Facility Self-Assessment (Mock Survey) Tool

SECTION 5 - FACILITY SELF-ASSESSMENT (MOCK SURVEY TOOLS)

Facility Self-Assessment - *Mock surveys are an opportunity to look at systems, procedures and processes of care and to identify potential survey-risk areas. Mock surveys should be performed on a scheduled basis and shared with nursing home staff. The most important part of the survey process is what you do after it is over with the results. F-tags are used in this section. Be advised that CMS makes revisions to the F-tags on a regular basis.*

ADMINISTRATION

Mock Survey: An Important Component of Survey Preparation

Many long-term care providers strive to be 'survey-ready' all year round. But just like many of us schedule the big spring cleaning some time in advance of company arriving for their annual summer visit; some LTC providers opt to conduct a Mock Survey in anticipation of their annual licensure/certification visit.

Mock Surveys can serve several purposes:

- A Mock Survey can be an opportunity to take a fresh look at systems, procedures and processes of care, and identify potential survey-***risk*** areas. And survey-risk can translate into litigation-risk.
- A Mock Survey also can reveal how staff will function under stressful circumstances.

Taking that fresh and objective look is essential in order to reap the maximum benefit from the Mock Survey process. LTC providers are discovering the hard way that the procedures, protocols and monitoring/QA systems that served them well enough in the past are no longer sufficient to avoid survey deficiencies. 'But we've always done it this way; the surveyors never cited us on this in the past; we thought we were doing this correctly; we've always done well on our surveys before – how could this be happening?' It is hard to stay current with new standards and the more stringent application of existing standards like F314 Pressure Ulcers, F315 Continence/Catheters, F323 Accidents, etc. It is hard to look at one's own organization and see its shortcomings.

One way to get a fresh and objective perspective and to minimize survey-risk is to have the Mock Survey process conducted by someone external to your organization. This 'someone' could be a consultant or an experienced and well informed professional from a neighboring LTC community. If, however, you elect to manage the process using your own personnel, incorporating the following approaches can facilitate objectivity:

- Assign department heads to 'survey' departments other than their own. In nursing, have charge nurses/unit managers, supervisors, etc., assigned to audit other units and/or aspects of care for which they are not usually responsible. *It is often hard to see your own forest for the trees.*
- Although obviously the internal 'surveyors' will know that a Mock Survey will be taking place at some point, it could be more beneficial if direct care staff and other workers were not informed. *This maximizes the surprise and stress factor.*
- Even though the internal 'surveyors' know that the process is planned, the Mock Survey should be unannounced. The Administrator walks in one morning and proclaims it to be Mock Survey Day. *This simulates 'real life' conditions...*

The most important part of the Mock Survey process is what you do after it's over. If you have about three months between the Mock Survey and the earliest likely date of the next survey, then I recommend the 'Systems' approach. The Systems approach includes a broader review and analysis of organizational policies, procedures, protocols and practices that may be contributing to Quality Indicator Report flags and/or to the 'findings' of the Mock Survey 'survey team.' If you have one month or less between the Mock Survey and the earliest likely date of the next survey, then I recommend you go into 'Manage the Damage Mode.' What are your high-risk areas, which residents have experienced negative outcomes, how can the risk be lessened and/or the negative outcome be explained and/or otherwise addressed?

In either scenario, "Systems" or "Manage the Damage Mode" develop a Corrective Action Roadmap that

assigns responsibility, targets timeframes and breaks down the plan into operational steps.

Pre-survey preparation and risk management are the two most effective tools we have to weather today's regulatory climate. Most LTC providers, if they haven't endured it already themselves, know of a provider in their area- good reputation, well respected in their community, satisfactory survey history – that has been blown out of the water during their last survey. Wouldn't you rather have a 'friendly outsider' or your own team discovers the dust-bunnies *before* the surveyors do?

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The Edge is provided to members of the Kansas Association of Homes and Services for the Aging in partnership with Life Services Network, the Illinois AAHSA affiliate. Authored by **Dorrie J. Seyfried**, Vice President of Method Management, Risk Management & LTC Consultants based in St. Charles, Illinois.

Disclaimer: This article predates the updated F-Tag numbering system. For a current listing please see pages 15 and 16.

Self-Assessment/Mock Survey

Today, more than ever, nursing facilities must be prepared to demonstrate compliance with federal regulations not only at survey time, but all year long. Survey teams can arrive at facilities as soon as nine months after the last annual survey. They can appear at any time to conduct complaint investigation surveys. And, these days, they are likely to begin surveys at nontraditional times and on weekends. These changes in the frequencies, times and types of surveys make it imperative that facilities be prepared at all times.

Nevertheless, with rapidly increasing turnover rates for nursing staff and managers, facility staff might not be familiar with surveyors' procedures, care observations, interviews, and record reviews and could be unprepared to meet these challenges.

To adequately prepare staff to succeed at survey time, and to ensure that the facility complies with regulations at all times, periodic self-assessments or mock surveys can be an important feature of a facility's quality assurance process. A mock survey can be performed by facility staff, by corporate advisors or by outside consultants. In whatever manner your facility chooses to provide these services, there are a few guidelines to bear in mind.

1. Enlist "fresh eyes" to see existing problems clearly. Be sure to include new employees, an "outsider" or other mock surveyors who are not overly familiar with the facility's staff and residents. If using facility staff, ask them to review areas outside their direct span of control.

2. Replicate "real" survey procedures as faithfully as possible. Use precise observation methods, select a sample of residents according to survey guidelines and interview the same staff that real surveyors are likely to interview.

The following pages include a variety of tools for you to use for your own self-assessment—use all or some of them. Remember, if you find any deficient practices be sure you bring it to your Quality Assurance Meetings/QAPI, document your findings, and come up with a workable plan to correct the problem.

ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
❑ 1. Census number
❑ 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
❑ 3. An alphabetical list of all residents (note any resident out of the facility).
❑ 4. A list of residents who smoke, designated smoking times, and locations.
ENTRANCE CONFERENCE
❑ 5. Conduct a brief Entrance Conference with the Administrator. Ask the Administrator to make the Medical Director aware that the survey team is conducting a survey. Offer an opportunity to the Medical Director to provide feedback to the survey team during the survey period if needed.
❑ 6. Information regarding full time DON coverage (verbal confirmation is acceptable).
❑ 7. Information about the facility's emergency water source (verbal confirmation is acceptable).
❑ 8. Signs announcing the survey that are posted in high-visibility areas.
❑ 9. A copy of an updated facility floor plan, if changes have been made, including COVID-19 observation and COVID-19 units.
❑ 10. Name of Resident Council President.
❑ 11. Provide the facility with a copy of the CASPER 3.
❑ 12. Does the facility offer arbitration agreements? If so, please provide a sample copy.
❑ 13. Has the facility asked any residents or their representatives to enter into a binding arbitration agreement?
❑ 14. Name of the staff responsible for the binding arbitration agreements.
INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
❑ 15. Schedule of mealtimes, 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.
❑ 16. Schedule of Medication Administration times.
❑ 17. Number and location of med storage rooms and med carts.
❑ 18. The actual working schedules for all staff, separated by departments, for the survey time period.
❑ 19. List of key personnel, location, and phone numbers including the Medical Director and contract staff (e.g., rehab services).
❑ 20. If the facility employs paid feeding assistants, provide the following information: 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) A list 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.
❑ 21. Name of the facility's infection preventionist (IP). Documentation of the IP's primary professional training and evidence of completion of specialized training in infection prevention and control.
INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE
❑ 22. Complete the matrix for all other residents. The TC confirms the matrix was completed accurately.
❑ 23. Admission packet.
❑ 24. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.

ENTRANCE CONFERENCE WORKSHEET

❑ 25. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable.
❑ 26. Agreement(s) or Policies and Procedures for transport to and from dialysis treatments, if applicable.
❑ 27. Does the facility have an onsite separately certified ESRD unit?
❑ 28. Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers).
❑ 29. Infection Prevention and Control Program Standards, Policies and Procedures, including: • the surveillance plan; • Antibiotic Stewardship program; and • Influenza, Pneumococcal, and COVID-19 Immunization Policy & Procedures.
❑ 30. QAA committee information (name of contact, names of members and frequency of meetings).
❑ 31. QAPI Plan.
❑ 32. Abuse Prohibition Policy and Procedures.
❑ 33. Description of any experimental research occurring in the facility.
❑ 34. Facility assessment.
❑ 35. Nurse staffing waivers.
❑ 36. List of rooms meeting any one of the following conditions that require a variance: • Less than the required square footage • More than four residents
INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY
❑ 37. 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."
❑ 38. Provide a list of residents, who are currently residing in the facility, that have entered into a binding arbitration agreement on or after 9/16/2019.
❑ 39. Provide a list of residents who resolved disputes through arbitration on or after 9/16/2019.
INFORMATION NEEDED FROM FACILITY WITHIN 24 HOURS OF ENTRANCE
❑ 40. Completed Medicare/Medicaid Application (CMS-671).
❑ 41. 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: _____

MATRIX INSTRUCTIONS FOR PROVIDERS

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.

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.
2. **Alzheimer's/Dementia:** Resident(s) who have a diagnosis of Alzheimer's disease or dementia of any type.
3. **MD, ID or RC & No PASRR Level II:** Resident(s) who have a serious mental disorder, intellectual disability or a related condition but does not have a PASRR level II evaluation and determination.
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). **NOTE:** Record meds according to a drug's pharmacological classification, not how it is used.
5. **Pressure Ulcer(s) (any stage):** Resident(s) who have a pressure ulcer at any stage, including suspected deep tissue injury (mark the highest stage: I, II, III, IV, U for unstageable, S for sDTI) that were not present on admission.
6. **Excessive Weight Loss without Prescribed Weight Loss program:** Resident(s) with an unintended (not on a prescribed weight loss program) weight loss > 5% within the past 30 days or >10% within the past 180 days. Exclude residents receiving hospice services.
7. **Tube Feeding:** Resident(s) who receive enteral (E) or parenteral (P) feedings.
8. **Dehydration:** Resident(s) identified with actual 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).
9. **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.
10. **Fall(s) (F) or Fall(s) with Injury (FI) or Major Injury (FMI):** Resident(s) who have fallen in the facility in the past 120 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.
11. **Indwelling Urinary Catheter:** Resident(s) with an indwelling catheter (including suprapubic catheter and nephrostomy tube).
12. **Dialysis:** Resident(s) who are receiving (H) hemodialysis or (P) peritoneal dialysis either within the facility (F) or offsite (O).
13. **Hospice:** Resident(s) who have elected or are currently receiving hospice services.
14. **End of Life/Comfort Care/Palliative Care:** Resident(s) who are receiving end of life or palliative care (not including Hospice).
15. **Tracheostomy:** Resident(s) who have a tracheostomy.
16. **Ventilator:** Resident(s) who are receiving invasive mechanical ventilation.
17. **Transmission-Based Precautions:** Resident(s) who are currently on Transmission-based Precautions.
18. **Intravenous therapy:** Resident(s) who are receiving intravenous therapy through a central line, peripherally inserted central catheter, or other intravenous catheter.
19. **Infections:** Resident(s) who has a communicable disease or infection (e.g., MDRO-M, pneumonia-P, tuberculosis-TB, viral hepatitis-VH, C. difficile-C, wound infection-WI, UTI, sepsis-SEP, scabies-SCA, gastroenteritis-GI such as norovirus, SARS-CoV-2 suspected or confirmed-COVID, and other-O with description).
20. **PTSD/Trauma:** Residents(s) who has a diagnosis of Post-Traumatic Stress Disorder (PTSD) and/or a history of trauma.

MATRIX FOR PROVIDERS

Resident Name	Resident Room Number	1 Date of Admission if Admitted within the Past 30 Days	2 Alzheimer's / Dementia	3 MD, ID or RC & No PASRR Level II	4 Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	5 Pressure Ulcer(s) (highest stage I, II, III, IV, U, S) not present on admission	6 Excessive Weight Loss Without Prescribed Weight Loss Program	7 Tube Feeding: Enteral (E) or Parenteral (P)	8 Dehydration	9 Physical Restraints	10 Fall (F), Fall with Injury (FI), Fall w/Major Injury (FMI)	11 Indwelling Catheter	12 Dialysis: Peritoneal (P), Hemo (H), in facility (F) or offsite (O)	13 Hospice	14 End of Life Care / Comfort Care / Palliative Care	15 Tracheostomy	16 Ventilator	17 Transmission-Based Precautions	18 Intravenous therapy	19 Infections (M, WI, P, TB, VH, C, UTI, SEP, SCA, GI, COVID, O - describe)	20 PTSD/Trauma	21	22

Federal Regulatory Groups for Long Term Care

***Substandard Quality of Care = one or more deficiencies with s/s levels of F, H, I, J, K, or L in Red**

**** Tag to be cited by Federal Surveyors Only**

F540	Definitions	**483.12**	**Freedom from Abuse, Neglect, and Exploitation**	**483.24**	**Quality of Life**
483.10	**Resident Rights**	F600	*Free from Abuse and Neglect	F675	*Quality of Life
F550	*Resident Rights/Exercise of Rights	F602	*Free from Misappropriation/Exploitation	F676	*Activities of Daily Living (ADLs)/ Maintain Abilities
F551	Rights Exercised by Representative	F603	*Free from Involuntary Seclusion	F677	*ADL Care Provided for Dependent Residents
F552	Right to be Informed/Make Treatment Decisions	F604	*Right to be Free from Physical Restraints	F678	*Cardio-Pulmonary Resuscitation (CPR)
F553	Right to Participate in Planning Care	F605	*Right to be Free from Chemical Restraints	F679	*Activities Meet Interest/Needs of Each Resident
F554	Resident Self-Admin Meds-Clinically Appropriate	F606	*Not Employ/Engage Staff with Adverse Actions	F680	*Qualifications of Activity Professional
F555	Right to Choose/Be Informed of Attending Physician	F607	*Develop/Implement Abuse/Neglect, etc. Policies	**483.25**	**Quality of Care**
F557	Respect, Dignity/Right to have Personal Property	F608	*Reporting of Reasonable Suspicion of a Crime	F684	Quality of Care
F558	*Reasonable Accommodations of Needs/Preferences	F609	*Reporting of Alleged Violations	F685	*Treatment/Devices to Maintain Hearing/Vision
F559	*Choose/Be Notified of Room/Roommate Change	F610	*Investigate/Prevent/Correct Alleged Violation	F686	*Treatment/Svcs to Prevent/Heal Pressure Ulcers
F560	Right to Refuse Certain Transfers	**483.15**	**Admission, Transfer, and Discharge**	F687	*Foot Care
F561	*Self Determination	F620	Admissions Policy	F688	*Increase/Prevent Decrease in ROM/Mobility
F562	Immediate Access to Resident	F621	Equal Practices Regardless of Payment Source	F689	*Free of Accident Hazards/Supervision/Devices
F563	Right to Receive/Deny Visitors	F622	Transfer and Discharge Requirements	F690	*Bowel/Bladder Incontinence, Catheter, UTI
F564	Inform of Visitation Rights/Equal Visitation Privileges	F623	Notice Requirements Before Transfer/Discharge	F691	*Colostomy, Urostomy, or Ileostomy Care
F565	*Resident/Family Group and Response	F624	Preparation for Safe/Orderly Transfer/Discharge	F692	*Nutrition/Hydration Status Maintenance
F566	Right to Perform Facility Services or Refuse	F625	Notice of Bed Hold Policy Before/Upon Transfer	F693	*Tube Feeding Management/Restore Eating Skills
F567	Protection/Management of Personal Funds	F626	Permitting Residents to Return to Facility	F694	*Parenteral/IV Fluids
F568	Accounting and Records of Personal Funds	**483.20**	**Resident Assessments**	F695	*Respiratory/Tracheostomy care and Suctioning
F569	Notice and Conveyance of Personal Funds	F635	Admission Physician Orders for Immediate Care	F696	*Prostheses
F570	Surety Bond - Security of Personal Funds	F636	Comprehensive Assessments & Timing	F697	*Pain Management
F571	Limitations on Charges to Personal Funds	F637	Comprehensive Assmt After Significant Change	F698	*Dialysis
F572	Notice of Rights and Rules	F638	Quarterly Assessment At Least Every 3 Months	F699	*{PHASE-3} Trauma Informed Care
F573	Right to Access/Purchase Copies of Records	F639	Maintain 15 Months of Resident Assessments	F700	*Bedrails
F574	Required Notices and Contact Information	F640	Encoding/Transmitting Resident Assessment	**483.30**	**Physician Services**
F575	Required Postings	F641	Accuracy of Assessments	F710	Resident's Care Supervised by a Physician
F576	Right to Forms of Communication with Privacy	F642	Coordination/Certification of Assessment	F711	Physician Visits- Review Care/Notes/Order
F577	Right to Survey Results/Advocate Agency Info	F644	Coordination of PASARR and Assessments	F712	Physician Visits-Frequency/Timeliness/Alternate NPPs
F578	Request/Refuse/Discontinue Treatment;Formulate Adv Di	F645	PASARR Screening for MD & ID	F713	Physician for Emergency Care, Available 24 Hours
F579	Posting/Notice of Medicare/Medicaid on Admission	F646	MD/ID Significant Change Notification	F714	Physician Delegation of Tasks to NPP
F580	Notify of Changes (Injury/Decline/Room, Etc.)	**483.21**	**Comprehensive Resident Centered Care Plan**	F715	Physician Delegation to Dietitian/Therapist
F582	Medicaid/Medicare Coverage/Liability Notice	F655	Baseline Care Plan	**483.35**	**Nursing Services**
F583	Personal Privacy/Confidentiality of Records	F656	Develop/Implement Comprehensive Care Plan	F725	Sufficient Nursing Staff
F584	*Safe/Clean/Comfortable/Homelike Environment	F657	Care Plan Timing and Revision	F726	Competent Nursing Staff
F585	Grievances	F658	Services Provided Meet Professional Standards	F727	RN 8 Hrs/7 days/Wk, Full Time DON
F586	Resident Contact with External Entities	F659	Qualified Persons	F728	Facility Hiring and Use of Nurse
		F660	Discharge Planning Process	F729	Nurse Aide Registry Verification, Retraining
		F661	Discharge Summary	F730	Nurse Aide Perform Review – 12Hr/Year In- service
				F731	Waiver-Licensed Nurses 24Hr/Day and RN Coverage
				F732	Posted Nurse Staffing Information

Federal Regulatory Groups for Long Term Care

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483.40	**Behavioral Health**	F811	Feeding Asst -Training/Supervision/Resident	**483.90**	**Physical Environment**
F740	Behavioral Health Services	F812	Food Procurement, Store/Prepare/Serve - Sanitary	F906	Emergency Electrical Power System
F741	Sufficient/Competent Staff-Behav Health Needs	F813	Personal Food Policy	F907	Space and Equipment
F742	*Treatment/Svc for Mental/Psychosocial Concerns	F814	Dispose Garbage & Refuse Properly	F908	Essential Equipment, Safe Operating Condition
F743	*No Pattern of Behavioral Difficulties Unless Unavoidable	**483.65**	**Specialized Rehabilitative Services**	F909	Resident Bed
F744	*Treatment /Service for Dementia	F825	Provide/Obtain Specialized Rehab Services	F910	Resident Room
F745	*Provision of Medically Related Social Services	F826	Rehab Services- Physician Order/Qualified Person	F911	Bedroom Number of Residents
483.45	**Pharmacy Services**	**483.70**	**Administration**	F912	Bedrooms Measure at Least 80 Square Ft/Resident
F755	Pharmacy Svcs/Procedures/Pharmacist/ Records	F835	Administration	F913	Bedrooms Have Direct Access to Exit Corridor
F756	Drug Regimen Review, Report Irregular, Act On	F836	License/Comply w/Fed/State/Local Law/Prof Std	F914	Bedrooms Assure Full Visual Privacy
F757	*Drug Regimen is Free From Unnecessary Drugs	F837	Governing Body	F915	Resident Room Window
F758	*Free from Unnec Psychotropic Meds/PRN Use	F838	Facility Assessment	F916	Resident Room Floor Above Grade
F759	*Free of Medication Error Rate sof 5% or More	F839	Staff Qualifications	F917	Resident Room Bed/Furniture/Closet
F760	*Residents Are Free of Significant Med Errors	F840	Use of Outside Resources	F918	Bedrooms Equipped/Near Lavatory/Toilet
F761	Label/Store Drugs & Biologicals	F841	Responsibilities of Medical Director	F919	Resident Call System
483.50	**Laboratory, Radiology, and Other Diagnostic Services**	F842	Resident Records - Identifiable Information	F920	Requirements for Dining and Activity Rooms
F770	Laboratory Services	F843	Transfer Agreement	F921	Safe/Functional/Sanitary/ Comfortable Environment
F771	Blood Blank and Transfusion Services	F844	Disclosure of Ownership Requirements	F922	Procedures to Ensure Water Availability
F772	Lab Services Not Provided On-Site	F845	Facility closure-Administrator	F923	Ventilation
F773	Lab Svs Physician Order/Notify of Results	F846	Facility closure	F924	Corridors Have Firmly Secured Handrails
F774	Assist with Transport Arrangements to Lab Svcs	F847	Enter into Binding Arbitration Agreements	F925	Maintains Effective Pest Control Program
F775	Lab Reports in Record-Lab Name/Address	F848	Select Arbitrator/Venue, Retention of Agreements	F926	Smoking Policies
F776	Radiology/Other Diagnostic Services	F849	Hospice Services	**483.95**	**Training Requirements**
F777	Radiology/Diag. Svcs Ordered/Notify Results	F850	*Qualifications of Social Worker >120 Beds	F940	{PHASE-3} Training Requirements - General
F778	Assist with Transport Arrangements to Radiology	F851	Payroll Based Journal	F941	{PHASE-3} Communication Training
F779	X-Ray/Diagnostic Report in Record-Sign/Dated	**483.75**	**Quality Assurance and Performance Improvement**	F942	{PHASE-3} Resident's Rights Training
483.55	**Dental Services**	F865	QAPI Program/Plan, Disclosure/Good Faith Attempt	F943	Abuse, Neglect, and Exploitation Training
F790	Routine/Emergency Dental Services in SNFs	F867	QAPI/QAA Improvement Activities	F944	{PHASE-3} QAPI Training
F791	Routine/Emergency Dental Services in NFs	F868	QAA Committee	F945	{PHASE-3} Infection Control Training
483.60	**Food and Nutrition Services**	**483.80**	**Infection Control**	F946	{PHASE-3} Compliance and Ethics Training
F800	Provided Diet Meets Needs of Each Resident	F880	Infection Prevention & Control	F947	Required In-Service Training for Nurse Aides
F801	Qualified Dietary Staff	F881	Antibiotic Stewardship Program	F948	Training for Feeding Assistants
F802	Sufficient Dietary Support Personnel	F882	Infection Preventionist Qualifications/Role	F949	{PHASE-3} Behavioral Health Training
F803	Menus Meet Res Needs/Prep in Advance/Followed	F883	*Influenza and Pneumococcal Immunizations		
F804	Nutritive Value/Appear, Palatable/Prefer Temp	F884	**Reporting – National Health Safety Network		
F805	Food in Form to Meet Individual Needs	F885	Reporting – Residents, Representatives & Families		
F806	Resident Allergies, Preferences and Substitutes	F886	COVID-19 Testing-Residents & Staff		
F807	Drinks Avail to Meet Needs/P references/ Hydration	F887	COVID-19 Immunization		
F808	Therapeutic Diet Prescribed by Physician	F888	COVID-19 Vaccination of Facility Staff		
F809	Frequency of Meals/Snacks at Bedtime	**483.85**	**Compliance and Ethics Program**		
F810	Assistive Devices - Eating Equipment/Utensils	F895	{PHASE-3} Compliance and Ethics Program		

Long Term Care Survey Process (LTCSP) Procedure Guide

Effective October 23, 2023

I. OFFSITE PREP

Step 1: Create survey shell in ASPEN Central Office (ACO)

- Create a survey shell in ACO according to your state practice.
- Add team members in ACO and designate the team coordinator.
    - Expand the facility's name.
    - Right click on the Event ID.
    - Select Team Roster from the list. It is recommended to add the team in ACO.
    - Select Update.
    - Check the box for each team member that will participate in the survey. Ensure each person has a check next to his or her name. Select **OK**.
    - Highlight the surveyor that is Team Coordinator (TC). Select Leader. The TC will have a diamond in front of their name.
    - Select Done.
- Link any complaints and Facility Reported Incidents (FRIs) to the survey according to your state practice.
- Based on state practice, you may enter the Offsite Prep information (excluding outstanding complaint/FRIs and the CASPER 3 review) directly into ACO.
    - Right click on the Event ID.
    - Select LTCSP Offsite Preparation.
    - Complete the available Offsite Prep screen items.
    - The ACO version of the Offsite Prep screen includes the current status for complaints. For any complaint being investigated during the survey, ensure the complaint(s) is linked to the Standard survey. **Complaint intakes not linked to the Standard survey will not be accessible to the team on the Offsite Prep screen in the LTCSP system.**
    - When the shell is exported from ACO, the ACO Offsite Prep information will be transferred and displayed on the LTCSP Offsite Prep screen.
    - When transferring information, the system shall present merge screens (i.e., Source and Destination) if there is already offsite prep information in the LTCSP system. The TC will then decide whether to retain the Source of Destination information.

LTCSP Application HELP

- Contact the designated state technical lead according to your state procedures for any hardware or software difficulties.
- If an "unhandled exception" error message occurs while using the LTCSP application OR you are having technical issues, make a print screen of the message or technical

concern. While still on the screen, press the Function [Fn] key and the Print Screen [Prnt Scrn] key. Open a new Word document and paste the print screen [Ctrl+V]. Describe in the Word document the actions being completed just before the error message or technical concern. Send the document to your state technical lead.

- If the designated state technical lead is not available and the technical difficulty stops the survey process, contact the QTSO Help Desk (1-888-477-7876). Inform the Help Desk responder that the contact is about a LTCSP and immediate assistance is required because the team cannot continue with the survey until the issue is resolved.
  - To send Server Log Files to the QTSO Help Desk, in the LTCSP left-side navigator menu go to System, click on Email Server Log, use the drop-down next to Log File to select the date(s) of the concern, and click Save. If you have internet access, you will be directed to email the Log Files to the QTSO Help Desk. If you do not have internet access, save the Log Files to email at a later time.

Step 2: Export shell from ACO

- In ACO, export the shell according to your state practice (e.g., flash drive or via Direct Connect) as close to the survey start date as possible but no more than 5 business days before the survey start date so the exported shell has the most up-to-date Minimum Data Set (MDS) data.
  - During the transfer, if there are no residents included in the shell you will receive a warning indicating there is no available MDS assessment data. It is recommended that the SA's MDS/RAI Coordinator resolve the issue if possible (e.g., address submission concerns with the facility) and reschedule the survey once the issue has been resolved. It is critical to have MDS data for the survey, if at all possible.
  - If the survey shell has already been exported, you will see a warning. You should only overwrite the data if the survey start date has significantly changed (e.g., the survey was postponed or delayed) or if you originally pulled the shell more than 5 working days before the survey start date. Otherwise, you will always answer No to the warning to avoid overwriting the data (e.g., when the SA attaches additional complaints after the survey has begun).

Step 3: Import shell into ASPEN Survey Explorer (ASE-Q)

- In ASE-Q (also referred to as ASE), import the shell according to your state practice (e.g., flash drive or via Direct Connect).
  - Click on the **Import** button.
  - Insert the **USB drive** (if using).
  - Select **Other Zip File Location**.
  - Click on the binoculars.
  - Locate the shell.
  - Switch to **All Files** if you renamed the shell - The default file type is ASPEN Export (ASPENTx.zip).

- Click the drop-down and select **All Files** (*.*).
- Double click on the survey shell.
- Click **OK.**
- Select **Continue with Import** in the Survey Import dialog box.
- During the transfer (both import and export), a **pop-up** will appear displaying the number of residents included in the shell (i.e., Residents Exported). This number will be used to identify the **maximum number of complaints/FRIs that may be included in the initial pool** (Step 6 below) since the number is **indicative** of the facility census size. If the number of residents is reasonable, click **OK**.

  NOTE: **Ensure there is an adequate number of residents included in the shell** as compared to the facility bed size. If there are very few residents, again the SA may need to resolve the issue with your SA's MDS/RAI Coordinator and the facility, if appropriate, which means the survey may need to be delayed depending on the specific circumstances.
- Click **Apply.**
- If there are Complaints or FRIs that will be investigated with the survey, they will appear under the event ID with a COMP or FRI indication.

Step 4: Add team members in ASE-Q (if team composition changes)

Best practice is always to add team members in ACO, but you can add them in ASE-Q when necessary (e.g., team members were changed after the shell was exported or added later in the survey process).

- **Team composition changes**: Add them in ASE-Q when necessary (e.g., team members were changed after the shell was exported or added later in the survey process).
  - **If a new surveyor is added to the team** because a surveyor (TC or team member) does not return, follow the steps below. You will **not** be able to remove the outgoing surveyor from the team roster in ASE-Q since the surveyor has data. Note: The only exception is if the team has not entered the facility yet. In that case, the TC should unassign facility tasks from the surveyor and then remove the surveyor from the team.
    - TC receives data from all team members. Team members should not continue to work in the system until the TC shares data with the team to reflect the incoming surveyor. However, if team members must continue to work in the system, the TC should receive the updated data before sending the consolidated data back to the team.
    - TC adds the new surveyor to the team roster in ASE-Q.
    - In ASE-Q, click on the appropriate alphabetical grouping
    - Click on the plus sign next to the facility name
    - Right click on the Event ID
    - Right click on **Team Roster**.

- Click on **Update Team**.
- Click on the Update button.
- Place a **checkmark next to each team member's name**, when all survey team members are selected, click **OK**.
- If you are adding more than one surveyor to the team, ensure each team member adds the names in the same order. Adding team members in ASE-Q in different orders could lead to duplicate resident IDs.
- To confirm there are no issues, every team member should go to the data sharing screen in the LTCSP system and confirm the system ID (last column in the table) is the same for each team member on all computers. If not, in the System ID column for the applicable surveyor, double click on the inconsistent number and manually update the system ID number, so they match.
- TC assigns areas to the new surveyor using the Investigation Assignments screen.
- **Export** the updated survey in ASE-Q for the incoming surveyor.
- The incoming surveyor should **import** the survey in ASE-Q.
- The TC shares data with the team in the LTCSP system to reflect the incoming surveyor and the updated assignments.

  - If **there** is a change within the team: **If the TC changes**, just change the TC designation in the team roster in ASE-Q. **Highlight** the name of the **TC (Team Coordinator)**, click **Leader** (a blue diamond will appear by the TC's name), then click **Done**. If a **team member leaves**, all team members should share their data with the TC, and then the TC should share the consolidated data back to the team after redistributing workload via the Assignments screen (if desired), or other team members can redistribute the outgoing team member's assignments accordingly on the Investigation screen.

Important: The system will protect the data and not allow a team member to be removed if they have contributed any data to the survey.

Step 5: Access the survey

- There are two ways to access the LTCSP survey:
  - Right click on the Event ID and select LTCSP from the drop-down menu.
  - Right click on the Event ID, select **Citation Manager,** and click the **LTCSP Survey button**.
- If you receive a warning message that the system is unable to connect to the server, click on the LTCSP button again and you should be able to access the LTCSP survey on the second try.

Step 6: TC completes offsite prep screen

- Click on Survey Preparation | Offsite Prep in the navigation menu.
- The administrator's name and previous survey date will automatically populate.

- Review the **CASPER 3** report for pattern of repeat deficiencies. Document your findings in the CASPER 3 report notes field.
- Document the **results** of the **last Standard survey**.
- Review **complaints (COMP)** and **Facility Reported Incidents (FRI) since** the **last Standard survey** to gain a general understanding of repeated issues or concerns that have been reported.
- Review the **CASPER PBJ Staffing Data Report** for identified concerns regarding staffing.
  - The TC can enter concerns from different quarters using the drop-down box.
  - For Standard Recertification Surveys **without** a staffing related complaint/Ombudsman concern, the TC should review the **most recent quarter** of staffing data available.
  - For Standard Recertification Surveys **with** a staffing related complaint/Ombudsman concern, the TC may need to review **previous quarters** reflecting a specific time period.
  - Use the Yes/No drop-down to indicate whether the facility has any staffing concerns.
  - If Yes, place a checkmark in the "Selected" column, next to the applicable staffing concerns. Identify the Fiscal Year (FY) quarter and year for each area of concern. The quarter and year will automatically populate after the first entry. Update the information, as needed.
    - *If the facility failed to submit PBJ data, CE1 (F851) on the Sufficient and Competent Nurse Staffing pathway will automatically be marked as No. Cite F851 at an F-level. Note: If the facility failed to submit PBJ data for a previous quarter but shows evidence that they have corrected the reporting noncompliance, the facility still must be cited, but can be cited at past noncompliance.*
  - Document details regarding the staffing concerns (e.g., infraction dates) in the Staffing Notes field.
  - Use the Yes/No drop-down to indicate if the facility has a **nurse staffing waiver** in place.
  - Document the specific staffing waiver details in the Staffing Waiver Notes field.
  - *Attach the PBJ staffing report by clicking on the paperclip icon on the far-right side and follow the instructions on the screen.*

  Note: There is a lag time between when the facility submits their staffing information and when that information is available as a **CASPER PBJ Staffing Data Report.**
- If you are investigating **complaints or FRIs** with the survey, identify the **maximum number of complaints/FRIs residents that may be included in the initial pool and sample based on the facility census size** (i.e., the number displayed on the pop-up when the survey shell was imported in Step 3)**.** This information is shown in **Attachment A to the LTCSP PG** (The Sample Size Grid, Recommended Team Size, Initial Pool Size, and Complaint/FRI Size). If you are including on a survey more than the designated maximum number of complaint/FRI residents for the facility census size, any residents over the maximum are considered **additional** complaint/FRIs; do

not include these additional complaint/FRI residents in the initial pool or sample. You will only investigate the allegations for these **additional** (i.e., more than the designated maximum number) residents.

- The **active/outstanding complaints/FRIs** that were linked from the ASPEN Complaints/Incidents Tracking System **(ACTS)** will be **listed on the Offsite Preparation screen** in the table. The following information is linked to each complaint/FRI: Intake ID with a link to notes entered in ACTS, Type (COMP or FRI), Complaint Resident Name from ACTS, and an indicator if the complaint resident is also an offsite selected resident. Expand the intake ID (using the down arrow) to review the allegations with a link to notes entered in ACTS. State-only complaints will be identified as such.
  - Review the intake ID notes and allegation notes to identify the concern.
  - Unknown/anonymous complaints are when the resident is unknown. The system will default the LTCSP Resident column to the general facility placeholder titled "Facility, Facility." Select Facility, Facility if the complaint resident is listed as anonymous.
  - If a resident is identified but was not added in ACTS, add the resident in ACTS, export the shell, but do not overwrite the data.
  - For any complaint resident identified, link the complaint resident name to the name listed in the LTCSP system by using the drop-down box under LTCSP Resident-Room.
  - If the resident isn't listed in the LTCSP Resident-Room drop-down, add the resident to the resident list by clicking on the Add New Resident icon above the table (be sure to first check the Resident-Room drop-down, as you do not want to add the resident if the resident is already in the system). Mark complaint/FRI as the subgroup. Identify the surveyor who will be assigned to the resident for the initial pool. You do not need to add a room number or admission date at this time. Click Save. Once added, select the resident from the drop-down in the LTCSP Resident-Room column. The resident will be automatically included in the initial pool. If you do not want to include the resident in the initial pool, deselect the checkmark in the In Pool column.
  - Identify the LTCSP areas that require investigation based on the allegations.
  - For residents included in the initial pool with allegations that are covered by the initial pool and for general complaints covered by the initial pool, add the **Initial Pool Areas**. Select the drop down next to the complaint or FRI intake ID. Click on Add the Initial Pool Area and select the applicable Initial Pool Area for that complaint or FRI. Click on each Intake ID and allegation to review notes (see below for including the resident in a facility task, closed records, or directly to an investigation). Once added, the areas will be listed next to the Care Areas label in the drop-down menu. The initial pool areas identified for general complaints will be flagged as a complaint for all initial pool residents.
  - If there are more complaint/FRI residents than the designated maximum identified in Attachment A, or an initial pool complaint/FRI resident has an allegation area that is not covered by the initial pool (e.g., a tag that is not mapped to the initial pool such as self-administration of meds or blood pressure medications), add the

area to be investigated using the **Directly Add New Investigations** option**.** Once added, the areas will be listed next to the Investigations label. The resident and investigation will be displayed on the assigned surveyor's investigation screen.
    - If the allegation is related to a mandatory or triggered **Facility Task**, add the task, which will be displayed on the facility task screen. Triggered facility tasks and sufficient staffing also will be displayed on the initial pool screens.
    - If the allegation is related to a **Closed Record**, add the closed record area, which will be displayed on the closed record screen.
  - Include the maximum number of complaint/FRI residents in the initial pool (refer to Attachment A for the maximum number) by placing a checkmark in the **In Pool** column and assigning the initial pool surveyor.
- Use the Yes/No drop-down to indicate whether the facility has a **history** of **abuse** allegations, **patterns of abuse**, or **citations** since the prior standard survey. This information can be useful to the survey team to help understand what issues may be present in the facility. Ideally, survey teams would review complaints and FRI's that have been reported since the last recertification survey during offsite prep. We believe this information is very important but understand that reviewing complaint and FRI information may be difficult, and that States have different ways of documenting these events. Therefore, we encourage States and survey teams to understand this information prior to entering a facility; however, it is not required.
- Note any facility Federal **variances/waivers**.
- Note **active enforcement cases** that should not be investigated (e.g., pending complaints already investigated that have a civil money penalty).
- **Contact the Ombudsman** in accordance with the policy developed for communicating between the State survey agency and State ombudsman agency. Notify the ombudsman of the proposed day of entrance into the facility and if applicable, obtain any information/concerns. Ascertain whether the ombudsman will be available if residents wish her/him to be present during the Resident Council Interview. Enter the Ombudsman's name, number, contact date, and areas of concern.
- Review CDC, state/local public health information, if available, to be aware of the **COVID-19 status of the facility** including the level of community transmission.

