime or a tour of the kitchen. The incident could be brief, but the description would be rich in cues—describing sights, smells, sounds, behaviors and so on. After reading the scenario, the trainees could be asked to pull out potential indicators of problems. They could be asked to describe what they believe the cues might indicate and what they would do or what they would look for to investigate further. This exercise could be conducted alone and with facilitated group discussion following it.

An additional recommendation would be to provide trainees with photos of areas within a facility or with video clips that depict what is seen through the eyes of a surveyor as he/she progresses through a survey. Given that many of the cues are perceptual in nature, surveyors would be able to gain practice in detecting indicators of problems (at least those that are visual) by observing pictures or video clips and being asked to identify red flags or what they would follow up on and investigate further. There are several ways in which this type of training could occur. Trainees could be presented with photos in a workbook, in a classroom slideshow or online. This would lend itself well to group discussion, allowing the surveyors to hear what others noticed and their rationale for why they would investigate a particular area further. If this is something that is done online, a facilitated chat function would be an option, with an expert surveyor noting anything additional that trainees did not notice and supplementing with real-lived examples.

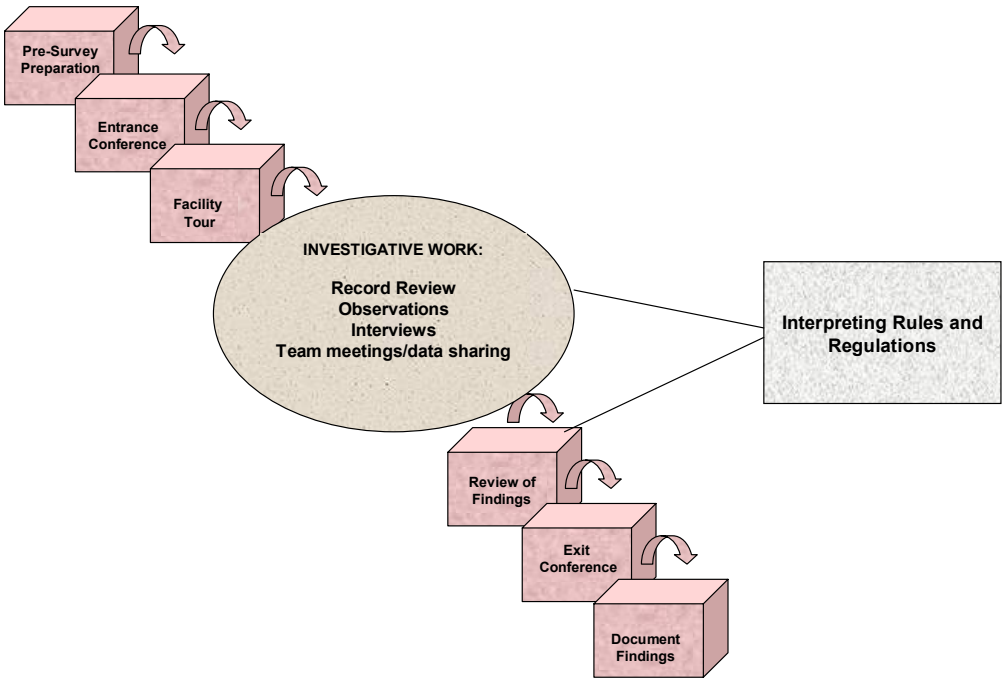
Video clips could be shown in a classroom setting or broadcast online. The strength of video clips over photos is that they can better depict dynamic behaviors and interactions with staff and administration. They could also be helpful in seeing an accumulation of cues over time. By themselves, certain cues might not raise a flag, but in combination with other cues that are encountered over the course of time, they may signal a problem. In addition, a video would lend itself well to a facilitated group discussion. The video could be organized in a series of clips and the facilitator could stop the video at key points to discuss indicators of potential problems.

Another possibility might be to set up three or four “walk-through rooms” (possibly at the place where they receive their initial training) that have various cues and indicators present

for them to see, smell, touch and hear. This would provide surveyors with practice on detecting problems that were indicated by olfactory, auditory or tactile cues, as opposed to just visual. This training possibility would be very high fidelity.

Stepping outside of a strictly training venue, it may also be possible to generate an on-line aid that surveyors could access and input combinations of cues they have seen during the survey. Based on their input, the tool could direct them towards possible interpretations or causes of the cues. This would likely be higher cost, but the pay-off would be great as well.

Interpreting Rules and Regulations



Aspects of Surveyor Expertise Associated with this Demand

- *Knowledge of the rules and regulations.*
- *Knowledge of what compliance and noncompliance "looks like" for general groupings of regulations.*
- *Awareness that there is more than one way to be in compliance with regulations.*
- *Understanding of the variety of ways in which a particular regulation (or groupings of regulations) could be met.*
- *Ability to step aside from emotions or personal preference (just because you don't agree, and that's not how you would do it doesn't mean it's not in line with regulation).*

Throughout the course of the survey, but particularly during the *Investigative Work* and *Review of Findings*, surveyors are faced with the challenge of interpreting rules and regulations. One of the primary reasons why this is challenging is because rules and regulations are not black and white. Rather, they are open to subjective judgment and interpretation. As a result, every facility creates their own unique policies in accordance with the regulations.

One of the problems associated with this is that a facility's policies may not match what the surveyor would like to see or what they are accustomed to seeing. Many surveyors are former RNs with experience "on the other side." In conducting their surveys, they frequently encounter policies that may be quite different from policies that they were accustomed to. Surveyors need to be aware, however, that this does not necessarily mean that a facility is

violating a regulation. The policy or policies that that the particular facility has adopted are likely to be a result of a different interpretation of a regulation. These differences can sometimes make it difficult for the surveyor to step outside of his or her frame for understanding how a regulation should be met or to leave his or her emotions behind.

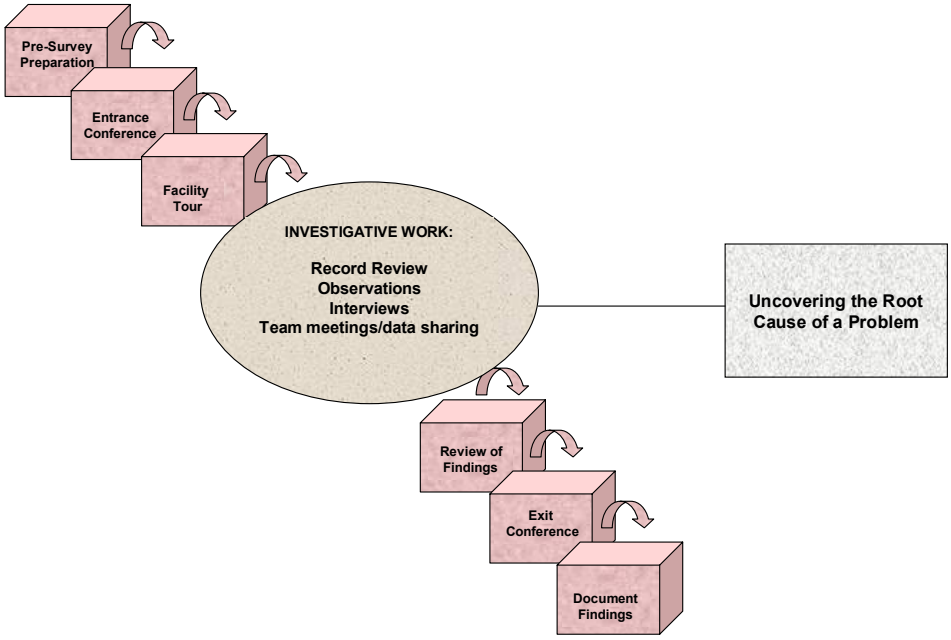
"Just because you don't agree, doesn't mean that it doesn't meet regulation. This assessment is difficult because you can't pull your emotions in to decide."

Training Recommendations—There are a variety of options for training surveyors to manage the challenge of interpreting regulations. One option is to provide surveyors with real examples elicited from experienced surveyors that reflect commonly encountered ambiguous situations. These situations can be fashioned into brief vignettes that depict how particular regulations can be met in several different ways with varying policies. This could be done in written form or with the use of photos or videos, depending on the type of regulation being addressed.

Another powerful exercise is to provide surveyors with a regulation and ask them to formulate several different policies that would meet the regulations. This would be a valuable tool for training surveyors to be aware that there are often several alternative ways in which a facility can be in compliance with regulations. The key is knowing what factors to consider in making the assessment of compliance.

In order to provide surveyors with practice in making the determination of whether a particular policy or behavior is in compliance with regulations, DMXs could be utilized. The DMX could present surveyors with scenarios that are based upon actual incidents provided by expert surveyors in which interpreting compliance was very ambiguous. These DMXs could be paper-and-pencil or computer-based and would be, ideally, facilitated by an expert surveyor. Although we have some initial examples from our current data set, additional follow-up interviews would enable us to obtain more examples of situations in which the interpretation of regulations was not clear-cut to feed into the development of DMXs.

Uncovering the Root Cause of a Problem



Aspects of Surveyor Expertise Associated with this Demand

- *Awareness that problems identified may reflect more serious, deeply-rooted issues.*
- *Awareness that there is not a direct one-to-one mapping of symptoms to underlying problems (i.e., particular symptoms could point to different underlying problems).*
- *Awareness of how particular underlying problems might manifest themselves in symptoms (e.g., if the problem is a falsification of documentation problem, some of the symptoms would be a, b, and c. If it's a security problem, some of the symptoms would be x, y, and z).*
- *Ability to determine what information to seek when there is ambiguity in root cause.*
- *Ability to determine when you have gathered enough information and it is time to stop.*

Situations encountered in long-term care facilities are highly complex and what is seen on the surface does not necessarily reflect the true problem. Instead, the surface indicators may actually be symptoms of a much deeper issue. As one of our interviewees stated, "*It's like an iceberg. Sometimes you see what's on top then find out there's a whole mess underneath*."

Even for highly experienced surveyors, uncovering the underlying issue is generally not straightforward. This is largely because similar symptoms might reflect different underlying problems. For example, if residents are not being fed, it might be because the kitchen staff doesn't get the food out on time or it might be because the nursing staff leaves the food sitting outside the door. If the number of falls is high, it might be because preventative measures are not in place or it could be because the staff is not following correct procedures. Uncovering the true nature of the problem requires patience, thoroughness and lot of investigative "digging." As one surveyor noted, uncovering the true problem "is like peeling an onion." Surveyors have to go several levels down in order to find the core problem.

Finding the root cause of the problem can be even more challenging in complaint surveys due to the need to maintain confidentiality of the complainant. During a complaint investigation, you do not want the facility administration and staff to know exactly what you are investigating, so it can be tricky to uncover the real problem without "tipping your hand." Another complicating factor during a complaint survey is that you may not be able to interview the resident in question because they are either gone (due to death, hospitalization or transfer to another facility) or they may have a condition that makes it difficult or

impossible to speak with them. Needing to rely on records and staff alone can make the task exceedingly tricky.

Experienced surveyors have several strategies for helping them deal with the challenge of uncovering the underlying problems. One surveyor described a strategy of using a mental checklist to determine the root of the problem. During an annual survey, this particular surveyor observed an incident in which a resident coded and the staff did not do anything about it until a significant amount of time had passed. In his mental checklist, the surveyor was considering:

- What did the staff do? What didn't they do? And when?
- Did they do ABC (Airway, Breathing, Circulation)?
- What is the facility's policy on codes?
- Do they have a crash cart (defibrillators, etc.)? Where is it located? Who's in charge of bringing the crash cart to the code?
- What is the facility's system for determining someone's code status? Do the nurses know this system?
- Do all the units handle a code status the same way?

Using this mental checklist was useful in helping the surveyor uncover the underlying problem in this incident and ultimately assign a tag.

Other strategies that the interviewees described to help them with this challenge include:

- Sharing information with team members and comparing notes and observations.
- Chit-chatting with staff in the break room/talking in a casual environment.
- Calling family members.
- Making comparisons between plan of care and what they are observing.

The ability to uncover the root cause of a problem feeds directly into the decision that surveyors face toward the end of the survey in the *Review of Findings* phase—determining what to cite and what tags to assign. If the true underlying issues can be identified through the *Investigative Work* and data sharing among team members, it will ultimately facilitate these subsequent cognitive challenges.

Several of our interviewees noted that one of the most challenging aspects of trying to find the root of the problem is determining at what point you have gathered sufficient evidence and need to move on: "*The most difficult thing about this is knowing at what point to stop.*" One strategy mentioned to help deal with this is to call back to the main office and say, "*This is what I looked at—can you think of anything else?*"

Training Recommendations—There are several approaches that could be useful in enhancing surveyors' ability to uncover the root cause of a problem. One approach that we recommend is to provide surveyors with specific examples of symptoms or groupings of symptoms that could indicate different underlying problems. For example, it would be useful for surveyors to know that pressure sores could be an indicator of underlying problems such

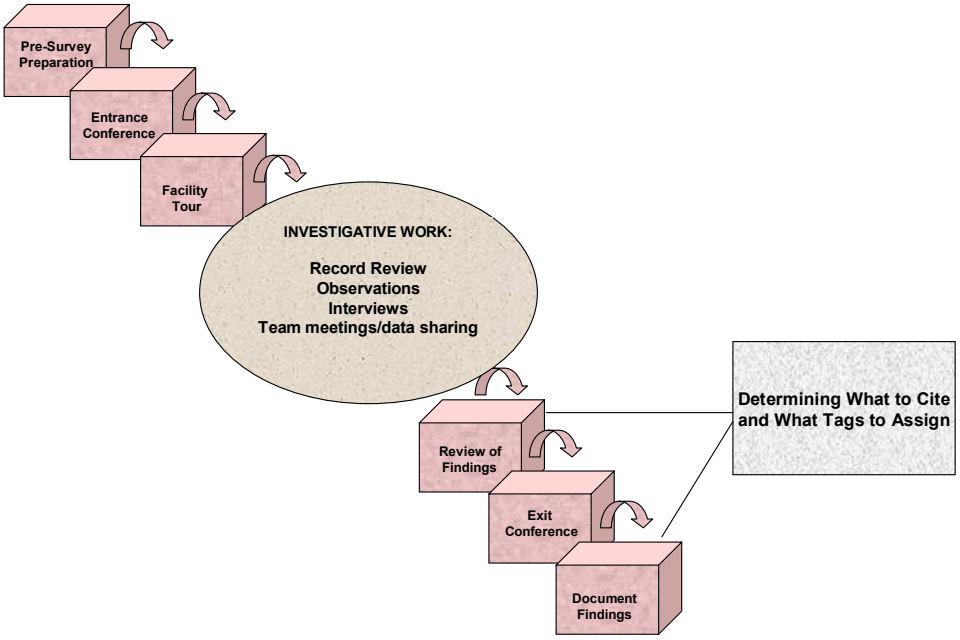
as poor nutrition, lack of incontinent care, not following care plans (i.e., if a resident needs to be turned every couple of hours) or inadequate treatment. Examples of how symptoms reflect particular underlying problems could be presented in class in a presentation format, in a workbook or online. The goal of this approach would be to build new surveyors' mental models of how particular symptoms and patterns of symptoms relate to certain underlying problems.

Another recommended approach is to present trainees with examples from expert surveyors of times when they have been challenged with sorting out ambiguities in root cause. We have some examples from our interviews that could be used as a starting point. These and other examples could be annotated with commentary from the experts that describes any techniques or tricks-of-the-trade used to help sort out the ambiguities, what key pieces of information they were looking for and so on. Similar to the approach recommended above, these examples could be presented in a variety of modalities. One possible way these could be presented is via video supplemented with commentary. The video could capture what would be seen through the eyes of a surveyor and the surveyor could describe their process of uncovering the underlying issues (i.e., what cues they were noticing, what the ambiguities were and what information they sought to sort out those ambiguities.) The commentary could also describe when the surveyors felt that he/she had gathered sufficient information to make an accurate determination of root cause.

In order to provide new surveyors with practice in uncovering the root cause of a problem, we recommend DMXs. These DMXs would include scenarios that describe an incident with a particular set of "symptoms." The trainees could then be asked to discuss how they would proceed with trying to uncover the root cause: what they would look for, where they would find it and so on. These DMXs could be paper-and-pencil or web-based. They could even be done as a video broadcast. Ideally they would be facilitated by an expert surveyor and open to discussion among several trainees.

Finally, since it is nearly impossible to remove all the uncertainty and ambiguity of determining the root causes of all the problems, it may be beneficial to provide the surveyors with some training on dealing with uncertainty. Exercises can help surveyors understand the types and sources of uncertainty they are facing and provide them with strategies for conducting their job effectively in the face of such inevitable uncertainty.

Determining What to Cite and What Tags to Assign



Aspects of Surveyor Expertise Associated with this Demand

- *Ability to prioritize citations when time might not permit citing everything that is found.*
- *Ability to sort out whether a particular incident or policy is in compliance with regulations.*
- *Knowledge of how determining root cause feeds into the determination of what tags to assign.*
- *Ability to discriminate between related tags.*
- *Awareness of the type of evidence necessary to support a citation.*
- *Awareness that there can be ambiguities in determining what tag to assign.*
- *Awareness that there can be disagreements amongst team members.*
- *Ability to reach team consensus on the citations.*

Surveyors are faced with an immense challenge of sifting through vast quantities of information accumulated from all their senses and somehow pulling all the information together into a coherent picture and an assessment of the situation. The decisions about what to cite and what tags to assign are informed by all the stages of the survey process, particularly the *Investigative Work*. However, the decision itself is generally made in the *Review of Findings* stage, with some modifications taking place in the documentation stage.

Determining what to cite is largely based upon the interpretation of regulations. As mentioned previously, regulations are not clear cut and are open to quite a bit of subjective interpretation. How a regulation is interpreted by surveyors affects whether they cite something as non-compliant. This is not the only factor that influences the determination of what to cite, however. This decision is also dependent upon what evidence the surveyors have accumulated throughout the course of the survey. Our interviewees noted that you cannot cite something just because you have a gut feel. In order for your citations to hold up in court, you must have the evidence to support them (e.g., detailed notes of conversations, copies of records, specific descriptions of observations and so on.). Often, surveyors are required to change their citations for this very reason. Once a citation write-up is reviewed by the supervisor, the surveyor may be asked to drop the cite or change it due to insufficient evidence to support it.

Determining the actual tags to assign is based largely upon what have been determined to be the root causes through the course of the *Investigative Work*. But given that the underlying

issues aren't always straightforward, determining what tags to assign is not always clear cut either. Sometimes there can be several different tags that would make sense to assign. One example provided by a surveyor we interviewed is the following:

"*We were watching a nurse do treatment for a pressure ulcer. She did things improperly and contaminated the area. One surveyor thought the incident should be written up under a tag specific to pressure ulcers. I thought it should go under an infection control tag."*

An additional challenge associated with determining what to cite is that surveyors are frequently very pressed for time. There may be hundreds of citations that are appropriate for a particular facility, but simply not enough time to write up every one of them and provide all the necessary supporting evidence. Due to time constraints, surveyors are faced with the requirement of prioritizing and selecting the most critical cites to make. Experienced surveyors are able to recognize which cites are more critical than others.

In annual surveys, the determination of what to cite and what tags to assign is conducted as a team. This team factor is critical to helping with the decision. Having others to bounce ideas off of, to share information with and get other information from, helps greatly in putting the pieces of the puzzle together and building a coherent assessment. "*When you meet back with the team, this is where you get a good idea of the big picture."* However, at the same, it can also result in conflicting interpretations and ambiguity. What might be clear to one surveyor, may be met with resistance by others on the team. One strategy used by surveyors to deal with ambiguity is to have team members make independent observations of the same area or record and then regroup to compare what they saw or read and determine whether they interpreted it the same way.

In complaint surveys, this team component generally does not exist. Building the big picture can be particularly challenging because surveyors are frequently by themselves and do not have others to share information with or bounce ideas off of. In these surveys, conferring with the office and talking with members of the staff can be helpful in filling in the gaps of the big picture in order to help the survey determine what to cite and the appropriate tags to assign.

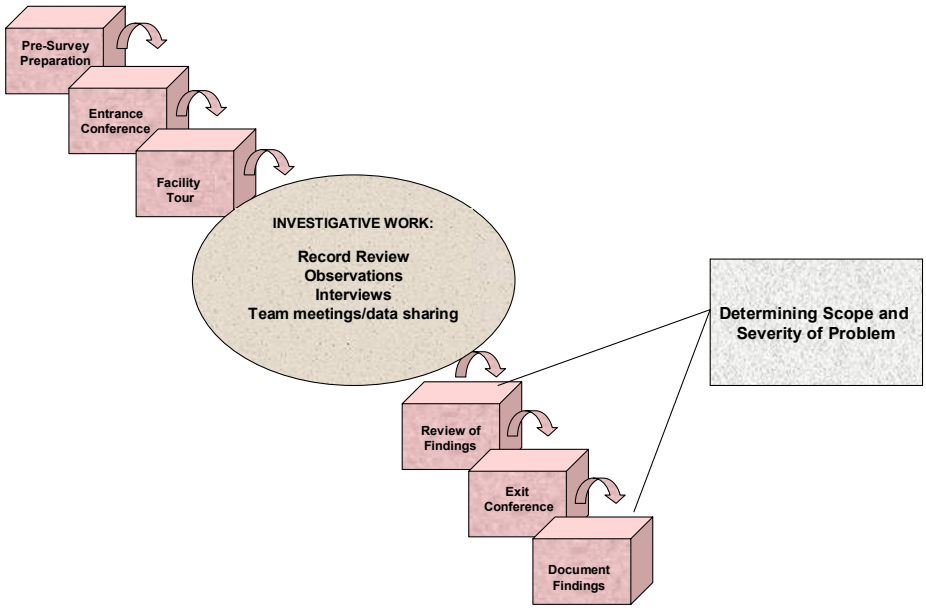
Training Recommendations—Although experienced surveyors may have some "rules of thumb" for helping to make these decisions, new surveyors are likely to struggle quite a bit with determining what to cite and what tags to assign. In order to prepare surveyors for the challenges of these decisions, it would be useful for them to have guidance for making these decisions. Additional interviews with experienced surveyors could be helpful in developing guides for some of the most common problems areas where there is great ambiguity in assigning tags. This could provide information to help novice surveyors understand which tags might be considered and why. These rules of thumb could be presented in workbooks, in class presentations or online.

A second option would be to provide surveyors with a compilation of case studies that illustrate examples of situations that surveyors found ambiguous, such as that of the pressure

ulcer incident described above. To be most effective, these examples could be followed by commentary that describes the steps the surveyors took to sort out the ambiguity, what questions they sought answers to, what additional information they gathered and their rationale for the final decision. These case studies would lend themselves well to a workbook or could be presented online. These could also include cases where the wrong cites or tags were made with explanations of why they were improper.

Finally, a DMX would allow surveyors to be engaged in the actual decision-making process. Surveyors could be provided with real-life examples and then be required to make a decision on what tag(s) needs to be assigned or what steps they would take to sort out the ambiguities. We have some initial examples from our data set that could be used to develop a DMX. In follow-up interviews, we could elicit additional examples by focusing the interviews on specific situations in which surveyors were faced with ambiguous situations in which they needed to differentiate between tags. Essentially the goal would be to build the experience base of novice surveyors in making these decisions.

Determining Scope and Severity of the Problem



Aspects of Surveyor Expertise Associated with this Demand

- *Knowledge of the grading scale and what each level "looks like" (for example, what do pressure sores look like for the various levels along the scale of severity).*
- *Ability to differentiate between the various levels of scope and severity.*
- *Awareness of the types of evidence needed to support each particular grade of scope.*
- *Knowledge of the types of evidence needed to support a particular level of severity.*
- *Knowledge of when enough information has been gathered to make an assessment of scope and severity versus when more is needed.*
- *Awareness of rules of thumb for determining the scope and severity.*

Similar to determining what to cite and what tags to assign, the decision of scope and severity takes place in the *Review of Findings* Stage and is sometimes modified during *documentation*. However, the determination is an ongoing process starting with the tour and continuing throughout the survey process. The key issues that play into this decision are: is the problem isolated, patterned or widespread (i.e., does it affect just one or two people or is there a pattern?) and, how severe is the problem and the potential for harm (i.e., does it pose an immediate risk to the life or health of the residents?).

One of the issues surveyors struggle with is trying to differentiate between the various levels when determining scope and severity. The gradations between the levels are not always clear cut, making it difficult to make this determination. Part of the reason this is challenging is because surveyors are required to describe a very complex situation by using a numerical rating system that does not necessarily correspond well to reality.

Contributing to the difficulty of the decision itself are the factors associated with the team process. Making this decision as a team requires effective communication and coordination throughout the course of the survey, as well as in team meetings. Through the information-sharing process, surveyors are able to fill in gaps in their own data collection and get a better sense of whether or not there are isolated cases or widespread problems based upon what the others have found. If a team can coordinate and share their findings with each other throughout the survey, then it makes the decision-making process of determining scope and severity more efficient because the team already has a focus and a shared sense of the situation.

Another component of determining scope and severity is the role of the supervisor. Almost all of the surveyors we interviewed, whether they were conducting a complaint survey by themselves or an annual survey with a team, used their supervisor for assistance in determining the scope and severity. If surveyors believe that they are seeing a jeopardy situation or something that seems widespread, they are likely to call the office and confer. The office generally will raise points or make suggestions for other things for the surveyors to investigate.

In order to support the level of scope and severity they ultimately assign, surveyors need to accumulate the necessary evidence. Individual surveyors and surveying teams may have a gut reaction that a particular problem is at the highest level of severity, but may only have evidence to support a lower level of severity. The surveyors must have the facts and evidence to ultimately support their conclusion in the documentation. As one surveyor noted, "*You have to be careful not to support the citation with information that makes it look either more or less severe than the level you've assigned*."

Contributing to the challenge of the scope and severity determination are factors related to the staff and administration. Given the harsh penalties associated with a more severe citation, surveyors may feel pressure from the facility administrators to decrease the level of scope or severity assigned. One surveyor described a time when she even felt that the administrators were trying to persuade her to "look the other way" and reduce the level of scope and severity assigned to a particular citation.

Training Recommendations—In order to help surveyors effectively manage the cognitive challenge of determining scope and severity there are several training recommendations that we have identified to make surveyors more knowledgeable and provide them with practice in making this determination.

The first recommendation is to provide surveyors with examples of scope and severity for general categories of problems (i.e., pressure sores, dehydration, falls, restraints, etc.).

Examples should illustrate the various levels for selected general categories. This could include pictures (if necessary) of the different levels and also documentation that could be used to support the level determined.

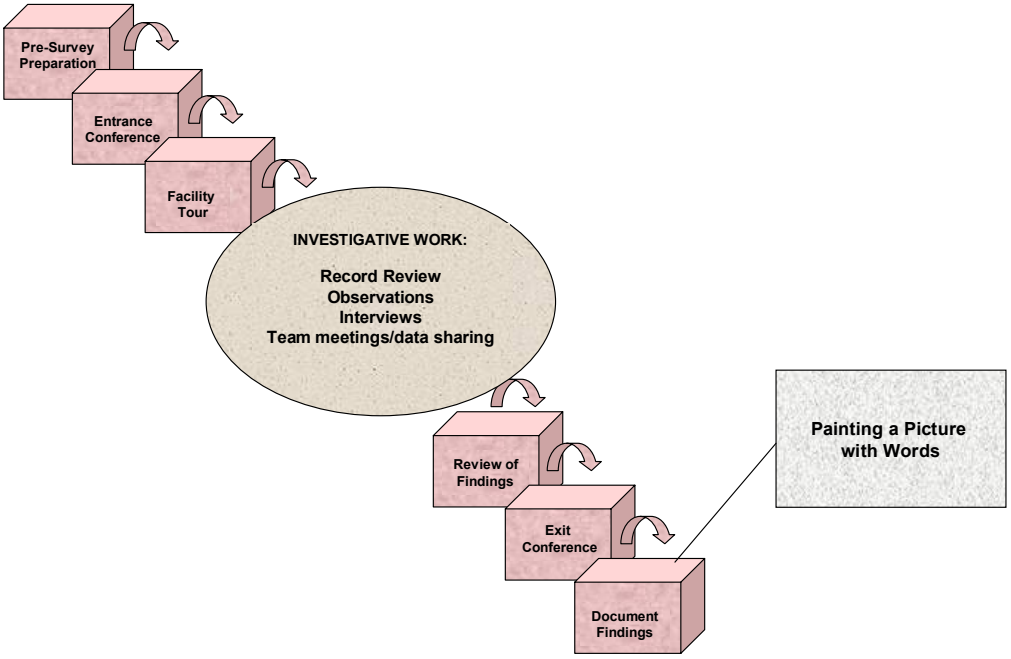
Another recommendation is to provide surveyors with “rules of thumb” to help them make these decisions. Surveyors could benefit from guidelines such as, the percentage of individuals who should have a problem in order to assign a particular level of scope. These “rules of thumb” could be taught in a classroom setting or they could be posted on the Internet. They could even come in the form of “cheat-sheets” or handouts that surveyors could easily take with them on a survey to refer to at any point in their decision-making process.

Providing surveyors with actual documented citations is another option. The examples could be annotated with the reasoning for why a particular level of scope and severity was assigned and what was needed to support that decision (observations, documentation, interviews and so on) or what would have been needed to support a higher level of scope and severity. This type of information could be presented in a workbook or online.

In order to acquire practice in making the determination of scope and severity, surveyors could be presented with DMXs. Surveyors could be presented with a scenario in which they would be required to determine the scope and severity of a problem or describe how they would go about making that determination. These DMXs could be “played” independently and then shared as a group. The power of this exercise comes from the after action review where surveyors would discuss each of the decisions they made and why. This exercise could be facilitated by an experienced surveyor and would encourage knowledge sharing of different approaches used for specific situations/problems.

Lastly, since this cognitive demand is dependent on the team decision-making process (specifically for annual surveys), it could be beneficial to provide team training. A framework such as Klein Associates’ Advanced Team Decision Making (ATDM) Model (Zsambok, Klein, Kyne, & Klinger, 1992) which describes behaviors critical to advanced team decision making, could be used to train surveying teams to make decisions effectively. This could be done in a workshop format for each individual office where surveyors could interact with their team members and also their supervisors.

Documenting the Findings: Painting a Picture with Words



Aspects of Surveyor Expertise Associated with this Demand

- *Knowledge about the appropriate steps, procedures, or formats for documentation.*
- *Awareness of the types of information needed for an effective write-up (i.e., one that will hold up in a court of law).*
- *Ability to effectively capture what you are sensing and turn those senses into words.*
- *Knowledge about the types of evidence that must be included to support citations (number of people affected, description and measurement of wounds, etc.)*

Once the *Review of Findings* has taken place, each team member writes up the deficiencies and then passes them on to the team coordinator. The team coordinator is then responsible for putting all the pieces together and *documenting the findings*. In complaint surveys, however, the documentation will usually not involve input from other team members.

Documentation is a challenging task for several reasons. For one, it is difficult to put perceptions into words. A lot of what the surveyor experiences is based upon a combination of senses and the overall feeling and conclusions that they reach about a facility can be very perceptual in nature. One of the surveyors described the task of documentation as "*painting a picture in words*." You need to relay your gut feelings in a written form and make a convincing case for your citation, but you also need to be careful not to make too many assumptions. *"If you put too many of your own assumptions in there, that can be a problem."*

The surveyors we interviewed described how they frequently spent a large amount of time on the write-up and often ended up feeling that they have a strong case, only to find out later that the office or the bureau chief does not agree. When this happens, the scope and/or severity may be downgraded by the office. Somehow, the feelings of the surveyors are not being communicated effectively in the documentation. *"It's difficult to relay what we're feeling on paper."* When talking about this challenge, the surveyors described how they may inadvertently neglect to include certain pieces of information in the documentation because they were so close to the situation and certain things were so obvious to them that it did not occur to them to write it down. It is very difficult to separate yourself and take a step back

and say, "OK, what questions would somebody have who hasn't seen/heard/smelled this situation?"

"Sometimes you're so close to it that it's difficult to get it all on paper. The picture someone gets when they read it is probably very different from the picture you got when you actually saw the situation. People reading it may have questions that you didn't even think to address in the citation because you were there and it was so obvious to you."

Overall, the task of documenting findings is extremely challenging. But, the surveyors we interviewed noted that documenting "Jeopardy" cases is the most challenging because of the need to provide sufficient detail to fully support the citation.

"It's difficult to write a Jeopardy case. Usually when writing a citation, you want to be as brief and to the point as possible. But with Jeopardy it's opposite. You have to put a lot of details in there. So they're usually very long."

Some of the strategies experienced surveyors use to facilitate documentation include taking detailed notes of every observation and every conversation so that those aspects and how they contributed to the final assessment could be pulled into the documentation.

"You need to document every conversation you have with the staff. Also make sure all the information is copied. You have to make sure you have facts to cover the deficiencies you report."

Others have different strategies for painting the picture in words. One surveyor spoke about putting more "umph" at the beginning of a write-up. She would start with a description of an observation and then move into the supporting evidence including facts from the records, from conversations with residents and interviews with staff members. Another surveyor spoke about picturing the write up as he progressed through the survey: "*You kind of take the information and picture how you're going to write it, how you're going to lay it out."*

Training Recommendations—To help new surveyors be prepared to manage the challenge of Painting a picture with words, they need to be trained on what a write-up should include. Surveyors seem to struggle with trying to figure out what information is necessary to construct an effective write-up and to fully support what they found throughout the survey. A training recommendation that we suggest is to provide surveyors with examples of documentation from actual surveys. Real-life examples from several different problem areas, with different levels of scope and severity, could help illustrate both effective and ineffective support of a particular citation. These examples would provide surveyors with a way to see all the evidence (notes from observations, interviews and records) included for a variety of write-ups. Differences between effective and ineffective write-ups could be discussed by a facilitator, followed by an opportunity for trainees to analyze write-ups independently and then discuss as a group.

