

Survey Preparedness

LONG-TERM CARE SURVEY MANUAL PREPARED BY MU NHA CONSULTANT

SECTION 1 - SURVEY PREPAREDNESS

Survey Preparedness - *The MU Long Term Care Leadership Coaches recommend that your home maintain a SURVEY BOOK. The purpose of the book is to help your staff be **survey ready every day**. To be ready for the annual visit, the SURVEY BOOK should be reviewed weekly so that it is kept up to date. Make sure that all your management staff knows where the book is located as surveyors might show up when the NHA and/or DON are not in the facility. This section provides you with several tools offered for you to consider. The key to a SURVEY BOOK is that it is organized, up-to-date, and designed to meet the needs of your nursing home.*

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SURVEY READINESS

Be Prepared:

- 1. BE SURVEY READY EVERY DAY OF THE YEAR!!**
 - a. Continuous training with staff
 - b. An effective QA/QAPI program
 - c. Active Resident Council
 - d. An effective Customer Service Program
 - e. An effective Grievance Program
 - f. Daily and weekly rounds
2. Make sure you maintain a SURVEY BOOK and it is complete and updated weekly.
See **“ITEMS NEEDED FOR YOUR SURVEY BOOK” Pages 1.4 thru 1.11**
3. Make sure that all staff knows their job functions before surveyors enter the facility.
4. Make an announcement on the intercom welcoming the survey team.
5. Have a plan for weekend, holiday, and after hour surveys.
6. Train staff on what to expect during the survey.
7. Train staff on how to respond to surveyors when questions are asked.
 - a. Review the list of questions surveyors could ask.

The Survey Book

The goal of every nursing home administrator and facility should be to be survey ready every day. You should think about your survey all year and not wait until the State survey team shows up at your door. Best practice is to be prepared for the nursing home survey with a Survey Book—this book should contain everything that the surveyors will ask for when they enter your building. Please refer to the Entrance Conference Form on the next few pages. The Entrance Conference Form is also available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>. This Survey Book should be ***available, organized, and kept current at least weekly***. Make sure that other management people know where you keep this notebook—surveyors might show up when you are not available.

Some of these items are required within one hour, some within four hours, some by the end of the first day and some within 24 hours of entrance. If you have these items available and current, you and your team will not be wasting time gathering this information. Each region should utilize the same Entrance Conference Form (referenced above); however, each region may have a different LSC Entrance Form. Be sure you keep current on what your region is asking for so you will be ready for the next survey.

You can organize these items in any way you wish—we would suggest you keep them all in one notebook. ***Do NOT*** hand this entire notebook to the survey team. Only give them what they ask for. If you just hand over your information, it may lengthen your survey as it might trigger them to look in areas they had not planned on. Also, do not hand them your originals. Make them a copy, because there is a good chance you will not get it back.

ENTRANCE CONFERENCE WORKSHEET (January 2022)

(Note: Surveyors in a state that is subject to [OSO-22-07-ALL](#) should start using this document on 01/27/2022. Surveyors in a state that is subject to [OSO-22-09-ALL](#) should continue using the Sept 2021 version until 02/13/2022 and start using this document on 02/14/2022. Surveyors in a state that is subject to [OSO-22-11-ALL](#) should continue using the Sept 2021 version until 02/21/2022 and start using this document on 02/22/2022.)

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
<input type="checkbox"/> 1. Census number
<input type="checkbox"/> 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
<input type="checkbox"/> 3. An alphabetical list of all residents (note any resident out of the facility).
<input type="checkbox"/> 4. A list of residents who smoke, designated smoking times, and locations.
<input type="checkbox"/> 5. A list of current residents who are confirmed or suspected cases of COVID-19.
<input type="checkbox"/> 6. Name of facility staff responsible for Infection Prevention and Control Program.
<input type="checkbox"/> 7. Name of facility staff responsible for overseeing the COVID-19 vaccination effort.
ENTRANCE CONFERENCE
<input type="checkbox"/> 8. Conduct a brief Entrance Conference with the Administrator.
<input type="checkbox"/> 9. Information regarding full time DON coverage (verbal confirmation is acceptable).
<input type="checkbox"/> 10. Information about the facility's emergency water source (verbal confirmation is acceptable).
<input type="checkbox"/> 11. Signs announcing the survey that are posted in high-visibility areas.
<input type="checkbox"/> 12. A copy of an updated facility floor plan, if changes have been made, including COVID-19 observation and COVID-19 units.
<input type="checkbox"/> 13. Name of Resident Council President.
<input type="checkbox"/> 14. Provide the facility with a copy of the CASPER 3.
INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
<input type="checkbox"/> 15. 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.
<input type="checkbox"/> 16. Schedule of Medication Administration times.
<input type="checkbox"/> 17. Number and location of med storage rooms and med carts.
<input type="checkbox"/> 18. The actual working schedules for all staff, separated by departments, for the survey time period.
<input type="checkbox"/> 19. List of key personnel, location, and phone numbers. Note contract staff (e.g., rehab services). Also include the staff responsible for notifying all residents, representatives, and families of confirmed or suspected COVID-19 cases in the facility.
<input type="checkbox"/> 20. If the facility employs paid feeding assistants, provide the following information: <ul style="list-style-type: none"> 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; 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; c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.

<input type="checkbox"/> 21. The facility's mechanism(s) used to inform residents, their representatives, and families of confirmed or suspected COVID-19 activity in the facility and mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., supply the newsletter, email, website, etc.). If the system is dependent on the resident or representative to obtain the information themselves (e.g., website), provide the notification/information given to residents, their representatives, and families informing them of how to obtain updates.
<input type="checkbox"/> 22. Documentation related to COVID-19 testing, which may include the facility's testing plan, logs of county level positivity rates (before 09-10-2021) and the level of community transmission (after 09-10-2021), testing schedules, list of staff who have confirmed or suspected cases of COVID-19 <i>over the last 4 weeks</i> , and if there were testing issues, contact with state and local health departments.
INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE
<input type="checkbox"/> 23. Complete the matrix for all other residents. The TC confirms the matrix was completed accurately.
<input type="checkbox"/> 24. Admission packet.
<input type="checkbox"/> 25. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.
<input type="checkbox"/> 26. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable.
<input type="checkbox"/> 27. Agreement(s) or Policies and Procedures for transport to and from dialysis treatments, if applicable.
<input type="checkbox"/> 28. Does the facility have an onsite separately certified ESRD unit?
<input type="checkbox"/> 29. Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers).
<input type="checkbox"/> 30. Infection Prevention and Control Program Standards, Policies and Procedures, to include the Surveillance Plan, Procedures to address resident and staff who refuse testing or are unable to be tested, and Antibiotic Stewardship Program.
<input type="checkbox"/> 31. Influenza, Pneumococcal, and COVID-19 Immunization Policy & Procedures.
<input type="checkbox"/> 32. List of residents and their COVID-19 vaccination status.
<input type="checkbox"/> 33. <i>Numbered list of resident cases of confirmed COVID-19 over the last 4 weeks. Indicate whether any resident cases resulted in hospitalization or death.</i>
<input type="checkbox"/> 34. <i>COVID-19 Healthcare Staff Vaccination Policies and Procedures.</i>
<input type="checkbox"/> 35. <i>COVID-19 Staff Vaccination Matrix (Note: Facilities may complete the COVID-19 Vaccination Matrix for Staff or provide a list containing the same information as required in the staff matrix).</i>
<input type="checkbox"/> 36. QAA committee information (name of contact, names of members and frequency of meetings).
<input type="checkbox"/> 37. QAPI Plan.
<input type="checkbox"/> 38. Abuse Prohibition Policy and Procedures.
<input type="checkbox"/> 39. Description of any experimental research occurring in the facility.
<input type="checkbox"/> 40. Facility assessment.
<input type="checkbox"/> 41. Nurse staffing waivers.
<input type="checkbox"/> 42. List of rooms meeting any one of the following conditions that require a variance: <ul style="list-style-type: none"> • Less than the required square footage • More than four residents
INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY
<input type="checkbox"/> 43. 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
<input type="checkbox"/> 44. Completed Medicare/Medicaid Application (CMS-671).
<input type="checkbox"/> 45. Completed Census and Condition Information (CMS-672).
<input type="checkbox"/> 46. Please complete the attached form on page 3 which is titled “Beneficiary Notice - Residents Discharged Within the Last Six Months”.

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).