Step 7: TC makes facility unit assignments

- **On the offsite prep screen**, **assign all units** equally across the team members using last year's floor plan.
  - Do not assign the same surveyor to the rehab and Alzheimer's unit.
  - If the facility's rehab unit is large, consider assigning two surveyors to cover it.
  - Consider the location of offsite selected residents and complaint or FRI residents.
  - Keep surveyors on one unit/floor as much as possible. Be mindful of the number of residents in each surveyor's workload. The expectation is that each surveyor screens all residents in their assigned area and includes about eight residents (may be adjusted depending on team size) in the initial pool.
  - Assign units according to surveyor specialty, when applicable (e.g., assign a social worker to the dementia care unit).

- To attach a copy of **the** floor plan with assignments in the software, click on the paperclip icon on the far-right side and follow the instructions on the screen.

Step 8: TC makes mandatory facility task assignments

- **Assign mandatory facility tasks** by selecting Investigation | Facility Tasks from the Navigation menu:
  - Beneficiary Notification Review
  - Dining Observation (assign all surveyors who are assigned to a dining area or room trays, select the Primary surveyor, and communicate who has primary responsibility)
  - Infection Control (assign all surveyors, select the Primary surveyor, and communicate who has primary responsibility)
  - Kitchen
  - Medication Administration
  - Medication Storage and Labeling
  - QAPI/QAA Review
  - Resident Council Interview
  - Sufficient and Competent Nurse Staffing (assign all surveyors, select the Primary surveyor, and communicate who has primary responsibility)

Step 9: TC prints documents

- **Print the following documents** (click the Reports icon – the clipboard without a pencil - on the right side of the screen or press **Alt+P**). If you are not printing the reports from the LTCSP system, ensure you are using the most recent version of the reports.
  - Facility Matrix with instructions (1 copy of instructions, multiple copies of the blank matrix)
  - Entrance Conference worksheet (1 copy)
  - Beneficiary Notices worksheet (3 copies) – The worksheet is titled, "Beneficiary Notification Review" in the Reports window

Step 10: TC shares offsite prep data with team members

The TC should **share the completed offsite prep data** with team members using the Data Sharing screen. **The Data Sharing Methods** instructions below **should be used for all data sharing throughout the survey.**

Data Sharing is always performed between the TC and team members. Team members cannot share data between themselves.

To **access the Data Sharing screen** click on the **flash drive icon** on the right tool bar menu or use **ALT + D**.

DATA SHARING METHODS

Using the File method

- **IMPORTANT:** TC should always receive data from all team members before sending the consolidated data back to the team if the team members have updated information. If team members share data with the TC, make additional changes in their system, and then receive data from the TC without sharing their newly added information, any newly added information may be lost.
- Some data sharing steps only require the TC sending out data (e.g., offsite prep or investigation assignments), so the sharing of data from team members can be skipped. For example, the TC shares offsite preparation data to team members without needing to receive any data from team members.
- File used for data sharing can be written to a USB device, to a central location accessible by all surveyors, or to another location where it can be sent by secured email**.** The file browser will default to the USB device if one is entered and the desktop if no USB device is found**.**
- In order to send or receive data, team members need to be on the Survey Team Data Sharing screen.
- To send data to TC, all team members should:
  - Insert a flash drive.
  - Click **Send Data**.
  - A file browser will open and default to the flash drive folder with the correct file name entered.
  - Click **Open**.
  - Message will confirm that data was successfully sent.
- To receive team member data, the Team Coordinator should:
  - Insert the flash drive containing one or more files from the team members.
  - Place a checkmark next to the team members' names.
  - Select **Receive Data**.
  - The flash drive folder should automatically appear. If not, browse to the flash drive.
  - The title of the browser window will contain the name of the survey team member it is currently processing.
  - Ensure the correct flash drive is entered and the correct file for that surveyor is selected. File name will default to the correct name for the team member currently being processed.
  - Click **Open**.
  - Message will confirm that data was successfully received.
- To **send consolidated data to team members** the Team Coordinator should:
  - Insert a flash drive.
  - Place a checkmark next to the team members' names.
  - Click **Send Data**.
  - The flash drive folder should automatically appear. If not, browse to the flash drive.

- Click **Open**.
- Message will confirm that data was successfully sent.

- To **receive consolidated data from the TC**, all Team Members should:
  - Insert the flash drive containing TC file.
  - Click **Receive data**.
  - The flash drive folder should automatically appear. If not, browse to the flash drive.
  - The TC's data file will automatically appear
  - Click **Open**.
  - Message will confirm that data was successfully received.

Using Secured Wireless method or using Wired method with a switch:

- If using other wireless network(s) during the survey (e.g., a facility provided network) ensure that all team members have disconnected from those networks prior to sharing data. Disconnect from your VPN as well.
- All team members must be connected to the same secured wireless or wired router your state is using for data sharing.
- To ensure that all team members receive data from all the other team members, it is recommended that all team members share data through the TC at the same time**.** This may not be possible when a team member has to leave the survey but is recommended at all other times.
- The **Team Coordinator should**:
  - Ensure everyone is connected to the same secured wireless connection or plugged into the same wired switch.
  - Select all the team members' names you want to share data with.
  - Ensure the team members have a server defined:
  - Use the pull-down to find the team members' machine.
  - The **Reload Server List** button can be used to refresh the pull-down list
  - ***OR*** have entered the Machine Address (IP).
  - Enter the IP address exactly as it is written on the team member's machine.
  - Click **Share Data Now**.
  - The TC will receive a message noting each team member that successfully sent data to the TC and each team member that successfully received data back from the TC.

Using Secured Wired method using a cable to connect two machines:

- If using other wireless network(s) during the survey (e.g., a facility provided network) ensure that all team members have disconnected from those networks prior to sharing data.

- Since this method involves connecting a single team member's machine to the TC at a time, multiple passes will be required to ensure everyone has received all data.
- The **Team Coordinator should**:
  - Connect the wire between a team member's machine and their machine.

- Select the team member's name from the list.
- Click **Share Data Now**.
- The TC will receive a message indicating the team member was successful in sending data to the TC and the team member successfully received data back from the TC.
- Repeat for each team member.
- To send consolidated data back, perform the same steps as above but reverse the order of the team members.
- You can skip the last team member since they have all team member data.

Note: **Surveyors should not export and import the survey shell in ASE-Q**. Instead, they should **share data within the LTCSP system**. The only time during the survey that an export is completed is when a team member is added to the team after the survey has begun and the TC exports the shell from ASE-Q to that surveyor.

Step 11: Team reviews offsite information

- **Team members independently review the Offsite Prep information prior to entering the facility.** There is no required offsite prep team meeting.
  - Review all information on the **Offsite Preparation screen** including the details for any general complaint or complaint/FRI residents assigned to you.
  - **MDS Indicator Facility Rate Report**. Review the report to get a sense of how many residents and which MDS indicators are of potential concern at the facility. Click on the Reports icon – the clipboard without a pencil - on the far-right side of the screen. Check the box in front of MDS Indicator Facility Rate Report, and then click the Run Reports button at the bottom of the page.
  - **Offsite selected residents**. Review the list of offsite selected residents and their MDS indicators. To access this list, click on the Reports icon, select Offsite Selected Resident List and click Run Reports. You also can review this information by going to Interview | Resident Manager in the Navigation menu, then filtering by group and choosing Offsite Selected. Next, click on Sort residents and choose Room to see the names of the offsite selected residents who are on your unit (based on the MDS-provided room number). Double click each resident's name to review their MDS indicators listed at the top right of the screen.
- **Assign yourself (in the software) to the offsite-selected residents** in your assigned unit/area, **if desired, or wait to do this onsite** when you know that the MDS room numbers are accurate. Once onsite, if you find the MDS room numbers are inaccurate, update the room numbers in the system with the room numbers provided by the facility.
- Ensure the electronic **Survey Resource Folder** is downloaded and saved to your desktop. The folder is located at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html.
- **Supplies**
  - The team should bring a power strip with surge protector for use as needed (do not use an extension cord).

II. FACILITY ENTRANCE

Step 12: Enter the facility and go to your assigned area

- TC: Upon **entering the facility, discuss with the Administrator information needed from the facility immediately,** which are listed on the Entrance Conference screen (located under Survey Preparation | Entrance Conference in the Navigation menu) **prior to conducting the brief Entrance Conference**. Ask facility about any policies for entering/exiting special units, if applicable.
- TC: Conduct a brief **Entrance Conference** (under Survey Preparation | Entrance Conference in the Navigation menu) and then go to your assigned area.
- The first time you click on the Entrance Conference screen, the date and time will populate at the top of the screen. To reflect the current **date and time,** click on the **Set** button. You cannot change the date or time to an earlier time period.
- Cover the remaining items on the entrance conference screen and ensure the administrator/facility representative understands what is needed.
- Ask the Administrator to make the Medical Director aware that the survey team is conducting a survey. Invite the Medical Director to provide feedback to the survey team during the survey period if needed.
- The facility should **exclude** bed holds from the facility census number.
- While you request the Facility Assessment upfront, you will only review it if there are systemic concerns identified in resident-specific areas (e.g., hospice, dialysis, ventilators, activities, nutrition, behavioral/emotional, dementia) or if there is a systemic concern with a lack of adequate resources (e.g., specialized rehabilitation, pharmacy).
    - Place a checkmark on the screen next to items once they are received, if desired. Document any notes regarding the Entrance Conference under the Notes field at the bottom of the screen.
- Indicate whether the facility has asked a resident or his/her representative to enter into a **binding arbitration agreement**. If the response is Yes, the arbitration task will be triggered. **Add three residents** (preferably two residents who signed a binding arbitration agreement and one resident who resolved a dispute) who will be reviewed for the task, if appropriate (e.g., there are only two residents on the list). Residents can be added using the "Add Residents For Task" icon or via the facility task screen in the resident box.
- Surveyor assigned to kitchen: Conduct an initial brief visit to the **kitchen** and then go to your assigned area. To access the kitchen task pathway:
    - Go to Investigation | Facility Tasks under the Navigation menu.
    - Verify that you are assigned to this task. If not, click the Assigned To drop-down list for Kitchen, select your name and click somewhere on the screen or press Esc(ape) to close.
    - Double click on Kitchen to open.
    - Review the guidance for each CE on the screen (applicable probe section is listed

before the CE) or by using the Pathway button.
  - Document any concerns under the Notes section.
  - In tablet mode, use your stylus to document your kitchen observation just as if you were writing on a piece of paper.
- **All other surveyors: Go to your assigned areas.**
- **Ask for** a **resident roster** for your assigned area with an indicator for the **new admissions** in last **30 days** (in addition to the nurse verbally identifying new admissions) and then begin your initial pool process. The facility will provide a matrix for new admission residents and then a matrix for all other residents a few hours into the survey. **Do not wait for the roster or matrices** to begin screening residents.

Note: If this is an **off-hour survey**, complete this step with the designated person in charge. Conduct a follow-up Entrance Conference with the administrator, as needed, upon his/her arrival at the facility.

III. INITIAL POOL PROCESS

Step 13: Briefly screen all residents in your assigned area and observe, interview, and complete a limited record review for initial pool residents

Overview:

During the initial pool process, you will **briefly screen all residents in your assigned area** to identify **about eight residents (per surveyor)** to include in your **initial pool.** The number of residents per surveyor could vary depending on the number of surveyors on the team (see below). The first eight to ten hours onsite are primarily spent completing the initial pool process. The initial pool process entails **screening all residents** in the facility and **narrowing down** residents, first to an initial pool of about eight residents per surveyor. Surveyors complete an observation, interview (if appropriate), and limited record review for the initial pool residents to help the team **further narrow residents from the initial pool to identify residents for the sample as well as potential concerns that exist in the facility and warrant further investigation (FI)**.

This section describes the following areas: the initial pool workload, the screening process, initial pool resident subgroups, organization options for conducting the screening process, completing the interview, observation, and record review for initial pool residents, and the system procedural steps for completing the initial pool process.

Initial Pool Workload:

Attachment A to this document (*Sample Size, Recommended Team Size, Initial Pool Size, and Complaint/FRI Size*) shows the **expected initial pool size** according to the **recommended survey team size**. For example, if the recommended survey team size is four surveyors, then each surveyor is expected to have about eight residents in their initial pool, which results in an initial pool of about 32 residents across the survey team. States

should **adhere closely to the expected initial pool size but can change the team size** if beneficial.

- If a State decides to send **more than the recommended number of surveyors** on a survey (e.g., to finish the survey more quickly), then it is acceptable for the team to split unit assignments and distribute the expected initial pool size across the larger team. For example, if a State sends a team of six surveyors when the recommendation is four surveyors, then the expected initial pool size remains 32 residents. These residents can be distributed across the team (e.g., four of the six surveyors have five residents in their initial pool and the other two surveyors have six residents in their initial pool).
- If a State sends **fewer than the recommended number of surveyors**, the smaller team also must adjust their initial pool numbers. For example, if a State sends three surveyors when the recommendation is four surveyors, then the three surveyors must still include about 32 initial pool residents across the team, or two surveyors with 11 initial pool residents and one surveyor with 10 initial pool residents.

Screening:

The purpose of briefly **screening residents in your assigned area** is to identify residents to include in the initial pool. Go **room to room** without staff. Screening and initial pool selection is based exclusively on surveyor-identified information and is not reliant on staff input at this point.

- **All offsite selected residents (unless discharged)** and **any complaint/FRI residents** (maximum number as outlined in Attachment A) are to be **included in the initial pool**, and therefore do not need to be screened. If the facility census is lower than what was expected, you do not have to remove any complaint/FRI residents added during offsite prep. If the facility census is higher than what was expected, additional complaints/FRI residents (up to the maximum) may be included in the initial pool. The TC should update the information on the offsite prep screen (Step 6) and share the data with the team (Step 10).
- You will screen all other residents to determine if they should be in the initial pool as onsite selected residents. If the team is including the maximum number of complaint/FRI residents in the initial pool, there may be fewer slots open in the initial pool for onsite selected residents. Prioritize and include residents with a higher number and/or more serious concerns in the initial pool even if this results in a slightly higher initial pool workload.
- Before you enter each room, **review the MDS indicators** (by selecting the Initial Pool (IP) Indicator option which is the colored lettered icon, to the left of the resident's name) **and matrix information** (if available) for the residents you will be screening in the room to give you a more complete picture. You also will know ahead of time if they are newly admitted residents.
- If you have no concerns based on the MDS indicators and matrix information, **conduct a quick head-to-toe observation** of the resident. If there are no

observation concerns, the screening is complete.

- If you identify a concern during your quick observation (e.g., staff are ignoring a resident yelling out in pain; resident has facial bruising) OR if you have a concern based on your review of the MDS indicators or matrix, introduce yourself and ask a few high-level questions (e.g., How long have you lived here? Do you have any concerns with your care?) and then ask the resident about your identified concern(s) to help decide if the resident should be included in the initial pool.
- Interactions should be quick to allow time to complete full interviews and observations with residents who are selected for the initial pool.
- Include **any newly admitted or vulnerable resident with potential concerns** in the initial pool. If numbers are too high, you may need to prioritize based on the most significant potential concerns and whether a potential concern is unique to a resident or if it is present for other residents who will be in the initial pool.
- If you identify a resident for the initial pool who is not in another subgroup (i.e., the resident is not offsite selected, complaint/FRI, new admission, or vulnerable), this resident will be included in the "Identified Concern" subgroup.
- There are no initial screening questions or screening tool included in the system. Conduct the screening based on your knowledge and critical thinking skills.

Here are three illustrative examples for the brief screening:

- Resident A has an MDS indicator for depression (and no other MDS indicators). The matrix shows the resident is receiving an antidepressant. I observe the resident in her room, well groomed, dressed appropriately, and playing cards. I have no observation concerns. My screening is complete and I would not include this resident in the initial pool.
- Resident B (who is not vulnerable or a new admission) has an MDS indicator for weight loss. I have not received the matrix yet. The resident is in her room at 8:30 am with her breakfast meal on the over-the-bed table. The resident consumed 100% of her breakfast. After introducing myself, I ask a few high level questions (e.g., how long have you lived here; do you have any concerns with your care?). I would then ask about the food and weight loss. The resident says she likes the food. The resident says she had a cold and lost her appetite a couple months back but has gained the weight back. My screening is complete after a couple of minutes and I would not include this resident in the initial pool.
- Resident C (who is not vulnerable or a new admission) has no MDS indicators listed. When I first observe the resident I haven't received the matrix yet. The resident is sitting in her recliner talking to another resident. I don't have any concerns based on my observations from the hall. An hour later, I receive the matrix. The matrix indicates the resident has a facility acquired pressure ulcer. I go back to the resident's room, introduce myself, ask a few general questions, and then ask if the resident has had any issues with her skin or any pressure ulcers. The resident says she had a pressure ulcer on her heel from a pair of new

shoes she got from her daughter. She said she wore them for a day and did not realize they were hurting until she took them off and she had an open area on her heel. The resident said the daughter returned the shoes and got a pair that are more comfortable. The resident said her sore was now healed and she has had no other issues. My screening is now complete and I wouldn't include this resident in the initial pool.

- During your screening, you are required to change the IP Indicator to Yes for the residents included in the initial pool. In addition, you may use the IP Indicator to help keep you organized during your screening.
  - All residents, excluding offsite selected and complaint/FRI residents, will have a default IP Indicator set to Unknown (gray U) which means the resident has not yet been screened. Offsite selected and complaint/FRI resident (who were included in the initial pool during offsite prep) will have a default of Yes (green Y).
  - Once you decide to exclude a resident from the initial pool you may change the IP Indicator to No (red N).
  - If a resident is unavailable (e.g., not in the room, sleeping) OR you identify a concern but aren't sure whether you want to include the resident in the initial pool, you may change the IP Indicator to Maybe (yellow M). Any resident who has an IP Indicator of Maybe is not part of the initial pool.
  - Once you know you will include a resident in the initial pool, the IP Indicator should be set to Yes.
- You are not required to document the results of your screening. However, it may help keep you organized as you determine who to include in the initial pool.
  - If you would like to **document your screening results** (e.g., Resident A is playing cards, well groomed – not for pool; OR Resident A is leaning in w/c, dirty nails – consider for pool) or take notes for the residents in your assigned area to help keep you organized (e.g., out of room, in therapy next half hour), document these notes under the **Surveyor Notes**.
  - To **pin Surveyor Notes** so they remain static on the Resident List and Card Views, click on the Surveyor Notes icon on the far-right side of the screen and select the pushpin icon in the upper right corner.
  - **Highlight** information in Surveyor Notes by using the highlight icon.
  - If **information is deleted** from your Surveyor Notes, view the document history by clicking on "hx". The "hx" is located on the surveyor notes tool bar. Select the date and time to determine if the information was **saved in the history**. If so, copy and paste the text from the history into the Surveyor Notes screen.
  - **Do not document your screening results on the RI, RO, RR screens**. You should not be completing the RI, RRI, RO, or RR areas when screening – these are to be completed only for residents that are included in the initial pool. The RI, RO, RR screens are read-only until the IP Indicator is set to Yes (i.e., these screens can only be completed for residents included in the initial pool).
  - **Do not enter an interview status** for any resident not included in the initial pool.
- If you determine that one of the residents you have screened will be in the initial pool and you have notes in the Surveyor Notes section, you can copy and paste those notes into the correct Initial Pool Care Area.
- If you exclude a resident from the initial pool, you do not have to update the resident list (e.g., add a resident not listed, update room number or d/c status) if the resident's

information in the system is incorrect.

Initial Pool Residents:

You will **complete observations, interviews, and limited record review** for the residents who are in **your initial pool** following the process steps identified below.

The initial pool will be comprised of the offsite selected residents still remaining in the facility, active complaint/FRI residents, and the team's onsite-selected residents (i.e., vulnerable, new admissions, or identified concerns).

When you are assigned to complaint/FRI residents, complete the interview, observation, and limited record review as you would for any other initial pool resident. You may begin to obtain information about the allegation during these activities. However, it is during the investigation portion of the survey that you will conduct the investigation of the allegation and of any other areas you marked for further investigation during the initial pool activities, unless it appears that there may be a significant concern (Immediate Jeopardy or actual harm). Note: Refer to Attachment B for the *Policy for Including Complaints and FRIs with the Standard Survey.*

- If an initial pool complaint resident is discharged, the TC should update the complaint areas on the offsite prep screen (e.g., change from the initial pool to a closed record or areas that go directly to the investigation). If the surveyor has completed any information in the system, the team member should share data with the TC before receiving the updated offsite prep data share to avoid losing any of the team member's data.

You will decide which **onsite-selected residents** to include in the initial pool based on your **screening and review of MDS indicators** (by selecting the IP Indicator next to the resident's name or going to the RI/RO screen) **and matrix** information when available. The onsite-selected residents will include:

- **Vulnerable residents** (dependent on staff such as a resident who has Alzheimer's, dependent on staff for care, or is quadriplegic);
- **New admissions** in the last 30 days; and
- **Identified Concern** residents - those who have serious concerns but do not meet the definition of the other subgroups above. You will be required to provide a rationale if you include a resident in the Identified Concern subgroup. This subgroup is <u>not</u> intended for indicating when concerns have been identified for a vulnerable, new admission, complaint/FRI, or offsite selected resident. It is intended only to include residents with identified concerns who are not in another subgroup.

If there are too many residents in your area to include in the initial pool (e.g., more than eight offsite selected residents, or too many qualifying residents who have issues), discuss the issue with the team to create a plan (e.g., adjust workload or increase initial pool time). It is the team's decision whether to include a resident admitted early during the initial pool process.

Organizational Options for Screening and Initial Pool Residents:

You can **choose the order in which you do the screening and initial pool activities**. These are some options (there are pros/cons to each approach):

- **Option A: Interview and observe initial pool residents as you choose them during screening**
  - **As you conduct your screening**, immediately decide if a resident should be in your initial pool. If so, change the IP Indicator from Unknown to Yes and conduct the observation and interview (if appropriate) for the resident at that time.
  - If you have about eight residents in your initial pool before you have screened all residents in your area, you must proceed with screening all remaining residents in your area and include any other appropriate residents in the initial pool.
- **Option B: Screen all residents, identify your initial pool, then return to conduct interviews and observations for all initial pool residents**
  - When you have completed screening all residents, choose your initial pool residents. The IP Indicator of Maybe may be useful to help you quickly identify potential candidates.
  - Once you select the residents for the initial pool, change the IP Indicator to Yes and go back to the rooms to conduct observations and interviews for all of your initial pool residents.
  - You likely will encounter the offsite selected and complaint/FRI residents in your area during your screening for onsite selected residents and may begin the interview (if appropriate) and observation for these residents (ensure you are assigned to the resident) or you may wait until you return to the rooms after choosing your initial pool.
- **Option C: Interview and observe offsite selected and complaint/FRI residents first, then screen all other residents**
  - Assign yourself to the resident and then conduct interviews and observations for your offsite selected and complaint/FRI residents first. If other residents are in the room, you may screen those residents for inclusion as an onsite selected resident at that time.
  - When the above is complete, go to the rooms with no offsite selected or complaint/FRI residents, and briefly screen all residents following Options A or B.
- Regardless of the approach you use, **look at the resident names** on the door or resident roster **before you enter a room** and determine if the residents are offsite selected, complaints or FRIs, or new admissions (which the nurse told you or new admission matrix shows). For residents who are not listed in the above subgroups, you will determine if they are vulnerable or are concerning in some other way and if they should be included in the initial pool as onsite selected residents.

There are **two ways to view the residents** on the Resident Manager screen: Resident List (the screen is labeled as "Residents") or Card View (the screen is labeled "Incomplete Residents"). You can switch between these two views using the icon in the right upper corner of the screen.

There are two **organizational methods in the system** to help you manage the screening and initial pool process:

- **Organizational Option 1: Assign initial pool residents to yourself as you identify them.**
  - Go to Interview | Resident Manager in the Navigation menu.
  - Sort Residents by Room.
  - As you go room to room and identify a resident for the initial pool, change the IP Indicator from Unknown ("U") to Yes ("Y") which will automatically assign you to the resident if not already assigned.
  - **Once the IP Indicator is Yes and you are assigned, that resident is included in your initial pool.**
  - Anytime you do not see a resident listed in the system, you should first **search for the resident's name** using the search feature in the upper right side of the screen to avoid duplicating names. Enter the full first or last name in the Search box, click the magnifying glass; click the x to clear the search.
    - If you **accidentally duplicate a resident's name**, place a checkmark next to the name on the Resident Manager screen, click the Update Selected Resident icon, click Delete Resident, and then click OK. Ensure you use the resident name that was already included in the resident list since the resident will have MDS indicator information. If you have responses or notes under the resident you've incorrectly added to the system, you will receive a warning message informing you to transfer the information to the correct resident.
    - If the resident is a new admission, the resident may not be in the Resident List, so you will add the resident using the Add New Resident icon (a bright blue person with a plus sign) at the top of the screen only if you decide to include the resident in the initial pool. Do not add New Residents if they will not be in your initial pool. Ensure you search for the resident to avoid duplicating the resident's name. (Residents' names are listed in the system according to MDS information. There may be only slight differences in names). Enter the resident name, room number, and admission date.
    - The system automatically assigns you as surveyor.
    - The system automatically assigns **New Admissions** as the **Subgroup.** Update the subgroup as necessary using the drop-down (e.g., the resident is newly admitted and vulnerable). Click out of the box or press Escape (Esc) to close.
    - Change **IP Indicator** to **Yes**.
    - Click **Save**.
  - After changing the IP Indicator to Yes, **select the appropriate subgroups** for the resident. In **List view**: Click in the **Subgroup** drop-down for that resident; select all applicable subgroups; click out of the box or press esc(ape) to close. In **Card view**: Click the resident name; click **Subgroup** and select all applicable

subgroups from the drop-down; click out of the box or press esc(ape) to close; click Save. When you select **Identified Concern**, all other subgroups deactivate and cannot be selected.

- If you need to update an initial pool resident's information (e.g., room number), click on the Update Selected Resident icon (a gray person with a circular arrow) on the Resident List view or double click on the resident's name on the Card View.
- Double click on the resident's name to access the interview, observation and limited record review screens if using the Resident List view or select the RI, RO or RR icon for a resident if using the Card View. Note: the IP Indicator must be set to Yes in order to enter information on the RI, RO or RR screens.
- If an offsite selected resident is discharged, there are multiple ways to remove the resident from the initial pool: 1) unassign yourself, 2) place a checkmark in the D/C column, or 3) change the IP Indicator to No. Enter the discharge location (i.e., death, unplanned [facility-initiated] or planned [resident-initiated] discharge [to a location other than the hospital], or hospitalization). If you have marked any area of concern (i.e., further investigation) for a discharged resident, you will manually have to change the IP indicator to No if you want to remove the resident from the initial pool. If an offsite selected resident has moved to a different unit, unassign yourself or change the IP Indicator to No and select the option "Assign to another surveyor" which will unassign you from the resident but keep the resident in the initial pool.
- You are not required to discharge any resident (excluding offsite selected residents) who is no longer in the facility. If you accidently place a checkmark in the D/C column for a resident, the IP Indicator will change to No. You can remove the checkmark in the D/C column, if this was done in error and then you can include the resident in the initial pool again. If you have marked any area of concern (i.e., further investigation) for a discharged resident you will manually have to change the IP indicator to No if you want to remove the resident from the initial pool.

- **Organizational Option 2**: **Assign all residents in your area to yourself** (after you receive your unit assignment) **and then unassign them or change the IP Indicator to No as you determine they are not appropriate for the initial pool**.
  - Go to Interview | Resident Manager on the Navigation menu.
  - Sort Residents by Room.
  - On the Resident List view, place a checkmark next to every resident in your assigned area. Assign yourself as surveyor for one checked resident and the system will automatically assign all other checked residents to you.
  - Filter to My Residents and use either the Resident List view or the Card view – as you go room to room and identify a resident that you do not want to include in the initial pool, you can
    - Remove your name from the resident (on the Resident List view) or drag the resident to the Unassign folder (on the Card view) which automatically changes the IP Indicator to No, or
    - Change the IP Indicator to No, which will automatically remove the

resident from your assignment.
    - It is important to remove your assignment or change the IP Indicator to No from any resident who is not included in the initial pool.
  - If an offsite selected resident is discharged, there are multiple ways to remove the resident from the initial pool: 1) unassign yourself, 2) place a checkmark in the D/C column, or 3) change the IP Indicator to No. Enter the discharge location (i.e., death, unplanned [facility-initiated] or planned [resident-initiated] discharge [to a location other than the hospital], or hospitalization). You will manually have to change the IP indicator to No if you have marked an area for further investigation for a discharged resident. If an offsite selected resident has moved to a different unit, unassign yourself or change the IP Indicator to No and select the option "Assign to another surveyor," which will unassign you from the resident but maintain the resident in the initial pool.
  - As with Organizational Option 1, you are not required to discharge any resident (excluding offsite selected residents) who is no longer in the facility. If you accidently place a checkmark in the D/C column for a resident, the IP Indicator will change to No. You can remove the checkmark in the D/C column, if this was done in error and then you can include the resident in the initial pool again. You will manually have to change the IP indicator to No if you have marked an area for further investigation for a discharged resident.
  - Select all appropriate subgroups for residents added to the initial pool.
  - Once the IP Indicator is Yes, open the RI, RO and Limited RR screens for the resident. If using the Card view, click on the RI, RO or RR icon to access those screens. If using the Resident List view, double click on the resident's name to access the RI, RO, or RR.
- For both options, be sure to use the names on the door or the resident roster as your reference point to ensure you are aware of any room changes. If a resident has changed rooms and is no longer in your area, you are no longer responsible for that resident.

Process Steps for Initial Pool Residents:

- On the Resident Manager screen, filter to My residents to display residents assigned to you. Any resident with an IP Indicator of Yes or Maybe will be listed.
- **Review the MDS indicators** (by selecting the IP Indicator or going to the RI/RO screen)**, matrix information** (when available), **PBJ staffing data** concerns, and **active complaint/FRI allegations** prior to entering the room. The MDS indicators are displayed in the IP Indicator pop-up or in the top right corner of the resident's Interview and Observation screen.
- **Complaint/FRI information** is flagged as "Complaint" with a link to the allegation details and is displayed under the MDS indicators and next to the applicable area. Allegation or intake notes can be copied and pasted into the applicable notes fields.
- The **complainant's phone number**(s) will display on the far right on the Complaint link details pop-up (you may have to scroll).
- **CASPER PBJ Staffing Data information** is flagged as "PBJ Staffing" with a link to

the staffing details the TC entered on the offsite prep screen (i.e., specific staffing area of concern, notes, and staffing waivers). This information is displayed under the MDS indicators and "Complaint" link, if applicable, and next to the Sufficient Staffing initial pool area.

- The facility should complete the facility matrix within four hours (check the conference room periodically). Once the matrix is received, each surveyor will **review the matrix** for residents in their assigned area to identify any substantial concern that should be followed-up. At least one resident who **Smokes**, one resident who is receiving **Dialysis**, one resident on **Hospice,** one resident on a **Ventilator**, and *three* residents who are on **Transmission-Based Precautions** should be included in the initial pool for the team if available.
- If you have not already entered the applicable subgroups for the resident, you can do so on the Interview, Observation, or Record Review screens. Every resident in the IP should have at least one subgroup.
- In order to enter any information on the RI, RO or RR screens, the IP Indicator must be Yes.
- **Assess the interview status** of **residents in your initial pool** and mark one of the following in the **Interview status** field based on your assessment and critical thinking, regardless of the resident's BIMS score.
  - Interviewable – Conduct a full resident interview.
  - Non-interviewable – Skip the resident interview, but complete the observation and record review. The resident is a candidate for a resident representative interview (RRI)/family interview.
  - Refused - If the resident refuses, do not attempt to interview the resident again. Complete the record review and you still may be able to complete the resident observation unless the resident refused to be observed or participate in the survey.
  - Unavailable for Interview - If the resident is busy when you attempt an interview, make a few more attempts or try to schedule an appointment before marking this option, but still complete the resident observation (as you are observing the resident during each encounter) and limited record review.
  - Out of Facility – If the resident is out of the facility for the duration of the initial pool process (dialysis), mark this option but still complete the record review.
- **If the initial pool resident is interviewable, conduct a full resident interview (RI)** using the RI in the survey software.
  - Conduct the interview in a manner that allows for the greatest degree of confidentiality for residents, particularly regarding the information gathered during the in-depth interviews.
  - To easily navigate to different care areas on the RI screen, you can pull out the list of care areas on the right side of the screen by clicking the tab for the Care Area Menu. To **alphabetize the initial pool list** in the Care Area Menu, click on the Alphabetize Pullout icon. The order of the initial pool areas on the screen will remain the same for all your IP residents. The areas listed in the Care Area menu will remain the same until the Alphabetize Pullout icon is de-selected.

- The interview care areas are organized first by quality of life/resident rights, followed by quality of care. The same resident interview and observation care areas are shown together to facilitate making observations while interviewing a resident. The resident interview Care Areas will not display for residents who are non-interviewable, refuse, or are unavailable for an interview.
- Questions listed for each care area may be used as a guide; however, you can **ask the questions as you would like,** just maintain the intent of the care area. Surveyors are not required to review or ask all of the questions listed.
- You can hide the pre-identified suggested Interview questions by unchecking the Show Probe Text box at the bottom left corner of the screen.
- You **must cover every care area** regardless of whether the area is an MDS indicator for a resident and determine if each area warrants further investigation (FI) or if there is no issue unless the area is **not applicable** (e.g., the resident doesn't have a catheter). Skip any care area that is not relevant to the resident you are interviewing (e.g., the resident doesn't have a tube feeding).
- To ensure all areas have been addressed, it is best practice to select the No Issues/NA checkbox when there are **no concerns or** a **concern is ruled out**. However, you are not required to mark No Issues/NA for areas with **one RI exception:**
  - For the required areas of dialysis, hospice, smoking, and TBP, mark No Issues if the area applied to the resident(s) but concerns were not identified so the system knows which residents were reviewed for these required areas.
- Any care area that has been marked as No Issues/NA will have a green checkmark next to the Care Area and on the Care Area pull-out menu.
- For any resident-expressed concern, ask follow-up questions to **determine if the concern warrants further investigation (FI)**, *which is comparable to potential noncompliance,* or if it can be ruled out. Probing is critical so you only identify concerns indicative of potential noncompliance.
- **If a concern warrants further investigation (FI),** select the Further Investigation checkbox and document the specifics of the concern in the Notes field to help guide your investigation. Any resident interview or observation area marked as FI will have an orange "!" next to the area since it is a combined RI/RO screen.
- You are **required to mark FIs** for any area of concern.
- **If you only mark FIs, check the Complete box** for the RI screen to attest to the fact that you addressed all areas with the resident.
- The date/time will be populated for your first entry in the Notes field. Any subsequent date/time can be added by using the **Insert Timestamp** icon (clock) or **Alt+T**.
- Enter the resident's ID in the notes field by clicking on the **Insert Resident ID** icon (the person next to the clock) in the bar above the notes field or **Alt+R**.
- If you identify a potential **MDS discrepancy** (e.g., MDS says the resident has pain and the resident says he/she has never had pain, or the resident has a contracture but the MDS doesn't have it marked), select the MDS Discrepancy checkbox. Base your decision to select MDS Discrepancy solely on the MDS indicator information and your initial pool findings – you do not have to confirm an actual

discrepancy at this time.

- For nutrition, use the **Weight Calculator** to calculate % weight loss/gain. If you identify a weight loss/gain concern, add the dates in the Weight Calculator, then click on the Red X. To insert the weight information in your notes, click in the Nutrition notes field where the information should be inserted and then click the Paste Weight Calculator icon next to the font size which looks like a picture of a scale. The system will identify the weight loss or gain in your inserted note.
- If you have answered every care area in the interview (best practice) or if you mark the FIs only and click on the Complete box, you should receive a **green checkmark** on the RI icon. This is your indication that the **interview is complete.**
- If the resident halts the interview midway, make additional attempts later to complete the interview. If you are unable to complete the interview, keep the responses you have and leave the rest of the interview blank. If you were unable to complete an interview with a resident, you can place a checkmark next to **Complete** on the resident's interview screen.
- If you **entered information under the wrong initial pool resident**, you can transfer part or all of your information to the correct initial pool resident. You can only transfer interview, observation, and/or record review data to an initial pool resident that has no data entered and is not assigned to another surveyor. If not assigned to you, the system will automatically assign the initial pool resident to you with the transfer. Open the Add/Update Resident dialog for the initial pool resident that you want to transfer data from:
  - From the Card view: Click the name of the resident.
  - From the List view: Select the resident and click the **Add/Update Resident** icon.
  - Click the **Transfer RI/RRI, RO, or RR Info to Another Resident** button at the bottom of the dialog box. You can only transfer responses between initial pool residents (i.e., ensure the IP indicator = Yes for both residents).
  - Click the down arrow for **To:** and select the name of the resident you want to transfer the data to.
  - Click the down arrow for **Types** and select the information you want transferred (i.e., RI/RRI, RO, and/or RR).
  - Click the **Transfer** button.
  - Review the message stating how many items transferred.
  - Click Ok.
  - Once you have successfully transferred the data, review all notes and update the resident ID if it was added to a notes field.

- **Conduct the full resident observation (RO)** for all residents in the initial pool.
  - On the RI and RO screen, any observation care area not paired with an interview care area is displayed at the end of the interview section. Once the interview is completed, you also can use the RO screen, which just lists the observation care areas.
  - If you want to collapse the care areas that have been completed, select the **Collapse Completed Care Areas** checkbox in the bottom left corner. Once you leave the screen, the care area completion will update or when you click the

Collapse Now button.