Another recommendation is to provide surveyors with scenarios in which they can practice writing up a citation. They can begin with a simple citation and gradually work their way up to more difficult citations. These exercises could be disseminated through a variety of mediums. They could be classroom exercises with handouts, followed by a discussion or they could be computer-based where surveyors could use the web or a CD-ROM to work through a situation asynchronously.

A final training recommendation that we see as beneficial is to provide an After Action Review for surveyors. It was clear from our interviews that surveyors are frequently asked to downgrade their citation after their documentation is reviewed by their supervisor or bureau chief. But they generally do not know why or know what was lacking in the documentation. As noted by one of our interviewees, "*I want upper management to tell me if they're going to drop a cite and tell me why so that I don't make the same mistake twice.*" An After Action Review would be an opportunity for surveyors to receive feedback pertaining to their write-ups from their supervisors.

Additional Complicating Factors of the Survey Process

As one can see from the descriptions of the cognitive demands provided above, the survey process is extremely challenging and requires a high level of expertise in judgment, assessment and decision making. It involves much more than simply following rote procedures or checking the correct boxes in a series of checklists. However, in addition to the cognitive challenges already present in the surveying process, there are certain factors that contribute even further to the difficulty of conducting a survey and add additional difficulty to the challenging nature of the decisions and judgments involved. While we would not classify these factors as "cognitive challenges" per se, they are complicating factors that add an additional layer of complexity to the already challenging survey process and they demand particular skill sets on the part of surveyors. Each factor is described next.

Time Constraints Factor

The issue of time was a characteristic that continually surfaced in our interviews. The surveyors conveyed that working against the clock was one of the biggest complicating factors in conducting a survey. Time pressure further complicates the challenge of making critical assessments, judgments and decisions. The time constraints that surveyors face on a daily basis are usually due to the fact that there is too much information to examine and not enough time to look at it all. As one surveyor noted, *"Time is always a factor and it is tough to prioritize the survey to fit into the time allotted."* Another surveyor noted, *"It's a race against time."* It is necessary to manage time effectively so that toward the end of the survey, they have the necessary time to "*tie all the pieces together*" and to "*make sure you have all the facts to cover the deficiencies you are reporting*."

The time factor is particularly prominent within complaint surveys. As mentioned previously, complaint surveys are generally conducted over the course of just one day, making it very challenging for the surveyors to thoroughly investigate all the pertinent issues. One of our surveyors noted that, due to the time constraints involved, *"I never come back from a*

complaint satisfied!" Surveyors are often forced to limit the number of allegations they can investigate, often choosing the one or two primary allegations involved in the complaint. For example, one surveyor discussed an incident in which she was called in to conduct a complaint survey related to a woman who escaped from the facility without anybody knowing that she had left. In addition to that particular complaint, there were additional allegations involved—14 in total. But, she was only able to focus on the allegation of the woman who escaped, noting *"You don't really have time to look at all of them."*

The time factor also comes into play due to the practical constraint of a 40-hour work week. Several interviewees referred to the need to be cognizant of not dipping into overtime hours. One surveyor spoke about the need to document the findings very quickly because *"I only had 15 minutes left that week."* In addition, other members of her team had to leave early because they had already worked their 40 hours.

Breadth of the Survey

An additional complicating factor that goes hand-in-hand with time constraints is the breadth of the actual survey itself. Certain surveys have such an incredibly large breadth that surveyors can easily become overwhelmed. This factor is particularly prominent within annual surveys. Rather than investigating specific issues or problems that have been raised within a complaint, annual surveys involve investigating a very broad range of factors. Simply put by one surveyor, *"Annual surveys are challenging because there are so many factors to look into."*

The breadth of a survey may be further increased when the surveyors become alerted to a potential problem. For example, if the surveyors find evidence that there may be a problem with pressure sores in a particular facility, they may have to broaden their sample even further.

"We had to look at records, at assessments, get the facility to give us all evidence of skin checks. We had a terrible time managing the information. And then we added people to the sample. We ended up with 30+ people in the sample and it was only a 100-bed facility."

Gravity of the Issues Investigated

The gravity of the issues investigated in a survey also adds an additional layer of complexity to a survey. Sometimes what the surveyors see is very disturbing and it is important to be mindful of the emotional toll that such situations can take on a surveyor and how that emotional toll can complicate the survey process. One surveyor we interviewed spoke of a very severe case of pressure sores and neglect that she encountered while conducting an annual survey:

"During observations I watched a particular individual for a full day (on and off) to see if he was being turned….I noticed he stayed on his right side the whole entire day…When I asked a nurse to turn him for me, I saw bandages all over his back.

When I asked the nurse to take the dressings off so that I could see what was underneath, I saw stage 4 pressure sores all over his back. I also noticed that the man wore an incontinent brief. His brief was so saturated with urine that he had goose bumps all over him."

When the interviewee was telling us this story, she had a very difficult time even explaining the situation. She was very emotional. From this incident, as well as others, it was apparent to us that certain surveys can become very emotionally charged when the problems are severe. The vast majority of surveyors are in this job for the right reasons—they truly care about the care provided to the residents. Because of this, when highly severe cases are found, it can make the survey that much more challenging. The severity of the problems really does add an additional layer of complexity to an already demanding job.

Confidentiality

As discussed previously, determining whether there is a problem or a deficiency in a facility is one of the main cognitive demands of being a surveyor. This task is complicated by the need to protect and maintain the confidentiality of the residents and the complainants. When a complainant or resident provides a surveyor with information regarding an incident or individual, the surveyors are ethically bound to protect the privacy and confidentiality of that person. This can make the task of determining if there is a problem and getting to the root of the problem, exceedingly difficult. As one surveyor described the challenge:

"The toughest part is trying to investigate the issue while still maintaining confidentiality of the complainant. You don't want the facility to know who made the complaint. Your goal is to confuse them on why you are there… Sometimes you can find a sample with lots of residents with similar problems and sometimes it is much harder. The smaller the sample, the tougher it is to maintain confidentiality."

To deal with this additional complicating factor, experienced surveyors develop strategies for ensuring that confidentiality is maintained.

"I try to confuse the facility by asking them as soon as I walk in the door if they are working with any problems they would like to share. Sometimes they give me issues I am not even interested in, but these serve as a decoy to help me maintain confidentiality… I asked for several records so the facility didn't know which particular individual I was investigating…mostly asking for other records was to assure confidentiality."

"You try not to tip your hand too much on the first couple days. You let the facility know you have some concerns, but you try not to give them enough info to try to change the situation (e.g., manufacture stuff, fix stuff, etc). You don't want to give them a chance to fix things yet. Yet, you have to be in communication with the facility and as each day goes you have to give them more information and give them an idea of what you are looking at. Early on I'll try not to share too much but say, 'We have some concerns in a general area but we are still investigating.' You want to make

broad statements, i.e., concerns with falls or pressure sores. You don't want to tip off to particular residents or staff. You keep them informed and as the week goes by they start to know. This is also when you've started to verify 'You didn't have X in place or Y…!"

Information/Detail Management

While conducting surveys, whether it is a complaint or an annual survey, surveyors are faced with an enormous amount of information to sift through and make sense of. Many times, the amount of information can become overwhelming. An additional complicating factor is that sometimes all the information that they need is not available or is not organized in a way that facilitates organization of their case. Often, the information is "scattered" throughout the facility and the surveyors must find ways to find it and piece it all together.

"Surveys for facilities may have everything in a different book—the information you need is not all in one place so you can't put all the links of the story together as easily."

Due to the necessity of handling a large amount of frequently dispersed and fragmented data, skills at information and detail management are very important for a successful surveyor to possess. This skill is particularly important for a team leader on an annual survey. Not only do team leaders need to handle their own information, but they need to be able to synthesize the information accumulated by other members of the surveying team.

Staff Cooperation

One factor that can make a survey exceedingly challenging is when the staff is not cooperative or is aggressive or hostile. Sometimes the facility staff may have an "us versus them" mindset and may view the surveyors as being "on the opposite side." As a result of this mindset, they may go out of their way to make things difficult for the surveyors. However, as one surveyor put it, "Y*ou need to make it clear that you really are on the same side. We all want good patient/resident care*." Surveyors get an initial "gut" feel about how cooperative the staff and administration is going to be when they first begin a survey. If the staff seems uncooperative or hostile, it makes it very difficult to get the necessary information to conduct the survey effectively. As one interviewee described:

"We were having trouble getting any information. If the facility knows what we need, sometimes they will stall. Sometimes the stalling is intentional and sometimes they are trying to come up with something that will minimize the problem."

Any problems that might occur with administration and staff can put a huge kink in the survey process. The surveyors emphasized the importance of the staff helping them ascertain information, build the big picture and fill in gaps in their understanding of the situation. Without the staff and administration's cooperation, the survey can become exceedingly difficult. Knowing this demands that surveyors be skilled in establishing good working

relationships with members of the staff and administration. The ability to establish rapport is a critical skill that surveyors must work to possess.

Survey Management

A final complicating factor that we discovered in our interviews is related to survey management. In annual surveys, where surveys are conducted as a team, there is always one person who serves as team leader. This person has the challenging task of managing the survey and the rest of the team. Holding this position, adds an additional layer of complexity to the already challenging task of conducting a survey. The team leader is charged with additional responsibilities that are not faced by the other members of the team. For example, team leaders are responsible for ensuring that the team stay focused on the right problems and that information is shared effectively and consistently among team members. The team leader is also responsible for shifting the team's direction or making changes depending upon identified problems. Furthermore, if an additional task is added to a survey, such as when a complaint is added to an annual survey, it is the team leader's responsibility to either take on this task or to assign it to another team member. Throughout all of this, the team leader must also understand the skill sets of each individual team member and attempt to assign roles to fit these skill sets:

"Depending on the surveyors' background/training there may be some things they cannot do. For example, the dietitian and social workers cannot do med pass, skin, etc. Because of these limitations, it requires more schedule-juggling by the team leader."

Being competent in project management and team leadership are essential skills for surveyors to possess.

Incorporating Complicating Factors into Decision-Making Exercises

Throughout the discussion of the cognitive demands of the surveying process, one of our recommendations for providing surveyors with practice in making the challenging decisions and judgments faced in surveys was to provide them with DMXs. The key to the effectiveness of DMXs is creating them to be as cognitively authentic as possible. That is, they should be a recreation of the natural decision making space, reflecting what a surveyor would actually be experiencing and eliciting the same necessary judgments and decisions. With that in mind, the complicating factors described in the previous section could be effectively incorporated into the scenarios that comprise the DMXs. Scenarios could vary in their level of complexity by incorporating one or more of these factors into the context. For example, the difficulty of a scenario could be enhanced by incorporating an uncooperative staff into it or by imposing time pressure. Since these factors are frequently present in surveys and add additional layers of complexity to the already challenging judgments and decisions of a survey, they should be incorporated into any exercises aimed at providing surveyors with practice in those judgments and decisions.

Conclusions

A recent report by the U.S. General Accounting Office reported that despite some industry improvement, an unacceptable number of nursing homes have serious quality problems and surveyors are failing to catch a large number of those problems (U.S. Senate, GAO-03-1016T, 2003). Surveyors must be better prepared to handle the complexities of the surveying task. They must have the cognitive skills that will enable them to make accurate assessments of facilities' compliance with State and Federal regulations and make the proper cites that will ultimately lead to improvements. What is needed is the development of solid training programs that will prepare surveyors to handle the cognitive challenges they will face on the job. Resident safety and welfare is dependent upon surveyors' ability to manage these demands.

The primary goal at the outset of this effort was to identify the cognitive components involved in long-term care facility surveying so that these elements can be better incorporated into surveyor training programs. Through use of CTA methodology, we gained insight into the critical judgments, assessments and decisions that surveyors face, in addition to a host of complicating factors that contribute additional layers of complexity to the cognitively demanding surveying task. It is clear that the surveying task goes far beyond mindlessly following rote procedures and checking the right box on a series of forms. It involves a high level of sensemaking, attention and uncertainty management, use of mental models, problem detection and decision making.

The CTA interviews with expert surveyors highlighted the primary cognitive demands that surveyors face while conducting long-term care facility surveys and that training should address. These demands come into play in various stages of the survey process. They include:

- Determining an accurate set of problems and issues to investigate.
- Identifying a representative sample to investigate the issues.
- Determining what to look for and where to find it.
- Interpreting rules and regulations.
- Noticing "red flags" (detecting indicators of potential problems).
- Uncovering the root cause of the problem.
- Determining what to cite and what tags to assign.
- Determining scope and severity of the problem.
- Documenting the findings: painting a picture with words.

A variety of training techniques have been recommended to prepare new surveyors to manage these cognitive demands. There are several possibilities that should be considered in developing training programs that better address the cognitive complexities of the surveying task. Depending on which skills one is attempting to train, different training approaches and media will be more effective. Within this report we have made some specific training recommendations and we will summarize the highlights of those recommendations here:

Workbook Exercises—One method that we have recommended for training aspects of surveyor expertise is the use of "workbook" exercises. The aim of this type of training would be to enable new surveyors to begin developing the mental models necessary to conducting an accurate survey. These exercises could be particularly useful for building surveyor's mental framework for what issues to focus on in the investigation. They could, for example, include example documents such as QI matrices, previous facility surveys and so on and require the trainees to determine a list of issues to focus on in the survey. These workbook exercises would not necessarily have to be standard paper-and-pencil, but could also be conducted online.

Cue Inventories—Cue inventories are another option that could be particularly useful in building mental models of what to look for in a facility and the types of things that should alert a surveyor. The inventories would include singular cues and patterns of cues that expert surveyors have identified as indicators of potential problems in long-term care facilities. The cue inventories could also include descriptions of how the various cues might be interpreted or potential problem areas to which they might be linked. The purpose of exposing new surveyors to cue inventories would be to build their mental models so that they are better able to detect potential problems in a facility.

Case Studies—The use of case studies is another method that we recommend to enable surveyors to better manage the cognitive challenges they will face during the surveys. Utilizing case studies as a training tool would enable surveyors to see real examples of how expert surveyors have dealt with the various demands of the surveying task. For example, a compilation of case studies could be used to illustrate examples of situations where expert surveyors investigated particular issues (such as pressure sores, severe weight loss, etc.) and what they looked for to help them make an assessment about whether or not the facility was in compliance with regulations. Case studies could also illustrate examples of situations that surveyors found ambiguous and what the surveyors did to clarify the ambiguity—what questions they asked, who they talked to, what they looked for and so on. Case Studies could be presented in booklets, online or as part of a video. They are also well suited for discussion within a small group or online.

Decision Making Exercises—Another training technique that we recommend is the use of DMXs. Decision Making Exercises have been shown to be highly effective in helping novices get up to speed more quickly by providing them with cognitively realistic opportunities to practice making the challenging judgments, assessments and decisions associated with their job (Schmitt, 1994; 1996). Decision Making Exercises could be used, for example, in providing surveyors with practice in determining what tags to assign to a particular problem uncovered in a facility. They could also be used to give surveyors practice in determining how they would try to uncover the root cause of a problem, after being presented with a particular set of "symptoms." As mentioned previously, complicating factors such as lack of staff cooperation and time constraints could be interwoven into the DMXs to enhance their realism. These DMXs could come in the form of paper-and-pencil exercises, but could also reside on the Internet, providing low-cost, highly effective training to a wide audience. Ideally these exercises would all be facilitated by an expert surveyor and open to discussion among several trainees.

Photographs and Videos—Given that much of the surveying task involves the development of perceptual skills, we have recommended the use of photographs or videos to develop these skills. One possibility is to provide a video that depicts what is seen through the eyes of a surveyor as he/she progresses through a survey. Trainees could be given the opportunity to view the video and to pick out potential "red flags." Another option would be to provide commentary with the videos that described what the expert surveyor was thinking, what he/she was noticing and why certain things alerted him/her to investigate an issue further. The videos could be presented in clips, with a facilitator stopping the video at key points for discussion.

Collaborative Development of Expertise—Another training technique that is valuable in teaching new surveyors about the critical decisions and assessments of the surveying task is the Collaborative Development of Expertise (CDE) process (Stanard et al., 2001). Collaborative Development of Expertise is a type of On-the-Job-Training and is a compilation of techniques that help foster collaboration, improve mentoring relationships and provide structured materials for the mentor to use in evaluating the student. The CDE process provides a practical step-by-step method for both the trainer and the trainee. One of the issues that we heard in the interviews was a lack of understanding for knowing how to be a good preceptor/mentor. *"Sometimes it is tough to teach new people the thought process; however, this is the most important piece of information to convey."* The CDE process is a training guide that can be utilized once surveyors enter a facility, ensuring that surveyors learn the right information from their mentors. Collaborative Development of Expertise can be helpful in allowing expert surveyors and novice surveyors improve communication, improve coordination and share common ground about how a situation is unfolding and *how* to proceed.

Job Aids—In addition to training interventions, there are certain areas in which job aids could be valuable in helping surveyors manage the cognitive demands that they will face as part of the surveying task. One recommendation is a series of checklists (populated by expert surveyors) that surveyors can carry with them on the survey. These checklists would contain items that a surveyor should examine or factors that he/she should consider when investigating a particular problem area such as pressure sores or nutrition. Another recommendation is an on-line job aid that surveyors could access and input combinations of cues they have seen during the survey. The tool would direct them towards possible interpretations or causes of those cues.

The best form of training, overall, is the accumulation of real-life experiences. However, this can often take years and it is impractical when there is a need to get new surveyors up to speed quickly. Classroom instruction and lecture environments are valuable for teaching the procedural and declarative knowledge (i.e., the "what to think"). Yet in order to better prepare new surveyors to manage the cognitive complexity inherent in the surveying tasks, it is important to also train them on "how to think." Our recommended approach to training is to utilize techniques that fill the gap between procedural training and real-life experiences. We recommend cost-efficient, but *cognitively authentic* (Ross, Halterman, Pierce, & Ross, 1998; Ross & Pierce, 2000) strategies, tools and exercises that can help surveyors better understand "how to think" and how to handle the complex judgments, assessments and

decisions of the surveying task. The techniques we have described extend beyond typical approaches for imparting declarative knowledge and provide surveyors with the skills they will need to manage the cognitive complexities inherent in their job.

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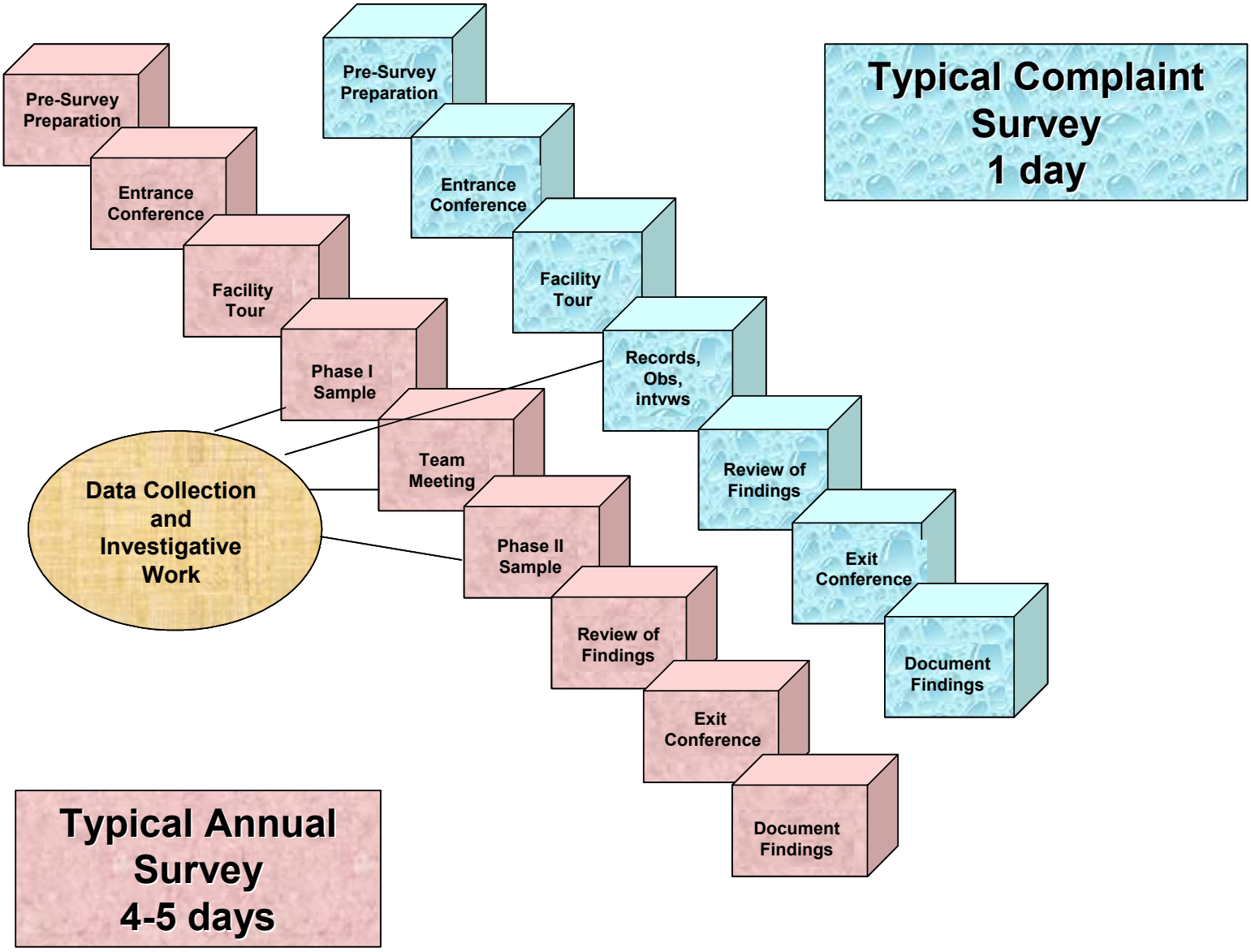
Appendix A

The Similarities and Differences in Process for Annual and Complaint Surveys


Typical Complaint Survey 1 day
Pre-Survey Preparation
Entrance Conference
Facility Tour
Records, Obs, intvws
Review of Findings
Exit Conference
Document Findings
Typical Annual Survey 4-5 days
Pre-Survey Preparation
Entrance Conference
Facility Tour
Phase I Sample
Team Meeting
Phase II Sample
Review of Findings
Exit Conference
Document Findings
Data Collection and Investigative Work

Lesson 3-V: Extended and Partial Extended Survey

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the circumstances that would require a survey team to conduct an extended survey or partial extended survey.
- Demonstrate an understanding of the activities required when conducting an extended or partial extended survey.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I
  - Appendix PP, Guidance to Surveyors for Long Term Care Facilities
- *Code of Federal Regulations:*
  - 42 CFR 483.13, Resident Behavior and Facility Practices
  - 42 CFR 483.15, Quality of Life
  - 42 CFR 483.25, Quality of Care
  - 42 CFR 483.40, Physician Services
  - 42 CFR 483.75, Administration

State

(Insert State reference[s] here.)

Other

Highlights

- Determining the existence of substandard quality of care
- Reviewing and verifying compliance with 42 CFR 483.30, 483.40 and 483.75

Training Techniques

- Lecture
- Group discussion
- Case study

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- *State Operations Manual (SOM):*
  - Chapter 7, Appendices P and PP
  - Form CMS-673, *Extended/Partial Extended Survey Worksheet*
  - Form CMS-805, *Resident Review Worksheet*
  - Form CMS-807, *Surveyor Notes Worksheet*
  - Sample completed Form CMS-2567, Statement of Deficiencies and Plan of Correction
- Handout:
  - *Severity and Scope Grid*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during a future training session

Audiovisual

Lesson 3-V:
Extended &
Partial Extended Survey

1

Slide 3-V-1

Outline or text of presentation

(This lesson is meant to build upon principles already presented in Lessons 2-I, Information Analysis for Deficiency Determination: Team Consensus Building, and 2-M, Appendix Q, Immediate Jeopardy.)

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the circumstances that would require a survey team to conduct an extended survey or partial extended survey.
- Demonstrate an understanding of the activities required when conducting an extended or partial extended survey.

2

Slide 3-V-2

(Inform the students of the objectives.)

Definitions

- Extended survey
  - Additional survey activities that must occur when standard survey finds that facility provides substandard quality of care
- Partial extended survey
  - Additional survey activities that must occur when abbreviated survey finds that facility provides substandard care
  - Another term for complaint survey

3

Slide 3-V-3

(Refer students to Lesson 3-U, Information Analysis for the Survey Process.)

Definitions

- Extended survey: Additional survey activities that must occur when a standard survey finds that a facility provides substandard quality of care.
- Partial extended survey: Additional survey activities that must occur when an abbreviated survey finds that a facility provides substandard care.

Audiovisual

Outline or text of presentation

– Abbreviated survey is another term for a complaint survey.

Definitions (cont.)

- Substandard quality of care
  - One or more deficiencies related to participation requirements under one of following:
    - 42 CFR 483.13, Resident Behavior & Facility Practices
    - 42 CFR 483.15, Quality of Life
    - 42 CFR 483.25, Quality of Care

4

Slide 3-V-4

- Substandard quality of care: One or more deficiencies related to participation requirements under one of the following.
  - 42 CFR 483.13, Resident Behavior and Facility Practices.
  - 42 CFR 483.15, Quality of Life.
  - 42 CFR 483.25, Quality of Care.

Deficiency Requirements

- Immediate jeopardy to resident health or safety at any scope
- Pattern or widespread at severity level 3
- Widespread at severity level 2

5

Slide 3-V-5

(Refer students to the handout "Severity and Scope Grid" on page 3-V-17.)

Deficiency Requirements

For the extended or partial extended survey, deficiencies must be one of the following:

- Immediate jeopardy to resident health or safety at any scope.
- Pattern or widespread at severity level 3.
- Widespread at severity level 2.

Severity & Scope Grid

4. Immediate jeopardy to resident health or safety	J PoC required	K PoC required	L PoC required
3. Actual harm that is not immediate jeopardy	G PoC required	H PoC required	I PoC required
2. No actual harm—potential for more than minimal harm	D PoC required	E PoC required	F PoC required
1. No actual harm—potential for minimal harm	A No PoC required, but to be corrected by the facility	B PoC required	C PoC required
	Isolated	Pattern	Widespread

Slide 3-V-6

Audiovisual

Timing

- May occur before exit conference
  - Facility should be told that team will be conducting extended survey
- At exit conference facility should be made aware of:
  - Findings related to information gathered
  - Deficiencies that will be cited

7

Slide 3-V-7

Outline or text of presentation

Timing of Extended/Partial Extended Surveys

- May occur before the exit conference.
  - The facility should be told that the team will be conducting an extended survey.
- At the exit conference the facility should be made aware of:
  - Findings related to the information that has been gathered.
  - Deficiencies that will be cited based on all of the survey activities.

Timing (cont.)

- If not possible before exit conference, may be conducted later
  - No later than 2 weeks after conclusion of survey
  - Advise facility that extended or partial extended survey will occur at later date

8

Slide 3-V-8

- If not possible before the exit conference, may be conducted later.
  - Must be completed no later than two weeks after the conclusion of the standard or abbreviated survey.
  - The facility should be advised that the extended or partial extended survey will occur at a later date.

Purpose of Extended Survey

- Explore extent to which facility's process may have contributed to severe outcomes
- Must include review of all tags under:
  - 42 CFR 483.30, Nursing Services
  - 42 CFR 483.40, Physician Services
  - 42 CFR 483.75, Administration

9

Slide 3-V-9

Purpose of an Extended Survey

- To explore the extent to which the facility's process may have contributed to severe outcomes.
- Must include a review of all tags under these headings:
  - 42 CFR 483.30, Nursing Services.
  - 42 CFR 483.40, Physician Services.
  - 42 CFR 483.75, Administration.

Audiovisual

Purpose of
Extended Survey (cont.)

- Focus on policies & procedures that may have contributed to substandard quality of care

10

Slide 3-V-10

Outline or text of presentation

- Will focus on the policies and procedures that may have contributed to substandard quality of care.

Resources for Extended Survey

- Policies & procedures
- Staffing records
  - Schedules
  - Assignments
- Staff qualifications
  - Job descriptions
  - Verification of license designation
- Recruitment procedures
- Training & proficiency documentation

11

Slide 3-V-11

Resources for an Extended Survey

- In addition to policies and procedures, may review:
  - Staffing records.
    - Schedules.
    - Assignments.
  - Staff qualifications.
    - Job descriptions.
    - Verification of license designation.
  - Recruitment procedures.
  - Training and proficiency documentation.

Extended Survey
Investigation

- If substandard quality of care is cited at 42 CFR 483.25, Quality of Care:
  - Review resident assessments for accuracy
  - Check sample comprehensive resident assessments (MDS) completed within 30 days of survey
    - See *Roster/Sample Matrix* for list of residents

12

Slide 3-V-12

Extended Survey Investigation

- If substandard quality of care is cited at 42 CFR 483.25, Quality of Care:
  - Include a review of resident assessments for accuracy.
  - Check sample comprehensive resident assessments (Minimum Data Set—MDS) that were completed within 30 days of the survey.
    - See the *Roster/Sample Matrix* for a list of residents.

Audiovisual

Extended Survey Investigation (cont.)

- Compare observations of resident with facility's assessment
- Review enough assessments to determine whether accuracy is issue
- Determine whether facility's assessment matches resident's condition & information gathered from family interview
  - If not, investigate further

13

Slide 3-V-13

Outline or text of presentation

- Compare observations of the resident with the facility's assessment.
- Review enough assessments to make a decision as to whether accuracy is an issue.
- Determine through interview whether the facility's assessment matches the resident's condition and information gathered from family interview.
- Investigate further if they don't match.

Extended Survey Investigation (cont.)

- Review RAPs & Care Plan decisions
- Investigate:
  - Nurses' notes
  - Physician's notes
  - Rehab/activity notes
  - Dietary notes

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Slide 3-V-14

- Include review of Resident Assessment Protocols (RAPs) and Care Plan decisions.
- Also investigate:
  - Nurses' notes.
  - Physician's notes.
  - Rehab/activity notes.
  - Dietary notes.

Followup to Extended Survey

- Revisit is conducted to reevaluate specific care & services cited in standard & extended survey
  - Focus on cited care issues
  - Sample selection is 60% of sample size for standard survey (Phase 1)
  - Revisit between date of correction & 60th day afterward

15

Slide 3-V-15

Followup to Extended Survey

- Revisit is conducted to reevaluate the specific care and services that were cited in the standard and extended survey.
  - Focus is only on cited care issues.
  - Sample selection is 60% of the sample size for a standard survey (Phase 1).
  - A revisit occurs between the date of correction and the 60th day afterward.

Audiovisual

Partial Extended Survey

Conducted after:
- Abbreviated survey
- Revisit when substandard quality of care is determined

16

Slide 3-V-16

Outline or text of presentation

Partial Extended Survey

Conducted after:
- An abbreviated survey.
- A revisit when substandard quality of care is determined.

Timing of Partial Extended Survey

- Conduct partial extended survey:
  - Prior to exit conference
  - No later than 2 weeks after standard survey
- Tell administrator you will conduct partial extended survey before leaving facility

17

Slide 3-V-17

Timing of Partial Extended Survey

- Conduct the partial extended survey:
  - Prior to exit conference.
  - No later than two weeks after the standard survey.
- Tell the facility administrator that there will be a partial extended survey conducted before you leave the facility.

Partial Extended Survey Investigation

Review:
- 42 CFR 483.30, Nursing Services
- 42 CFR 483.40, Physician Services
- 42 CFR 483.75, Administration

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Slide 3-V-18

Partial Extended Survey Investigation

Fully review:
- 42 CFR 483.30, Nursing Services.
- 42 CFR 483.40, Physician Services.
- 42 CFR 483.75, Administration.

Audiovisual

Partial Extended Survey Investigation (cont.)

- Concentrate on facility policies & procedures that may have caused substandard quality of care
- Review staffing, in-service training & infection control program

19

Slide 3-V-19

Outline or text of presentation

- Concentrate on the facility policies and procedures that may have caused substandard quality of care.
- Review staffing, in-service training and infection control program.

Partial Extended Survey Investigation (cont.)

- Conduct detailed review of accuracy of resident assessment
  - MDS & RAPs
- Review:
  - Nurses' notes
  - Physician's notes
  - Rehab/activity notes
  - Dietary notes

20

Slide 3-V-20

- Conduct a detailed review of the accuracy of resident assessment.
  - MDS and RAPs.
- Review:
  - Nurses' notes.
  - Physician's notes.
  - Rehab/activity notes.
  - Dietary notes.

Reviewing Accuracy of Resident Assessment

- Use MDS completed no more than 30 days prior to survey
- Compare observations of resident with facility's assessment
- Review enough assessments to determine whether accuracy is issue

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Slide 3-V-21

Reviewing Accuracy of Resident Assessment

- Use MDS completed no more than 30 days prior to conducting the survey.
- Compare observations of resident with the facility's assessment.
- Review enough assessments to make a decision if accuracy is an issue.

Audiovisual

Reviewing Accuracy of Resident Assessment (cont.)

- Determine whether facility's assessment matches resident's & information gathered at time of family interview
  - If not, investigate further

22

Slide 3-V-22

Outline or text of presentation

- Determine through interview whether the facility's assessment matches the resident's and information gathered at the time of family interview.
- Investigate further if they don't match.