Resident Name	Discharge Date	Discharged to:	
		Home/Lesser Care	Remained in facility
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

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: Medications	EHR: Orders – Reports – Administration Record – eMAR – Confirm date range – Run Report
Example: Hospitalization	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)
1. Pressure ulcers	
2. Dialysis	
3. Infections	
4. Nutrition	
5. Falls	
6. ADL status	
7. Bowel and bladder	
8. Hospitalization	
9. Elopement	
10. Change of condition	
11. Medications	
12. Diagnoses	
13. PASARR	
14. Advance directives	
15. Hospice	
16. COVID-19 test results	

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: _____

COVID-19 Focused Infection Control (FIC) Survey with Staff Vaccination Mandate Entrance Conference Worksheet

*(Note: Surveyors in a state that is subject to [QSO-22-07-ALL](#) should start using this protocol on 1/27/2022.
Surveyors in a state that is subject to [QSO-22-09-ALL](#) should start using this protocol on 2/14/2022.
Surveyors in a state that is subject to [QSO-22-11-ALL](#) should start using this protocol on 2/22/2022).*

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE*
<input type="checkbox"/> 1. Census number
<input type="checkbox"/> 2. An alphabetical list of all residents and room numbers (note any resident out of the facility).
<input type="checkbox"/> 3. A list of residents who are confirmed or suspected cases of COVID-19
<input type="checkbox"/> 4. Name of facility staff responsible for Infection Prevention and Control Program.
<input type="checkbox"/> 5. Name of facility staff responsible for overseeing the COVID-19 vaccination effort.
ENTRANCE CONFERENCE
<input type="checkbox"/> 6. Conduct a brief Entrance Conference with the Administrator.
<input type="checkbox"/> 7. Signs announcing the survey that are posted in high-visibility areas.
<input type="checkbox"/> 8. A copy of an updated facility floor plan, if changes have been made, including observation and COVID-19 units.
<input type="checkbox"/> <i>9. Complete the COVID-19 Staff Vaccination Matrix or provide a list containing the same information as soon as possible.</i>
INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE*
<input type="checkbox"/> 10. The actual working schedules for all staff, separated by departments, for the survey time period.
<input type="checkbox"/> 11. List of key personnel location, and phone numbers. Note contract staff (e.g., rehab services). Also include the staff responsible for notifying all residents, representatives, and families of confirmed or suspected COVID-19 cases in the facility.
<input type="checkbox"/> 12. Provide each surveyor with access to all resident electronic health records (EHRs) – do not exclude any information that should be a part of the resident’s medical record. Provide instructions on how surveyors can access the EHRs outside of the conference room. Please complete the attached form on page 3 which is titled “Electronic Health Record Information.”
<input type="checkbox"/> 13. Facility Policies and Procedures: <ul style="list-style-type: none"> Infection Prevention and Control Program Policies and Procedures, to include the Surveillance Plan Procedures to address residents and staff who refuse testing or are unable to be tested Emergency Preparedness Policy and Procedure to include Emergency Staffing Strategies Influenza, Pneumococcal, and COVID-19 Vaccination Policy & Procedures <i>COVID-19 Healthcare Staff Vaccination Policies and Procedures</i>
<input type="checkbox"/> 14. The facility’s mechanism(s) used to inform residents, their representatives, and families of confirmed or suspected COVID-19 cases in the facility and mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., supply the newsletter, email, website, etc.). If the system is dependent on the resident or representative to obtain the information themselves (e.g., website), provide the notification/information given to residents, their representatives, and families informing them of how to obtain COVID-19 updates.

COVID-19 Focused Infection Control (FIC) Survey with Staff Vaccination Mandate Entrance Conference Worksheet

<input type="checkbox"/>	15. Documentation related to COVID-19 testing, which may include the facility's testing plan, logs of county level positivity rates (before 09-10-2021) and the level of community transmission (after 09-10-2021), testing schedules, list of staff who have confirmed or suspected cases of COVID-19 over the last 4 weeks, and, if there were testing issues, contact with state and local health departments.
<input type="checkbox"/>	16. A list of residents and their COVID-19 vaccination status.
<input type="checkbox"/>	<i>17. Numbered list of resident cases of confirmed COVID-19 over the last 4 weeks. Indicate whether any resident cases resulted in hospitalization or death.</i>

*The timelines for requested information in the table are based on normal circumstances. Surveyors should be flexible on the time to receive information based on the conditions in the facility. For example, do not require paperwork within an hour if it interrupts critical activities that are occurring to prevent the transmission of COVID-19.

**COVID-19 Focused Infection Control (FIC) Survey with Staff Vaccination Mandate
Entrance Conference Worksheet
ELECTRONIC HEALTH RECORD (EHR) INFORMATION**

Please provide the following information to the survey team within one hour of Entrance.

Provide specific instructions on where and how surveyors can access the following information in the EHR (or	
-	
1. Infections	
2. Hospitalization	
3. Change of condition	
4. Medications	
5. Diagnoses	
6. COVID-19 test results	
7. Immunization data	

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

IT Name and Contact Info: _____

Back-up IT Name and ContactInfo: _____

COVID-19 STAFF VACCINATION MATRIX INSTRUCTIONS FOR PROVIDERS

The Matrix is used to identify the vaccination status for all staff. The facility completes this form, including section I, staff name, and columns 1–11, which are described in detail below, or provide a list containing the same information required in the matrix.

Unless stated otherwise, for each staff mark an X for all columns that are pertinent.

1. **Direct facility hire (DH), Contracted hire (C), or Other (O):** Direct facility hires (DH) are employees who are directly hired by the facility. Contracted hires (C) provide care, treatment, or other services for the facility and/or its residents under contract or by other arrangements. Other (O) includes adult students, trainees, and volunteers.
2. **Title:** Identify the staff's title (e.g., RN, LPN, CNA, PA, RD).
3. **Position:** Identify the staff's position (e.g., staff nurse, charge nurse, infection preventionist, restorative aide).
4. **Assigned work area:** The physical location in the facility (e.g., laundry room, kitchen, unit, ward, wing). If the staff is PRN/floater/agency, indicate their assigned work area on the first day of the survey.
5. **Partially vaccinated:** Staff who have received one dose of a multi-dose vaccine.
6. **Completely vaccinated:** Staff who have received one dose of a single dose vaccine or all doses of a multi-dose vaccine. (For the purpose of this document, fully vaccinated and completely vaccinated are the same)
7. **Booster dose:** A dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have waned over time.
8. **Pending (P) or Granted (G) medical exemption:** Per CDC certain allergies or recognized medical conditions, which may provide grounds for a medical exemption (Please refer to the [CDC](#)).
9. **Pending (PN) or Granted (GN) non-medical exemption:** May be a religious exemption in accordance with Title VII.
10. **Temporary delay per CDC/new hire:** Vaccination that must be temporarily postponed, as recommended by the [CDC](#), due to clinical precautions and considerations. Newly hired staff, who are not completely vaccinated due to timing requirements

between doses.

11. **Not vaccinated without exemption or delay:** Any staff who have not received any doses of a vaccine and do not qualify for any of the exemptions or delays.

Section I

Total number of staff: All staff that work in the facility. Staff includes facility employees (regardless of clinical responsibilities or resident contact), licensed practitioners, adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

Number partially vaccinated staff (column 5): Number of current staff who received partial vaccination at any time as defined as, current staff who have received at a minimum, the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine.

Number completely vaccinated staff (column 6): Number of current staff who completed vaccination at any time is defined as, current staff with administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine

Number of staff with pending exemption (columns 8 and 9): Number of current staff with a request (pending) a medical or non-medical exemption.

Number of staff with granted exemption (columns 8 and 9): Number of current staff who was granted a qualifying medical or non-medical exemption.

Number of staff with temporary delay (column 11): Number of current staff whose COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations.

Number of staff not vaccinated without exemption or delay: Number of current staff who have not received any doses of a vaccine and do not qualify for an exemption or temporary delay.

COVID-19 Staff Vaccination Status for Providers

[illegible]

Instructions for Surveyors to Determine Compliance at §483.80(i) COVID-19 Vaccination of Facility Staff

Note: A Staff Formula spreadsheet is available in the Survey Resources folder that can be used to calculate the formulas listed below. **Please attach the completed spreadsheet to the LTCSP software or the survey shell.**

Section II – Verification of National Health Care Safety Network (NHSN) data

- Please fill in the blanks with data directly from [this link](#).
- NHSN as reported for week ending on (report header):
- Recent Percentage of Staff who are Fully Vaccinated: If there is no data present in NHSN, please ask the facility staff the rationale while onsite. (For the purpose of this document, fully vaccinated and completely vaccinated are the same)
- Review the staff matrix or the facility's list of all staff and their vaccination status, which is obtained on the first day of the survey. Calculate the percentage of the current staff who have completed vaccinations using the formula listed in Figure 1 (do not round). Compare the facility's data with the above NHSN data.

Figure 1: Formula to calculate percentage of current vaccinated staff to compare with NHSN data

% current staff received completed vaccination	=	<div style="border: 1px solid black; padding: 5px; display: inline-block;"># Completely vaccinated (6)</div> <hr style="width: 100%;"/> <div style="border: 1px solid black; padding: 5px; display: inline-block;"># of total staff</div>	X 100
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- If there is a 10% or less difference between the facility documentation and the NHSN data, no further investigation is required.
- If there is a greater than 10% difference, ask the facility to verify and explain why there is a significant variation.
- If the information presented to the surveyor is incorrect (and NHSN is correct), or if both sources are incorrect, this likely demonstrates the facility's failure to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff [per §483.80(i)(3)(iv)], consider citing F888.
- If the information reported to NHSN is incorrect (and the information reviewed onsite is correct) or data is not present, inform the facility to immediately correct the information in the NHSN system.

Section III – Determine when to cite F888

Determine the percentage of staff vaccinated: (Follow the data in Section I provided on the facility matrix)

- **When surveying between 30 - 59 days following issuance of the [QSO-22-07-ALL](#) (effective 1/27/2022–2/27/2022) / [QSO-22-09-ALL](#) (effective 2/14/2022-3/14/2022) / [QSO-22-11-ALL](#) (effective 02/22/2022-03/20/2022) :** Use the formula below (or in the Staff Formula spreadsheet) to calculate the percentage (round to the whole number) of staff that received a COVID-19 vaccination using the information the facility completed in Section I above.

