NEW SURVEY PROCESS AND FREQUENTLY CITED DEFICIENCIES

OBJECTIVES

• Overview of new survey process
• Review the Critical Element Pathways
• Review the top cited health deficiencies
  – Why they were cited
  – How to tackle them
• Review the CMS QCOR Website
NEW SURVEY PROCESS OVERVIEW
Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements: CMS will provide an 18-month moratorium on the use of certain enforcement remedies (CMP, DPNA and discretionary termination) for specific Phase 2 requirements (see below). However, CMS may use directed plans of correction or directed in-services for these specific Phase 2 requirements. This 18-month period will be used to educate facilities about specific new Phase 2 standards.
F TAGS INCLUDED IN THE MORATORIUM

- F655 (Baseline Care Plan); §483.21(a)(1)-(a)(3)
- F740 (Behavioral Health Services); §483.40
- F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); §483.40(a)(1)-(a)(2)
- F758 (Psychotropic Medications) related to PRN Limitations §483.45(e)(3)-(e)(5)
- F838 (Facility Assessment); §483.70(e)
- F881 (Antibiotic Stewardship Program); §483.80(a)(3)
- F865 (QAPI Program and Plan) related to the development of the QAPI Plan;
  §48375(a)(2) and,
- F926 (Smoking Policies). §483.90(i)(5)

TEMPORARY MORATORIUM

- Does not change the date of implementation and you can be cited
- But no imposition of civil money penalties
APPLICATION OF DISCRETIONARY ENFORCEMENT REMEDIES DURING 18 MONTH MORATORIUM

<table>
<thead>
<tr>
<th>Discretionary Enforcement Remedies</th>
<th>Phase 1 Tags only</th>
<th>Both Phase 1 and Phase 2 Tags</th>
<th>Phase 2 Tags Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discretionary Enforcement Remedies Normal Enforcement Policies Apply or 18 month Moratorium Enforcement Policies Apply (Directed plan of Correction/Directed In Service training)</td>
<td>Normal Enforcement Policies Apply</td>
<td>Normal Enforcement Policies Apply for the Phase 1 tag(s) and DPOC/DIST only may be imposed for Phase 2 tag(S)</td>
<td>18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)</td>
</tr>
</tbody>
</table>

S & C 18-04-NH

- **Freeze Health Inspection Star Ratings:** Following the implementation of the new survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare website for any surveys occurring between November 28, 2017 and November 27, 2018. There is no change to the staffing or quality measure component and the overall rating can still change based on your staffing and quality measure component.

- **Availability of Survey Findings:** The survey findings of facilities surveyed under the new survey process will be published on Nursing Home Compare, but will not be incorporated into calculations for the Five-Star Quality Rating System for 12 months. CMS will add indicators to Nursing Home Compare that summarize survey findings.

- **Methodological Changes and Changes in Nursing Home Compare:** In early 2018, Nursing Home Compare health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspection.
SURVEY PROCESS

• The new computer-based LTCSP will be effective November 28, 2017.
• Appendix P will no longer be available: Beginning with surveys occurring on November 28, 2017, Appendix P will no longer be accessible. The LTCSP procedure guide will replace Appendix P as the procedural and technical guide for conducting LTC standard surveys. Chapter 7 of the State Operations Manual (SOM) will be revised to include survey policy.
• Survey Resources: A link to resources surveyors will need to conduct LTC surveys will be made available on November 17, 2017. Surveyors must download items included on this link to their survey laptops by November 28, 2017.

SURVEY PROCESS

• Revisions to State Operation Manual (SOM), Appendix PP Guidance to Surveyors for Long Term Care Facilities
• Revisions are being made to entire Appendix PP. All F Tag numbers are new and much content of the Appendix is also new.
• NEW/REVISED MATERIAL - EFFECTIVE DATE: November 28, 2017
• IMPLEMENTATION: November 28, 2017
The Most Important Website

- [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html)

Resources You Need to Know

<table>
<thead>
<tr>
<th>Downloads</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC Survey FAQs - Updated 02/06/2018 [PDF, 701KB]</td>
</tr>
<tr>
<td>Appendix PP State Operations Manual (Revised 11/22/2017) [PDF, 3MB]</td>
</tr>
<tr>
<td>List of Revised FTags [Effective November 28, 2017] [PDF, 152KB]</td>
</tr>
<tr>
<td>SNF Memo: Revision to State Operations Manual Appendix PP for Phase 2 (Includes Training Information and Related Issues) [PDF, 121KB]</td>
</tr>
<tr>
<td>F-Tag Crosswalk [XLSX, 495KB]</td>
</tr>
<tr>
<td>Training for Phase 1 Implementation of new Nursing Home Regulations [PDF, 108KB]</td>
</tr>
<tr>
<td>New Long-term Care Survey Process - Slide Deck and Speaker Notes [PPTX, 5MB]</td>
</tr>
<tr>
<td>Entrance Conference Form Beneficiary Notice Worksheet (Updated 12/06/2017) [ZIP, 164KB]</td>
</tr>
<tr>
<td>LTC Survey Pathways - Updated 12/13/2017 [ZIP, 2MB]</td>
</tr>
<tr>
<td>LTCSP Procedure Guide [PDF, 1MB]</td>
</tr>
<tr>
<td>LTCSP Initial Pool Care Areas - Updated 11/17/2017 [ZIP, 1MB]</td>
</tr>
<tr>
<td>Survey Resources - Updated 01/18/2018 [ZIP, 10MB]</td>
</tr>
<tr>
<td>Matrix with Instructions_ Content Unchanged [PDF, 299KB]</td>
</tr>
<tr>
<td>LTCSP Mapping Document [PDF, 740KB]</td>
</tr>
<tr>
<td>LTCSP Interim Revisit Instructions [PDF, 171KB]</td>
</tr>
</tbody>
</table>
OVERVIEW OF REGULATION REFORM

• The regulation reform implements a number of pieces of legislation from the Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, including the following:
  • Quality Assurance and Performance Improvement (QAPI)
  • Reporting suspicion of a crime
  • Increased discharge planning requirements
  • Staff training section

IMPLEMENTATION GRID

<table>
<thead>
<tr>
<th>Implementation Date</th>
<th>Type of Change</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: November 28, 2016</td>
<td>Nursing Home Requirements for Participation</td>
<td>New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags</td>
</tr>
<tr>
<td>(Implemented)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 2: November 28, 2017</td>
<td>F Tag numbering Interpretive Guidance (IG)</td>
<td>New F Tags Updated IG</td>
</tr>
<tr>
<td></td>
<td>Implement new survey process</td>
<td>Begin surveying with the new survey process</td>
</tr>
<tr>
<td>Phase 3: November 28, 2019</td>
<td>Requirements that need more time to implement</td>
<td>Requirements that need more time to implement</td>
</tr>
<tr>
<td>(Implemented)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FACILITY ENTRANCE

• Team Coordinator (TC) conducts an Entrance Conference
  ▪ Updated Entrance Conference Worksheet
  ▪ Updated facility matrix
• Brief visit to the kitchen
• Surveyors go to assigned areas

ENTRANCE CONFERENCE WORKSHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE

☐ 1. Census number
☐ 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
☐ 3. An alphabetical list of all residents (note any resident out of the facility).
☐ 4. A list of residents who smoke, designated smoking times, and locations.
### ENTRANCE CONFERENCE WORKSHEET

<table>
<thead>
<tr>
<th>ENTRANCE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Conduction a brief Entrance Conference with the Administrator.</td>
</tr>
<tr>
<td>6. Information regarding full time DON coverage (verbal confirmation is acceptable).</td>
</tr>
<tr>
<td>7. Information about the facility’s emergency water source (verbal confirmation is acceptable).</td>
</tr>
<tr>
<td>8. Signs announcing the survey that are posted in high-visibility areas.</td>
</tr>
<tr>
<td>9. A copy of an updated facility floor plan, if changes have been made.</td>
</tr>
<tr>
<td>10. Name of Resident Council President.</td>
</tr>
<tr>
<td>11. Provide the facility with a copy of the CASPER 3.</td>
</tr>
</tbody>
</table>

### INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE

<table>
<thead>
<tr>
<th>INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Schedule of meal times, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in from visitors.</td>
</tr>
<tr>
<td>13. Schedule of Medication Administration times.</td>
</tr>
<tr>
<td>14. Number and location of med storage rooms and med carts.</td>
</tr>
<tr>
<td>15. The actual working schedules for licensed and registered nursing staff for the survey time period.</td>
</tr>
<tr>
<td>16. List of key personnel, location, and phone numbers. Note contract staff (e.g., rehab services).</td>
</tr>
<tr>
<td>17. If the facility employs paid feeding assistants, provide the following information:</td>
</tr>
<tr>
<td>a) Whether the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training;</td>
</tr>
<tr>
<td>b) The names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks;</td>
</tr>
<tr>
<td>c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.</td>
</tr>
</tbody>
</table>
### ENTRANCE CONFERENCE WORKSHEET

**INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE**

1. Complete matrix for all other residents. Ensure the TC confirms the matrix was completed accurately.
2. Admission packet.
3. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.
4. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable.
5. Agreement(s) or Policies and Procedures for transport to and from dialysis treatments, if applicable.
6. Does the facility have an onsite separately certified ESRD unit?
7. Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers).