Followup to Partial Extended Survey

- Revisit is conducted to reevaluate specific care & services cited in standard & extended survey
  - Focus on cited care issues
  - Sample selection is 60% of sample size for standard survey (Phase 1)
  - Revisit occurs between date of correction & 60th day afterward

23

Slide 3-V-23

Followup to Partial Extended Survey

- Revisit is conducted to reevaluate the specific care and services that were cited in the standard and extended survey.
  - Focus only on cited care issues.
  - Sample selection is 60% of the sample size for a standard survey (Phase 1).
  - A revisit occurs between the date of correction and the 60th day afterward.

Followup to Partial Extended Survey (cont.)

- Revisit required if G-level or higher severity or scope

24

Slide 3-V-24

- A revisit must occur if a G-level or higher severity or scope is determined during a survey or complaint investigation.

Audiovisual

Lesson 3-V:
Extended &
Partial Extended Survey

Questions

25

Slide 3-V-25

Outline or text of presentation

Skill Assessment

Extended and Partial Extended Survey

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Identified circumstances requiring an extended or partial extended survey.	
					Determined the extent to which structure and process factors (such as written policies and procedures, staff qualifications and functional abilities, and specific agreements and contracts of the facility) may have contributed to survey outcomes.	
					Conducted the survey: • Prior to the exit conference. • No later than two weeks after the standard/ abbreviated survey was completed.	

					Fully reviewed and accurately verified compliance with *each* tag number under: • Nursing services. • Physician services. • Administration. Focused on facility policies and procedures that may have produced substandard quality of care.	
					Appropriately and accurately reviewed: • Staffing. • In-service programs. • Infection control.	
					For substandard quality of care, accurately conducted a detailed review of the accuracy of resident assessments: • Reviewed a sample of comprehensive resident assessments completed not more than 30 days prior to the survey. • Compared observations of the resident with the facility's assessment. • Conducted the number of assessment reviews needed to make a decision about accuracy of facility assessments. • Determined whether observations and interviews matched the facility's assessment (or specific portions of the assessment).	

Comments/Recommendations:

Severity and Scope Grid

4. Immediate jeopardy to resident health or safety	**J** PoC required	**K** PoC required	**L** PoC required
3. Actual harm that is not immediate jeopardy	**G** PoC required	**H** PoC required	**I** PoC required
2. No actual harm—potential for more than minimal harm	**D** PoC required	**E** PoC required	**F** PoC required
1. No actual harm—potential for minimal harm	**A** No PoC required, but to be corrected by the facility	**B** PoC required	**C** PoC required
	Isolated	Pattern	Widespread

Lesson 3-W: Exit Conference

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Coordinate with team members and conduct an exit conference, following both Federal and State directives.
- Explain the value of team preparation and coordination before the exit conference, including the importance of information gathering, communicating findings to facility staff before the exit conference and documenting decisions regarding the facility's compliance.
- Demonstrate appropriate conduct and professional attitude, behavior and appearance during the exit conference.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 2, The Certification Process, Sections 2722–2724
  - Appendix P, Survey Protocol for Long Term Care Facilities - Part I

State

(Insert State reference[s] here.)

Other

Highlights

- *SOM* directives and survey process requirements regarding the exit conference
- Individual and survey team preparation before the exit conference

Training Techniques

- Lecture
- Group discussion
- Small group exercise to solve a problem using examples developed by the State agency trainer
- Brainstorming
- Role-play
- Return demonstration during actual survey with feedback evaluation by Preceptor

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - *Required State/Regional Office Forms for Exit Conferences (to be generated locally)*
  - *Exit Conference Procedure*
  - *Example: Long Term Care Exit Conference*
- Optional handout: *SOM* sections 2722–2726

Methods of Evaluation

- Completion of skill assessment
- Feedback evaluation to be developed by State agency trainer

Audiovisual	Outline or text of presentation
Lesson 3-W: Exit Conference 1 Slide 3-W-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Coordinate with team members & conduct an exit conference, following both Federal & State directives. 2 Slide 3-W-2	*(Inform the students of the objectives.)*
Learning Objectives (cont.) • Explain the value of preparation & coordination before the exit conference, including the importance of information gathering, communicating findings to facility staff before the exit conference and documenting decisions regarding the facility's compliance. • Demonstrate appropriate conduct & professional attitude, behavior & appearance during the exit conference. 3 Slide 3-W-3	

Audiovisual

Preparing for Exit Conference

- Good exit conference requires careful preparation beforehand:
  - Team must reach consensus on deficiencies to be cited prior to conference
  - Documentation that supports findings of noncompliance should be obtained
    - Regulation number & portion
    - Evidence

4

Slide 3-W-4

Outline or text of presentation

Preparing for the Exit Conference

A good exit conference requires careful preparation beforehand:

- The team must reach a consensus on the deficiencies to be cited prior to the conference.
- The appropriate documentation—the regulation number and portion and evidence that supports the findings of noncompliance—should be obtained.

Preparing for Exit Conference (cont.)

- Survey team must agree to conduct conference in one of following ways:
  - Survey team coordinator leads entire exit conference
  - Survey team coordinator:
    - Provides opening remarks
    - Calls on each team member in predetermined order to present certain findings or discuss certain deficiencies
    - Provides closing remarks

5

Slide 3-W-5

- The survey team must agree to conduct the conference in one of the following ways:
  - The survey team coordinator leads the entire exit conference.
  - The survey team coordinator:
    - Provides the opening remarks.
    - Calls on each team member in a predetermined order to present certain findings or discuss certain deficiencies.
    - Provides closing remarks.

Preparing for Exit Conference (cont.)

- If team foresees problem during exit conference, it should contact supervisor before exit conference
- Conduct meeting with all team members to determine facility's noncompliance
- Notify facility's administrator of date & time of exit conference

6

Slide 3-W-6

- If the team feels it may encounter a problem during the exit conference, it should contact the supervisor before the exit conference.
- Conduct a meeting with all team members to determine the facility's noncompliance.
- Notify the facility's administrator of the date and time of the exit conference.

Audiovisual

Preparing for Exit Conference (cont.)

- For long term care facilities:
  - Invite ombudsman, officer of resident council & 1 or 2 residents to attend exit conference
    - Abbreviated exit conference specifically for residents may be conducted after normal facility exit conference
    - Ombudsman should be invited to attend both conferences

7

Slide 3-W-7

Outline or text of presentation

- For long term care facilities:
  - Invite the ombudsman, an officer of the resident council and one or two residents to attend the exit conference.
    - An abbreviated exit conference specifically for residents may be conducted after the normal facility exit conference.
    - The ombudsman should be invited to attend both conferences.

Proper Attire & Conduct

- Survey team must dress & conduct themselves appropriately for exit conference:
  - Dress in professional attire & maintain professional image
  - Exercise discretion during conference
  - Avoid undesirable behaviors such as sarcasm & arrogance

8

Slide 3-W-8

Proper Attire and Conduct

The survey team must dress and conduct themselves appropriately for the exit conference:

- Dress in professional attire and maintain a professional image.
- Exercise discretion during the conference.
- Avoid undesirable behaviors such as sarcasm and arrogance.

(Demonstrate appropriate dress, professional image, discretion and proper behaviors and attitudes. Give positive and negative examples of each.)

Exit Conference

- Thank everyone for cooperation throughout survey
- Introduce all team members, including those not present
- Discuss reason for survey (annual, complaint investigation, revisit, etc.)

9

Slide 3-W-9

The Exit Conference

- Thank everyone for his/her cooperation throughout the survey.
- Introduce all of the team members, including those who are not present.
- Discuss the reason for the survey (annual, complaint investigation, revisit, etc.).

Audiovisual

Exit Conference (cont.)

Explain:
- That exit conference is informal meeting to discuss preliminary findings
- How team will conduct exit conference & explain ground rules

10

Slide 3-W-10

Outline or text of presentation

Explain:
- That the exit conference is an informal meeting to discuss preliminary findings.
- How the team will conduct the exit conference, and explain any ground rules.

Exit Conference (cont.)

- State that provider:
  - Will have opportunity to present additional information to try to resolve any issues before team departs
  - May submit additional evidence to survey agency immediately after survey

11

Slide 3-W-11

- State that the provider will have an opportunity to present additional information to try to resolve any issues before the team departs or may submit additional evidence to the survey agency immediately after the survey.

Exit Conference (cont.)

- Present findings of noncompliance, explaining why violation
- Do not provide regulation or tag
- Provide regulatory basis (e.g., paraphrase regulation if asked)
  - Present information in manner understandable to all present

12

Slide 3-W-12

- Present the findings of noncompliance, explaining why the findings are a violation.
- Do not provide the regulation/tag.
- Provide the regulatory basis (e.g., paraphrase the regulation if asked).
  - Present information in a manner understandable to all present.

Audiovisual

Exit Conference (cont.)

- Do not identify individuals
- Do not use resident or staff names
- Use resident number & staff title
- Avoid statements such as:
  - "Condition was not met"
  - "Standard was not met"
  - "I find that care standard was not met"

13

Slide 3-W-13

Outline or text of presentation

- Do not identify individuals.
  - If residents are present do not use resident names or staff names. Use resident number and staff title (e.g., "The nursing assistant assigned to care for Resident #23…").
- Avoid statements such as:
  - "The condition was not met."
  - "The standard was not met."
  - "I find that the care standard was not met."

Immediate Jeopardy

- If immediate jeopardy was identified or survey was extended, explain significance & need for immediate correction
  - Consequences will vary with provider type

14

Slide 3-W-14

- If immediate jeopardy was identified or the survey was extended, explain the significance and the need for immediate correction.
  - Consequences will vary with provider type.

Problems During Exit Conference

- If problem arises (such as staff member arguing about finding), allow survey team coordinator to handle it
- The *SOM,* section 2724, states:
  - Surveyors may refuse to continue conference if entity's attorney attempts to turn it into evidentiary hearing

15

Slide 3-W-15

Problems During the Exit Conference

- If a problem arises (such as a staff member arguing about a finding), allow the survey team coordinator to handle it.
- The *SOM*, section 2724, states:
  - Surveyors may refuse to continue the conference if the entity's attorney attempts to turn it into an evidentiary hearing.

Audiovisual

Problems During Exit Conference (cont.)

– Surveyors may refuse to conduct or continue conference any time provider creates environment that is hostile, overly intimidating or inconsistent with informal & preliminary nature of exit conference

16

Slide 3-W-16

Outline or text of presentation

– Surveyors may refuse to conduct or continue the conference any time the provider creates an environment that is hostile, overly intimidating or inconsistent with the informal and preliminary nature of an exit conference.

Problems During Exit Conference (cont.)

- Under problematic circumstances, team coordinator should state that exit conference is concluded & that survey agency will contact facility
- Team should leave facility immediately & contact team supervisor after leaving

17

Slide 3-W-17

- Under problematic circumstances, it is suggested that the team coordinator state that the exit conference is concluded and that the survey agency will contact the facility.
- The team should leave the facility immediately and contact the team supervisor after leaving.

Concluding Exit Conference

- If facility wishes to audiotape or videotape conference, surveyors should contact supervisor for guidance
- Explain that Statement of Deficiencies will be mailed to facility within 10 working days

18

Slide 3-W-18

Concluding the Exit Conference

- If the facility wishes to audiotape or videotape the conference, the surveyors should contact their supervisor for guidance.
- Explain that a Statement of Deficiencies will be mailed to the facility within 10 working days.

Audiovisual

Concluding Exit Conference (cont.)

- If deficiencies, facility will have 10 calendar days to complete & return Plan of Correction (POC) for achieving compliance within reasonable period of time—generally no longer than 60 calendar days

19

Slide 3-W-19

Outline or text of presentation

- If there are deficiencies, the facility will have 10 calendar days to complete and return the Plan of Correction (POC) for achieving compliance within a reasonable period of time—generally no longer than 60 calendar days.

Contents of Acceptable POC

- Plan for correcting specific deficiency
  - Should address processes that led to cited deficiency
- Procedure for implementing POC for specific cited deficiency

20

Slide 3-W-20

Contents of an Acceptable POC

- A plan for correcting the specific deficiency.
  - The plan should address the processes that led to the cited deficiency.
- A procedure for implementing the acceptable POC for the specific cited deficiency.

Contents of Acceptable POC (cont.)

- Monitoring procedure to ensure that POC is effective & that specific deficiency cited remains corrected &/or in compliance with regulatory requirements
- Title of person responsible for implementing POC

21

Slide 3-W-21

- A monitoring procedure to ensure that the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
- The title of the person responsible for implementing POC.

Audiovisual

After Exit Conference

- All team members should leave together immediately following exit conference
  - If facility staff present additional documents for review, team should decide who will remain
    - It may be prudent for two individuals to remain

22

Slide 3-W-22

Outline or text of presentation

After the Exit Conference

All team members should leave together immediately following the exit conference.

- If the facility staff present additional documents for review, the team should decide who will remain.
  - It may be prudent for two individuals to remain.

(Review the locally generated handout "Required State/Regional Office Forms for Exit Conferences.")

(Review the handouts "Exit Conference Procedure" and "Example: Long Term Care Exit Conference" on pages 3-W-17 and 3-W-19, respectively.)

(Optional: review SOM sections 2722–2726.)

(Conduct a role-play of an exit conference, including good and poor examples of:

- *Dress.*
- *Maintaining a professional appearance and demeanor.*
- *Discretion.*
- *Attitude—sarcasm, arrogance.*

Review the role-play, providing good alternatives to poor examples.)

Lesson 3-W:
Exit Conference

Questions

23

Slide 3-W-23

Skill Assessment

Exit Conference

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					With facility staff and team: • Confirmed date, time and place of exit. • For long term care (LTC), invited ombudsman, resident council officer and one or two residents. • Organized team presentation.	
					In LTC facility, if team chose, additionally held and appropriately communicated deficiencies during an abbreviated exit conference specifically for residents after the normal facility exit conference.	

					During the exit conference: • As needed, set "ground rules" at beginning of conference (*SOM* 2724). • Did not reveal identity of individual residents, patients or clients. • Presented information in a manner understandable to those present (including families, ombudsman, others). • Clearly described deficiencies not in compliance and the findings that substantiated the deficiencies. • Refrained from arguing with the provider and remained receptive (*SOM* 2724).	
					In LTC facility, if requested, provided a list of residents included in the sample (did not include the completed roster or sample matrix).	
					In LTC facility, if the extended survey was not yet completed, advised the facility that deficiencies may be amended upon completion of the extended survey.	
					Provided the facility staff with opportunity to discuss and/or supply additional pertinent information (because of ongoing dialogues, the facility should have been aware of all concerns prior to exit conference and had an opportunity to present additional information).	

					Discontinued the exit conference under conditions that were hostile, overly intimidating or inconsistent with informal and preliminary nature of the exit conference (*SOM* 2724).	
					Following the *SOM* 2726, accurately and thoroughly explained the process of preparation of the Statement of Deficiencies, timing and parts of an acceptable POC.	
					If immediate jeopardy was identified, clearly explained significance, need for immediate action and implications (*SOM* 2726).	
					Following *SOM* 2724, if the provider taped the exit conference, the entire exit conference was taped and a copy of the tape was secured by the team at the conclusion of the exit conference.	

Comments/Recommendations:

Exit Conference Procedure

Before the Exit Conference:

1. If the team feels it may encounter a problem during the exit conference, it should contact its supervisor beforehand. Allow sufficient time to respond to any directions received.
2. Meet with all team members to determine facility noncompliance, document the regulation, supply a phrase that describes the regulation if needed and support findings.
3. Notify the facility administrator of the date and time of the exit conference and who should be present. Arrange for the location of the exit conference.
4. For long term care facilities:
    a. Invite the ombudsman, an officer of the resident council and one or two residents to attend the exit conference.
    b. An abbreviated exit conference specifically for residents may be conducted after the normal facility exit conference.
    c. The ombudsman should be invited to attend both conferences.

During the Exit Conference:

1. Thank everyone for his/her cooperation throughout the survey.
2. Introduce all team members, including those who are not present.
3. Discuss the reason for the survey (annual, complaint investigation, revisit).
4. Explain that the exit conference is an informal meeting to discuss preliminary findings.
5. Inform those present that these are *preliminary findings*. Throughout the exit conference, refrain from making any general comments, such as "Overall, the facility is very good."
6. Explain how the team will conduct the exit conference and any ground rules (e.g., waiting until all findings have been presented or after each surveyor has presented his/her findings before commenting). State that the provider will have an opportunity to present additional information before the team departs to try to resolve any issues or may submit additional evidence to the survey agency immediately after the survey.
7. Present the findings of noncompliance, explaining why the findings are a violation. *Do not* provide the regulation/tag. *Do* provide the regulatory basis (paraphrase the regulation) if asked.
    a. Present information in a manner understandable to all present.
    b. Do not identify individuals.
    c. Avoid statements such as "the condition was not met" or "the standard was not met."

8. If immediate jeopardy was identified or the survey was extended, explain the significance and the need for immediate correction. Consequences will vary with provider type.
9. If a problem arises (such as a staff member arguing about a finding), allow the survey team coordinator to handle it. The *SOM*, section 2724, states:
    a. Surveyors may refuse to continue the conference if the entity's attorney attempts to turn it into an evidentiary hearing or
    b. Any time the provider creates an environment that is hostile, overly intimidating, or inconsistent with the informal and preliminary nature of an exit conference, surveyors may refuse to conduct or continue the conference.

    Under such circumstances, it is suggested that the team coordinator state that the exit conference is concluded and that the survey agency will be contacting the facility. The team should leave the facility immediately and contact the team supervisor after leaving.
10. If the facility wishes to audiotape the conference, it must tape the entire meeting and provide the team with a copy of the tape at the conclusion of the conference. Videotaping is also permitted if it is not disruptive to the conference and a copy is provided at the conclusion of the conference. It is at the sole discretion of the surveyors to determine whether the videotaping will be permitted.
11. Explain that a Statement of Deficiencies will be mailed to the facility within 10 working days.
12. If there are deficiencies, explain that the facility will have 10 calendar days to complete and return the Plan of Correction (POC) for achieving compliance within a reasonable period of time—generally no longer than 60 calendar days. An acceptable POC must contain the following elements, which will be included in the cover letter:
    a. A plan for correcting the specific deficiency. The plan should address the processes that led to the deficiency cited.
    b. A procedure for implementing the acceptable POC for the specific deficiency cited.
    c. A monitoring procedure to ensure that the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
    d. The title of the person responsible for implementing the acceptable POC.

After the Exit Conference:

All team members should leave together immediately following the exit conference. If the facility staff present further documents for review, the team should decide who should remain. It may be prudent for two individuals to remain.

Example:
Long Term Care Exit Conference

"Good [morning, afternoon]. Thank you for coming to the exit conference. As you know, this is the exit conference for your [annual, recertification, partial, complaint] survey. I am [name], Team Coordinator for this survey. Let me introduce the rest of the team [name & discipline]."

(Depending on the size of the group and other circumstances, you may or may not have the facility staff introduce themselves. Depending on the office protocol, you may want to have an attendance sheet for all those who attend the conference.)

"I want to recognize and thank the residents in attendance [include ombudsman if present]. As voluntary participants in the Medicare/Medicaid program for which the facility receives Federal monies, the facility is required to be in compliance with all Federal regulations within the 15 regulatory groupings."

(Give examples and include regulatory groupings of Quality of Life, Quality of Care and Resident Behavior & Facility Practice, especially if there is to be an adverse action.)

"I also want to thank the staff for cooperating with the team (answering our many questions, finding missing documents, providing us with water, etc.)."

"To determine compliance with the Federal regulations, we have been onsite for [number] days. We determined our findings by the following methods: multiple observations of care, treatments and activities; interviews with residents, families, direct care staff and administrative staff; and reviews of resident records and facility documents."

(Be specific: use discretion and good surveyor judgment. Some surveyors include a brief overview of the survey process itself, explaining the various tasks.)

"As we have shared our findings with you throughout the survey, there should be no surprises. We will be citing our findings but will not include specific tag numbers or specific severity and scope. The team will address questions and evaluate additional information at the end of the presentation of the findings, so please hold your questions until the end."

(State the findings. Don't forget to include the medication error rate. At the conclusion, ask the team if there is anything else that needs to be addressed.)

"These findings are preliminary. They will be submitted to a supervisor for review, and the facility will receive a written document (Form CMS-2567, Statement of Deficiency) within 10 working days. The facility may be required to submit a Plan of Correction. In this event, further written instructions will be provided in the cover letter."

"On behalf of the survey team, I thank the residents and staff for their cooperation with this survey process."

Lesson 3-X: Enforcement

Learning Objectives

At the conclusion of this lesson, you will be able to:

- State the requirements of an acceptable Plan of Correction.
- Describe a variety of enforcement actions.
- List the steps in enforcement.

Lesson Plan

References

Federal

- *State Operations Manual (SOM):*
  - Chapter 7

State

(Insert State reference[s] here.)

Other

Highlights

- Available enforcement remedies
  - Termination of the provider agreement
  - Temporary management
  - Denial of payment for all new Medicare and/or Medicaid admissions
  - Civil monetary penalties (CMP)
  - State monitoring
  - Transfer of residents
  - Transfer of residents with closure of facility
  - Directed Plan of Correction
  - Directed in-service training
  - Alternative or additional State remedies approved by CMS
- Section 7301—Immediate Jeopardy (IJ) may include:
  - Termination
    - As few as two calendar days
    - No later than 23 calendar days from the last day of survey if IJ not removed
    - CMP $3,050–$10,000 per day of IJ
- Non-IJ—see other remedies
  - While provider agreement terminations are authorized in non-IJ cases, it is not generally necessary or desirable to choose that remedy when compliance may be achieved rapidly through imposition of one or more alternative remedies
  - See Enforcement Grid—Section 7400E for more specific information for remedies
- Substandard Quality of Care (SQC)
  - Notification of doctor of each resident receiving SQC
  - Notification of State board for licensing the facility administrator
  - NACEPT (nurse's aide training) lost for three years
- Civil monetary penalties:
  - If facility waives right to hearing, the CMP is reduced by 35%
  - CMP is distributed to the US Treasury for Medicare and to State, depending on the facility resident population the date CMP begins to accrue

Training Techniques

- Lecture
- Group discussion
- Onsite survey
- Review of Form CMS-2567 with Plan of Correction

Training Aids

- PowerPoint slides and handouts
- Review of *SOM*
- Handouts:
  - *Enforcement Remedies*
  - *Postsurvey Revisits*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Review of surveyor decision logic in classroom setting and onsite

Audiovisual

Lesson 3-X:
Enforcement

1

Slide 3-X-1

Learning Objectives

At the conclusion of this lesson, you will be able to:

- State the requirements of an acceptable Plan of Correction.
- Describe a variety of enforcement actions.
- List the steps in enforcement.

2

Slide 3-X-2

Enforcement

- Policies & procedures necessary to remedy deficient practices & to ensure correction is lasting
- Facilities must take responsibility for monitoring own performance to sustain compliance

3

Slide 3-X-3

Outline or text of presentation

(This lesson builds on Lessons 3-U and 3-V. Inform the students of the objectives.)

Enforcement

- Policies and procedures necessary to remedy deficient practices and to ensure correction is lasting.
- Facilities must take the responsibility for monitoring their own performance to sustain compliance.

Audiovisual

Enforcement (cont.)

- A Plan of Correction emphasizes ability to achieve & maintain compliance leading to improved quality of care

4

Slide 3-X-4

Outline or text of presentation

- A Plan of Correction emphasizes the ability to achieve and maintain compliance leading to improved quality of care.

Steps in Enforcement

- CMS or State may impose one or more remedies in addition to or instead of termination of provider agreement when State or CMS finds that facility is out of compliance with participation requirements
  - *SOM,* Chapter 7

5

Slide 3-X-5

Steps in Enforcement

- CMS or the State may impose one or more remedies in addition to or instead of termination of the provider agreement when the State or CMS finds that a facility is out of compliance with participation requirements.

(Discussed in Chapter 7 of the State Operations Manual (SOM)—Survey & Enforcement Process for Skilled Nursing Facilities & Nursing Facilities.)

State Role

- State recommends appropriate enforcement actions to State Medicaid Agency for Medicaid & to Regional Office for Medicare

6

Slide 3-X-6

State Role

- The State recommends appropriate enforcement actions to the State Medicaid Agency for Medicaid and to the Regional Office for Medicare.

Audiovisual

Elements of Plan of Correction

A Plan of Correction must:
- Address all deficiencies
- Contain details on how facility will correct deficiency as it relates to an individual
- Indicate how facility will act to protect residents in similar situations

7

Slide 3-X-7

Outline or text of presentation

Elements of a Plan of Correction

A Plan of Correction must:
- Address all deficiencies.
- Contain details on how the facility will correct the deficiency as it relates to an individual.
- Indicate how the facility will act to protect residents in similar situations.

Elements of Plan of Correction (cont.)

- Include proposed corrective measures & systems to prevent recurrence of problem
- Indicate plans to monitor sustained performance
- Provide dates for completion of corrective action

8

Slide 3-X-8

- Include measures the facility will take or the systems it will alter to ensure that the problem does not reoccur.
- Indicate how it plans to monitor its performance to make sure that solutions are sustained.
- Provide dates when corrective action will be completed.

Processing Plan of Correction

- State agency must review & accept plan
- Unacceptability allows State to ask Regional Office or Medicaid agency to impose remedies
- Residents must receive all needed services

9

Slide 3-X-9

Processing the Plan of Correction

- Must be reviewed and accepted by the State Agency.
- If not acceptable, the State agency may ask Regional Office or Medicaid agency to impose remedies.
- Residents must receive all care and services that they need.

Audiovisual

Situations Requiring Enforcement of Regulations

- Immediate Jeopardy (IJ)
- Non-IJ violations of regulations

10

Slide 3-X-10

Outline or text of presentation

Situations Requiring Enforcement of Regulations

- Immediate Jeopardy (IJ).
- Non-IJ violations of regulations.

Immediate Jeopardy

- Provider's noncompliance caused or is likely to cause serious injury, harm, impairment or death
- Only *one* individual needs to be at risk

11

Slide 3-X-11

Immediate Jeopardy

This condition is defined as a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death to a resident. Only *one* individual needs to be at risk.

Immediate Jeopardy (cont.)

- Serious harm, injury, impairment or death does not have to occur before considering Immediate Jeopardy
- Serious harm can result from either physical or psychological abuse or neglect

12

Slide 3-X-12

Serious harm, injury, impairment or death does not have to occur before considering IJ. Serious harm can result from either physical or psychological abuse or neglect.

Audiovisual

Immediate Jeopardy (cont.)

- If condition of Immediate Jeopardy seems evident, investigation continues until condition is confirmed or ruled out

13

Slide 3-X-13

Outline or text of presentation

Upon recognizing a situation which may constitute IJ, proceed with the investigation process until IJ is confirmed or ruled out.

Examples of Immediate Jeopardy

- Failure to:
  - Protect from abuse
  - Prevent neglect
  - Protect from psychological harm
  - Protect from undue adverse medication consequences
  - Provide adequate nutrition & hydration

14

Slide 3-X-14

Examples of Immediate Jeopardy

- Failure to:
  - Protect from abuse.
  - Prevent neglect.
  - Protect from psychological harm.
  - Protect from undue adverse medication consequences.
  - Provide adequate nutrition and hydration.

Examples of Immediate Jeopardy (cont.)

- Protect from widespread nosocomial infections
- Identify individuals correctly
- Administer blood products & organ transplants safely
- Provide safety from fire, smoke & environmental hazards
- Provide medical services

15

Slide 3-X-15

- Protect from widespread nosocomial infections.
- Identify individuals correctly.
- Administer blood products and organ transplants safely.
- Provide safety from fire, smoke and environmental hazards.
- Provide medical services.

Audiovisual

Outline or text of presentation

Failure to Protect from Abuse

- Serious injuries (trauma, fractures)
- Nonconsensual sexual interactions
- Unexplained serious injuries not investigated
- Staff striking or roughly handling residents

16

Slide 3-X-16

Failure to protect from abuse:

- Serious injuries (trauma, fractures).
- Nonconsensual sexual interactions.
- Unexplained serious injuries not investigated.
- Staff striking or roughly handling residents.

Failure to Protect from Abuse (cont.)

- Staff yelling, swearing, gesturing or calling residents names
- Bruises around breasts or genitals
- Suspicious injuries (black eye, cigarette burns on skin)

17

Slide 3-X-17

- Staff yelling, swearing, gesturing or calling residents names.
- Bruises around the breasts or genitals.
- Suspicious injuries (black eye, cigarette burns on skin).

Failure to Prevent Neglect

- Lack of timely assessment after injury
- Lack of supervision for residents with special needs
- Failure to follow doctor's orders
- Repeated occurrences (e.g., falls) without interventions
- Access to chemicals & physical hazards

18

Slide 3-X-18

Failure to prevent neglect:

- Lack of timely assessment after injury.
- Lack of supervision for residents with special needs.
- Failure to follow doctor's orders.
- Repeated occurrences (e.g., falls) without interventions.
- Access to chemicals and physical hazards.

Audiovisual

Failure to Prevent Neglect (cont.)

- Hot water temperature too high
- Broken call system without alternatives
- Unsupervised smoking
- Lack of supervision of cognitively impaired residents at risk for elopement
- Failure to adequately monitor individuals with known severe self-injurious behavior

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Slide 3-X-19

Outline or text of presentation

- Hot water temperature too high.
- Broken call system without alternatives.
- Unsupervised smoking.
- Lack of supervision of cognitively impaired residents at risk for elopement.
- Failure to adequately monitor individuals with known severe self-injurious behavior.

Failure to Prevent Neglect (cont.)

- Failure to monitor serious medical condition
- Use of restraints without adequate monitoring
- Improper feeding or positioning of resident with known aspiration risk
- Inadequate supervision to prevent physical altercations

20

Slide 3-X-20

- Failure to monitor serious medical condition.
- Use of restraints without adequate monitoring.
- Improper feeding or positioning of resident with known aspiration risk.
- Inadequate supervision to prevent physical altercations.

Failure to Protect from Psychological Harm

- Use of chemical or physical restraints without clinical indications
- Threatening or demeaning behaviors from staff resulting in fearful residents
- Lack of interventions to prevent individuals from creating an environment of fear

21

Slide 3-X-21

Failure to protect from psychological harm:

- Use of chemical or physical restraints without clinical indications.
- Threatening or demeaning behaviors from staff resulting in fearful residents.
- Lack of interventions to prevent individuals from creating an environment of fear.

Audiovisual

Failure to Protect from Undue Adverse Medication Consequences

- Administration of medication to resident allergic to it
- Lack of monitoring to identify side effects
- Administration of contraindicated medications
- Lack of diabetic monitoring
- Lack of timely & appropriate monitoring for drug titration

22

Slide 3-X-22

Outline or text of presentation

Failure to protect from undue adverse medication consequences:

- Administration of medication to a resident allergic to it.
- Lack of monitoring to identify side effects.
- Administration of contraindicated medications.
- Lack of diabetic monitoring.
- Lack of timely and appropriate monitoring for drug titration.

Failure to Provide Adequate Nutrition & Hydration

- Inadequate food to meet nutritional needs
- Failure to provide adequate nutrition, resulting in malnutrition
- Withholding nutrition & hydration without advance directive orders
- Lack of potable water supply

23

Slide 3-X-23

Failure to provide adequate nutrition and hydration:

- Inadequate food to meet nutritional needs.
- Failure to provide adequate nutrition, resulting in malnutrition.
- Withholding nutrition and hydration without advance directive orders.
- Lack of potable water supply.

Failure to Protect from Widespread Nosocomial Infections

- Improper handling of body fluids
- High number of infections without appropriate reporting, intervention & care
- Ineffective infection control precautions
- High number of nosocomial infections from cross-contamination

24

Slide 3-X-24

Failure to protect from widespread nosocomial infections:

- Improper handling of body fluids.
- High number of infections without appropriate reporting, intervention and care.
- Ineffective infection control precautions.
- High number of nosocomial infections from cross-contamination.

Audiovisual

Failure to Correctly Identify Individuals

- Blood products given to wrong person
- Treatments performed on wrong person or wrong body part
- Administration of medication or treatments to wrong person
- Discharge of an infant to wrong individual

25

Slide 3-X-25

Outline or text of presentation

Failure to correctly identify individuals:

- Blood products given to wrong person.
- Treatments performed on wrong person or wrong body part.
- Administration of medication or treatments to wrong person.
- Discharge of an infant to wrong individual.

Failure to Safely Administer Blood Products & Organ Transplants

- Transfusion with wrong blood type
- Improper storage of blood products
- High number of serious blood reactions
- Incorrect cross-match & use of blood products or transplant organs
- Lack of monitoring for reactions during transfusions

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Slide 3-X-26

Failure to safely administer blood products and organ transplants:

- Transfusion with wrong blood type.
- Improper storage of blood products.
- High number of serious blood reactions.
- Incorrect cross-match and use of blood products or transplant organs.
- Lack of monitoring for reactions during transfusions.

Failure to Provide Safety from Fire, Smoke & Environmental Hazards

- Nonfunctioning equipment or lack of emergency equipment &/or power source
- Smoking in high-risk areas
- Incidents such as electrical shock, fires
- Ungrounded electrical equipment

27

Slide 3-X-27

Failure to provide safety from fire, smoke and environmental hazards:

- Nonfunctioning equipment or lack of emergency equipment and/or power source.
- Smoking in high-risk areas.
- Incidents such as electrical shock, fires.
- Ungrounded electrical equipment.

Audiovisual

Failure to Provide Safety from Fire, Smoke & Environmental Hazards (cont.)