Formula for surveys conducted between 30 - 59 days following issuance of the QSO memo

$$\% \text{Vaccinated} = \frac{\begin{array}{|c|} \hline \# \text{ Partially} \\ \text{vaccinated} \\ \hline (5) \end{array} + \begin{array}{|c|} \hline \# \text{ Completely} \\ \text{vaccinated} \\ \hline (6) \end{array} + \begin{array}{|c|} \hline \# \text{ Pending} \\ \text{exemption} \\ \hline (8 \text{ and } 9) \end{array} + \begin{array}{|c|} \hline \# \text{ Granted} \\ \text{exemption} \\ \hline (8 \text{ and } 9) \end{array} + \begin{array}{|c|} \hline \# \\ \text{Temporarily} \\ \text{delayed} \\ \hline (10) \end{array}}{\begin{array}{|c|} \hline \# \text{ of total staff} \\ \hline \end{array}} \times 100$$

- If the percent vaccinated is less than 100%, cite F888.

- **When surveying 60 days following issuance of the [QSO-22-07-ALL](#) (effective 2/28/22 and thereafter) / [QSO-22-09-ALL](#) (effective 3-15-2022 and thereafter) / [QSO-22-11-ALL](#) (effective 03/21/2022 and thereafter):** Use the formula below (or in the Staff Formula spreadsheet) to calculate the percentage (round to the whole number) of staff that received a completed COVID-19 vaccination series.

Formula for surveys conducted 60 following issuance of the QSO memo

$$\% \text{Vaccinated} = \frac{\begin{array}{|c|} \hline \# \text{ Completely} \\ \text{vaccinated} \\ \hline (6) \end{array} + \begin{array}{|c|} \hline \# \text{ Granted} \\ \text{exemption} \\ \hline (8 \text{ and } 9) \end{array} + \begin{array}{|c|} \hline \# \text{ Temporarily} \\ \text{delayed} \\ \hline (10) \end{array}}{\begin{array}{|c|} \hline \# \text{ of total staff} \\ \hline \end{array}} \times 100$$

- If the percent vaccinated is less than 100%, cite F888.
- Note: If the facility's staff vaccination rate is below 100% because of newly hired staff, who are not yet eligible to receive the second dose in a two-dose series, the facility will be considered compliant with the 100% staff vaccination requirement. The facility would need to be in compliance with §483.80(i)(3)(iii), including adhering to additional precautions that are intended to mitigate the spread of COVID-19.

QIPMO Entrance Conference Supplement

The Missouri Department of Health and Senior Services-Section for Long-Term Care has seven regional offices. Each regional office may have additional entrance conference information that they may need in addition to the CMS Entrance conference form.

Common items requested in addition to those listed on the CMS Entrance Conference Form Include:

1. List of current employees with date of hire and SSN
2. List of employees hired since the last recertification survey with date of hire, title and SSN
3. List of volunteers who have direct access to residents
4. Current activity schedule (may request last three months)
5. List of discharges, transfers and admissions for past three months
6. CPR Policy and list of CPR Certified employees
7. Copy of written information that is provided to residents regarding their rights
8. Resident funds bank statements for previous 12 months
9. Copy of Surety Bond
10. CLIA Waiver

Life Safety and Emergency Preparedness Information:

1. Documentation that the automatic fire alarm system has been inspected, tested, and maintained in accordance with the NFPA 101, 2012 edition. Include smoke alarm sensitivity testing records. Annual and semi-annual testing required.
2. Annual fire door inspections
3. Automatic sprinkler system inspection documentation - include facility check logs
4. Fire extinguisher testing and maintenance records
5. Maintenance/Certification of the Range Hood Suppression System
6. Electrical Wiring Certification
7. Logs of the checks on all battery powered smoke detectors.
8. Fire drill records for the past 12 months
9. Documentation that newly installed curtains, drapes, and blinds used in the facility are flame resistant and meet required specifications, including cubicle/privacy curtains.
10. Fire safety and emergency preparedness in-service records.
11. Documentation and logs that the emergency power is inspected and tested in accordance with NFPA 101, 2012 edition.
12. For Battery Backup Emergency Lights
 - Monthly 30-second check logs
 - Annual 90-minute check logs
13. For Generator
 - Weekly logs for automatic rollover
 - All inspection and testing records, including fuel testing if required
14. Documentation of the inspection of elevators (if applicable).
15. Facility Layout
16. Fire watch policy (used when fire alarm or sprinkler system is out of service)
17. Policies and procedures related to the facility's "Building Maintenance Program" and "Building Inspection Programs"
18. Policies and Procedures related to the facility's smoking prohibitions and use areas.
19. Policies and Procedures related to water outages affecting the sprinkler system. Reference the 2012 edition of NFPA 101.
20. Maintenance records of any fusible link dampers (if any).
21. Disaster/Emergency Preparedness Plan/Program (All Hazards Approach-As required by Appendix Z)



Division of Regulation and Licensure
Section for Long Term Care Regulation
 3418 Knipp Drive, Suite F
 P.O. Box 570
 Jefferson City, MO 65102-0570
 Phone: (573) 526-8524
 Fax: (573) 751-8493

Long Term Care Regions

Region 4

207 East McElwain Drive
 Cameron, MO 64429
 (816) 632-6541
 Fax: (816) 632-1810
Regional Manager: Candice Talbot
Region Supervisor: Sheila Winchester

Region 5

1716 Prospect Drive, Suite C
 Macon, MO 63552
 (660) 385-5763
 Fax: (660) 385-4706
Regional Manager: Amy Rehard
Region Supervisor: Shay Patterson

Region 6

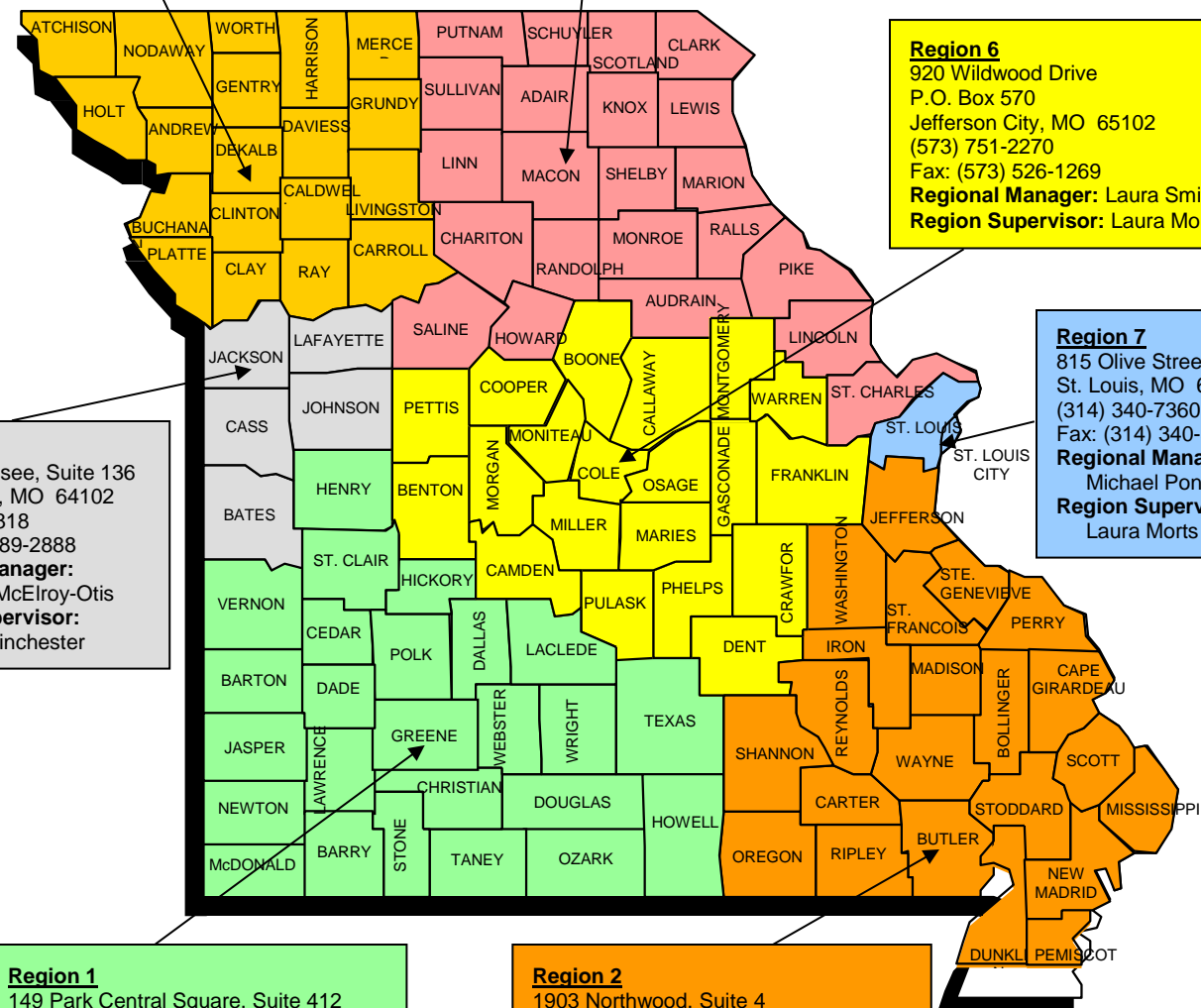
920 Wildwood Drive
 P.O. Box 570
 Jefferson City, MO 65102
 (573) 751-2270
 Fax: (573) 526-1269
Regional Manager: Laura Smith
Region Supervisor: Laura Morts