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### ENTRANCE CONFERENCE WORKSHEET

10. QAA committee information (name of contact, names of members and frequency of meetings).
11. QAPI Plan.
13. Description of any experimental research occurring in the facility.
15. Nurse staffing waivers.
16. List of rooms meeting any one of the following conditions that require a variance:
   - Less than the required square footage
   - More than four residents
   - Below ground level
   - No window to the outside
   - No direct access to an exit corridor
ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY

☐ 34. Provide each surveyor with access to all resident electronic health records – do not exclude any information that should be a part of the resident’s medical record. Provide specific information on how surveyors can access the EHRs outside of the conference room. Please complete the attached form on page 4 which is titled “Electronic Health Record Information.”

INFORMATION NEEDED FROM FACILITY WITHIN 24 HOURS OF ENTRANCE

☐ 35. Completed Medicare/Medicaid Application (CMS-671).
☐ 37. Please complete the attached form on page 3 which is titled “Beneficiary Notice - Residents Discharged Within the Last Six Months”.

ENTRANCE CONFERENCE WORKSHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET

Beneficiary Notice - Residents Discharged Within the Last Six Months

Please complete and return this worksheet to the survey team within 24 hours. Please provide a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. Please indicate if the resident was discharged home or remained in the facility. (Note: Exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or were transferred to an acute care facility or another SNF during the sample date range).

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Discharge Date</th>
<th>Discharged to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home/Lesser Care</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ENTRANCE CONFERENCE WORKSHEET

ENTRANCE CONFERENCE WORKSHEET

ELECTRONIC HEALTH RECORD (EHR) INFORMATION

Please provide the following information to the survey team before the end of the first day of survey.

Provide specific instructions on where and how surveyors can access the following information in the EHR (or in the hard copy if using split EHR and hard copy system) for the initial pool record review process. Surveyors require the same access staff members have to residents’ EHRs in a read-only format.

**Example:**

<table>
<thead>
<tr>
<th>Example: Medications</th>
<th>EHR: Orders – Reports – Administration Record – eMAR – Confirm date range – Run Report</th>
</tr>
</thead>
</table>

**Example:**

<table>
<thead>
<tr>
<th>Example: Hospitalization</th>
<th>EHR: Census (will show in/out of facility) MDS (will show discharge MDS) Prog Note – View All - Custom – Created Date Range - Enter time period leading up to hospitalization – Save (will show where and why resident was sent)</th>
</tr>
</thead>
</table>

1. Pressure ulcers

2. Dialysis

---

ENTRANCE CONFERENCE WORKSHEET

<table>
<thead>
<tr>
<th>3. Infections</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Nutrition</td>
<td></td>
</tr>
<tr>
<td>5. Falls</td>
<td></td>
</tr>
<tr>
<td>6. ADL status</td>
<td></td>
</tr>
<tr>
<td>7. Bowel and bladder</td>
<td></td>
</tr>
<tr>
<td>8. Hospitalization</td>
<td></td>
</tr>
<tr>
<td>9. Elopement</td>
<td></td>
</tr>
<tr>
<td>10. Change of condition</td>
<td></td>
</tr>
<tr>
<td>11. Medications</td>
<td></td>
</tr>
<tr>
<td>12. Diagnoses</td>
<td></td>
</tr>
<tr>
<td>13. PASARR</td>
<td></td>
</tr>
<tr>
<td>14. Advance directives</td>
<td></td>
</tr>
<tr>
<td>15. Hospice</td>
<td></td>
</tr>
</tbody>
</table>

Please provide name and contact information for IT and back-up IT for questions:

IT Name and Contact Info:

Back-up IT Name and Contact Info:
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fall (F), Fall with Injury (FI), or Fall w/Major Injury (FMI)</td>
</tr>
<tr>
<td>2</td>
<td>Indwelling Catheter</td>
</tr>
<tr>
<td>3</td>
<td>Dialysis: Peritoneal (P), Hemo (H), in facility (F) or offsite (O)</td>
</tr>
<tr>
<td>4</td>
<td>Hospice</td>
</tr>
<tr>
<td>5</td>
<td>End of Life Care / Comfort Care / Palliative Care</td>
</tr>
<tr>
<td>6</td>
<td>Tracheostomy</td>
</tr>
<tr>
<td>7</td>
<td>Ventilator</td>
</tr>
<tr>
<td>8</td>
<td>Transmission-Based Precautions</td>
</tr>
<tr>
<td>9</td>
<td>Intravenous therapy</td>
</tr>
<tr>
<td>10</td>
<td>Infections (M, WI, P, TB, VH, C, UTI)</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Resident Name</td>
</tr>
<tr>
<td></td>
<td>Resident Room Number</td>
</tr>
<tr>
<td></td>
<td>Date of Admission if Admitted within the Past 30 Days</td>
</tr>
<tr>
<td></td>
<td>Alzheimer’s / Dementia</td>
</tr>
<tr>
<td></td>
<td>MD, ID or RC &amp; No PASARR Level II</td>
</tr>
<tr>
<td></td>
<td>Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opoid (O), Hypnotic (H), Anti-anxiety (RRA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)</td>
</tr>
<tr>
<td></td>
<td>Facility Acquired Pressure Ulcer(s) (any stage)</td>
</tr>
<tr>
<td></td>
<td>Worsened Pressure Ulcer(s) (any stage)</td>
</tr>
<tr>
<td></td>
<td>Excessive Weight Loss w/out Prescribed Weight Loss Program</td>
</tr>
<tr>
<td></td>
<td>Tube Feeding</td>
</tr>
<tr>
<td></td>
<td>Dehydration</td>
</tr>
<tr>
<td></td>
<td>Physical Restraints</td>
</tr>
</tbody>
</table>
INITIAL POOL PROCESS

- Surveyor request names of new admissions
- Identify initial pool—about eight residents
  - Offsite selected
  - Vulnerable
  - New admissions
  - Complaints or FRIs (Facility Reported Incidences- federal only)
  - Identified concern

RESIDENT INTERVIEWS

- Screen every resident
- Suggested questions—but not a specific surveyor script
- Must cover all care areas
- Includes Rights, QOL, QOC
- Investigate further or no issue
SURVEYOR OBSERVATIONS

- Cover all care areas and probes
- Conduct rounds
- Complete formal observations
- Investigate further or no issue

RESIDENT REPRESENTATIVE/FAMILY INTERVIEWS

- Non-interviewable residents
- Familiar with the resident’s care
- Complete at least three during initial pool process or early enough to follow up on concerns
- Sampled residents if possible
- Investigate further or no issue
LIMITED RECORD REVIEW

• Conduct limited record review after interviews and observations are completed prior to sample selection.
• All initial pool residents: advance directives and confirm specific information
• If interview not conducted: review certain care areas in record
• Confirm insulin, anticoagulant, and antipsychotic with a diagnosis of Alzheimer’s or dementia, and PASARR (Pre-Admission Screening and Resident Review)
• New admissions – broad range of high-risk medications
• Extenuating circumstances, interview staff
• Investigate further or no issue

DINING – FIRST FULL MEAL

• Dining – observe first full meal
  ▪ Cover all dining rooms and room trays
  ▪ Observe enough to adequately identify concerns
  ▪ If feasible, observe initial pool residents with weight loss
  ▪ If concerns identified, observe another meal
SURVEY TEAM MEETINGS