- Lack of knowledge of emergency action
- Widespread infestation by insects or rodents
- Lack of functioning ventilation system
- Improper handling or disposal of hazardous material, chemicals or waste

28

Slide 3-X-28

Outline or text of presentation

- Lack of knowledge of emergency action.
- Widespread infestation by insects or rodents.
- Lack of functioning ventilation system.
- Improper handling or disposal of hazardous material, chemicals or waste.

Failure to Provide Safety from Fire, Smoke & Environmental Hazards (cont.)

- Locked exit doors not in compliance with *NFPA 101*
- Obstructed hallways & exits
- Lack of maintenance of fire alarm systems
- Unsafe dietary practices

29

Slide 3-X-29

- Locked exit doors not in compliance with *NFPA 101*.
- Obstructed hallways and exits.
- Lack of maintenance of fire alarm systems.
- Unsafe dietary practices.

Failure to Provide Medical Services

- Individuals turned away from emergency room (ER) without medical screening
- Women with contractions not medically screened
- Absence of ER & obstetrics (OB) records
- Failure to stabilize emergency condition
- Failure to appropriately transfer an individual with unstable emergency condition

30

Slide 3-X-30

Failure to provide medical services:

- Individuals turned away from emergency room (ER) without medical screening.
- Women with contractions not medically screened.
- Absence of ER and obstetrics (OB) records.
- Failure to stabilize emergency condition.
- Failure to appropriately transfer an individual with unstable emergency condition.

Audiovisual

Investigation

- Impartial, objective to obtain accurate data
- Observations
- Interviews of staff & residents
- Record review to support observations & interviews
  - Obtain physical evidence if needed

31

Slide 3-X-31

Outline or text of presentation

Investigation

- Impartial, objective to obtain accurate data.
- Observations.
- Interviews of staff and residents.
- Record review to support observations and interviews.
  - Obtain physical evidence if needed.

Team Actions

- Who was involved in IJ?
- What harm has occurred or will occur?
- When did situation first occur?
- Where did it occur; was it isolated or widespread?
- Why potential for harm?
- Why did actual harm occur?

32

Slide 3-X-32

Team actions:

- Who was involved in the IJ?
- What harm has occurred or will occur?
- When did the situation first occur?
- Where did it occur; was it isolated or widespread?
- Why the potential for harm?
- Why did the actual harm occur?

Decision Making

- Harm—was it actual or potential?
- Immediacy—when will harm occur?
- Culpability—did facility know about situation & attempt to correct it?

33

Slide 3-X-33

Decision making should focus on:

- Harm—was it actual or potential?
- Immediacy—when will harm occur?
- Culpability—did facility know about situation and attempt to correct it?

Audiovisual

Implementation

- If team decides IJ is present, contact State agency
- State agency will contact Regional Office

34

Slide 3-X-34

Outline or text of presentation

Implementation

- If team decides an IJ is present, contact the State agency.
- State agency will contact Regional Office.

Implementation (cont.)

- Team will notify the facility administration of IJ immediately
- Include specific details, individuals at risk
- Facility must begin immediately to remove the risk to individuals, implementing corrective action before team leaves

35

Slide 3-X-35

- Team will notify the facility administration of IJ immediately.
- Include specific details, individuals at risk.
- Facility must begin immediately to remove the risk to individuals, implementing corrective action before the team leaves.

Documentation

- Onsite confirmation of implementation of facility's corrective action to justify removal of IJ
- IJ removed, deficient practice corrected
- IJ removed, deficient practice not corrected
- IJ not removed

36

Slide 3-X-36

Documentation should capture:

- Onsite confirmation of implementation of facility's corrective action to justify removal of IJ.
- IJ removed, deficient practice corrected.
- IJ removed, deficient practice not corrected.
- IJ not removed.

Audiovisual

Remedies

- Directed Plan of Correction
- Directed in-service training
- State monitoring—temporary manager
- Denial of payment for all new Medicare & Medicaid admissions
- Civil monetary penalties
- Revisits

37

Slide 3-X-37

Outline or text of presentation

Remedies

(Refer students to the handout "Enforcement Remedies" on page 3-X-23.)

Remedies include:

- Directed Plan of Correction.
- Directed in-service training.
- State monitoring—temporary manager.
- Denial of payment for all new Medicare and Medicaid admissions.
- Civil monetary penalties.
- Revisits.

Remedies (cont.)

- Loss of certified nurse's aide training programs
- Termination of provider agreement
- Transfer of residents
- Transfer of residents with closure of facility
- Alternative or additional State remedies approved by CMS

38

Slide 3-X-38

- Loss of certified nurse's aide training programs.
- Termination of provider agreement.
- Transfer of residents.
- Transfer of residents with closure of facility.
- Alternative or additional State remedies approved by CMS.

Remedies for Immediate Jeopardy

- Termination
  - In as few as 2 calendar days
  - No later than 23 calendar days from last day of survey if IJ not removed
- Civil monetary penalties
  - $3,050–$10,000 per day of IJ
- Reference: *SOM,* Section 7301

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Slide 3-X-39

Remedies for Immediate Jeopardy

- Termination.
  - In as few as two calendar days.
  - No later than 23 calendar days from last day of survey if IJ not removed.
- Civil monetary penalties.
  - $3,050–$10,000 per day of IJ.
- Reference: *SOM,* Section 7301.

Audiovisual

Remedies for Non-IJ Situations

- Termination authorized, but not usually necessary or desirable
- Compliance may be achieved rapidly through 1 or more alternative remedies

40

Slide 3-X-40

Outline or text of presentation

Remedies for non-IJ situations

- Termination authorized, but not usually necessary or desirable.
- Compliance may be achieved rapidly through one or more alternative remedies.

Enforcement Grid

- *SOM,* Section 7400

41

Slide 3-X-41

Enforcement grid

- *SOM*, Section 7400.

Remedies for Substandard Quality of Care

- Notification of doctor of each resident affected
- Notification of State board responsible for facility licensing
- Nurse's aide training lost for 3 years

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Slide 3-X-42

Remedies for substandard quality of care

- Notification of doctor of each resident affected.
- Notification of State board responsible for facility licensing.
- Nurse's aide training lost for three years.

Audiovisual

Civil Monetary Penalties

- If facility waives right to hearing, penalty reduced by 35%
- Payment of penalty for Medicare-related cases is distributed to US Treasury
- Payment of penalty for Medicaid-related cases distributed to State

43

Slide 3-X-43

Outline or text of presentation

Civil monetary penalties

- If facility waives right to hearing, penalty is reduced by 35%.
- Payment of penalty for Medicare-related cases is distributed to US Treasury.
- Payment of penalty for Medicaid-related cases is distributed to State.

Lesson 3-X:
Enforcement

Questions

44

Slide 3-X-44

(Review the handout "Postsurvey Revisits" on page 3-X-25 with students.)

Skill Assessment

Enforcement

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Discussed an acceptable Plan of Correction.	
					Described a variety of enforcement actions.	
					Discussed the steps in enforcement.	

Comments/Recommendations:

Enforcement Remedies

- Available enforcement remedies:
  - Termination of the provider agreement.
  - Temporary management.
  - Denial of payment for all new Medicare and/or Medicaid admissions.
  - Civil monetary penalties (CMP).
  - State monitoring.
  - Transfer of residents.
  - Transfer of residents with closure of facility.
  - Directed Plan of Correction.
  - Directed in-service training.
  - Alternative or additional State remedies approved by CMS.
- Section 7301—IJ may include:
  - Termination.
    - As few as two calendar days.
    - No later than 23 calendar days from the last day of survey if IJ not removed.
    - CMP $3,050–$10,000 per day of IJ.
- Non-IJ—see other remedies.
  - While provider agreement terminations are authorized in non-IJ cases, it is not generally necessary or desirable to choose that remedy when compliance may be achieved rapidly through imposition of one or more alternative remedies.
  - See Enforcement Grid—Section 7400E for more specific information for remedies.
- Substandard Quality of Care (SQC).
  - Notification of doctor of each resident receiving SQC.
  - Notification of State board for licensing the facility administrator.
  - NACEPT (nurse's aide training) lost for three years.
- Civil monetary penalties:
  - If facility waives right to hearing, the CMP is reduced by 35%.
  - CMP is distributed to the US Treasury for Medicare and to State, depending on the facility resident population the date CMP begins to accrue.

Postsurvey Revisits

Refer to the SOM, Appendix P

Revisits (RV) are required for standard and abbreviated standard surveys whenever the facility *is not in substantial compliance* (i.e., any deficiency cited above a C on the Severity/Scope [S/S] grid.) Phone revisits are allowed if the highest S/S for all deficiencies is D, E or F. One onsite revisit must be conducted if the highest S/S for all deficiencies is G or higher. A revisit must occur between the latest correction date on the survey report and the 60th day after the survey.

Revisit objective: confirm that the facility is in substantial compliance and has the ability to remain in compliance.

1. Presurvey Preparation: Review the survey report.
   - Decide which survey tasks should be conducted and the extent of those tasks. The nature of the noncompliance dictates the scope of the revisit. Conduct as many survey tasks as needed to determine compliance.
   - Decide which worksheets might be needed and organize the packet. Use appropriate CMS forms during this survey.
   - If there are deficiencies related to a resident sample, a resident sample must be selected. Decide what the focus areas are and which residents from the original sample to include. An up-to-date Quality Indicator report may be helpful if there are many resident focus areas. The Roster/Sample Matrix (Form CMS-802) may also be helpful.
   - Obtain access as needed to a laptop computer, printer, paper and any environmental equipment.

2. Entrance Conference:
   - Make introductions and establish a private place to work.
   - Explain to the facility administrator how the revisit will proceed.
   - Give approximate timeframes for the Exit Conference.
   - Ask the administrator (or whomever he/she designates) to identify the residents that flag the focus areas.
   - The Roster/Sample Matrix may be requested from the facility.

3. Sample Selection: Focus on selecting residents who are most likely to have those conditions/needs/problems cited in the original survey. Include some previously sampled residents. The sample size will vary depending on the number of focus areas but should not exceed 60% of the original sample.

4. Information Gathering: Gather information regarding the:
   - Corrective actions for the previously sampled residents that are included in the RV sample. Also review the focus areas for the newly sampled residents. A review of Resident Assessment Instrument and care planning information may be necessary to determine whether negative outcomes in the resident focus areas were avoidable or unavoidable for each RV sampled resident.
   - System change to determine if the change has been completed.
   - Quality monitoring plan to determine if there is a reasonable possibility that this deficient practice will not recur.

   However, the team is not prohibited from gathering information related to any requirement during a post-survey revisit. Document information as necessary on whichever CMS worksheets are helpful to determine compliance.

5. Decision Making: Decide whether the facility has satisfactorily completed the corrective actions and system change and whether the quality monitoring plan appears adequate to identify future potential problems for each tag cited. If not, a tag may be cited again using the information gathered during the RV. New tags may also be cited to document additional noncompliance identified during the RV. Determine severity and scope of each tag cited.

6. Exit Conference: Inform the administrator of the RV findings. The administrator may decide who should be present during the conference.

7. Postsurvey Documentation: Prepare Form CMS-2567B on ASPEN. Prepare Form CMS-2567 if deficiencies are cited again or new ones are cited. Record time in ASPEN on Form CMS-670. Prepare the Resident Identifier List if an RV sample was selected. Organize the packet and route it to the Regional Office.

Lesson 3-Y: Test-Taking Skills

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Develop an individualized plan for review or study.
- Identify three concepts or clinical areas that are top priorities for review or study.
- Describe at least three useful skills for taking the Surveyor Minimum Qualifications Test (SMQT).
- Explain how to arrange the date and time of the test.
- Describe the process of nomination to the CMS Long Term Care (LTC) Basic Training class.
- List the materials that can be brought into the testing center.

Lesson Plan

References

Federal

- Social Security Act:
  - 1819(g)(2)(E)(ii)
  - 1819(g)(2)(E)(iii)
  - 1919(g)(2)(C)(ii)
  - 1919(g)(2)(E)(iii)
- *State Operations Manual (SOM):*
  - Chapter 4, Program Administration and Fiscal Management, Section 4009.1
  - Chapter 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, Section 7201B

State

(Insert State reference[s] here.)

Other

- Landsberger, J. (2005). Study Guides and Strategies–Tips for Better Test Taking. [Online]. Available: http://www.studygs.net
- Hopper, C. (2004). *Practicing College Learning Strategies* (3rd edition). Boston: Houghton Mifflin.
- Kesselman-Turkel, J. (2004). *Test-Taking Strategies.* Madison: University of Wisconsin Press.

Highlights

- Information from the *SMQT Automation Test Manual*
- Information from the *SMQT Automation Registration Manual*

Training Techniques

- Lecture
- Group discussion
- Small group exercise

Training Aids

- PowerPoint slides and handouts
- Chart pad with colored markers
- Handouts:
  - State-developed study plan or *Plan of Review and Study*
  - *Knowledge, Skills and Abilities (KSAs) Covered by the SMQT*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment
- Effective use of information during the SMQT

Audiovisual	Outline or text of presentation
Lesson 3-Y: Test-Taking Skills 1	
Slide 3-Y-1	
Learning Objectives At the conclusion of this lesson, you will be able to: • Develop an individualized plan for review or study. • Identify three concepts or clinical areas that are top priorities for review or study. • Describe at least three useful skills for taking the Surveyor Minimum Qualifications Test (SMQT). 2	*(Inform the students of the objectives.)*
Slide 3-Y-2	
Learning Objectives (cont.) • Explain how to arrange the date & time of the test. • Describe the process of nomination to the CMS Long Term Care (LTC) Basic Training class. • List the materials that can be brought into the testing center. 3	
Slide 3-Y-3	

Audiovisual

Outline or text of presentation

(Refer the students to the handout "Plan of Review and Study" on page 3-Y-25. The Skill Assessments provided elsewhere in the Preceptor Manual may also be used. Review the handout "Knowledge, Skills and Abilities (KSAs) Covered by the SMQT" on page 3-Y-29 with the students. Have students plan their review using handout "Plan of Review and Study" on page 3-Y-25 or State-developed assessment worksheets. Have the students keep the planning sheets in front of them.)

Assess, Plan & Implement

- Assess your skill level
- Plan review

4

Slide 3-Y-4

Assess Your Skills

The only time an exam should be a trial is when you are not prepared for it.

Prepare Early in Your Orientation

- Strengthen memory trace by identifying & documenting areas of process, regulations & content to review
  - Clarify
  - Gain experience

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Slide 3-Y-5

Prepare Early in Your Orientation

- Strengthen the memory trace by identifying and documenting areas of process, regulations and content topics of which you are unsure or with which you have little experience.
- Clarify the material, concepts and principles you find confusing.

Audiovisual

Start First Day

- Get special notebook & write down questions from first day of orientation
- Review with trainer or experienced surveyor
- Write answers next to questions

6

Slide 3-Y-6

Outline or text of presentation

- Get a special notebook and write down your questions from the first day of orientation.
- Review these with a trainer or experienced surveyor.
- Write the answers next to the questions.

Review Periodically

- Review presented materials
  - Do more than read & reread assignments
- Review for short periods rather than 1 long period
  - Facilitates retaining information

7

Slide 3-Y-7

- Review the presented materials.
  - Reviews are more than passive learning (reading and rereading assignments).
- Review for short periods rather than for one long period.
  - Short reviews make it easier to retain information.

Plan Your Review

- Begin studying or reviewing well before exam
  - Build understanding & memory in gradual fashion
  - Focus on critical knowledge, skills & abilities

8

Slide 3-Y-8

Develop a Review or Study Plan

- Don't begin studying or reviewing the night before your scheduled exam.
  - Most adult learners build understanding and memory in a gradual fashion.
  - The SMQT focuses on the knowledge, skills and abilities that are critical to perform the job.

Audiovisual

Identify Resources

Find:
- *SOM* chapters & appendices
- Relevant CMS broadcasts
- Internet sites for medical & clinical nursing skills

9

Slide 3-Y-9

Outline or text of presentation

- Identify resources:
  - Source of the exam material: which *SOM* chapters and which appendices.
  - The CMS broadcasts that focus on relevant areas.
  - Internet sites for medical and clinical nursing skills.
- Schedule review of the broadcasts.

Use Study Materials

- Take notes & make flashcards & recite from both
- Review 3 or 4 tasks or protocols per survey

10

Slide 3-Y-10

- Use study materials:
  - Take notes on the text, make flashcards and recite from these notes and cards.
  - Review three or four tasks or protocols each time you participate in a survey.

Do Final Review

- Make summary sheets: key & unlearned material
- Meet with experienced surveyors
  - Discuss unlearned topics or clinical areas
  - Team up with experienced surveyor on relevant complaint survey
- Pay special attention to intent of each task & regulation

11

Slide 3-Y-11

Do a Final Review

- Make summary sheets of the most important material and any important unlearned material.
- Meet with experienced surveyors.
  - Discuss the topics or clinical areas of which you are unsure.
  - Arrange to team up with an experienced surveyor on a relevant complaint (abbreviated) survey (e.g., find a surveyor who has experience as a dietician or is a skilled investigator of dietary issues and work with him/her on a complaint regarding weight loss and cold food).

Audiovisual

Outline or text of presentation

- Pay special attention to the intent of each of the tasks and regulations.

Prepare for Test Day

- Be sure of time & location of exam
- Avoid stress or worry
- Wear something comfortable
- Anticipate temperature issues

12

Slide 3-Y-12

Prepare for the Test Day

- Be sure of the time and location of the exam.
- Avoid stress or worry before the test, to cut down on distractions.
- Wear something comfortable.
- Anticipate temperature issues (e.g., if you anticipate getting cold, wear a long-sleeved shirt that allows you to roll up the sleeves).

Prepare for Test Day (cont.)

- Get sufficient sleep
- Eat something beforehand
- Choose an advantageous test time
- Be early
- Be confident
- Relax & practice slow, deep breathing

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Slide 3-Y-13

- Get sufficient sleep.
- Eat something beforehand so you will have energy throughout the test.
- Choose an advantageous test time.
  - Work with your training coordinator to choose the time of day and day of the week when you are most alert and focused.
- Arrive early at the testing center.
- Be confident of your abilities—psych yourself up!
- Relax and practice slow, deep breathing.

Manage Test Anxiety

- Some anxiety keeps you sharp
- Excess anxiety can be channeled
  - Picture your summary notes
  - Rehearse key concepts & terms
  - Picture yourself performing each task & protocol
  - Breathe slowly & deeply & relax
  - Focus on test items

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Slide 3-Y-14

Manage Test Anxiety

- Some anxiety is good for motivation and helps to keep you sharp.
- If you have excessive anxiety, try to channel it elsewhere.
  - Before the test begins, picture your summary notes and visualize key concepts and terms.
  - Picture yourself during the survey performing each task and protocol.

Audiovisual

Outline or text of presentation

– Take several slow, deep breaths and concentrate on relaxing your whole body.
– During the test, focus on the test items, not on how you think you are doing.

Optimize Physical Setting

- Adjust chair & monitor
- Position materials nearby
- Tell proctor of any difficulty
- Relax & practice deep breathing

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Slide 3-Y-15

Help Yourself During the Exam

Optimize the physical setting

- Make sure the chair is at the correct height, the monitor is adjusted and your materials are nearby.
- Tell the proctor if you are having difficulty adjusting your chair, desk or monitor.

Carefully Read Directions

- Misreading causes majority of mistakes
  - Reading & understanding directions prevent errors
  - Each question may have different directions

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Slide 3-Y-16

Carefully read the directions

- Misreading the questions causes the majority of incorrect answers.
  – Taking enough time to read and understand the directions prevents careless errors.
  – Each question may have different directions; thus, it is important to exercise caution.

Audiovisual

Monitor Time

- Estimate time needed for each question
- Monitor progress periodically

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Slide 3-Y-17

Outline or text of presentation

Monitor your time

- Avoid a last-minute rush to finish the test:
  - Estimate how much time you should leave for each question.
  - Monitor your progress periodically to make sure you do not get caught in a time crunch.

Change Answers Sparingly

- Avoid second-guessing yourself & changing your original answers
- Change answers only on questions you misread or answered incorrectly

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Slide 3-Y-18

Change answers sparingly

- Don't second-guess yourself and change your original answers.
  - Only change answers on questions you misread or determined with certainty that you have answered incorrectly.

Cover Whole Test

- Answer all questions
  - There is no penalty for guessing if you are unsure of answer

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Slide 3-Y-19

Cover the whole test

- Answer all questions.
  - There is no penalty for guessing if you are unsure of the answer.

Audiovisual

Outline or text of presentation

Answering in Phases

- Phase 1: easy questions
- Phase 2: harder questions
- Phase 3: best guesses

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Slide 3-Y-20

Phase 1

- Answer easy questions & bookmark harder questions
  - Later questions sometimes answer earlier ones
  - You may remember harder answers later

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Slide 3-Y-21

Phase 2

- Focus on items you skipped
- Use different strategy
- Try relating question to *State Operations Manual (SOM):*
  - Intent of task or protocol & Condition of Participation
  - Specific regulation & guidance
  - Decision on answer

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Slide 3-Y-22

Answer in Phases

Phase 1

- Answer the easy questions first and bookmark those you are less sure about for later review.
  - Answering later questions sometimes helps answer earlier, difficult ones.
  - You may spontaneously remember answers to hard questions later.
  - You won't miss any easy questions by running out of time.

Phase 2

- Review the test and focus on items you skipped in the first phase, using a slightly different strategy.
- If you get stuck on a question, try to relate the question to a protocol or task in the *SOM*.
  - Try to remember the intent of the task or protocol and the related Condition of Participation.
  - This will help you locate the specific regulation and guidance.
  - This may also help you decide on an answer.

Audiovisual

Phase 2 (cont.)

- Reread question if unclear
- Rephrase question
  - Can clarify meaning
  - Can cause errors if meaning is changed

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Slide 3-Y-23

Outline or text of presentation

- Reread a question if it is unclear.
- Rephrasing a question can sometimes make it clear to you, but be sure you don't change the meaning of the question.

Phase 3

- Make your best guess
- Pare down information
  - Eliminate double negatives
  - Underline absolutes
- Make these strategic changes & visualize result:
  - In mind's eye
  - With fingers in front of monitor
  - On dry-erase board or paper provided

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Slide 3-Y-24

Phase 3

- Once you have exhausted your knowledge and narrowed the choices remaining by eliminating unlikely answers, make your best guess.
- Pare down information:
  - Cross out both negatives of a double negative.
  - Underline absolute terms. They are usually false because few things in the world meet the requirements of *always, never, best,* etc.
- Make these strategic changes to the question and visualize the result:
  - In your mind's eye.
  - With fingers in front of monitor.
  - On the dry-erase board or paper provided.

Audiovisual

Analyze Questions (T/F)

If T/F statement contains:	Then
• "and"	• Both clauses . . .
• "or"	• Only one clause . . .

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Slide 3-Y-25

Outline or text of presentation

- Analyze question structure:
  - Be careful of true or false statements with two clauses.
    - If the statement contains "and," both clauses have to be true for the statement to be true.
    - If the statement contains "or," only one of the clauses has to be true.

Analyze Questions (Matching)

If	Then
• Statement requires matching	• Read all items before making matches

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Slide 3-Y-26

  - Read all items in matching questions before making any matches.

Analyze Questions (Multiple Choice)

If	Then
• 2 or more choices generally correct	• Consider more specific one
• No answer seems correct	• Try recalling answer before reading choices
• Some choices obviously false	• Cross them out

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Slide 3-Y-27

  - Examine multiple choice questions carefully:
    - If two or more choices are generally correct, consider the one that is more specific than the other (e.g., "a triangle has three sides" is more accurate than "a triangle has more than two sides").
    - Try to recall the correct answer before reading the choices and choose the response closest to the answer that came to mind.
    - Cross out the letters of the obviously false choices to help narrow the selection.

Audiovisual

Analyze Questions
(Multiple Choice) (cont.)

- Other techniques:
  - Change question into statements using choices
  - Consider each choice as true or false question
  - Read all choices before final selection
  - Check answer based on content, not tally of As, Bs, etc.

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Slide 3-Y-28

Check Your Answers

- Use all time allowed
- Make sure you answered all questions
- Review all answers if you have time

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Slide 3-Y-29

Outline or text of presentation

- Change the question into statements using the answers and choose the one that sounds the most valid.
- Remember, each alternative in a multiple-choice question is a true or false question.
- Remember to read all of the choices before making your final selection.
- Choose answers based on content. Do not pay attention to how many As, Bs, Cs and Ds you have marked.

Check your answers

- Use all the time allowed.
- Make sure you have answered all the questions.
- Review all answers if you have time.

Summary

Keeping in mind general test-taking strategies will help you with the SMQT.

Audiovisual

Introduction to SMQT

- Requirements of Omnibus Budget Reconciliation Act of 1987 for all surveyors of long term care facilities
- Purpose is to ensure minimum qualifications to evaluate compliance with Federal requirements
- Product of CMS collaboration with testing experts

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Slide 3-Y-30

Outline or text of presentation

Introduction to the SMQT

- The Omnibus Budget Reconciliation Act of 1987 requires that all surveyors of long term care (LTC) facilities successfully complete a training and testing program.
- The intent is to ensure that surveyors have the minimum qualifications necessary to evaluate compliance of LTC facilities with Federal requirements.
- CMS worked with contractors who are experts in test development and administration of computerized examinations.

Introduction to SMQT (cont.)

- Minimum qualification test
  - Expertise in all areas not required to complete test
- Reasonable amount of preparation should result in successful completion of test

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Slide 3-Y-31

- The exam is a minimum qualification test; you do not have to be an expert in all areas to complete the test.
- With a reasonable amount of preparation, most surveyors should be able to successfully complete the test.

Test Content Areas

- LTC facility
- Survey process
- Related laws
- Regulation guidelines
- Environmental quality
- Sanitation
- Resident assessment & care plans
- Quality of life
- Nutrition

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Slide 3-Y-32

Test content areas

- LTC facility.
- Survey process.
- Related laws.
- Regulation guidelines.
- Environmental quality.
- Sanitation.
- Resident assessment and care plans.
- Quality of life.
- Nutrition.

Audiovisual

Test Content Areas (cont.)

- Facility records
- Medicine
- Nursing
- Rehabilitation
- Gerontology
- Disability
- Chronic disease
- Resident rights
- Pharmacy
- Infection control

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Slide 3-Y-33

Outline or text of presentation

- Facility records.
- Medicine.
- Nursing.
- Rehabilitation.
- Gerontology.
- Disability.
- Chronic disease.
- Resident rights.
- Pharmacy.
- Infection control.

Test Setting

You:

- Have 4 hours to complete test
- Are not to bring papers, pencils or other supplies
- May bring *SOM* Appendices P, PP & R
  - Don't bring loose or extra papers
- Must allow approximately 5 hours for testing & administration

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Slide 3-Y-34

Test setting

- You have four hours to complete the test.
- Do not bring any papers, pencils or other supplies to the testing center.
- You may bring *SOM* Appendices P, PP and R.
- The testing center proctor will look through the materials you bring to make sure there are no loose or extra papers.
- The SMQT is timed and will require approximately five hours of testing and administration time.

Test Setting (cont.)

- Will be advised by State training coordinator or someone within your State agency of:
  - Test location
  - Date & time of test
- Independent testing centers are used for testing

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Slide 3-Y-35

- Your State's training coordinator or someone within the State agency will advise you of the location, date and time of your test.
- Independent testing centers are used for the testing.

Audiovisual

Attendance Requirements

- Report 15 minutes before scheduled test time
- If you arrive late, test proctor will determine whether you may still take test
- If too late, CMS will be charged for test time & your supervisor will be notified

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Slide 3-Y-36

Outline or text of presentation

Testing

- Report 15 minutes before your scheduled test time.
- If you arrive late, the test proctor will determine whether you are still allowed to take the test.
- If you arrive too late to take the test, CMS will be charged for the test time and your supervisor will be notified.

Attendance Requirements (cont.)

- Do not smoke, eat or drink in testing center during exam
- You may:
  - Take breaks
  - Go to restroom
  - Get drink
    - No "time out"
- You must follow posted security rules

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Slide 3-Y-37

- There is no smoking, eating or drinking in the testing center during the exam.
- You may take breaks and leave the room to use the restroom and get a drink of water; however, the time does not stop and you must follow the security rules posted at the testing center.

Sign In

- Bring 2 forms of identification, 1 with photo ID
  - Will be photographed & fingerprinted with scanner
  - Will also be asked to read & agree to comply with all security procedures
- Use dry-erase board & marker presented as scratch paper

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Slide 3-Y-38

Sign In

- You will need two forms of identification, one with a photo ID.
  - You will be photographed and fingerprinted with a scanner.
  - You will be asked to read and agree to comply with all security procedures.
- You will receive a dry-erase board and marker to serve as your scratch paper.

Audiovisual

Sign In (cont.)

- You will be assigned:
  - Calculator
  - Workstation
- You will be given instructions
- Ensure comfort:
  - Monitor position
  - Chair height, etc.

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Slide 3-Y-39

Outline or text of presentation

- You will receive a calculator and then be led to a computer workstation and given instructions on how to use the computer.
- Make sure the monitor and chair are at the appropriate height.

Special Test-Taking Needs

- Needs will be accommodated on individual basis
  - Candidate must provide documentation of special needs that satisfies supervisor

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Slide 3-Y-40

Special Needs

- If you have special test-taking needs because of a physical or mental impairment such as dyslexia that substantially limits major life activities, the needs will be accommodated on an individual basis.
  - The candidate must provide documentation that satisfies his/her supervisor of the need for special accommodations.

Special Test-Taking Needs (cont.)

- Documentation will pass through State education coordinator to Regional Office & Central Office
- CMS Regional & Central Offices make decision about accommodation
- Testing contractor will contact State about special arrangements

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Slide 3-Y-41

- Documentation will pass through the State educational coordinator to the Regional Office and Central Office.
- CMS Regional and Central Offices will make a decision about any accommodation.
- The testing contractor will contact the State education coordinator about special arrangements.

Audiovisual

Outline or text of presentation

Test Proctoring

Test proctor:
- Answers questions about testing procedures or computer use
- Gives assistance
- Cannot give answers to questions

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Slide 3-Y-42

Test Proctoring

- The testing proctor is there to answer any questions about the testing procedures or using the computer.
- Do not hesitate to ask for assistance; however, the test proctor cannot give answers to individual test questions.

Receiving Your Test Scores

- State designee receives results within 1 week
- Supervisor gives feedback on results

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Slide 3-Y-43

Receiving Your Test Scores

- Within a week after the test, the person designated to receive results in your State will receive your test results.
- You will receive feedback from your supervisor as to whether you have successfully completed the test.

Retakes

- Retakes are permitted for unsuccessful attempts
- Sections 4009.1–4009.3 in *SOM* provide more specific information on testing program & implications for you

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Slide 3-Y-44

- If you do not successfully complete the test the first time, you will have additional opportunities to retake the examination.
- Sections 4009.1–4009.3 in the *SOM* provide more specific information on the testing program and its implications for you.

Audiovisual

Lesson 3-Y:
Test-Taking Skills

Questions

45

Slide 3-Y-45

Outline or text of presentation

Skill Assessment

Test-Taking Skills

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					Developed an individualized review or study plan.	
					Identified three concepts or clinical areas as top priorities for review or study.	
					Described at least three useful skills for taking the SMQT.	
					Explained how to arrange the date and time of the test.	
					Described the process of nomination to the CMS LTC Basic Training class.	
					Listed the materials that can be brought into the testing center.	

Comments/Recommendations:

Plan of Review and Study

Develop the following list:

Tasks or knowledge I am sure of but need to review:

1.

2.

3.

Tasks or knowledge that I am unsure of:

1.

2.

3.

		Review	Skills, Tasks or Clinical Areas to Learn	Resources	Date Completed
Current Month	Week 1				
	Week 2				
	Week 3				
	Week 4				
Month 2	Week 1				
	Week 2				
	Week 3				
	Week 4				

Month 3	Week 1				
	Week 2				
	Week 3				
	Week 4				
Month 4	Week 1				
	Week 2				
	Week 3				
	Week 4				

Month 5	Week 1				
	Week 2				
	Week 3				
	Week 4				
Month of Testing	Week 1				
	Week 2				
	Week 3				
	Week 4				

Knowledge, Skills and Abilities (KSAs) Covered by the SMQT

A. Knowledge of the Long Term Care Facility, Survey Process, and Related Laws, Regulations and Interpretive Guidelines refers to knowledge of pertinent sections of the Code of Federal Regulations and the use of the State Operations Manual (SOM) as well as an understanding of when and how to use these resources in conducting surveys. It also, refers to an understanding of the steps involved in planning, conducting, and documenting a long term care facility survey. Included is a working knowledge of the procedural instructions outlined in Appendix P and an understanding of how and where to document survey observations. Examples of specific topics include:

- Statutes pertinent to Title XVIII and XIX (1819 and 1919)
- Regulations 42CFR483, et al
- State Operations Manual
- Other types of survey process, including complaint, re-visit, and extended surveys.