Region 3

1410 Genessee, Suite 136
 Kansas City, MO 64102
 (816) 889-2818
 Fax: (816) 889-2888
Regional Manager:
 Michele McElroy-Otis
Region Supervisor:
 Sheila Winchester

Region 7

815 Olive Street, Suite 10
 St. Louis, MO 63101
 (314) 340-7360
 Fax: (314) 340-3414
Regional Manager:
 Michael Ponder
Region Supervisor:
 Laura Morts



Region 1

149 Park Central Square, Suite 412
 Springfield, MO 65806
 (417) 895-6435
 Fax: (417) 895-6290
Regional Manager: Ruth Tuttle
Region Supervisor: Sheila Winchester

Region 2

1903 Northwood, Suite 4
 Poplar Bluff, MO 63901
 (573) 840-9580
 Fax: (573) 840-9586
Regional Manager: Cindy Rexroad
Region Supervisor: Shay Patterson

The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents.

The facility completes the resident name, resident room number and columns 1-20, which are described in detail below. Blank columns are for Surveyor Use Only.

All information entered into the form should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of survey.

Unless stated otherwise, for each resident mark an X for all columns that are pertinent.

- | | |
|--|--|
| <p>1. Residents Admitted within the Past 30 days: Resident(s) who were admitted to the facility within the past 30 days and currently residing in the facility.</p> <p>2. Alzheimer's/Dementia: Resident(s) who have a diagnosis of Alzheimer's disease or dementia of any type.</p> <p>3. MD, ID or RC & No PASARR Level II: Resident(s) who have a serious mental disorder, intellectual disability or a related condition but does not have a PASARR level II evaluation and determination.</p> <p>4. Medications: Resident(s) receiving any of the following medications: (I) = Insulin, (AC) = Anticoagulant (e.g. Direct thrombin inhibitors and low weight molecular weight heparin [e.g., Pradaxa, Xarelto, Coumadin, Fragmin]. Do not include Aspirin or Plavix), (ABX) = Antibiotic, (D) = Diuretic, (O) = Opioid, (H) = Hypnotic, (AA) = Antianxiety, (AP) = Antipsychotic, (AD) = Antidepressant, (RESP) = Respiratory (e.g., inhaler, nebulizer).</p> <p>NOTE: Record meds according to a drug's pharmacological classification, not how it is used.</p> <p>5. Facility Acquired Pressure Ulcer(s) (any stage): Resident(s) who have a pressure ulcer at any stage, including suspected deep tissue injury (mark I, II, III, IV, U for unstageable, S for sDTI)</p> <p>6. Worsened Pressure Ulcer(s) at any stage: Resident(s) with a pressure ulcer at any stage that have worsened.</p> <p>7. Excessive Weight Loss without Prescribed Weight Loss program: Resident(s) with an unintended (not on a prescribed weight loss</p> | <p>program) weight loss > 5% within the past 30 days or >10% within the past 180 days. Exclude residents receiving hospice services.</p> <p>8. Tube Feeding: Resident(s) who receive enteral (E) or parenteral feedings (P).</p> <p>9. Dehydration: Resident(s) identified with <u>actual</u> hydration concerns takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups).</p> <p>10. Physical Restraints: Resident(s) who have a physical restraint in use. A restraint is defined as the use of any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body (e.g., bed rail, trunk restraint, limb restraint, chair prevents rising, mitts on hands, confined to room, etc.). Do not code wander guards as a restraint.</p> <p>11. Fall(s), Fall(s) with Injury, Fall(s) with Major Injury: Resident(s) who have fallen <u>in the facility</u> in the past 90 days or since admission and have incurred an injury or not. A major injury includes bone fractures, joint dislocation, closed head injury with altered consciousness, subdural hematoma.</p> <p>Use (F) to identify residents with a fall(s), (FI) to identify a resident who has sustained an injury excluding major injury, and (FMI) to identify a resident who has sustained a fall(s) with Major Injury.</p> <p>12. Indwelling Urinary Catheter: Resident(s) with an indwelling catheter (including suprapubic catheter and nephrostomy tube).</p> |
|--|--|

13. **Dialysis:** Resident(s) who are receiving **(H)** hemodialysis or **(P)** peritoneal dialysis either within the facility **(F)** or offsite **(O)**.
14. **Hospice:** Resident(s) who have elected or are currently receiving hospice services.
15. **End of Life/Comfort Care/Palliative Care:** Resident(s) who are receiving end of life or palliative care (not including Hospice).
16. **Tracheostomy:** Resident(s) who have a tracheostomy.
17. **Ventilator:** Resident(s) who are receiving invasive mechanical ventilation.
18. **Transmission-Based Precautions:** Resident(s) who are currently on Transmission-based Precautions.
19. **Intravenous therapy:** Resident(s) who are receiving intravenous therapy through a central line, peripherally inserted central catheter, or other intravenous catheter.
20. **Infections:** Residents(s) who has a communicable disease/contagious infection. For example, **(M)** MDRO, **(P)** pneumonia, **(TB)** tuberculosis, **(VH)** viral hepatitis, or **(C)** c-diff OR has a healthcare-associated infection (e.g., **(WI)** wound infection or **(UTI)** Urinary Tract Infection).

MATRIX FOR PROVIDERS

Resident Name	Resident Room Number	Date of Admission if Admitted within the Past 30 Days	Alzheimer's / Dementia	MD, ID or RC & No PASARR Level II	Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	Facility Acquired Pressure Ulcer(s) (any stage)	Worsened Pressure Ulcer(s) (any stage)	Excessive Weight Loss w/out Prescribed Weight Loss Program	Tube Feeding	Dehydration	Physical Restraints	Fall (F), Fall with Injury (FI), or Fall w/Major Injury (FMI)	Indwelling Catheter	Dialysis: Peritoneal (P), Hemo (H), in facility (F) or offsite (O)	Hospice	End of Life Care /Comfort Care/Palliative Care	Tracheostomy	Ventilator	Transmission-Based Precautions	Intravenous therapy	Infections (M,WI, P, TB, VH, C, UTI)	Other
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:

From: F1 (mm/dd/yyyy)

To: F2 (mm/dd/yyyy)

Extended Survey:

From: F3 (mm/dd/yyyy)

To: F4 (mm/dd/yyyy)

Name of Facility

Provider Number

Fiscal Year Ending: F5 (mm/dd/yyyy)

Street Address

City

County

State

Zip Code

Telephone Number: F6

State/County Code: F7

State/Region Code: F8

F9

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- 01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 ☐ Yes ☐ No

If yes, indicate Hospital Provider Number: F11

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Ownership: F12

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For-Profit

- 01 Individual
02 Partnership
03 Corporation

Non-Profit

- 04 Church Related
05 Nonprofit Corporation
06 Other Nonprofit

Government

- 07 State
08 County
09 City
10 City/County
11 Hospital District
12 Federal

Owned or leased by Multi-Facility Organization: F13 ☐ Yes ☐ No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units: (show number of beds for all that apply)

F15 AIDS

--	--	--

F16 Alzheimer's Disease

--	--	--

F17 Dialysis

--	--	--

F18 Disabled Children/Young Adults

--	--	--

F19 Head Trauma

--	--	--

F20 Hospice

--	--	--

F21 Huntington's Disease

--	--	--

F22 Ventilator/Respiratory Care

--	--	--

F23 Other Specialized Rehabilitation

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Does the facility currently have an organized residents' group? F24 ☐ Yes ☐ No

Does the facility currently have an organized group of family members of residents? ☐ Yes ☐ No

Does the facility conduct experimental research? F26 ☐ Yes ☐ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ☐ Yes ☐ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:

Date: F28 (mm/dd/yyyy)

Hours waived per week: F29

Waiver of 24 hr licensed nursing requirement:

Date: F30 (mm/dd/yyyy)

Hours waived per week: F31

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ☐ Yes ☐ No

Name of Person Completing Form

Time

Signature

Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility. For the purpose of this form “the facility” equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey: LEAVE BLANK – Survey team will complete.

Extended Survey: LEAVE BLANK – Survey team will complete.

INSTRUCTIONS AND DEFINITIONS

Name of Facility: Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number: Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address: Street name and number refers to physical location, not mailing address, if two addresses differ.

City: Rural addresses should include the city of the nearest post office.

County: County refers to parish name in Louisiana and township name where appropriate in the New England States.

State: For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code: Zip Code refers to the “Zip-plus-four” code, if available, otherwise the standard Zip Code.

Telephone Number: Include the area code.

State/County Code: LEAVE BLANK. State Survey Office will complete.

State/Region Code: LEAVE BLANK. State Survey Office will complete.

Block F9: Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10: If the facility is under administrative control of a hospital, check “yes,” otherwise check “no.”