- Probes listed for each care area may be used as a guide when conducting your observations.
- Conduct rounds until you know whether all observation areas should be answered with No Issues/NA, Further Investigation *(i.e., potential noncompliance)*, or NA for hospice, ventilator, transmission-based precautions, and smoking.
    - Even if continuous observations are not completed, you can identify repositioning and incontinence care concerns based on whether a resident is in the same position for an extended period of time during your rounds.
    - Complete formal observation (e.g., wound or incontinence care) if the situation presents itself or is necessary (e.g., resident has not been provided incontinence care for a long period of time or a resident is covered in bed).
    - Only a licensed nurse, physician's assistant, or a physician may make an observation of a resident's genitals, rectal area, and for females, the breast area.
- You **must cover every care area** regardless of whether the area is an MDS indicator for a resident and determine if each area warrants further investigation or if there is no issue unless the area is **not applicable** (e.g., the resident doesn't have a catheter). Skip any care areas that is not relevant to the resident (e.g., the resident doesn't have a tube feeding). As stated previously, surveyors may use the questions/probes to guide their interviews, observations, and record reviews, but are not required to address each probe.
- To ensure all areas have been addressed, it is best practice to select the No Issues/NA checkbox when there are **no concerns or** a **concern is ruled out**. However, you are not required to mark No Issues/NA for areas with **one RO exception:**
    - For the required areas of hospice, vent, smoking, and TBP, mark No Issues if the area applied to the resident(s) but concerns were not identified so the system knows which residents were reviewed for the required areas.
- Any care area that has been marked as No Issues/NA will have a green checkmark next to the Care Area and on the Care Area pull-out menu.
- If a concern warrants further investigation (FI), document the specifics of the concern in the Notes field to help guide your investigation. You will receive an orange "!" for any area marked as FI.
- **If you only mark FIs, check the Complete box** for the RO screen to attest to the fact that you addressed all areas for the resident.
- Once you have **completed the observation** (i.e., answered all areas or marked FIs and the Complete box), you will receive a **green checkmark on the RO icon**. This is your indication that the observation is complete.

- **Conduct resident representative interviews (RRI)/family interviews**.
    - The RRIs/family interviews are for non-interviewable residents.
    - The person (e.g., friend, family or other resident representative) should be familiar with the resident's care.
    - The goal is to complete **<u>at least</u> three RRI/family interviews across the team on the first day** of the survey to be better informed for sampling decisions. You may

call the resident representative/family, especially if you have observational concerns with a resident in the initial pool.

- If you complete an RRI/family interview during the initial pool process, include the resident in the initial pool and follow the same guidance as the RI (e.g., address every care area, document details for any area that warrants further investigation).
- To access the RRI/family interview care areas, select **Non-interviewable** for the Interview Status and select the checkbox for **Representative Interview**. In the RRI Contact Info notes field, document the RRI/family member's name, relationship, and contact information if contacted by phone.
- You **must cover every care area** regardless of whether the area is an MDS indicator for a resident and determine if each area warrants further investigation or if there is no issue unless the area is **not applicable** (e.g., the resident doesn't have a catheter). Skip any care areas that is not relevant to the resident (e.g., the resident doesn't have a tube feeding).
- To ensure all areas have been addressed, it is best practice to select the No Issues/NA checkbox when there are **no concerns or** a **concern is ruled out.** However, you are not required to mark No Issues/NA with **one RRI exception:**
  - For the required areas of dialysis, hospice, smoking, and TBP, mark No Issues if the area applied to the resident(s) but concerns were not identified so the system knows which residents were reviewed for the required areas.
- You are required to **mark FIs** for any area of concern *that is indicative of potential noncompliance*.
- **If you only mark FIs, check the Complete box** for the RRI screen to attest to the fact that you addressed all areas with the resident representative/family.
- If the three RRI/family interviews have not been completed when the sample is selected, an RRI can be conducted after sample finalization for a sampled resident (preferably) or a non-sampled resident if you are having difficulty locating a representative/family member for resident in the sample. If an RRI/family interview is conducted after the sample is selected, you must complete it early enough in the survey to follow up on any concerns.
- **If you complete an RRI after the sample has been finalized**, the areas you mark for Further Investigation will not carry forward automatically for investigation. Instead, you will have to initiate the areas for investigation by going to Investigation/Investigations and clicking on the icon with a plus sign at the top of the screen.
- The system will track the RRIs/family interviews and display the number completed on the team meeting screen.
- If three cannot be completed (e.g., all residents are interviewable), document a rationale on the team meeting screen.

- **Conduct a limited record review (RR) after** your interviews and observations are completed for all initial pool residents. Surveyors should continue to complete observations of the residents while working on record reviews by completing the RRs on the floor and not in the conference room.
  - Go to the RR screen for the resident by clicking on the RR icon in the upper left-

hand corner of the screen if you are in Resident View or on the RR icon on the resident's card if you are in Card View.

- The system will automatically show the record review areas required for your initial pool resident based on interview status, new admissions, and specific MDS indicators.
- If the facility uses Electronic Health Records (EHRs), refer to the EHR information the facility provided to quickly locate the information required for the initial pool record review. For the initial pool limit your record review to the areas on the RR screen unless you notice a serious concern (Harm or a Potential for IJ) while you are identifying the RR areas.
- Follow the RR screen to guide you in the record review. For all residents in the initial pool, you will briefly review the record for the following: 1) **advance directives**, 2) **confirm specific information** based on interviews and observations (e.g., questionable interview status or pressure ulcer), and 3) any **other concerns** (e.g., identify a resident-to-resident altercation) you may identify as you review the record for the areas required for the resident. An FI for **other concerns** will trigger an investigation at F684 using the **general pathway**. If your investigation is not related to F684, use the drop down next to Additional Care Areas in the header to add the applicable area.
- For any resident marked as non-interviewable, refused, unavailable, or out of facility, review the record for the following information: **pressure ulcers, dialysis, infections, nutrition** (system can help calculate % weight loss)**, falls** in the last 120 days**, ADL decline** in the last 120 days**, low risk bladder and bowel (B&B), unplanned hospitalizations, elopement** and **change of condition** in the last 120 days**.**
- For any resident in the initial pool who is currently receiving **insulin, an anticoagulant, an antipsychotic with a diagnosis of Alzheimer's** or **dementia**, **an antibiotic, is 65+ years and has a new diagnosis of schizophrenia with an antipsychotic,** or has an appropriate diagnosis but is not receiving **PASARR Level II** services, review the record to confirm the information**.**
- Additionally, for newly admitted residents in the initial pool who did not have an MDS, complete a review of the record to identify current **high-risk meds, diagnoses,** and **hospice**. If a newly admitted resident is marked as having a diagnosis of schizophrenia (diagnoses) and is receiving an antipsychotic (high-risk meds), then a new record review item (i.e., **new schiz and antipsychotic**) will appear asking if the schizophrenia diagnosis is new since admission.
- If you **identify a concern for an area not listed on the RR screen**, add the applicable area using the drop down next to area titled, Additional Care Areas, in the header. Any newly added RR area will be listed in the Care Area Menu.
- To ensure all areas have been addressed, it is best practice to select the No Issues/NA checkbox when there are **no concerns or** a **concern is ruled out**. However, you are not required to mark No Issues/NA with **two RR exceptions:**
    - For dialysis, mark No Issues if the area applied to the resident but concerns were not identified so the system knows which residents were reviewed for dialysis.

        - For medications (insulin, AC, antipsychotic, antibiotic, new diagnosis of schizophrenia with antipsychotic, high risk meds/diagnosis/new schiz and antipsychotic/hospice), document whether the resident is currently receiving the medication to ensure the Unnecessary Med selection is based on accurate and current medication information.
    - You are required to **mark FIs** for any area of concern *that is indicative of potential noncompliance*.
    - **If you only mark FIs, check the Complete box** for the RR screen to attest to the fact that you addressed all areas.
    - If you have **answered every care area within the record review** (including any newly added RR area) or you marked FIs and medication information and then clicked the Complete box, you should receive a **green checkmark on the RR icon.** This is your indication that the record review is complete. If there are extenuating circumstances (e.g., you cannot gain access to the EHR), you may interview staff. However, every effort should be made to review the information in the resident's record.
    - The majority of your time should be spent conducting interviews and observations, and limited time spent on record review.
- **Once you respond to all care areas** (best practice) **for the RI or RRI/family interview, RO, and RR, or you mark FIs and click the Complete box, the system will mark the resident as complete** and automatically move the resident into the Complete folder on the Card View or display a green checkmark next to the resident's name on the Resident List view.
- **If you identify a significant concern (IJ or harm)** during your observations, interviews or limited record review, select Harm or IJ in the **Include in sample due to** (under the interview status) to ensure the resident is included in the sample. At any time during the survey, if immediate jeopardy is identified, the team should meet immediately to confer.
    - Immediate jeopardy is defined as a situation in which the facility's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, serious harm, serious impairment, or death to a resident.
    - The guiding principles to determine immediate jeopardy and serious threat make it clear that the threat can be related to mental or psychosocial functioning, as well as physical well-being.
    - If the team concurs, the team coordinator must consult immediately with his/her supervisor. If the supervisor concurs that the situation constitutes immediate jeopardy, the team coordinator immediately informs the facility Administrator or designee of the presence of IJ. The team coordinator should explain the nature of the IJ to the Administrator or designee. The Administrator/designee should immediately begin to take actions to remove the IJ. If the IJ is not removed prior to the end of the survey, a revisit must be conducted for determination of removal of the IJ. The SA and/or RO will invoke appropriate termination procedures.
    - See Appendix Q for guidance regarding determination of immediate jeopardy, and §3010 for procedures to follow if the immediate jeopardy termination procedures are invoked.

- You may use the writable "**Immediate Jeopardy Template**" in the LTCSP Reports section.
  - In the Reports section, click on the "Immediate Jeopardy Template" icon to open the document.
  - Enter information into the template. Once you have entered some text, from the File menu, select **Save As** to save the PDF and automatically attach it to the LTCSP survey.
  - The **Save in recent folder** dialog opens. You must use the default directory.
  - Click **Save** in the **Save As** dialog and **Yes** to overwrite the file. The system automatically names the form with the Event ID and the surveyor ID (eventide-surveyorID-IJ_Template.pdf).
  - Close the document and click **Attach** in the **File Open in Another Program** dialog. The system automatically attaches the document and lists it on the **Attachments** screen. Enter a description for the IJ Template on the Attachments list.
  - If you close the template and **want to make changes**, use the **Edit** button on the **Attachments** screen. When you use **File – Save As** again, the system attaches the updated version of the document to the survey with a new date/time stamp.
  - If you want to **add a new template** once you have already created and saved one (e.g., more than one tag cited at IJ), open a new template from Reports. Answer **Yes** to create a new document or **No** if you want to edit an already existing template. If you click **Yes** to create a new template, from the **File** menu, select **Save As** to save and attach a new copy of the template. To **help distinguish between multiple copies**, enter a description on the Attachments screen for each.

- Complete all resident observations, interviews and limited record review for the initial pool residents within eight to ten hours (e.g., by the end of Day 1 or beginning of Day 2).

Additional Initial Pool Process Information:

- To **navigate to another resident**, click on the back arrow at the top left corner of the screen to return to the resident view you were previously working with.
- **If you finish your initial pool activities early** or you are having **difficulty finding at least eight appropriate residents** to include in the initial pool, check to see if other team members need assistance. If not, continue making observations for your initial pool residents, conduct interviews or observations for additional residents (e.g., include more than eight residents in your initial pool), begin the investigation for any complaint/FRI resident who was **not included** in the initial pool, or begin facility tasks (such as Resident Council Interview).
- To **share a resident** during the initial pool:
  - If the assigned surveyor has completed a portion of the resident, both surveyors (the assigned surveyor and the surveyor providing assistance) must share their data with the TC (follow Step 10 for instructions).

- The TC then shares the data with the surveyor assisting.
- Once the data is received, the assisting surveyor will assign themselves to the resident. The newly assigned surveyor should see the other surveyor's information.
- The surveyor helping out finishes any outstanding areas for the resident.
- When the initial pool process is complete and data is shared with the TC, the TC will receive a warning message asking **who should retain the assignment** for the resident. Confirm with the team that the assignment should stay with the originally assigned surveyor. All responses and notes will merge, and any area marked for Further Investigation will override a response of No Issue.

- If a **complaint is called into the State Agency and added to the survey during the initial pool process**, the team should discuss whether to include the complaint resident in the initial pool as long as there are fewer complaint/FRI residents than the maximum number (from Attachment A) already in the initial pool and there is enough time left (in the initial pool time frame) to complete the interview, observation, and record review. To include the complaint resident in the initial pool:
  - The SA should attach the complaint to the survey shell.
  - The TC should re-import the shell and answer No to the warning message (do not overwrite the data) so only complaints are updated.
  - On the Offsite Prep screen, the TC will link the ACTS complaint resident to the LTCSP resident list, identify the initial pool areas based on the allegations, include the complaint resident in the initial pool, and assign the resident to a surveyor.
  - The TC will then share the data with the team.
- For **off-hour surveys**, modify the Initial Pool Process as necessary to accommodate the residents' activities occurring at the time of entry. Introduce yourself, make observations and begin screening residents that are available. Begin other facility tasks as appropriate (e.g., medication administration, medication storage).
- **Dining Observation**: Each surveyor will **observe the first scheduled FULL meal** using the Dining facility task pathway in the software.
  - Note: Starting on 11/12/21, CMS is temporarily allowing the dining task to be discretionary and completed only if a resident is investigated for nutrition, weight loss, or FIs related to dialysis.
  - Go to Investigations – Facility Tasks in the Navigation menu (ensure you are assigned the task; if not, add yourself to the task) – double click on Dining to access the investigation screen.
  - Expand the Use, Instructions and CEs to use the investigative probes on the screen to guide your investigation OR you can click on "Pathway" to see a full screen display of the pathway (you will have to toggle between the pathway and entering notes on the screen or do a split screen to keep the pathway static while entering notes).
  - The team should cover all dining locations and room trays. If there are more dining areas than surveyors, prioritize the dining areas with the most dependent residents. If dining rooms are not being used during the PHE, determine whether residents are receiving assistance and ensure observation of room tray delivery.
  - Observe the beginning of the first scheduled full meal and enough of the dining

experience for all residents to adequately identify concerns.
  - Use the Notes field for your documentation regarding dining. To see a full screen display of the Notes field, click on the center icon in the blue Expander bar above the Notes field.
  - In tablet mode, use your stylus to document any dining observations just as if you were writing on a piece of paper (e.g., to draw the layout of a table or meal).
  - If feasible, observe the meal for your initial pool residents who have weight loss, food, or hydration concerns. A list of residents will be displayed on the screen if the resident had an MDS indicator or you marked further investigate for nutrition/hydration concerns. If nutrition/hydration concerns are identified, document the concern under the resident (not on the dining screen).
  - If concerns are identified, a second meal observation may occur after the sample is selected.
  - To add a resident who has dining concerns to the notes section and to the sample list report for the facility, click on the **Add Resident** icon in the upper right corner OR add the resident's ID in the Notes field using **Alt+R** or the person icon (next to the clock icon).
- **General Observation of the Facility**: During the initial pool process, all surveyors should make general observations of the facility to determine whether there are concerns in the common areas. During the team meeting, discuss any of these concerns to determine whether the Environment task should be initiated.

Step 14: Share data at the end of each day

- **At the end of each day, share your data with the TC** prior to the team meeting using the Data Sharing screen. Click on the flash drive icon on the right side of the screen. Follow the data sharing instructions in Step 10.
- For team members to follow along on the team meeting screen, the **TC should share data** with the team. To increase the effectiveness of the team meeting, we highly recommend team members have access to the same information as the TC to follow along.
- Following the meeting, the TC should share all team members' **data with each team member** so every surveyor has all survey data (in case of team composition changes). If team members share data with the TC, make additional changes in their system, and then receive data from the TC without sharing their newly added information with the TC, any newly added information will be lost.

Step 15: End of Day 1 team meeting

- Meet at the end of Day 1.
- It is important for the TC to receive all team member's data prior to the team meeting.
- Team members should follow along on the screen while the TC conducts the team meeting. Team members will have read-only access to the screen.
- If the team members wish to review the team meeting information, the TC should send the data to each team member. After each team member has received the data; team members should click on the reports icon and then Run Team Meeting Notes.

- The TC should cover the areas listed on the Team Meeting screen – Initial Pool (Go to Team Meeting in the Navigation menu).
- There are a number of areas that are system-populated and updated each day (after all team member's data is received) to assist the TC in the discussion. The TC should still **discuss the system-populated items**. If the team has different information than the system-populated information, enter the information under the Notes field. The TC should ensure that the following information is covered and the TC includes notes from each team meeting in the notes field.
- The following questions have **information provided in the system** that the TC should discuss with the team:
  - Were any offsite selected residents discharged?
  - Ensure all offsite-selected residents were included in the initial pool, unless discharged.
  - Was at least one resident who smokes included in the initial pool? This is system populated if a surveyor marked further investigate or no issue for smoking. If no residents were marked for further investigation or no issue, then ensure that one resident, if available, is observed for safe smoking. If a resident who smokes was included in the initial pool, document the name of the resident in the Notes field.
  - Is each surveyor identifying vulnerable residents?
  - Go over each newly admitted resident listed on the matrix and ensure each resident listed was screened by a team member.
  - Did anyone include a resident in the "identified concerns" subgroup?
  - **Ensure the residents each surveyor included in the initial pool is accurate**. If a resident is listed who shouldn't be in the initial pool, the surveyor should change the IP Indicator to No or unassign his/her name from the resident on the Resident Manager screen. Any resident who has an IP Indicator of Maybe is not a part of the initial pool.
  - How much work does each surveyor have left to do?
  - Any harm, SQC, IJ, or other concern that should be discussed? All concerns will be discussed during the sample meeting.
  - **If SQC is suspected** – when you meet to select the sample, expand the sample as necessary to determine scope and whether there is sufficient evidence to rule out SQC. If the evidence is not adequate and the number of observations only allowed for isolated scope when there is a severity level 3, or pattern for scope when there is a severity level 2, then expand the sample to include additional reviews of that requirement. For example, if 6 residents in the facility are receiving care for a colostomy, and for the one resident in the sample with a colostomy, it is determined that care provided caused actual harm to the resident, there would be a deficiency of isolated actual harm, but there would not be sufficient evidence to determine that there was substandard quality of care. Thus, the sample would need to be expanded before determining that substandard quality of care did or did not exist. On the other hand, if the number of individuals with a colostomy in the facility was 6, and 4 residents with colostomies were included in the sample and only one had deficient care, there would be no need to expand the sample. If the team verifies the existence of SQC, the Administrator should be informed that the

facility is in SQC and an extended survey will be conducted. When communicating the issues to the facility, identify the resident(s) by name if the situation was identified through observation or record review (e.g., practices such as improperly applied restraints, medication error, cold food, gloves not worn for a sterile procedure, and diet inconsistent with order). Do not identify residents or family members/representatives who provided information through interviews (e.g., about injuries due to broken equipment, prolonged use of restraints, and opened mail) without their permission. If expanding the sample determines that SQC does not exist, no extended survey will be conducted.

  - Review the list of initial pool areas of concerns (i.e., FIs) and ensure the team discusses potential staffing concerns. To see specific details (e.g., residents, assigned surveyor, and initial pool notes), refer to the Resident Marked for FI by Care Area Report. **CASPER PBJ Staffing Data information** is flagged as "PBJ Staffing" with a link to the staffing details.
  - How many resident representative/family interviews were completed?
- The system **does not automatically provide information** for these questions:
  - Ensure any resident on the matrix who has a unique significant concern was included in the initial pool or was screened and ruled out. For example, if only one resident with a facility-acquired pressure ulcer is noted on the matrix, include the resident in the initial pool.
  - Discuss any discrepancy between the matrix and information from the interview, observation, and limited record review.
  - What is the status and pertinent information for complaint and FRI residents?
  - Enter the total number of new admissions.

IV. SAMPLE SELECTION

Step 16: Share Completed Initial Pool Data and TC Confirms Initial Pool Data is Completed

- When you complete the initial pool process, share your data with the TC using the Data Sharing screen. Click on the flash drive on the right side of the screen. Refer to Step 10 for instructions. **All data must be shared before selecting the sample.**
- If not reviewed during the initial team meeting, **confirm the residents included in the initial pool are accurate** by reviewing the team meeting screen section titled: How many residents did each surveyor include in the initial pool? If a resident is listed who should not be in the initial pool, the surveyor should change the IP Indicator to No or unassign his/her name from the resident on the Resident Manager screen.
- Open the **Initial Pool by Resident report** and **confirm a subgroup** was added **for every initial pool resident**. If a resident does not have a subgroup, the TC can add the subgroup on the Resident Manager screen.
- Review the team meeting screen and **ensure all initial pool work has been completed** under the system populated section titled: How much work does each

surveyor have left to do?

- If there is incomplete work, the surveyor should complete the initial pool work, and then share the data with the TC.
- Any changes that are made to an Initial Pool Resident's information needs to be shared with the TC (follow Step 10 for instructions).

Step 17: Select the Closed Records, Finalize the Sample, and Make Investigation Assignments

Once the initial pool process is finished and the data is shared with the TC, meet for an hour, on average, to finalize the closed records and the sample. Each team member should follow the PG steps to help the team follow the sample selection process.

Select Closed Records:

- **Finalize the selection of residents for the three closed record reviews** (death, hospitalization and discharge) on the Investigation | Closed Record Sample screen in the Navigation menu. You are required to finalize the closed record selection before you can start the sample selection.
  - Select an unplanned (facility-initiated) discharge. If none, select a planned (resident-initiated) discharge.
  - The survey team may replace system-selected resident with discharged offsite selected residents or another resident who had a concern brought to the attention of the team for the closed record reviews, as long as the discharged offsite selected residents fit the required discharge types.
  - If there is an active **complaint resident** for one of the closed record areas, the complaint resident should be selected for review. The team should discuss whether additional residents are needed to adequately investigate the complaint.
    - For death, the team is required to sample three residents and may need to ask for a list of additional residents from the facility.
    - If there are other residents who had further investigation marked for hospitalization or discharge, the team is required to sample three residents. The team should discuss whether they need to include any additional closed record resident or whether the team has enough active residents who had concerns from the initial pool that will be included when the sample is finalized.
    - If there weren't any other residents who had concerns regarding the complaint allegation of hospitalization and discharge, the team is only required to investigate the complaint resident. In this case, the TC should replace the system-selected closed record with the complaint resident.
  - If the system did not identify a resident in one of the three closed record review care areas (e.g., a resident did not unexpectedly die in the last 90 days and there are no discharged offsite selected or complaint residents who died unexpectedly), you do not need to find a resident that fits that care area. Just don't complete the closed record review for that area.
  - Once you have finalized the closed record review selection, click on the **Finalize**

Closed Record Sample button, which will then display the closed records on the Finalize Sample and Investigation Assignment screens.

- On the Investigation screen (All Investigations), the surveyor who reviews the closed record can assign him/herself to the applicable area once the data is shared OR the TC can assign the closed records now.

Finalize Sample Selection:

- Select **Finalize Sample** in the navigator.
- The team will complete an in-depth investigation for all concerns marked for the residents included in the sample.
- Some residents who had concerns from the initial pool may not be included in the sample. Ensure their concerns are covered by the sampled residents.
- The sample should include only active residents.
- Residents investigated for closed records and investigative areas that were initiated are not included in the total sample number. These residents cannot be removed on the sample screen.
- Discuss the triggered task concerns as a team.
- As you discuss concerns for each sample resident, determine if any concerns may indicate staffing concerns.
- **Complaint/FRI residents**: The team may include up to the maximum number of complaint/FRI residents in the sample based on the current facility census (see Attachment A). If there are more than the maximum number of complaint/FRI residents, the TC will have assigned the resident and complaint area directly to the investigation screen during offsite prep (i.e., the residents/investigations will be displayed as read-only on the sample screen). Surveyors will only investigate the allegations for the complaint/FRI residents above the maximum number shown in Attachment A for each facility census size. The team should ensure that three residents are sampled for each of the care area(s) being investigated for the COMP/FRI residents.
- The TC should **enter the facility census number** provided by the facility upon entrance if different than the number in the Facility Census box. The sample size number will automatically be adjusted, if necessary.
- Click on the **Start Sample Finalization** button. You are required to finalize the Closed Record selection before you can click on the Start Sample Finalization button.
- To **refresh the screen**, use **ALT+U** if the TC pushed the Start Sample Finalization button before completing the initial pool and receiving all surveyors' data. Do not use **ALT+U** once any changes have been made to the sample (e.g., residents added, sampled areas adjusted). Once the TC finalizes the sample, **Alt+U** will not work.
- **Unnecessary Medication Review:** The system will select and display five initial pool residents for this review – these residents may or may not be in the sample.
  - The system will only select non-initial pool residents for an Unnecessary Medication Review for two reasons: 1) A resident does not exist in the initial pool to cover the four required medications of insulin, anticoagulant, new diagnosis of

schizophrenia with an antipsychotic for a person 65+ years, and Alzheimer's/dementia with an antipsychotic, and 2) If there are not five residents in the initial pool with medication concerns.

- Confirm any non-initial pool resident(s) selected for the medication review are still in the facility. If one of these residents has been discharged, replace the discharged resident. To do this, click on the red "x," and a pop up will appear with the name of a resident to replace the discharged resident. Ensure the replacement resident is still in the facility.

- **Share the data** with team members using the Data Sharing screen (refer to Step 10 for instructions). Team members will be able to view, but not alter, the Finalize Sample screen.
- Return to the Finalize Sample screen.
- Description of Screen Display:
  - The Finalize Sample screen **displays all potential investigations** to ensure the team is aware of and adequately samples every investigative area. The displayed investigations include initial pool residents with at least one FI, initial pool residents with an FI associated with triggered task(s) or residents added to the arbitration task if triggered, sufficient staffing and infection control (for TBP and Infections [not UTI, Pressure Ulcer, or Respiratory]), closed record residents, unnecessary med residents, and any initiated area such as complaints that went directly to the investigation screen.
  - To assist with sample selection, all resident information is expanded to facilitate the team discussion of specific concerns. After a resident is discussed, close the resident section.
  - The **concern areas** (e.g., FIs, closed records, or initiated investigative areas) for a resident have a **Y listed under the Included in Investigation** column.
  - To review your **initial pool notes** and the **reason Infection Control triggered** *(which is displayed on the first line of the notes pop-up)*, select the care area or facility task.
  - To remove a care area because of a **data entry error** (Included in Investigation = Y), click on the Y and select 'data entry error' from the drop down. *Follow the on-screen messages to change a response for hospice, dialysis and ventilator (e.g., changing an FI or No Issue to NA). You can change the response for TBP to N/A, if applicable, by clicking on the Infection Control area and selecting the 'Change TBP to NA' option in the Notes pop-up.*
  - To **transfer your initial pool notes** *(for a care area or triggered task)* **to a different area** for the same resident, ensure both areas are listed. If not, add the area by selecting the Modify Care Areas button. Click on the area with the notes you want moved. Next to the "Copy Notes To" field, select the area you want the notes moved to. Select Save.
  - A **complaint label** (COMP/FRI) will display next to the resident and complaint/FRI care areas. If a complaint allegation is specific to a facility task, the complaint label is listed for any resident who triggered the task; however, the complaint label will be bolded for the complaint resident. A **facility task label** (TASK) will display next to triggered tasks, sufficient staffing, and infection control if at least one resident has an FI. A **closed record label** (CR) will display

in the Sample column.
  - Click on the resident's name to see other subgroups that may be listed in addition to the COMP/FRI subgroup you can already see for the resident.
  - The **# of Care Areas** columns lists the total number of investigations for the resident which includes all FIs (resident-specific or triggered tasks) and any initiated area (e.g., COMP that went directly to the investigation screen).
  - The **Care Area Menu** only displays areas of concern. The Menu is organized by Investigative Area (e.g., Accidents). Listed below the Investigative Area, you will see an indented list of the initial pool areas that are mapped to the Investigative Area (e.g., for Accidents, the IP areas are: Falls, Elopement, Smoking, and Accident Hazards). Only the IP areas that have been marked as a concern are shown on this menu. If you need to **access the icons in the right pane** (e.g., surveyor notes), close the Care Area Menu.
    - Each Investigative Area displays: 1) the number of residents included in the sample so far who have a concern in the relevant area (# sampled) and the total number of residents who have the concern marked (total # of concerns) – that is, all residents with the concern whether selected for the sample yet or not.
    - The indented Initial Pool areas show the same information (# sampled)/ (total # of concerns) specific to the IP area.
    - Using the Accidents area as an example, you might see the following: Accidents (2/5). This means that two of the five residents with Accidents concerns are in the sample. The team needs to determine whether one or more of the three remaining residents with Accidents concerns should be included or if Accidents is sufficiently covered for the particular sample.
    - The Investigative Areas are displayed by the total # of concerns from highest to lowest.
    - Use the **Alphabetize Pullout icon** to alphabetize the list for easier navigation.
    - If an area is selected in the Care Area Menu, to **refresh back to the default sort order (which is by Surveyor)**, uncheck the selected Care Area.
- The system will identify the residents that should be included in the sample, even if the sample number is exceeded. **Discuss the system-selected residents** to determine if the team wants to replace any of the residents (note that if a system-selected resident is removed, you must provide a rationale in the system). The system-selected residents include:
  - Any offsite-selected resident who had at least one care area marked as further investigation.
  - Any resident that a surveyor marked as Include in Sample (i.e., harm or IJ), which is displayed under the Sample Reason column. If you try to remove one of these residents, you will receive a warning reminding you the resident had harm/IJ marked.
  - Any identified residents with abuse concerns from the initial pool.

Note: If abuse is being investigated based exclusively on a facility history of abuse (refer to Offsite Prep screen), ask the facility for all allegations of abuse since the last survey so you can select at least one resident to review (different from residents reviewed by the State Survey Agency in the past).

- COMP/FRI residents included in the initial pool on the Offsite Prep screen. These residents cannot be removed from the sample since they were part of the initial pool.

- **Have each surveyor identify additional residents they want to include in the sample** and provide the reason why, even if the sample number must be exceeded. **To include a resident in the sample**, the TC selects the checkbox for the resident's name**.** Surveyors should include:
  - Residents who have the most concerns.
  - If the TC did not link COMP/FRIs to the LTCSP on the Offsite Prep screen, the COMP/FRI residents added on the Resident Manager screen will not be system selected; therefore, up to the maximum number of complaint/FRI residents for the team based on the facility census (see Attachment A) may be added to the sample.
  - If not already in the system-selected sample, the team should add at least one resident for **hospice, dialysis, and ventilator**, if available, even if there were no potential concerns identified in the applicable area during the initial pool process. Note: Transmission-based precautions is mapped to the infection control task. The system populates *three* residents who had TBP marked as further investigation *(or No Issue, if needed)* on the *sample screen and the* infection control screen once the sample is finalized (see Step 20).
    - For **hospice, dialysis, and ventilator**, the sample screen displays the initial pool response (Y = FI and NI = No Issue) for all residents associated with each of these required areas. If a required area has both FIs and NIs listed on the screen, you are only required to sample at least one resident with a Y. For example, two residents are listed for dialysis. One resident has dialysis listed with a Y and the other resident has dialysis listed with a NI. The TC should include the resident who has dialysis = Y in the sample. If the required area only has residents with a NI, the team is required to include at least one of those residents in the sample.
  - The team should ensure that **all areas of concern noted for any resident are covered by at least one resident in the sample** (i.e., the sample number shown for the Investigative Area on the Care Area Menu should not = 0). Click on the **0's button** at the top of the Care Area Menu to filter the areas that are not yet represented in the sample. If there are areas listed, select residents with concerns in these areas to add to the sample. If there aren't any care areas listed, this confirms you have sampled at least one resident for every area. Uncheck the 0's button to return to the list in the previous order.

- If **COMP/FRI residents were added on the Resident Manager screen or new COMP/FRIs were received during the sample meeting, identify the complaint or FRI areas being investigated**.
  - Select the Modify Care Areas option for the resident.
  - Ensure the COMP/FRI allegation area is listed next to the Care Areas field. If not,

select the areas associated with the complaint/FRI.
  - Using the drop down next to the Complaint Care Areas field, select the complaint allegations being investigated.
  - The COMP indicator will now be listed next to the area.
  - If the resident didn't have the COMP subgroup listed already, the COMP indicator will be listed next to the resident's name. If the area is associated with a FRI, click on the left bar under the expansion arrow to update the subgroup.
  - Select Save.
- Using the **Care Area Menu**, adjust the sampled areas as necessary:
  - Ensure enough residents have been **sampled for the complaint areas**.
    - If there are other residents who had FI marked for the complaint area, the team is required to sample three residents.
    - If there weren't any other residents who had concerns regarding the complaint allegation, the team is only required to investigate the complaint resident.
    - For general complaint areas not associated with a resident, if there were not any concerns identified during the initial pool for the complaint area *(resident-specific initial pool areas, personal funds and environment)*, the area does not require any further investigation, with the **exception of abuse.**
      - The abuse care area will automatically be initiated for the facility and will be listed on the TC's investigation screen once the sample is finalized. Since there is not a resident to review, you will complete a review of the facility's policy and procedures and QAA system for monitoring reported allegations of abuse (refer to F607 and F867).
    - If the complaint allegation is not covered by the interview, observation, or record review areas addressed in the initial pool process (e.g., record keeping or death), then the team is required to sample three residents to investigate the area.
    - Any complaint related to medications will be investigated in addition to the five system-selected residents for the Unnecessary Medication Review. If this is the case, you only have to investigate the complaint-specific medication.
  - **Adequately investigate the scope of each resident-specific area**: If an area has a high number of residents with the identified concern or the team has to rule out SQC, the TC should ensure the area is adequately sampled.
    - To add areas, select the **Modify Care Area** and check any area listed
  - **Remove sampled areas if oversampled:** If the team determines a resident-specific area is oversampled (e.g., six sampled residents for Activities), the TC may remove sampled areas specific to a particular resident if another resident has a higher likelihood of deficient practice in the area. For example, the team may remove the Activities area for three of the sampled residents but still keep it for the other three residents. The three who had Activities removed may still be in the sample but will not be investigated for Activities. If the area was the only reason

the resident was in the sample, then that resident would be dropped from the sample once the Activities area was removed.
    - Click on the Y under the Included in the Investigation column.
    - Select 'another resident with higher likelihood of deficiency' as the rationale.
    - The Y indicator will change to an N on the screen. You will receive a warning if you try to remove an area that will no longer be covered by any resident in the sample.
    - Click on the N to stop the removal of the area and keep it included.
- **If the sample size is not met, consider the criteria below, listed in priority order, to include more residents in the sample**:
    1. Residents who were selected for the Unnecessary Medication review but are not a part of the sample.
    2. Residents with concerns related to QOL and resident rights.
    3. Initial pool residents who only had a FI (or complaint) in one or more of the following facility tasks: infection control, sufficient staffing, personal funds and/or environment.
    4. Unrepresented area(s) of the building – determine whether residents in the sample are representing all parts of the building.
    5. Prior survey and complaint results.
- If you have met the total sample number, but there is a **concern you want to investigate for a resident who did not make it into the sample**, include the resident and just the specific area of concern even though the team is over the total sample number, so you have sufficient time to investigate the additional resident. To include a resident in the sample that is not listed on the sample screen, change the filter to 'All residents' to select a resident from the resident list on the Resident Manager screen.
- Once the sample is finalized, select the **Finalize Sample** button. You will receive a warning if there is a concern with the sample (e.g., sample size not met, a complaint area not covered). Dialysis, hospice, or ventilator will be displayed on the warning message if a resident was not sampled for the area and a surveyor marked No Issue or FI. Resolve the issue or provide a rationale for the reason. You will receive a warning if there are initial pool residents with an FI for hospitalization or discharge who haven't been included in the sample AND there are closed record residents for those two areas. Ensure you include the initial pool resident in the sample to adequately cover hospitalization or discharge for residents currently residing in the facility. If you realize you made a mistake but already finalized the sample, make any sample adjustments on the Investigation screen.

Make Investigation Assignments:

- Click on the **Assignments screen** in the navigator.
- The investigation assignments screen includes all sampled areas, non-sampled, complaint/FRI areas, unnecessary med residents, initiated investigations, mandatory and triggered facility tasks, and closed records.

- Complaint allegations will be displayed on this screen with (COMP) next to it to identify that it triggered due to a complaint allegation.
- Again, if you realize you made a mistake but already finalized the sample, make any sample adjustments on the Investigation screen.
- The **left side** of the screen displays areas **Not Assigned** (e.g., triggered tasks and closed records) and each **surveyor's investigation workload**.
- The **right side** of the screen is where **assignments are made or adjusted**.
- **Ensure a surveyor is assigned** to all areas listed under **Not Assigned.**
  - Select a surveyor from the drop down in the right pane under the Assigned column while considering each surveyor's workload listed in the left pane.
  - The TC should ensure that every surveyor who had MDS discrepancy concerns is assigned to the Resident Assessment task since each surveyor will follow up on their own concerns.
- **Make additional adjustments until the workload is balanced.** The team should discuss any current workload concerns. In addition to balancing workload units, the team should also consider the complexity and increased time it takes for some investigations (e.g., Pressure Ulcers versus a Personal Property concern).
  - Click on the surveyor's name in the left pane to display all of the surveyor's assignments on the right side of the screen.
  - If all areas associated with a resident will be reassigned, check the box next to the resident's name, and update one assignment field by removing the current surveyor and checking the newly assigned surveyor's name. All other areas associated with that resident will automatically be reassigned to the new surveyor.
  - If the team wants to assign all residents with a certain area to one surveyor (e.g., pressure ulcers or abuse), sort by Investigative Area.
  - Facility task assignment adjustments are linked to the Facility Task screen.
- If needed, identify or adjust the surveyor who has **primary responsibility for dining, infection control, and sufficient staffing**.
  - Assign or adjust the primary surveyor under the Primary column. This surveyor has primary responsibility for the task (e.g., answer all CEs).
  - Remind the primary surveyor which task(s) they are responsible for.
- Once the TC is finished making assignments, ensure the "Not Assigned" placeholder listed at the top of the left pane is not displayed to confirm all assignments have been made.
- After finalizing the investigation assignments, the TC **shares the data** with team members using the Data Sharing screen (follow the steps listed in Step 10) so every surveyor has their investigation assignments.
- Team members will only be able to make assignments for themselves on the Investigation Assignments screen.