• Brief meeting at the end of each day
  ▪ Workload
  ▪ Coverage
  ▪ Concern
  ▪ Synchronize/share data (if needed)

SAMPLE SELECTION

• Select sample
• Prioritize using sampling considerations:
  ▪ Replace discharged residents selected offsite with those selected onsite
  ▪ Can replace residents selected offsite with rationale
  ▪ Harm, SQC if suspected, IJ if identified
  ▪ Abuse Concern
  ▪ Transmission based precautions
  ▪ All MDS indicator areas if not already included
SAMPLE SELECTION – UNNECESSARY MEDICATION REVIEW

• System selects five residents for full medication review
• Based on observation, interview, record review, and MDS
• Broad range of high-risk medications and adverse consequences
• Residents may or may not be in sample

RESIDENT INVESTIGATION – GENERAL GUIDELINES

• Conduct investigations for all concerns that warrant further investigation for sampled residents
• Continuous observations, if required
• Interview representative, if appropriate, when concerns are identified
INVESTIGATIONS

- Majority of time spent observing and interviewing with relevant review of record to complete investigation
- Use Appendix PP and critical elements (CE) pathways

CLOSED RECORD REVIEWS

- Complete timely during the investigation portion of survey
- Unexpected death, hospitalization, and community discharge last 90 days
- System selected or discharged resident
- Use Appendix PP and CE pathways
FACILITY TASK INVESTIGATIONS

• Complete any time during investigation
• Use facility task pathways
• CE compliance decision

DINING – SUBSEQUENT MEAL, IF NEEDED

• Second meal observed if concerns noted
• Use Appendix PP and CE Pathway for Dining
• Dining task is completed outside any resident specific investigation into nutrition and/or weight loss
**INFECTION CONTROL**

- Throughout survey, all surveyors should observe for infection control
- Assigned surveyor coordinates a review of influenza and pneumococcal vaccinations
- Assigned surveyor reviews infection prevention and control, and antibiotic stewardship program

**SNF BENEFICIARY PROTECTION NOTIFICATION REVIEW**

- A new pathway has been developed
- List of residents (home and in-facility)
- Randomly select three residents
- Facility completes new worksheet
- Review worksheet and notices
KITCHEN OBSERVATION

- In addition to the brief kitchen observation upon entrance, conduct full kitchen investigation
- Follow Appendix PP and Facility Task Pathway to complete kitchen investigation

MEDICATION ADMINISTRATION

Medication Administration
- Recommend nurse or pharmacist
- Include sample residents, if opportunity presents itself
- Reconcile controlled medications if observed during medication administration
- Observe different routes, units, and shifts
- Observe 25 medication opportunities
MEDICATION STORAGE

Medication Storage

- Observe half of medication storage rooms and half of medication carts
- If issues, expand medication room/cart

RESIDENT COUNCIL MEETING

- Group interview with active members of the council
- Complete early to ensure investigation if concerns identified
- Refer to updated Pathway
SUFFICIENT AND COMPETENT NURSE STAFFING REVIEW

- Is a mandatory task, refer to revised Facility Task Pathway
- Sufficient and competent staff
- Throughout the survey, consider if staffing concerns can be linked to QOL and QOC concerns

ENVIRONMENT

- Investigate specific concerns
- Eliminate redundancy with LSC
  - Disaster and Emergency Preparedness
  - O2 storage
  - Generator
POTENTIAL CITATIONS

- Team makes compliance determination.
  - Compliance decisions reviewed by team
  - Scope and severity (S/S)
- Conduct exit conference and relay potential areas of deficient practice

SURVEYOR ACCESS TO MEDICAL RECORDS

- Surveyors will ask for a computer if you have EMR
- **TURN OFF THE ACCESS WHEN THEY LEAVE YOUR BUILDING EVERY DAY!**
  - Others have shared that surveyors have tried to access the web-based EMR/EHR from a hotel in the evenings. Hotel networks are not secure enough to protect health information.
PBJ UPDATE

QSO-18-17-NH – QUALITY, SAFETY AND OVERSIGHT GROUP

DATE: April 06, 2018
TO: State Survey Agency Directors
FROM: Director
Quality, Safety and Oversight Group (formerly Survey & Certification Group)
SUBJECT: Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five Star Quality Rating System

Ref: QSO-18-17-NH
QSO-18-17-NH – QUALITY, SAFETY AND OVERSIGHT GROUP

Memorandum Summary

- **Transition to Payroll-Based Journal (PBJ) Data** – Starting in April, 2018, CMS will use PBJ data to determine each facility’s staffing measure on the Nursing Home Compare tool on Medicare.gov website, and calculate the staffing ratio using the Nursing Home Five Star Quality Rating System.
- **Staffing data audits** – We are providing lessons-learned from audits conducted, and guidance to facilities for improving their accuracy. Nursing homes whose audit identifies significant inaccuracies between the hours reported and the hours verified, or facilities who fail to submit any data by the required deadline will be presumed to have low levels of staff. This will result in a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter.
- **Requirement for registered nurse (RN) staffing** – We are reminding nursing homes of the importance of RN staffing and the requirement to have an RN onsite 8 hours a day, 7 days a week. Nursing homes reporting 7 or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter. This action will be implemented in July 2018, after the May 15, 2018 submission deadline for 2018 Calendar Quarter 1, 2018 (January-March, 2018) data.
- **Technical assistance** – CMS is continuing its efforts to help nursing homes submit accurate data, and there are a variety of ways described below in which facilities can seek support.
- **Future Actions** – As of June 1, 2018, we will no longer collect facility staffing data through the CMS-671 form, and we will announce other future activities.

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QSO-18-17-NH – QUALITY, SAFETY AND OVERSIGHT GROUP

Staffing Data Audits

CMS and its contractors have begun conducting audits aimed at verifying that the staffing hours submitted by facilities are aligned with the hours staff were paid to work over the same timeframe. We have found that facilities are submitting their data in good faith, and appreciate facilities’ efforts to submit accurate data. As with many new programs, we expect to find areas that are more prone to errors than others. Below are common errors identified through the audits. We encourage facilities to review these items, and adjust their submissions as necessary to ensure accuracy.

- **Exclude time for meal breaks**. Per the PBJ Policy Manual, “Meal times, paid or unpaid, shall not be reported for all staff (exempt, nonexempt, and contract). Facilities must deduct the time allotted for meals from each employee’s daily hours.” The PBJ Policy manual can be found on the PBJ website through the link at the end of this memorandum.
- **Each employee must have their own unique identifier (ID).** Facilities must not use the same ID to submit hours for multiple employees (exempt, nonexempt, or contract).
- **Submit Minimum Data Set (MDS) assessments in accordance with 42 CFR §483.20 and the resident assessment instrument (RAI) 3.0 User’s Manual.** Since each facility’s census is calculated using MDS data, it is critical that facilities adhere to the completion and transmission requirements. This includes submitting discharge assessments timely, and completing required assessments for every resident within the certified facility.
- **Exclude hours for staffing that provide care to individuals in non-certified areas of a larger institution or institutional complex that houses the certified facility.** For example, for facilities that share staff between the certified nursing home and an area (e.g., unit, wing, floor) that is separate and not part of the nursing home, like a hospital, assisted living or state licensed area, only those hours of the staff that are dedicated to the residents of the nursing home will be reported.
- **Respond promptly to the audit contractor if contacted for an audit.** Nursing homes will be contacted via email and certified mail sent to the administrator when they have been selected for an audit. If selected, the facility is required to upload supporting documentation by a date specified in the audit notification letter. It is important that facilities respond within the allotted timeframe in order to verify compliance.
CRITICAL ELEMENT PATHWAYS

AND MANDATORY TASKS

CRITICAL ELEMENT PATHWAYS

- CMS-20052 Beneficiary Notice
- CMS-20053 Dining
- CMS-20054 Infection Prevention Control and Immunization
- CMS-20055 Kitchen
- CMS-20056 Med Admin
- CMS-20057 Resident Council
- CMS-20058 QAA and QAPI
- CMS-20059 Abuse
- CMS-20061 Environment
- CMS-20062 Sufficient and Competent Staff
- CMS-20063 Personal Funds
- CMS-20065 Activities
- CMS-20066 Activities of Daily Living
- CMS-20067 Behavioral-Emotional
- CMS-20068 Urinary Catheter or UTI
- CMS-20069 Comm-Sensory
- CMS-20070 Dental
- CMS-20071 Dialysis
- CMS-20072 General
- CMS-20073 Hospice and End of Life
- CMS-20074 Death
- CMS-20075 Nutrition