Block F11: The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12: Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

For-Profit: If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

Non-Profit: If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

Government: If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13: Check “yes” if the facility is owned or leased by a multi-facility organization, otherwise check “no.”

A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14: If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23: Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show “8” in F19.

Block F24: Check “yes” if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check “no.”

Block F25: Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

Block F26: Check "yes" if the facility conducts experimental research; otherwise check "no."
Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27: Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31: If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.35(e) or (f), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32: Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
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ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79	F80	F81
Dressing	F82	F83	F84
Transferring	F85	F86	F87
Toilet Use	F88	F89	F90
Eating	F91	F92	F93

A. Bowel/Bladder Status

- F94** ____ With indwelling or external catheter
- F95** Of the total number of residents with catheters, how many were present on admission ____?
- F96** ____ Occasionally or frequently incontinent of bladder
- F97** ____ Occasionally or frequently incontinent of bowel
- F98** ____ On urinary toileting program
- F99** ____ On bowel toileting program

B. Mobility

- F100** ____ Bedfast all or most of time
- F101** ____ In a chair all or most of time
- F102** ____ Independently ambulatory
- F103** ____ Ambulation with assistance or assistive device
- F104** ____ Physically restrained
- F105** Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints ____?
- F106** ____ With contractures
- F107** Of the total number of residents with contractures, how many had a contracture(s) on admission ____?

C. Mental Status

F108-114 – indicate the number of residents with:

- F108** ____ Intellectual and/or developmental disability
- F109** ____ Documented signs and symptoms of depression
- F110** ____ Documented psychiatric diagnosis (exclude dementias and depression)
- F111** ____ Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease
- F112** ____ Behavioral healthcare needs
- F113** Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them ____?
- F114** ____ Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

- F115** ____ Pressure ulcers (exclude Stage 1)
- F116** Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission ____?
- F117** ____ Receiving preventive skin care
- F118** ____ Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 ____ Hospice care

F120 ____ Radiation therapy

F121 ____ Chemotherapy

F122 ____ Dialysis

F123 ____ Intravenous therapy, IV nutrition, and/or blood transfusion

F124 ____ Respiratory treatment

F125 ____ Tracheostomy care

F126 ____ Ostomy care

F127 ____ Suctioning

F128 ____ Injections (exclude vitamin B12 injections)

F129 ____ Tube feedings

F130 ____ Mechanically altered diets including pureed and all chopped food (not only meat)

F131 ____ Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.)
Exclude health rehabilitation for MI and/or ID/DD

F132 ____ Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 ____ Any psychoactive medication

F134 ____ Antipsychotic medications

F135 ____ Antianxiety medications

F136 ____ Antidepressant medications

F137 ____ Hypnotic medications

F138 ____ Antibiotics

F139 ____ On pain management program

G. Other

F140 ____ With unplanned significant weight loss/gain

F141 ____ Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 ____ Who use non-oral communication devices

F143 ____ With advance directives

F144 ____ Received influenza immunization

F145 ____ Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form

Title

Date

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ____ Yes ____ No

F147 Was ombudsman present during any portion of the survey? ____ Yes ____ No

F148 Medication error rate _____%

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

GENERAL INSTRUCTIONS:

THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is no federal requirement to automate the 672 form. A facility may use its MDS data to assist in completing the entry fields for the 672 form, however, facilities should ensure that the MDS information is not simply counted and copied over into the form. **All conditions noted on this form that are not identified on the MDS must be counted manually.** This information is designed to be a representation of the facility during survey; it does not directly correspond to the MDS data in every field. **The information entered on this form must be reflective of all residents as of the day of survey; therefore all information entered must be independently verified.**

Following certain entry fields, the related MDS 3.0 item(s) is noted. Remember, that although MDS items are noted for some fields, the field itself may need to be completed differently to reflect the current status of all residents as of the day of survey. The MDS items are provided only as a reference point, the form is to be completed using the time frames and other specific instructions as noted below.

Where a field refers to the “admission assessment,” use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

For the purpose of completing this form the terms: “facility” means certified beds (i.e., Medicare and/or Medicaid certified beds) and “residents” means residents in certified beds regardless of payer source.

INSTRUCTIONS AND DEFINITIONS:

Complete each field by specifying the number of residents in each category. If no residents fall into a category enter a “0”.

Provider Number: Facility CMS certification provider number. A0100B; leave blank for initial certifications.

Block F75: Residents whose primary payer is Medicare.

Block F76: Residents whose primary payer is Medicaid.

Block F77: Residents whose primary payer is neither Medicare nor Medicaid.

Block F78: Residents for whom a bed is maintained on the day the survey begins, including those temporarily away in a hospital or on leave. This should be representative of residents in the nursing facility or those who have a bed-hold.

ADLS (F79 – F93): To determine resident status, unless otherwise noted, consider the resident’s condition for the 7 days prior to the survey. Horizontal totals across the three columns (Independent, Assist of One or Two Staff, and Dependent) must equal the number in Block F78, Total Residents, for each of the ADL categories (Bathing, Dressing, Transferring, Toilet Use and Eating).

Bathing (F79 – F81): This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. G0120A = 0 for F79, G0120A = 1, 2, OR 3 for F80. OR G0120A = 4 for F81.

Facilities may provide “setup” assistance to residents such as drawing water for a tub bath or laying out clothes, bathing supplies/toiletries, etc. Also, a resident may only need assistance with washing their back or shampooing their hair. If either of these are the case, and the resident requires no other assistance, count the resident as independent.

Dressing (F82 – F84): How the resident puts on, and takes off all items of clothing, including donning/removing prostheses (e.g., braces and artificial limbs) or elastic stockings. G0110G1 = 0 for F82 OR G0110G1 = 1, 2, OR 3 for F83 OR G0110G1 = 4 for F84.

Facilities may set out clothes for residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance, such as with dressing, donning a brace, elastic stocking, a prosthesis, or securing fasteners, etc. count the resident as needing the assistance of 1 or 2 staff, as appropriate.

Transferring (F85 – F87): How the resident moves between surfaces, including, to or from bed, chair, wheelchair, or standing position. (EXCLUDES transfers to/from the bath/toilet). G0110B1 = 0 for F85 OR G0110B1 = 1, 2, or 3 for F86 OR G0110B1 = 4 for F87.

Facilities may provide “setup” assistance to residents, such as handing equipment (e.g., quad cane) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use (F88 – F90): How the resident uses the toilet, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad(s); manages ostomy or catheter, and adjusts clothing. If all that is done for the resident is to open a package (e.g., a clean incontinence pad), count the resident as independent. G0110I1 = 0 for F88 OR G0110I1 = 1, 2, or 3 for F89 OR G0110I1 = 4 for F90.

Eating (F91 – F93): How a resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, includes IV fluids administered for nutrition or hydration). Facilities may provide “setup” activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the only assistance a resident needs, count this resident as independent. G0110H1 = 0 for F91 OR G0110H1 = 1, 2, or 3 for F92 OR G0110H1 = 4 for F93.

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

A. BOWEL/BLADDER STATUS (F94 – F99) - RESIDENTS

F94: With an indwelling or an external catheter:

Whose urinary bladder is constantly drained by a catheter (e.g., an indwelling catheter, a suprapubic catheter or nephrostomy tube) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., condom catheter or similar appliance). H0100A or B = checked.

F95: Of the total number of residents with catheters:

Who had a catheter present on admission/entry or reentry. H0100A or B = checked. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

F96: Occasionally or frequently incontinent of bladder:

Who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. H0100A and B = not checked AND H0300 = 1, 2, or 3.

F97: Occasionally or frequently incontinent of bowel:

Who have a loss of bowel control two or more times per week. H0400 = 2 or 3.

F98: On urinary toileting program: With a systematically implemented, individualized urinary toileting program (i.e. bladder rehabilitation/retraining, prompted voiding, habit training/scheduled voiding) to decrease or prevent urinary incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., pelvic floor exercises). Count all residents on urinary training programs including those who are incontinent. H0200A = 1 OR H200C = 1 OR H0300 = 1, 2 or 3.

F99: On bowel toileting program: With a systematically implemented, individualized bowel toileting program to decrease or prevent bowel incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., use of adequate fluid intake, fiber in the diet, exercise, and scheduled times to attempt bowel movement). Count all residents on toileting programs including those who are incontinent. H0400 = 2 or 3 OR H0500 OR H0600 = 1.

B. MOBILITY (F100 – F107) - RESIDENTS

Total for F100 – F103 should = the number in Block F78, Total Residents. Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.

F100: Bedfast all or most of time: Who are bedfast all or most of the time (e.g., in bed or geriatric chair/recliner) includes bedfast with bathroom privileges.

F101: In a chair all or most of time: Who depend on a chair for mobility includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. G0300A or E = 2 OR G0600C = checked.

F102: Independently ambulatory: Who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. G0110C1 or G0110D1 = 0 or 7 and G0110C2 or G0110D2 = 0 or 1 AND G0600A and G0600B = not checked.

F103: Ambulation with assistance or assistive devices:

Who require oversight, cueing, physical assistance or who use a cane, walker, or crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. G0110C1 or G0110D1 = 1, 2, or 3 AND G0110C2 or G0110D2 = 1, 2 or 3 OR G0600A and/or G0600B = checked.