V. INVESTIGATION

Step 18: Conduct investigations for sampled residents

- You will **investigate all concerns** identified as requiring further investigation (FI) **for your sampled residents** for the remainder of the survey.
- Go to Investigations in the Navigation menu. You will see your assignments and the reason that caused the care area to be investigated under the **Inv Reason** column.
- A **complaint indicator** is added next to the applicable investigative area. The complaint indicator links to the complaint details from the Offsite Prep screen.
- There are **two ways to view your investigations**:
  - **Investigation By Resident** – you can access all of the care areas being investigated for that resident. Click on the resident's name and you will see all the care areas (one investigative area is listed per screen) in the pull-out on the right side of the screen. This option is useful when making observations, interviewing the resident, RR or family, or reviewing the record.
  - **Investigation By Care Area** – you can access all of your residents being investigated for that care area. Click on the care area and see all the residents you are investigating for that resident listed in the pullout menu on the right. This option is useful when interviewing staff.
- Using either of the screens above, refer to the Critical Element (CE) Pathway to help guide your investigation. You can access **the full Critical Element (CE) Pathway** for a care area, if one is available, by clicking on the pathway icon on the upper right part of the screen. You can scroll through the pathway to use the observation, interview and record review probes as a guide. You can copy and paste probes into your notes section, as desired.
- If a **care area does not have a pathway** or you initiate an Ftag directly, the system will indicate that there is no pathway for this investigative area. In such cases, refer to Appendix PP to guide your investigation. To access the **regulation (reg)** or **Interpretive Guidance (IG)**, click on the tag that is underlined in blue next to the CE question. If "no" is selected you will then be asked to determine severity. The team will determine the final severity and scope (S/S).
- **To view the MDS**, minimize your LTCSP or click the ASE-Q aspen leaf in the toolbar. If Citation Manager is still open, click **Done**. Expand your facility in the alpha tree and right-click **Residents MDS 3.0**, select **MDS 3.0 Resident Viewer**. You cannot copy and paste from the MDS Viewer but you can:
  - Document specifics in your notes field,
  - Attach a particular section to the survey (right click in the section; select **Export**; select Acrobat (PDF) file; save the file; then follow the steps below to attach the document to the survey), or
  - Refer back to any MDS assessment in ACO.
- You can **attach documents to the survey (**it also will be added to ASE-Q). Click the Attachments icon or press **Alt+A**; locate the file you want to attach, and then drag and drop the file into the attachments screen or copy the file and click the Paste from Clipboard button on the bottom of the Attachments screen. You may add a description of the document in the blank field, if desired. The attachment must be smaller than 4

MG; any attachment that is larger will not attach.

- Investigate the concerns thoroughly so you can make a compliance decision.
  - Observe care (e.g., AM care, wound care, restorative, incontinence care, transfers) if warranted for the investigation. For pressure ulcers and abuse, you can click on the icon in the upper right corner to access a **body map** to draw your observations of the wound. You can access a blank document to **handwrite or draw** using the Draw icon in the top right corner for any care area.
  - If concerns are identified with areas such as pressure ulcers and incontinence, complete continuous observations to adequately determine whether appropriate care and services are provided in accordance with the care plan.
  - If a non-interviewable resident has a representative or family who visits often, make an effort to interview the representative/family just like you would interview the resident, as part of your investigation.
  - For nutrition investigations, use the **Weight Calculator** to calculate % weight loss/gain. If you identify a weight loss/gain concern, add the dates in the Weight Calculator, then click on the Red X. To insert the weight information in your Investigation notes (not Resident Notes), click in the Nutrition notes field where the information should be inserted and then click the Paste Weight Calculator icon next to the font size. The system will identify the loss or gain when inserted.
  - The facility must conduct a **facility-wide assessment** to determine what resources are needed to competently care for residents each day and during emergencies. If systemic concerns are identified in resident-specific areas (e.g., hospice, dialysis, ventilators, activities, nutrition, behavioral/emotional, dementia) or if there is a systemic concern with a lack of adequate resources (e.g., specialized rehabilitation, pharmacy), review the facility assessment.
- There are **two ways to document your investigation**:
  - You may use the **Investigation Notes** field to document any information specific to the care area being investigated (e.g., observations, interviews, specific record review such as relevant MDS information, care plan, physician orders, and other pertinent information). Any notes entered during the initial pool process will be displayed in the investigation notes.
  - You may use the **Resident Notes** field to document any general information about the resident that you would like to have access to for all care areas (e.g., diagnoses, BIMS, general MDS information regarding cognition and ADL status, and general care plan information.
  - Either documentation option is acceptable. Resident Notes may be a more efficient option to document your information during your investigation since your documentation is one continuous notes field; however, you may spend more time editing your documentation for the CMS-2567. Using Investigation Notes will have the reverse pros and cons as Resident Notes.
  - **Highlight** information (e.g., reminder to follow up on an area) by using the highlight icon. Ensure you remove any highlighting for any CE marked as No s the highlighting is not visible on the CMS-2567.
- To see a full screen display of the Notes field, click the center icon in the blue Expander bar above the Notes field.

- If **information is deleted** from your Investigation Notes, view the document history by clicking on "hx". Select the date and time to determine if the information was **saved in the history**. If so, copy and paste the text from the history into the Investigation Notes screen.
- Record your **final citation and severity decision** by selecting Yes (compliance), No (noncompliance identified) or NA (if the CE does not apply to your investigation). If you mark a CE as No, you should have investigative documentation and a severity. If you need severity guidance, click on the information icon (the **Severity** column header).
- You must **answer every Critical Element (CE)** as either Yes, NA, or No. For any No you should have documentation supporting the determination of noncompliance.
- The Investigation screen is defaulted to "**Hide Completed Investigations**." If you prefer to see your investigations or need to update information for a completed investigation, uncheck the box next to "Hide Completed Investigations." The system will retain your setting until manually changed.
- If you are not hiding your completed investigations, you will receive a **green checkmark** next to the investigative area once you answer all CEs and enter a severity for any CE marked as No. You will receive a green checkmark next to the resident's name once all investigative areas have been completed.
- The Resident Investigation screen will **display the tags cited by the surveyor** (after data is shared, the tags that are in bold are cited by you). The team will review these tags during the potential citations meeting.
- To **switch to another resident or investigative area**, click on the Back arrow button to return to the Investigation main screen.
- If **additional concerns are identified** for sampled residents or concerns are identified for non-sampled residents, they can be added with team consensus to determine if there is deficient practice.
    - To initiate a new care area, on the Investigations screen, click on the **Add New Investigation** icon; select a resident; select all applicable care areas and click out of the box or press Esc(ape) to exit; click **Save**.
    - To initiate an Ftag directly, on the Investigation screen, click on the **Add New Investigation** icon; select a resident; select Ftag Direct Cite for the investigation; click **Save**. On the Investigation screen, click Ftag Direct Cite next to the applicable resident and then click **Select Tags** link (under CEs) and check the applicable tags to be investigated; click **Save**.
- If you do not see the care area or Ftag in the list, that means the area already exists on the Investigation screen and cannot be initiated again.
- To **remove a care area** (e.g., the information was inaccurate or the resident was discharged and an investigation cannot be completed without additional observations), on the Investigations screen, click on the X in the Remove column and provide a reason for the removal. You can only remove those Investigations assigned to you unless you are the TC who can delete any investigations.
- To **share a resident** during investigations (e.g., a nurse conducts the wound observation or for workload adjustments), if the assigned surveyor has completed a

portion of the resident, the assigned surveyor and the surveyor helping out should share data via the TC (see Data Sharing instructions at Step 10).
  - The surveyor helping out should then assign themselves to the resident (multiple surveyors can be assigned to the same resident/care area).
  - If you need to view another surveyor's documentation, at the bottom left of the screen, select **All Surveyors** from the **Show Answers** for drop-down menu. All notes and CEs marked by other surveyors display in read-only format. A No for In Compliance overwrites any Yes marked for the same CE. To view another surveyor's **drawing** or **body map** information, in the bottom left of the screen select the surveyor from the **Staff ID** drop-down menu.
  - The surveyor helping out finishes any outstanding areas for the resident or just completes the applicable portion (e.g., wound or incontinence care observation).
  - When investigations are complete, all responses and notes will merge and any CE marked as No will override a response of Yes.
- If you accidently **entered CE responses under the wrong resident**, you can transfer the CE responses by clicking **Transfer Investigation Answers to Other Resident** and selecting the appropriate resident from the drop-down (only those residents with the same care area marked for investigation appear in the list). Only the CE responses transfer; you will have to manually cut and paste any investigation notes.
- For any CE marked No, the Resident and Investigation Notes pull forward to the Edit Potential Docs screen for **editing documentation prior to the potential citation meeting**, if time permits.
  - On the Edit Potential Docs screen, click on a resident or facility task to enable the right screen.
  - The right pane will display the CEs marked as No for the applicable area and the Resident and Investigation Notes will display on the screen as read-only.
  - You can access the reg or IG if needed.
  - The Resident/Investigation Notes will copy to the editable section at the bottom of the screen as read-only until you begin editing the documentation.
  - **Select Edit Citation Doc** to edit your investigative notes.
  - Collapse the CEs and Tags, Resident Notes, and Investigation Notes as needed to have more of the editable notes field visible.
  - If you edit your documentation, only your edited notes are displayed on the Potential Citations screen.
  - If you do not have time to edit your investigative notes prior to the potential citation meeting, your resident notes and investigation notes will continue to display on the Potential Citation screen.
  - Once you begin to edit your citation documentation, a clipboard is displayed next to the Investigation on the left side of the screen.
  - If you receive **additional information after you begin editing** your documentation, add the new information to the applicable facility task or resident investigation screen. The changes are displayed in the notes field at the top of the right pane on the Edit Potential Docs screen. However, the changes will not automatically be included in the edited version of the documentation. In this case, you can copy and paste the new text added on the investigation screen into your

edited text.

- If a **complaint is called into the state and added to the survey during the investigative process**, we do not recommend the TC re-import the shell to reflect the new complaint at this late point in the survey process.
  - **If the complaint resident is in the resident list**, the assigned surveyor should add the COMP/FRI subgroup (from the Resident Manager screen), and then initiate the complaint resident, and the applicable allegation areas on their Investigations screen. Click the **Add New Investigation** icon; select a resident; select all applicable care areas and click out of the box or press esc(ape) to exit; click **Save**.
  - **If the complaint resident is not in the system**, go to the Resident Manager screen on the navigation menu and click on the Add New Resident icon (icon with the plus sign). After you add the resident's information (including the COMP/FRI subgroup), go back to the Investigations screen. Click on the resident you just added and add the complaint allegations as the areas you are going to investigate (e.g., if the resident had concerns with falls, you would initiate accidents).
- If a **RRI/family interview** is completed during the **investigative process**, complete the RRI interview on the Resident Manager screen.
  - If the resident was already included in the initial pool, go to the RI screen to complete the RRI interview.
  - If the resident was not a part of the initial pool, go to the RI screen and select the "Add to Initial Pool for Representative Interview" button in the header to complete the RRI interview.

VI. ONGOING AND OTHER SURVEY ACTIVITIES

Step 19: Complete closed record reviews

- Complete the closed record reviews any time during the investigation but early enough in the survey to afford you enough time to investigate any concerns.
- Use the hospitalization, discharge, and death pathways to complete the closed record reviews.
- If concerns are identified with the discharge summary, the team can discuss whether to expand and review additional closed records.
- Record your **final citation and severity decision** by selecting Yes (compliance), No (noncompliance identified) or NA (if the CE does not apply to your investigation).
- If you mark a CE as No, you should have investigative documentation and severity. When determining severity, refer to the severity grid and the psychosocial outcome severity guide in the software.

Step 20: Complete facility task assignments

- **Complete facility task investigations** any time during the survey (as long as it does not interfere with completing initial pool activities), unless otherwise noted.
- Go to **Facility Tasks in the Navigation menu**
- Click on the facility task to access the investigation screen (confirm you are assigned

to the task).

- To access the **reg** or **IG**, click on the tag.
- Complete a thorough investigation for facility tasks (as described below) referring to the Facility Task pathway for guidance (on-screen pathway probes are listed before the CE).
- Record your **final citation and severity decision** by selecting Yes (compliance), No (noncompliance identified), or NA (if the CE does not apply to your investigation).
- If you mark a CE as No you should have investigative documentation. When determining severity, refer to the severity grid and the psychosocial outcome severity guide in the software.
- **Highlight** information (e.g., reminder to follow up on an area) by using the highlight icon. Ensure you remove any highlighting for any CE marked as No. If the highlighting is not removed from the text, it will appear on the CMS-2567.
- If **information is deleted** from your Investigation Notes, view the document history by clicking on "hx". Select the date and time to determine if the information was **saved in the history**. If so, copy and paste the text from the history into the Investigation Notes screen.
- If you need to view another surveyor's documentation, at the bottom left of the screen, select **All Surveyors** from the **Show Answers** for drop-down menu. All notes and CEs marked by other surveyors display in read-only format. A No for In Compliance overwrites any Yes marked for the same CE.
- Once you have answered all CEs, you will receive a **green checkmark** on the Facility Task screen indicating the task is complete.
- The Facility Task screen will **display the tags cited by the surveyor** (after data is shared, the tags that are in bold are cited by you). The team will review these tags during the potential citations meeting.
- To **add a facility task**, click on the Add New Task icon.
- All facility tasks have the ability to **add a resident to the notes field**. In the notes field, use **ALT+R** or click on the person icon (next to the clock icon) to open a box with a list of residents, select the resident by placing a checkmark next to their name and click OK. The resident will be displayed in the notes field and listed on the "Sample List Provided to the Facility" report.
- You can also **add a resident to the Sample List report** for the facility by selecting the resident on the Sample List Facility screen. If the **resident isn't listed** in the drop-down, add the resident's name and room number to the resident list by clicking on the Add New Resident icon on the facility task screen. The admission date, subgroup, and assigned surveyor are not required if the resident is not a part of the initial pool. Click Save.
- Any general **facility task complaint** or complaint resident associated with a facility task that was added on the Offsite Prep screen will display on the facility task screen and will be displayed as a complaint (COMP).

Dining

- Note: Starting on 11/12/21, CMS is temporarily allowing the dining task to be discretionary and completed only if there is an outstanding complaint or if a resident is investigated for nutrition, weight loss, or FIs related to dialysis. If the task will not be completed, remove the task and document the rationale (i.e., removed at the discretion of the SA).
- Residents may be displayed in the resident box if they had an MDS indicator of weight loss or dehydration or they had further investigate marked for nutrition, hydration or food quality. Clicking on the resident's name will show the relevant interview notes.
- All surveyors complete dining observations for the first full meal. However, only the surveyor assigned responsibility of the task has to answer all CEs. All other surveyors just answer the CEs of concern (and/or those that are applicable to their observations).
- If concerns are identified, a second meal observation may occur after the sample is selected.
- In tablet mode, use your stylus to document any dining observation just as if you were writing on a piece of paper (e.g., to draw the layout of a table or meal).
- Two tags are applicable for **CE6** (F676 and F677). If you determine noncompliance with CE6, mark the CE as No; click Select; put a checkmark next to the tag(s) you want to cite, and indicate the appropriate severity; click Save.

Infection Control

- All surveyors observe for breaks in infection control throughout the survey, as specified on the pathways and investigative protocols.
- The assigned surveyor(s) should **coordinate a review** of the infection prevention and control program, review of relative infection prevention and control policies and procedures, interview of qualified designated infection preventionist), testing of staff and residents for communicable diseases (e.g., COVID-19) in accordance with national standards, antibiotic stewardship program, and the influenza, pneumococcal and COVID-19 immunizations for residents.
- The system will display any initial pool resident who had an FI marked for **Infections (not UTI, Pressure Ulcers, or Respiratory)** and *the three* **Transmission-Based Precautions** that will require an investigation. Clicking on the resident's name will show the initial pool notes. *Under the 'Originating Initial Pool Area' column, the initial pool response (FI or No Issue) will be displayed for TBP.*
- **Sample one staff** to verify compliance with staff-related requirements and national standards, such as offering and educating on immunization and testing.
- **Sample three residents** for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions (TBP), as well as resident care, screening, testing, and reporting.
- **Sample five residents** for influenza, pneumococcal and COVID-19 immunizations.
- The **residents reviewed for influenza, pneumococcal and COVID-19**

vaccinations, should be **added to the resident box** on the infection control screen. To add a resident to the box, click on the resident icon in the upper right corner, place a checkmark next to the resident you want to add and click OK. **Include the immunization reason** the resident is being added by using the drop-down in the Reason column. You do not have to add a reason for initial pool residents with an FI for an infection.

- If there is a concern about a water management program in the facility, ask the facility to identify if any residents have been diagnosed with Legionnaires' disease.
- If there are concerns with the Antibiotic Stewardship Program, surveyors should complete an investigation for at least one resident on an antibiotic and utilize the Unnecessary Medication Review CE Pathway to assess whether the resident(s) are being prescribed antibiotic(s) unnecessarily. If concerns are identified, expand the sample as needed to determine S/S of findings.
    - Determine if at least one resident who is receiving an antibiotic is already included in the sample from the initial pool or was selected for the Unnecessary Medication Review.
    - If there aren't any sampled residents, select a high-risk resident receiving an antibiotic from the infection log (e.g., UTI without a culture, long-term use, repeated use, no active infection noted) to add to the sample.
- Only the surveyor assigned responsibility of the task has to answer all CEs. All other surveyors just answer the CEs of concern (and/or those that are applicable to their observations).

SNF Beneficiary Notification Review

- Randomly select three residents from the list provided by the facility on the Entrance Conference worksheet.
- Give the facility three Beneficiary Notification worksheets to complete, one for each resident.
- The **residents reviewed** should be **added to the resident box** on the Beneficiary Notices screen. To add a resident to the box, click on the resident icon in the upper right corner, place a checkmark next to the resident you want to add and click OK.
- Review the completed worksheets and notices with the provider if issues are identified.
- If the facility is a Medicaid-only facility, the Beneficiary facility task will not be listed.

Kitchen

- Make observations throughout the survey to gather all needed information.
- In tablet mode, use your stylus to document your any kitchen observation just as if you were writing on a piece of paper.
- For CE16 (unit refrigerators), either the assigned surveyor can review all unit refrigerators or the review can be shared amongst team members. In that case, each team member should assign themselves to the task and only answer CE16 based on their findings.

Med Admin

- We highly recommend that nurses and pharmacists conduct this task.
- More than one surveyor can be assigned to the med admin task. However, only the surveyor assigned responsibility of the task has to answer all CEs. All other surveyors just answer the CEs of concern (and/or those that are applicable to their observations).
- If the opportunity presents itself, observe meds for a sampled resident whose med regimen is being reviewed. Otherwise, observe meds for any resident to whom the nurse is ready to administer meds.
- Observe different routes, units and shifts.
- Observe **25 medication** opportunities, including whether the administered med is expired.
- There are two options to document your med observations (click Med Admin Observation icon in the upper right corner):
    - Option 1: Handwriting panel – Uncheck the Show Text Editor box. In tablet mode, use your stylus to document your med observation just as if you were writing on a piece of paper. Enter YOUR number of errors and opportunities in the error calculator at the top of the screen.
    - Option 2: Text editor – Uncheck the Handwriting Panel box. You can type in your med observations. Enter YOUR number of errors and opportunities in the error calculator at the top of the screen.
- On the main med admin screen, once the team shares their data, you can review the team's med error rate by changing Show Answers for to All Surveyors (the system will consolidate and calculate the team's error rate from each individual surveyor's error rate).
- If the team has a med error rate of five percent or greater, once data is shared, one surveyor should insert the combined med error rate in the investigation notes by clicking the **Paste Med Admin Rate** icon next to the font size.
- To view another surveyor's **medication observations**, click the **Med Admin Observation icon** in the upper right corner. In the bottom left of the screen, select the applicable surveyor from the **Staff ID** drop-down menu.

Med Storage and Labeling

- Note: Starting on 11/12/21, CMS is temporarily allowing the med storage task to be discretionary and only completed if there is an outstanding complaint, or concerns from the ombudsman or concerns identified when completing the med admin observation task. If the task will not be completed, remove the task and document the rationale (i.e., removed at the discretion of the SA).
- Any surveyor can complete the med storage task.
- At the top of the screen, enter the number of med storage rooms and the number of med carts the facility has. The system will tell you how many areas should be reviewed.
    - Review half of the med storage rooms, covering different units.
    - Review half of the med carts on units where the storage room was not observed.

- If there are no concerns, the review is complete.
- If there are concerns, expand and review more meds in the med carts and med storage rooms.

Resident Council Interview

- Note: Starting on 11/12/21, CMS is temporarily allowing the resident council task to be discretionary and only completed if there's an outstanding complaint, or concerns from the ombudsman or during the initial pool (e.g., with visitation or grievances). If the task will not be completed, remove the task and document the rationale (i.e., removed at the discretion of the SA).
- Complete an interview with active members of the Resident Council early enough in the survey to afford you enough time to investigate any concerns preferably on Day 2 of the survey.
- If there is not a Resident Council, do not conduct this task; however, determine whether residents have attempted to form one and have been unsuccessful, and if so, why. To remove the task, on the Facility Task screen, the TC selects the X in the Remove column and select "No Resident Council" as the reason for the removal.
- Request the assistance of the president for arranging the meeting. If there is no president, ask for a list of active Resident Council participants and select a resident to assist in arranging the meeting.
- Surveyors can invite residents (even those not in the Resident Council) they encounter who are able to converse and provide information.
- Try to keep the group manageable, usually no more than 12 residents to facilitate communication.
- Obtain permission from the president to **review council minutes**.
- Review three months of minutes prior to the interview to identify any unresolved areas of concern to discuss during the meeting.
- If the ombudsman has indicated interest in attending the interview, ask the president if that is acceptable; if it is, notify the ombudsman of the time/place of the meeting.
- When conducting the interview, refer to the questions on the Resident Council screen.
- For **CE11**, the **CASPER PBJ Staffing Data information** is flagged as "PBJ Staffing" with a link to the staffing details.
- For **CE24,** if the response is Yes (i.e., residents have been asked to enter into a binding arbitration agreement), the **arbitration** task will be triggered, if not already triggered during the Entrance Conference. If the response to CE24 is No, CE25 will automatically be marked as NA. Communicate to the surveyor who is assigned the arbitration task the names of the residents who should be reviewed.
- For **CE26**, if **additional concerns** are identified and your investigation determines noncompliance, you can select the appropriate Ftag and severity level by clicking Yes for the resident council answer; then clicking No for In compliance; and then clicking Select to view all the tags—select the appropriate tags and assign a severity; click Save.
- Document the names of the residents in the meeting by selecting the **Add**

Residents icon in the top right corner of the screen and selecting all attending residents' names; click OK. Under the Other column, indicate whether the resident is the President, attends resident council meetings or does not attend meetings.

Sufficient and Competent Nurse Staffing

- Any initial pool resident who had further investigate marked for sufficient staffing will be displayed in the resident box. Clicking on the resident's name will show the initial pool notes.
- Part I completed by all surveyors. Throughout the survey, all surveyors are considering whether concerns with staffing can be linked to resident or resident representative complaints, or quality of life and care concerns.
- Part II is completed by the TC or the surveyor assigned primary responsibility to assess off-hour surveys, staffing waivers, and the nurse aide training/competency evaluation program.
- Only the surveyor assigned primary responsibility for the task has to answer all CEs. All other surveyors just answer the CEs of concern (and/or those that are applicable to their observations).
- The **CASPER PBJ Staffing Data information** is flagged as "PBJ Staffing" with a link to the staffing details. Use this information to aide in the investigation into staffing and PBJ staffing concerns.
    - Surveyors may copy and paste from the PBJ table into the Facility Task Notes field.
        - To copy and paste the PBJ Staffing table information, click the "PBJ Staffing" link.
        - Click on each concern listed in the table.
        - Use **CTRL+C** (to copy).
        - Close the table, place your cursor in the Facility Task Notes field and use **CTRL+V** (to paste).
    - *If the facility failed to submit PBJ data, CE1 (F851) on the Sufficient and Competent Nurse Staffing pathway was automatically marked as No, from information input by the Team Coordinator completed on the Offsite Preparation screen. F851 should be cited at an F-level so severity level 2 will be marked. It should be an extremely rare circumstance when a facility is not cited if the PBJ data report indicates they did not submit PBJ data for the quarter. If the team thinks the facility should not be cited, the team coordinator must email NHStaffing@cms.hhs.gov. CMS will respond by the end of the next business day and copy the CMS location.*

The following **triggered tasks** are completed only if the survey team has concerns:

- To review a consolidated list of residents and initial pool notes, click on the Resident Initial Pool Notes radio button at the bottom right of the screen. Copy and paste any applicable initial pool notes into the Facility Task Notes. Only the Facility Task Notes pull forward to the Potential Citation screen.

Personal Funds

- Complete this review when there are identified concerns with sampled residents not having access to funds or not receiving a quarterly statement. Only complete the applicable section of the pathway.

Environment

- Complete an environmental review only if there are concerns identified with sampled residents.
- If you are assigned to the task and you double click on Environment, you will receive a pop-up screen where you should place a **checkmark next to the area(s) you are investigating**. All areas that are not checked will be automatically marked as NA.
    - If you don't know which areas you are investigating, you may bypass the pop-up. After reviewing the consolidated initial pool notes on the screen, click the Task Matrix in the top right corner to mark the areas you are investigating.
    - During your investigation, if you identify concerns for an area marked as NA, you may override the NA with the appropriate CE decision.
- Review the specific concerns the team has with the environment. Note: it may not be necessary complete a review of the entire environment.
- Do not complete a review of oxygen storage, the generator, or the Emergency Preparedness review as these areas are reviewed by life safety and not required to be done by the Health Survey team unless required by state practice or the Health Survey team is conducting the Emergency Preparedness Review during the LTCSP Standard survey.

Resident Assessment

- Complete this review if there were concerns with 1) a delay with the completion and/or submission of MDS assessments (i.e., admission, quarterly, annual, or significant change assessment); and/or 2) MDS discrepancies for care areas that were not marked for further investigation.
- Each surveyor should review their own residents who had MDS discrepancy concerns (review the screen for the list of residents who had concerns).

Binding Arbitration Agreement

- Complete this review if a resident or representative was asked to enter into a binding arbitration agreement.
- The task may trigger based on the TC's response on the Entrance Conference screen or the surveyor's response to CE24 on the Resident Council Interview task.
- **Select three residents**, as available. We recommend selecting up to two residents who signed the binding arbitration agreement and one resident who had a resolved dispute, if available. Attempt to select residents that are already in the finalized sample, when possible.
- **Add the name of the selected residents** in the resident box on the Arbitration screen (or via the "Add Residents To Facility Task" icon in the right panel) and

identify the reason the resident is being selected: 1) Signed binding arbitration agreement, and/or 2) Resolved dispute.

Extended Survey

- If SQC is cited, the team will complete the extended survey. If the team plans to complete the extended during the survey (or once the team returns to complete the extended survey), go to Facility Tasks from the Navigation menu, initiate the task, and assign the surveyor(s) who will investigate the extended survey.

Step 21: End of the day meeting

- Each team member **shares their data with the TC** (follow step 10 for instructions) prior to the team meeting.
- The **TC should share data** with the team so they can follow along on the team meeting screen.
- **Meet for about 30 minutes at the end of each day** to discuss the areas noted on the Team Meeting screen (Go to Team Meeting in the Navigation menu, select the Investigation button).
- Team members should follow along on the screen while the TC conducts the team meeting.
- The system populated areas include:
  - Are there newly identified harm or IJ concerns (system populates only if severity 3 or 4 is marked)?
  - How much work does each surveyor have left to complete?
  - Review the list of investigation concerns (i.e., CEs = No) and ensure the team discusses potential staffing concerns. **CASPER PBJ Staffing Data information** is flagged as "PBJ Staffing" with a link to the staffing details.
  - Have at least three resident representative interviews been completed?
- The team should discuss whether there are any concerns regarding **unethical, criminal, civil or administrative violations** by the facility. The TC will indicate a response (Yes or No) at the bottom of the team meeting screen. If Yes, the assigned surveyor will initiate F895, Compliance and Ethics, for the Facility on the Investigation screen.
- **If the team determines SQC** at any point during the survey, the extended survey should be completed. If the team plans to complete the extended during the survey, go to Facility Tasks from the Navigation menu, initiate the task, and assign the surveyor(s) who will investigate the extended.

Step 22: Complete QAPI/QAA

- This facility task should take place at the **end of the survey;** however, with enough time to investigate and follow-on potential concerns.
- Prior to interviewing the facility staff about the QAA program, **review** the Facility Rates for MDS Indicators, prior survey history, FRIs, and complaints to remind yourself of present concerns and repeat deficiencies.
- Review the **QAPI plan**.

- During team meetings, ensure you have a list of concerns the facility should be aware of (e.g., high-risk areas, harm or IJ, pattern or widespread issues, or concerns identified by two or more surveyors).
- If a surveyor cites F600 (abuse or neglect), the information will be displayed on the QAPI/QAA screen to ensure the TC determines whether the QAA committee also identified the issue and made a "Good Faith Attempt" to correct it.
- To access the **reg** or **IG**, click on the tag.
- Record your **final citation and severity decision** by selecting Yes (compliance), No (noncompliance identified), or NA (if the CE does not apply to your investigation).
- If you mark a CE as No you should have investigative documentation. If you need severity guidance, click on the information icon.

VII. POTENTIAL CITATIONS

Step 23: Share Completed Investigation Data, Confirm Investigation Data is Complete, and Team Deficiency determination

- When you complete all investigations, share your data with the TC using the Data Sharing screen. Click on the flash drive on the right side of the screen. Refer to Step 10 for instructions. **All data must be shared before conducting the potential citation meeting.**
- Review the Investigation (filter to All Surveyors) and Facility Task screens and ensure all **investigation work has been completed** by ensuring a green checkmark is next to every area listed.
- If there is incomplete work, the surveyor should complete the work, and then share the data with the TC.
- Verify the combined med error rate is consistent with the response for CE1 (med error rate). If the error rate is less than 5% but a surveyor marked CE1 as No, do not cite the tag during the potential citation meeting. If the error rate is 5% or greater but CE1 is not marked as No, update the response for CE1 prior to the potential citation meeting.
- The TC should then share the consolidated list of potential citations with the team (refer to Step 10 for instructions).
- For each potential citation, the team makes a **compliance determination**. If noncompliance exists, the team determines the **S/S** of the deficiency.
- Select a tag to have the information display on the right side of the screen.
- To **cite a tag**, place a checkmark next to each resident who should be included in the citation, mark Cite and include the final severity and scope.
  - When determining S/S, refer to the severity and scope grid (click the arrow in front of S/S), guidance on S/S, and the psychosocial outcome severity guide found in the Survey Resources folder.
  - For any tag cited at a G or J S/S, mark the singular event box, if applicable. Refer to the link for the singular event definition.
  - For any tag cited at Immediate Jeopardy, identify the IJ start and end dates. Refer

to the link for the IJ start and end date definitions.

- If the evidence gathered during the survey for a particular requirement includes examples of various S/S levels, surveyors should classify the deficiency at the highest level of severity, even if most of the evidence corresponds to a lower severity level. For example, if there was a deficiency in which one resident suffered a severity 3, while there were widespread findings of the same deficiency at severity 2, then the deficiency would be classified as severity 3, isolated.
- Past noncompliance may be identified during any survey of a nursing home. When a citation of past noncompliance is written, a nursing home does not provide a plan of correction as the deficiency is already corrected. However, the survey team documents the facility's corrective actions on Form CMS-2567. (Additional information about citations of past noncompliance is found at Chapter 7). To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:
  - The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;
  - The noncompliance occurred after the exit date of the last Standard survey and before the survey currently being conducted; and
  - There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s).
- Document the Deficient Practice Statement, universe, or notes for the exit conference in the Opening Statement field. The **universe** is the number of residents investigated for each care area as noted on the Final Sample screen in the Care Area Menu.
- Select the appropriate **survey categories** such as recertification and complaint for each cited tag. If the cited tag was associated with a complaint on the Offsite Prep screen, the complaint category will automatically be checked, but you will need to check the recertification category for the complaint tags.
- If the team cites a tag at **SQC**, a warning will appear on the right pane above the Opening Statement title reminding you that an extended survey has to be conducted.

- If you **don't cite a tag**, ensure no residents are checked, mark Don't Cite and include a rationale.
  - *If the facility failed to submit PBJ data, F851 will automatically be cited at an F-level. It should be an extremely rare circumstance when a facility is not cited if the PBJ data report indicates they did not submit PBJ data for the quarter. If the team thinks the facility should not be cited, the team coordinator must email NHStaffing@cms.hhs.gov. CMS will respond by the end of the next business day and copy the CMS location.*
- If you want to **move the citation to a different tag**:
  - Mark Don't Cite.
  - Select the reason not to cite as, Move to another tag.
  - Click on the Select Tag button.

  - Place a check mark next to Select? For the correct tag.
  - Click Save.
  - To undo this action and return to the original tag, locate the tag you moved, select the original tag (it will be listed under the title Moved Tags), click on the Select Tag button, uncheck the tag you moved it to, and click Save. The tag is now refreshed to its original tag. Ensure the tag was moved to the original tag.
- If during decision making you receive additional information from the facility (e.g., an interview, a document relevant to a citation), enter the information in your investigation screen and edited text if appropriate. Any newly added text will pull forward to the potential citation screen.
- To assist with the Exit Conference, the TC may refer to the "Potential Citations – Opening Statement for Cited Tags" report. The report displays cited tags, residents, and just the notes that were documented in the Opening Statement.

Step 24: Exit Conference with Facility

- Conduct an exit conference with the facility administration/leadership to inform the facility of the survey team's observations and preliminary findings. Ask the Administrator to invite the Medical Director to the exit conference.
- Invite the ombudsman and an officer of the organized residents' group, if one exists, to the exit conference. Also, invite one or two residents to attend. The team may provide an abbreviated exit conference specifically for residents after completion of the normal facility exit conference. If two exit conferences are held, notify the ombudsman and invite the ombudsman to attend either or both conferences
- Do not discuss survey results in a manner that reveals the identity of an individual resident. Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure ulcers," not "Tag F686." If the provider asks for the specific tag, you should provide this information, cautioning the facility that the tags are preliminary. Under no circumstances, should you provide the S/S for a given deficiency, unless it is an immediate jeopardy. If a provider asks if the noncompliance is isolated, pattern, or widespread, you should respond with the facts such as the noncompliance was found to affect "X" number of residents (Ref: S&C: 16-11-ALL).
- Describe the team's preliminary deficiency findings to the facility and let them know they will receive a report of the survey that will contain any deficiencies that have been cited (Form CMS-2567).
- If an extended survey is required and the survey team cannot complete all or part of the extended survey prior to the exit conference, inform the Administrator that the deficiencies, as discussed in the conference, may be amended upon completion of the extended survey.
- During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.

- If your state provides the sample list during the exit, click the Reports icon; select the "**Sample List Provided to Facility**" report; click **Run Reports** and then send the report in a secure method electronically OR print the report. States may also elect to send the Sample List with the CMS-2567. To add any resident to the report, select Add Residents to List in the navigation menu.

Step 25: Load Cites

- Exit the tool and click on **Load Cites** on the Citation Manager screen.
- If any potential citations are incomplete for any tags, you will receive a warning that the LTSCP Load Validation Failed.
  - The tags listed cannot be loaded from LTCSP because the tags listed have errors.
  - Click okay.
  - Return to the LTC Survey to fix the errors.
  - Exit the tool.
  - Click on Load Cites on the Citation Manager screen.
  - Repeat this until all errors have been corrected and you are able to Load Cites.
- Edit the potential citation documentation following your state practice (e.g., either in ASE-Q or ACO). Refer to the **Editing Finalizing Statement of Deficiencies** document in the Survey Resource folder for specific guidance. The general objective of this section is to write the statement of deficiencies in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. For findings of past noncompliance and or current noncompliance indicate the data prefix tag and regulatory citation, followed by a summary of the evidence and supporting observations using resident identifiers. This documentation must be written in language specific enough to use to identify levels of S/S at the completion of the survey. If information was identified during confidential resident interviews, do not include a resident identifier when recording the source of the evidence. List the data tags in the order specified in the Code of Federal Regulations. The statement of deficiencies should:
  - Specifically reflect the content of each requirement that is not met;
  - Clearly identify the specific deficient entity practices and the objective evidence concerning these practice
  - Identify the extent of the deficient practice, including systemic practices, where appropriate; and
  - Identify the source(s) of the evidence, e.g., interview, observation, or record review.
- If SQC is identified but the **Extended survey is completed after the Standard survey**, documentation of noncompliance should be completed in the same survey shell. Do not upload the survey in ACO until the extended is completed; however, you may load citations to begin finalizing tags for the CMS-2567.

Step 26: Save and Delete Completed Survey

- Export the completed survey from ASE-Q and import the survey back into ACO following your State's practice.
- If the floor plan was inaccurate, ensure the TC includes an updated floor plan for the

next survey.

- After the completed survey is imported back to ACO according to your State's practice, delete the survey from ASE-Q.
  - Right click on the Event ID or Facility name (depending on what you want to delete)
  - Select Send to Recycler
  - Select Yes at the message, "Are you sure you want to send this survey (Event ID) to the ASPEN Recycler?"
  - Delete the survey from the ASE Recycler
  - Expand the Recycle listing
  - Right click the Event ID
  - Select Delete

Attachment A: Sample Size, Recommended Team Size, Initial Pool Size, and Complaint/FRI Size

This table shows the following survey expectations based on facility census size: recommended number of surveyors, maximum number of complaint/FRI residents that can be included in the initial pool and sample, expected initial pool size, and sample size. Also see "Note on Survey Team Size" below the table.