- CMS-20076 Pain Mgt
- CMS-20077 Physical Restraints
- CMS-20078 Pressure Ulcer
- CMS-20080 Rehab and Restorative
- CMS-20081 Respiratory Care
- CMS-20082 Unnecessary Medications
- CMS-20089 Medication Storage
- CMS-20090 PASARR
- CMS-20091 Extended Survey
- CMS-20092 Hydration
- CMS-20093 Tube Feeding
- CMS-20120 Positioning, Mobility, ROM
- CMS-20123 Hospitalization
- CMS-20125 Bladder and Bowel Incontinence
- CMS-20127 Accidents
- CMS-20130 Neglect
- CMS-20131 Resident Assessment
- CMS-20132 Discharge
- CMS-20133 Dementia Care
MANDATORY TASK

☐ Mandatory facility task assignments:
1) Dining Observation
2) Infection Control and Immunizations
3) Kitchen/Food Service Observation
4) SNF Beneficiary Protection Notification Review
5) Medication Administration
6) Med Storage
7) QAA/QAPI
8) Resident Council Meeting
9) Sufficient and Competent Nurse Staffing

MAPPING DOCUMENT

Rows 1 through 455 provide the mapping for all initial pool (IP) areas. Rows 456 through 598 provide the mapping for neglect, mandatory and triggered facility tasks, and closed record reviews. A more detailed mapping document is available upon request.

<table>
<thead>
<tr>
<th>Initial Pool Area</th>
<th>Initial Pool Intent (Key Probing Words)</th>
<th>Initial Pool Source</th>
<th>Investigative Tool</th>
<th>Critical Element #</th>
<th>Tag #</th>
<th>Tag Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Staff made resident feel afraid, humiliated, degraded, sad, tense things; hurt resident; made resident feel uncomfortable. Evidence of abuse (fractures, gashes, dislocations; burns, blisters, sores on hands or torso; bite marks, scratches, skin tears, abrasions in unusual area, bruises or injuries in unusual areas; fear of others). Physical/verbal aggression (biting, kicking, pushing, striking out, threatening others).</td>
<td>CMS-20053</td>
<td>Abuse Pathway for all CCs</td>
<td>F600</td>
<td>Free from Abuse and Neglect</td>
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<tr>
<td>Accident Hazards</td>
<td>Bed rail or mattress entrapment; Restrains applied correctly; Unsafe cords, outlets, or handrails; Inadequate safety equipment or lighting (grabs bars, ambulation, transfer, or therapy). Chemicals/other hazards; Exposure to unsafe heating surfaces. Locks disabled, propped fire doors, irregular walking surfaces; Residents inadequately supervised.</td>
<td>CMS-20054</td>
<td>Abuse Pathway for all CCs</td>
<td>F607</td>
<td>Not Employ Engage Staff with Adverse Actions</td>
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<tr>
<td></td>
<td></td>
<td>CMS-20055</td>
<td></td>
<td>F507</td>
<td>Develop Implement Abuse Neglect, etc Policies</td>
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<tr>
<td></td>
<td></td>
<td>CMS-20056</td>
<td></td>
<td>F407</td>
<td>Abuse Neglect and Exploitation Training</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>CMS-20057</td>
<td></td>
<td>F407</td>
<td>Required In-service Training for Nurse Aides</td>
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<tr>
<td></td>
<td></td>
<td>CMS-20058</td>
<td></td>
<td>F407</td>
<td>Reporting of Reasonable Suspicion of a Crime</td>
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<td></td>
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<td>CMS-20059</td>
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<td>Reporting of Alleged Violations</td>
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<td>CMS-20062</td>
<td></td>
<td>F407</td>
<td>Investigate Prevent Correct Alleged Violation</td>
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</table>
• Mapping Document

**DINING OBSERVATION CMS-20053**
### Infection Control and Immunizations CMS-20054

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<tr>
<th>Initial Pool Area</th>
<th>Initial Pool Intent (Key Probing Words)</th>
<th>Initial Pool Source</th>
<th>Investigative Tool</th>
<th>Critical Element</th>
<th>Tag #</th>
<th>Tag Description</th>
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</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>Infection Prevention &amp; Control Task Pathway</td>
<td></td>
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### Kitchen/Food Service Observation CMS 20055

<table>
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<th>Initial Pool Intent (Key Probing Words)</th>
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<tbody>
<tr>
<td>Kitchen</td>
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SNF BENEFICIARY PROTECTION
CMS 20052
SUFFICIENT AND COMPETENT NURSE STAFFING
CMS 20062

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<th>Tag Description</th>
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<tr>
<td>1</td>
<td>F725</td>
<td>Sufficient Nursing Staff</td>
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</tr>
<tr>
<td>2</td>
<td>F726</td>
<td>Competent Nursing Staff</td>
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<tr>
<td>3</td>
<td>F741</td>
<td>Sufficient/Competent Staff/Special Health Needs</td>
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<tr>
<td>4</td>
<td>F727</td>
<td>RN &amp; Hrs/7 days/Week, Full Time DON/Charge Nurse</td>
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<tr>
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<td>F727</td>
<td>RN &amp; Hrs/7 days/Week, Full Time DON/RN</td>
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<tr>
<td>6</td>
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<td>RN &amp; Hrs/7 days/Week, Full Time DON/DON</td>
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<td>8</td>
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<td>9</td>
<td>F729</td>
<td>Nurse Aide Registry Verification, Retaining</td>
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<td>Facility Hiring and Use of Nurse Aide</td>
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<td>11</td>
<td>F730</td>
<td>Nurse Aide Performs Review - 12 Hr/In-Service</td>
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<td>16</td>
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<td>Facility Amenity</td>
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</tbody>
</table>

SUFFICIENT AND COMPETENT NURSE STAFFING CMS 20062

Residents/Resident Representatives or Family Members:
Staff Sufficiency (list of probes addressed during the initial pool process): During team meetings, the team should discuss whether any of the areas listed below were concerns to alert the team of potential concerns with sufficient or competent staff.

- Do you feel that there is enough staff to meet your needs and concerns, such as answering your call light timely or responding quickly to your alarm if you have one? If not, why, and what care or services do you feel are not provided, such as receiving or refilling a cup of water, toileting, dressing, eating, going to activities? Is there a specific time of day or weekends that are more problematic?
- Has anything occurred because you had to wait for staff to respond and assist you, such as being incontinent, missing a shower, or falling? How often does this occur?
- Do you routinely eat in your room? If so, is this your choice and if needed, is assistance provided to help you? Are room trays delivered timely?
- Are you able to wake, dress, eat, or engage in other activities at times that are preferable to you?
- Does staff interact with you and explain to you what care or services they are providing and why? Does staff rush you when they provide care?
- Do you get your medications on time?
- Do you now or have you ever had a position-change alarm used — for example, a device that makes a sound when you change your position while sitting or in bed? If so, do you know why these alarms are used for you?
- Do you receive medications that make you sleepy, tired, lethargic, or sedated?

Staff Competency (surveyors should ask residents about staff competency throughout the survey):
- Do you feel safe and comfortable when staff assist you?
- Do you think the nursing staff are experienced and knowledgeable when providing your care? If not, what concerns have you experienced?
- Do you recall a time when you didn’t feel well? Did you tell a staff member? What happened? For example, did you get better or worse?
- Have you been transferred to the hospital? For what reason?
SUFFICIENT AND COMPETENT NURSE STAFFING CMS 20062

Nursing Aide and Licensed Nurse Interview: If concerns are identified with sufficient or competent staff, complete the following interviews.

Staff Sufficiency:
☐ How many residents are you responsible for on a regular basis during your shift?