F104: Physically restrained: For whom restraints were used. Restraints include any manual or physical method or mechanical device, material or equipment attached or adjacent to the resident's body in such a way that the individual cannot remove easily and it restricts freedom of movement or normal access to one's body. Do not include devices such as braces which are used for medical/clinical reasons. P0100A through H = 1 or 2.

F105: Of total number of restrained residents: On admission/entry or reentry with an order for restraint(s). P0100A through H = 1 or 2. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

F106: With contractures: With a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc., includes loss of range of motion in neck, fingers, wrists, elbows, shoulders, hips, knees and ankles. G0400A and/or B = 1 or 2.

F107: Of the total number with contractures, those who had a contracture(s) on admission: To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident). (neck contractures not included in MDS data).

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

C. MENTAL STATUS (F108 – F114) - RESIDENTS

F108: With Intellectual Disability (ID) (Mental retardation as defined at 483.45(a)) or Developmental Disability (DD):

In all of the categories of intellectual or developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. A1550A, B through E = checked.

F109: With documented signs and symptoms of depression:

With documented signs and symptoms of depression. D0200A1 through D1 = 1 for any indicator present OR D0200I1 = 1 OR D0200A2 through D2 = 2 or 3 for symptom frequency OR D0300 = 05 - 27 OR D0500A1 through D1 = 1 for any indicator present OR D0500I1 = 1 OR D0500A2 through D2 = 2 or 3 for symptom frequency OR D0600 = 05 - 30.

F110: With documented psychiatric diagnosis (exclude dementias and depression): With primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Anxiety disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis and atypical psychosis). I5700, I5900, I5950, I6000 or I6100 = checked.

F111: Dementia: Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease: With a primary or secondary diagnosis of dementia or organic mental syndrome including, Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases). I4200 or I4800 = checked

F112: With behavioral health care needs: With one or more of the following indicator(s): wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, and resistive to care. E0200A, B, or C = 1, 2, or 3 OR E0300 = 1 OR E0500A, B, or C = 1 OR E0600A, B, or C = 1 OR E0800 = 1, 2, or 3 OR E0900 = 1, 2, or 3 OR E1000A or B = 1.

F113: Of the total number with behavioral healthcare needs, those having an individualized care plan to support them: With behavior symptoms who are receiving an individualized care plan/program designed to support and manage behavioral needs (as noted in F112).

F114: Receiving health rehabilitative services for Mental Illness (MI) and/or ID/DD: Receiving health rehabilitative services for MI and/or ID/DD.

D. SKIN INTEGRITY (F115 – F118) - RESIDENTS

F115: With pressure ulcers: With localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction (exclude Stage I). M0300B1, M0300C1, M0300D1, M0300E1, M0300F1 and/or M0300G1 > 0.

F116: Of the total number of residents with pressure ulcers (excluding Stage I), those who had pressure ulcers on admission/entry or reentry: M0300B2, M0300C2, M0300D2, M0300E2, M0300F2 and/or M0300G2 > 0. To complete this field, use only the counts from the first assessment since the most recent admission/entry or reentry. (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident.)

F117: Receiving preventive skin care: Receiving non-routine skin care ordered by a physician, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.). M1200A through I = checked.

F118: With rashes: Who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., may include but are not limited to antifungals, corticosteroids, emollients, diphenhydramines or scabicides).

E. SPECIAL CARE (F119 – F132) - RESIDENTS

F119: Receiving hospice care: Who have elected or are currently receiving the hospice benefit. O0100K2 = checked.

F120: Receiving radiation therapy: Who are under a treatment plan involving radiation therapy. O0100B1 or O0100B2 = checked.

F121: Receiving chemotherapy: Who are under a treatment plan involving chemotherapy. O0100A1 or O0100A2 = checked.

F122: Receiving dialysis: Receiving hemodialysis or peritoneal dialysis either within the facility or offsite. O0100J1 or O0100J2 = checked.

F123: Receiving intravenous therapy, IV nutrition and/or blood transfusion: Receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. K0510A2, O0100H2, or O0100I2 = checked.

F124: Receiving respiratory treatment: Receiving treatment by the use of respirators/ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheostomy care or respiratory suctioning. O0100C2, O0100F2, or O0100G2 = checked.

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F125: Receiving tracheostomy care: Receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. O0100E2 = checked.

F126: Receiving ostomy care: Receiving care for a colostomy, ileostomy, uretostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheostomy. H0100C = checked.

F127: Receiving suctioning: That require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the oral cavity, nasal passage, or tracheostomy. O0100D2 = checked. (Note: O0100D2 does not include oral suctioning, so residents who receive oral suctioning will have to be counted separately.)

F128: Receiving injections: That have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) Review residents where N0300 > 0. Omit from the count any resident whose only injection currently is B12.

F129: Receiving tube feeding: Who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). K0510B2 = checked.

F130: Receiving mechanically altered diets: Receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). K0510C2 = checked.

F131: Receiving rehabilitative services: Receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist). Exclude health rehabilitation for MI and/or ID/DD. Any minutes > 0 entered in O0400.

F132: Assistive devices with eating: Who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). O0500C or H > 0.

F. MEDICATIONS (F133 – F139) - RESIDENTS

F133: Receiving psychoactive medications: That receive medications classified as antipsychotics, anxiolytics, antidepressants, and/or hypnotics. Days entered > 0 for N0410A, B, C or D.

Use the following lists to assist you in determining the number of residents receiving psychoactive medications. These lists are **not meant** to be all inclusive; therefore, a resident receiving a psychoactive medication not on this list, should be counted under F133 and any other medication category that applies: F134, F135, F136, and/or F137.

F134: Antipsychotic medications: Days entered for N0410A > 0

- Clozapine
- Haloperidol
- Haloperidol Deconate
- Droperidol
- Loxapine
- Thioridazine
- Molindone
- Theothixene
- Zyprexa
- Pimozide
- Fluphenazine Deconate
- Fluphenazine
- Quetiapine
- Risperidone
- Mesoridazine
- Promazine
- Trifluoperazine
- Chlorprothixene
- Chlorpromazine
- Acetophenazine
- Perphenazine

F135: Antianxiety medications (anxiolytics): Days entered for N0410B > 0

- Lorazepam
- Oxazepam
- Prazepam
- Diazepam
- Clonazepam
- Hydroxyzine
- Chlordiazepoxide
- Halazepam
- Alprazolam

F136: Antidepressant medications: Days entered for N0410C > 0

- Aripiprazole
- Amoxapine
- Nortriptyline
- Wellbutrin
- Trazodone
- Venlafaxine
- Amitriptyline
- Lithium
- Maprotiline
- Isocarboxazid
- Phenelzine
- Serzone
- Desipramine
- Tranlycypromine Paroxetine
- Fluoxetine
- Sertraline
- Doxepin
- Imipramine
- Protriptyline

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F137: Hypnotic medications: Days entered for N0410D > 0

- Flurazepam
- Quazepam
- Estazolam
- Temazepam
- Triazolam
- Zolpidem

F138: Receiving antibiotics: Receiving antibacterial sulfonamides, antibiotics, etc., either for prophylaxis or treatment. Days entered for N0410F > 0.

F139: On a pain management program: With a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with non-medication interventions (e.g., massages heat/cold, biofeedback, etc.). J0100A, B, or C = 1.

G. OTHER RESIDENT CHARACTERISTICS (F140 – F145)

F140: With unplanned significant weight loss/gain: Who have experienced unplanned weight loss/gain of > 5% in one month or > 10% over six months. K0300 or K0310 = 2.

F141: Who do not communicate in the dominant language at the facility: Who do not speak or understand the dominant language spoken in the facility and need or want an interpreter to communicate. A1100A = 1.

F142: Who use non-oral communication: Who communicate via non-oral methods, including, picture boards, computers, etc. A1100B, Preferred Language (e.g. American Sign Language).

F143: Who have advance directives: Who have advance directives, such as Physician's Orders for Life-Sustaining Treatment (POLST), a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated.

F144: Received influenza immunization: Who received the influenza immunization within the last 12 months. O0250A = 1.

F145: Received pneumococcal vaccine: Who received the pneumococcal vaccine. O0300A = 1.

LEAVE BLANK (F146-F148) – To Be Completed By Survey Team

F146: Ombudsman notice: Indicate whether or not the State Ombudsman was notified prior to the survey.

F147: Ombudsman presence: Indicate whether or not the State Ombudsman was present at any time during the survey.

F148: Medication error rate: Calculate and enter the medication error percentage of the facility.