Facility Census	Recommended # of Surveyors	Max # Complaint/ FRI Residents in IP and Sample	Initial Pool Size (approximate)	Sample Size #
1-8	2	5	All residents	All residents
9 – 15	2	5	All residents	8
16 -19	2	5	16	8
20 – 48	2	5	16	12
49 – 52	3	6	24	13
53 - 56	3	6	24	14
57 – 61	3	7	24	15
62 – 65	3	7	24	16
66 – 69	3	7	24	17
70 – 90	3	8	24	18
91 – 95	3	8	24	19
96 – 100	4	9	32	20
101 – 105	4	9	32	21
106 – 110	4	9	32	22
111 – 115	4	10	32	23
116 – 123	4	10	32	24
124 – 128	4	10	32	25
129 – 133	4	10	32	26
134 – 138	4	11	32	27
139 – 143	4	11	32	28
144 – 148	4	11	32	29
149 – 153	4	12	32	30
154 – 158	4	12	32	31
159 – 164	4	13	32	32
165 – 169	4	13	33	33
170 – 174	4	13	34	34

Facility Census	Recommended # of Surveyors	Max # Complaint/ FRI Residents in IP and Sample	Initial Pool Size (approximate)	Sample Size #
≥175	5	14	40	35

*For facilities with a census from 149 to 174, if the survey team includes the maximum number of complaint/FRI residents shown in the table, the total number of offsite selected residents combined with the complaint/FRI residents may slightly exceed the initial pool size shown in the table. However, a review of survey data shows teams include more residents in the initial pool than what is required for larger facilities.

Note on Survey Team Size

The recommended number of surveyors shown in the second column in the table is for a typical standard recertification survey without any complaints/FRIs that will be investigated with the survey. We note that team size for an initial certification or annual recertification survey also will depend on other tasks that may need to be performed at the time of the survey (e.g., complaints/ FRIs, licensure tasks, facility history of larger care concerns). Survey agencies should staff the team to promote an effective and efficient survey process.

The recommended number of residents to include in the initial pool is based on the recommended number of surveyors indicated in the table above. For example, if the facility has 32 residents, two surveyors can complete the survey. This means that there will be about 16 residents in the initial pool (eight residents per surveyor). However, States have some **flexibility** around the recommended number of surveyors for a survey. **If the SA sends more or fewer surveyors than what is recommended, the initial pool size stays the same** but the number of residents per surveyor will be adjusted.

- If a State decides to send **more than the recommended number of surveyors** (e.g., because the survey needs to be done in a shorter time period), then it is acceptable for the team to split unit assignments and distribute the expected initial pool size across the larger team.
    - Example: A facility has a census of 56. Three surveyors are recommended for the expected initial pool of 24 residents. The SA sends six surveyors instead of three. Each of the six surveyors then has four initial pool residents, for a total of 24 across the team.
- If a State sends **fewer than the recommended number of surveyors**, the smaller team also must adjust their initial pool numbers and have more initial pool residents per surveyor.
    - Example: A facility has a census of 125. Four surveyors are recommended for the expected initial pool of 32 residents. The SA sends two surveyors instead of four. Each of the two surveyors then has 16 initial pool residents, for a total of 32 across the team.

Because SAs typically do not know the current facility census until the survey team arrives onsite, they can estimate the census based on bed size, past experience, or other knowledge when deciding how many surveyors to send. Once onsite, if the census differs from the estimate, the survey team will refer to the table and adjust the sample size and initial pool size as needed.

Attachment B: Policy for Including Complaints and Facility Reported Incidents with Standard Survey

A maximum number of complaint/FRI residents that can be included in the initial pool and sample is designated for each facility census size. While SAs may now include a larger number of complaint/FRIs in the initial pool and sample (following the designated maximums), the system will still select offsite selected residents to include in the initial pool, and for surveys at most facility sizes, surveyors will still identify additional residents (although a lower number) to include in the initial pool based on screening results.

If a team is including more than the maximum number of residents named in complaints or FRIs (as listed in Attachment A) with the standard survey, those residents would be in addition to the initial pool and sample size. **In these cases, we expect either the size of the survey team to be increased, or the duration of the survey to be lengthened.**

The two exceptions to this policy are 1) if the LTCSP software selects a number of offsite-selected residents who also have a complaint/FRI that exceeds the maximum number of complaint/FRI residents to be included in the initial pool and sample per Attachment A. In this case, you do not have to remove the additional complaint/FRI residents from the offsite-selected residents since you would be including these residents in the initial pool; or 2) there is a general care concern that is not tied to a specific resident and would be addressed during the standard survey (e.g., the complaint is tied to a facility task or to a care concern -- for example, there is not enough water available for residents).

Complaints deriving from noncompliance with state licensure regulations would be operationalized separately. In other words, the complaints threshold has been developed to capture those complaints and FRIs that are associated with federally related activities that need to be completed. This does not change CMS' policy that noncompliance with federal Requirements of Participation must be evaluated under the federal survey process and cannot be surveyed only under state licensure requirements.

Enforcement Considerations

Please note, when imposing an enforcement remedy for past noncompliance, CMS may reach back no further than the "last standard survey" to do so. This means that a State should not postpone serious complaints that could lead to enforcement and expect to conduct them after the standard recertification survey.

Scope and Severity Grid

Severity	Scope		
	Isolated	**Pattern**	**Widespread**
Level 4 **Immediate jeopardy to resident health or safety**	**J** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2	**K** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2	**L** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2
Level 3 **Actual harm that is not immediate jeopardy**	**G** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination	**H** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination	**I** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Temporary Management Optional: Termination
Level 2 **No actual harm with potential for more than minimal harm that is not immediate jeopardy**	**D** Plan of Correction Required: Category 1 Optional: Category 2 Optional: Termination	**E** Plan of Correction Required: Category 1 Optional: Category 2 Optional: Termination	**F** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination
Level 1 **No actual harm with potential for minimal harm**	**A** No Plan of Correction No remedies Commitment to Correct Not on CMS-2567	**B** Plan of Correction	**C** Plan of Correction

A, B, C: Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm (42 CFR §488.301).
J, K, L, H, I, F: Substandard quality of care is any deficiency in 42 CFR §483.13, Resident Behavior and Facility Practices, 42 CFR §483.15, Quality of Life, or 42 CFR §483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Offsite Preparation Worksheet

Survey Date: _____ Previous Recertification Survey Date: _____ Offsite Review Date: _____

Facility Name: _____ EventID: _____

Administrator Name: _____

Team (List Coordinator First): _____

☐ Review the CASPER 3 report to determine whether the facility has any patterns of repeat deficiencies.

☐ Results from the last Standard survey.

☐ Review complaints since the last Standard survey.

☐ Review facility reported incidents (FRIs) since the last Standard survey.

☐ Review the CASPER PBJ Staffing Data Report for identified concerns regarding staffing.

Mark all that apply and the applicable quarter.

Concern	***Selected***	***FY Quarter***	***Year***
Low weekend staffing	☐		
RN coverage for 8 consecutive hours/day	☐		
Licensed nurses for 24 hours/day	☐		
1 star staffing rating	☐		
*Failed to submit PBJ data**	☐		

**If the facility failed to submit PBJ data, F851 (CE1) on the Sufficient and Competent Nurse Staffing pathway cite at Severity/Scope of F.*

Staffing Notes:

Note any nurse staffing waiver for onsite review.

☐ List active Complaints and FRIs that will be investigated during this survey. Document the following: the complaint/FRI details; whether a complaint/FRI resident is also offsite selected; and link from the ACTS allegation to the LTCSP (i.e., initial pool, facility task, directly to investigation, closed record). Assign a surveyor.

☐ Was abuse cited on the prior standard survey or have there been any abuse allegations or citations for complaints?

☐ Note any federal waivers/variances for onsite review.

☐ Note any active enforcement cases (resident/issues/dates/reason) that shouldn't be investigated:

☐ Ombudsman Name : Ombudsman Contact date:

Ombudsman's Phone Number:

Ombudsman Area(s) of Concern:

☐ Mandatory facility task assignments:

1) Dining Observation _____
2) Infection Control and Immunizations _____
3) Kitchen/Food Service Observation _____

4) Beneficiary Notification Review
5) Medication Administration
6) Med Storage and Labeling
7) QAPI/QAA
8) Resident Council
9) Sufficient and Competent Nurse Staffing

☐ Team unit assignments:

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Abuse	Staff made resident feel afraid, humiliated/degraded, said mean things, hurt resident; made resident feel uncomfortable. Evidence of abuse (fractures, sprains, dislocations; burns, blisters, scalds on hands or torso; bite marks, scratches, skin tears, lacerations in unusual area; bruises or injuries in unusual areas; fear of others)? Physical/verbal aggression (hitting, kicking, pushing, striking out, threatening others)?	RI/RRI/RO	Abuse Pathway for all CEs Additionally, Investigative Protocol for CE6 (F608)	1	F600	Free from Abuse and Neglect
				2	F606	Not Employ/Engage Staff with Adverse Actions
				3	F607	Develop/Implement Abuse/Neglect, etc Policies
				4	F943	Abuse, Neglect, and Exploitation Training
				5	F947	Required In-Service Training for Nurse Aides
				6	F609	Reporting of Alleged Violations
				7	F610	Investigate/Prevent/Correct Alleged Violation
Accident Hazards	Bed rail or mattress entrapment; Restraint applied correctly; Unsafe cords, outlets, or handrails; Unsafte hot water in room; Inadequate safety equipment or lighting (grab bars, ambulation, transfer, or therapy); Chemicals/other hazards; Exposure to unsafe heating surfaces; Locks disabled, propped fire doors, irregular walking surfaces; Residents adequately supervised.	RO	Accidents Pathway for all CEs Additionally, Investigative Protocol for CE2 (F700)	1	F689	Free of Accident Hazards/Supervision/Devices
				2	F700	Bedrails
				3	F909	Resident Bed
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision
Accommodation of Needs (Physical)	Easily get around room, to/from bathroom, use sink; Reach call device, including reaching the emergency call device if on the floor near your bed, toilet or bath, works; and alternatives if needed; Roommate's items taking over your space; Difficulty getting around room; Enough light in room that can be operated; Difficulty opening/closing drawers or bedroom/bathroom doors; Unable to see self in mirror; Unable to reach items easily; Adaptive equipment available and used.	RI/RRI/RO	Environment Task Pathway	1	F558	Reasonable Accommodations of Needs/Preferences
Activities	Actively participates or is encouraged; Meets interest; Offered on weekends and evenings; Activities provided to do on own; Younger resident engaged in age appropriate activities; Variety of activities available.	RI/RRI/RO	Activities Pathway	1	F679	Activities Meet Interest/Needs of Each Resident
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision
ADLs	Help to get out of bed or walk; Help to use the bathroom; Help to during meals, to clean teeth or get dressed; Hair disheveled, uncombed or greasy; Fingernails untrimmed, jagged or dirty; Facial hair unkempt or present on female resident; Face, clothing, hands unclean or with food debris; Body or mouth odor; Teeth or dentures not brushed or dentures stored in unsanitary manner; Clothing soiled or in disrepair.	RI/RRI/RO	ADL Pathway	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities
				2	F677	ADL Care Provided for Dependent Residents
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
ADL Decline	Change in ability to dress, bathe, transfer, walk, toilet use, clean teeth, or eat. Staff interventions (e.g., to improve, prevent further decline, or no restorative or therapy provided).	RI/RRI/RR	ADL Pathway	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities
				2	F677	ADL Care Provided for Dependent Residents
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Advance Directives (CPR)	Advance directive in place; If kept in two places, information matches.	RR	Guidance to Surveyors and Investigative Protocol	1	F578	Request/Refuse/Discontinue Treatment; Formulate Adv Directives
Antibiotic Use (selected for Unnecessary Med Rev)	Currently receiving an antibiotic; Length of time receiving the antibiotic; Any issues; Staff response.	RI/RRI/RR	Unnec Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Antibiotic Use (not selected for Unnecessary Med Rev)			Guidance to Surveyors	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
Anticoagulant (Selected for Unnecessary Medication Review)	Currently receiving blood thinner; Bleeding, bruising or other issues; Staff response.	RI/RRI/RR	Unnec Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Anticoagulant (Not selected for Unnecessary Medication Review)	Currently receiving blood thinner; Bleeding, bruising or other issues; Staff response.	RI/RRI/RR	Guidance to Surveyors	1	F675	Quality of Life
				2	F684	Quality of Care
				3	F756	Drug Regimen Review, Report Irregular, Act On
				4	F757	Drug Regimen is Free From Unnecessary Drugs

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Antipsychotic with Alzheimer's or Dementia	Currently receiving an antipsychotic and has Alzheimer's or dementia.	RR	Dementia Care Pathway	1	F744	Treatment/Service for Dementia
				2	F552	Right to be informed/Make Treatment Decisions
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
			Unnec. Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Antipsychotic with New Schizophrenia Diagnosis (New Schiz and Antipsychotic)	Older adult with a new schizophrenia diagnosis and receiving an antipsychotic.	RR	Unnec. Meds, Psychotropic Meds and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Bladder and Bowel (B&B) Incontinence and/or Low Risk B&B	Incontinence - when, why, interventions, toileting program? Told to urinate in brief? Incontinent and not at high risk? Urine or BM odor; Resident, clothing or linens soiled with urine or BM; Timely incontinence care; Implementing maintenance programs appropriately.	RI/RRI/RO/ RR	B&B Incontinence Pathway	1	F690	Bowel/Bladder Incontinence, Catheter, UTI
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Call devices in reach, call system functioning	Call device in reach if able to use? Emergency call device system functioning in room, bathroom and bathing areas.	RO	Environment Task Pathway	2	F919	Resident Call Device System
Catheter	Urinary catheter - Why? How long? Problems? Infections? Pain? Tubing properly secured, free of kinks, unobstructed; Drainage bag below level of bladder; Drainage bag off the floor; Signs or symptoms of infection; Drainage bag emptied using separate, clean collection container for each resident; Drainage spigot doesn't touch the collection container.	RI/RRI/RO	Urinary Catheter or UTI Pathway	1	F690	Bowel/Bladder Incontinence, Catheter, UTI
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Change of Condition	Change of condition not identified, monitored, or treated appropriately.	RR	Guidance to Surveyors	1	F684	Quality of Care
Choices	Choices about daily life, bathing, food and fluids, meal time, getting up, going to bed, activities, medication times, doctor, visitors any time.	RI/RRI	Guidance to Surveyors	1	F561	Self Determination
Constipation/ Diarrhea	Bowel or colostomy problems; Constipation (> three days); Diarrhea; Effectiveness of a bowel management program, if applicable.	RI/RRI	General Pathway	1	F684	Quality Of Care
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Dental	Problems with teeth, gums, dentures; Broken, missing or loose teeth; Inflamed or bleeding gums; Ill fitting, damaged, or missing dentures; Difficulty chewing food; Available oral hygiene products; Assistance with oral hygiene, as needed; Help making dentist appointments.	RI/RRI/RO	Dental Status & Services Pathway	1	F790	Routine/Emergency Dental Services in SNFs
				2	F791	Routine/Emergency Dental Services in NFs
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Dialysis	Hemodialysis or peritoneal dialysis (HHD): Where and how often receive dialysis; Who administers in facility; Access site location, how often monitored, arm used for B/P, bleeding; Infections; Problems before, during or after dialysis; Weights, vital signs, meals, medications, fluid and dietary restrictions; Communication between dialysis center and facility. Offsite hemodialysis: Transportation arrangements and concerns.	RI/RRI/RR	Dialysis Pathway	1	F698	Dialysis
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
			Nutrition Pathway	1	F692	Nutrition/Hydration Status Maintenance
				2	F710	Resident's Care Supervised by a Physician
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Dignity	Treated with respect and dignity; Searched self, room or belongings without permission; Knock, ask permission to enter room; Explain service or care provided; Include resident in conversation; Visual privacy of body while visible to others; Urinary catheter bag/other body fluid collection device covered; Respond to resident's call for assistance timely; Poorly fitting clothing; Clothing or face soiled after meals; Staff used a label or pet name; Confidential clinical/personal care instructions in viewable areas; Dressed in institutional fashion; Name visible on clothes.	RI/RRI/RO	Guidance to Surveyors	1	F550	Resident Rights/Exercise of Rights
Discharge	Discharge goals include going back to the community? Included in discharge planning? Referrals to agencies to assist with living arrangement or cares?	RI/RRI	Discharge Pathway	1	F660	Discharge Planning Process
				2	F661	Discharge Summary
				3	F622	Transfer and Discharge Requirements: Discharge Appropriate
				4	F622	Transfer and Discharge Requirements: Discharge Documentation in Record
				5	F623	Notice Requirements Before Transfer/Discharge
				6	F626	Permitting Residents to Return to Facility

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Edema	Legs, feet, arms, or hands swollen? Elevated? Support stockings?	RO	General Pathway	1	F684	Quality Of Care
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision
Environment	Comfortable room or building sound levels; Temperature in room and building not too warm or too cool; Room and building clean; Water temperature aren't too hot or cold; Bed clean and comfortable; Walls, floors, ceiling, drapes, furniture not clean or in disrepair; Bed linens or fixtures soiled; Resident care equipment unclean, disrepair, stored improper; Hot water too cold; Room not homelike; Lighting levels inadequate; Stains from water damage; Transmission-based precautions: dedicated or disposable noncritical resident care equipment used.	RI/RRI/RO	Environment Task Pathway (only investigate the CE of concern)	1	F558	Reasonable Accommodations of Needs/Preferences
				2	F919	Resident Call Device System
				3	F584	Safe/Clean/Comfort/Homelike Envir: Sound Levels
				4	F584	Safe/Clean/Comfort/Homelike Envir: Temperature Levels
				5	F584	Safe/Clean/Comfort/Homelike Envir: Lighting Levels
				6	F584	Safe/Clean/Comfort/Homelike Envir: Clean Building
				7	F584	Safe/Clean/Comfort/Homelike Envir: Building and Equipment in Good Condition
				8	F908	Essential Equipment, Safe Operating Condition
				9	F584	Safe/Clean/Comfort/Homelike Envir: Homelike
				10	F584	Safe/Clean/Comfort/Homelike Envir: Water Too Cool
				11	F584	Safe/Clean/Comfort/Homelike Envir: Linens
				12	F925	Maintains Effective Pest Control Program
				13	F923	Ventilation
				14	F924	Corridors Have Firmly Secured Handrails
				15	F921	Safe/Functional/Sanitary/Comfortable Environment
Falls	Fall(s) with/without injury? What happened? Fall prevention interventions? Prevention devices in use and functional? Appropriate foot covering?	RI/RRI/RO/RR	Accidents Pathway for all CEs Additionally, Investigative Protocol for CE2 (F700), if applicable	1	F689	Free of Accident Hazards/Supervision/Devices
				2	F700	Bedrails (NA, unless issue identified during investigation)
				3	F909	Resident Bed (NA, unless issue identified during investigation)
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision
Food	Food tastes good, looks good, proper temperature; Accommodate food preferences, allergies, or sensitivities; Provide substitutions, receives preferred snacks.	RI/RRI	Guidance to Surveyors	1	F803	Menus Meet Res Needs/Prep in Advance/Followed
				2	F804	Nutritive Value/Appear, Palatable/Prefer Temp

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
High Risk Meds/Diagnoses/Hospice (Selected for Unnecessary Medication Review)	Currently received antipsychotic with diagnosis of Alzheimer's/dementia, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, insulin, opioids. Excluded if on hospice. Excluded if has a diagnosis of Huntington's syndrome, Tourette's Syndrome, Manic Depression (bipolar disease), Schizophrenia. Cerebral Palsy, Multiple Sclerosis, Seizure Disorder/Epilepsy Note: Do not code aspirin or Plavix as an anticoagulant. Code medications accoring to a drug's pharmacological classification, not how it is used.	RR	Unnec Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Hospice	How long? How often does hospice staff come? Type of care provided? Involved in care planning? Who coordinates care with hospice? Contacted you? Hospice concerns? Who do you talk to about your concerns? Comfortable, agitated, respiratory distress, pain; Privacy for visits.	RI/RRI/RO	Hospice and End of Life Care and Services Pathway	1(A)	F684	Quality of Care (End of Life care)
				1(B)	F684	Quality of Care (receiving Hospice Services)
				2	F849	Hospice Services
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Hospitalization	Recent hospitalizations or ER visits - frequency and why? Bed hold?	RI/RRI/RR	Hospitalization Pathway	1	F684	Quality of Care
				2	F622	Transfer and Discharge Requirements
				3	F623	Notice Requirements Before Transfer/Discharge
				4	F623	Notice Requirements Before Transfer/Discharge
				5	F624	Preparation for Safe/Orderly Transfer/Discharge
				6	F625	Notice of Bed Hold Policy Before/Upon Transfer
				7	F626	Permitting Residents to Return to Facility
				8	F655	Baseline Care Plan
				9	F636	Comprehensive Assessments & Timing
				10	F637	Comprehensive Assmt After Significant Change
				11	F641	Accuracy of Assessments
				12	F656	Develop/Implement Comprehensive Care Plan
				13	F657	Care Plan Timing and Revision
Hydration	Provide or assist with water or other beverages throughout day? Dehydrated and/or received IV fluids? Dry, cracked lips, dry mouth, sunken eyes, signs of thirst; Water pitcher accessible; Provided meal assistance (meal tray/cups/cartons opened and accessible) or resisting or refusing fluids.	RI/RRI/RO	Hydration Pathway	1	F692	Nutrition/Hydration Status Maintenance
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Infections (not UTI, Pressure Ulcer, or Respiratory)	Access to soap and assistance to wash hands? Have you had any other infections recently (e.g., surgical infection, eye infection, blood infection, C. difficile, sepsis, or gastroenteritis such as norovirus, or illness with nausea and vomiting)? Tell me about the infection. Are you currently having any symptoms? Display symptoms? Medical device insertion site or wound dressing have redness or swelling, drainage? If drainage present (document color/amount/type/odor). Does the resident currently have any other infection (e.g., surgical wound infection, eye infection)?	RI/RRI/RO/RR	Infection Prevention, Control & Immunizations Pathway	1	F880	Infection Prevention & Control: Implement Standard & Transmission Based Precautions (TBP), Hand Hygiene, Personal Protective Equipment (PPE) and Source Control
				2	F880	Infection Prevention & Control: IPCP Standards, P&P
				3	F880	Infection Prevention & Control: Infection Surveillance
				4	F880	Infection Prevention & Control: Water Management
				5	F880	Infection Prevention & Control: Linens
				6	F881	Antibiotic Stewardship Program
				7	F882	Infection Preventionist (IP)
				8	F883	Influenza and Pneumococcal Immunizations
				9	F887	COVID-19 Education and Immunization for Residents
				10	F887	COVID-19 Immunization for Staff: Screening, Education & Offering
Insulin (Selected for Unnecessary Medication Review)	Currently receiving insulin; Issues with blood sugars; Staff response.	RI/RRI/RR	Unnec Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Insulin (Not selected for Unnecessary Medication Review)	Currently receiving insulin or anticoagulant; Issues with blood sugars; Issues with bleeding or bruising; Staff response.	RI/RRI/RR	Guidance to Surveyors	1	F675	Quality of Life
				2	F684	Quality of Care
				3	F756	Drug Regimen Review, Report Irregular, Act On
				4	F757	Drug Regimen is Free From Unnecessary Drugs

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Language/ Communication	Different language, uses sign language, other alternative communication means? Staff can communicate with the resident? Communication systems available?	RO	Communication & Sensory Pathway	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities
				2	F685	Treatment/Devices to Maintain Hearing/Vision
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Limited Range of Motion (ROM)	Limitation in joints or contracture? Interventions? Splints in place and correctly applied?	RI/RRI/RO	Positioning, Mobility and Range of Motion Pathway	1(A)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted Without Limited ROM)
				1(B)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted With Limited ROM)
				2	F684	Quality of Care
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Mood/Behavior	Concerns with how the facility addresses history of trauma; Depressed, socially withdrawn, isolated, fatigued, not eating, anxious; Lack emotional affect, short tempered, frustrated, angry, easily annoyed; Hallucinations; Physical or verbal distress towards others; Wandering/pacing (in and out of rooms), rummaging in other's belongings; Combative, confrontational, hitting, scratching, throwing or smearing food or bodily waste, constant vocalizations or sounds annoying to others. Staff recognize behavior/distress? Response is person-centered?	RI/RRI/RO	Behavioral-Emotional Status Pathway	1	F699	Trauma Informed Care
				2	F740	Behavioral Health Services
				3	F741	Sufficient/Competent Staff-Behav Health Needs
				4	F742	Treatment/Svc for Mental/Psychosocial Concerns
				5	F743	No Pattern of Behavioral Difficulties Unless Unavoidable
				6	F745	Provision of Medically Related Social Services
				7	F655	Baseline Care Plan
				8	F636	Comprehensive Assessments & Timing
				9	F637	Comprehensive Assmt After Significant Change
				10	F641	Accuracy of Assessments
				11	F656	Develop/Implement Comprehensive Care Plan
				12	F657	Care Plan Timing and Revision
Notification of Change	Change in condition, treatment, or any accidents? Notified promptly?	RRI	Guidance to Surveyors	1	F580	Notify of Changes (Injury/Decline/Room, Etc.)
Nutrition	Unplanned weight gain or loss and interventions; Meals/eating: assistance, special diet, altered consistency, cueing, difficulty swallowing, encouragement, assistive devices, substitute offered if refused or not eating; Supplements and snacks timing and consumed; Physical appearance of an altered nutritional status.	RI/RRI/RO/ RR	Nutrition Pathway	1	F692	Nutrition/Hydration Status Maintenance
				2	F710	Resident's Care Supervised by a Physician
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Oxygen	Oxygen mask and tubing properly placed? Tubing and humidification dated? Flow rate (liters/minute)? Discomfort or respiratory distress?	RO	Respiratory Care Pathway	1	F695	Respiratory/Tracheostomy Care and Suctioning
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Pain	Verbal or non-verbal signs of pain or discomfort (where, what, how often)? Pain impacts your daily activities? Interventions (prior to opioid use)? Pain relieved? Involved in pain management? Pain meds when needed and timely? Unaddressed med side effects?	RI/RRI/RO	Pain Recognition and Management Pathway	1	F697	Pain Management
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision
Participation in Care Planning	Involved in decisions about care, medication, therapy, treatments, setting goals, care plan meetings? Receive care according to the plan? New admits: Get written summary of your initial care plan? Did they explain it?	RI/RRI	Guidance to Surveyors	1	F657	Care Plan Timing and Revision
Personal Funds	Quarterly statements? Access your money, including weekends?	RI/RRI	Personal Funds Facility Task	1	F567	Protection/Management of Personal Funds
				2	F568	Accounting and Records of Personal Funds: Quarterly Statement
				3	F582	Medicaid/Medicare Coverage/Liability Notice
				4	F568	Accounting and Records of Personal Funds: Separate Accounting
				5	F568	Accounting and Records of Personal Funds: Follow Accounting Principles
				6	F571	Limitations on Charges to Personal Funds
				7	F567	Protection/Management of Personal Funds
				8	F569	Notice and Conveyance of Personal Funds
				9	F570	Surety Bond - Security of Personal Funds
Personal Property	Missing personal items? Asked to sign paper saying facility not responsible for lost items? Encouraged to bring personal items?	RI/RRI	Guidance to Surveyors	1	F584	Safe/Clean/Comfortable/Homelike Environment

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Positioning	Lack of arm/shoulder support; Head lolling to one side, awkward angle; Hyperflexion of the neck; Leaning to the side without support to maintain an upright position; Lack of needed torso or head support; Uncomfortable Geri-chair positioning, sliding down in the chair; Wheelchair too big or too small, seat too long, short, low or high; Dangling legs and feet from chair or too short mattress; Sagging mattress while laying in bed; Bed linens tight holding feet in plantar flexion.	RO	Positioning, Mobility and Range of Motion Pathway	1(A)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted Without Limited ROM)
				1(B)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted With Limited ROM)
				2	F684	Quality of Care
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Preadmission Screening and Resident Review (PASARR)	Level II PASARR adequately completed despite serious mental illness, ID or other organic condition related to ID/DD?	RR	PASARR Pathway	1	F645	PASARR Screening for MD & ID: Level I Prior to Admission
				2	F645	PASARR Screening for MD & ID: Short Stay Longer than 30 Days
				3	F645	PASARR Screening for MD & ID: Refer for Level II
				4	F644	Coordination of PASARR and Assessments: Refer for Newly Evident Condition
				5	F644	Coordination of PASARR and Assessments: Incorporate Level II Recommendations
				6	F644	Coordination of PASARR and Assessments: Notify Authority Timely of Newly Evident Condition
				7	F646	MD/ID Significant Change Notification
				8	F655	Baseline Care Plan
				9	F636	Comprehensive Assessments & Timing
				10	F637	Comprehensive Assmt After Significant Change
				11	F641	Accuracy of Assessments
				12	F656	Develop/Implement Comprehensive Care Plan
				13	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Pressure Ulcers	Sores, open areas, pressure ulcers (where, when, how); Developed in facility, worsened, or improved; Treatment; Wound covered with dressing, drainage, redness, swelling, pain; Pressure relieving devices used and used correctly; Positioned off pressure ulcer, wheelchair and bed repositioning; Access to sink to wash hands; Staff wash hands before treatment; Wound infected and getting better.	RI/RRI/RO/ RR	Pressure Ulcer/Injury Pathway	1	F686	Treatment/Svcs to Prevent/Heal Pressure Ulcers
				2	F710	Resident's Care Supervised by a Physician
				3	F880	Infection Prevention & Control
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision
Privacy	Privacy during care or treatments? Visitor or telephone privacy? Bedroom equipped to assure full privacy? Private electronic or verbal communication about resident?	RI/RRI/RO	Guidance to Surveyors	1	F583	Personal Privacy/Confidentiality of Records
Psych/Opioid Med Side Effects (Selected for Unnecessary Medication Review)	Excessive sedation; Dizziness.	RO	Unnec. Meds, Psychotropic Meds, and Med Regimen Review Pathway	1	F756	Drug Regimen Review, Report Irregular, Act On
				2	F757	Drug Regimen is Free From Unnecessary Drugs
				3	F758	Free from Unnec Psychotropic Meds/PRN Use
				4	F881	Antibiotic Stewardship Program
				5	F655	Baseline Care Plan
				6	F636	Comprehensive Assessments & Timing
				7	F637	Comprehensive Assmt After Significant Change
				8	F641	Accuracy of Assessments
				9	F656	Develop/Implement Comprehensive Care Plan
				10	F657	Care Plan Timing and Revision
				11	F658	Services Provided Meet Professional Standards
Psych/Opioid Med Side Effects (Not selected for Unnecessary Medication Review)	Excessive sedation; Dizziness.	RO	Guidance to Surveyors	1	F675	Quality of Life
				2	F684	Quality of Care
				3	F756	Drug Regimen Review, Report Irregular, Act On
				4	F757	Drug Regimen is Free From Unnecessary Drugs
				5	F758	Free from Unnec Psychotropic Meds/PRN Use

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Rehab	Receiving therapy? Effectiveness?	RI/RRI	Specialized Rehabilitative or Restorative Services Pathway	1	F825	Provide/Obtain Specialized Rehab Services
				2	F676	Activities of Daily Living (ADLs)/Maintain Abilities
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Resident Assessment	MDS Discrepancy (checkbox is selected and "No Issue" is marked)	RI/RRI/RO/RR	Resident Assessment Task Pathway	1	F641	Accuracy of Assessments
				2	F636	Comprehensive Assessment and Timing
				3	F638	Quarterly Assessment At Least Every 3 months
				4	F640	Encoding/Transmitting Resident Assessment
				5	F642	Accuracy of Assessments
				6	F642	Coordination/Certification of Assessment
Resident-to-Resident Interaction	Confrontations with other residents? Reported? What happened?	RI/RRI	Abuse Pathway	1	F600	Free from Abuse and Neglect
				2	F606	Not Employ/Engage Staff with Adverse Actions
				3	F607	Develop/Implement Abuse/Neglect, etc Policies
				4	F943	Abuse, Neglect, and Exploitation Training
				5	F947	Required In-Service Training for Nurse Aides
				6	F609	Reporting of Alleged Violations
				7	F610	Investigate/Prevent/Correct Alleged Violation
			Accidents Pathway for all CEs Additionally, Investigative Protocol for CE2 (F700), if applicable	1	F689	Free of Accident Hazards/Supervision/Devices
				2	F700	Bedrails (NA, unless issue identified during investigation)
				3	F909	Resident Bed (NA, unless issue identified during investigation)
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Respiratory Infection	Easy access to a sink with soap to wash your hands? Staff assist with washing your hands, if needed? Fever lately? Recent respiratory infection? Treated? Are you currently having any symptoms? Signs or symptoms of a respiratory infection? Currently have a respiratory infection?	RI/RRI/RO/RR	Respiratory Care Pathway	1	F695	Respiratory/Tracheostomy Care and Suctioning
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Restraints	Anything that restricts movement or access to body? Trunk restraint, limb restraint, bed rails, chair that prevents rising, mitts, or personal alarms used? Applied correctly?	RO	Physical Restraints Pathway	1	F604	Right to be Free from Physical Restraints
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision
Skin Conditions (non-pressure related)	Bruises, burns, abrasions, lacerations, skin tears, rash, hives, dry skin, other skin issues? How did it occur? How are they preventing it from happening again?	RI/RRI/RO	General Pathway	1	F684	Quality Of Care
				2	F655	Baseline Care Plan
				3	F636	Comprehensive Assessments & Timing
				4	F637	Comprehensive Assmt After Significant Change
				5	F641	Accuracy of Assessments
				6	F656	Develop/Implement Comprehensive Care Plan
				7	F657	Care Plan Timing and Revision
Smoking	Smoking/vaping safely (appropriate place, who keeps materials, oxygen use, ash/cigarette butt disposal, supervision, safety precautions or devices used); Accidents, burns or burn marks; Smoke/vape when desired - smoking times.	RI/RRI/RO	Accidents Pathway for all CEs Additionally, Investigative Protocol for CE2 (F700), if applicable	1	F689	Free of Accident Hazards/Supervision/Devices
				2	F700	Bedrails (NA, unless issue identified during investigation)
				3	F909	Resident Bed (NA, unless issue identified during investigation)
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Sufficient Staffing	Get the help and care needed without waiting a long time? What happens if you have to wait? How long do you wait for staff to respond to call light?	RI/RRI	Sufficient and Competent Nurse Staffing Task Pathway	*1*	*F851*	*Payroll Based Journal (PBJ)*
				2	*F725*	*Sufficient Nursing Staff*
				3	*F726*	*Competent Nursing Staff*
				4	*F725*	*Sufficient Nursing Staff*
				5	*F727*	*RN 8 Hrs/7 days/Week, Full Time DON: Charge Nurse*
				6	*F731*	*Waiver-Licensed Nurses 24 Hr/Day and RN Coverage*
				7	*F728*	*Facility Hiring and Use of Nurse Aide*
				8	*F729*	*Nurse Aide Registry Verification, Retraining*
				9	*F730*	*Nurse Aid Perform Review - 12 Hr/Year In-Service*
				10	*F947*	*Required In-Service Training for Nurse Aides*
				11	*F732*	*Posted Nurse Staffing Information*
Transmission - Based Precautions (TBP)	Staff and visitors wearing gowns, gloves, and/or masks when entering your room? Restrictions on where you can and can't go in the facility? Reason for these restrictions? Staff explained why and how long you will be on the precautions? Restrictions for visitors coming into your room? Changes in mood since being placed in isolation? PPE readily accessible in resident areas? Appropriate PPE supplies outside of the resident's room and signage?	RI/RRI/RO	Infection Prevention, Control & Immunization Pathway	1	F880	Infection Prevention & Control: Implement Standard & Transmission Based Precautions (TBP), Hand Hygiene, Personal Protective Equipment (PPE) and Source Control
				2	F880	Infection Prevention & Control: IPCP Standards, P&P
				3	F880	Infection Prevention & Control: Infection Surveillance
				4	F880	Infection Prevention & Control: Water Management
				5	F880	Infection Prevention & Control: Linens
				6	F881	Antibiotic Stewardship Program
				7	F882	Infection Preventionist (IP)
				8	F883	Influenza and Pneumococcal Immunizations
				9	F887	COVID-19 Education and Immunization for Residents
				10	F887	COVID-19 Immunization for Staff: Screening, Education & Offering
Tube Feeding	Tube feeding (g-tube, peg tube, TPN, naso-gastric); Reason for tube feeding; Head of bed elevated when infusing; Feeding properly labeled; Amount left seem reasonable; Weight loss or gain; Any issues; Site clean and free of infection.	RI/RRI/RO	Tube Feeding Status Pathway	1	F693	Tube Feeding Management/Restore Eating Skills
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision

Mapping for Initial Pool Areas

Initial Pool Area	Initial Pool Intent (Key Probing Words)	Initial Pool Source	Investigative Tool	Critical Element #	Tag #	Tag Description
Unsafe Wandering/ Elopement	Tube feeding (g-tube, peg tube, TPN, naso-gastric); Reason for tube feeding; Head of bed elevated when infusing; Feeding properly labeled; Amount left seem reasonable; Weight loss or gain; Any issues; Site clean and free of infection.	RO/RR	Accidents Pathway for all CEs Additionally, Investigative Protocol for CE2 (F700) if applicable	1	F689	Free of Accident Hazards/Supervision/Devices
				2	F700	Bedrails (NA, unless issue identified during investigation)
				3	F909	Resident Bed (NA, unless issue identified during investigation)
				4	F655	Baseline Care Plan
				5	F636	Comprehensive Assessments & Timing
				6	F637	Comprehensive Assmt After Significant Change
				7	F641	Accuracy of Assessments
				8	F656	Develop/Implement Comprehensive Care Plan
				9	F657	Care Plan Timing and Revision
Urinary Tract Infection (UTI)	Access to soap and assistance to wash hands? Recent UTI or symptoms? Treated?	RI/RRI/RO/ RR	Urinary Catheter or UTI Pathway	1	F690	Bowel/Bladder Incontinence, Catheter, UTI
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Vent/Trach	Ventilator: Signs of anxiety, distress, labored breathing; Head of bed elevated; Suction equipment immediately accessible; Staff respond timely when alarm sounds. Tracheostomy: Site clean; Emergency trach equipment, ambu bag, suction equipment accessible in room.	RO	Respiratory Care Pathway	1	F695	Respiratory/Tracheostomy Care and Suctioning
				2	F880	Infection Prevention & Control
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision
Vision and Hearing	Problems with vision or hearing? Glasses or hearing aids available, used, clean, working, and not broken? Help make appointments and transportation?	RI/RRI/RO	Communication and Sensory Pathway	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities
				2	F685	Treatment/Devices to Maintain Hearing/Vision
				3	F655	Baseline Care Plan
				4	F636	Comprehensive Assessments & Timing
				5	F637	Comprehensive Assmt After Significant Change
				6	F641	Accuracy of Assessments
				7	F656	Develop/Implement Comprehensive Care Plan
				8	F657	Care Plan Timing and Revision