B. Knowledge of Factors affecting Environmental Quality; Sanitation refers to knowledge of how physical factors affect resident quality of life. This includes characteristics such as space, construction, sanitation, maintenance, ventilation, temperature, noise, and accident prevention. Examples of specific topics include:

- Call light systems function
- Designated smoking areas
- Homelike environment
- Pest-free environment
- Functional furniture
- Accessibility of telephone
- Availability of water
- Hazard-free environment
- Cleanliness
- Sanitation as applied to kitchen and dining areas

C. Knowledge of Resident Assessment and Care Plans and Long Term Care Facility Records refers to knowledge of how to determine if the assessment and the comprehensive care plan address the needs of the resident. This includes ensuring that the facility has identified each resident's needs/problems(s) and developed a written plan of care based on that assessment. It also refers to knowledge of the information required in medical records and of the records used in planning, monitoring, and evaluating care. Included are general medical records (active and discharged), medication and treatment records, and physician orders. Examples of specific topics include:

- Initial comprehensive assessment as basis of care plan
- Written care plan for each resident
- Ongoing assessment and updating of care plan
- Care plan problems reflected in program notes
- Implementation and ongoing evaluation of care plan
- Knowledge of general principles and practices of medical record systems

D. Knowledge of Medicine, Nursing, and Rehabilitation, Gerontology, Disability, and Chronic Disease refers to an understanding of standards of medical, nursing, and rehabilitation practice. It also refers to a basic knowledge of residents' physical and mental abilities, potential for rehabilitation, and care requirements. Examples of specific topics include:

- Planned regimen of care
- Adequate progress notes
- Treatments
- Positioning and assistive devices
- Range of motion
- Pressure sore prevention
- Bowel/bladder programs
- Promotion of independence in activities in daily living
- Functional limitations
- Prosthesis
- Adequate personal hygiene
- Common diseases affecting the elderly
- Common manifestations of disease processes

E. Knowledge of Resident Rights and Quality of Life Issues refers to an understanding of how long term care facility programs and practices affect resident rights. Also included is knowledge of how social services and activities can protect and promote quality of life and how these programs and services should be tailored to resident cognitive abilities. Examples of specific topics include:

- Privacy
- Freedom from physical and verbal abuse
- Choice of roommate and room arrangement
- Social and activity needs recognized in care plan
- Right to manage personal finances
- Resident involvement in decisions about care
- Resident security
- Respect for residents' personal property
- Choice in activities
- Freedom to register complaint
- Restraints

F. Knowledge of Nutritional and Dietary Service Principles and Practices refers to elements of the dietary services that affect nutritional adequacy. These elements range from routine menu planning, food preparation, and distribution to therapeutic diets. Also included is an understanding of how dining may impact resident quality of life. Examples of specific topics include:

- Menu planning
- Food preparation
- Food delivery
- Therapeutic diets
- Aesthetics of food delivery
- Recognition of food choice and provision for substitutes
- Record keeping of meal consumption
- Supervision and assistance, as required, with eating
- Safe food preparation, handling, and storage procedures

G. Knowledge of Drug Therapies and Drug Administration Principles and Practices refers to an understanding of basic pharmacological practices including techniques of drug administration and distribution, drug classification, interactions/side effects, and basic human physiology as related to drug therapy and allergies. Examples of specific topics include:

- Rules for determining medication errors as they relate to the medication pass
- Physician orders v. drug and dose administered
- Significant v. nonsignificant errors
- Use of psychotropic drugs
- Unnecessary drugs

H. Knowledge of Infection Control Procedures refers to knowledge both of Federal regulatory standards of infection control and also of principles of acceptable professional practice. Included is the application of such standards and principles to the evaluation of factors such as building maintenance, handling of linen, management of contaminated materials, and aseptic and isolation techniques. Examples of specific topics include:

- Storage of clean and soiled linen
- Universal precautions
- Infectious waste storage and disposal procedures
- Hand washing
- Evidence of surveillance and monitoring
- Aseptic technique

I. Skill in Documentation refers to skill in recording information factually, clearly, and objectively. Also included is skill in describing conditions and circumstances, their relationship to regulations, and their effect on resident care. Examples of specific topics include:

- Making documents quantitative and complete: who, what, when, where, and why
- Organization: logical presentation of facts
- Proper use of forms

J. Skill in Gathering and Integrating Information refers to skill in gathering information from a variety of sources, assessing its characteristics, and identifying commonalties and trends. It also refers to proficiency in noting usual and unusual circumstances in relation to residents and their environments. Included is skill in using all senses to assimilate information. It also refers to skill in eliciting necessary information, to generating responsiveness, clearly articulating ideas, and evaluating receiver response while maintaining an environment conducive to communicating with others. Included is the skill required to communicate and interact with a variety of people, such as survey team members, residents' family members, facility staff, and facility administrators. It also refers to a proficiency in identifying and tracking relevant information using an objective, systematic approach and adeptness in assessing if the facets of data collected are relevant to requirements. Examples of specific topics include:

- Integrating team members' observations and findings
- Identifying trends by combining information from interviews, record reviews, and observation
- Team leading/coordinating
- Negotiating
- Establishing rapport
- Identifying pertinent information
- Achieving balance between focus and empathy
- Identifying areas to probe
- Active listening
- Nonjudgmental expression of ideas
- Professional demeanor
- Conflict resolution

K. Deficiency Determination and Scope and Severity refers to consistent application of requirements when determining first whether or not a deficiency exists, and if one does, what the scope and severity of the deficiency is. It also refers to the ability to analyze the written evidence of a deficient practice in order to determine the appropriate level of harm/impact and the prevalence of the problem. Example:

- Immediate jeopardy

Lesson 3-Z: Evaluation of Skills

The sample forms provided in this lesson are intended for the preceptor's review. These forms are available to use as a guide or as written.

There is no lesson plan. Each State trainer should feel free to revise any of the forms to meet any State-mandated performance evaluations or criteria established by the State peer review committee, if such a committee exists.

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Nursing Home Staff Progress Tool
Observational Survey

Staff Name:	
Date of Hire:	
Coach Name:	
Region/Unit:	
Onsite Visit Date(s): (MM/DD/YY)	
NH Name:	

PROGRESS LEVEL KEY

Progress Level	Code	Description
Observation Only	**O**	Observed survey; did not perform any tasks or elements.
Demonstrated with Coaching	**DC**	Required the availability of the PC to provide *directed* assistance and *identify* areas for improvement.
Demonstrated with Minimal Coaching	**D**	Required the availability of the PC to answer questions and give minimal direction.
Performed Independently	**I**	Performed the survey tasks and elements independently.
Not Applicable	**NA**	Element has previously been performed at the independent level or was not attempted.

Expectation:
It is expected that new staff members will perform at least one "observation only" survey prior to attending residential care services orientation.

Key Elements:
- Due to the added responsibilities, peer coach (PC) should be assigned minimal extra survey tasks and protocols. PC should be assigned a full resident review assignment, closed record review, a portion of the medication pass and other protocols as appropriate for resident sample. PC should not be assigned as the team leader.
- Staff member (SM) should not be assigned any resident reviews. Staff member should be encouraged to *practice* recording of observations.
- PC should review all staff member recordings for elements required for evidence.

Place appropriate observed code next to each critical element. When appropriate, the peer coach should describe in the "Notes" sections the event that led to the coding within the section and identify and add specific opportunities for growth in needed areas.

1. **Offsite Prep**
   Staff Member Preparation:
   - Review the team's *Offsite Survey Preparation Worksheet* (Form CMS-801).

Objectives/ Critical Elements:

O	Actively observed team in review of offsite materials and selection of sample residents.
O	Listened attentively and actively observed the team during the offsite team meeting in coordination of survey tasks and assignments.
O	Asked appropriate questions of peer coach.

Notes:

2. Initial Tour
Staff Member Preparation:
- Review the *Surveyor Notes Worksheet* (Form CMS-807).

Objectives/ Critical Elements:

O	Actively observed the peer coach during the tour.
O	Focused and recorded observations of clean, safe and homelike environment and appropriate infection control practices. Specifically noted and recorded issues and concerns of those residents who were designated as sample residents during offsite prep.
O	Practiced documenting observations on correct form (Form CMS-807, *Surveyor Notes Worksheet*) with correct time, date, heading.
O	Actively observed peer coach introducing himself/herself to residents and staff. Observed peer coach in his/her interactions with staff and residents.
O	Listened and identified types of questions asked by surveyor of residents, family and staff.

Notes:

3. Sample Selection—Phase I
Staff Member Preparation:
- Review the *Surveyor Notes Worksheet* (Form CMS-807).
- Review *Roster/Sample Matrix Instructions* (Form CMS-802S) in *State Operations Manual (SOM)* Collated Transmittals, page 9-751, with instructions on page 9-755.
- Review forms and information provided by nursing home to familiarize yourself with the types/sources of information.

Objectives/ Critical Elements:

O	Observed the team during information sharing gathered during the tour and provided by the nursing home.
O	Identified methods of selecting sample residents.
O	Identified team's justification for selecting and removing residents from the sample list.
O	Actively observed the team during the Phase 1 sample selection. Reviewed materials that were used.
O	Asked appropriate questions of peer coach at the appropriate times.

Notes:

4. Resident Review and Information Gathering
Staff Member Preparation:
- Review *Resident Review Worksheet* (Form CMS-805) in *SOM,* pages 5-374, 5-375, 5-376 and 5-378.

Objectives/ Critical Elements:

O	Actively observed peer coach observing care of sample residents.
O	Listened intently during resident and staff interviews.
O	Asked questions and requested information at the appropriate time.

O	Observed team member reviewing an assigned comprehensive and focused sample resident and reviewed peer coach's *Resident Review Worksheet* (Form CMS-805).
O	Practiced identifying and recording the details of peer coach's sample resident's physical, cognitive and emotional status based on observations.
O	With peer coach, reviewed a closed record to gain familiarity with nursing home resident records, location of information, etc.

Notes:

5. Quality of Life Assessment
Staff Member Preparation:

- Review *Quality of Life Assessment* forms for interviews—Resident (Form CMS-806A), Family (Form CMS-806C) and Group (Form CMS-806B).

Objectives/ Critical Elements:

O	Observed various team members conducting individual and family interviews as assigned and available.
O	Observed group interview.
O	Actively practiced documenting informal statements by residents and staff.

Notes:

6. Sample Selection—Phase 2
Staff Member Preparation:

- Review Task 4 guide sheet for Phase 2 resident selection.

Objectives/ Critical Elements:

O	Observed how concerns and residents are selected for Phase 2 sample selection.
O	Observed how peer coach performed focused resident reviews.

Notes:

7. Medication Review
Staff Member Preparation:

- Review *Medication Pass Worksheet* (Form CMS-677), *SOM* Collated Transmittals, page 363. Review F332 and F333 in *SOM*.

Objectives/ Critical Elements:

O	Observed team member conducting a medication pass.
O	Reviewed resident records with team member(s) to determine whether there were medication issues.
O	Actively discussed the findings of the team with peer coach.

Notes:

8. Task 6—Team Meeting

Objectives/ Critical Elements:	O	Observed team discussion and determination of issues/concerns regarding nursing home practices.
	O	Observed the team process for determination of noncompliance and scope and severity.

Notes:

9. Exit Conference

Objectives/ Critical Elements:	O	Observed how failed nursing home practice determinations from Task 6 are summarized and presented to the public audience.
	O	Observed how team coordinator/team member(s) obtained further information about failed practice from the facility.
	O	Observed how team coordinator informed facility of Statement of Deficiencies process, informal dispute rights and Plan of Correction expectations.

Notes:

10. Report Writing

Objectives/ Critical Elements:	O	Reviewed survey report during various stages of preparation.
	O	Reviewed regulation and guidelines for each tag cited.

Notes:

11. Professional Manner
Check all that apply:
(Peer coach may add other descriptors next to the "Other" box.)

☐ Projects & promotes a positive image/attitude/working relationship	☐ Forceful/argumentative	☐ Applies new concepts and techniques effectively
☐ Identifies areas of improvement and responds favorably to suggested actions for improvement	☐ Tactful	☐ Strident
☐ Stern	☐ Punctual	☐ Condescending
☐ Challenging	☐ Focuses on relevant and essential issues	☐ Assertive
☐ Communicates effectively	☐ Unsure/hesitant/ indecisive	☐ Other

Notes:

☐ **Staff member brought the appropriate State statutes and regulations on inspection.**
☐ **Staff member used the appropriate residential care services-approved forms.**

☐ **Goals for improvement:**

PC Signature _____ **Date:** _____

SM Signature _____ **Date:** _____

FM Signature _____ **Date:** _____

Nursing Home Staff Progress Tool
Level 2 Participatory Survey

Staff Name:	
Date of Hire:	
Coach Name:	
Region/Unit:	
Onsite Visit Date(s): (MM/DD/YY)	
NH Name:	

PROGRESS LEVEL KEY

Progress Level	Code	Description
Observation Only	**O**	Observed survey; did not perform any tasks or elements.
Demonstrated with Coaching	**DC**	Required the availability of the PC to provide *directed* assistance and *identify* areas for improvement.
Demonstrated with Minimal Coaching	**D**	Required the availability of the PC to answer questions and give minimal direction.
Performed Independently	**I**	Performed the survey tasks and elements independently.
Not Applicable	**NA**	Element has previously been performed at the independent level or was not attempted.

Expectation:
Staff member should be assigned no more than three residents for the total survey and should participate in performing the tasks assigned to the peer coach (PC) listed below as well as perform any resident care protocols which are appropriate for the resident sample.

Key Elements:
- Peer coach should be assigned:
  - Offsite survey information preparation.
  - Sub-Task 5F—Quality Assessment and Assurance Review.
  - Abuse Prevention Protocol.
  - No more than a total of five resident reviews for both Phases 1 and 2.

Place appropriate observed code next to each critical element. When appropriate, the peer coach should describe in the "Notes" sections the event that led to the coding within the section and identify and add specific opportunities for growth in needed areas.

1. Offsite Prep

Objectives/ Critical Elements:

O	Performed offsite preparation, gathered pertinent concerns and information for team. Gathered information from quality assurance nurse, complaint staff and ombudsman. Located and reviewed files for nursing home, including previous survey, complaints, OSCAR Reports 3 and 4 and quality indicators (QIs). **By at least the second Level 2 participatory survey, the peer coach is to perform independent offsite preparation form, while the new staff member performs the same review. They should then compare their findings.**
O	Identified appropriate concerns and recorded them from the above information on the appropriate form. Appropriately analyzed information to determine concerns.
O	Identified the correct number of sample residents, including wounds, hydration, and pressure sores (WHP) and sentinel events.
O	Identified the correct oversampling technique during sample selection, taking into account WHP.

O	Identified at least five residents who were appropriate for the resident sample according to the concerns the team identified from the quality indicator report.
O	Identified other sample criteria and assisted the team in choosing appropriate sample residents.

Notes:

2. Initial Tour

Objectives/ Critical Elements:

O	Conducted initial tour on assigned area, identified environmental concerns, resident concerns and staffing concerns and recorded his/her observations within the level required for evidence on paper forms.
O	Performed introductions and interviews appropriately.
O	Recorded appropriate information at a level necessary to be used as evidence.
O	Obtained critical information which assisted in team discussion of concerns and sample selection.
O	Identified and analyzed offsite-selected concerns for validity.

Notes:

3. Sample Selection—Phase 1

Objectives/ Critical Elements:

O	Identified residents who met the definition of case-mix stratified. Identified a sample based on offsite information, tour information and other areas as per the *State Operations Manual (SOM)*.
O	Compared nursing home matrix to QI offsite matrix, identifying differences.
O	Participated in Phase 1 sample selection using information obtained from observations and initial tour.
O	Analyzed information appropriately which helped the team determine concerns and sample selection.

Notes:

4. Resident Review and Information Gathering
Staff Member Preparation:

- Review Sub-Tasks 5F and 5G in *SOM,* pages P-60 and P-62.
- Review specific elements for hospice and dialysis residents' care in *SOM,* pages P-53 and P-54.

Objectives/ Critical Elements:

O	Identified resident-centered information.
O	Completed the resident reviews and interviews of staff and residents about quality-of-care and quality-of-life issues.

O	Performed care observations as indicated by identified resident concerns, observational rounds and dining observations and performed appropriate care protocols.
O	Shared information of findings and consulted with team appropriately.
O	Appropriately continued observations to determine whether the concern identified was an ongoing facility practice.
	During the first Level 2 participatory survey:
O	Selected and reviewed two comprehensive sample residents to review during Phase 1.
O	Performed as the facilitator at the group meeting.
O	Selected and reviewed three comprehensive sample residents to review during Phase 1.
O	Conducted quality-of-care protocol tasks as appropriate. ***Please note in the "Notes" section below which protocols were performed.***
O	Performed Sub-Task 5G—Abuse Prohibition Review and Abuse Prevention Protocol review and documented findings. Reviewed incident log.
O	Performed the appropriate portions of Sub-Task 5F—Quality Assessment and Assurance Review. (Completed part 1. Reviewed part 2 and completed, if appropriate.)
O	Performed closed record review(s) as assigned.
O	Reviewed resident rights for admission information received, discharge notification and discharge planning issues.
O	Performed Nursing Services/Sufficient Staffing Protocol.
O	Reviewed at least one resident receiving hospice or dialysis services, if applicable.

Notes:

Protocols Performed:

5. Quality of Life Assessment

Objectives/ Critical Elements:

O	Conducted two interviews, at least one with a cognitively impaired resident and a family member of a cognitively impaired resident.
O	Performed follow-up for identified issues and concerns from individual interviews.
O	Performed observations and interviews on appropriate quality-of-life areas identified by team to verify or substantiate compliance. Analyzed information appropriately in determining finding versus deficient practice, compliance versus noncompliance.
O	Performed interviews with staff and/or residents to verify information obtained.

Notes:

6. Sample Selection—Phase 2

Objectives/ Critical Elements:

O	Participated in team discussion with specific additional information gathered by the staff member that was used in selection of Phase 2 concerns and sample residents.
O	Participated in selecting Phase 2 sample selection.
O	Reviewed assigned focused-sample resident(s) for team-identified concerns.
O	Participated in status meeting with nursing home, contributing to the team information as appropriate.

Notes:

7. Medication Review (Nursing Staff Only)

Objectives/ Critical Elements:

O	Participated in medication pass for five to ten medications and reconciled review of physician orders.
O	Participated in the team discussion of medication error rates.
O	Identified unsafe medication practices correctly.
O	Determined the medication error rate for the nursing home correctly.
O	Performed review of glucometer use and/or infection control issues when identified by observations or interview as a concern for resident medication administration and diabetic care.
	All staff reviewing sample residents.
O	Reviewed assigned sample residents' medications for unnecessary drugs and identified those with a potential for adverse drug reactions. Investigated the residents' reaction to the use of the medication.
O	Performed review of the pharmacy consultant reviews as appropriate to issues identified, if applicable.
O	Followed up on concerns identified from medication system reviews.

Notes:

8. Task 6—Team Meeting

Objectives/ Critical Elements:

O	Demonstrated ability to determine the difference between noncompliance deficiencies and findings.
O	Demonstrated ability to gather sufficient evidence: observations, interviews with residents and facility staff and record reviews to identify deficient practice.
O	Demonstrated ability to analyze data and identify potential F-tags for failed practices found on survey.
O	Demonstrated ability to verify and substantiate findings with further observations, interviews and record reviews.
O	Correctly identified the different types of tags and regulations and demonstrated an understanding of the differences in the types of evidence needed to determine noncompliance.

O	Appropriately identified and investigated any immediate jeopardy that was found.
O	Participated appropriately if immediate jeopardy was identified, according to the requirements in the State procedures and Federal process requirements.
O	Demonstrated an understanding and ability to analyze the presence of a possible immediate jeopardy.
O	Demonstrated an understanding of substandard quality of care. Assisted in its identification and demonstrated an understanding of how to proceed.
O	Consulted with the field manager (FM) when appropriate.
O	Consulted appropriately with team and peer coach regarding issues or concerns on resident safety.

Notes:

9. Exit Conference
Staff Member Preparation:

- Review Management Bulletin on Communication during Survey and Exits.

Objectives/ Critical Elements:

O	Presented during final status meeting with nursing home staff.
O	Participated in exit conference and ensured completion of exit conference attendance list.
O	Actively communicated with the facility staff and administrator throughout the survey process.

Notes:

10. Report Writing

Objectives/ Critical Elements:

O	Performed writing citations with team review that complied with the elements of the Principles of Documentation.
O	Citations were written clearly and in a concise manner following the Principles of Documentation.
O	Participated in team collaborative process in production and editing of Statement of Deficiencies.
O	Working papers were completed, compiled and forwarded to the team coordinator.
O	Participated in presentation of substandard or harm-level findings and citations to the enforcement officer.
O	Prepared the civil fine recommendations, licensed history memo and State forms appropriately.

Notes:

11. Professional Manner
Check all that apply:
(Peer coach may add other descriptors next to the "Other" box.)

☐ Projects & promotes a positive image/attitude/working relationship	☐ Forceful/argumentative	☐ Applies new concepts and techniques effectively
☐ Identifies areas of improvement and responds favorably to suggested actions for improvement	☐ Tactful	☐ Strident
☐ Stern	☐ Punctual	☐ Condescending
☐ Challenging	☐ Focuses on relevant and essential issues	☐ Assertive
☐ Communicates effectively	☐ Unsure/hesitant/ indecisive	☐ Other

Notes:

☐ **Staff member brought the appropriate State statutes and regulations on inspection.**
☐ **Staff member used the appropriate residential care services-approved forms.**

☐ **Goals for improvement:**

PC Signature _____ **Date:** _____

SM Signature _____ **Date:** _____

FM Signature _____ **Date:** _____

Nursing Home Staff Progress Tool
Team Coordinator Survey

Staff Name:	
Date of Hire:	
Coach Name:	
Region/Unit:	
Onsite Visit Date(s): (MM/DD/YY)	
NH Name:	

PROGRESS LEVEL KEY

Progress Level	Code	Description
Observation Only	**O**	Observed survey; did not perform any tasks or elements.
Demonstrated with Coaching	**DC**	Required the availability of the PC to provide *directed* assistance and *identify* areas for improvement.
Demonstrated with Minimal Coaching	**D**	Required the availability of the PC to answer questions and give minimal direction.
Performed Independently	**I**	Performed the survey tasks and elements independently.
Not Applicable	**NA**	Element has previously been performed at the independent level or was not attempted.

Expectation:
It is expected that this tool will be used only after the staff person has achieved independent practice in Level 1, Level 2 and the Environmental and Administrative Progress Tools. Staff member should have also attended Part 2 orientation. Staff member may attend CMS Basic prior to completing the team coordinator progress tool.

Key Elements:
- Peer coach (PC) should be assigned minimal extra survey tasks and protocols but should be assigned a full resident review assignment.
- Staff member (SM) should be assigned as team coordinator depending on progress toward independence with critical elements. Staff member should assign himself/herself one comprehensive review in Phase 1 and one focused review and one closed record review in Phase 2.

Place appropriate observed code next to each critical element. When appropriate, the peer coach should describe in the "Notes" sections the event that led to the coding within the section and identify and add specific opportunities for growth in needed areas.

1. Offsite Prep

Objectives/ Critical Elements:

O	Performed all offsite prep activities and facilitation of team meeting; notified ombudsman.
O	Gathered appropriate forms and copies of materials for the team, the entrance conference, the facility administrator and other tasks within the survey process.
O	Prepared the *Offsite Survey Preparation Worksheet* (Form CMS-801).
O	Completed the *Roster/Sample Matrix* (Form CMS-802) to highlight concerns for Phase 1 and listed residents preselected for offsite sample selection.
O	Planned team assignments for specific tasks and protocols and comprehensive and focused reviews.

O	Facilitated discussion of team regarding issues and concerns and team task assignments.
O	Facilitated team sample selection ensuring correct selection of sentinel health events and residents identified as having wounds, hydration, and pressure sores (WHP) concerns.
O	Selected the appropriate number of residents with WHP and the roster matrix included more than the required number for sample selection.
O	Ensured that sample selection had enough selected for each concern and sentinel to allow team to determine compliance.
O	Ensured that sample selection had enough of each concern to determine at least isolated to pattern scope.
O	Ensured that all criteria for sample selection had been met.

Notes:

2. Entrance Conference

Objectives/ Critical Elements:

O	Introduced team members and obtained a room for team to work in.
O	Performed entrance conference with appropriate forms and materials.
O	Requested the appropriate facility information.
O	Explained the survey process and answered any questions the facility administrator had regarding the process.
O	Provided the administrator the appropriate materials and copies of materials.
O	If the survey commenced at times outside of normal business hours, ascertained who was in charge and requested that he/she notify the administrator.
O	Called the field office and notified it that the team had entered.
O	Posted signs announcing the survey and contacted the resident council president to arrange the group interview.

Notes:

3. Sample Selection—Phase I

Objectives/ Critical Elements:

O	Assured that the early kitchen review was completed.
O	Facilitated team sample selection and reviewed nursing home information on offsite matrix.
O	Determined whether sample was case-mix stratified and contained the correct number of residents with WHP. If not, facilitated team in selecting the correct sample distribution.
O	Assigned other necessary assignments to team members.
O	Ensured environmental concerns noted during initial tour were forwarded to team member assigned to environmental task review, including early and later kitchen review, laundry, etc.

Notes:

4. Resident Review and Information Gathering

Objectives/ Critical Elements:

O	Completed all aspects of data collection and investigation, including care protocols, for assigned residents.
O	Ensured that all team members were completing their assignments and resident reviews.

Notes:

5. Quality of Life Assessment

Objectives/ Critical Elements:

O	Lead group interview. Demonstrated good group interviewing techniques (i.e., following up on concerns, facilitating the interview on specific required subjects, clarifying issues and encouraging residents to participate).
O	Completed follow-up of issues raised during the meeting.
O	Met with the team daily and shared issues from the group interview and other issues or concerns team members had.

Notes:

6. Sample Selection—Phase 2

Objectives/ Critical Elements:

O	Facilitated team discussion to determine status/completion of assigned tasks and records and discussion of issues. Assured that previously assigned tasks were completed.
O	Reviewed environmental findings and group interview findings with team.
O	Followed up on concerns and issues discussed in team meetings using notes from daily team meetings.
O	Worked with team in preparation of sample matrix roster and team assignments for Phase 2.
O	Assigned or completed review of demand billing in Medicare facilities.
O	Ensured Quality Assurance Protocol Part 1 was completed, determined whether Part 2 needed to be completed and ensured its completion if appropriate.
O	Ensured Nursing Services/Sufficient Staffing Protocol was completed when appropriate.
O	Ensured Abuse Prevention Protocol was completed across all shifts.

Notes:

7. Medication Review (Nursing Staff Only)

Objectives/ Critical Elements:		
	O	Determined whether further medication pass reviews needed to be performed.
	O	Facilitated the team discussion of medication error rates.
	O	Identified unsafe medication practices correctly.
	O	Determined the medication error rate for the nursing home correctly.
	O	Obtained needed pharmacy consultant reviews from administrator as appropriate to issues identified.

Notes:

8. Status Meeting with Management Staff of Home
Staff Member Preparation:

- Review Management Bulletin #03-056B, Nurse Aide Training Program Review.

Objectives/ Critical Elements:		
	O	Ensured all forms from facility were complete, accurate and signed.
	O	Ensured the nursing home training forms and information were collected and reviewed.
	O	Gathered information of findings with team. Conducted daily status meeting summarizing the status of the survey, tasks completed, results of medication pass, protocols and probable time for completion of data gathering.
	O	Solicited any questions and tentatively scheduled exit conference. Requested the nursing home have at least two cognitively intact residents present.
	O	Notified ombudsman of exit.
	O	Requested any final clarification on any issues or concerns.

Notes:

9. Task 6—Team Meeting

Objectives/ Critical Elements:		
	O	Lead/facilitated Task 6 meeting; reviewed daily team meeting notes and documentation of discussion of findings.
	O	Facilitated discussion in sequential tags/regulations and assisted the team to consensus in determination of scope and severity, including determination of the total number of residents affected by each deficiency.
	O	Facilitated the discussion to determine the universe of the resident population with the concern or the potential to be affected by the concern.
	O	Assigned appropriate portions of survey report writing to team members, including “based on” statements.
	O	Appropriately identified and investigated any immediate jeopardy that was found.
	O	Consulted with field manager (FM) when appropriate.
	O	Performed appropriately if an immediate jeopardy was identified. Consulted own copy of Appendix Q and State procedures on immediate jeopardy.

O	Demonstrated an understanding and ability to analyze the presence of a possible immediate jeopardy.
O	Demonstrated an understanding of substandard quality of care. Assisted in its identification and demonstrated an understanding of how to proceed.

Notes:

10. Exit Conference

Objectives/ Critical Elements:

O	Led exit conference.
O	Actively communicated with the facility staff and administrator throughout the survey process.
O	Consulted appropriately with team and peer coach regarding issues or concerns on resident care and safety.

Notes:

11. Report Writing

Objectives/ Critical Elements:

O	Completed Automated Survey Processing Environment (ASPEN) Form 2567 initial comments tag.
O	Ensured that proper records of deficient practice, events, process and agreements were maintained under guidelines established for retention of records.
O	If there were no deficiencies, ensured that the appropriate cover letter was completed, ASPEN requirements were completed and copies were reviewed and signed by the field manager and sent to the provider.
O	If there were deficiencies, coordinated team production and editing, ensuring Statement of Deficiencies (SOD) was written clearly, concisely and following the Principles of Documentation. Performed edit using the review tool.
O	Ensured timely production of SOD as appropriate for field manager and enforcement officer review as appropriate.
O	Reviewed the repeat deficiencies for possible civil fine remedy recommendations. Completed or delegated and ensured that licensed history memo was completed if appropriate.
O	Ensured State licensing forms were completed appropriately. Ensured that the administrative code selected for deficient practice was accurate and matched with the F-tag cited.
O	Completed all federal paperwork with completed SOD and forwarded to field manager for review and signature.
O	Completed or ensured that all paperwork, including finalized SOD, was forwarded to support staff to aid in timely data entry.
O	Reviewed and identified whether the Plan of Correction was acceptable and had been received within ten days after the provider received the SOD.

Notes:

12. Professional Manner
Check all that apply:
(Peer coach may add other descriptors next to the "Other" box.)

☐ Projects & promotes a positive image/attitude/working relationship	☐ Forceful/argumentative	☐ Applies new concepts and techniques effectively
☐ Identifies areas of improvement and responds favorably to suggested actions for improvement	☐ Tactful	☐ Strident
☐ Stern	☐ Punctual	☐ Condescending
☐ Challenging	☐ Focuses on relevant and essential issues	☐ Assertive
☐ Communicates effectively	☐ Unsure/hesitant/ indecisive	☐ Other

Notes:

☐ **Staff member brought the appropriate State statutes and regulations on inspection.**
☐ **Staff member used the appropriate residential care services-approved forms.**

☐ **Goals for improvement:**

PC Signature _____ **Date:** _____

SM Signature _____ **Date:** _____

FM Signature _____ **Date:** _____

Nursing Home Staff Progress Tool
Environmental and Administrative Focused Survey

Staff Name:	
Date of Hire:	
Coach Name:	
Region/Unit:	
Onsite Visit Date(s): (MM/DD/YY)	
NH Name:	

PROGRESS LEVEL KEY

Progress Level	Code	Description
Observation Only	**O**	Observed survey; did not perform any tasks or elements.
Demonstrated with Coaching	**DC**	Required the availability of the PC to provide *directed* assistance and *identify* areas for improvement.
Demonstrated with Minimal Coaching	**D**	Required the availability of the PC to answer questions and give minimal direction.
Performs Independently	**I**	Performed the survey tasks and elements independently.
Not Applicable	**NA**	Element has previously been performed at the independent level or was not attempted.

Expectation:
It is expected that the new staff member will have a good understanding of the concepts and process of sample selection for both Phase 1 and Phase 2 prior to starting this tool. The peer coach (PC) should be observing those areas as "independent" prior to initiation of other tasks and processes, such as team coordination and environmental and administrative reviews.

Key Elements:
- PC should be assigned as the team coordinator.
- Staff member (SM) should not be assigned any resident reviews. SM should perform/participate with each team member who is assigned the listed tasks within the objectives. SM should be assigned to participate and/or perform environmental tasks and reviews, Sub-Task 5B—Kitchen/Food Service Observation, Nursing Services Protocol, Infection Control Review, and Personnel Record Review along with Surety Bond Review, any other financial issues such as trust fund issues and Medicare demand billing.

Place appropriate observed code next to each critical element. When appropriate, the peer coach should describe in the "Notes" sections the event that led to the coding within the section and identify and add specific opportunities for growth in needed areas.

1. **Offsite Prep**
   Staff Member Preparation:
   - Review team coordinator responsibilities and forms for entrance conference.
   - Review Sub-Task 5B—Kitchen/Food Service Observation and Sub-Task 5A—General Observations of the Facility.

Objectives/ Critical Elements:

O	Performed offsite tasks and participated in the offsite team meeting.
O	Observed team coordinator facilitate offsite preparation and discussion of issues, concerns and sample selection with team.

Notes:

2. Initial Tour
Staff Member Preparation

Objectives/ Critical Elements:

O	Performed early kitchen review efficiently, demonstrating knowledge of regulations.
O	Observed team coordinator during entrance conference with administrator, demonstrating an understanding of information given to administrator and information that needed to be obtained.
O	Performed initial environmental review, including identifying where surveys, ombudsman and CRU information are posted for residents. Identified resident access to telephones. Identified issues and followed up appropriately.
O	Performed review of admission packets.

Notes:

3. Environmental Information Gathering
Staff Member Preparation

Objectives/ Critical Elements:

O	Performed the kitchen food preparation and sanitation review.
O	Performed a tray line observation.
O	Performed a test tray review.
O	Performed the general environmental rounds, including laundry, beauty shop, ice machines, outside areas (including smoking area), waste disposal, and chemical storage and oxygen storage.
O	Performed review of the call light system.
O	Performed group interview. Followed up on issues and concerns identified.
O	Interviewed residents, staff and others appropriate to environmental and kitchen issues.
O	Reviewed physical environment for dementia unit, including locked and key-padded doors and outdoor area, if appropriate.