PRE-SURVEY CHECKLIST

Area Reviewed	Date	Action Needed
Previous survey results (focus areas)		
QM/QI (6 month history)		
Fall and Accident logs		
Care Plan for Falls/Accidents		
Abuse reporting immediate & investigated		
Grievance logs and follow up		
Care plan accurate (sample 5%)		
Pressure ulcer documentation		
Med administration review		
Med room storage (expired/labeled)		
Call lights answered and within reach		
Knocking on doors		
Speaking respectfully		
Hygiene and grooming		
Catheters with proper diagnosis		
Bladder incontinence assessments		
Toileting program		
Handwashing observation		
Dressing change observation		
Lab work reconciliation system		
24 Hour report used		
MD/Family notification		
Observe peri-care		
Observe meal assistance		
Check shower schedule		
Check splint schedules		
Turn and position program in place		
Review MD visits (timely?)		
Check pharmacists' reports		
Review weight loss report and Care Planned		
Menu accuracy/served as listed		
Therapeutic diet service (consistency)		
Test tray, temp and palatability		
Kitchen sanitation		
Food storage practices		
Environment rounds		
Odors		
Dirty floors		
Trash storage		
Broken furniture		
Shower room condition		
Windows and doors		
Education records		
12 hour CNA in-service		
CNA training (cognitive impair)		
Background/Reference checks complete		
Agency orientation conducted		
Staffing list posted		
Survey results posted		
Evidence of QA committee		
Facility Assessment Completed (reviewed annually)		
Emergency Preparedness Program (reviewed annually)		

THINK SURVEY PREPAREDNESS

- ◆ Identify your 4-month window for Annual Survey - Every nursing home is required to have at least an annual survey in the range of every 9-15 months. Of course, if you have complaints or are a *special* focus facility, your survey will have a shortened span.
- ◆ Read your last annual survey and plan of correction. Sustain the plan!
- ◆ Make sure the last Annual Survey is posted.
- ◆ Make sure “daily staffing” is posted, per federal requirements.
- ◆ Make rounds daily using a variety of rounding tools or QA audit forms.
- ◆ Review QA Committee minutes, Grievance Log and Incidents for trends to focus on.
- ◆ Review facility Quality Measure/Indicator Report for anything ranked above the 90th percentile.
- ◆ Schedule Medication Pass Audits with consultant pharmacist.
- ◆ Monitor dining service and room trays. Ask for a test tray and monitor hot food and cold food temperatures.
- ◆ All meals served timely.
- ◆ Interventions for residents with weight loss and gain? Are they care planned?
- ◆ Make sure your staff is not handling food with bare hands.
- ◆ Accurate and complete meal monitoring with an alternative menu posted and offered.
- ◆ Conduct frequent Infection Control rounds with nursing assistants. Work toward making improvements.
- ◆ Check refrigerator temps and temps for resident room refrigerators. Are they clean, food items labeled and dated?
- ◆ Check microwaves. Are they clean?
- ◆ Are there unpleasant odors?
- ◆ Conduct in-services, as needed. For example: one-on-one coaching at the bedside for proper pericare technique and pressure relief positioning.
- ◆ In-service staff for comprehension of residents rights, abuse, neglect, etc.
- ◆ Is your staff knocking on doors, waiting for permission to enter before entering a resident room?
- ◆ Is your staff closing window curtains, privacy curtains, and room doors before providing care?
- ◆ Are privacy curtains missing, soiled?
- ◆ Is fresh water within reach for each resident?
- ◆ Is there mold in shower rooms, cold and hot water temps, unsecured chemicals or sharps?
- ◆ Is there linen, refuse, or devices on the floor?
- ◆ Are personal items labeled?
- ◆ Oral care separate from pericare supplies?
- ◆ Wheelchairs and seat cushions clean and free from odor?
- ◆ Is your staff answering call lights within 3-5 minutes?
- ◆ Are call lights within reach?
- ◆ Are noise levels low - excessive overhead paging, staff chatter, unnecessary noise?
- ◆ Do your employees know how to respond to complaints, concerns, or grievances?
- ◆ Are there background checks on all employees?
- ◆ Are licenses/certifications current?
- ◆ Are annual or new residents given a “two-step” TB skin check and are they up-to-date?
- ◆ CNAs compliant with 12-hours education annually?
- ◆ Care plans address resident needs? Current and updated? Staff is following care according to care plans?
- ◆ No holes in documentation? Check random MARs.
- ◆ No missed signatures.
- ◆ Staff performs proper hand washing between glove changes or between moving from soiled to clean?
- ◆ Ensure proper wheelchair and bed positioning.

- ◆ Are glucometers being properly calibrated each month? Disinfected correctly? Used for more than one resident?
- ◆ Check for good resident grooming i.e., post-meal grooming, good oral care, no facial hair (men and woman - unless residents choice and care planned), dirty nails, long finger and toe nails, etc.
- ◆ Check designated smoking area. Proper cigarette disposal system in place? Smoking aprons? Supervision? No burn holes in clothing or linen.
- ◆ Foley catheter tubing not on floor? Leg straps used? Bag covered?
- ◆ Disaster/Emergency Preparedness. Does your staff know what to do?
- ◆ Med carts clean?
- ◆ Disposed of all expired meds?
- ◆ Oxygen cylinders properly stored and chained?
- ◆ O2 tubing off floors?
- ◆ All O2 concentrators have clean filters.
- ◆ No ice scoops stored in ice chests.
- ◆ Labs are tracked and timely.
- ◆ Dumpsters closed.
- ◆ 24-hour report utilized.
- ◆ Gait belts used. Fall prevention program in place.
- ◆ Check restorative programs i.e. Walk-to-dine are functioning.
- ◆ Fire drills done at varied times on different shifts.
- ◆ Are generators tested and run under load weekly?
- ◆ Is resident trust fund balanced and reconciled? Signed agreement in business file? Quarterly statements mailed and interest allocated to each account?
- ◆ Activity calendar posted? Evening and weekend activities?
- ◆ Is resident mail delivered when received including Saturdays?
- ◆ Are residents able and encouraged to vote during elections?
- ◆ Safety committee in place and evidence that accidents/incidents are monitored
- ◆ Are your Resident Census and Conditions (CMS 672) and your Application for Medicaid/Medicare (CMS 671) current?
- ◆ Annual Fire Department Consultation form complete and current?
- ◆ Certification of Electrical Wiring complete and current?
- ◆ Do you have a written resident evacuation plan?
- ◆ Do you have a disaster plan for loss of water supply?
- ◆ Are fire alarms inspected annually with recent smoke detector sensitivity test?
- ◆ Are Sprinklers inspected annually? Quarterly flow test documentation? Weekly visual inspection documentation?

COMMON QUESTIONS STATE SURVEYORS MIGHT ASK CNAs

1. Do you participate on a regular basis in resident care conferences?
2. Name some of the topics presented at the past in-service education program you attended.
3. If you saw someone hurt a resident, what would you do?
4. If you discovered a fire in a resident's room, name the first two things you would do.
5. What type of orientation did you receive when you began working here?
6. How often do you have staff meetings on your unit?
7. What is the purpose of range of motion exercises, why are they done, and when do you do them?
8. What is the difference between active and passive range of motion exercises?
9. How do you know which residents to ambulate?
10. In what situation would you suggest the social worker to see the resident?
11. How often do you reposition residents who are confined to bed?
12. Where on the body are pressure ulcers most likely to occur?
13. Where do you place pillows or other forms of support when you are positioning a resident on their side?
14. What do you do if you walk into a room and find a resident on the floor?
15. Describe and demonstrate what you would do if someone was choking?
16. At what times are between-meal nourishments provided to residents?
17. Describe the proper place for dentures when they are not in the resident's mouth?
18. Where would you find information about what a resident is able to do for themselves?
19. How many confused or disoriented residents do you have on your assignment today?
20. When was the last fire drill you participated in?
21. Have you ever attended training on abuse or neglect?
22. How many residents on your assignment are incontinent?
23. Describe mental abuse of a resident?
24. Describe what you do if a resident refuses to eat?
25. How and when do you report what a resident has eaten?
26. How often do you check bedridden incontinent residents?
27. Are gelatin desserts considered a liquid or solid on intake forms?
28. Describe your role in a bladder management program.
29. Do any of your residents use adaptive devices to eat? If so, describe them and their purpose.
30. Under what circumstances is it necessary to have an incident/accident report filled out?
31. At what time do you wash your hands?
32. Name as many of the resident rights, as you can.
33. What do you do if a resident refuses care, such as a bath?
34. I've noticed you were helping Joe. Can you tell me what you do for him?

Employee: _____ Date: _____

SURVEY PREPAREDNESS QUIZ

1. CNAs are not allowed to see a resident's care plan; only nurses need to know the information there.
True False
2. The resident's current care plan is kept where?
 - a. The DON's office
 - b. In a notebook at the nurses' station
 - c. In each resident's chart
 - d. In the computer
 - e. b and c
3. Who can have input when a resident's care plan is being completed?
 - a. Any staff member who works with that resident
 - b. Only licensed nurses
 - c. The care plan team
4. QA&A meetings are a requirement under state and federal guidelines?
True False
5. According to State and Federal Regulations, the QA&Q committee must meet at least:
 - a. Quarterly
 - b. Monthly
 - c. Weekly
 - d. Annually
6. Who attends the facility QA&A meeting?
 17. The Medical Director, Administrator, DON and other staff members and professional consultants as designated
 18. Only the facility department heads
 19. The Medical Director and DON go out for lunch and call it QA&A
 20. All of the above
7. The family and resident have the right to participate in their care plan process and have input into how the care is directed.
True False
8. At a QA&A meeting, the committee discusses various aspects of resident care and facility practices such as falls, pressure ulcers, restraints, weight loss, environmental, resident and family grievances, injuries, pharmacy and other aspects of facility care.
True False
9. Nursing Policy and Procedure Manual, as well as other pertinent policy and procedure manuals are kept ONLY in the Administrator and DON's offices.
True False
10. When a resident is on Hospice services, the facility staff is not required to do anything for them such as bathing, passing medications, turning, etc. That is what the hospice staff is for.
True False