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Arbitration	Binding Arbitration Agreement Review Task Pathway	1	F847	Enter into Binding Arbitration Agreements: Not Required to Sign for Admission
		2	F847	Enter into Binding Arbitration Agreements: Explained in a Manner that was Understood
		3	F847	Enter into Binding Arbitration Agreements: Acknowledge Understanding
		4	F847	Enter into Binding Arbitration Agreements: Right to Rescind Agreement in 30 Days
		5	F847	Enter into Binding Arbitration Agreements: States Not Required to Sign for Admission
		6	F847	Enter into Binding Arbitration Agreements: Communication with Officials
		7	F848	Select Arbitrator/Venue, Retention of Agreements: Neutral Arbitrator
		8	F848	Select Arbitrator/Venue, Retention of Agreements: Convenient Venue
		9	F848	Select Arbitrator/Venue, Retention of Agreements: Retain Copy
Death (Closed Record)	Death Pathway	1	F684	Quality of Care
		2	F655	Baseline Care Plan
		3	F636	Comprehensive Assessments & Timing
		4	F637	Comprehensive Assmt After Significant Change
		5	F641	Accuracy of Assessments
		6	F656	Develop/Implement Comprehensive Care Plan
		7	F657	Care Plan Timing and Revision

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Dining		1	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		2	F880	Infection Prevention & Control
		3	F550	Resident Rights/Exercise of Rights
		4	F584	Safe/Clean/Comfortable/Homelike Environment
		5	F561	Self Determination
		6	F676 and/or F677	Activities of Daily Living (ADLs)/Maintain Abilities and/or ADL Care Provided for Dependent Residents
		7	F810	Assistive Devices - Eating Equipment/Utensils
		8	F675	Quality of Life
		9	F806	Resident Allergies, Preferences and Substitutes
		10	F811	Feeding Asst - Training/Supervision/Resident
		11	F948	Training for Feeding Assistants
		12	F804	Nutritive Value/Appear, Palatable/Prefer Temp
		13	F692	Nutrition/Hydration Status Maintenance
		14	F807	Drinks Avail to Meet Needs/Preferences/Hydration
		15	F806	Resident Allergies, Preferences and Substitutes
		16	F808	Therapeutic Diet Prescribed by Physician
		17	F920	Requirements for Dining and Activity Rooms: lighting
		18	F584	Safe/Clean/Comfortable/Homelike Environment:
		19	F920	Requirements for Dining and Activity Rooms: Ventilation
		20	F584	Safe/Clean/Comfortable/Homelike Environment: Comfortable Sound Levels
		21	F584	Safe/Clean/Comfortable/Homelike Environment: Comfortable and Safe Temperature Levels
		22	F920	Requirements for Dining and Activity Rooms: Furnished to Meet Residents' Physical and Social Needs
		23	F920	Requirements for Dining and Activity Rooms: Sufficient Space
		24	F809	Frequency of Meals/Snacks at Bedtime
		25	F802	Sufficient Dietary Support Personnel
		26	F809	Frequency of Meals/Snacks at Bedtime
Discharge (Closed Record)	Discharge Pathway	1	F660	Discharge Planning Process
		2	F661	Discharge Summary
		3	F622	Transfer and Discharge Requirements: Discharge Appropriate
		4	F622	Transfer and Discharge Requirements: Discharge Documentation in Record
		5	F623	Notice Requirements Before Transfer/Discharge
		6	F626	Permitting Residents to Return to Facility

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Environment	Environment Task Pathway (only investigate the CE of concern)	1	F558	Reasonable Accommodations of Needs/Preferences
		2	F919	Resident Call System
		3	F584	Safe/Clean/Comfortable/Homelike Environment: Sound Levels
		4	F584	Safe/Clean/Comfortable/Homelike Environment: Temperature Levels
		5	F584	Safe/Clean/Comfortable/Homelike Environment: Lighting Levels
		6	F584	Safe/Clean/Comfortable/Homelike Environment: Clean Building
		7	F584	Safe/Clean/Comfortable/Homelike Environment: Building and Equipment in Good Condition
		8	F908	Essential Equipment, Safe Operating Condition
		9	F584	Safe/Clean/Comfortable/Homelike Environment: Homelike
		10	F584	Safe/Clean/Comfortable/Homelike Environment: Water Too Cool
		11	F584	Safe/Clean/Comfortable/Homelike Environment: Linens
		12	F925	Maintains Effective Pest Control Program
		13	F923	Ventilation
		14	F924	Corridors Have Firmly Secured Handrails
		15	F921	Safe/Functional/Sanitary/Comfortable Environment

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Extended	Extended Task Pathway - Physician Services	1	F710	Resident's Care Supervised by a Physician
		2	F711	Physician Visits - Review Care/Notes/Order
		3	F712	Physician Visits - Frequency/Timeliness/Alternate NPPs
		4	F713	Physician for Emergency Care, Available 24 Hours
		5	F714	Physician Delegation of Tasks to NPP
		6	F715	Physician Delegation to Dietitian/Therapist
	Extended Task Pathway - Administration for all CEs Additionally, Investigative Protocol for Admissions Policy	1	F835	Administration
		2	F836	License/Comply w/Fed/State/Local Law/Prof Std
		3	F837	Governing Body
		4	F838	Facility Assessment
		5	F839	Staff Qualifications
		6	F840	Use of Outside Resources
		7	F841	Responsibilities of Medical Director
		8	F842	Resident Records - Identifiable Information
		9	F843	Transfer Agreement
		10	F844	Disclosure of Ownership Requirements
		11	F845	Facility Closure-Administrator
		12	F846	Facility Closure
		13	F849	Hospice Services
		14	F850	Qualifications of Social Worker >120 Beds
	Extended Task Pathway - Training	1	940	Training Requirements -General
		2	941	Communication Training
		3	942	Resident Rights Training
		4	943	Abuse Neglect, and Exploitation Training
		5	944	QAPI Training
		6	945	Infection Control Training
		7	946	Compliance and Ethics Training
		8	947	Required In-Service Training for Nurse Aides
		9	948	Training for Feeding Assistants
		10	949	Behavioral Health Training
Hospitalization (Closed Record)	Hospitalization Pathway	1	F684	Quality of Care
		2	F622	Transfer and Discharge Requirements
		3	F623	Notice Requirements Before Transfer/Discharge
		4	F623	Notice Requirements Before Transfer/Discharge
		5	F624	Preparation for Safe/Orderly Transfer/Discharge
		6	F625	Notice of Bed Hold Policy Before/Upon Discharge
		7	F626	Permitting Residents to Return to Facility
		8	F655	Baseline Care Plan
		9	F636	Comprehensive Assessments & Timing
		10	F637	Comprehensive Assmt After Significant Change
		11	F641	Accuracy of Assessments
		12	F656	Develop/Implement Comprehensive Care Plan
		13	F657	Care Plan Timing and Revision

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Infection Control	Infection Prevention, Control & Immunization Pathway	1	F880	Infection Prevention & Control: Implement Standard & Transmission Based Precautions (TBP), Hand Hygiene, Personal Protective Equipment (PPE) and Source Control
		2	F880	Infection Prevention & Control: IPCP Standards, P&P
		3	F880	Infection Prevention & Control: Infection Surveillance
		4	F880	Infection Prevention & Control: Water Management
		5	F880	Infection Prevention & Control: Linens
		6	F881	Antibiotic Stewardship Program
		7	F882	Infection Preventionist (IP)
		8	F883	Influenza and Pneumococcal Immunizations
		9	F887	COVID-19 Education and Immunization for Residents
		10	F887	COVID-19 Immunization for Staff: Screening, Education & Offering

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Kitchen	Kitchen Task Pathway	1	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		2	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		3	F812	Food Procurement, Store/Prepare/Serve-Sanitary: Appropriate Temperatures
		4	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		5	F800	Provided Diet Meets Needs of Each Resident
		6	F804	Nutritive Value/Appear, Palatable/Prefer Temp
		7	F805	Food in Form to Meet Individual Needs
		8	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		9	F813	Personal Food Policy
		10	F812	Food Procurement, Store/Prepare/Serve-Sanitary
		11	F812	Food Procurement, Store/Prepare/Serve-Sanitary: Dishes and Utensils
		12	F812	Food Procurement, Store/Prepare/Serve-Sanitary: Food Preparation Equipment Clean
		13	F908	Essential Equipment, Safe Operating Condition
		14	F814	Dispose Garbage and Refuse Properly
		15	F925	Maintains Effective Pest Control Program
		16	F812	Food Procurement, Store/Prepare/Serve-Sanitary: Snack/Nourishment Refrigerators on the Unit
		17	F803	Menus Meet Resident needs/Prep in Advance/Followed
		18	F801	Qualified Dietary Staff
		19	F802	Sufficient Dietary Support Personnel
Medication Administration	Medication Administration Task Pathway	1	F759	Free of Medication Error Rates of 5% or More
		2	F760	Residents Are Free of Significant Med Errors
		3	F755	Pharmacy Svcs/Procedures/Pharmacist/Records
		4	F761	Label/Store Drugs & Biologicals
		5	F880	Infection Prevention & Control
		6	F658	Services Provided Meet Professional Standards
Medication Storage	Med Storage Task Pathway	1	F755	Pharmacy Svcs/Procedures/ Pharmacist/Records
		2	F755 and/or F761	Pharmacy Svcs/Procedures/ Pharmacist/Records and/or Label/Store Drugs & Biologicals
		3	F755	Pharmacy Svcs/Procedures/Pharmacist/Records
Neglect	Neglect Pathway	1	F600	Free from Abuse and Neglect
		2	F606	Not Employ/Engage Staff with Adverse Actions
		3	F607	Develop/Implement Abuse/Neglect etc Policies
		4	F609	Reporting of Alleged Violation
		5	F610	Investigate/Prevent/Correct Alleged Violation
		6	F943	Abuse Neglect, and Exploitation Training
		7	F947	Required In-Service Training for Nurse Aides

Mapping for Neglect, Mandatory and Triggered Facility Tasks, and Closed Record Reviews

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Personal Funds	Personal Funds Facility Task	1	F567	Protection/Management of Personal Funds
		2	F568	Accounting and Records of Personal Funds: Quarterly Statement
		3	F582	Medicaid/Medicare Coverage/Liability Notice
		4	F568	Accounting and Records of Personal Funds: Separate Accounting
		5	F568	Accounting and Records of Personal Funds: Follow Accounting Principles
		6	F571	Limitations on Charges to Personal Funds
		7	F567	Protection/Management of Personal Funds
		8	F569	Notice and Conveyance of Personal Funds
		9	F570	Surety Bond - Security of Personal Funds
Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) Review	QAPI and QAA Task Pathway	1	F867	QAPI Policies and Procedures
		2	F867	QAPI/QAA Improvement Activities, Analysis and Action
		3	F865	QAPI Program/Plan: systemic non-compliance identified by the State Agency, the Facility identified prior to the survey.
		4	F865	QAPI Program/Plan, Disclosure/Good Faith Attmpt
		5	F841	Responsibilities of Medical Director
		6	F868	QAA Committee
		7	F865	QAPI Program, Plan, Disclosure, and Governance and Leadership
Resident Assessment	Resident Assessment Task Pathway	1	F641	Accuracy of Assessments
		2	F636	Comprehensive Assessment and Timing
		3	F638	Quarterly Assessment At Least Every 3 months
		4	F640	Encoding/Transmitting Resident Assessment
		5	F642	Accuracy of Assessments
		6	F642	Coordination/Certification of Assessment

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
Resident Council	Resident Council Task Pathway	1	F565	Resident/Family Group and Response: Meet Regular Basis
		2	F565	Resident/Family Group and Response: Facility Makes Arrangements
		3	F565	Resident/Family Group and Response: Adequate Space
		4	F565	Resident/Family Group and Response: Meet Without Staff
		5	F565	Resident/Family Group and Response: Act Upon Grievances
		6	F565	Resident/Family Group and Response: Respond to Group's Concerns
		7	F565	Resident/Family Group and Response: Rationale if Doesn't Respond to Group's Concerns
		8	F585	Grievances: File a Grievance
		9	F585	Grievances: Complaint Without Retribution
		10	F600	Free from Abuse and Neglect
		11	F725	Sufficient Nursing Staff
		12	F809	Frequency of Meals/Snacks at Bedtime
		13	NA	NA
		14	F563	Right to Receive/Deny Visitors
		15	F565	Resident/Family Group and Response
		16	F572	Notice of Rights and Rules
		17	F550	Resident Rights/Exercise of Rights
		18	F561	Self Determination
		19	F576	Right to Forms of Communications with Privacy: Mail delivered unopened and on Saturday
		20	F577	Right to Survey Results/Advocate Agency Info
		21	F574	Required Notices and Contact Information
		22	F573	Right to Access/Purchase Copies of Records
		23	F574	Required Notices and Contact Information
		24	NA	NA
		25	F847	Enter into Binding Arbitration Agreements
		26	All F-tags	Display all F-Tags

Neglect (Not Mapped to IP), Closed Records, Mandatory/Triggered Facility Tasks	Facility Task or CE Pathway	Critical Element #	Tag #	Tag Description
SNF Beneficiary Protection Notification Review	SNF Beneficiary Protection Notification Review Task Pathway	1	F582	Medicaid/Medicare Coverage/Liability Notice
Sufficient & Competent Nurse Staffing	Sufficient and Competent Nurse Staffing Task Pathway	*1*	*F851*	*Payroll Based Journal (PBJ)*
		2	*F725*	*Sufficient Nursing Staff*
		3	*F726*	*Competent Nursing Staff*
		4	*F725*	*Sufficient Nursing Staff*
		5	*F727*	*RN 8 Hrs/7 days/Week, Full Time DON: Charge Nurse*
		6	*F731*	*Waiver-Licensed Nurses 24 Hr/Day and RN Coverage*
		7	*F728*	*Facility Hiring and Use of Nurse Aide*
		8	*F729*	*Nurse Aide Registry Verification, Retraining*
		9	*F730*	*Nurse Aid Perform Review - 12 Hr/Year In-Service*
		10	*F947*	*Required In-Service Training for Nurse Aides*
		11	*F732*	*Posted Nurse Staffing Information*

F-tags Not Mapped to a Care Area

Ftag	SQC Tag X = Yes	Tag Title	Investigative Protocol X = Yes
F540		Definitions	
F551		Rights Exercised by Representative	
F553		Right to Participate in Planning Care	
F554		Resident Self-Admin Meds-Clinically Appropriate	
F555		Right to Choose/Be Informed of Attending Physician	
F557		Respect, Dignity/Right to have Personal Property	
F559	X	Choose/Be Notified of Room/Roommate Change	
F560		Right to Refuse Certain Transfers	
F562		Immediate Access to Resident	
F564		Inform of Visitation Rights/Equal Visitation Privileges	
F566		Right to Perform Facility Services or Refuse	
F575		Required Postings	
F579		Posting/Notice of Medicare/Medicaid on Admission	
F586		Resident Contact with External Entities	
F602	X	Free from Misappropriation/Exploitation	X
F603	X	Free from Involuntary Seclusion	X
F605	X	Right to be Free from Chemical Restraints	X
F620		Admissions Policy	
F621		Equal Practices Regardless of Payment Source	
F635		Admission Physician Orders for Immediate Care	
F639		Maintain 15 Months of Resident Assessments	
F659		Qualified Persons	
F678	X	Cardio-Pulmonary Resuscitation (CPR)	X
F680	X	Qualifications of Activity Professional	
F687	X	Foot Care	
F691	X	Colostomy, Urostomy, or Ileostomy Care	
F694	X	Parenteral/IV Fluids	
F696	X	Prostheses	
F770		Laboratory Services	
F771		Blood Bank and Transfusion Services	
F772		Lab Services Not Provided On-Site	
F773		Lab Svs Physician Order/Notify of Results	
F774		Assist with Transport Arrangements to Lab Svcs	
F775		Lab Reports in Record-Lab Name/Address	
F776		Radiology/Other Diagnostic Services	
F777		Radiology/Diag. Svcs Ordered/Notify Results	
F778		Assist with Transport Arrangements to Radiology	
F779		X-Ray/Diagnostic Report in Record-Sign/Dated	
F826		Rehab Services- Physician Order/Qualified Person	
F895		Compliance and Ethics Program	
F906		Emergency Power	
F907		Space and Equipment	
F910		Resident Room	
F911		Bedroom Number of Residents	
F912		Bedrooms Measure at Least 80 Square Ft/Resident	
F913		Bedrooms Have Direct Access to Exit Corridor	
F914		Bedrooms Assure Full Visual Privacy	
F915		Resident Room Window	
F916		Resident Room Floor Above Grade	
F917		Resident Room Bed/Furniture/Closet	
F918		Bedrooms Equipped/Near Lavatory/Toilet	
F922		Procedures to Ensure Water Availability	
F926		Smoking Policies	

Dining Observation

Dining Observation - *Each survey team member will be assigned a dining area. If there are fewer surveyors than dining areas, observe the dining areas with the most dependent residents. The team is responsible for observing the first meal upon entrance into the facility. Additional observations may be required if the team identifies concerns. The surveyor assigned primary responsibility will answer all CEs. Any other surveyor assigned a dining location will complete the observations and answer CEs of concern. While it is not mandatory, the team member responsible for the Kitchen task should also consider completing the Dining task. Potential nutrition or hydration concerns should be investigated under the resident.*

Meal Services

☐ Determine whether staff are using proper handling techniques, such as:

- Preventing the eating surfaces of plates from coming in contact with staff clothing;
- Handling cups/glasses on the outside of the container; and
- Handling knives, forks, and spoons by the handles.

☐ Observe whether staff are using proper hygienic practices such as keeping their hands away from their hair and face when handling food.

1. Does staff distribute and serve food under sanitary conditions? ☐ Yes ☐ **No F812**

Infection Control

☐ Determine whether staff have any open areas on their skin, signs of infection, or other indications of illness.

☐ Appropriate hand hygiene must be practiced between residents after direct contact with resident's skin or secretions.

2. Did the facility provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections? ☐ Yes ☐ **No F880**

Dignity: Observe whether staff (list is not all-inclusive):

☐ Provide meals to all residents at a table at the same time.

☐ Provide napkins and nondisposable cutlery and dishware (including cups and glasses).

☐ Consider residents' wishes when using clothing protectors.

☐ Wait for residents at a table to finish their meals before scraping food from plates at that table.

☐ Sit next to residents while assisting them to eat, rather than standing over them.

☐ Talk with residents for whom they are providing assistance rather than conducting social conversations with other staff.

☐ Allow residents adequate time to complete their meal.

☐ Speak with residents politely, respectfully, and communicate personal information in a way that maintains confidentiality.

☐ Respond to residents' requests in a timely manner?

3. Does the facility promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality?
☐ Yes ☐ **No F550**

Homelike Environment: A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible. A determination of "homelike" should include, whenever possible, the resident's or representative of the resident's opinion of the living environment.

☐ Determine the presence of institutional practices that may interfere with the quality of the residents' dining experience, such as:

- Meals served on trays in a dining room;
- Medication administration practices that interfere with the quality of the residents' dining experience.
  Note: Medication administration during meal service is not prohibited for:
  - Medications that must be taken with a meal.
  - Medication administration requested by a resident who is accustomed to taking the medication with a meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

☐ Has the facility attempted to provide medications at times and in a manner that does not distract from the dining experience of the resident, such as:

- Pain medications being given prior to meals so that meals can be eaten in comfort;
- Foods served are not routinely or unnecessarily used as vehicles to administer medications (mixing the medications with potatoes or other entrees)

4. Did the facility provide a homelike dining environment? ☐ Yes ☐ **No F584**

Resident Self-Determination or Preferences

☐ Determine staff response to a resident who refuses to go to the dining area, refuses the meal or meal items offered, or requests a substitute. If concerns are identified, interview the resident to determine whether:

- The resident was involved in choosing when to eat;
- The resident was involved in choosing where to eat; and/or
- The food offered takes into account the resident's food preferences.

☐ Interview staff regarding the facility protocol to identify where and when a resident eats, how staff knows whether a specific resident eats in a specific dining room or other location, and how food preferences are identified and submitted to the dietary department.

5. Does the facility honor the resident's right to make choices about aspects of his/her life in the facility that are significant to the resident? ☐ Yes ☐ **No F561**

Dining Assistance

☐ Determine during the meal service, whether staff are providing services to meet the residents' needs, such as:

- Provision of cueing, prompting, or assisting a resident to eat in order to improve, maintain, or prevent the decline in eating abilities;
- How meals and assistance to eat is provided to those residents who wish to eat in their rooms;

- Staff availability and presence during the dining process; and
- Assistance to eat for residents who are dependent on staff.

☐ If residents are not receiving timely assistance to eat related to lack of sufficient nursing staff, review this under the Sufficient Nursing Staff task.

6. Does the facility provide assistance with meals, assisting with hydration, and nutritional provisions throughout the day? ☐ Yes ☐ **No F676 and/or F677**

Assistive Devices

☐ Determine during the meal service, whether staff are providing services to meet the residents' needs, such as:

- Whether adaptive devices are provided to residents requiring them.

7. Does the facility provide resident with assistive devices if needed? ☐ Yes ☐ **No F810**

Positioning

☐ Determine during the meal service, whether staff are providing services to meet the residents' needs, such as:

- Proper positioning to maximize eating abilities (e.g., wheelchairs fit under tables so residents can access food without difficulty and residents are positioned in correct alignment).

8. Is the resident positioned correctly to provide care and services that promote the highest practical well-being? ☐ Yes ☐ **No F675**

Dietary Needs

☐ Determine during the meal service, whether staff are providing services to meet the residents' needs, such as:

- How staff identify and meet residents' special dietary requirements (e.g., allergies, intolerances, and preferences).

9. Are residents receiving food that accommodates resident allergies, intolerances, and preferences? ☐ Yes ☐ **No F806**

Paid Feeding Assistants

☐ If you observe a resident who is being assisted by staff, and the resident is having problems eating or drinking:

- Determine whether a paid feeding assistant is assisting the resident;
- Determine whether the paid feeding assistants are properly trained, adequately supervised, assisting only those residents without complicated feeding problems, and providing assistance in accordance with the residents' needs; and
- If the staff is not a paid feeding assistant, and if technique concerns are identified in the provision of assistance by CNAs, initiate F727 Proficiency of Nurse Aides, for further review.

10. Are residents selected based on an IDT assessment? Are paid feeding assistants supervised or used in accordance to State law? ☐ Yes ☐ **No F811** ☐ NA

11. Have the paid feeding assistants completed a State-approved training program prior to working in the facility? ☐ Yes ☐ **No F948** ☐ NA

Food and Drink Quality

☐ If concerns regarding palatability and/or appearance are identified, determine whether:

- Mechanically altered diets, such as pureed foods, were prepared and served as separate entree items, excluding combined foods such as stews, casseroles, etc.; and
- Food placement, colors, and textures were in keeping with the resident's needs or deficits, such as residents with vision or swallowing deficits.

☐ Interview residents to confirm or validate observations and to assess food and drink palatability and temperature.

☐ If the team has identified concerns with food quality or residents complain about the palatability/temperature of food or drink served, the survey team coordinator may request a test tray to obtain quantitative and qualitative data to assess the complaints.

☐ Send the meal to the unit that is the greatest distance from the kitchen or to the affected unit or dining room.

☐ Check food temperature and palatability of the test meal close to the time the last resident on the unit is served and begins eating.

12. Does the facility serve meals that conserve nutritive value, flavor, and appearance, and are palatable, attractive, and a safe and appetizing temperature (e.g., provide a variety of textures, colors, seasonings, pureed foods not combined)? ☐ Yes ☐ **No F804**

13. Do the residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise? ☐ Yes ☐ **No F692**

Drinks and Other Liquids

☐ Are drinks and other fluids provided when the resident requests and consistent with the resident's care plan?

☐ Are the resident's preferences honored when providing drinks and other fluids?

14. Does the facility provide drinks including water and other liquids consistent with residents' needs and preferences? ☐ Yes ☐ **No F807**

Food Substitutes: If concerns are identified with a resident who is not consuming his/her meal or has refused the meal served:

☐ Determine whether staff attempt to determine the reason(s) for the refusal and offer a substitute item of equal nutritive value or another food item of the resident's choice.

☐ If staff do not offer an alternative item, interview the resident to determine whether he/she is provided a substitution when he/she does not wish to have the item being served.

☐ Interview staff in order to determine what is available for substitutes for the meal observed.

15. Does the facility offer an appealing option of similar nutritive value to residents who refuse food being served? ☐ Yes ☐ **No F806**

Therapeutic Diets

☐ Observe residents to ensure they are being served a therapeutic diet, if prescribed.

☐ Review the residents' records to ensure the resident is prescribed a therapeutic diet.

☐ Review additional information the dietary staff uses to identify those residents in need of a therapeutic diet (e.g., tray cards, dietary cards).

16. Are residents receiving therapeutic diets as prescribed? ☐ Yes ☐ **No F808**

Lighting

☐ Determine whether the dining areas are well lighted:

- Illumination levels are task-appropriate with little glare;
- Lighting supports maintenance of independent functioning and task performance; and
- Ask residents whether they feel the lighting is comfortable and adequate, and how the lighting affects their ability to eat.

17. Does the facility provide one or more rooms designated for dining that are well lighted? ☐ Yes ☐ **No F920**

18. Does the facility provide adequate and comfortable lighting levels in the dining areas? ☐ Yes ☐ **No F584**

Ventilation: Determine whether the dining areas have:

☐ Efficient ventilation.

☐ Good air circulation.

☐ Acceptable temperature and humidity.

☐ Avoidance of drafts at the floor level.

☐ Adequate removal of smoke exhaust and odors.

19. Does the facility provide one or more rooms designated for dining that is well ventilated? ☐ Yes ☐ **No F920**

Sound Levels: Determine whether sound levels in dining areas interfere with social interaction during the meal services. Consider the following:

☐ Residents or staff have to raise their voices to be heard.

☐ Residents can't be heard due to background noise.

☐ Residents have difficulty concentrating due to the background noise.

☐ Residents have no control over unwanted noise.

20. Does the facility provide comfortable sound levels in the dining areas? ☐ Yes ☐ **No F584**

Comfortable and Safe Temperatures: Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds.

☐ Observe whether residents complain of heat or cold in the dining areas.

☐ Observe what actions staff take in relation to complaints about the temperature levels in the dining areas.

☐ Interview staff to determine how the temperature levels are set and maintained.

☐ Ask staff what measures they take to address the issues related to temperatures out of the 71-81 degree Fahrenheit (°F) range.

21. Does the facility maintain comfortable and safe temperature levels in the dining areas?
☐ Yes ☐ **No F584**

Furnishings: An ***adequately furnished*** dining area accommodates different residents' physical and social needs.

☐ Observe table height to determine whether it provides the residents with easy visibility and access to food.

☐ Observe whether furnishings are structurally sound and functional (e.g., chairs of varying sizes to meet varying needs of residents, wheelchairs can fit under the dining room table).

22. Are the dining areas adequately furnished to meet residents' physical and social needs?
☐ Yes ☐ **No F920**

Space

☐ Observe whether the dining areas have sufficient space.

☐ Residents can enter and exit the dining room independently without staff needing to move other residents out of the way.

☐ Residents could be moved from the dining room swiftly in the event of an emergency.

☐ Staff would be able to access and assist a resident who is experiencing an emergency, such as choking.

☐ There is no resident crowding.

23. Do the dining areas have sufficient space to accommodate all dining activities? ☐ Yes ☐ **No F920**

Frequency of Meals

☐ Interview residents and/or staff to determine how often meals are served beyond the posted serving times.

☐ If a concern is identified regarding the timing of a meal service, interview staff to identify how the meal service is organized, times for meal availability, and how staff assures that a resident has received a meal.

☐ Interview the residents and staff to determine:

- What happens if they miss the allocated meal service time periods;

- Whether snacks are available, types, and when available;
- If suitable, nourishing alternative meals and snacks are provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, and they are consistent with the residents' plan of care.

24. Does the facility provide at least three meals daily at regular times comparable to mealtimes in the community or in accordance with residents' needs? ☐ Yes ☐ **No F809**

25. Does the facility provide sufficient staff to safely and effectively carry out the functions of the food and nutrition services, including preparing and serving meals, in the scheduled time frames? ☐ Yes ☐ **No F802**

26. Does the facility provide meals with no greater than a 14 hour lapse between the evening meal and breakfast, or 16 hours with approval of a resident group and provision of a substantial evening snack? ☐ Yes ☐ **No F809**

Infection Prevention, Control & Immunizations

Infection Control: This facility task must be used to investigate compliance at F880, F881, F882, F883, *and* F887. For the purpose of this task, "staff" includes all 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. The infection prevention and control program (IPCP) must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IVs, and oral/IM/respiratory medications.

Focused Infection Control (FIC) Survey (not associated with a recertification):

- Surveyors must evaluate the facility's compliance at all critical elements (CE) in the CMS 20054, Infection Prevention, Control & Immunizations pathway with the exceptions of CE#4 (Water Management), CE#5 (Laundry Services), and CE#6 (Antibiotic Stewardship Program).

Infection Prevention, Control & Immunizations

Coordination:

☐ Each surveyor is responsible for assessing the facility for breaks in infection control throughout the survey and is to answer CEs of concern (e.g., standard and transmission-based precautions, source control).

☐ One surveyor performs or coordinates (e.g., immunization review) the facility task to review for:

- Standard and transmission-based precautions
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Water management
- Laundry services
- Antibiotic stewardship program (review at least one resident who is receiving an antibiotic if there are concerns)
- Infection Preventionist
- Influenza, pneumococcal, and COVID-19 immunizations

☐ Sample residents/staff as follows:

- *Sample one staff to verify compliance with requirements for educating and offering COVID-19 immunization (select one staff from the actual working schedules for all staff provided during entrance conference).*
- Sample three residents on transmission-based precautions (TBP) for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions, as well as resident care, screening, testing, and reporting.
- Sample five residents for influenza, pneumococcal, and COVID-19 immunizations review.

General Standard Precautions:

☐ Staff are performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use).

☐ Residents, visitors, and others at the facility wear appropriate source control, in accordance with national standards.

☐ When there is a known communicable disease outbreak, the facility should screen visitors for signs and symptoms of the communicable disease in accordance with national standards and/or state and local health department recommendations. Screening may be conducted by active or passive (e.g., self-screening) means, depending upon national, state or local recommendations.

Hand Hygiene:

☐ Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR) or soap and water) are followed.

Infection Prevention, Control & Immunizations

☐ Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.

☐ Staff perform hand hygiene (even if gloves are used) in the following situations:

- Before and after contact with the resident;
- After contact with blood, body fluids, or visibly contaminated surfaces;
- After contact with objects and surfaces in the resident's environment;
- After removing personal protective equipment (e.g., gloves, gown, eye protection, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).

☐ When being assisted by staff, resident hand hygiene is performed after toileting and before meals. How are residents reminded to perform hand hygiene?

☐ Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

Personal Protective Equipment (PPE) Use For Standard Precautions:

☐ Determine if staff appropriately use and discard PPE including, but not limited to, the following:

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin (and hand hygiene performed);
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing);
- Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions;
- All staff are following appropriate source control (i.e., facemasks or respirators) in accordance with national standards;
- PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene;
- If facilities are experiencing PPE shortages outside of their control, they are using PPE optimizing strategies in accordance with national standards; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).

Infection Prevention, Control & Immunizations

☐ Interview appropriate staff to determine if PPE supplies are readily available, accessible, and used by staff, and who they contact for replacement supplies.

- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
- How do you obtain PPE supplies before providing care?
- Who do you contact for replacement supplies?

Transmission-Based Precautions (TBP):

☐ Determine if appropriate transmission-based precautions are implemented, including but not limited to:

- For a resident on contact precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
- For a resident on droplet precautions: staff don a facemask and eye protection (goggles or face shield) within six feet of a resident and prior to resident room entry;
- For a resident on airborne precautions: staff don a fit-tested N95 or higher-level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection: staff follow standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis);
- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then reusable resident medical equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare settings and effective against the identified organism (if known) prior to use on another resident.
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare settings and effective against the organism identified (if known) at least daily and when visibly soiled.
- Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide).
- Residents on TBP are placed in a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards.
- Before visiting a resident, who is on TBP or quarantine, the facility informs visitors of the potential risk of visiting and precautions necessary when visiting the resident.

☐ Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units and other areas of the facility.

☐ Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.

☐ If concerns are identified, expand the sample to include more residents on transmission-based precautions.

Infection Prevention, Control & Immunizations

1. Did the staff implement appropriate standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and transmission-based precautions (if applicable)? ☐ Yes ☐ **No F880**

IPCP Standards, Policies, and Procedures:

☐ The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on the facility assessment [according to §483.70(e)] and national standards (e.g., for undiagnosed respiratory illness and COVID-19).

☐ The facility's policies or procedures include which communicable diseases are reportable to local and/or state public health authorities. The facility has a current list of reportable communicable diseases.

☐ Staff (e.g., infection preventionist) can identify and describe the communication protocol with local/state public health officials (e.g., to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported).

☐ The policies and procedures are reviewed at least annually.

2. Does the facility have an IPCP including standards, policies, and procedures that are current, based on national standards, and reviewed at least annually? ☐ Yes ☐ **No F880**

Infection Surveillance:

☐ The facility prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease. Staff are excluded from work according to national standards.

☐ The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff. Interview staff and review the surveillance plan to determine how the staff monitors residents to identify possible infections and communicable diseases.

☐ The plan includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate TBP/PPE (the plan may include tracking this information in an infectious disease log).

☐ The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.

☐ The plan includes ongoing analysis of surveillance data and documentation of follow-up activity in response.

☐ The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider the diagnosis to include infection or multidrug-resistant organism colonization status, special instructions or precautions for ongoing care such as transmission-based precautions, medications [e.g., antibiotic(s)], laboratory and/or radiology test results, treatment, and discharge summary (if discharged).

Infection Prevention, Control & Immunizations

☐ The facility has a process for obtaining pertinent notes such as discharge summary, lab results, current diagnoses, treatment, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.

☐ Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

☐ The facility conducts testing of staff and residents for communicable diseases (e.g., COVID-19) in accordance with national standards.

☐ Based on observation or interview, the facility conducts specimen collection and testing in a manner consistent with standards of practice.

3. Did the facility provide appropriate infection surveillance? ☐ Yes ☐ **No F880**

Water Management:

Through interview (or record review as necessary), determine whether the facility has:

☐ Assessed (e.g., description of the building water systems using text and flow diagrams) where Legionella and other opportunistic waterborne pathogens can grow and spread;

☐ Measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems that is based on nationally accepted standards (e.g., ASHRAE, CDC, U.S. Environmental Protection Agency or EPA). For example, control measures can include visible inspections, disinfectant, temperature control (that may require mixing valves to prevent scalding);

☐ A way to monitor the measures they have in place (e.g., testing protocols, acceptable ranges), and established ways to intervene when control limits are not met; and

☐ Had a resident with legionellosis since the last recertification survey. Interview the infection preventionist (IP) to determine whether the facility has had a case(s). Interview the IP (and perform record review as necessary) to determine what actions the facility took in response to the identified case in the facility. The State Survey Agency should work with local/state public health authorities, if possible, to determine if the water management program was inadequate to prevent the growth of Legionella or other opportunistic waterborne pathogens and whether the facility implemented adequate prevention and control measures once the issue was identified.

4. Did the facility have measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems? ☐ Yes ☐ **No F880** ☐ N/A, not a recertification survey

Laundry Services:

☐ Determine whether staff handle, store, and transport linens appropriately including, but not limited to:

- Using standard precautions (e.g., gloves, gowns when sorting and rinsing) and minimal agitation for contaminated linen;
- Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
- Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if the outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);

Infection Prevention, Control & Immunizations

- Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil; and
- If a laundry chute is in use, laundry bags are closed with no loose items.

☐ Laundry Rooms – Determine whether staff:

- Maintain/use washing machines/dryers according to the manufacturer's instructions for use;
- If concerns, request evidence of maintenance log/record; and
- Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer's instructions for use.

5. Did the facility store, handle, transport, and process linens properly? ☐ Yes ☐ **No F880** ☐ N/A, not a recertification survey

Antibiotic Stewardship Program:

☐ Determine whether the facility has an antibiotic stewardship program that includes:

- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee;
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic; and
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

☐ If there are concerns with the antibiotic stewardship program, surveyors must complete an investigation utilizing the Unnecessary Medication Review CE Pathway for at least one resident on an antibiotic to assess whether the resident(s) is being prescribed an antibiotic unnecessarily. Expand the sample as needed to determine scope and severity of findings.

Infection Prevention, Control & Immunizations

- Determine whether a resident is already included in the sample from the initial pool or as one of the five residents selected for the unnecessary medication review.
- If there are not any sampled residents, select a high-risk resident receiving an antibiotic from the facility's infection surveillance log (e.g., UTI without a culture, long-term use, no signs or symptoms noted) to add to the sample.

6. Did the facility conduct ongoing review for antibiotic stewardship? ☐ Yes ☐ **No F881** ☐ N/A, not a recertification survey

Infection Preventionist (IP):

During interview with facility administration and Infection Preventionist(s), determine the following:

☐ The facility designated one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP.

☐ The Infection Preventionist (s) works at least part-time at the facility.