Notes:

4. Administrative Information Gathering
Staff Member Preparation:

- Review Abuse Protocol, Quality Assurance Protocol, Nursing Services Protocol, Infection Control Review.
- Review Purple Book requirements for Incident and Accident Investigations and Incident Log.

Objectives/ Critical Elements:

O	Performed personnel record review, including tuberculosis testing, nurse aide certification and criminal background checks.
O	Performed review of veterinary certificates and pet review.
O	Performed review of emergency preparedness and water supply, Medicare demand billing and trust fund/surety bond reviews.
	Completed the following protocols:
O	Nursing Services Protocol (review and complete if appropriate).
O	Infection Control Review.
O	Followed up on all issues and concerns identified from kitchen, environmental reviews and personnel record reviews, as appropriate.

Notes:

5. Quality of Life
Staff Member Preparation:

- Review *Quality of Life Assessment* form for group interview (Form CMS-806B) and instructions.

Objectives/ Critical Elements:

O	Arranged for group interview by arranging the time with the president of the resident council and/or facility staff, posted signs, etc.
O	Led group interview. Identified issues, followed up with clarifying questions on specific issues.

Notes:

6. Task 6—Team Meeting
Staff Member Preparation:

- Review State and Federal process for immediate jeopardy.
- Review Management Bulletin on Communication with Providers.

Objectives/ Critical Elements:

O	Participated in final status meeting with facility staff and administrator.
O	Participated in nursing home failed-practice determinations.
O	Presented findings of the administrative reviews.
O	Presented findings of the protocol reviews and the environmental reviews.
O	Presented findings of group interview.
O	Appropriately identified and investigated any immediate jeopardy that was found. Reviewed and followed Transmittal 19 and State process.
O	Consulted with the field manager (FM) when appropriate.

Notes:

7. Exit Conference
Staff Member Preparation:

- Reviewed written presentation of findings.
- Reviewed deficient practice and practiced presenting exit with peer coach.

Objectives/ Critical Elements:		
	O	Performed exit conference with peer coach.

Notes:

8. Report Writing

Objectives/ Critical Elements:		
	O	Performed writing citations with team review that complied with the elements of the Principles of Documentation.
	O	Citations were written clearly and in a concise manner following the Principles of Documentation.
	O	Participated in team collaborative process in production and editing of Statement of Deficiencies.
	O	Participated in review of the survey report using the auditing tool.
	O	Participated in presentation of substandard or harm-level findings and citations to the enforcement officer.
	O	Prepared the civil fine recommendations, licensed history memo and State forms appropriately.

Notes:

9. Professional Manner
Check all that apply:
(Peer coach may add other descriptors next to the "Other" box.)

☐ Projects & promotes a positive image/attitude/working relationship	☐ Forceful/argumentative	☐ Applies new concepts and techniques effectively
☐ Identifies areas of improvement and responds favorably to suggested actions for improvement	☐ Tactful	☐ Strident
☐ Stern	☐ Punctual	☐ Condescending
☐ Challenging	☐ Focuses on relevant and essential issues	☐ Assertive
☐ Communicates effectively	☐ Unsure/hesitant/ indecisive	☐ Other

Notes:

☐ **Staff member brought the appropriate State statutes and regulations on inspection.**
☐ **Staff member used the appropriate residential care services-approved forms.**

☐ **Goals for improvement:**

PC Signature _____ **Date:** _____

SM Signature _____ **Date:** _____

FM Signature _____ **Date:** _____

Nursing Home Staff Progress Tool
Complaint Abbreviated Survey

Staff Name:	
Date of Hire:	
Coach Name:	
Region/Unit:	
Onsite Visit Date(s): (MM/DD/YY)	
NH Name:	

PROGRESS LEVEL KEY

Progress Level	Code	Description
Observation Only	**O**	Observed survey; did not perform any tasks or elements.
Demonstrated with Coaching	**DC**	Required the availability of the PC to provide *directed* assistance and *identify* areas for improvement.
Demonstrated with Minimal Coaching	**D**	Required the availability of the PC to answer questions and give minimal direction.
Performed Independently	**I**	Performed the survey tasks and elements independently.
Not Applicable	**NA**	Element has previously been performed at the independent level or was not attempted.

Expectation:
It is expected that the new staff member will have participated in the residential care services orientation and performed an observation-only survey.

Key Elements:
- Peer coach (PC) should be assigned minimal extra survey tasks and protocols but should be assigned a full resident review assignment. Peer coach should not be the team coordinator.

Place appropriate observed code next to each critical element. When appropriate, the peer coach should describe in the "Notes" sections the event that led to the coding within the section and identify and add specific opportunities for growth in needed areas.

1. **Offsite Prep**
   The purpose of the offsite survey preparation is to obtain as much information about the complaint before beginning to plan the investigation.
   Staff Member Preparation:
   - Review State investigational protocols and Federal process guidelines.
   - Review the process for abbreviated surveys, *State Operations Manual (SOM),* pages P-73 to P-76.

Objectives/ Critical Elements:

O	Developed a written plan of data gathering, including information that would need to be obtained in order to make determinations about the issues within the complaint. Identified the practical methods of obtaining that information (i.e., interviews with specific individuals, specific logs, etc.).
O	Called/e-mailed the ombudsman to discuss other or ongoing issues within the home as needed. Contacted the quality assurance nurse, complaint investigator and/or surveyor team for previous issues and concerns.
O	Reviewed the Quality Indicators, OSCAR Reports 3 and 4, the nursing home survey files and previous complaints to identify possible trends or repeat issues.

Notes:

2. Initial Tour and Entrance Conference
Staff Member Preparation:

- Review *SOM,* page P-75. Review guidelines for Task 3—Initial Tour from *SOM,* page P-14.

Objectives/ Critical Elements:

O	Onsite investigation was unannounced.
O	Administrator was advised only of the general purpose of the visit.
O	Confidentiality of the complaint and information was maintained, giving the investigator opportunities for pertinent observations, interviews and record reviews.
O	Requested needed facility records appropriate to the issues.
O	Performed an initial focused tour identifying whether the residents involved in the complaint were still in the facility.
O	Identified from tour other residents who may have the same issues and concerns.
O	Identified other appropriate issues requiring investigation.
O	Used appropriate forms and recorded information at the level needed for evidence.

Notes:

3. Task 5—Information Gathering
The purpose of this task is to determine the information needed and in what sequence it should be obtained, in order to verify and/or substantiate the issues within the complaint.

Objectives/ Critical Elements:

O	Prioritized information gathering, obtaining the most critical information first.
O	Performed appropriate observations, interviews and record reviews of resident(s), staff and home; focused on the issue(s) in order to verify the allegation within the complaint.
O	Performed observations and interviewed the resident(s) identified within the complaint. Performed protocols that were appropriate to the complaint.
O	Determined whether the issues identified within the complaint happened or were substantiated.
O	Determined whether noncompliant facility practices were associated with the complaint.
O	Identified additional residents with the same or similar issues. (The Facility QI Resident Summary may assist with this.)
O	Conducted comprehensive or focused information gathering and/or closed record reviews for the other residents at risk in regard to the issue as appropriate for the type of complaint to determine the scope of the noncompliance.
O	Maintained confidentiality of the complainant throughout the investigation to the highest degree possible at all times.
O	Recorded information at the level needed of evidence for determination, to be clear as to the facility's compliance or noncompliance.

Notes:

4. Task 6—Team Meeting

The purpose of this task is to review all of the information collected and determine whether there is noncompliant facility practice. Where there are inconsistencies in the findings, further data collection should be done to resolve the inconsistencies in order to make a determination of compliance or noncompliance.

Objectives/ Critical Elements:

O	Reviewed recorded information for completeness of data related to the complaint issue and gathered further evidence if needed.
O	Determined whether all protocols and tasks were performed appropriate to the issues identified within the complaint.
O	Determined whether the issue was verified to have happened or not.
O	Determined the compliance of the facility practice(s).
O	Determined severity and scope if noncompliance was verified.
O	Identified and investigated under the State and Federal process requirements any immediate jeopardy that was found.
O	Contacted the field manager (FM) appropriately.

Notes:

5. Exit Conference

The purpose of this task is to inform the facility of the surveyor's observations, preliminary findings and deficiencies in facility practice that were identified.

Objectives/ Critical Elements:

O	Summarized findings clearly for facility administrator or designated facility staff person.
O	Notified the facility administrator if the complaint was unsubstantiated and that there was no indication of deficient practice.
O	Answered questions the facility had without revealing the specifics of the complaint or the identity of the complainant or other residents named within the complaint.

Notes:

6. Report Writing/Post-Investigation Activities

The purpose of the Statement of Deficiencies (SOD) is to provide written verification and documentation: for the public, the facility and the residents and as a permanent record for the Federal and State enforcement agencies.

Objectives/ Critical Elements:

O	If the facility received a citation, the citation and cover letter were written clearly and in a concise manner following the Principles of Documentation.
O	The complaint survey was entered into the Automated Survey Processing Environment (ASPEN) and the complaint-tracking system.
O	The investigation summary was written within the guidelines for complaint summaries.
O	Working papers were completed, compiled and forwarded to administrative assistant.

O	The Complaint Closure Fact Sheet was completed along with the hours for Form CMS-670 (*Survey Team Composition and Workload*).
O	If enforcement action was taken, the complaint investigator consulted with the field manager and the enforcement officer appropriately.
O	The SOD and letters were to the field manager for review and signature.
O	The complaint and the paperwork required were completed within the time requirements.
O	Contacted the complainant with results of the investigation if appropriate.

Notes:

7. Professional Manner
Check all that apply:
(Peer coach may add other descriptors next to the "Other" box.)

☐ Projects & promotes a positive image/attitude/working relationship	☐ Forceful/argumentative	☐ Applies new concepts and techniques effectively
☐ Identifies areas of improvement and responds favorably to suggested actions for improvement	☐ Tactful	☐ Strident
☐ Stern	☐ Punctual	☐ Condescending
☐ Challenging	☐ Focuses on relevant and essential issues	☐ Assertive
☐ Communicates effectively	☐ Unsure/hesitant/ indecisive	☐ Other

Notes:

☐ **Staff member brought the appropriate State statutes and regulations on inspection.**
☐ **Staff member used the appropriate residential care services-approved forms.**

☐ **Goals for improvement:**

PC Signature _____ **Date:** _____

SM Signature _____ **Date:** _____

FM Signature _____ **Date:** _____

Surveyor Orientation Assessment: Offsite Preparation

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of process
2. Gathering information
3. Preparation of offsite form
4. Communication
5. Delegation of tasks
6. Organization/prioritization

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Individual Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Entrance Conference

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:
1. Knowledge of process
2. Explanation of forms and visit
3. Professionalism
4. Communication

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:
Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Tour

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:
1. Knowledge of process
2. Conduct of tour
3. Completes tour in a timely manner
4. Quality of documentation—identifies and notes problems
5. Communication of data
6. Team cooperation

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:
Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Sample Selection

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:
1. Knowledge of process
2. Timeliness
3. Team cooperation/communication of data
4. Decision making and problem solving
5. Identification of residents/interviewable and noninterviewable

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:
Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Environment

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:
1. Knowledge of process
2. Quality of documentation
3. Identification and documentation of problems
4. Timely communication of data

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:
Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Quality of Care, Including Closed Record Review

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of process
2. Pertinent observations of residents
3. Organization and accuracy
4. Timeliness
5. Analysis/interpretation of problems/follow through
6. Allowing facility explanations
7. Completion of tasks
8. Identified outcome
9. Decision making
10. Completion of worksheets

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Individual Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Resident Rights Assessment

Surveyor's Name _____ Initiation Date_____

Check one: Individual____ Family____ Group____

ONE NEEDS ASSESSMENT FORM PER TASK AS NOTED ABOVE

The orientee will demonstrate:

1. Knowledge of process
2. Interview protocol
3. Listening skills
4. Professionalism
5. Organization and accuracy
6. Analysis/interpreting problems/follow through
7. Timely completion of tasks
8. Outcome identification
9. Decision making

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Individual Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Dietary Service

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of process
2. Analysis/problem interpretation/follow through
3. Timely completion of task
4. Organization/accuracy
5. Determining compliance
6. Communication of data
7. Completing forms

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Medication Pass

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of process
2. Determination of medication errors
3. Calculation of error to determine compliance
4. Organization/accuracy/completed forms
5. Problem solving and decision making
6. Communicating data in a timely manner

Orientee Self-Assessment:

1. Outstanding—exceeds standard consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Information Analysis and Decision Making

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of process
2. Timely completion of all assigned tasks
3. Organization and accuracy
4. Review of regulatory requirements
5. Determination of compliance
6. Determination of need for extended survey

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Information Analysis/Decision Making, Preparation of Forms CMS-2567 and 767

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:

1. Knowledge of principles
2. Completion of all assigned tasks in a timely manner
3. Organization & accuracy
4. Review of regulatory requirements
5. Determination of compliance
6. Timely reports of findings to the office

Orientee Self-Assessment:

1. Outstanding—exceeds standard consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:

Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Surveyor Orientation Assessment: Exit Conference

Surveyor's Name _____ Initiation Date_____

The orientee will demonstrate:
1. Knowledge of process
2. Explanation of findings
3. Professionalism/maintaining resident confidentiality
4. Communication

Orientee Self-Assessment:

1. Outstanding—exceeds standards consistently _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect _____

Date _____

Preceptor Assessment:

1. Outstanding—consistently explains tasks clearly, with explanation and reference to task guidelines _____
2. Exceeds standards—meets standards consistently, exceeds standards at times _____
3. Meets standards consistently _____
4. Needs improvement to meet standards consistently _____
5. Unsatisfactory—documented failure to meet standards with negative effect on orientation process _____

Date _____

Office Use Only

Check one of the following:
Independent____ Does Not Meet____ Training Plan____

Supervisor's Signature _____ Date _____

Preceptor's Signature _____ Date _____

Surveyor's Signature _____ Date _____

Standards for Orientee Assessment Process

1. Knowledge of process
   Demonstrates knowledge of the task objectives, procedures and protocols as outlined in the Federal survey procedure for the assigned task.

2. Gathering information
   a. Demonstrates knowledge of where to obtain presurvey data, OSCAR report.
   b. Assembles packet, including any outstanding complaints.

3. Preparation of offsite form
   a. Guides team through OSCAR Reports 3 and 4 to determine areas of team focus during survey tour and review.
   b. Documents findings of offsite team meeting.
   c. Identifies potential residents to be included in sample from the electronic transmission of the MDS data, once available.
   d. Contacts ombudsman in accordance with department policy.

4. Communication with team
   a. Communicates any information received from ombudsman/complaint department and coordinator.
   b. Keeps team members apprised of changes in assignments, pertinent data obtained through interview or observation as related to the task being completed.
   c. Keeps open lines of communication between the surveyor and the facility staff.

5. Delegation of tasks
   Assigns team members tasks for information gathering in accordance with individual surveyor discipline.

6. Organization/prioritization
   a. Presents and conducts offsite review in an organized manner.
   b. Prioritizes tasks and assignments in order of importance as identified on OSCAR Reports 3 and 4 and team decision-making process.

7. Explanation of forms and visit
   a. During entrance conference informs facility administrator reason for visit (recertification, follow up, interim, etc.).
   b. Answers facility staff questions or refers staff to appropriate source in the department.

8. Professionalism
   a. Neat appearance.
   b. Communicates information in a manner which promotes a positive public image for the department.
   c. Acts in accordance with accepted standards of practice for individual discipline as outlined in CMS surveyor training manual.

9. Communication with facility/office and teammates
   a. Identifies or introduces team members to facility administrator.
   b. Keeps open lines of communication between the team and facility staff.
   c. Contacts team coordinator with team findings when appropriate (e.g., extended survey as needed).

10. Conduct of tour
   a. Identifies areas of concern or residents to be in sample.
   b. Recognizes resident's right to privacy when entering rooms.
   c. Identifies interviewable residents and notes family members or noninterviewable residents.

11. Quality of documentation
   a. Identifies and notes problems on appropriate Federal forms.
   b. Documentation reflects time, place and observation, including resident name where applicable.
   c. Documentation includes all pertinent data as related to findings that can result in negative outcome.

12. Decision making and problem solving as related to sample selection
   a. Awareness of case-mix stratification as outlined in the Federal guidelines.
   b. Selects residents who represent areas of concern as noted in Task 1 and during tour observation.
   c. Completes *Roster/Sample Matrix* selection list in accordance with Federal protocols for Phase 1 and Phase 2.

13. Timeliness
   Completes task within reasonable time as assigned/specified by the team leader.

14. Analysis/interpretation of problems/follow through
   a. Demonstrates the ability to compare data gathered relative to survey discipline and understand the problem.
   b. Identifies and carries forward (e.g., investigates further, interviews resident and/or staff).

15. Identified outcome
   Analyzes final data and determines whether negative or potential for negative outcome exists.

16. Interview protocol
   a. Asks residents and staff open-ended questions.
   b. Follows protocols as established by Federal guidelines.

17. Calculation of medication errors
   Uses formula as established by Federal protocol.

18. Knowledge of Principles of Documentation
    a. Consistently applies the Principles of Documentation as established by Federal protocols for a *Statement of Deficiencies* (Form CMS-2567).
    b. Applies the Principles of Documentation in the writing of State reports (e.g., Form 767, complaint investigations that do not result in completion of Form CMS-2567 or Form 767).

19. Compliance determination
    a. Demonstrates knowledge of scope and severity enforcement grid.
    b. Demonstrates knowledge of remedy categories as related to the scope and severity determination.

Appendices

Appendix A: Training Modalities and Techniques

Training Design Template

Purpose of Training	
Expected Benefits (In general terms, describe exactly what this training is to accomplish.)	
Audience Analysis (Number of participants, positions/title, knowledge level, background, biases, age, special needs or accommodations required.)	
Key Concepts (List topics to be covered.)	**Methods** (List teaching/training methods for each topic: handouts, audiovisual, lecture, discussion, activity, overheads, etc.)

Openings/Closings/Transitions (Identify appropriate icebreakers, energizers, get-acquainted exercises.)	
Method(s) of Evaluation (Determine how you want your training program evaluated/your method for collecting feedback.)	
Supplies (List needed materials, including handouts, audiovisual equipment, name cards, etc.)	

Seating Arrangements

Style	Dynamics
Traditional Seating X O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O	• Works well for short lectures to large groups. • Discourages interaction among participants. • Obstructs trainer view of learners in the back. • Favors one-way communication.
Horseshoe X O O O O O O O O O O O	• Encourages participation by allowing eye contact between the trainer and all learners. • Facilitates close trainer-learner contact. • Works well when all learners must be able to see a demonstration. • Works well when learners will be involved in large group discussions. • Promotes equality and interaction. • Facilitates presentation of visuals placed at the opening of the horseshoe. • Allows the trainer to move freely throughout the group, working with members one on one.
Modular O O O O O O O O O O O O x O O O O O O O O O O O O	• Facilitates small group exercises and projects. • Deemphasizes communication between trainer and learners. • Fosters communication among learners. • Requires trainer to move among groups during lectures and activities. • Favors group work. • Restricts some participants' view of audiovisuals.
Circle O O O X O O O O O O O O	• Fosters democratic interaction. • Encourages equal participation of all members. • Gives participants full view of one another. • As a table shape (as opposed to square or rectangle), fosters conversations, shorter inputs, and member participation. • Hampers presentation of audiovisuals.
Square O O O O O O O O O O O O O O O O O O	• Encourages formality more than a circle arrangement does. • Obscures faces of some participants. • Depending on where visual aids are placed, makes one side the "head of the table." • As a shape for a solid table, encourages conversation; if square shape is used for a table with a hole in the middle of it, some people do not speak at all, and some who do speak tend to talk for longer periods of time.

Appendix B:
Sample Lesson Plans

Sample Lesson Plans

- Following are three sample lesson plan formats that may be further individualized.
- If working on a computer, consider establishing and working in a “table” format for the portions of the examples that include two or more columns.
- PowerPoint software has an outline format that is useful when organizing the topic, objectives, outline, handouts and overhead or slide show presentation.

Sample 1

Topic

Learning Objectives

- At the conclusion of the lesson, the surveyor will be able to:

References

Federal

- *Code of Federal Regulations (CFR):*
  - 42 CFR [section number]
- *State Operations Manual (SOM):*
  - [Title and number of the section]
- Social Security Act:
  - [Title and number of the section]

State

(Insert State reference[s] here.)

Other

Highlights

- [Optionally, may attach outline or other documentation]

Training Techniques

- Lecture
- [Small/large] group discussion
- Brainstorming
- Role play
- Demonstration
- Case study
- PowerPoint presentation and discussion
- Small group buzz session

Training Aids

- PowerPoint slides and handouts
- Easel pad with colored markers
- Prop(s)
- Handouts
  - *Title of 1st Handout*
  - *Title of 2nd Handout*
- Video/film [title of the video or film]

Methods of Evaluation

- Verbalization/discussion of understanding
- Return demonstration
- Review of surveyor documentation
- Effective use of information during a future training session
- Completion of skill assessment

Time	Audiovisual	Outline/Text of Presentation
00 min.	Overhead of lesson objectives.	*(Read objectives on overhead.)*
00 min.		

Sample 2

Topic

Initial tour

Purpose

To teach Task 3 and reiterate and show examples of the investigative process (observe, interview and review records) for focused areas on the Roster/Sample Matrix.

Learning Objectives

At the conclusion of this lesson, the surveyor will be able to:

- Conduct an initial tour.
- Interact with staff who accompany the surveyor on what information should be shared.
- Make observations.
- Interview residents during the tour.
- Effectively document appropriate information.
- Appropriately share information with the team.

References/Regulations

[Select ones that are source material for the topic.]

Federal

- *Code of Federal Regulations (CFR):*
  - 42 CFR [section number]
- *State Operations Manual (SOM):*
  - [Title and number of the section]
- Social Security Act:
  - [Title and number of the section]

State

(Insert State reference[s] here.)

Other

Length of Presentation

- Total time [hours/minutes]
- Audiovisual time [hours/minutes]
- Presentation time [hours/minutes]

Outline and Time Estimates

- Introduction and objectives. 5 min.
- Review Roster/Sample Matrix form. For first 10 focused areas, solicit and, as needed, provide examples of relevant observations, interview questions and records to review. 60 min.
- Small group discussion to identify observations, interview questions and records to review for each remaining focused area. 30 min.
- Report from each small group discussion. 60 min.
- Discussion of forms and methods to use and information to document. 20 min.
- Demonstration of initial tour by instructor. 15 min.

Space Arrangements

[Select arrangements that support the presentation.]

- Comfortable chairs and table space for individuals to take notes and work in small groups.
- Chairs and round tables to hold five people each.
- Classroom-style tables and seating.
- Theatre-style seating.
- Conference room in facility.
- Kitchen/medication area, etc., in facility.
- Lectern/lectern with microphone.
- Table for demonstration/example __ feet long.

Training Techniques

[Select techniques appropriate for the topic, the group and the setting.]

- Lecture.
- [Small/large] group discussion.
- Brainstorming.
- Role-play.
- Demonstration.
- Case study.
- PowerPoint presentation and discussion.
- Small group or individual exercise.
- Small group buzz session.

Training Aids

[Select audiovisuals that enhance learning the material or skill.]

- PowerPoint slides and handouts
- Easel pad with colored markers
- Prop(s)
- Handouts
  - *Title of Handout*
- Video/film [title of the video or film]

Methods of Evaluation

- Verbalization/discussion of understanding
- Demonstration
- Observation of _____
- Review of surveyor documentation
- Effective use of information during a future training session
- Completion of skill assessment

Sample 3

Topic

Sources of information to have in front of you

Estimated Time Frame	Lesson	Audiovisuals
00 min.	• Topic • Objectives for this lesson • Anticipated length of lesson • Breaks anticipated • Other information as desired	[Select appropriate tools]

Introduction

Information to be covered

Closing

Evaluation

Appendix C: Sample Training Objectives

Sample Training Objectives

The overall objective for training can be expressed in many ways. It can be as direct as the following example:

At the completion of the initial surveyor orientation program for long term care surveyors, the surveyor will have acquired minimal knowledge of and be able to demonstrate the following basic competencies:

- Communication skills.
- Problem solving.
- Investigative skills.
- Medical terminology.
- Resident Assessment Instrument.
- Medical record review.
- Skills including:
  - Interpretation and application of Federal and State regulations.
  - Observation.
  - Interviewing.
  - Record review.
- Knowledge of standards of practice for:
  - Environment.
  - Dietary services.
  - Pharmacy.
  - Infection control for:
    - Nursing.
    - Dietary.
    - Housekeeping.
    - Laundry/linen handling.
- Basic computer skills.
- Principles of Documentation.
- English grammar.

You can also write training objectives such as the examples provided below. In all cases, choose what is appropriate or tailor the examples to your training needs and presentation. The following examples are arranged in broad groups. Note that an objective in one group may also be appropriate for another.

General Lead Statements

- At the completion of the orientation program and prior to attending a Basic training course, the surveyor will be able to . . .
- The goal and purpose of this program is to assist the newly employed surveyor to . . .
- At the satisfactory conclusion of initial training, the new surveyor will have the information and skills necessary to . . .

Specific Performance Factors

How surveyors conduct themselves can impact the survey process. The following performance factors can be used to pinpoint a particular problem area where a surveyor or survey team may need either clarification or further training. The performance criteria merely represent the behaviors and skills which are most commonly observed and are minimally expected to be present for the surveyor to satisfactorily complete initial training as a new employee. Preceptors may observe other behaviors which also relate to a performance factor and may consider such observations in determining training.

Surveyor Characteristics

The surveyor will:

- Develop survey skills necessary to evaluate a provider's or supplier's ability to meet the Medicare/Medicaid health and safety regulations.
- Become a confident and contributing member of the survey staff of a State survey agency or Regional Office as rapidly as possible.
- Cooperate with other surveyors.
- Adhere to assignments and established timetables or seek out adjustments with other surveyors when problems arise.
- Not permit personal life and needs to interfere with accomplishment of assigned work.
- Provide team members timely, complete and concise information/findings that will assist in conducting the survey.
- Relate to provider staff in a straightforward, objective way.
- Respect the role of the provider but not be influenced by intimidation.
- Demonstrate awareness that his/her special position as an "inspector" may potentially intimidate provider staff and seek to minimize perceptions of threat to the maximum extent feasible while completing the survey.
- During data collection period, collect and provide compliance information in a neutral manner, without critique of provider staff with respect to performance or nonperformance of their duties.
- Respond to criticism and discussion of sensitive issues without expressing anger or aggressiveness.
- Remain sensitive to the feelings of the provider's staff while completing the survey.
- Neither ask for personal favors of provider staff nor engage in social activities with provider personnel during the survey.
- Relate to individuals being served in a professional, courteous and dignified manner.
- Not provide any treatment, care or otherwise therapeutic handling to a beneficiary and contact facility staff if a beneficiary requests such attention.
- Respect the privacy and/or dignity of the beneficiary in the conduct of all survey procedures and interactions.
- Request permission before entering a beneficiary's bedroom and before examining a beneficiary's personal belongings.
- Adjust to change or difficult situations without undue stress and implement methods to minimize stress placed on others.

- Take advantage of continuing education programs and available readings.
- Perform surveys as a team member under supervision.
- Interact with individuals and groups utilizing good communication skills and techniques.
- Support survey decisions reached by the survey team.
- Demonstrate knowledge of the legal framework within which the survey process must occur.
- Describe the responsibilities of the surveyor to use the authority of the survey process carefully, wisely and to the benefit of Medicare/Medicaid beneficiaries.
- Use the surveyor role to ensure that beneficiaries receive the needed care and services to which they are entitled by law.
- Not use the surveyor role to meet personal needs or to manipulate, seek reward or overtly intimidate suppliers or providers of services.
- Demonstrate sensitivity to the subtle variations and differences inherent in provider-specific situations that influence the survey process.
- Demonstrate openness to new ideas and changing patterns of organizing and delivering services that may differ from previous experiences.
- Confer with other surveyors and arrive at a resolution when a decision change is indicated.
- Pronounce no "personal opinions" about survey findings to facility/provider staff if different from the agreed-upon team decisions.
- Coordinate special appointments for personal needs with the team leader.
- Organize related problems, issues and/or deficiencies in a logical way.
- Provide neither advice nor consultation to facility staff (e.g., telling staff how to correct the problem).

Certification and Licensure

The surveyor will:

- Describe the Federal survey and certification process and how it is used to administer the Medicare and Medicaid programs in conjunction with statutory agreements with States.
- Describe the differences between State and Federal rules and regulations.
- Explain terminology and abbreviations used in the survey, licensure and certification processes.
- Describe the provider group being surveyed, Federal rules that apply to the provider group and the beneficiaries of the provider group.
- Describe the legal authority from which the State survey agency and the Federal government receive their powers and duties for the licensure and certification programs.
- Explain the organizational structures and relationships of the State and Federal governments with respect to licensure, survey and certification processes.
- Identify significant historical actions regarding the establishment and growth and current major legislation affecting a provider/supplier.
- Be able to identify and locate provider/supplier-related references in the Social Security Act, the *Code of Federal Regulations* and the *State Operations Manual (SOM).*
- Accurately verbalize understanding of the intent of Medicare/Medicaid health and safety regulations.

Survey Procedures

The surveyor will:

- Explain the roles of the health facility surveyor, team members and team leader/coordinator.
- Demonstrate knowledge of and ability to follow the Federal and State survey processes, completion of required forms and Federal certification and State licensure procedures for the provider/supplier.
- Demonstrate knowledge of Federal and State survey procedures for both standard and abbreviated surveys, extended and partial extended surveys and complaint investigations.
- Utilize procedures and guidance to surveyors for conducting each task/responsibility of the survey as set forth in the *SOM* and subsequent directives, such as CMS Regional Office letters.
- Use appropriate presurvey offsite preparation in order to implement an efficient and effective survey.
- Complete assigned work in a timely and efficient manner.
- Interact with beneficiaries, staff and others as instructed in survey procedures.
- Collect information from documentation, observations and interviews that is accurate and complete and enhances the ability to make accurate compliance decisions.
- Investigate regulations/requirements not directly addressed in survey procedures where evidence is present to indicate possible noncompliance.
- Share relevant information with facility staff during the survey, but not before the problem is thoroughly investigated.
- Complete assigned and required reviews at various times of the day when required by survey process.
- Describe conditions that are waiverable.
- Function as an effective team member by sharing information and findings and by helping the team make its collective determinations.
- As appropriate, discuss discrepancies with other team members to resolve concerns.
- Describe the *general procedures* related to potential enforcement sanctions to providers, based on provider/supplier certification procedures.
- Present factual information about the survey process to providers, consumers or families in a manner that is nonthreatening, understandable, objective and professional.
- Describe the content and intent of provider-specific regulations to administrative representatives, staff and beneficiaries appropriately.
- Not substitute personal preferences, agendas, feelings or professional preferences for the prescribed methods determined by Federal and State entities to evaluate compliance with the Federal regulations.
- Explain decisions in a clear, logical sequence, rather than using semantic tricks or other such devices.
- When questioned, provide the “facts” that have been collected about noncompliant practices and not interject personal opinion.
- Seek clarification of regulations or regulatory interpretations when necessary.
- Explain context or other information essential to understanding the problems identified.
- Participate with team members in the evaluation of the Plan of Correction.

Investigative Skills

The surveyor will:

- Conduct onsite surveys in an organized manner, using developed, appropriate observations, interviews and record reviews to investigate compliance with Federal and State regulations.
- Demonstrate preparation, professionalism and organization in data collection.
- Understand and demonstrate use of the basic methods of data collection effectively.
- Gather information within the context of the regulations, interpretive guidelines, other written official policy directives and discipline-specific standards of practice.
- Primarily focus on health and safety, quality-of-care and quality-of-life issues and outcomes within the context of the survey process. Refrain from emphasizing structure and process details unless there are specific survey requirements for this type of review.
- Make accurate decisions regarding the type and amount of additional data needed to substantiate findings or make decisions.
- Use information from facility/provider documentation, as appropriate, to structure further survey procedures.
- Elicit information from other team members pertinent to their individual assignment which will enhance effective collection of information.
- Use information already collected as a base for the collection of additional necessary information to assist team members in their collection of sample data, determining facility practice and compliance.
- Effectively follow up (e.g., collect additional information) on information that suggests provider/supplier practice may not be in compliance with regulatory requirements.
- Identify information that would be useful to other team members in their reviews.
- Identify discrepancies in information obtained from various sources and/or at different times in the survey.
- Effectively investigate discrepancies in information through additional interviews, observations and/or review of documentation.

Observations

The surveyor will:

- Perform observations in an unobtrusive manner following any instructions in the *SOM*.
- Remain tactful, unobtrusive and skilled in obtaining nonverbal information as appropriate.
- Make observations throughout the course of the days and evenings, as appropriate, while sufficient information is collected.
- Obtain relevant information through observations of beneficiaries and staff.
- Intervene with staff practice only when that practice would put a beneficiary at risk of injury or harm (e.g., intervene before the beneficiary is given an incorrect medication, etc.).

Interviews

The surveyor will:

- Conduct interviews with beneficiaries, staff or others in accordance with survey protocol.
- Introduce himself/herself to any beneficiary who is part of the sample.

- Discuss an individual who is present only when the individual is included in the conversation.
- Use appropriate, respectful, nonstigmatizing language during verbal interactions.
- Terminate the resident/patient interviews if requested by beneficiary or if beneficiary becomes fatigued.
- Question interviewee as necessary to explore, clarify and resolve issues.
- Respect confidentiality by not disclosing source or specifics of findings from interview inappropriately or unnecessarily.
- Elicit relevant information through interviews.
- Speak and/or communicate information with clarity and volume sufficient to ensure that the audience hears.
- Elicit pertinent information from staff to determine compliance with regulations.