Sufficient and Competent Nurse Staffing Review

☐ Do you have enough time to complete your required assignments each day? If not, why not, and what assignments are you not able to complete?
☐ How often does this occur?
☐ How often are you asked to stay late, come in early, or work overtime?
☐ Do you use position-change alarms? Why?
☐ Are there any devices used to help keep residents from falling, moving in certain ways, or wandering into certain areas? If so, why? Which residents?
☐ Are you able to complete rehabilitation services as ordered for the residents?
☐ How are current staffing needs determined? Does management ask for your input into their facility assessment for sufficient staffing? If so, can you provide some examples of what you provided and if you know whether or not these were considered?

MEDICATION ADMINISTRATION CMS 20056
MEDICATION STORAGE CMS 20089

<table>
<thead>
<tr>
<th>Initial Pool Area</th>
<th>Initial Pool Intent (Key Probing Words)</th>
<th>Investigative Tool</th>
<th>Critical Element</th>
<th>Tag #</th>
<th>Tag Description</th>
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<tr>
<td>Medication Admin</td>
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<td>1</td>
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<td>Free of Medication Error Rates of 5% or More</td>
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<td>Residents Are Free of Significant Med Errors</td>
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<td>Label/Store Drugs &amp; Biologicals</td>
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<td>Services Provided Meet Professional Standards</td>
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<td>Pharmacy Svs/Procedures/Pharmacist Records and/or Label/Store Drugs &amp; Biologicals</td>
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<td>Infection Prevention &amp; Control</td>
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<td>F867</td>
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<td>QAA/QAPI Improvement Activities</td>
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<td>QAA Committee: Required Members</td>
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<td>F188</td>
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<td>QAA Committee: More Quarterly</td>
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<tr>
<td>F165</td>
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<td>QAA Committee: Good Faith Attempts</td>
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<tr>
<td>F165</td>
<td></td>
<td>QAPI Program Plan, Disclosure/Good Faith Attempts</td>
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<tr>
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<td>Resident Family Group and Response: Facility</td>
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<td>Resident Family Group and Response: Adequate Space</td>
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<td>Resident Family Group and Response: Meet Without Staff</td>
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<td>Resident Family Group and Response: Act Upon Determinations</td>
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<td>Resident Family Group and Response: Respond to Grievance</td>
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<td>Resident Family Group and Response: Resolved if Doesn’t Respond to Grievance</td>
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<td>Grievances: File a Grievance</td>
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<td>Grievances: Complaint Without Retribution</td>
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<td>From Abuse and Neglect</td>
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<td>Inadequate Nursing Staff</td>
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<td>Frequency of Meals Snacks at Bedtime</td>
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<td>Right to Receive/Defer Visitors</td>
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<td>Notice of Rights and Rules</td>
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<td>Resident Rights/Exercise of Rights</td>
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<td>Right to Ensure Communication Privacy</td>
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<td>Right to Survey Results Advocate Agency Info</td>
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<td>Right to Access/Purchase Copies of Records</td>
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<td>Required Notices and Contact Information</td>
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**TROUBLING TAGS**

**LESSONS FROM THE FIELD**
### MISSOURI TOP TEN MOST FREQUENTLY CITED HEALTH DEFICIENCIES CMS QCOR CALENDAR YEAR 2018-FEBRUARY

<table>
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<tr>
<th>Tag #</th>
<th>Tag Description</th>
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<td>F0880</td>
<td>Infection Prevention &amp; Control</td>
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<td>F0656</td>
<td>Develop/Implement Comprehensive Care Plan</td>
<td>13</td>
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<tr>
<td>F0812</td>
<td>Food Procurement, Store/Prepare/Serve Sanitary</td>
<td>12</td>
</tr>
<tr>
<td>F0658</td>
<td>Services Provided Meet Professional Standards</td>
<td>12</td>
</tr>
<tr>
<td>F0689</td>
<td>Free of Accident Hazards/Supervision/Devices</td>
<td>7</td>
</tr>
<tr>
<td>F0679</td>
<td>Activities Meet Interest/Needs Each Resident</td>
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<tr>
<td>F0758</td>
<td>Free from Unnec Psychotropic Meds/PRN Use</td>
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<td>F0677</td>
<td>ADL Care Provided for Dependent Residents</td>
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<td>F0761</td>
<td>Label/Store Drugs and Biologicals</td>
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<tr>
<td>F0692</td>
<td>Nutrition/Hydration Status Maintenance</td>
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### MISSOURI TOP TEN MOST FREQUENTLY CITED HEALTH DEFICIENCIES CMS QCOR CALENDAR YEAR 2018

<table>
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<tr>
<th>State</th>
<th>Missouri</th>
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<tbody>
<tr>
<td>Deficiency Tags:</td>
<td>Any F Codes</td>
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<td>Survey Focus:</td>
<td>Health</td>
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#### Year Type: Calendar Year: 2018 Month: Full Year

<table>
<thead>
<tr>
<th>State</th>
<th>Tag #</th>
<th>Tag Description</th>
<th># Citations</th>
<th>% Providers Cited</th>
<th>% Surveys Cited</th>
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<td></td>
<td>F0880</td>
<td>Infection Prevention &amp; Control</td>
<td>47</td>
<td>9.0%</td>
<td>63.5%</td>
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<td>F0656</td>
<td>Develop/Implement Comprehensive Care Plan</td>
<td>30</td>
<td>5.8%</td>
<td>40.5%</td>
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<td>Food Procurement, Store/Prepare/Serve Sanitary</td>
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<td>5.4%</td>
<td>37.8%</td>
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<tr>
<td></td>
<td>F0658</td>
<td>Services Provided Meet Professional Standards</td>
<td>28</td>
<td>5.4%</td>
<td>37.8%</td>
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<td>F0689</td>
<td>Free of Accident Hazards/Supervision/Devices</td>
<td>22</td>
<td>4.2%</td>
<td>29.7%</td>
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</table>

Totals represent the # of providers and surveys that meet the selection criteria specified above.

Missouri Active Providers: 520
Total Number of Surveys: 74
WHY F880?

- Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection for residents accessed with the multiple use blood glucometer (a device used to measure blood sugar). This affected two residents (Resident #? and Resident #??) out of a sample of ??.
- Review of the Super Sani-Cloth Germicidal disposable wipe manufacture's disinfection directions showed:
  - Thoroughly wet surface; Allow treated surface to remain wet for a full two minutes; Let air dry.

1. Observation on at 8:16 A.M., of Resident #? showed:
   - Registered Nurse (RN) A entered the room, laid the glucometer (machine used to perform blood glucose monitoring) on the resident's bed;
   - RN A performed the glucose monitoring on the resident and laid the glucometer on the bed;
   - RN A cleaned the glucometer for 10 seconds with a Super Sani-Cloth Germicidal disposable wipe (a cleansing and disinfecting wipe), but did not leave the glucometer in contact with the Super Sani-cloth for the required two minutes for the disinfection of the glucometer.

2. Observation on at 8:30 A.M., showed:
   - Registered Nurse (RN) A performed blood sugar monitoring with the multi-use glucometer for Resident #??;
   - RN A cleaned the glucometer for 10 seconds with a Super Sani-Cloth Germicidal disposable wipe;
   - RN A placed the glucometer on top a clean wipe on the medication cart;
   - RN A did not leave the glucometer in contact with the Super Sani-Cloth for the required two minutes for the disinfection of the glucometer.

WHY F880?