☐ The Infection Preventionist(s) completed specialized training in infection prevention and control.

Review facility records for the following related to the designated IP:

☐ Professional training: the facility must provide documentation of the IP's primary professional training. There must be one of the following:

- Certificate/diploma or degree in nursing; or
- Bachelor's degree (or higher) in microbiology or epidemiology; or
- Associate's degree or higher in medical technology or clinical laboratory science; or
- Completion of training in another related field such as that for physicians, pharmacists, and physician's assistants.

☐ Specialized training in infection prevention and control.

- Completed prior to assuming the role of the IP; and
- Evidence of completion is available (e.g., certificate).

7. Did the facility designate at least one qualified IP, who is responsible for the facility's IPCP? ☐ Yes ☐ **No F882**

Influenza, Pneumococcal, and COVID-19 Immunizations for Residents:

☐ Review the records of the five residents (influenza, pneumococcal, and COVID-19) for documentation of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education related to the influenza, pneumococcal, and COVID-19 vaccines (such as the benefits and potential side effects);
- The administration of vaccines in accordance with national recommendations, which includes doses administered.
- Facilities must follow the CDC and Advisory Committee on Immunization Practices (ACIP) recommendations for vaccines; and

Infection Prevention, Control & Immunizations

- Allowing a resident or representative to accept or refuse the influenza, pneumococcal, and COVID-19 vaccines. If not provided, documentation as to why the vaccine(s) was not provided.

☐ For surveys occurring during influenza season, unavailability of the influenza vaccine can be a valid reason why a facility has not implemented the influenza vaccine program, especially during the early weeks of the influenza season. Similarly, pneumococcal or COVID-19 vaccine supplies may be limited anytime of the year. Ask the facility to demonstrate that:

- The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available; and
- Plans are developed on how and when the vaccines will be administered when they are available.

☐ As necessary, determine if the facility developed influenza, pneumococcal, and COVID-19 vaccine policies and procedures for residents. Review policies and procedures and interview facility staff and residents and/or resident representatives to determine:

- How residents and/or resident representatives receive education on the benefits and potential side effects before being offered a vaccine. If multiple doses are required, how residents and/or resident representatives, will again receive education on the benefits and potential side effects before being offered the vaccine; and
- How screening is conducted for eligibility (e.g., medical contraindications, previous vaccination), the vaccines are offered, and consent or refusal is obtained.

8. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate for residents? ☐ Yes ☐ **No F883**

9. Did the facility educate and offer COVID-19 immunization as required or appropriate for residents? ☐ Yes ☐ **No F887**

Educate and Offer COVID-19 Immunizations for Staff

☐ Review facility documentation for sampled staff for evidence of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education regarding the benefits, risks and potential side effects associated with the vaccine;
- Being offered the vaccine or provided information on obtaining the vaccine;
- The administration of vaccines, if accepted in accordance with national recommendations.

☐ As necessary, review facility policies and procedures and interview staff to determine:

- How staff are educated on the benefits, risks and potential side effects before being offered a vaccine, for each dose offered;
- How staff vaccination status is documented;
- How staff are screened for eligibility (e.g., medical contraindications, previous vaccination), vaccines offered, and consent is obtained; and
- If the facility provided information to staff on obtaining the vaccine if it is not available in the facility.

10. Did the facility maintain staff documentation of screening, education, offering, and current COVID-19 vaccination status?
☐ Yes ☐ **No F887**

Kitchen Observation

Kitchen/Food Service Observation*: Complete the initial brief kitchen tour upon arrival at the facility, with observations focused on practices that might indicate potential for foodborne illness. Make additional observations throughout the survey process in order to gather all information needed. Refer to the current FDA Food Code as needed.*

Initial Brief Tour of the Kitchen: Review the first two CEs to ensure practices prevent foodborne illness.

☐ Potentially hazardous foods, such as beef, chicken, pork, etc., have not been left to thaw at room temperature.

☐ Food items in the refrigerator(s) are labeled or dated.

☐ Potentially hazardous foods such as uncooked meat, poultry, fish, and eggs are stored separately from other foods (e.g., meat is thawing so that juices are not dripping on other foods).

☐ Hand washing facilities with soap and water are separate from those used for food preparation.

☐ Staff are practicing appropriate hand hygiene and glove use when necessary during food preparation activities, such as between handling raw meat and other foods, to prevent cross-contamination.

☐ Cracked or unpasteurized eggs are not used in foods that are not fully cooked (per observation or interview).

☐ Food is prepared, cooked, or stored under appropriate temperatures and with safe food handling techniques.

☐ Staff are employing hygienic practices (e.g., not touching hair or face without hand washing) and then handling food.

1. During the initial brief tour, are foods stored and/or prepared under sanitary conditions? ☐ Yes ☐ **No F812**

2. During the initial brief tour, does the facility handle, prepare, and distribute food in a manner that prevents foodborne illness to the residents? ☐ Yes ☐ **No F812**

Follow Up Visits to the Kitchen: If staff are preparing food during the initial brief tour, proceed with observations. If not, answer the remaining items in future trips to the kitchen.

Storage Temperatures

☐ Refrigerator temperatures that are at or below 41 degrees Fahrenheit (°F) (check temperatures between meal service activities to allow for stable temperatures).

☐ Freezer temperatures maintained at a level to keep frozen food solid.

☐ Internal temperatures of 41°F or lower for potentially hazardous, refrigerated foods (e.g., meat, fish, milk, egg, poultry dishes) that are not within acceptable ranges:

- What are the temperatures?
- What foods are involved?

Kitchen/Food Service Observation

3. Is the food stored at the appropriate temperatures? ☐ Yes ☐ **No F812**

Food Storage

☐ Frozen foods are thawing at the correct temperature.
☐ Foods in the refrigerator/freezer are covered, dated, and shelved to allow circulation.
☐ Foods are stored away from soiled surfaces or rust.
☐ Canned goods have an uncompromised seal (e.g., punctures).
☐ Staff are only using clean utensils when accessing bulk foods and/or ice.
☐ Containers of food are stored off the floor, on surfaces that are clean or protected from contamination (e.g., 6 inches above the floor, protected from splash).
☐ There are no signs of water damage from sewage lines and/or pipelines.
☐ There are no signs of negative outcome (e.g., freezer burn, foods dried out, foods with a change in color).
☐ Raw meat is stored so that juices are not dripping onto other foods.
☐ Food products are discarded on or before the expiration date.
☐ Staff are following the facility's policy for food storage, including leftovers.

4. During follow-up visits to the kitchen, are foods stored under sanitary conditions? ☐ Yes ☐ **No F812**

Food Preparation and Service

☐ Hot foods are held at 135°F or higher on the steam table.
☐ Cold foods are held at 41°F or lower.
☐ Food surfaces are thoroughly cleaned and sanitized after preparation of fish, meat, or poultry.
☐ Cutting surfaces are sanitized between uses.
☐ Equipment (e.g., food grinders, choppers, slicers, and mixers) are cleaned, sanitized, dried, and reassembled after each use.
☐ If staff is preparing resident requests for soft cooked and undercooked eggs (i.e., sunny side up, soft scrambled, soft boiled), determine if a pasteurized egg product was used.
☐ Proper final internal cooking temperatures (monitoring the food's internal temperature for 15 seconds determines when microorganisms can no longer survive and food is safe for consumption). Foods should reach the following internal temperatures:

- Poultry and stuffed foods: 165°F;
- Ground meat (e.g., ground beef, ground pork, ground fish) and eggs held for service: at least 155°F;

Kitchen/Food Service Observation

- Fish and other meats: 145°F for 15 seconds;
- When cooking raw animal foods in the microwave, foods should be rotated and stirred during the cooking process so that all parts of the food are heated to a temperature of at least 165°F, and allowed to stand covered for at least 2 minutes after cooking to obtain temperature equilibrium; and
- Fresh, frozen, or canned fruits and vegetables: cooked to a hot holding temperature of 135°F to prevent the growth of pathogenic bacteria that may be present.

☐ Food items that are reheated to the proper temperatures:

- The potentially hazardous food (PHF) or time/temperature controlled for safety (TCS) food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165°F for at least 15 seconds before holding for hot service; and
- Ready-to-eat foods that require heating before consumption are best taken directly from a sealed container (secured against the entry of microorganisms) or an intact package from an approved food processing source and heated to at least 135°F for holding for hot service.

☐ Food is covered during transportation and distribution to residents.

☐ Food is cooked in a manner to conserve nutritive value, flavor, appearance, and texture.

☐ Nourishments and snacks that are held at room temperature are served within 4 hours of delivery. Potentially hazardous foods (e.g., milk, milk products, eggs) must be held at appropriate temperatures.

☐ Staff properly wash hands with soap and water to prevent cross-contamination (i.e., between handling raw meat and other foods).

☐ Staff utilize hygienic practices (e.g., not touching hair, face, nose, etc.) when handling food.

☐ Staff wash hands before serving food to residents after collecting soiled plates and food waste.

☐ Opened containers of potentially hazardous foods or leftovers are dated or used within 7 days in the refrigerator or according to facility policy.

☐ Proper cooling procedures were observed, such as cooling foods in shallow containers, and not deep or sealed containers, facilitating foods to cool quickly as required.

☐ Potentially hazardous foods are cooled from 135°F to 70°F within 2 hours; from 70°F to 41°F within 4 hours; the total time for cooling from 135°F to 41°F should not exceed six hours.

☐ Food procured from vendors meets federal, state, or local approval.

☐ Review the policies and procedures for maintaining nursing home gardens, if applicable.

☐ The time food is put on the steam table and when meal service starts. If unable to observe, determine per interview with the cook.

☐ How staff routinely monitors food temperatures on the steam table (review temperature logs).

☐ When staff starts cooking the food. If unable to observe, determine per interview with the cook.

☐ What cooking methods are available and used (e.g., steamer, batch-style cooking).

☐ Ensure staff do not compromise food safety when preparing modified consistency (e.g., pureed, mechanical soft) PHF/TCS foods.

☐ Ask staff about their knowledge of the food safety practice and facility policy around the particular concern identified.

☐ Does the facility have written policies (e.g., eggs) that honor resident preferences safely?

Kitchen/Food Service Observation

☐ Does the facility have a written policy regarding food brought in by family or visitors?

☐ Ask staff what the facility practice is for dealing with employees who come to work with symptoms of contagious illness (e.g., coughing, sneezing, nausea, fever, vomiting) or open wounds.

☐ If a foodborne illness outbreak occurred, did you report the outbreak to the local health department?

☐ Was the facility food service identified as the cause of the outbreak and what remediation steps were taken?

5. Does the facility provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and dietary needs, taking into consideration the preferences of each resident? ☐ Yes ☐ **No F800**

6. Does the facility provide food prepared by methods that conserve nutritive value, flavor, and appearance and provide food and drink that is palatable, attractive, and at a safe and appetizing temperature? ☐ Yes ☐ **No F804**

7. Is food prepared in a form to meet individual needs of the residents? ☐ Yes ☐ **No F805**

8. Was food procured from approved or satisfactory sources and was food stored, prepared, distributed, and served in accordance with professional standards for food service safety? ☐ Yes ☐ **No F812**

9. Does the facility have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption? ☐ Yes ☐ **No F813**

10. During follow-up visits to the kitchen, does the facility handle, prepare, and distribute food in a manner that prevents foodborne illness to the residents? ☐ Yes ☐ **No F812**

Dinnerware Sanitization and Storage

☐ Staff ensure dishwasher temperatures are:

- For a stationary rack, single temperature machine, 74°C (165°F);
- For a stationary rack, dual temperature machine, 66°C (150°F);
- For a single tank, conveyor, dual temperature machine, 71°C (160°F);
- For a multi-tank, conveyor, multi-temperature machine, 66°C (150°F); or
- For the wash solution in spray-type washers that use chemicals to sanitize, less than 49°C (120°F).
- Sanitizing solution must be at level required per manufacturer's instructions.

Kitchen/Food Service Observation

☐ Manual water temperature solution shall be maintained at no less than 110°F. After washing and rinsing, dishes are sanitized by immersion in either:

- Hot water (at least 171°F) for 30 seconds; or
- A chemical sanitizing solution. If explicit manufacturer instructions are not provided, the recommended sanitation concentrations are as follows:
  - Chlorine: 50 – 100 ppm minimum 10 second contact time
  - Iodine: 12.5 ppm minimum 30 second contact time
  - QAC space (Quaternary): 150 – 200 ppm concentration and contact time per manufacturer's instructions (Ammonium Compound)

☐ Dishes, food preparation equipment, and utensils are air dried. (Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross-contamination.).

☐ Wet wiping cloths are stored in an approved sanitizing solution and laundered daily.

☐ Clean and soiled work areas are separated.

☐ Dishware is stored in a clean, dry location and not exposed to splash, dust, or other contamination, and covered or inverted.

☐ Ask staff how they test for proper chemical sanitization (observe them performing the test).

☐ Ask staff how they monitor equipment to ensure that it is functioning properly. (Review temperature/chemical logs.)

11. Were dishes and utensils cleaned and stored under sanitary conditions? ☐ Yes ☐ **No F812**

Equipment Safe/Clean

☐ Refrigerators, freezers, and ice machines are clean and in safe operating condition.

☐ Fans in food prep areas are clean.

☐ Utensils/equipment are cleaned and maintained to prevent foodborne illness.

☐ Food trays, dinnerware, and utensils are clean and in good condition (e.g., not cracked or chipped).

☐ Appropriate equipment and supplies to evaluate the safe operation of the dish machine and the washing of pots and pans (e.g., maximum registering thermometer, appropriate chemical test strips, and paper thermometers).

☐ How does the facility identify problems with time and temperature control of PHF/TCS foods and what are the processes to address those problems.

☐ Whether the facility has, and follows, a cleaning schedule for the kitchen and food service equipment.

☐ If there is a problem with equipment, how staff informs maintenance and follows up to see if the problem is corrected.

Kitchen/Food Service Observation

12. Is the food preparation equipment clean? ☐ Yes ☐ **No F812**

13. Is essential kitchen equipment maintained in safe operating condition? ☐ Yes ☐ **No F908**

Refuse/Pest Control

☐ Is there evidence of pests in the food storage, preparation, or service areas?
☐ Is the facility aware of the current problem?
☐ If the facility is aware of the current problem, what steps have been taken to eradicate the problem?
☐ Is garbage and refuse disposed of properly?
☐ Is there documentation of pest control services that have been provided?
☐ Notify team of observations and review other areas of the environment for pest concerns under the Environment task.

14. Was garbage and refuse disposed of properly? ☐ Yes ☐ **No F814**

15. Was food storage, preparation, and service areas free of visible signs of insects and/or rodents? ☐ Yes ☐ **No F925**

Unit Refrigerators

☐ Snack/nourishment refrigerators on the unit are maintained to prevent the potential for foodborne illness.
☐ Proper snacks/nourishment refrigerators' temperatures are maintained and food items are dated and labeled.

16. Are snack/nourishment refrigerators on the unit maintained with the proper temperature and food items are dated and labeled so as to prevent the potential for foodborne illness? ☐ Yes ☐ **No F812**

Menus

☐ Ensure staff are following the menus.
☐ Menus meet the nutritional needs of the residents.

17. Does the facility follow the menus and does the menu meet the nutritional needs of the residents? ☐ Yes ☐ **No F803**

Kitchen/Food Service Observation

Dietary Staff

☐ Interview dietary staff members to ensure the facility has a full-time qualified dietitian or other clinically qualified professional either full-time, part-time, or on a consultant basis (refer to the regulation for qualification details).

☐ If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, interview staff to ensure the person designated as the director of food and nutrition services is qualified (refer to the regulation for qualification details).

☐ Interview staff to ensure they have appropriate competencies and skill set to carry out functions of the food and nutrition services, taking into account resident assessments, care plans, number, acuity, and diagnoses of the facility's population in accordance with the facility assessment.

18. Does the facility have a qualified dietitian, other clinically qualified nutrition professional, and/or director of food and nutrition services who met the required qualifications in the timeframe allowed? ☐ Yes ☐ **No F801**

19. Does the facility have a sufficient number of competent staff to safely and effectively carry out the functions of the food and nutrition services? ☐ Yes ☐ **No F802**

SNF Beneficiary Protection Notification Review

Beneficiary Protection Notification Review: Complete the review for residents who received Medicare Part A Services. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Fee for Service (Original) Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. The objective of the Beneficiary Liability Protection Notices Review is to determine if the facility issues notices as required under 42 CFR Part 405.1200-1204 and §1879(a)(1) of the Social Security Act. This protocol is intended to evaluate a nursing home's compliance with the requirements to notify Original Fee-For-Service (FFS) Medicare beneficiaries when the provider determines that the beneficiary no longer meets the skilled care requirement. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare **Part A** skilled services when the resident has not used all the Medicare benefit days for that episode. This review does not include Admission notifications or Medicare Part B only notifications.

The two forms of notification that are evaluated in this review are:

1. **Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN)**—Form CMS-10055;
2. **Notice of Medicare Non-coverage-- Form CMS 10123-NOMNC**, also referred to as a "generic notice."

Entrance Conference Worksheet: The following information was requested during the Entrance Conference:

☐ A list of Original FFS Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Exclude the following residents from this review:

- Beneficiaries who received Medicare Part B benefits only.
- Beneficiaries covered under Medicare Advantage insurance.
- Beneficiaries who expired during the sample date range.
- Beneficiaries who were transferred to an acute care facility or another SNF.

Review Three Notices:

☐ Randomly select 3 residents from that list. We recommend selecting one resident who went home and two residents who remained in the facility, if available.

☐ Fill in the name of the selected residents at the top of each Beneficiary Notification Checklist.

☐ Give the provider one Beneficiary Notification Checklist for each of the three residents to complete and return to the surveyor. Do not give the provider the scenarios.

☐ The provider completes one checklist for each of the three residents in this sample and returns the checklist and notices to the survey team.

☐ Review the checklists and notices with the provider.

1. Were appropriate notices given to the residents reviewed? ☐ Yes ☐ **No F582** ☐ **NA**

SNF Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services

Facility Representative: *Please complete* all fields of this form. The intent of the checklist is to provide the surveyor with all copies of the forms issued to the resident, and if the notification was not required, an explanation of why the form was not issued.

Resident Name: _____

Medicare Part A Skilled Services Episode Start Date: _____

SNF Beneficiary Protection Notification Review

Last covered day of Part A Service: _____ (Part A terminated/denied or resident was discharged) How was the Medicare Part A Service Termination/Discharge determined? ☐ Voluntary, i.e., self-initiated in consultation with physician, family, or AMA. ☐ The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. ☐ Other (explain):	
1. Was an SNF ABN, Form CMS-10055 provided to the resident?	☐ Yes →If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No →If no, explain why the form was not provided: ☐ The resident was discharged from the facility and did not receive non-covered services. ☐ Other Explain: ☐ ***If NOT issued and should have been: F582**
2. Was a NOMNC (CMS 10123) provided to the resident?	☐ Yes→ If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No → If no, explain why the form was not provided: ☐ 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA). ☐ 2. Other Explain: ☐ ***If NOT issued and should have been: F582**

Beneficiary Liability Protection Notice Scenarios for Surveyors

Scenario	SNF ABN	Notice of Medicare Non-Coverage (NOMNC)	Notice(s) Not Required
Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day. *This does not apply to NOMNC if beneficiary initiated discharge.		X	
Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility *This does not apply to NOMNC if beneficiary initiated discharge.	X	X	
Resident has skilled benefit days remaining and elects the Hospice benefit.			X
Resident discharges self as an unplanned discharge.			X
Resident has an unplanned discharge to the hospital.			X
Resident discharges to another SNF for continued skilled care.			X
Resident exhausts their skilled Part A benefit (has no days remaining).			X

Medication Administration Observation

Medication Administration Observation: Make random medication observations of several staff over different shifts and units, multiple routes of administration -- oral, enteral, intravenous (IV), intramuscular (IM), subcutaneous (SQ), topical, ophthalmic, and a minimum (not maximum) of 25 medication opportunities. Do NOT preselect residents for observation. Observe and document all of the resident's medications for each observed medication administration (this does not mean all of the medications for that resident on different shifts or times). Additionally, if possible, observe medications for a sampled resident whose medication regimen is being reviewed. Otherwise, observe medications for any resident to whom the nurse is ready to administer medications.

General Medication Administration

NOTE: There may be times when the surveyor should intervene before the person administering the medication makes a potential medication error. If a surveyor intervenes to prevent a medication error from occurring, each potential medication error would be counted toward the facility's medication error rate.

- ☐ Hand hygiene was performed prior to handling medication(s) and after administering medication(s) if resident contact was necessary.
- ☐ The correct medication was administered to the resident.
- ☐ The correct medication dose was administered to the resident.
- ☐ Medications administered with a physician's order.
- ☐ Medications administered as ordered (e.g., before, after, or with food such as antacids).
- ☐ Medications administered before the expiration date on the label.
- ☐ Medications administered to the resident via the correct route.
- ☐ Medication held and physician notified in the presence of an adverse effect, such as signs of bleeding or abnormal lab results with anticoagulants.
- ☐ Checked pulse and/or blood pressure prior to administering medications when indicated/ordered.
- ☐ Staff ensured medications were administered to the resident (e.g., left medications at bedside).
- ☐ Resident was properly positioned to receive medications (e.g., head of the bed is elevated at an angle of 30-45°).
- ☐ Resident was properly informed of the medications being administered.
- ☐ Medication cart was locked if left unattended in resident care area.
- ☐ If a controlled medication was administered, make sure the count in the cart matches the count in the facility's reconciled records.
- ☐ Insulin suspensions − "mix" or "roll" the suspension without creating air bubbles.
- ☐ Shake a drug product that is labeled "shake well," such as Dilantin Elixir.
- ☐ Nutritional and dietary supplements are given as ordered and documented by staff but not counted in the medication observation except for vitamins and minerals. Administration of vitamins and minerals are part of medication administration observation and errors with vitamins and minerals are counted in the error rate calculation.

Oral or Nasogastric Tube Administration

- ☐ The administration of medications with adequate fluid as manufacturer specifies such as bulk laxatives, non-steroidal anti-inflammatory drugs, and potassium supplements.

- ☐ Staff did not crush tablets or capsules that manufacturer states "do not crush," such as enteric coated or time-released medications.
- ☐ Staff did not crush and combine medications and then give medications all at once via feeding tube.
- ☐ Prior to medication administration, nasogastric or gastrostomy tube placement is confirmed (**NOTE:** If the placement of the tube is not confirmed, this is not a medication error. For concerns related to care of a resident with a feeding tube, refer to guidance at 483.25(g)(4)-(5), F693 Enteral Nutrition.
- ☐ Nasogastric or gastrostomy tube flushed with the required amount of water before and after each medication unless physician orders indicate a different flush schedule due to the resident's clinical condition.
- ☐ Staff separate the administration of enteral nutrition formula and phenytoin (Dilantin) to minimize interaction. Simultaneous administration of enteral nutrition formula and phenytoin is considered a medication error.

Injection Practices and Sharps Safety (Medications and Infusates)

- ☐ Injections are prepared using clean (aseptic) technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids).
- ☐ Needles, cannulas, and syringes are used for one resident.
- ☐ Medication vials (labeled single dose) are used for one resident.
- ☐ Bags of IV solutions and medication administration are used for one resident.
- ☐ Mixed the suspension (e.g., insulin) without creating air bubbles.
- ☐ Multi-dose vials used for more than one resident are kept in a centralized medication area and do not enter the immediate resident treatment area (e.g., resident room). If multi-dose vials enter the immediate resident treatment area they are dedicated for single-resident use only.
- ☐ Multi-dose vials which have been opened or accessed (e.g., needle-punctured) are dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial.
- ☐ Multi-dose vials that are not opened or accessed (e.g., needle-punctured) should be discarded according to the manufacturer's expiration date.
- ☐ Insulin pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person even when the needle is changed,
- ☐ Insulin pens must be clearly labeled with the resident's name and other identifier(s) to verify that the correct pen is used on the correct resident.
- ☐ Insulin pens should be stored in a sanitary manner to prevent cross-contamination.
- ☐ The rubber septum on any medication vial, whether unopened or previously accessed, is disinfected with alcohol prior to piercing.
- ☐ Proper technique used for IV/IM/SQ injection.
- ☐ Sharps containers are readily accessible in resident care areas.
- ☐ Sharps are disposed of in puncture-resistant sharps containers.
- ☐ Sharps containers are replaced when the fill line is reached.
- ☐ Sharps containers are disposed of appropriately as medical waste.
- ☐ IM/SQ injection sites are rotated.
- ☐ Insulin pens used for one resident.
- ☐ Observe for the safe use of point of care devices (e.g., blood glucose meter, International Normalized Ratio (INR) monitor).
- ☐ Finger stick devices (both lancet and lancet-holding devices) are used for one resident.
- ☐ If used for more than one resident, the point-of-care testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to manufacturer's instructions. If manufacturer does not provide instructions for cleaning and disinfection, then the device

should not be used for more than one resident.
☐ IV pumps are clean and a protocol exists for cleaning between residents.

Topical, Ophthalmic, and Inhalation Medications
☐ Transdermal patch sites are rotated.
☐ Transdermal patch is dated and timed.
☐ Used transdermal patches are disposed of properly, .
☐ Multiple eye drops administered with adequate time sequence between drops.
☐ Inhaler medication administered, handled, or stored according to physician's orders and/or manufacturer's instructions.
☐ Single-dose vials for aerosolized medications used for one resident.
☐ Metered dose inhalers administered per manufacturer instructions.
☐ Sterile solutions (e.g., water or saline) are used for nebulization.
☐ Jet nebulizers used for single resident or cleaned and stored as per facility policy (e.g., rinsed with sterile water, and air-dried between treatments on the same resident).
☐ Gloves worn when in contact with respiratory secretions and changed before contact with another resident, object, or environmental surface.

Coordination: At team meetings, discuss the number of residents and opportunities observed.

	Date/Time	Resident Name	Room/Bed	Drug / Dosage / Route *(oral, enteral, IV, IM, SQ, topical, ophthalmic, etc.)*	Administration Error	Prescriber's Order If Administration Error (Describe Error as Necessary)	Staff Name
1.					☐		
2.					☐		
3.					☐		
4.					☐		
5.					☐		
6.					☐		
7.					☐		
8.					☐		
9.					☐		

Medication Administration Observation

	Date/Time	Resident Name	Room/Bed	Drug / Dosage / Route *(oral, enteral, IV, IM, SQ, topical, ophthalmic, etc.)*	Adminis-tration Error	Prescriber's Order If Administration Error (Describe Error as Necessary)	Staff Name
10.					☐		
11.					☐		
12.					☐		
13.					☐		
14.					☐		
15.					☐		
16.					☐		
17.					☐		
18.					☐		
19.					☐		
20.					☐		
21.					☐		
22.					☐		
23.					☐		
24.					☐		
25.					☐		

Medication Administration Observation

Observation Findings

Calculations for Team's Combined Medication Administration Observations

Step 1. Combine all surveyor observations into one overall calculation for the facility. Record the Total Number of Errors. Record the number of Opportunities for Errors (doses given plus doses ordered but not given).

Step 2. Medication Administration Error Rate (%) = Number of Errors divided by Opportunities for Errors (doses given plus doses ordered but not given) multiplied by 100.

Step 3. After the overall error rate is determined, the team will determine whether a facility citation is appropriate during the team meetings. If the Medication Administration Error Rate is 5% or greater, cite F759.
If any one medication error is determined to be significant, cite F760.

Total Number of Errors / Opportunities for Errors * 100: Medication Administration Error Rate = ____%

1. **Does the facility ensure that it is free of medication error rates of five percent or greater?** ☐ Yes ☐ **No F759**

2. **Does the facility ensure that residents are free of any significant medication errors?** ☐ Yes ☐ **No F760**

3. **Did the facility provide medications and/or biologicals and pharmaceutical services to meet the needs of the resident?**
☐ Yes ☐ **No F755**

4. **Did the facility appropriately label and store drugs and biologicals in accordance with currently accepted professional principles?**
☐ Yes ☐ **No F761**

5. **Did the facility implement appropriate infection prevention and control practices during medication administration including hand hygiene, injection safety and point-of-care testing?** ☐ Yes ☐ **No F880**

6. **Did the facility meet professional standards of quality? Note: If F658 is cited, an associated tag should be cited.**
☐ Yes ☐ **No F658**

Medication Storage and Labeling

Medication Storage and Labeling: The team should review half of the med storage rooms, covering different units and review half of the med carts on units where the storage room was not observed. Surveyors, other than the one assigned coordination of the Medication Storage task, who are reviewing medication storage areas, need only answer the CE question if there are "No" responses to observations. *NOTE: For initial certification survey, review ALL of the medication storage rooms and medication carts using this pathway.*

☐ Medications and biologicals in medication rooms, carts, boxes, and refrigerators were maintained within:
- Secured (locked) locations, accessible only to designated staff;
- Clean and sanitary conditions; and
- Maintain temperatures in accordance with manufacturer specifications and monitor according to national guidelines (e.g., see CDC vaccine storage and handling).

☐ Schedule II-V controlled medications (excluding single-unit packaging in minimal quantities that can readily be detected if missing) were maintained within a separately locked permanently affixed compartment.

☐ Sufficiently detailed records of receipt and disposition of controlled medications were maintained to enable an accurate reconciliation.

☐ All medication records were in order and an account of all controlled medications was maintained and periodically reconciled.

☐ Were medications and biologicals labeled in accordance with currently accepted professional principles, and include:
- Appropriate accessory and cautionary instructions, and
- Expiration date, when applicable.

☐ Multi-dose vials to be used for more than one resident are kept in a centralized medication area and do not enter the immediate resident treatment area (e.g., resident room). If multi-dose vials enter the immediate resident treatment area they should be dedicated for single-resident use only.

☐ Multi-dose vials which have been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.

☐ Multi-dose vials which have not been opened or accessed (e.g., needle-punctured) should be discarded according to the manufacturer's expiration date.

☐ Insulin pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person, even when the needle is changed; insulin pens must be clearly labeled with the resident's name and other identifier(s) to verify that the correct pen is used on the correct resident; insulin pens should be stored in a sanitary manner to prevent cross-contamination.

☐ Disposal methods for controlled medications involve a secure and safe method to prevent diversion and/or accidental exposure.

Unit or area where the medication storage task was conducted: _____

1. **Did the facility provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident?** ☐ Yes ☐ **No F755**

2. **Are all medications and biologicals stored and labeled properly (medication rooms, carts, boxes, refrigerators)?** ☐ Yes ☐ **No F755 and/or F761**

3. **Does the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications?** ☐ Yes ☐ **No F755**

Other Tags and Care Areas to consider: Misappropriation of Resident Property/Exploitation Related to Drug Diversion (F602), Infection Prevention and Control (F880)

Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review

QAA Review – *This review should occur at the end of the survey, after completion of investigation into all other requirements. However, identification of systemic concerns to be reviewed during the QAA review should begin with Offsite Preparation and occur throughout the survey.*

Offsite: Make note of concerns identified during offsite preparation, which will be further investigated during the survey (repeat deficiencies, ombudsmen concerns, and complaints/facility-reported incidents). These represent possible systemic issues, which if validated during the survey, should be cited under the relevant outcome tag, and incorporated into the QAA review for investigation.

Team Meetings: During end of day team meetings, the survey team discusses potential systemic issues or shared concerns for further investigation, or those that have been validated for incorporation into the QAA review.

☐ Were any offsite concerns (repeat deficiencies, ombudsman concerns, and complaints/facility-reported incidents) validated during the survey?

☐ Were new systemic concerns validated (concerns which will likely be cited at pattern or widespread, or substandard quality of care) during the survey?

☐ Has more than one surveyor identified and validated the same concern?

Note: Disclosure of documents generated by the QAA committee may be requested by surveyors only if they are used to determine compliance with QAA regulations.

QAA Committee: Determine through review of the information requested by the TC during Entrance, an interview with the QAA contact person and review of QAA records:

☐ Does the facility have a QAA committee that meets at least quarterly?

☐ Does the QAA committee include the required members?

- Director of Nursing Services;
- Medical Director;
- Nursing home administrator, owner, board member, or other individual in a leadership role; and
- Two other staff members.

For every systemic issue identified and validated during the survey, determine if the QAA committee also has identified the issue and made a "Good Faith Attempt" to correct it. To determine this, do the following: a) interview the QAA contact person, and b) review evidence in order that will answer the following questions:

☐ Is the QAA committee aware of this issue?

☐ Is the issue a high risk, high volume, or problem-prone issue that the committee should know about?

☐ Has action been taken to correct this issue since it was identified?

☐ Is the QAA committee monitoring to ensure the corrective action has been implemented and the correction is being sustained?

Quality Assessment and Assurance (QAA) and QAPI Plan Review

☐ Is the issue corrected? That is was the facility in substantial compliance as of the first day of the survey because of the corrective action taken? If corrected, consider citing the related tag as Past Noncompliance.

☐ Has the QAA committee revised its corrective action based on its monitoring and evaluation?

If No to any of the above, interview the staff responsible for conducting QAA activities to determine how the facility is able to identify and correct its own quality deficiencies any time they occur throughout the facility. Select from among the following questions, or ask your own:

☐ How does the QAA committee know when an issue arises in any department?

☐ How does the QAA committee know when a deviation from performance or a negative trend is occurring?

☐ Is there a mechanism for staff to report quality concerns to the QAA committee?

☐ How does the QAA committee decide which issues to work on?

☐ How does the QAA committee know that corrective action has been implemented?

☐ How does the QAA committee know when improvement is occurring?

☐ How long will the QAA committee monitor an issue that it has corrected? How is this decided?

☐ Interview staff in various departments to determine whether they know how to bring an issue to the attention of the QAA committee.

1. Did the QAA committee develop and implement appropriate plans of action to correct identified quality deficiencies? ☐ Yes ☐ **No F867**

2. Does the QAA committee consist of the minimum, required members? ☐ Yes ☐ **No F868**

3. Does the facility have a QAA committee that meets at least quarterly? ☐ Yes ☐ **No F868**

4. Does the QAA committee put forth Good Faith Attempts to identify and correct its own quality deficiencies? ☐ Yes ☐ **No F865**

QAPI Plan Review

Review the QAPI Plan to ensure it includes policies and protocols describing how the facility will identify and correct its own quality deficiencies.

Does the QAPI plan have policies/protocols describing how it will:

☐ Track and measure its performance?

☐ Establish goals and thresholds for performance measurement?

Quality Assessment and Assurance (QAA) and QAPI Plan Review

- ☐ Identify and prioritize deviations from performance and other problems and issues?
- ☐ Systematically investigate and analyze to determine underlying causes of systemic problems and adverse events?
- ☐ Develop and implement corrective action or performance improvement activities?
- ☐ Monitor and evaluate the effectiveness of corrective action/performance improvement activities?

5. Does the facility have a QAPI plan containing the necessary policies and protocols describing how they will identify and correct their quality deficiencies? ☐ Yes ☐ **No F865**

Resident Council Interview

Resident Council Interview - *Complete an interview with active members of the Resident Council early enough in the survey to afford the team enough time to investigate any concerns. If there is not a resident council, determine whether residents have attempted to form one and have been unsuccessful, and if so, why.*

☐ Introduce yourself to the president of the council and ask for assistance in arranging the meeting. If there is no president, ask for a list of active resident council participants and select a resident to assist in arranging the meeting. Try to keep the group manageable, no more than 12 residents. Explain the survey process and the purpose of the interview using the following concepts. It is not necessary to use the exact wording.

> **"*[Name of facility]* is inspected periodically by a team from the *[Name of State Survey Agency]* to ensure that residents receive quality care. While we are here, we make observations, review the nursing home's records, and talk to the residents and family members or friends who can help us understand what it's like to live in this nursing home. We appreciate that you are taking the time to talk with us. We would like to know more about the Resident Council and interactions of the group and staff."**

☐ At all times, be cognizant of resident confidentiality. Obtain permission from the Resident Council President or Officer to review the Resident Council minutes and become familiar with some of the issues that have been discussed. Review three months of minutes prior to the interview to identify any unresolved areas of concern.

☐ Review the grievance policy to ensure prompt resolution of all grievances and that the facility has maintained results of grievances for a minimum of 3 years.

☐ It is suggested that the interview begin with some discussion of issues that have been discussed during the most recent Council meeting and how the facility has responded. For example, "I read in the minutes that you had discussed noise at night during the last meeting. Has the facility responded to your concern?" or "During the last meeting, several participants brought up an issue with food being cold. Has that situation been resolved to your satisfaction?" This initial discussion of current issues before the Council may prove helpful to establish a rapport with the Resident Council President (or Officer) and help make the remainder of the interview more informative.

☐ Document the names of residents in the meeting.

☐ Follow up on any concerns that are within the scope of the long-term care requirements with reference to specific F-tags identified on this pathway. Further investigation should include interviews with appropriate staff members to determine how concerns are resolved.

☐ Team meetings will provide opportunities to share concerns and focus on particular problematic areas. Any potential concerns noted during the interview should be shared with all team members.