Record Review

The surveyor will:
- Review and identify information in records necessary for completing survey tasks/responsibilities.
- Validate information collected through observations and interviews when required by survey process.
- Identify appropriate information for review.

Documentation Skills

The surveyor will:
- Record pertinent observations and information accurately on appropriate survey forms or in another retrievable manner.
- Produce accurate, well-organized documentation of factual information obtained during surveys through observations, interviews and record review.
- Present findings in a clear, logical sequence.
- Use focused, descriptive information to support the rationale for citations; write deficient-practice statements based on survey findings in accordance with CMS's Principles of Documentation.

Evaluation Skills

The surveyor will:
- Consider relevant information provided by the facility during the survey regarding problems identified by the surveyor.
- Consistently distinguish conditions/regulations accurately for each provider/supplier.
- Evaluate the provision of care and services to beneficiaries, determining whether any declines that occurred were avoidable or unavoidable and whether the beneficiary attained and then maintained the highest practicable well-being.
- Demonstrate analytical skills necessary for making appropriate compliance decisions as shown by appropriateness of insights and questions.

- Gather and synthesize a large amount of disparate information into concise facts which address individual provider compliance requirements.
- Ascertain a need for further investigation/data collection to validate or disprove concerns and/or identify frequency and severity of information. Implement appropriate actions based on this evaluation.
- Determine whether specific findings are relevant to compliance or noncompliance with regulatory requirements.
- Review and approve/disapprove the Plan of Correction based on whether the plan is appropriate to the cited deficiencies and the provider capacity to correct cited deficiencies within acceptable time frames.

Decision-Making Skills

The surveyor will:

- Not allow personal knowledge or feelings about the provider to interfere with compliance decisions.
- Not impose or substitute personal or professional preferences for achieving compliance with regulations.
- During team meeting, contribute relevant, reliable and accurate compliance data that were collected during survey to make provider/supplier compliance or noncompliance decisions.
- Accurately integrate information collected from various sources.
- Demonstrate program expertise necessary to make compliance decisions by interrelating findings from observations, documentation review and interviews with appropriate regulations.
- Consistently distinguish conditions/regulations accurately for each provider/supplier.
- Apply the Medicare/Medicaid health and safety regulations in a consistent manner.
- Follow provider-specific procedural steps consistent with the *SOM* and other directives from the Centers for Medicare & Medicaid Services and State agency to guide compliance decisions.
- Make decisions based on facts, not assumptions or suppositions.
- Determine any immediate serious threat to health and safety in an appropriate, defensible context according to *SOM,* Appendix Q, guidelines.
- Participate with team members in the development of a list of deficiencies and evaluation of the Plan of Correction.
- Make decisions confidently, based on surveyor and educational training.
- Explain the difference in termination action between an immediate and serious threat and a nonimmediate and serious threat.

Postsurvey Activities

The surveyor will:

- Utilize understanding of the legal aspects of surveying and the importance of the surveyor's findings.
- Be familiar with the steps necessary to provide testimony at an administrative hearing.
- Be familiar with appropriate witness responses during an administrative hearing.

- Be familiar with guidelines for proper conduct following the conclusion of an administrative hearing.
- Understand the distinction between fact and inference and the importance of each.

Appendix D:
Training Resources

Federal Regulations and Survey Procedures

Following is a list of suggested training resources that should be available at each State agency and Regional Office for use by new and experienced staff.

A hard copy of the following documents may be purchased by contacting:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
Telephone: (202) 512-1800

These documents are also available through the Internet at the following sites:

Social Security Act
The table of contents may be found on the Internet at:
http://www.ssa.gov/OP_Home/ssact/comp-toc.htm

Code of Federal Regulations
Federal regulations for survey and certification are found in 42 CFR. The Internet site for the main page is: http://www.gpoaccess.gov/cfr/index.html

Federal Register
Documents will be found most easily by selecting the date of publication. The Internet site for the main page is: http://www.gpoaccess.gov/fr/index.html

State Operations Manual
The table of contents may be found on the Internet at:
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filter

Centers for Medicare & Medicaid Services

Internet sites for documents and other information commonly sought by individuals include the following:

Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/

Web-based learning: http://cms.internetstreaming.com/

CMS Guidance to State Survey Agency Directors and CMS Regional Offices: http://www.cms.hhs.gov/SurveyCertificationGenInfo/

Surveyor information:	http://www.cms.hhs.gov/SurveyorTraining/
Nursing Home Compare:	http://www.medicare.gov/NHCompare/Home.asp
Hospital Compare:	http://www.medicare.gov/Hospital/Home.asp
Open Door Forum schedule for providers, suppliers and interested parties:	http://www.cms.hhs.gov/OpenDoorForums/

Survey & Certification Letters

Survey & Certification Letters are periodically issued by the Centers for Medicare & Medicaid Services' (CMS) Central Office to provide clarification and other information needed in the survey and certification processes. A table of contents for those letters follows, and the letters can be found at https://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage.

Title	S&C #	Date
Fiscal Year 2005		
Nursing Home Compliance with the Requirements Related to Preventing Abuse	46	09/22/05
Updates to the SOM for OPTs and CORFs	45	09/22/05
Optometrists and/or Ophthalmologists serving as Lab Directors under CLIA	44	09/22/05
S&C Issues Related to Hurricane Katrina	43	09/02/05
Revisions to Interpretive Guidelines for Hospital Conditions of Participation 42 CFR §§482.12, 482.13, 482.27 and 482.28	42	08/18/05
Nursing Homes - Issuance of Technical Corrections to Appendix PP, SOM, for LTC Facilities	41	08/18/05
Eligibility for Conversion to Critical Access Hospital (CAH)	40	08/18/05
Extension of the CLIA Educational Period Regarding the Final CLIA Regulation	39	07/14/05
Clarification of Life Safety Code Survey Issues in Nursing Homes	38	07/14/05
Responsible State Agency for PRTF Surveys	37	07/14/05
Assigning Provider ID Numbers to Extension Locations of OPT or OSP Service Providers	36	06/22/05
Suspension of Processing New Provider Enrollment Applications for Specialty Hospitals	35	06/09/05
Issuance of Revisions to Appendix P, SOM, Survey Protocol for LTC Facilities	34	06/09/05
Adoption of a New Fire Safety Amendment for the Use of ABHRs	33	06/09/05
CAH Requirement for MD/DO Review of Medical Records for Mid-Level Practitioners	32	06/09/05
Promising Practices to Support the Intake of Nursing Home Complaints	31	06/09/05
The National Provider Identifier (NPI)	30	06/09/05
Advance Issuance of Revised Interpretive Guidelines for Tag F501, Medical Director	29	06/09/05
Renewal of Deeming Authority for Hospitals	28	05/12/05
Guidelines to Support Entry of Data into ASPEN/Acts System	27	05/12/05
Interaction of the EMTALA & the Born-Alive Infants Protection Act of 2002	26	04/22/05
Adoption of a New Fire Safety Requirement (Smoke Alarms) in LTC Facilities	25	04/14/05
Changes to Staffing Data on Nursing Home Compare Web Site	24	04/14/05

Delay in Effective Date for Revision of Appendix PP	23	04/14/05
Updated Facility Computer Specifications	22	03/10/05
Imminent Revisions to Appendix PP	21	03/10/05
Independent but Associated Deficiency Citations	20	03/10/05
Release of LTC/MDS Data to State Medicaid Agencies	19	02/18/05
Pressure Ulcer Prevention & Treatment Pilot - **Invitation**	18	02/10/05
Description of Recent Changes to State Operations Manual (SOM), Appendix PP	17	02/10/05
Needs Assessment Survey – Identification & Documentation of Abuse & Neglect	16	02/10/05
Renewal of AAAASF's Deemed Status	15	01/13/05
Electronic Signatures - **Clarification**	14	01/13/05
Special Focus Facilities	13	12/16/04
Response to Referrals from Public Entities	12	12/16/04
Implementation/Enforcement of Cytology Proficiency Testing	11	12/16/04
IDR Process for Nursing Homes	10	12/16/04
Nursing Home Reporting Requirements	9	12/16/04
Civil Rights Clearances for Initial Certification & CHOWs	8	11/12/04
HHA Drop Sites	7	11/12/04
Application of HHA CoPs to Chore Services	6	11/12/04
Nurse Aide Registry Requirements	5	11/12/04
CMS Requirements for Hospital Medical Staff Privileging	4	11/12/04
FY 2005 State Performance Review Protocol Guidance	3	10/14/04
Impact of Nursing Shortage on Hospice Care	2	10/14/04
Guidance on Working with Quality Improvement Organizations	1	10/14/04
Fiscal Year 2004		
FY 2004 State Performance Review Protocol Guidance, August 2004 Edition	47	09/09/04
Electronic Signature Guidance	46	09/09/04
Clarification of Comprehensive Assessment Timing Requirements	45	09/09/04
Availability and Implementation of the Pharmaceutical and Herbal Products Database	44	09/09/04
ASPEN AEM for NHs	43	08/12/04
Rural Health Clinics	42	08/12/04
Corridor Width & Corridor Mounted Computer Touch Screens	41	08/12/04
Resident Assessment Instrument (RAI) Training Program	40	08/12/04

CLIA State Agency Performance Review FY 2004	39	08/12/04
Additional Language Required in Initial Letter to Nursing Homes	38	08/12/04
Addendum 1 to S&C Letter 04-24 on the Care for Residents of LTC Facilities	37	07/08/04
Corrections to Appendix H of the SOM Web Version	36	07/08/04
Physician's Rubber Stamp Signature	35	07/08/04
EMTALA Guidelines	34	05/13/04
Life Safety Code (LSC) and State Performance Standards	33	05/13/04
Availability of Surveyor Aptitude Test	32	05/13/04
Status of Form CMS-1514	31	05/13/04
Clarification of Scoring for Measure 5 (FOSS)	30	05/13/04
Life Safety Code (LSC) Surveyor Reference Materials	29	05/13/04
Pilot Program for the Pharmaceutical and Herbal Products Database – Part 2	28	05/13/04
Opening of Best Practices Website	27	05/13/04
Clarification of the MMA of 2003 for Non-Medicare/Non-Medicaid Patients in HHAs	26	04/08/04
Upcoming Criminal Background Checks Pilot Project	25	04/08/04
Clarification of Certification Requirements for Residents Who Receive ESRD Services	24	03/19/04
Procedures in the Event of a Fire in a Medicare- or Medicaid-Certified Facility	23	03/11/04
Overnight Stays in Ambulatory Surgical Centers	22	03/11/04
Impact of MMA Section 946 on the Hospice Core Services Requirement	21	02/12/04
Psychiatric Residential Treatment Facilities (PRFTs)	20	02/12/04
Automated Survey Processing Environment (ASPEN) Software	19	02/12/04
Health Insurance Portability and Accountability Act (HIPAA) - **Clarification**	18	02/12/04
Clarification on Nursing Homes Requiring Promissory Notes	17	01/08/04
CLIA Policy & Data Reporting Guidance	16	01/08/04
Definitions of Terms Used in the LSC of the NFPA	15	12/11/03
Implementation of Critical Access Hospital Bed Size Increase	14	12/11/03
Psychiatric Residential Treatment Facilities	13	12/11/03
The Collection & Transmission of the OASIS Data for Private Pay Patients	12	12/11/03
State Survey Agency Performance Standards for Fiscal Year (FY) 2004	11	11/19/03

Emergency Medical Treatment and Labor Act (EMTALA) Interim Guidance	10	11/13/03
Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS)	9	11/09/03
Physician Delegation of Tasks in SNFs and NFs	8	11/13/03
Minimum System Requirements	7	11/13/03
Definition of "Significant Difference" FOSS and LTC Comparative Surveys	6	11/13/03
Guidance On Test Systems That Are Categorized as Either Waived or Moderate Complexity Under CLIA	5	11/13/03
Comparative Surveys for Fiscal Year 2004	4	10/09/03
Input Instructions for Comparative Surveys for FY 2004	3	10/09/03
Use of Mapping to Determine Rural Eligibility for Rural Health Clinics	2	10/09/03
Mandatory On-Line Prerequisites for Basic Long Term Care Training	04-01	10/09/03
Fiscal Year 2003		
Correction Policy for HHA Administrative Data on the Home Health Compare Web Site	33	09/11/03
Pilot Program for Surveyor Technical Assistant for Renal Disease (STAR)	32	08/14/03
Transfer of Data from the ACTS to State Systems - **Decision**	31	08/14/03
CLIA Policy Letters for First Survey Cycle Following CMS 2226-F	30	08/14/03
Discontinuance of Forms HCFA-1513, "Ownership and Control Interest Disclosure Statement" and HCFA-2572, "Statement of Financial Solvency"	29	08/14/03
Automation of SMQT and Clarification of Survey Activities	28	07/10/03
State Survey Agency Performance Standards for Fiscal Year (FY) 2003	27	07/10/03
Impact of HIPAA on the Nursing Home Requirement for Posting Survey Results	26	06/12/03
Clarification of Issues Related to Informal Dispute Resolution	25	06/12/03
Long Term Care Medication Pass Survey Requirement Clarification	24	06/12/03
Clarification of Designations of "Distinct Part" in the State Operation Manual	23	06/12/03
Clarification of CMS Payment Policies Regarding ASCs/IDTFs Conducting Business from the Same Location	22	06/12/03
Adoption of New Fire Safety Requirements for RNHCIs, ASCs, Hospice, PACE, Hospitals, Long Term Care, ICFs/MR, and CAHs	21	05/08/03
Medicare ID Number Assignment for End Stage Renal Dialysis (ESRD) Facilities	20	05/08/03

Policy for Interim Period Between the Effective Date of CMS-2226-F and Publication of Surveyor Guidelines	19	05/08/03
Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) - **Rescinded - See S&C-04-08**	18	04/10/02
Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations - **Action**	17	04/10/02
Interim Guidance for the Hospital Quality Assessment and Performance Improvement Conditions of Participation	16	04/10/02
Impact of HIPAA on Survey and Certification	15	03/14/03
Clarification of Instructions for Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid	14	02/13/03
Home Health Survey Protocol Enhancements	13	02/13/03
Coordinated Survey Approach For CAHs Having Multiple Affiliated Providers	12	02/13/03
BIPA 941 Nursing Home Requirement Effective 1/1/03; Follow-up to S&C-03-03	11	01/09/03
Binding Arbitration in Nursing Homes	10	01/09/03
Revised Resident Assessment Instrument User's Manual Release Effective 1/1/03	9	01/09/03
Information Exchange by Surveyors During the Nursing Home Survey Process	8	12/12/02
CLIA SA Performance Review (SAPR)—Introductory Version for FY 2003	7	12/12/02
Conversion of SMQT from a Two-Day to a One-Day Test	6	12/12/02
FY 2003 Training Requirements for ESRD, HHA, Hospice and ICF/MR Surveyors	5	11/14/02
Interim Guidance to Support National Pilot of the ACTS	4	11/14/02
Modification of S&C-02-33: Delay in the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS)	No # assigned	10/15/02
BIPA 941 Nursing Home Requirement Effective 1/1/03	3	10/10/02
Change in Requirement for Signed Physician's Order for Flu and Pneumonia Vaccine	2	10/10/02
Policy and Procedures for Conducting the Federal Comparative Survey, FY 2003	03-1	10/10/02
Fiscal Year 2002		
Comparative Surveys for Fiscal Year 2003	45	09/12/02
Impact of Nursing Shortage on Hospice Care	44	09/12/02

Centers for Disease Control and Prevention (CDC) Revised Recommendations for Single-Use Intravenous Medication Vials in ESRD Facilities	43	09/12/02
Use of Civil Money Penalty (CMP) Funds by States	42	08/08/02
Proposed Changes to the Outcome and Assessment Information Set (OASIS)	41	08/08/02
Fiscal Year (FY) 2003 State Survey and Certification Budget Call Letter	40	07/02/02
NH That Has No Arrangement to Provide Dialysis Services To Its Residents	39	08/08/02
Final Guidance Package for CLIA Federal Monitoring Survey Process	38	08/08/02
Assigning Provider Identification Numbers to Home Health Agency Branches	37	08/08/02
Privacy of Medical Record Information in Rural Health Clinics	36	06/13/02
Simultaneously On-Call	35	06/13/02
On-Call Requirements-EMTALA	34	06/13/02
Interim Guidance to Support Information of the ASPEN Complaints/Incidents Tracking System (ACTS)	33	06/06/02
Resident Assessment Instrument Coordinator Responsibilities in Minimum Data Set Training of Swing Bed Hospital Staff	32	06/06/02
Mandatory Viewing of Satellite and Webcast Training Program	31	05/10/02
Requests for HHA Branch Office Approval and the Use of a Reciprocal Agreement	30	05/10/02
Promising Practices for Implementing the Medicare Hospice Benefit for Nursing Home (NH) Resident	29	05/10/02
State Agency Performance Standards for Fiscal Year (FY) 2002 - Revised	28	04/29/02
Update to Data Posted on Nursing Home Compare Website	27	04/29/02
ICFs/MR Form-3070G Revisions - Action	26	04/29/02
Onsite Versus Paper Revisits - Applicability to May 3, 2001 Revisit Policy	25	04/29/02
Clarification of Memo S&C-02-19 - Recalled Sprinkler Heads - Action	24	04/29/02
Voluntary Termination of a SNF or NF	23	04/29/02
Initiating On-Site Visits To Facilities Enrolled In the CLIA Program That Have Waiver Certificates - **Revised**	22	04/01/02
Resolving Disagreements Resulting from Federal Oversight and Support Surveys	21	03/25/02

Review of Time frames for Reporting Abuse; Reporting Abuse to Law Enforcement; Displaying Complaint Telephone Numbers; and Clarification on Defining and Citing Abuse	20	03/28/02
Recalled Sprinkler Heads	19	03/08/02
ICFs/MR Form 3070G Revisions	18	02/06/02
Completion of Minimum Data Set (MDS) in Critical Access Hospitals (CAHs)	17	02/01/02
Clarification of CMS Policies Regarding ASCs-Effective Immediately	16	02/01/02
Clarification of Hospital Admission and Presurgical H&P Requirements	15	01/28/02
Certification of False Labor - EMTALA	14	01/16/02
Services Provided by Home Health Agencies (HHAs)	13	01/07/02
Implementation of Outcome-Based Quality Improvement (OBQI) Reports	12	01/09/02
Nursing Home Off-Hour Data Indicator in OSCAR	11	12/20/01
Comparative Surveys for Fiscal Year 2002	10	12/20/01
Discontinuance of Contract with Integriguard (Division of California Medical Review Inc.) to visit CMHCs after January 15, 2002	9	12/20/01
ICF/MR Federal Monitoring and Oversight Survey Data	8	12/21/01
Hospital Capacity-EMTALA	6	11/29/01
Alert and Action: End Stage Renal Disease (ESRD) Dialyzer Recall by Baxter	5	11/14/01
Question and Answer Relating to Bioterrorism and EMTALA	4	11/08/01
Training Request for CMS's Nutrition/Hydration Awareness Campaign	3	10/30/01
OASIS Requirements in New HHAs Seeking Medicare Certification Including HHAs Seeking Deemed Status Through an Approved AO	2	10/16/01
Abuse and Neglect Detection and Prevention Training	02-1	10/10/01
Fiscal Year 2001		
Clarification: Monthly Quality Indicator Comparison Reports Policy	24	09/20/01
Response to Questions about Verification Policy	23	08/15/01
New HCFA-855(A) and (B) Applications and Procedures	22	08/15/01
Wound Ostomy Continence Nurses Society (WOCN) OASIS Guidance Document	21	08/06/01
Clarification of Nurse Aide Training Requirements with Regard to Transporting versus Transferring Nursing Home Residents	20	07/05/01
Reporting Requirements: Use of Restraint and Seclusion in Psychiatric Treatment Facilities Providing Inpatient Psychiatric Services to Individuals Under Age 21	19	06/01/01

Response to Questions from the National Hospice and Palliative Care Organization (NHPCO)	18	05/03/01
Monthly Quality Indicator Comparison Reports	17	05/03/01
Sharing State Licensure Information	16	05/03/01
Potential Impact of the HHPPS on Services Provided by HHAs	15	04/30/01
Home Health Agency Questions and Answers	14	04/23/01
Hospice Questions and Answers	13	04/24/01
New OASIS Correction Policy for Home Health Agencies (HHAs)	12	04/20/01
State Agency Performance Standards for Fiscal Year (FY) 2001	11	04/06/01
Policies about Verification of Compliance and Setting 3- and 6-month Remedy Effective Dates	10	05/03/01
Off-Hour Surveys--Clarification	9	03/23/01
Instructions Regarding the Implementation of Section 506(a)(1) of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA): Treatment of HHA Branch Offices	8	03/09/01
Implementation of the OBQM Reports as Part of the HHA Survey Process	6	03/06/01
Number 5 Deleted	5	Deleted
Revisions to CMHC Instructions as a Result of Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement & Protection Act of 2000 (BIPA)	4	02/16/01
The Application of OASIS Requirements to Medicare Beneficiaries Procedures Affecting Home Health Agencies (HHAs) and OASIS Requirements	3	02/12/01
OASIS Considerations for HHAs Seeking Initial Certification	2	02/01/01
Clarification of Appeal of Nurse Aide Training & Competency Evaluation Programs	01-1	02/15/01
Confidentiality of Survey Records - Disclosing Medicare\Medicaid\CLIA Records and Information to the Public	No # assigned	12/21/00
Recertification of Accredited Providers - Requirements of Recertification Packets for Accredited Hospitals	No # assigned	11/14/00
Fiscal Year 2000		
Principles of Documentation 2000	No # assigned	09/00
Survey Agency Director Letter - Guiding Principles for Complaint Investigations	No # assigned	10/13/99

Satellite Broadcasts

Beginning in December 1996, CMS implemented satellite transmission of broadcasts to State agencies, CMS Regional Offices and others. Each broadcast provides information that surveyors may use when conducting surveys and providers may use to meet regulations. Current standards of practice are also provided.

Beginning in July 2001, viewing of certain broadcasts became mandatory for individuals who surveyed certain providers and suppliers. Following is a list of those satellite transmissions and the individuals for whom the broadcast was and remains mandatory.

Date	Name	Mandatory	No Longer Mandatory	For Whom
12/09/1996	Psychopharmacological Medication: Safety Precautions for Persons with Developmental Disabilities	No	12/09/1996	
03/02/1997	Enteral Feeding	No	03/02/1997	(not mandatory)
04/14/1997	Pressure Ulcers and Nutritional Implications	No	04/14/1997	(not mandatory)
07/01/1997	Investigating Elder Abuse	No	07/01/1997	(not mandatory)
08/22/1997	Interviewing People with Developmental Disabilities	No	08/22/1997	(not mandatory)
09/19/1997	Aging and People with Developmental Disabilities	No	09/19/1997	(not mandatory)
02/19/1998	MDS Automation	No	02/19/1998	(not mandatory)
02/27/1998	Person-Centered Planning	No	02/27/1998	(not mandatory)
05/05/1998	Natural Rubber/Latex Allergy: Recognition, Treatment and Prevention	No	05/05/1998	(not mandatory)
07/13/1998	Nursing Home Deficiency Review & Scope & Severity Determination for Supervisors	No	07/13/1998	(not mandatory)
08/20/1998	Outcome and Assessment Information Set (OASIS)	No	08/20/1998	(not mandatory)
04/19/1999	Nursing Home Initiatives Overview	No	04/19/1999	(not mandatory)
09/29/2000	Surveying the LTC Activities Requirements	No	09/29/2000	(not mandatory)
01/19/2001	OASIS - Case Mix and Adverse Events Reports	No	01/19/2001	(not mandatory)
07/20/2001	Mental Illness in Nursing Homes	Yes		All NH surveyors and supervisors
08/24/2001	Flu and Pneumonia Immunization in Nursing Homes	Yes		All NH surveyors and supervisors
09/21/2001	Assuring Dental Health in Nursing Homes	Yes		All NH surveyors and supervisors
02/22/2002	Outcome-Based Quality Improvement (QBQI) Reports for HHAs	Yes		All HHA surveyors and supervisors
04/19/2002	FOSS Update - Bridging the Gap	Yes		All NH surveyors and supervisors

08/16/2002	Standards of Care and Strategies for Immunizing Nursing Home Residents	Yes		All NH surveyors and supervisors
09/27/2002	Nursing Home Quality Initiative National Release Broadcast	Yes		RO and SA nursing home LTC managers
11/22/2002	OASIS Burden Reductions	Yes		RO and SA OASIS coordinators, HHA surveyors and their supervisors
12/13/2002	Publicly Reported Quality Measure and MDS Coding	Yes		RAI/MDS coordinators
01/24/2003	ASPEN Complaints/Incidents Tracking System (ACTS)	Yes		RO and SA staff that use ACTS or are involved in complaint/ incident procedures
04/04/2003	Preventing Spread of Severe Acute Respiratory Syndrome (SARS)	No	04/04/2003	(not mandatory)
04/25/2003	Federal Outcome Monitoring Contract for ICFs/MR	Yes	Contract no longer in effect 10/2005	ICFs/MR surveyors, supervisors and managers of ICFs/MR surveyors, DD specialists and designees for Federal Monitoring Contracts
06/20/2003	Data Assessment and Verification (DAVe)	Yes		RAI coordinators
08/06/2003	CLIA - Quality System Rule			
10/03/2003	Home Health Quality Initiative (HHQI)	Yes		RO and SA managers, OASIS educational and automation coordinators and training coordinators
10/09/2003	LSC 2000 Update	Yes		All LSC surveyors who have not attended a CMS-sponsored LSC 2000 Update training course
10/24/2003	Investigative Techniques	No	10/24/2003	(not mandatory)
10/31/2003	Forensic Wound Identification and Documentation	No	10/31/2003	(not mandatory)
11/14/2003	Psychiatric Residential Treatment Facilities	Yes		All RO and SA managers and surveyors who will have responsibility for surveying PRTFs
11/21/2003	Basic Medication in an ICF/MR	No	11/21/2003	(not mandatory)
01/09/2004	Treatment Modalities for the Management of Distressed Behaviors in Elderly Nursing Home Residents	No	01/09/2004	(not mandatory)
01/16/2004	Fall Prevention	No	01/16/2004	(not mandatory)
01/30/2004	How People with Severe Disabilities Learn	Yes		All RO and SA ICF/MR surveyors
02/20/2004	Basic Medications in Nursing Homes	Yes		All new RO and SA surveyors
02/27/2004	Alzheimer's and Related Dementia - Part 1	Yes		All RO and SA nursing home surveyors
03/12/2004	Hydration	No	03/12/2004	(not mandatory)
03/26/2004	Alzheimer's and Related Dementia - Part 2	Yes		All RO and SA nursing home surveyors

04/23/2004	Wound Care	Yes		All RO and SA HHA surveyors and OASIS educational and automation coordinators
04/30/2004	Decision Making	No	04/30/2004	(not mandatory)
05/07/2004	Orientation for Newly Employed Surveyors	Yes		All new RO and SA survey and certification staff
05/14/2004	Abuse and Neglect in Psychiatric Hospitals	Yes		All RO and SA surveyors of psychiatric facilities
05/21/2004	Interviewing Technique	No	05/21/2004	(not mandatory)
07/16/2004	Diabetes	No	07/16/2004	(not mandatory)
07/23/2004	Pain Management	No	07/23/2004	(not mandatory)
08/03/2004	Pressure Ulcers	Yes		All RO and SA LTC surveyors
08/27/2004	Improving MDS Accuracy - ADLs and Restorative Nursing	Yes		All RO and SA RAI coordinators
10/27/2004	Urinary Incontinence - Volume 2	Yes		All RO and SA LTC surveyors
10/29/2004	Improving MDS Accuracy - Disease Diagnosis, Medications and Health Conditions	Yes		All RO and SA RAI coordinators
03/18/2005	Making Sense of Data	No	03/18/2005	(not mandatory)
04/29/2005	Facilitating Communication in Individuals with Neurological Disease	No	04/29/2005	(not mandatory)
05/20/2005	Home Dialysis in the Long Term Care Setting	No	05/20/2005	(not mandatory)
07/22/2005	Delivery of Care to a Diverse Population	No	07/22/2005	(not mandatory)
07/29/2005	Hospice - End of Life Issues - Part 1	No	07/29/2005	(not mandatory)
08/12/2005	Hospice/Hospitalization or Death – Part 2	No	08/12/2005	(not mandatory)
09/08/2005	Nursing Home Immunization	Yes		RAI coordinators, LTC surveyors and Medicaid states using the MDS for payment
09/23/2005	Reducing the Use of Seclusion and Restraints in Psychiatric Facilities	No	09/23/2005	(not mandatory)
10/14/2005	Medical Aspects of Neglect	No	10/14/2005	(not mandatory)
10/21/2005	2005 Survey and Certification's LTC Policy Year in Review	Yes		All LTC surveyors
11/04/2005	Medicare Part D Impact on Nursing Home Surveys	Yes		All LTC surveyors
11/18/2005	Semi-Annual SCG News Magazine Part 1 - Delivering Bad News	No	11/18/2005	(not mandatory)

Videos and CD-ROM

Through the years, CMS training staff have provided a number of videos and, more recently, CDs to State agency and CMS Regional Office trainers. Trainers have typically used these resources to train not only new and experienced surveyors, but also the staff of providers and suppliers and other interested parties. Following is a list of videos and CDs that, at a minimum, all trainers should have. Although your office may retain other videos, we

encourage you to preview newer videos and discard any that no longer reflect a current survey process or standard of practice.

Resources are listed by provider or supplier or subject.

Miscellaneous				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
Delivery of Care to a Diverse Population	Undated	52:18	X	X
Diabetes Life	Undated	64:00	X	X
Hydration	Undated	86:54	X	
Investigative Techniques	Undated	146:45	X	
Orientation for Newly Employed Survey and Certification Staff	Undated	71:00		X
Pain Management	Undated	89:05 and 9:56	Two tapes	X
State of Science in Wound Care Management	Undated	64:12		X
Enteral Feeding: Safe and Effective Practices	03/24/1997	1:20:50	X	
Investigating Elder Abuse	07/10/1997	58:31 and 1:06:35	Two tapes	
Pressure Ulcers and Nutritional Implications	04/14/1997	1:56:02	X	
Abuse and Neglect	09/27–30/1999	1:18:01	X	
Infection Control	09/27–30/1999	1:30:35	X	
Malnutrition	09/27–30/1999	1:10:58	X	
Pressure Sores	09/27–30/1999	1:59:36	X	
Forensic Wound Identification	10/31/2002	62:00	X	
ASPEN Complaints/Incidents Tracking System (ACTS)	01/24/2003		Two tapes	
Fall Prevention	01/01/2004	67:00	X	
Dementia 2004 Update	02/27/2004	101:00	X	
Dementia – A Surveyor's Perspective	03/26/2004	147:44	X	
Making Sense of Data	03/18/2005	1:30:17 and 91:41	Two tapes	X
Facilitating Communication in Individuals with Neurological Disease	04/29/2005	55:00	X	

Home Health Agencies				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
Enhanced HHA Survey Protocols	Undated		X	
Outcome and Assessment Information Set (OASIS)	08/20/1998	1:30:52 and 1:17:27	Two tapes	
Home Health Agency Assessment Strategies for Outcome and Assessment Information Set	05/09/2000	21:20	X	
OASIS Case Mix and Adverse Events Report	01/19/2001		X	
OBQI Reports for HHAs	02/22/2002		Two tapes	
OASIS Burden Reductions	11/22/2002		Two tapes	
DAVE	06/20/2003	1:43:00	X	
HHQI Broadcast	10/03/2003		Two tapes	

Intermediate Care Facilities for Individuals with Mental Retardation				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
Pharmaceutical Medications Safety Precautions for Persons with Developmental Disabilities	12/09/1996		Two tapes	
Interviewing Persons with Developmental Disabilities	08/22/1997	112:00	X	
Aging and People with Developmental Disabilities	09/19/1997	119:00	X	
Federal Monitoring Contract for ICF/MR	04/25/2003	48:00	X	
Basic Medications for an ICF/MR Facility	11/21/2003	1:05:00	X	
How People with Severe/Profound Disabilities Learn	01/30/2004	90	X	

Long Term Care				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
CMS Nursing Home Journal Volume 1: Clinical Aspects of Pressure Ulcer Care and LTC Facilities	Undated			X
CMS Nursing Home Journal Volume 2: Urinary Incontinence and Catheters	Undated	1:29:54 and 16:26	Two tapes	X
Nutrition and Hydration in Long Term Care	08/25/2000		Two tapes	
Surveying Activity Requirements for Nursing Homes	08/29/2000		Two tapes	

Nursing Home Quality Initiative	09/20/2002		Two tapes	
Mental Illness in Nursing Homes	07/20/2001		X	
Assuring Dental Health in Nursing Homes	09/21/2001	93:00 and 59:00	Two tapes	
Standards of Care and Strategies for Immunizing Nursing Home Residents	08/16/2002			
"Pioneer Network" Innovations in Quality of Life	09/27/2002		Two tapes	
Survey and Certification's LTC Policy Year in Review	10/21/2003	60:00	X	
Treatment Modalities for the Management of Distressed Behaviors in Elderly Nursing Home Residents	01/09/2004	97:00:00	X	
Basic Medications in Nursing Homes	02/20/2004	1:20:00	X	

Resident Assessment Instrument/Minimum Data Set				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
Overview of MDS and Final Rule: Data Collection and Requirements	02/19/1998	1:27:00	X	
MDS Automation Satellite Broadcast: Data Transmission Process and Vendor Issues	02/19/1998	1:28:00	X	
MDS Automation Satellite Broadcast: Other Facility Implementations and Wrap Up	02/19/1998	54:00	X	
MDS for Swing Bed Hospitals: Coding Instructions	05/16/2002	89:00 and 88:00	Two tapes	
Publicly Reported Quality Measures and MDS Coding	12/13/2002		Two tapes	
Town Hall Meeting	06/02/2003	1:57:00 and 25:00	Two tapes	
Improving MDS Accuracy: Disease Diagnosis, Medications and Health Conditions	Undated	1:28:49 and 39:43	Two tapes	X
Improving MDS Accuracy: Train-the-Trainer (DAVe)	July, 2004			X
MDS Resident Assessment Validation and Entry System	Undated			X

Other Providers and Suppliers				
NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
CLIA – Final Quality System Regulations	08/06/2003		X	
Hospice and End of Life Issues	07/29/2005	45:33	X	
Hospice End of Life Issues	Undated	46:00	X	X
2000 Life Safety Code Update	10/09/2003		X	
Psychiatric Residential Treatment Facilities (Under Age 21)	11/14/2001	1:29:00	X	

Other CDs provided include the following:

NAME	**DATE ISSUED**	**TIME**	**VIDEO**	**CD**
2005 Leadership Summit: Sustain the Gains – Maintain the Connections	04/19–22/2005			X
Principles of Documentation	Undated			X
Orientation to the Basic Life Safety Code Surveyor Training	2002			X
Surveying for Resident Rights and Quality of Life	Undated, but issued 05/21/1998			X
Basic Long Term Care Course/Life Safety Code Course	Undated, but issued 09/09/2004			X

Appendix E: Sample Surveyor Skill Assessment Procedure and Forms

Sample Surveyor Skill Assessment Procedure and Forms

Frequent assessment of learning throughout training will assist the preceptor, the trainer and the new surveyor's direct supervisor in assessing the new surveyor's ability to retain and demonstrate learning. It will also allow modification of the new surveyor's training plan to include methods and information best suited to maximize the individual's learning.