- Based on observation, interview, and record review, the facility failed to maintain proper infection control practices for two residents (Resident #? and #?) out of ?? sampled residents and two residents (Resident #?? and #??) outside the sample.
- 1. Observation on at 6:47 P.M., showed:
  - Resident #? lay in bed and wore a brief soiled with urine;
  - Certified Nurse Aide (CNA) ? and Nurse Aide (NA) ? wore gloves and provided incontinent care for the resident;
  - CNA ? with soiled gloves, touched a package of disposable wipes and a bottle of peri-wash (a no-rinse cleanser);
  - NA ?, with soiled gloves, touched the resident’s shirt, arms, and legs, as he/she rolled the resident from side to side;
  - NA ?, with soiled gloves, placed a clean incontinent pad under the resident;
  - CNA ? and NA ?, removed soiled gloves, did not wash hands or use hand sanitizer, touched the package of disposable wipes and the bottle of peri-wash;
  - CNA ? and NA ?, with soiled hands, placed pillows under the resident’s head and between his/her knees;
  - CNA ? and NA ?, with soiled hands, placed a sheet and blanket over the resident and touched a light switch;
  - CNA ? and NA ?, did not wash hands or use hand sanitizer before leaving the resident’s room.
  - During an interview at 7:00 P.M., CNA ? said he/she was taught to clean his/her hands before and after care, with each glove change, and before leaving a resident’s room. He/she said he/she should not have touched clean items with dirty hands or gloves.
**INFECTION CONTROL CEP QUESTIONS**

1. Did staff implement appropriate hand hygiene? Yes No F880
2. Did staff implement appropriate use of PPE? Yes No F880
3. Did the staff implement appropriate transmission-based precautions? Yes No F880 NA
4. Did the facility store, handle, transport, and process linens properly? Yes No F880
5. Did the facility develop and implement an overall IPCP including policies and procedures that are reviewed annually? Yes No F880
6. Did the facility provide appropriate infection surveillance? Yes No F880

Remember ALL surveyors will be observing for infection controls concerns

CEP's Bladder and Bowel Incontinence 20125; Urinary Catheter or UTI 20068; Dialysis 20071; Respiratory Care 20081; Pressure Ulcer 20078; Tube Feeding 20093; Dining 20053; Kitchen 20054; Medication Administration 20056

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**TIPS TO AVOID F880 (F441) INFECTION CONTROL-PROCESS SURVEILLANCE**

- Process surveillance is the review of practices by staff directly related to resident care
- Areas to consider for process surveillance are the following:
  - Hand hygiene;
  - Appropriate use of personal protective equipment (e.g., gowns, gloves, facemask);
  - Injection safety;
  - Point-of-care testing (e.g., during assisted blood glucose monitoring);
  - Implementation of infection control practices for resident care such as but not limited to urinary catheter care, wound care, injection/IV care, fecal/urinary incontinence care, skin care, respiratory care, dialysis care, and other invasive treatments;
  - Managing blood borne pathogen exposure.
  - Cleaning and disinfection products and procedures for environmental surfaces and equipment;
  - Appropriate use of transmission-based precautions; and
  - Handling, storing, processing, and transporting linens so as to prevent the spread of infection.
INFECTION CONTROL - LINENS AND LAUNDRY SERVICES

• **Handling Laundry**
  – Contaminated laundry is bagged or contained at the point of collection
  – Leak-resistant containers or bags are used for linens or textiles contaminated with blood or body substances
  – Sorting and rinsing of contaminated laundry at the point of use, hallways, or other open resident care spaces is prohibited
  – handle soiled textiles/linens with minimum agitation to avoid the contamination of air, surfaces, and persons

• **Transport of Laundry:**
  – Contaminated linen and laundry bags are not held close to the body or squeezed when transporting
  – Contaminated linen carts must be cleaned and disinfected
  – Separate carts must be used for transporting clean and contaminated linen

• **Linen Storage:**
  – Clean linen must always be kept separate from contaminated linen
  – Covers are not needed on contaminated textile hampers in resident care areas

INFECTION CONTROL - LINENS AND LAUNDRY SERVICES

• **Washing/drying processes**
  – Laundry equipment is used and maintained according to the manufacturer’s instructions
  – Damp laundry is not left in machines overnight
  – *Laundry detergents, rinse aids or other additives are used according to the manufacturer’s instructions*

• **Mattresses and Pillows**
  – Methods for cleaning and disinfecting items that are to be used for another resident after an individual resident’s use
Infection Control - So What?

- Monitor and educate staff: MAKING ROUNDS, RE-TRAINING
  - proper hand-washing techniques?
  - gloves worn if there is contact with blood, specimens, tissue, body fluids, or excretions?
  - Are gloves changed between resident contacts?
  - Are staff who are providing direct care free from communicable diseases or infected skin lesions?
  - Are precautions observed for the disposal of soiled linens, dressings, disposable equipment (sharps, etc.), and for the cleaning of contaminated reusable equipment?
  - Are linens and laundry handled or transported in a manner to prevent the spread of infection?
  - Are isolation precautions implemented when it is determined that a resident needs isolation?
  - Are all other staff practices consistent with current infection control principles and do those practices prevent cross-contamination?
  - demonstrates practices to reduce the spread of infection and control outbreaks through transmission-based precautions (e.g., isolation precautions);
  - demonstrates handling, storage, processing, and transporting of linens so as to prevent the spread of infection.

Why F658?

Based on observation, interview, and record review the facility failed to ensure expired medications were not given to one resident (Resident #??) outside the sample of ?? residents. This practice had the potential to affect all residents receiving medications.

- Record review of Resident #??’s physician’s orders [REDACTED]. - [DIAGNOSES REDACTED]. - an order for [REDACTED].

- Observation on of the medication cart on the ?? Hall showed [MEDICATION NAME] 0.5 mg. tablet sheet with an expiration date of prescribed to Resident #??.

- Record review of the resident’s controlled substance distribution record showed:
  - [MEDICATION NAME] 0.5 mg. had been given by three different licensed nurses.

- During an interview at 11:00 A.M., Licensed Practical Nurse (LPN) said it is the nurses’ responsibility to check the medication’s expiration date before giving the medication.

- 3:10 P.M., Register Nurse (RN) said the medications should have been removed and destroyed as per facility policy. It is not our policy to give expired medications.

- During an interview at 9:30 A.M., the Director of Nursing (DON) said the expired medications should not have been given. The nurse should check the date before giving the medication to the resident. The expired medications should have been pulled from the cart and destroyed as per facility policy.
Based on observation, interview, and record review, the facility staff failed to meet professional standards by failing to check and document the medication rooms refrigerator temperatures, failed to document the open date of two medications, and failed to discard one expired medication. The facility census was ???.

1. Review of the Refrigerator Temperature/Defrost Status Log located in the main medication room, dated [DATE], showed staff are directed to check the refrigerator temperature twice daily on the day shift and evening shift. Review showed staff did not document they checked the refrigerator temperatures as directed on [DATE], [DATE], [DATE] and [DATE].
   - During an interview on [DATE] at 8:15 A.M., Licensed Practical Nurse (LPN) said the refrigerator temperatures are to be checked daily by the nurse passing medications and it is to be documented on the Refrigerator Temperature/Defrost Status Log which is kept in a notebook on the medication cart. The LPN said he/she did not know why staff did not record the temperatures.
   - During an interview on [DATE] at 9:00 A.M., the Assistant Director of Nursing (ADON) said he/she expects staff to check the refrigerator temperature every shift and did not know why staff did not record the temperatures at least twice daily. The ADON said the nurse responsible for the medication pass should be checking and recording the temperature.

2. Observation on [DATE] at 8:00 A.M., showed the Main medication room contained two opened vials of [MEDICATION NAME] Purified Protein Derivative (PPD) (used to test [MEDICAL CONDITION]) without an open date and one vial of [MEDICATION NAME] PPD with an open date of [DATE]. Additional observation showed a bottle of liquid [MEDICATION NAME] (an antianxiety medication) without an open date.
   - During an interview on [DATE] at 8:15 A.M., LPN said all medications are to be dated when opened. The LPN was not sure how long it was appropriate to keep [MEDICATION NAME] after the vial is opened. The LPN said it is the responsibility of the nurse passing medications to check each day for outdated medications. The LPN said the Pharmacist checks the medication room monthly.
   - During an interview on [DATE] at 9:00 A.M., the ADON said he/she expects staff to label all medications when the bottle/vial is opened. The ADON said the [MEDICATION NAME] dated [DATE] should have been discarded. The ADON said the Pharmacist checks the medication room monthly and the nurse responsible for the medication pass should check daily for outdated and undated medications.

WHY F658?-SYSTEM FAILURES

Based on observation, interview, and record review, the facility staff failed to meet professional standards by failing to check and document the medication rooms refrigerator temperatures, failed to document the open date of two medications, and failed to discard one expired medication. The facility census was ??.

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WHY F658?-SYSTEM FAILURES

Based on observation, interview, and record review, the facility failed to follow professional standards of practice for six residents, in a review of ?? sampled residents. Facility staff failed to apply bilateral palm protectors as ordered by the physician for Resident #??, failed to document the effectiveness of as needed (PRN) medications and the rationale for why medications were not administered as ordered by the physician for Residents #? and #? and failed to ensure care plan interventions to prevent falls were consistently followed for Residents #?, #? and #??.
WHY F658?-COMMUNICATION

Based on observation, interview and record review, the facility failed to administer dorzolamide [MEDICATION NAME] (eye drops for the treatment of [REDACTED].#?) of three reviewed residents. Staff documented they administered the medication on five occasions despite not having the medication in the facility.