11. Associates who are told by a resident of abuse, neglect or other concerns, or associates who notice bruising or other injuries should:
- Not pay any attention because all residents are confused and bruise easily
 - Report the situation to their charge nurse, the DON, Social Services Director, or the Administrator immediately so the incident can be investigated
 - Tell all the other staff that someone abused the resident so the story can be fully embellished and circulated through the grapevine because that is the best way to make sure it doesn't happen again
12. CNAs and other nursing staff should not do range of motion or use wheelchair seating devices, splints or other adaptive equipment because only therapists are allowed to do this.
- True False
13. It is not necessary for staff to wash their hands after doing patient care if they wear gloves, nor is it necessary to wash hands if you have used alcohol sanitizer gel.
- True False
14. The facility's policy is to keep various logs for temperatures in facility and resident refrigerators, but it is up to the individual employee whether they complete the logs or not.
- True False
15. A facility can be cited a deficiency for NOT following a facility designated policy and procedure even if it doesn't result in harm to a resident.
- True False
16. If a resident appears distressed, upset, crying or is having other unusual behaviors, all staff members, including environmental, nursing and dietary staff, should:
- Ignore it; it's probably a full moon
 - Leave the resident's room and let them cry in peace
 - Report the situation to the Social Services Director and/or Charge nurse so it can be appropriately addressed
17. The facility has an obligation to provide for not only the resident's physical well-being, but also for the resident's mental and psychosocial well-being.
- True False
18. Residents should be turned and repositioned per their plan of care, not every 2 hours.
- True False
19. If a staff member is assisting a resident with personal care, there is no need to shut the door, pull the privacy curtain or close the window curtains.
- True False
20. Before performing any care for a resident, staff members should:
- Tell the charge nurse and other staff what they are going to do so someone has a clue
 - Explain to the resident what is being done during the care so the resident will be at ease and the resident does have the right to know what is being done for them
 - Just get the care done because the resident is confused and wouldn't understand what was happening to them anyway

21. When feeding residents who must have assistance, staff should:
- Stand up and carry on a conversation with the other staff members in the room
 - Sit down, focus attention on the residents at the table and ensure that the dining experience is pleasant for each resident
 - Feed one resident at a time letting the food for the others get cold
 - Start a food fight in the dining room so the residents can be entertained
22. There is never really a need to call residents by their preferred names because they are usually hard of hearing and wouldn't understand anyway.
- True False
23. Staff should be familiar with resident's rights because the residents are people too and deserve to be treated with dignity and respect which includes addressing their immediate needs, knocking on doors before entering and ensuring that their privacy is respected during care.
- True False
24. It is acceptable to tell a surveyor that you don't have the information they are requesting and go to your supervisor for assistance. Additionally, it is acceptable for a staff member to go to the facility policy and procedure manual at the nurse's station and look up a policy if the surveyor asks if they know the information.
- True False
25. The term "MSDS" stand for:
- An assessment process, required by the government which is completed by nursing.
 - Material Safety Data Sheets which outline precautionary measures for chemical handling.
 - A lady who is unmarried and has a Doctorate Degree in Sociology.
 - A computer operating system by Microsoft.
26. The first thing an employee should do upon discovering a fire in a resident's room is to:
- Evacuate all residents from the facility
 - Rescue the resident from the location of the fire
 - Contain and extinguish the fire
 - Activate the facility fire alarm
27. You observe another staff member remove a wig from a resident's head stating, "You can have your hair back when you finish eating". This would not be considered as a reportable incident to your supervisor, since the goal was positive in getting the resident to eat their meal.
- True False
28. Upon entering a resident's room, you observe the resident lying on the floor next to the bed. Your first action would be to:
- Call the doctor
 - Call the family
 - Check the resident and if OK assist backup
 - Check the resident and notify the nurse immediately before moving

29. When doing rounds on your assigned unit, you observe a Medication Cart outside a resident's room with a med drawer standing open. You should:
- Go about your business since you are not skilled in passing meds.
 - Look through the drawer and see if there is anything you could use.
 - Access the facility intercom and announce "attention, the med cart is now open".
 - Close the drawer and stay with the cart to assure no unauthorized access occurs until the responsible person returns.
30. It is OK to call a resident by a pet name such as "honey" or "grandma" because you usually always call the resident this.
- True False

Write your response:

- Where are blood spill kits located in your facility and when would you use one?
- You find medications in a residents room, what would you do?
- A call light is not working in a resident's room. What would you do?
- During a meal time you are feeding a resident and another resident asks to be taken to the bathroom. What would you do?
- While in the dining room you notice a resident not eating. What should you do?
- While dressing a resident, he/she begins crying in pain. What should you do?
- Where is the Disaster Manual kept?

Answers

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 - Feed one resident at a time letting the food for the others get cold
 - Start a food fight in the dining room so the residents can be entertained
22. There is never really a need to call residents by their preferred names because they are usually hard of hearing and wouldn't understand anyway.
- True False
23. Staff should be familiar with resident's rights because the residents are people too and deserve to be treated with dignity and respect which includes addressing their immediate needs, knocking on doors before entering and ensuring that their privacy is respected during care.
- True False
24. It is acceptable to tell a surveyor that you don't have the information they are requesting and go to your supervisor for assistance. Additionally, it is acceptable for a staff member to go to the facility policy and procedure manual at the nurse's station and look up a policy if the surveyor asks if they know the information.
- True False
25. The term "MSDS" stand for:
- An assessment process, required by the government which is completed by nursing
 - Material Safety Data Sheets which outline precautionary measures for chemical handling
 - A lady who is unmarried and has a Doctorate Degree in Sociology
 - A computer operating system by Microsoft
26. The first thing an employee should do upon discovering a fire in a resident's room is to:
- Evacuate all residents from the facility
 - Rescue the resident from the location of the fire
 - Contain and extinguish the fire
 - Activate the facility fire alarm
27. You observe another staff member remove a wig from a resident's head stating, "You can have your hair back when you finish eating". This would not be considered as a reportable incident to your supervisor, since the goal was positive in getting the resident to eat their meal.
- True False
28. Upon entering a resident's room, you observe the resident lying on the floor next to the bed. Your first action would be to:
- Call the doctor
 - Call the family
 - Check the resident and if OK assist backup
 - Check the resident and notify the nurse immediately before moving

29. When doing rounds on your assigned unit, you observe a Medication Cart outside a resident's room with a med drawer standing open. You should:
1. Go about your business since you are not skilled in passing meds
 2. Look through the drawer and see if there is anything you could use
 3. Access the facility intercom and announce "attention, the med cart is now open"
 4. Close the drawer and stay with the cart to assure no unauthorized access occurs until the responsible person returns
30. It is OK to call a resident pet names such as "honey" or "grandma" because you usually always call the resident this.
- True False

Write your response:

1. Where are blood spill kits located in your facility and when would you use one?
2. You find medications in a residents room, what would you do?
3. A call light is not working in a resident's room. What would you do?
4. During a meal time you are feeding a resident and another resident asks to be taken to the bathroom. What would you do?
5. While in the dining room you notice a resident not eating. What should you do?
6. While dressing a resident, he/she begins crying in pain. What should you do?
7. Where is the Disaster Manual kept?

SCAVENGER HUNT FOR SURVEY PREPAREDNESS

1. Where are blood spill kits located? _____
2. Where is the Disaster Manual located? _____
3. Where can you find an MSDS? _____
4. Locate 4 fire extinguishers: 1. _____ 2. _____
3. _____ 4. _____
5. Where are the State Survey results located? _____
6. Where are Resident's Care Plans located? _____
7. Where is the nearest eye wash station? _____
8. Where are Medicaid/Medicare numbers posted? _____
9. Where is the Daily Staffing Schedule posted? _____
10. Name 3 members who participate on the QA&A Committee?
1. _____ 2. _____ 3. _____
11. Who is the Resident Council President? _____
12. Where are Resident Council Minutes located? _____
13. Where are meal alternate items posted? _____
14. Where are grievance forms located? _____
15. Where is Maintenance Request slips located? _____
16. Where are the "Wet Floor" signs stored? _____
17. Find Therapy's Hydroculator. Is it locked or secured from residents? _____

Culture change is a movement to transform a facility to a home, a resident to a person, and a schedule to a choice. States and the federal government have worked over the years to examine regulations to evolve them into a more responsive regulatory system. The recent Appendix PP update is one example of the commitment of CMS and regulators to culture change and person-centered care.

Resources below are offered to home nursing homes to work to change the environment of their homes while meeting the regulations.

Pioneer Network

<https://www.pioneernetwork.net/>

Pioneer Network Resource Library

<https://www.pioneernetwork.net/resource-library/>

Artifacts of Culture Change

<http://www.artifactsofculturechange.org/ACCTool/>

New Dining Practice Standards

<https://www.pioneernetwork.net/wp-content/uploads/2016/10/The-New-Dining-Practice-Standards.pdf>

Missouri Coalition Celebrating Care Continuum Change (MC5)

<http://www.momc5.com/index.html>

Quality Improvement for Missouri Nursing Homes (QIPMO)

www.nursinghomehelp.org

National Nursing Home Quality Improvement Campaign

<https://www.nhqualitycampaign.org/default.aspx>

Action Pact-Culture Change Now!

<http://actionpact.com/>