Points to consider in assessing the new surveyor:

- Determine what training needs to be assessed. This should include both knowledge and demonstration of skills learned. Use the lessons found in this manual to list what specific knowledge and skills the new surveyor needs to do his or her job.
- Determine who will assess the new surveyor—the preceptor, survey team coordinator, trainer, team members or direct supervisor.
- Determine how frequently the assessment will be done by each individual.
- Determine the form to be used.
- Determine the method of evaluation (formal or informal, location, what documents will be provided to the new surveyor, who will sign documents, how the information will be transmitted to other concerned individuals, where the documents will be kept, etc.).
- Consult your agency policies and procedures and union contract, if appropriate.
- Write the assessment procedure, have it approved as required by your agency and distribute it to all appropriate staff.
- Communicate the policy and procedure to the new surveyor during orientation.

Following are three examples of forms you can use to document assessments of surveyor knowledge and skills learned through training. Modify any form as desired to meet your needs.

Sample Skill Assessment 1
Form to assess training after one lesson

[Name of Lesson]

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					1. [ ]	
					2. [ ]	
					3. [ ]	
					a. [ ]	

Comments/Recommendations

Sample Skill Assessment 2
Form to track learning after one lesson
[Name of Lesson]

Trainee: _____ Preceptor: _____ Date Completed: _____

OO means "Observation Only"

NMSE* means "Needs More Supervised Experience"

PMS* means "Performed with Minimal Supervision"

PI means "Performed Independently"

* Requires written comment

References: [ ]

Date(s)	OO	NMSE*	PMS*	PI	SKILL	COMMENTS

Additional Comments/Recommendations

Sample Skill Assessment 3
Form to track knowledge and skill development throughout training
[Name of Provider Type] Training

Trainee Name _____ Preceptor Name _____

For each survey, assess the learning level and demonstrated ability for each listed item using the following:

VKMP "Verbalize knowledge with much prompting"
VKSP "Verbalize knowledge with some prompting"
VKLP "Verbalize knowledge with minimal/little or no prompting"

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision" (Competent: Following the survey protocol, policies and procedures.)
PI "Performed Independently"

Provide a comment to support any assessment that appears in the shaded areas above.

Survey Date(s)	Knowledge or Skill	Rating	Comments

On separate sheets, include amplification on the new surveyor's strengths, weaknesses, problem areas and training needs and recommend methods best utilized by the new surveyor.

Appendix F:
Sample Evaluation Forms

Sample Evaluation Forms

Evaluating training is difficult to do, especially after the training has concluded and participants scatter to distant locations. Although an evaluation of the training would best determine how each individual who completed the training has changed or used the information he/she received, this is frequently impossible. Therefore, variations on the following forms are used as a substitute in an effort to improve the presentation of the training and the environment in which it occurs.

Individual Presentation Evaluation

Course Name _____ Date _____

Presenter's Name _____

In an effort to make future training conferences as meaningful as possible, please complete this evaluation.

For items 1–8, please rate the value of the presentation using the following key:

4 =	3 =	2 =	1 =
Very valuable	Moderately valuable	Somewhat valuable	No/not useful information

	4	3	2	1
1. The course content was beneficial.				
2. In general, the content presented was applicable to your job.				
3. The objectives of the session were clearly identified.				
4. The objectives of the training were met.				
5. The discussion topics were interesting and useful.				
6. The handout materials will be a useful reference.				
7. The visual aids were effective and visible.				
8. The presentation will be applicable on the job.				

9. What specific information presented will be the most helpful to you in the future?

_____

_____

_____

10. Was information presented which you will not use?

_____

_____

_____

11. What would helpful training program topics for future training be?

_____

_____

_____

12. Additional comments and/or concerns:

_____

_____

_____

Individual Presenter Evaluation

Name of training _____ Date(s) _____

Presenter _____

In an effort to make future training as meaningful as possible, please complete this evaluation.

Circle your response for items 1–6 based on the following scale:

5 =	4 =	3 =	2 =	1 =
Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied

1. Presenter's knowledge of the material	5	4	3	2	1
2. Content of presentation	5	4	3	2	1
3. Level of audience participation	5	4	3	2	1
4. Usefulness of overheads, activities, etc.	5	4	3	2	1
5. Usefulness of handout materials	5	4	3	2	1
6. Usefulness of information in your job	5	4	3	2	1

Give two examples of ways you will apply what you learned in this presentation/program:

1. _____
2. _____

Please list two improvements that would have made this presentation/program better:

1. _____
2. _____

Other comments:

_____
_____
_____
_____
_____

What future presentations/programs would you recommend?

_____
_____
_____
_____
_____

Overall Conference Evaluation

Conference Name _____

Inclusive Dates _____

Your input is important to the planning of future training sessions. Please complete the items on this page using the following evaluation scale:

5 = Excellent	4 = Good	3 = Okay	2 = Could be better	1 = Poor	NA = Not applicable

	5	4	3	2	1	NA
General Conference						
1. What is your general overall evaluation of the conference?						
2. The conference flowed smoothly and followed logical sequence.						
3. Enough time was allotted for discussion, questions, and idea sharing.						
4. The environment promoted a good training experience.						
5. Food service was satisfactory during meetings.						
6. Conference committee members were courteous and helpful.						
7. Adequate opportunities were planned for networking with peers.						
8. All participants and speakers interacted as I would have wanted.						
Individual Sessions						
Name of session						
1. Content was relevant to the conference.						
2. Presenter's style of training was effective.						
3. Presenter communicated in an understandable manner.						
4. The handouts/visual aids were effective.						
Name of session						
1. Content was relevant to the conference.						
2. Presenter's style of training was effective.						
3. Presenter communicated in an understandable manner.						
4. The handouts/visual aids were effective.						
Name of session						
1. Content was relevant to the conference.						
2. Presenter's style of training was effective.						
3. Presenter communicated in an understandable manner.						
4. The handouts/visual aids were effective.						

1. What information from the conference will you be able to use back on the job?

2. What was the least valuable part of the conference?

3. What could be eliminated at future conferences?

4. How could future conferences better meet the needs of your organization?

5. Additional comments and recommendations.

Checklist for Evaluating Training Audiovisuals

Name of Audiovisual _____

Date on Material _____ Date Evaluated _____

Name of Evaluator _____

INSTRUCTIONS: Circle or check your evaluation.

Yes	No	1.	The information poses interesting problems for discussion among viewers.
Yes	No	2.	Problems/events portrayed parallel/oversimplify those encountered by viewers.
Yes	No	3.	Problems/events are realistic/accurate.
		4.	The video is best suited for learning objectives that are: ☐ Cognitive/knowledge ☐ Practical/skill ☐ Affective/feeling
Yes	No	5.	Simulates viewers' actual work environment/experience.
Yes	No	6.	Terminology is consistent with that used by viewers.
Yes	No	7.	Provides examples of correct/incorrect role behavior.
Yes	No	8.	The whole video should be shown. If only part should be shown, list which section(s):
		9.	Content seems: ☐ Artificial/simplistic ☐ Complex/about right
Yes	No	10.	Periodically summarizes key information/concepts.
Yes	No	11.	Is conducive to note taking by viewers.
Yes	No	12.	Supplemental materials needed. If yes, please list:
Yes	No	13.	Conducive to stopping periodically to ask questions.
Yes	No	14.	Requires additional instruction before/following use.
Yes	No	15.	Graphics are clear and legible.
Yes	No	16.	Sound/voice-over narration is clear and easily understood.
Yes	No	17.	Program content is well-organized; concepts introduced in logical steps/sequence.

Appendix G: Orientation to the Workplace Form

Orientation to the Workplace
[Name of State agency/Regional Office]
[Date of implementation or revision]

Directions for use:

- Preceptor/designee:
  - Tour the building and office, then provide required documents.
  - Discuss the information listed.
  - Initial and date each section when completed.
- New employee:
  - Initial each section when information is understood.
  - Write comments as needed (e.g., information not clearly understood or further information needed).
  - File the form as required by office policies and procedures.

Instructions	Preceptor/ Designee	New Employee	Comments
Before the Employee Arrives Prepare the work area (desk, chair, telephone, trash container, computer, printer, in-out baskets, calendar, stapler, staple remover, pens, pencils, writing paper, phone book(s), helpful telephone numbers, maps, name tag and other supplies).			
Oath of Office Allegiance			
Tour Location and Building Parking.			
Area restaurants/cafeteria.			
Security to enter office (code/number).			

Instructions	Preceptor/ Designee	New Employee	Comments
Break room/coffee-snack area.			
Restroom.			
Emergency exits.			
Procedures for fire/bomb threat/earthquake/tornado.			
Tour Department/Office Introduce to staff.			
Procedures to report in and out.			
Mailbox.			
Telephone messages.			
Fax machine.			
Copy machine.			
Shredder.			

Instructions	Preceptor/ Designee	New Employee	Comments
Supplies: Office. Survey.			
File location.			
Resource manuals and books.			
State/Federal Orientation Manual Provide copy.			
Identification Photo/identification badge.			
Assign Federal/State number.			
Assign other/position number.			
General Work Information and Completion of Forms Health plan/medical examination.			
Dental plan.			
Vision plan.			

Instructions	Preceptor/ Designee	New Employee	Comments
Individuals to contact in case of illness, accident, emergency (family, physician, significant other).			
Employee assistance program.			
Retirement Information Retirement plan (and options).			
Designation of beneficiary.			
Payroll Pay period.			
Wage.			
Common deductibles.			
Optional deductibles and deferred compensation programs [e.g., life insurance, 401(k)/(a)].			
W-2.			

Instructions	Preceptor/ Designee	New Employee	Comments
Direct deposit authorization/distribution of paycheck and earnings statement.			
Credit Cards Corporate credit card.			
Telephone card.			
Responsibilities.			
Limitations.			
Expected behaviors.			
CMS Surveyor Characteristics Form (complete)			
Standard Operations Forms, Procedures, Expected Behaviors, and Professional Performance, Union Contract and Name of Union Representative(s) (if applicable)			
Working Days/Hours Legal holidays.			

Instructions	Preceptor/ Designee	New Employee	Comments
Normal/alternate work hours.			
Meal and break periods.			
Working: Credit hours.			
Overtime.			
Compensatory time.			
Weekends.			
Working at home.			
Working at other work sites (in State/out of State).			
Recording time (e.g., time sheet).			
Travel (related to official work time).			

Instructions	Preceptor/ Designee	New Employee	Comments
Vacation/annual leave accrual.			
Sick leave accrual.			
Request for leave: Vacation.			
Medical/dental appointments.			
Family illness.			
Death.			
Absences: Unplanned absence from work or delay in reporting to work (e.g., illness of self or significant other, emergency, etc.).			
Planned absence from work or during workday.			
Leave of absence.			
Family and Medical Leave Act.			

Instructions	Preceptor/ Designee	New Employee	Comments
Work-related injury.			
Illness and injury prevention program.			
Security Office (keys, equipment, identification, State/Federal vehicle, cellular phone, computer, etc.).			
Personal (e.g., parking, purse, travel, hotel).			
Conduct/Expected Behavior Changes to information provided on forms.			
Dress in office and at other work sites.			
Confidentiality.			
Report of contact with providers/others.			
Public affairs and the media.			
Speaking engagements.			

Instructions	Preceptor/ Designee	New Employee	Comments
Sexual harassment.			
Political activity.			
Smoking.			
Alcohol and substance abuse.			
Maintenance and security department records.			
Computer.			
Internet.			
Postemployment restrictions.			
Conflict of interest/ incompatible or prohibited activities (official position, outside employment, supplies, gifts, money, favors, market products, etc.).			
Telephone usage (at desk and cellular).			

Instructions	Preceptor/ Designee	New Employee	Comments
Incoming mail/confidential mail.			
Emergency duty roster and call list.			
Use of Equipment Telephone procedures.			
Significant telephone numbers.			
Copy machine.			
Fax machine.			
Computer and printer.			
Writing document.			
Internet: Office site.			
State Operations Manual (SOM).			
Code of Federal Regulations.			

Instructions	Preceptor/ Designee	New Employee	Comments
Other commonly used software: Access/database software.			
Excel/spreadsheet software.			
PowerPoint.			
Automated Case Tracking System (ACTS).			
Automated Survey Processing Environment (ASPEN).			
Other: Ordering supplies and additional equipment.			
Filing system.			
Routing system.			
Mail (personal and office).			
Resource individuals: Telephone numbers. E-mail addresses.			
Job Description/Duties Performance appraisal procedure (including timing and potential outcomes).			

Instructions	Preceptor/ Designee	New Employee	Comments
Probationary period.			
Grievances.			
Roles and Responsibilities of the Preceptor Trainee			
Communication with Supervisor(s)			
Survey-Related Information State/Federal vehicle. Procedure to get a vehicle.			
Gasoline use and purchase.			
Vehicle maintenance and location to have done.			
Accident procedures.			
Restrictions (use, maintenance, other).			
Use of private vehicle (e.g., reimbursement rate and accident/insurance coverage).			
Allowance/reimbursement (e.g., form to complete, what is allowed and not allowed, mileage record).			

Instructions	Preceptor/ Designee	New Employee	Comments
Travel and Reservation Procedures Making reservations.			
Hotel/motel rates: in State (e.g., rural versus urban areas), out of State.			
Airline.			
Rental vehicle.			
Cabs/shuttle/other.			
Travel advance.			
Reimbursement procedure and time frames.			
Tracking/Documenting Training Assignments and Progress Assignment sheets.			
Orientation skills checklist.			
Professional development and/or training requests for training outside the office.			

Instructions	Preceptor/ Designee	New Employee	Comments
State licensing requirements.			
Receive Copies to be Used Later in Training *State Operations Manual (SOM)* with appropriate appendices.			
Long Term Care Resident Assessment Instrument User's Manual.			
Principles of Documentation (PoD).			
ASPEN manual.			
State licensing requirements.			
List of State facilities/providers and suppliers.			
Federal survey and certification letters.			
List of Federally mandated training videos/webcasts based on employee position.			
State directives regarding survey and certification policies and procedures and other related information.			

Instructions	Preceptor/ Designee	New Employee	Comments
Federal directives regarding survey and certification policies and procedures.			
Other: Personnel procedure handbook. Employee orientation manual. Electronic resources/manuals. Electronic forms.			

Sign when the entire form has been completed:

Surveyor Signature _____ **Date** _____

Preceptor Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

Appendix H: Planning and Holding a Meeting

Planning and Holding a Meeting

Any meeting or training session requires planning, preparation and hard work. You need to consider many details from the initial planning through the conclusion of the meeting.

Appendices H-1 through H-3 provide valuable assistance to those with the responsibility of planning and holding a meeting. Included are three checklists that may be used to address many of the details involved in meeting planning. Remember that every situation is different, so it may not be necessary to answer every question or plan each detail on each checklist.

Step 1: Planning the Training Session (Appendix H-1)

This checklist will assist you in considering everything from "What is the purpose of the training?" to "What are the budget issues?" A well-planned proposal will help you convince management that the meeting is necessary and that it is possible to conduct it efficiently. A well-planned proposal will also assist you in producing a successful meeting.

Step 2: Arranging a Meeting Location (Appendix H-2)

This checklist will help you search for the perfect location for the meeting. It includes many details that are necessary to achieve a successful session. Before contacting hotels or conference centers, consult with financial staff in your office to determine whether the State agency has a contract with a specific site. Follow your agency procedures for getting approvals, making payments, etc. Even if the State agency routinely deals with a specific site, use this checklist to be certain that everything that needs to be done, will be.

Step 3: The Day of the Meeting (Appendix H-3)

After all the planning and preparation the day has finally arrived; however, the work is not over yet! This checklist will assist you in remembering everything that needs to be done at the site and anticipating problems which may arise during the meeting. One caution: Don't wait until the day of the training to review the checklist.

Other sections within this manual will help you develop the objectives and content of the training session or meeting. As a start, refer to Appendix A, Training Modalities and Techniques, and Lesson 1-E, General Training Techniques, as well as one of the relevant lesson plans, for information.

Appendix H-1: Planning the Training Session

Planning the Training Session

Planning the training session and arranging a meeting location go hand in hand. Review or complete this worksheet and then review Appendix H-2, Arranging a Meeting Location.

Proposed Title of Training Session: _____

Content of Training

What is the purpose?

☐ To inform

☐ To solve problems

☐ To improve morale

☐ Other _____

What are the expected benefits?

☐ Improved quality

☐ Increased compliance

☐ Increased productivity

☐ Other _____

What are the objectives of the training?

1. _____

2. _____

3. _____

When will the training occur?_____

What is the length of the training? _____

Proposed starting time and date _____

Proposed ending time and date _____

What is the course content and proposed agenda? _____

_____

_____

_____

What are the training activities? _____

_____

_____

_____

How will the learning be measured?_____

_____

_____

_____

Who will coordinate the training session(s)? _____

What is the total budget?_____

What is the estimated revenue?_____

What are the projected costs? _____

Participants

Who is the intended audience?

☐ Supervisors

☐ Surveyors

☐ Providers

☐ Other _____

What is the relevant background of the audience?

☐ Education _____

☐ Profession _____

☐ Knowledge of training topic _____

How many participants will attend? _____

Is there a ceiling on the number of participants? _____

Do the participants have a choice in attending? _____

What are the personnel issues?

Work time _____

Travel costs _____

Care for young children _____

How will the training be promoted?

☐ Invitations

☐ Brochures

☐ Flyers

☐ Posters

☐ Websites

☐ Periodicals

☐ Newsletters

☐ Other _____

Promotional Material

What is the budget?_____

What is the estimated cost?_____

Which type of shop will print the material?

☐ State/Federal

☐ Contract

What logistical information will the material include?

- ☐ Day, date and time of the training
- ☐ Location, including directions and map
- ☐ Parking information, including location and cost
- ☐ Refreshment information (included or self-provided?)
- ☐ Lodging information, including location and cost
- ☐ Cost of training

What programmatic information will the material include?

- ☐ Sponsor
- ☐ Objectives
- ☐ Agenda
- ☐ Target audience and space limitation
- ☐ Faculty
- ☐ Continuing education offered for which specific organizations and/or professions:

_____

- ☐ Contact person for registration
- ☐ Mailing address, phone and fax numbers and e-mail address for registration
- ☐ Deadline for registration
- ☐ Costs

  For registration not received by deadline _____

  For registration on first day of meeting _____

  Cost for partial attendance _____

What are the printing options?

- ☐ Quantity: _____

☐ White paper

☐ Colored paper

☐ One-sided

☐ Two-sided

☐ Punched (three holes)

☐ Stapled

☐ Bound

What is the deadline for distribution or mailing to potential participants?_____

What is the deadline for ordering printed materials? _____

Handouts

What is the budget?_____

What is the estimated cost?_____

Which type of shop will print the handouts?

☐ State/Federal

☐ Contract

Who will be responsible for developing the handouts? _____

Who will be responsible for printing the handouts?_____

Will there be a limit for each speaker? _____

What are the printing options?

☐ Quantity

☐ White paper

☐ Colored paper

- ☐ One-sided
- ☐ Two-sided
- ☐ Punched (three holes)
- ☐ Stapled
- ☐ Bound
- ☐ Shrink-wrapped

What is the deadline for ordering printed materials? _____

Who will be responsible for delivering the handouts to the training site?

_____

Supplies

What supplies will the participants need?

- ☐ Paper
- ☐ Pens
- ☐ Highlighters
- ☐ Name tents or badges
- ☐ Folders or binders
- ☐ Other _____

What is the budget?_____

What is the estimated cost?_____

Who will be responsible for purchasing the supplies? _____

How will the supplies be purchased? _____

Who will be responsible for delivering the supplies to the training site?

_____

Faculty

Who will be responsible for contacting the speakers? _____

Who are the faculty?

Name	Title	Contact Information

What is the budget?_____

What is the expected cost?

Item	Cost

What information is to be given to each speaker? _____

_____

_____

_____

(See *Speaker Information Packet Cover Sheet* on the next page.)

Speaker Information Packet Cover Sheet

Speaker name, title, organization:_____

What is the information required from this speaker? _____

_____

Name of session _____

Speaking fee _____

Charges for travel and per diem expenses _____

Travel requirements including lodging and commute to training site _____

_____

Audiovisual needs_____

Equipment needs (refer to the "Equipment" section of this checklist for specific items to consider)

_____

Handout needs_____

_____

Outline of presentation (attach a copy, if necessary) _____

_____

_____

Resume (attach a copy, and summarize for speaker introduction)_____

_____

_____

Agreement specific to date, time and location of training/contract (attach a copy)

Travel and lodging (attach itinerary) _____

Final copy of promotional brochure _____

Location

Refer to Appendix H-2, Arranging a Meeting Location, for more specific information.

Who will be responsible for finding and reserving the location? _____

_____

What is the budget? _____

What is the expected cost? _____

What are the specific needs for room arrangement? (Attach a sketch.) _____

Who will be responsible for arranging the room? _____

Equipment

What is the budget? _____

What is the estimated cost? _____

Who will be responsible for making arrangements for equipment? _____

_____

Who will be responsible for installing and checking the equipment prior to the day of the training? _____

_____

What equipment will each speaker need?

- ☐ Pitcher of water and glasses
- ☐ Lectern with microphone
- ☐ Lavaliere microphone
- ☐ Slide projector
- ☐ Projection screen
- ☐ Presentation projector
- ☐ Laptop computer
- ☐ Overhead projector

- ☐ Chart pad and eraser
- ☐ Colored markers
- ☐ Videocassette recorder (VCR)
- ☐ DVD player
- ☐ Television monitor
- ☐ Video camera
- ☐ Audio tape recorder
- ☐ LCD projector
- ☐ Other: _____

Additional Information

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Training Plan

Use the chart on the next page to plan the training sessions.

Training Plan

Name of training session: _____ Day of week/date: _____

Note: Plan a break every 1½ to 2 hours.

Estimated Time	Topic & Presenter/Break	Content	Teaching Method(s)	Activity(ies)

Estimated Time	Topic & Presenter/Break	Content	Teaching Method(s)	Activity(ies)

Appendix H-2: Arranging a Meeting Location

Arranging a Meeting Location

Use this form when contacting individuals to arrange a meeting. If these questions trigger others, add them to the list.

Facility

Name of facility (hotel, conference center, office) _____

Address _____

Telephone _____

Fax_____

☐ Identify the contact person by name and title:

Name _____

Title _____

Determine whether meeting rooms and sleeping rooms are available for the dates desired. At that point, proceed to work with hotel staff regarding the following questions.

Sleeping Rooms

☐ Determine the availability of the required number of sleeping rooms.

☐ Determine or negotiate a cost per person based on the number of rooms needed. Determine whether the cost is based on the number of sleeping rooms and whether meeting rooms are included at no charge given a certain number of sleeping room reservations.

☐ Determine whether the facility can reserve a block of rooms. If so, determine the date reservations are due in order to receive the negotiated cost per room.

☐ Determine whether rooms will be single or double.

☐ Determine whether individuals will make reservations directly with the facility or in some other way.

☐ Determine when the rooms will be ready for occupancy.

☐ Determine whether billing can occur at any time during the meeting in case individuals want to leave before the end.

- ☐ Determine whether two individuals can share a room and have the facility bill each individual separately.

- ☐ Determine whether the facility can bill an organization, etc.

- ☐ Determine the check-in time and the check-out time:

  Check-in time _____

  Check-out time _____

- ☐ Determine whether the facility will allocate sleeping rooms for speakers based on a certain number of participant rooms reserved.

Meeting Rooms

Determine whether meeting rooms are available for the dates and the size of the group you plan. Include the time needed to set up the room before the meeting. To determine the size of the room needed, first decide how the room will be set with tables and chairs (e.g., classroom style, banquet style—round or long tables, U-shaped or open square, conference table style or theater style—chairs only).

- ☐ Determine whether the facility will provide free meeting rooms based on a certain number of sleeping rooms reserved.

- ☐ For registration tables, determine:

  Whether there is a charge for the tables _____

  Total length _____

  Whether there is a charge for covering the tables _____

  How many chairs you will want _____

  Whether you will need a table for backup materials _____

- ☐ Determine charge for each meeting room:

  Charge _____

- ☐ Determine whether an additional charge will be made to set up each meeting room. If so, determine whether charges are different for classroom style versus theater style, etc.

  Setup charge _____

☐ Determine whether a charge will be made to rearrange any meeting room:

Charge for rearrangement: _____

☐ Determine charges for:

Full-day versus half-day use _____

Raised dais per room or fixed/erected stage _____

Sound/speaker equipment per room _____

Length of tables on the dais (and covering charges) per room _____

Overhead projectors _____

Movie projectors _____

Easel pads _____

Covering tables for class participants _____

Providing fresh ice water and glasses and "refreshing" at the end of each meeting session and/or at least at the noon break _____

☐ Determine whether the rooms will be used before or after your session.

☐ Determine how to control the:

Temperature _____

Lighting _____

Sound system _____

☐ Determine where signs will be posted to direct participants.

Snacks for Breaks

☐ Determine charges and how charged (by quantity or per person and taxes and gratuity percentage) for:

Coffee (per person or per gallon) _____

Tea, hot and/or iced (per person or per gallon) _____

Sweet rolls/bagels/other _____

Soft drinks with ice and glasses _____

Napkins, plates, utensils, etc. _____

Number of tables/stations for snacks _____

- ☐ Determine what beverages and snacks will be provided each day and the delivery timing.

Miscellaneous

- ☐ Determine handicapped accessibility and availability of other handicap-assistive devices.
- ☐ Determine location for parking (e.g., inside, outside, valet, street) and charge and whether some parking spaces will be free or at a reduced rate.
- ☐ If a meal is served, determine charge, how charged (based on plate, menu style of service—buffet versus ordering off menu, number of guaranteed versus walk-in number of individuals, automatic gratuity) and when bill is due.
- ☐ Determine whom to contact during the meeting if problems arise.
- ☐ Determine availability of restaurants in the facility and nearby, transportation to other portions of the city, entertainment during the meeting (e.g., contact the Convention and Visitor's Bureau or the Chamber of Commerce).
- ☐ Determine whether data lines are available for laptop computers and location(s).
- ☐ Inquire whether construction or renovation of any facility area is scheduled to coincide with the meeting.
- ☐ Determine what business services are readily available, the exact location and common charges (e.g., printing from a disk, copying, faxing, etc.).
- ☐ Determine whether storage space is available for supplies before and during the meeting, the location and any related charges.
- ☐ Determine whether restrooms are adequate for the number and sex of participants.

Appendix H-3:
The Day of the Meeting

The Day of the Meeting

Following is a checklist to use at the meeting location to anticipate questions and problems.

Location of Training

Person (name to call for assistance and the phone number) _____

Snacks [location and time(s) they will be available] _____

_____

Parking location, cost or complimentary procedure _____

_____

Telephone number for messages_____

Copy machine location and cost per page_____

Location(s) to smoke_____

Signs for directions to meeting _____

Coat rack or room _____

Restroom location(s)_____

Telephone location(s) _____

Stairs/elevator location(s) _____

Fire alarm procedures _____

For Registration and Each Session

- ☐ List of individuals and job duties for each (see *"Training Responsibilities"* chart on page A-H-3-9)
- ☐ Name of individual to whom people will go if problems arise

Training representative _____

Facility representative_____

Name of individual who will post sign of session outside door and check each meeting room before the session to ensure that it has been set up as requested (see *"Room Checks and Sign Posting"* chart on page A-H-3-11)

_____

Registration

- ☐ Post signs about where to register based on profession, last name (alphabetically) or other method
- ☐ Conveniently and conspicuously arrange:
  - ☐ List(s) of participants
  - ☐ Pens
  - ☐ Folder/binder for each participant
  - ☐ Name tags/tents
  - ☐ Pads of paper
  - ☐ Post-it notes
  - ☐ Clips
  - ☐ Stapler full of staples
  - ☐ Three-hole punch
  - ☐ Information for after-hours entertainment/recreation

Meeting Room(s)

For each room you will need:

- ☐ Sign to post outside the door (optional)
- ☐ Checklist for how the room should be set up, number of seats, etc.
- ☐ List of equipment needed for the session (e.g., chart pad with holder, screen overhead projector, etc.)
- ☐ Marking pens for overhead projector, chart pad, etc., and blank transparencies

- ☐ Banner for the session (optional)
- ☐ Tent card for table or for participant name at each place
- ☐ Pens/paper for each participant (optional)

Within each room:

- ☐ Display sign-in sheet (optional)
- ☐ Have signs for “10 minutes,” “5 minutes” and “STOP”
- ☐ Organize agenda, handouts and packets if not provided at registration
- ☐ Locate and check light controls and set level
- ☐ Locate and check temperature controls (if temperature can be controlled in the room)
- ☐ Disconnect telephone in room
- ☐ Check table/chair arrangement

Check for:

- ☐ Extension cord
- ☐ Pencil sharpener (if needed)
- ☐ Electrical cords (taped down)
- ☐ Lectern
- ☐ Water pitcher and glasses
- ☐ Location of electrical outlets
- ☐ Adapter plugs: three-prong and two-prong
- ☐ Position of spotlights

As appropriate for each room, check the following:

- ☐ Overhead projector:
  - ☐ Spare bulb
  - ☐ Focused

- ☐ Cleaned of fingerprints and lint
- ☐ First transparency in place

- ☐ Slide projector:
  - ☐ Spare bulb
  - ☐ Focused
  - ☐ Tray cued to slot 1
  - ☐ Opaque slide in slot 1
- ☐ Movie projector:
  - ☐ Spare bulb
  - ☐ Focused and set to fill screen
  - ☐ Sound level check
  - ☐ Film cued up to title frame
- ☐ LCD projector:
  - ☐ Laptop computer
  - ☐ CD with files to use (usually PowerPoint)
  - ☐ Cable connectors
  - ☐ Surge protector
  - ☐ Extension cords
  - ☐ Prop on which to place LCD projector
  - ☐ Mouse to facilitate moving files or slides
  - ☐ Files loaded from the CD to the computer's desktop
- ☐ Screen:
  - ☐ Location

- ☐ Size of the image (viewability throughout the room)

- ☐ Easel pad:
  - ☐ Paper supply
  - ☐ Various colored markers
  - ☐ Markers checked for usability (e.g., ink has not dried out)
- ☐ Videotape:
  - ☐ Check controls
  - ☐ Tape cued
  - ☐ Sound-level test
- ☐ High-tech and computer-driven equipment:
  - ☐ Arrive two hours early
  - ☐ Technician on standby (have telephone/pager numbers)
  - ☐ Backups or alternatives
- ☐ Microphone:
  - ☐ Lavaliere attachment
  - ☐ Extra cord length for movement
  - ☐ Sound check
  - ☐ Backup microphone
- ☐ Chalkboard:
  - ☐ Chalk
  - ☐ Eraser
  - ☐ Board is clean
  - ☐ Wet cloth

- ☐ Dry-erase board:
  - ☐ Appropriate pens
  - ☐ Eraser

Mini-Rehearsal

Conduct the following:

- ☐ Opening
- ☐ Sequence check
- ☐ Close

Refreshments

As arranged, check for:

- ☐ Coffee/decaffeinated coffee
- ☐ Hot tea/iced tea
- ☐ Juice
- ☐ Soft drinks
- ☐ Coffee cups/teacups and drinking glasses
- ☐ Condiments (sugar/sugar substitute/cream/cream substitute)
- ☐ Spoons or stirrers
- ☐ Ice
- ☐ Napkins
- ☐ Other (rolls, bagels, fruit, dessert, etc.)

Training Responsibilities

If problems arise, contact:

Facility representative: _____

Location: _____ Telephone number: _____

Training representative: _____

Location: _____ Telephone number: _____

Name	Tasks

Room Checks and Sign Posting

Room	Person Responsible	Sign Posted (initial)	Room Checked (initial)