1. Record review of Resident #1’s physician’s orders [REDACTED].
   - Record review of Resident #1’s Medication Administration Record [REDACTED] M. Certified Medication Technician (CMT) signed the MAR indicated [REDACTED].
   - During an interview at 10:30 A.M., Registered Nurse (RN) said Resident #1 just reported that staff had not administered dorzolamide [MEDICATION NAME] since Sunday because they ran out. RN said the CMTs administered eye drops and no one reported they ran out of the resident’s medication. RN said the medication should have been re-ordered on Monday. He/she was going to call and see if had been ordered by the CMT. RN said the facility used to have a communication system in place between the CMTs and the nurses but staff no longer used the system. He/she also said the pharmacy often did not follow up on orders. RN reviewed the resident’s MAR indicated [REDACTED].
   - During an interview at 10:45 A.M., CMT said he/she did not administer dorzolamide [MEDICATION NAME] as there had not been any since CMT returned to work on. CMT said he/she must have erroneously documented the administration of the medication on the five occasions by pushing the wrong button. CMT said there had been problems with re-ordering medication from the pharmacy at times and he/she notified the former Administrator. CMT did not re-order the dorzolamide [MEDICATION NAME] for Resident #1 but assumed the CMT who worked on his/her days off ordered it. CMT did not tell the charge nurse that the resident was out of medication because he/she had too much to do and was too busy since the facility did not have enough staff.
   - Observation at 10:45 A.M. showed the facility had no dorzolamide [MEDICATION NAME] for Resident #1 in the medication cart.
   - During an interview with the Administrator, Director of Nursing (DON), MDS Coordinator, and Corporate staff at 10:50 A.M., the DON said no one reported Resident #1 ran out of dorzolamide [MEDICATION NAME]. Staff should have reordered the medication when it was low. The MDS Coordinator said she was present when the resident reported he/she had not been administered her medication since Sunday. The Administrator and DON said staff should have notified the nurse when they did not have medication to administer and staff should not have documented they administered medication when they did not.

TIPS TO AVOID F658 (F281) SERVICES MEET PROFESSIONAL STANDARDS

Ask yourself these questions (Hint-Surveyor Guidance):

- Do the services provided or arranged by the facility, as outlined in the comprehensive care plan, reflect accepted standards of practice?
- Are the references for standards of practice, used by the facility, up to date, and accurate for the service being delivered?
- Provided or arranged for services or care that did not adhere to accepted standards of quality;
- Provided a service or care when the accepted standards of quality dictate that the service or care should not have been provided;
- Failed to provide or arrange for services or care that accepted standards of quality dictate should have been provided.

CEP’s-Medication Administration 20056; Positioning, Mobility & ROM 20120; General 20072; Hospitalization 20123
TIPS TO AVOID F658 (F281) SERVICES MEET PROFESSIONAL STANDARDS

Use the resources available to you

- NPUAP [http://www.npuap.org](http://www.npuap.org) National Pressure Ulcer Advisory Panel
- Advancing Excellence [https://www.nhqualitycampaign.org](https://www.nhqualitycampaign.org) Quality Campaign
- AHCA [https://www.ahcancal.org](https://www.ahcancal.org) American Healthcare Association
- QIPMO [https://nursinghomehelp.org](https://nursinghomehelp.org) Quality Improvement Program for Missouri Nursing Homes
  - Care plan and MDS related as well as other resources available
- Pioneer Network [https://www.pioneernetwork.net](https://www.pioneernetwork.net) Person Directed Care

WHY 689?

- Based on observation, interview, and record review, the facility failed to provide safe transfer techniques for two residents (Resident #? and #!) out of 12 sampled residents and one resident (Resident #??) outside of the sample.
- 1. Record review of Resident #1’s quarterly Minimum Data Set (MDS), (a federally mandated assessment instrument required to be completed by facility staff), showed the resident transfers independently with set-up assistance from staff.
- Observation at 6:26 PM, showed:
  - The resident sat in a wheelchair in his/her room;
  - Nurse Aide (A) did not place a gait belt (a device used for assistance with transfers and walking) on the resident;
  - NAA grabbed under the resident’s arms and lifted the resident to a standing position;
  - NAA pivoted the resident onto his/her bed;
  - Resident said, Don’t turn me so quick;
  - NAA assisted the resident to a lying down position on the bed;
  - NAA positioned both of the resident’s arms around the NAA’s neck and wrapped his/her arms under the resident’s arms;
  - NAA lifted the resident toward the head of the bed.
- During an interview at 6:34 PM, NAA said he/she was taught to use a gait belt during transfers but does not like to use one. He/she said it is more comfortable for the resident during a transfer if he/she hugs the resident instead of using the gait belt.
WHY 689?

- Based on observation and interview, the facility failed to prevent resident access to razors in a clean utility room and the secured unit whirlpool room and lock the treatment cart, which contained chemicals. This deficient practice had the potential to affect all residents.
  
  1. Observation of the unlocked cabinet in the unlocked clean utility room on the Missouri Rehabilitation unit at 9:51 A.M. and 3:24 P.M., 5:22 A.M. and 12:30 P.M., 6:34 A.M. and 1:40 P.M. and at 6:44 A.M., showed four disposable razors in the cabinet over the counter, easily accessible to all ambulatory residents.
  
  2. Observation of the unlocked whirlpool room on the ?? unit at 10:20 A.M., at 5:55 A.M. and 12:06 P.M., at 1:28 P.M. and 4:27 P.M. and at 7:14 A.M. and 1:38 P.M., showed two disposable razors in an unlocked cabinet, easily accessible to all residents who resided on that unit.
  
  3. Observation of the unlocked whirlpool room on the ??? unit on 1:38 P.M., showed an unlocked treatment cart, which contained the following:
    - One approximately full 16 ounce container of Dakin's solution (bleach antimicrobial cleanser that can cause severe deep burns to the skin, burns to the esophagus if swallowed and death);
    - One open full container of bleach wipes, which held 150 wipes.

WHY 689?

- Based on observation and interview, staff failed to provide a resident environment that remained as free from accidents as possible by not appropriately storing nail polish, nail polish remover and various other nail products in a manner inaccessible to residents in the locked ??.
  
  Observation at 11:12 A.M. and at 11:40 A.M. showed a room labeled Women and was also labeled This room is not for storage. The room was located across the corridor from the dining room inside the locked unit on the ?? Hall. A tan and dark red rolling cart sat inside the room door on the left side. The top shelf of the cart was missing and items were stored on the lower two shelves of the cart. The middle shelf contained the following items:
    - A large red-colored open storage container with numerous bottles of nail polish (approximately greater than 25 bottles); Two 7.5-ounce aerosol cans of nail dryer; A box of alcohol prep pads; Two boxes of manicure sticks; Two 10-ounce partial bottles of nail polish remover; White rag with dried nail polish on the surfaces; A 4-ounce partial bottle of nail polish thinner; A 4-ounce bottle of Foamtastic, a super strength bond for Styrofoam and floral foams.
    - Review of the label on the bottle of nail polish removed showed
      - Do not use when smoking, do not use near fire, flame or heat. Keep out of eyes. In case of eye contact, immediately flush eyes with water, remove any contact lenses and continue to flush with plenty of water for at least 15 minutes. Harmful if ingested. In case of accidental ingestion, give fluids liberally and consult with poison control center.
WHY 689?

- Based on observation, interview and record review, the facility staff failed to ensure the resident environment remained as free from accident hazards as possible and failed to provide protective oversight and supervision for one resident (Resident #?) out of ??? sampled residents with a [DIAGNOSES REDACTED]. Resident #? exited the locked memory care unit without staff knowledge when the facility staff failed to respond appropriately to door alarms. Staff found the resident outside the facility at the bottom of a four foot sinkhole, with the resident's wheelchair on top of him/her. The resident was last seen approximately four hours prior to being found. The sinkhole developed on the facility property in ??? 2017 and was located ?? feet from the rear exit of the facility. The resident sustained [REDACTED].

TIPS TO AVOID F689 (F323) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

- Educate
- Communicate
- Follow Physician Orders
- Fall Prevention Plan
- Know Resident Routines-Toileting, dining, activities, etc.
- Safe Transfer Techniques

CEP Accidents CMS 20127
ACCORDING TO THE SOM...

A facility with a commitment to safety:

• Acknowledges the high-risk nature of its population and setting;
• Develops effective communication, including a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;
• Engages all staff, residents and families in training on safety, and promotes ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families;
• Encourages the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise;
• Directs resources to address safety concerns; and
• Demonstrates a commitment to safety at all levels of the organization.

WHY F812???

• Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices affected all residents. 1. Observation at 9:45 A.M., in kitchen #? showed:
  – The door seal of the two door reach in refrigerator had a black substance build up on the door seal;
  – The walk in freezer had ice build up on the ceiling and the shelves;
  – The stove had food and grease debris on the right side of the stove.
• Observation at 10:45 A.M., in kitchen #? showed:
  – Paint had peeled away from the metal arms of the stand up mixer, exposing bare metal;
  – The knobs of the stove had food and grease debris and inside the stove near the knobs;
  – The door seal of the walk in refrigerator had a black substance build up;
  – The door seal of the walk in freezer had a black substance build up.
• During an interview at 8:32 A.M., the Dining Service Director said:
  – The door seals will be cleaned;
  – The ice build up in the freezer will be removed;
  – The grease and food debris around the stove knobs will be cleaned;
  – The mixer arms will be repaired;
  – The grease and food debris will be cleaned from the stoves;
  – Most of the areas should be cleaned daily.
WHY F812???

Based on observation, interview and record review, the facility failed to maintain the cleanliness of the kitchen increasing the risk of food-borne illness for all ?? residents who resided in the facility.

• 1. Observation of the kitchen from 9:30 A.M. through 11:15 A.M. showed:
  – The hand washing sink had a thick, dark colored build-up. Two trash cans had dried food splatters covering the exterior surfaces.
  – Dried food and debris covered a rack used to store clean lids and dishes. Dried food spills splattered the preparation counters, shelves and walls. Dried food and debris covered the exterior of a plastic cabinet used to store condiments.
  – The floor below the preparation sink had a build-up of a white substance and debris. A thick, black substance surrounded the base of the counter mounted can opener. Dried food splattered the interior surface of the microwave.
  – A thick layer of dust covered a large fan used in the kitchen. Paint peeled and chipped from the front of the cabinets in the serving area. A dark substance splattered the surface of the doors.
  – Staff stored flour, powdered sugar, and brown sugar in plastic containers. Staff left the lids to the flour and brown sugar open. Dried food and debris splattered the exterior surfaces of all three containers. Staff stored dry cereal in six plastic containers. Staff left three containers open, and did not label or date two of the containers. Dried food splattered the containers.
  – Staff stored 10 stacks of bowls and saucers with the food contact surfaces exposed. The steam table wells contained a thick, dark colored liquid and debris. Staff turned the steam table on and placed food on it to serve residents for lunch. Staff placed 26 cups out for resident use. A white substance covered the interior surface of 16 of the cups. The substance wiped off when touched.

WHY F812???

• During interviews the Dietary Manager (DM) said:
  – She was temporarily filling in as DM and training her replacement.
  – The kitchen was dirty due to issues with staffing. The facility could not fill positions, and she had to fill in leaving her with no time to monitor staff.
  – Not all cleaning had been assigned and staff did not complete cleaning lists.
  – Staff should have inverted dishes to store them but did not because the bowls tended to fall over.
  – Staff left the steam table on causing it to burn. They should have cleaned it but did not.
  – Staff should have checked the cups to ensure cleanliness before putting them out for resident use.

• During an interview at 9:50 A.M., the Dietary Manager in training (DM-T) said:
  – He was aware the microwave needed cleaning.
  – He worked on developing cleaning schedules but the Corporate Staff had not yet approved them for use.

• During an interview at 9:53 A.M., Cook C said, although a cleaning assignment was posted on the board, he/she had never been told to follow it.

• During an interview at 10:50 A.M., the Administrator and Corporate Staff said they knew the kitchen cleanliness had not been maintained. The Corporate Staff said the former Administrator was supposed to be doing rounds but did not. The Corporate Staff had been working with the DM-T and reviewed cleaning schedules but they had not yet implemented them.
TIPS TO AVOID F812 (F371) FOOD PROCUREMENT, STORE/PREPARE/SERVE - SANITARY

• Weekly audits to ensure compliance with
  – Labeled and dated items in the refrigerators/freezers
  – Proper food handling techniques
  – Be familiar with the Missouri Food Code

_CEP’s Dining 20053; Kitchen 20055_

TIPS TO AVOID F812 (F371) FOOD PROCUREMENT, STORE/PREPARE/SERVE - SANITARY

Receiving Food
– Inspect products on delivery
– Check temperatures of products
– Dry Food Storage

Refrigerator Storage
– Cover, label, and date - have expiration date on product
– Determine policy for discarding perishable foods
– Monitor temperatures of all refrigerator equipment
– Refrigerator should be below 41 degrees F – if above this, contact a supervisor
– Cover all foods
– Raw Meats on bottom shelves
Infection Control/Cross Contamination
– Avoid Cross-Contamination through Safe Food Handling.
– Basic infection control practices will prevent the contamination of food with infectious microorganisms (bacteria, viruses).
– All employees associated with the handling of food must wash their hands.

Safe Food Preparation
– Thawing – Keep foods out of the danger zone
– In refrigerator
– Cold running potable water
– Microwaved, then cooked immediately
– As part of a continuous cooking process
– Preparation – Be aware of the length of time PHF is in the Danger Zone

Cooking Temperatures
– Cooking is a Critical control point for preventing Foodborne illness.
– Cook to the appropriate temperature
– Hold the food at the appropriate temperature

Procedure for taking a temperature
– Temperature Logs
– Reheating Foods
TIPS TO AVOID F812 (F371) FOOD PROCUREMENT, STORE/PREPARE/SERVE - SANITARY

• Key Areas for Regulatory Success in Your Kitchen
  – General Kitchen walk through
  – Refrigerators-temp logs
  – Dishwasher/Pot & Pan area
  – Ensure that proper air gaps and/or backflow preventers are in place.
  – Storeroom
  – Refrigerators on nursing units-temp logs
  – Production
### TOP LSC CALENDAR YEAR 2018

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<th>Description</th>
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<td>K0353</td>
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<td>K0712</td>
<td>Fire Drills</td>
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<td>Electrical Systems - Essential Electric Syste</td>
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<td>Means of Egress - General</td>
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### TOP EMERGENCY PREPAREDNESS DEFICIENCIES CALENDAR YEAR 2018

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<td>E0015</td>
<td>Subsistence needs for staff and patients</td>
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<td>E0035</td>
<td>LTC and ICF/IID sharing plan with patients</td>
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<td>E0004</td>
<td>Develop EP Plan, review &amp; update annually.</td>
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<td>E0001</td>
<td>Establishment of the Emergency Program (EP)</td>
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<td>E0009</td>
<td>Local, State, Tribal Collaboration Process</td>
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<td>E0020</td>
<td>Policies for Evac. and Primary/Alt. Comm.</td>
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<td>E0006</td>
<td>Plan based on all hazards risk assessment</td>
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<td>E0022</td>
<td>Policies/Procedures for Sheltering in Place</td>
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<td>E0039</td>
<td>Emergency Prep Testing Requirements</td>
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CMS QCOR replaced the former Survey and Certification Providing Data Quickly (S&C PDQ) system in order to provide more transparency.

August 22, 2017: S&C: 17-43-ALL Revealed the launch of the QCOR Website

Website: https://qcor.cms.gov
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“Quality is not an act, it is a habit.”

ARISTOTLE
• New survey process in full force—Will be different than we are used to.
• Use the CMS resources available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
• Read and understand the CEP’s for the nine required task—use them for staff training
• No big difference in the deficiencies being cited, however numbers are on the rise but scope and severity is fairly consistent with old survey process
• Network with your peers; share your best practices, survey stories and experiences
• CMS QCOR can provide a lot of data if you are interested

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Check out the new QIPMO website at:
www.nursinghomehelp.org