Resident Council Interview

Interview		
Council		
	Resident Council Response	**Is the Facility in Compliance?**
1. Does the Resident Council meet on a regular basis?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
2. Does the facility help with arrangements for council meetings?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
3. Is there enough space for everyone who wants to attend?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
4. Can you meet without staff present, if you desire?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
Grievances		
	Resident Council Response	**Is the Facility in Compliance?**
5. Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
6. Does the Grievance Official respond to the resident or family group's concerns?	☐ Yes ☐ **No** (If Yes, Skip Question #7)	☐ Yes ☐ **No F565**
7. If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
8. Do you know how to file a grievance?	☐ Yes ☐ **No**	☐ Yes ☐ **No F585**
9. Do you feel a resident or family group can complain about care without worrying that someone will 'get back' at them?	☐ Yes ☐ **No**	☐ Yes ☐ **No F585**

Resident Council Interview

Resident Specific Areas		
	Resident Council Response	**Is the Facility in Compliance?**
10. Do staff treat you with respect and dignity so that you do not feel afraid, humiliated, or degraded? (If concerns are identified, refer to the Abuse Pathway)	☐ Yes ☐ **No**	☐ Yes ☐ **No F600**
11. Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely? (If concerns are identified, refer to the Sufficient Staffing Pathway)	☐ Yes ☐ **No**	☐ Yes ☐ **No F725**
12. Do you receive snacks at bedtime or when you request them?	☐ Yes ☐ **No**	☐ Yes ☐ **No F809**
13. Ask about concerns identified during survey:		

Rules		
	Resident Council Response	**Is the Facility in Compliance?**
14. Have you (residents) been informed of the rules at the facility (such as are there restrictions on visiting hours)?	☐ Yes ☐ **No**	☐ Yes ☐ **No F563**
15. If the Resident Council makes suggestions about some of the rules, does the facility act on those suggestions?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**

Resident Council Interview

Rights		
	Resident Council Response	**Is the Facility in Compliance?**
16. Does staff talk about and review the rights of residents in the facility?	☐ Yes ☐ **No**	☐ Yes ☐ **No F572**
17. Are residents able to exercise their rights?	☐ Yes ☐ **No**	☐ Yes ☐ **No F550**
18. Do you feel that the rights of residents at this facility are respected and encouraged?	☐ Yes ☐ **No**	☐ Yes ☐ **No F561**
19. Is mail delivered unopened and on Saturdays?	☐ Yes ☐ **No**	☐ Yes ☐ **No F576**
20. Without having to ask, are the results of the State inspection available to read?	☐ Yes ☐ **No**	☐ Yes ☐ **No F577**
21. Do residents know where the ombudsman's contact information is posted?	☐ Yes ☐ **No**	☐ Yes ☐ **No F574**
22. Does the facility allow you to see your medical records if you ask?	☐ Yes ☐ **No**	☐ Yes ☐ **No F573**
23. Have residents been informed of their right (and given information on how) to formally complain to the State about the care they are receiving?	☐ Yes ☐ **No**	☐ Yes ☐ **No F574**
Other		
Investigation of responses from this question should be conducted through initiation of a care area, if available. If an applicable care area is not available, a direct F-tag initiation is appropriate.		
24. Do you have any questions, or is there anything else you would like to tell me about the Resident Council?	☐ **Yes** ☐ No	☐ Yes ☐ **No (Display all F-tags)**

Sufficient and Competent Nurse Staffing Review

Evaluate *whether* the facility has sufficient and competent nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. States who have mandatory nurse-to-resident ratios are not exempt from this regulation.

Coordination:

☐ *Mandatory Submission of Staffing Information (Only completed by Team Coordinator [TC])*

☐ Part I is completed by all surveyors. Each surveyor is responsible for assessing the facility for compliance with the requirements for sufficient and competent nurse staffing throughout the survey and is to answer CEs of concern. The survey team should determine whether concerns with staffing can be linked to resident or resident representative complaints or any other regulatory requirements, such as but not limited to quality of life and care concerns.

☐ Part II is completed by the Team Coordinator or surveyor assigned primary responsibility of the task who is responsible for assessing the following areas: off-hour surveys, staffing waivers, nurse aide training/competency evaluation program.

MANDATORY SUBMISSION OF STAFFING INFORMATION *(Only completed by TC)*:

☐ *During offsite preparation, the TC reviews the information in the CASPER Payroll-Based Journal (PBJ) Staffing Data Report to determine if the facility submitted the required staffing information.*

1. Did the facility submit the required staffing information based on payroll data? ☐ Yes ☐ **No F851** ***(CE1) Cite at Severity/Scope of F if No. If considering not citing F851, email NHStaffing@cms.hhs.gov***

PART I – COMPLETED BY ALL TEAM MEMBERS

General Concepts When Considering Compliance:

- Quality of life and care concerns, Payroll-Based Journal (PBJ) Staffing Data Report, census, resident/representative complaints, and/or staff's ability to complete assignments are used to assess if the facility has sufficient staff to meet the residents' needs.
- Trainings are used to assess if staff retained the information provided by training to maintain the required competencies to meet each resident's needs.
- Turnover and QAA are used to assess if the facility is operating an effective QAA process.

Sufficient and Competent Nurse Staffing Review

OBSERVATIONS (During Initial Pool Process and/or Investigations): Make observations throughout the survey of staff over different shifts and units to determine their availability to meet the needs of residents. During team meetings, discuss whether any concerns (e.g., refer to the list below for examples) should alert the team of potential concerns with sufficient or competent staff. Note: The team meeting screen displays initial pool concerns (day 1) and investigation concerns (day 2) as a reminder for the team to discuss potential staffing concerns.

☐ Are there offensive odors? If so, what is the source?

☐ If mid-morning (e.g., 9-11 a.m.) or later, are residents still in bed and not dressed?

☐ Are residents care activities consistent with the time of day/night and their individual personal preferences?

☐ Are residents sitting around the nurse's station, in the hallways, or in front of the television without any interaction from staff?

☐ Are call devices and alarms responded to timely?

☐ Are residents displaying behavioral or pain concerns such as being combative, yelling, or crying out without staff intervention?

☐ Are residents who wander unsupervised and susceptible to, or creating, issues?

☐ Do staff rush when providing resident care?

☐ Do staff explain to residents what they are doing when assisting or providing services to the resident?

☐ Are residents provided timely assistance with eating during meals and are nursing staff monitoring the dining area during meals?

☐ Potential use of restraints:

- Are residents subdued or sedated, indicating the potential use of chemical restraints?
- Are there devices or practices in use that restrict residents' freedom of movement indicating the potential use of physical restraints?
- Is there a high incidence of position-change alarm use?

☐ Are residents' choices honored and their dignity maintained? For example:

- Do residents remain unkempt or unclean for extended periods of time (e.g., after sleeping or eating); or
- Are residents woken up and assisted with activities, such as eating, bathing, or dressing at times that is convenient for staff (e.g., during shift change), rather than at the residents' preference?

☐ Do residents receive timely assistance with toileting to prevent avoidable incontinence (including physical and psychosocial complications)

- Preventing skin irritations and/or skin breakdown, and
- Preventing negative psychosocial consequences (embarrassment).

☐ Is there a delay in residents receiving their medications timely?

☐ Are residents repositioned or turned timely in accordance with their plan of care?

☐ Are residents experiencing avoidable accidents (e.g., falls), elopements, or incidences of resident-to-resident altercations or abuse?

Sufficient and Competent Nurse Staffing Review

☐ If concerns about staff responsiveness exist, the surveyor should monitor when the resident's call device is activated and record the response time of the staff.

☐ When observing care or services provided to residents by nursing staff, determine if they demonstrate competency. Such as, their abilities to provide care according to professional standards in the following areas: Refer to other regulations and IGs as appropriate.

- Inability for staff to identify any obvious signs of residents' change in condition;
- Transfers and positioning (e.g., use of mechanical lifts, bed to chair);
- Infection control techniques, including wound care and residents on isolation precautions;
- Tracheostomy, ventilator care, or tube feeding; and
- Incontinence, including catheter care.

☐ If the PBJ Staffing Data Report reveals no RN hours (4 or more days) is triggered: is an RN on duty as required throughout the survey?

☐ If the PBJ Staffing Data Report reveals a high number of days without licensed nursing staff (4 or more days) is triggered: is a licensed nurse on duty as required throughout the survey?

☐ If an off-hour survey is conducted because of the PBJ Staffing Data Report (Excessively Low Weekend Staffing), observe staffing coverage and determine whether there are resident/family concerns with staffing, and/or resident quality of life or care concerns?

Note: The rule of 4 or more days is used for the purposes of the PBJ Staffing Data Report. The expectation of CMS is that the survey team would consider issuing a citation when a minimum of one day is identified to not meet the nurse staffing requirement for both a Registered Nurse and Licensed nursing staff.

INTERVIEWS:

Residents/Resident Representatives or Family Members:

Staff Sufficiency (list of probes addressed during the initial pool process and/or Investigations): During team meetings, discuss whether any concerns (e.g., refer to the list below for examples) should alert the team of potential concerns with sufficient or competent staff. Note: The team meeting screen displays initial pool concerns (day 1) and investigation concerns (day 2) as a reminder for the team to discuss potential staffing concerns.

☐ Do you feel that there is enough staff to meet your needs and concerns without having to wait a long time? If so, is there a specific time of day or weekends that are more problematic? Examples include:

- answering your call device timely or responding quickly to your alarm if you have one?
- receiving or refilling a cup of water?
- toileting, dressing, eating, going to activities?

Sufficient and Competent Nurse Staffing Review

- ☐ Has anything occurred because you had to wait for staff to respond and assist you, such as being incontinent, missing a shower, or falling? How often does this occur?
- ☐ Do you routinely eat in your room? If so, is this your choice? If it is not your choice, why are you routinely eating in your room? If needed, is assistance provided to help you eat and get to and from the dining room? Are room trays delivered timely? Are there enough staff to ensure hot foods are hot and cold foods are cold?
- ☐ Are you able to wake, dress, eat, or engage in other activities at times that are preferable to you? If not, do you think it is due to staffing concerns?
- ☐ Does staff interact with you and explain to you what care or services they are providing and why? Does staff rush you when they provide care?
- ☐ Do you get your medications on time?
- ☐ Have you needed a nurse (e.g., to be assessed) but a nurse wasn't in the facility?
- ☐ Are you aware if there is a nurse on duty during the day and night? (If the PBJ Staffing Data Report reveals RN or Licensed Nursing Coverage is triggered)

Staff Competency (surveyors should ask residents about staff competency throughout the survey):

- ☐ Do you feel safe and comfortable when staff assist you?
- ☐ Do you think the nursing staff are experienced and knowledgeable when providing your care? If not, what concerns have you experienced?
- ☐ Do you recall a time when you didn't feel well?
  - Did you tell a staff member?
  - Did you receive the assistance you needed?
  - Did you require hospitalization?

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

Staff Sufficiency:

- ☐ How many residents are you responsible for on a regular basis during your shift?
- ☐ Do you have enough time to complete your required assignments each day?
  - How about on the weekend?
  - If not, why not, and what assignments are you not able to complete?
  - How often does this occur?
- ☐ How often are you asked to stay late, come in early, or work overtime?

Sufficient and Competent Nurse Staffing Review

☐ Do you use position-change alarms? If yes, Why?

☐ Are there any devices used to help keep residents from falling, moving in certain ways, or wandering into certain areas? If so, why? Which residents?

☐ Are you able to complete rehabilitation services as ordered for the residents (e.g., range of motion –ROM)?

☐ How are current staffing needs determined? Has the facility management asked you about staffing levels required to take care of current resident needs? If so, can you share some examples of what you provided and if you know whether or not these were considered?

Staff Competency:

☐ How are you made aware of the care and services residents require and what their individual choices are?

☐ For Licensed Nurses: How do you communicate changes in residents' care to the Nurse Aides?

☐ For Nurse Aides: How are changes in a residents' care communicated to you? How do you communicate a resident's change in condition or concerns to other staff?

☐ Have you been trained to provide care (e.g., infection control techniques) and use of resident care equipment?

☐ Do you receive periodic evaluations on your skills, knowledge, and abilities?

☐ Do you have regular in-services regarding the following areas:

- Abuse/neglect/exploitation,
- Resident rights,
- Dementia care,
- Infection control,
- Communication,
- Behavioral health, and
- Specific resident needs (e.g., ventilators, dialysis, hospice, medication side effects, pain, or changes in condition)?

☐ Does your facility use agency staff? If so, how does that impact your daily activities? Do you have any concerns about resident care when agency staff are used?

DON and Staff Development Coordinator Interviews: If concerns are identified with sufficient or competent staff, coordinate the completion of the following interviews. Note: Surveyors may find it more efficient to ask similar questions during investigations into other more specific Quality of Life/Quality of Care concerns.

Sufficient and Competent Nurse Staffing Review

Staff Sufficiency:

☐ How do you determine the staffing levels needed to meet each resident's needs each day and during emergencies? How often is this reassessed?

☐ How are the residents' acuity, needs, and diagnoses considered when determining staffing requirements and assignments?

☐ How does the facility's census impact staffing levels? How do you accommodate for the changes and for weekend staffing adjustments?

☐ How do you handle call-ins or unanticipated staffing shortages?

☐ Do staff, residents, or families bring workload concerns to you? What is the system to address these concerns?

☐ Do you conduct exit interviews with staff that resign? Do you report interview findings to your QA&A meeting?

Staff Competency:

☐ How do you determine the competency needed to meet each resident's needs each day and during emergencies? How often is this reassessed?

☐ How do staff communicate changes in resident condition?

☐ What are the most common reasons why residents are transferred to the hospital?

☐ How do you assure that staff are appropriately assigned to meet the needs of residents and are implementing care-planned approaches for each resident on each shift and unit?

☐ Do you use temporary/contract staff? If so, how often and why?

- How do you ensure these staff are competent and have the knowledge and skills to care for residents?
- What is covered in your agreement with the staffing agency regarding the skill set of contract staff?
- How do you ensure the work assigned to contract staff is within their skill set?

☐ Is ongoing training provided for all staff, (permanent, temporary/contracted, etc.)? If not, why not? If yes, how often is this conducted and what areas are covered?

☐ Who is responsible for competency oversight?

- How often is staff evaluated to assess their competencies, skills, and knowledge?
- What type of education or training has been provided based on the outcomes of these reviews?

2. Does the facility have sufficient nursing staff on a 24-hour basis to care for residents' needs, as identified through resident assessments and the plan of care? Unless waived, does the facility designate a licensed nurse to serve as a charge nurse on each tour of duty?

☐ Yes ☐ **No F725**

Sufficient and Competent Nurse Staffing Review

3. Does the facility's nursing staff have the competencies required to care for residents' needs, as identified through resident assessments and the plan of care? Have nurse aides demonstrated competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in their care plans? ☐ Yes ☐ **No F726**

PART II - THE BELOW SECTION IS TO BE COMPLETED BY THE TEAM COORDINATOR OR ASSIGNED SURVEYOR:

Facility Documents/Records

☐ Review the staffing schedule, including call-ins and staff postings for the past month and/or for the specific timeframes of concern based on the information contained on the PBJ Staffing Data Report (triggered low weekend staffing, RN and/or LPN coverage). Depending on identified concerns, it may be necessary to expand your review.

☐ If the PBJ Staffing Data Report reveals no RN hours (4 or more days) is triggered, determine whether there are continued days without an RN on duty at least 8 hours/day? Request confirmation from the facility.

☐ If the PBJ Staffing Data Report shows a high number of days (4 or more days) with less than 24 hours of licensed nursing is triggered, determine whether there are continued days without 24 hour licensed coverage? Request confirmation from the facility.

☐ Review specific policies as needed (e.g., staff response to call device, resident rights, change of condition, position-change alarms, pressure ulcers, incontinence care, and ADLs).

☐ Does the facility have a waiver to provide licensed nurses on a 24 hour basis or a registered nurse for more than 40 hours a week (for SNFs)?

- Is there evidence that it is approved and reviewed by the state annually?
- Has the facility notified the residents or representatives of the waiver?

Note: The rule of 4 or more days is used for the purposes of the PBJ Staffing Data Report. The expectation of CMS is that the survey team would consider issuing a citation when a minimum of one day is identified to not meet the nurse staffing requirement for both a Registered Nurse and Licensed nursing staff.

Front Line Staff (e.g., nurse aides, LPN/LVN) Interviews:

☐ If the surveyor is made aware of the absences of a Registered Nurse for at least 8 consecutive hours a day:

- Is there an RN in the building at least 8 consecutive hours in the day?
- Are you ever made aware there is no RN in the building?
- Are you ever aware of a resident who needed care or services only performed by an RN (i.e., intravenous medications, assessment) and did not receive it?

Sufficient and Competent Nurse Staffing Review

☐ If the surveyor is made aware of the absences of licensed nursing staff in a 24 hour period:

- Are you ever made aware of the absence of licensed nursing staff during your shift?
- How often does this occur?
- How does this impact residents in the facility?
- Are you aware of any residents that missed medications or treatments due to no available licensed nurse?
- Who do you notify in the event of an emergency and there is no licensed nurse available?

Director of Nursing or Administrator Interviews:

☐ What does the facility do when there is not a licensed nurse available in a 24 hour period?

- How does the facility provide care to residents that require a licensed nurse if one is not available to work?
- How does this impact residents in the facility?

☐ Does the facility have an RN to serve as the DON on a full time basis?

☐ Does the facility ensure that the DON services as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents?

☐ What does the facility do when there is not an RN available to work the required 8 consecutive hours a day?

- How does the facility provide care to residents that require an RN if one is not available to work?

☐ If the surveyor is made aware of low weekend staffing:

- How do you determine staffing for the weekends?
- What actions has the facility taken to address the low weekend staffing?
- Have you had weekends with low staffing? If so, why?

☐ If the PBJ Staffing Data Report reveals a high number of days (4 or more days) without an RN, why wasn't an RN on duty [identify specific days from PBJ Staffing Data Report]? What is the facility doing to address a lack of RN coverage? Have you had any additional days without an RN on duty at least 8 hours/day? If so, why?

☐ If the PBJ Staffing Data Report shows a high number of days (4 or more days) with less than 24 hours of a licensed nurse, why was there inadequate licensed nursing coverage? What is the facility doing to address a lack of 24 hour licensed coverage? Have you had any additional days without 24 hour licensed coverage? If so, why?

4. Does the facility have sufficient nursing staff on a 24-hour basis to care for residents' needs, based on the staffing schedule, staff posting, and PBJ Staffing Data Report? Unless waived, does the facility designate a licensed nurse to serve as a charge nurse on each tour of duty? ☐ Yes ☐ **No F725**

Sufficient and Competent Nurse Staffing Review

5. Except when waived: Does the facility
- **have an RN at least 8 consecutive hours a day for 7 days a week,**
- **have an RN to serve as the DON on a full time basis, and**
- **ensure the DON serves as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents?**

☐ Yes ☐ **No F727**

6. Has the facility been granted a waiver to provide 24 hour licensed nursing staff coverage or have RN coverage for more than 40 hours a week? ☐ Yes ☐ **No F731** ☐ NA, the facility does not have any waivers.

NURSE AND NURSE AIDE TRAINING/COMPETENCY EVALUATION PROGRAM (Only evaluate when staffing concerns are identified)

☐ Review a minimum of five personnel files including any specific staff members with whom concerns were identified.

- Review the nurse aide personnel folder to determine if the facility received registry verification that the individual has met competency evaluation requirements before the employee start date. Exceptions are noted in 483.35(d)(i)(ii).
- Review the nurse aide personnel folder to determine if the facility verified information from every State registry that the facility believes will include information of that individual before the employees start date.
- Review the nurse aide personnel folder to determine if the facility verified the most recent completion of a training and competency evaluation program to determine if there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation.
- Review staff evaluations and/or training records, including in-services that may demonstrate an assessment of nurse staffing competencies, skills, and knowledge.

7. Does the facility ensure full-time nurse aides have become certified within 4 months of nurse aide training? ☐ Yes ☐ **No F728**
☐ NA, no concerns were identified with staffing.

8. Are nurse aides re-trained either by completing (1) a new training and competency evaluation program or (2) a new competency evaluation program, if there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation? ☐ Yes ☐ **No F729** ☐ NA, no concerns were identified with staffing.

☐ If concerns are identified with the care provided by a particular nurse aide, review his/her in-service record to determine whether a performance review was completed annually.

Sufficient and Competent Nurse Staffing Review

☐ Based on the results of the performance review, did the facility provide regular in-service education?

9. Does the facility complete a performance review of nurse aides at least once every 12 months, and provide regular in-service education based on the outcome of the review? ☐ Yes ☐ **No F730** ☐ NA, no concerns were identified with staffing.

☐ If concerns are identified with the care provided by a particular nurse aide, review his/her in-service record to determine:

- In-service training provided for any areas of weakness,
- At least 12 hours of in-service provided annually, and
- Training that addresses the special needs of the resident population residents as determined by the facility assessment.

10. Does the facility provide nurse aide in-services, at least 12 hours in a year, including dementia training, abuse prevention training, areas of weakness as determined in the nursing aides' performance reviews, facility assessment, special needs of residents determined by facility staff, and care of the cognitively impaired resident for those nursing aides providing cares for individuals with cognitive impairments? ☐ Yes ☐ **No F947** ☐ NA, no concerns were identified with staffing.

Posting:

☐ Is nursing staffing posted daily at the beginning of the shift and includes facility name, date, census, and the total number and actual hours worked per shift for RNs, LPN, CNAs who are responsible for resident care?

☐ Is nursing staffing posted in a clear and readable format? Is the posting in a prominent place readily accessible to residents and visitors?

11. Is nurse staffing posted daily and includes facility name, date, census, and the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care? ☐ Yes ☐ **No F732**

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Pressure Ulcer (CA), Bladder and Bowel (CA), Dental (CA), Positioning/Mobility/ROM (CA), Accidents (CA), Nutrition (CA), Catheter/UTI (CA), Tube Feeding (CA), Respiratory (CA), ADLs (CA), Environment (Task), Abuse (CA), Neglect (CA), Physical Restraints (CA), Chemical Restraints F605, Behavioral-Emotional Status (CA), Infection Control (Task), Facility Assessment F838, QAPI/QAA (Task).

FIRST IMPRESSIONS CHECKLIST

Item to be Inspected	Met	Not met	Corrective Action	Date corrected
Facility signage visible, well lit, clean, sturdy and in good repair.				
Parking lot is clean, striped and well lit.				
Handicap stall is present and clearly marked with signage.				
Lawn /grounds are well kept, neat in appearance and well-manicured without trash or clutter. Shrubbery is trimmed and flowerbeds weeded.				
Lawn furniture is clean, in good repair and adequate.				
Lawn hoses are stored and do not pose a tripping hazard.				
Entrance landscaped seasonally. Out of season decorations removed timely. Outside potted plants alive & well groomed.				
Entrances clean, well-lit and without clutter.				
Front doors clean, in good repair with weather stripping secure.				
Sidewalk poses no tripping hazards and is in good repair.				
Receptacle for cigarettes available at entrance and is emptied regularly.				
Lobby neatly organized, appropriate lighting (all bulbs working), low noise levels (including overhead paging).				
Greeted upon entrance by a staff member.				
Inside “potted” plants alive / well groomed.				
Staff members appropriately dressed with name badge.				
Visible office spaces neatly organized and clutter free.				
All areas odor free.				
Public restrooms clean and comfortable.				
Public posting information is well organized and easily accessible (i.e., State Survey Results, other required info by law).				
Facility has a feel of comfort and is not institutional.				
Hallways are free of obstruction.				
Dining areas are clean, neat and offer a home like appeal.				
Resident smoking areas clean of cigarette butts and other trash. Available ashtrays and trash cans cleaned/dumped at least daily if not more often. Patio furniture clean, good repair and adequate.				
Patio poses no tripping hazards and is in good repair.				
Staff’s smoking area clean of cigarette butts and other trash. Available ashtrays and trash cans cleaned/dumped at least daily if not more often.				
Areas around dumpsters are clean and clutter free. Lids on dumpsters are closed.				
Laundry and Dietary outside areas clean and uncluttered.				
Surrounding area outside storage buildings clean and uncluttered.				
Gutters and down spouts securely attached and function properly.				
Siding/brick is in good repair, not chipped, cracked or broken nor is paint chipped.				
Window panes are in good condition without chipped paint and no broken windows.				
Window screens are clean, not torn and in good repair.				

ADMINISTRATION CHECKLIST

Area	Yes	No	Comments
Past survey reports displayed			
Medicare/Medicaid benefit information displayed			
Resident Trust Fund Balanced			
Surety Bond equals one and one half times the total amount of the average resident fund balance			
Ombudsman information posted			
Private access to a telephone available for residents			
Administrator licensure current			
Contract book current			
Safety Committee meetings held regularly			
Disclosure of ownership			
Bed Reconciliation form			
Waiver(s) available if applicable			
Daily Nursing staffing posted and current			

CONTRACT BOOK CHECKLIST

	Contract	License	Insurance	Comments
Activities Consultant				
Audiologist				
Background Check				
Barber/Beauty				
Biohazardous Waste				
Blood Products				
Cable TV				
CLIA Waiver	N/A		N/A	
Dentist				
Dialysis (all providers)				
Electrical				
E.T. Nurse (Wound Nurse)				
Facility Insurance	N/A	N/A		
Fire Alarm P/M				
Hospice (all providers)		N/A		
Laboratory				
Landscaping		N/A		
Medical Director				
Medical Records Consultant				
Mobile x-ray				
Modified Barium Study				
Nursing Agency (supplemental staffing)				
Optometrist				
Oxygen				
Pest Control				
Pharmacy				
Pharmacy Consultant				
Podiatrist				
Psychiatrist				
Psychologist				
RT Agreement		N/A	N/A	
Radon Testing		N/A	N/A	
Dietitian Consultant				
Social Services Consultant				
Sprinkler System P/M				
Surety Bond	N/A	N/A		
Therapy PT				
Therapy OT				
Therapy SLP				
Therapy RT				
Transfer Agreement		N/A		
Utilization Review		N/A	N/A	

PERSONNEL FILE CHECK LIST

Instructions:

1. Complete review on charts indicated in columns across
2. Indicate with a √ if complete
3. Utilize "I" for incomplete
4. Utilize "N/A" for not applicable

Criteria	Requirement	R.N.	R.N.	L.P.N.	L.P.N.	C.N.A.	C.N.A.	D/H	D/H	HRLY	HRLY	Comments
Hiring Information	Pre-Employment References											
	Credentials/License Verified											
Orientation	Checklist for General Orientation											
	Checklist for Dept. Orientation											
	Signature Resident Rights											
	Standards of Conduct											
	Employee Handbook > Facility Policies											
	Fire & Disaster Plan											
	State Specific:											
	Abuse & Neglect											
Separate Personnel Records (keep in a separate location from personnel file and with very limited access)	Medical File:											
	TB Testing											
	HepB											
	Consents/documentation											
	Criminal Background checks											
	I-9 Information											
	EDL checked											
Other												
	Family Care Registry											
	C.N.A. Registry											
	OIG											
	Drug testing											

Abuse Critical Element Pathway

Use this pathway for investigating an alleged violation of abuse to a resident. This would include allegations where a resident was deprived of goods or services by an individual, necessary to attain or maintain physical, mental and psychosocial well-being. If photographic documentation is obtained during the survey, refer to S&C-06-33. In addition, for investigating other concerns:

- Refer to the Investigative Protocol found at F603 for concerns related to involuntary seclusion;
- Refer to the Neglect CE Pathway to investigate concerns about structures or processes leading to a resident(s) with an outcome, for example, unrelieved pain, avoidable pressure ulcers/injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment; or
- Refer to the Investigative Protocol for F608-Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or for an allegation of retaliation.

NOTE: If you witness an act of abuse or receive an unreported allegation of abuse, you must immediately report it to the facility administrator, or his/her designated representative if the administrator is not present. The survey team would then determine whether the facility takes appropriate action in accordance with the requirements at F608, F609 and F610, including implementing safeguards to prevent further potential abuse. If you witness an act of abuse, you must document who committed the abusive act, the nature of the abuse, where and when it occurred, and potential witnesses.

Review the following in Advance to Guide Observations and Interviews*:*

☐ Information related to an alleged violation of abuse, such as:

- Date, time, and location (e.g., unit, room, floor) where alleged abuse occurred;
- Name of alleged victim(s), alleged perpetrator(s) and witnesses, if any;
- Narrative/specifics of the alleged abuse(s) including frequency and pervasiveness of the allegation; and
- Whether the allegation was reported by the facility and/or to other agencies, such as Adult Protective Services or law enforcement.

☐ Sources for this information may include:

- Resident, representative, or family interviews, observations or record review;
- Reports from the long-term care ombudsman or other State Agencies;
- Deficiencies related to abuse (CASPER 3 Report); and
- Complaints and facility-reported allegations of abuse, including any facility investigation reports, received since the last standard survey.

☐ Facility's abuse prohibition policies and procedures provided during the Entrance Conference (review only those components necessary during the investigation to determine if staff are implementing the policies as written). Refer to F607.

Abuse Critical Element Pathway

Observation across Various Shifts:. Request staff assistance to make observations, as needed. Only if you are a licensed nurse or practitioner can you observe the resident's private areas.

- ☐ Observe whether the alleged perpetrator (staff, other resident, or visitor) is present in the facility. What access does the alleged perpetrator have to the alleged victim and other residents?
- ☐ Describe the alleged victim's reaction, if any, when the alleged perpetrator, or a specific resident(s) or staff person(s) is present:
  - o Avoids or withdraws from conversations or activities;
  - o Displays fear of, or shies away from being touched; and/or
  - o Exhibits behaviors such as angry outbursts, tearfulness, or stress (agitation, trembling, cowering)?
- ☐ Describe physical injuries, if any, related to the alleged abuse, such as:
  - o Fractures, sprains or dislocations;
  - o Burns, blisters, or scalds;
  - o Bite marks, scratches, skin tears, and lacerations with or without bleeding, including those that would be unlikely to result from an accident;
  - o Bruises, including those forming shapes (e.g., finger imprints) or found in unusual locations such as the head, neck, lateral locations on the arms, posterior torso and trunk, inner thigh, genital area and/or breasts; and/or
  - o Facial injuries, including but not limited to, broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks.
- ☐ Observe and describe:
  - o If the alleged perpetrator is a resident, whether he/she displays symptoms, such as
    - ▪ Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;
    - ▪ Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
    - ▪ Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;
    - ▪ Taking, touching, or rummaging through other's property;
    - ▪ Wandering into other's rooms/space; or
    - ▪ Resistive to care and services.
  - o If the alleged perpetrator is staff, whether he/she displays rough handling of residents, appears rushed, dismisses requests for assistance, expresses anxiety, or frustration regarding work and lack of staffing.
- ☐ Observe for possible environmental factors related to the alleged abuse, such as:
  - o If in a resident's room, the room configuration, presence of privacy curtains, and the availability of a working call light/call bell;
  - o Lighting levels; or
  - o Location in relation to the nurse's station, staff lounges, or outside access such as windows, doors, or hallways.
- ☐ For an allegation that a resident was deprived of goods or services by staff, observe for physical/psychosocial outcomes related to care deficits.

Abuse Critical Element Pathway

Interviews: Be impartial, use discretion, and non-judgmental language. Use an interpreter as needed to obtain as accurate information as possible. Attempt to interview the alleged victim and witnesses as soon as possible.

Alleged Victim or Representative and Witness(es) Interview: Conduct private interviews unless the alleged victim requests the presence of another person. Observe the alleged victim's emotions and tone, as well as any nonverbal expressions or gesturing to a particular body area, in response to the questions. Maintain the confidentiality of witnesses and the person who reported the allegation (e.g., change the order of the interviews, location or time), to the extent possible. During the interview with the witnesses, the surveyor may ask him/her to re-create or re-enact the alleged incident, to better understand the sequence of events.

☐ For the **alleged victim/resident representative/witness**, ask, as applicable:

- What occurred prior to, during, and immediately following the alleged abuse?
- When and where did the alleged abuse occur?
- Could he/she identify the alleged perpetrator and any witnesses? Who?
- What was said? What was the tone of the alleged perpetrator's voice or volume?
- Did you report the alleged abuse? Who did you report it to? What was their response? If not reported, what prevented you from reporting the alleged abuse?
- Did you report the alleged abuse to any external entities (e.g., police, physician, ombudsman, and other state agencies)? Who did you report it to? What was their response?
- Do you think retaliation has occurred since you reported the alleged abuse? If so, what actions were taken?

☐ For the **alleged victim/resident representative**, document as applicable:

- Did you suffer any injuries (e.g., bruises, cuts, fractures) from the alleged abuse? Please describe, including the alleged victim's response to the injuries (e.g., pain, new difficulty sitting or walking).
- Did you go to the hospital or physician's clinic for evaluation and treatment? When and which facility?
- Do you feel safe?
- Have there been past encounters with the alleged perpetrator?
- Have there been past instances of abuse?

☐ For the **resident's representative**, ask, as applicable:

- Have you observed any changes in the alleged victim's behavior, and if so, describe?

☐ For an **allegation that a resident was deprived of goods or services by staff, for the alleged victim/resident representative**, ask, as applicable:

- How do staff respond to your requests for assistance? If staff do not respond, what happens?
- Do you have any concerns about the manner in which care is provided to you? If so, describe. Did you report this to anyone? If so, to whom, when, and what was the response?
- Do you feel that you have had any negative changes (e.g., weight loss, pressure ulcers) because of the failure to receive the care that you need?
- Have you had any changes in medication (e.g., antipsychotics) that may be impacting the care you receive?

Abuse Critical Element Pathway

Alleged Perpetrator Interview: If the alleged perpetrator is a staff member, the staff member may have been suspended or re-assigned until the facility's investigation is completed and in some situations, the facility may have terminated the employment of the individual. In some cases the alleged perpetrator may not be in the facility or may refuse to be interviewed. If possible, interview the alleged perpetrator in person or by phone even if the alleged perpetrator is no longer working in the facility. In addition, the alleged perpetrator may be a resident or visitor. Interview the alleged perpetrator to determine the following, to the extent possible, and include information regarding inability, if any, to conduct the interview:

- ☐ What information can you provide regarding the alleged abuse?
- ☐ Were you present in the facility at the time of the alleged abuse? If so, where were you at?
- ☐ What is your relationship, if any, to the alleged victim?
- ☐ For an allegation that a resident was **deprived of goods or services**, ask the staff member:
  - How do you respond to the resident's requests for assistance;
  - Have you had any concerns when you have been assigned to this resident? If so, describe. Did you report this to anyone? If so, to whom, when, and what was the response?
  - Have you noticed any negative changes (e.g., weight loss, pressure ulcers) with this resident? If so, describe; and
  - Has the resident had any behavioral symptoms (e.g. combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting the care that they receive? If so, have you reported this? If reported, to whom, when, and what was the response?
- ☐ If the **alleged perpetrator is a staff member**:
  - What is your position?
  - Describe any contact that you have with the alleged victim.
  - Do you continue to have access to the alleged victim? If not, why?
  - How long have you worked in the facility?
  - What type of orientation, training, work assignments, and supervision did you receive?
  - What training have you received related to abuse prevention, reporting abuse, and the facility's abuse policy and procedures?
- ☐ Do you have any other information you wish to share in regard to the investigation?

Abuse Critical Element Pathway

Staff Interviews: Interview the most appropriate direct care staff member. Review staff schedules from all departments to determine who was working at the time of the alleged abuse and who may have had contact with the alleged perpetrator or alleged victim. Interview the most appropriate direct care staff member:

- ☐ Did you have knowledge of the alleged abuse? If so, describe.
- ☐ What actions, if any, did you take in response to the allegation?
- ☐ If you're familiar with the alleged victim, have you noticed any changes in the alleged victim's behavior as a result of the alleged abuse? If so, describe.
- ☐ How did the alleged perpetrator and victim act towards one another prior to and after the incident?
- ☐ Did the alleged perpetrator and/or victim exhibit any behaviors that would provoke one another? If so, what actions were taken to address this?
- ☐ If the alleged perpetrator was staff, had the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past, such as using derogatory language, rough handling, or ignoring residents while giving care?
- ☐ If the alleged perpetrator was a visitor, did the visitor exhibit any inappropriate behaviors in the past or have any indication of risk to the resident(s)?
- ☐ Did you report the alleged abuse to any supervisors/administration? Who did you report it to? What was their response?
  - o If reported, do you think retaliation has occurred since you reported the alleged abuse? If so, describe. Do you fear retaliation?
  - o If not reported, what prevented you from reporting the alleged abuse?
- ☐ Did you report the alleged abuse to any external entities (e.g., police, physician, ombudsman, and other state agencies)? Who did you report it to? What was their response?
- ☐ Have you received training on abuse identification, prevention, and reporting requirements?
- ☐ For an allegation that a resident was **deprived of goods or services** by staff, ask:
  - o How do staff respond to the resident's requests for assistance? If staff do not respond, what do they say;
  - o Do you have any concerns about the manner in which care is provided to the resident? If yes, describe. Did you report this to anyone? If so, to whom, when, and what was the response;
  - o Has the resident had any negative changes (e.g., weight loss, pressure ulcers) because of the failure to receive the care that he/she needs;
  - o Has the resident had any changes in medication (e.g., antipsychotics) that may be impacting the care that they receive? Note: Determine if the resident may have received unnecessary medications such as chemical restraints.

Abuse Critical Element Pathway

Other Healthcare Professionals (DON, Social Worker, Attending Practitioner) Interviews, as Appropriate Ask the appropriate personnel:

- ☐ Do you have knowledge of the alleged abuse? If so, describe.
- ☐ When and by whom were you notified of the alleged abuse?
- ☐ Did you conduct an assessment of the alleged victim for potential injuries or a change in mental status? What interventions or treatment (e.g., counseling) were provided, if any?
- ☐ Was the alleged victim assessed and/or treated at a hospital after the alleged incident? NOTE: Attempt to interview the practitioner from the hospital who examined the alleged victim to determine physical findings and mental status at the time.
- ☐ Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses?
- ☐ If there are discrepancies in injuries based on the alleged victim's description, how was this investigated?
- ☐ Did the alleged perpetrator and/or victim exhibit any behaviors that would provoke one another? If so, what actions were taken to address this?
- ☐ Did you report the alleged abuse to administration? Who did you report it to? What was their response? If not reported, what prevented you from reporting the alleged abuse? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)?
- ☐ Were any external entities (e.g., APS or law enforcement) contacted? If so, who made the report, to whom, and when?
- ☐ If the **alleged perpetrator was a resident**:
  - o Did you conduct any interviews related to the alleged abuse and identify the circumstances of what occurred prior to, during and after the alleged abuse?
  - o Does the care plan identify interventions to address any behaviors of the alleged perpetrator?
  - o Was the care plan implemented?
- ☐ If the **alleged perpetrator is a visitor**:
  - o Was there any indication of a prior history of abuse, aggression, or other inappropriate behaviors?
  - o Was there any indication of a physical or psychosocial change in the alleged victim after a visit with the alleged perpetrator, whether onsite or outside of the facility?
  - o Did you interview the alleged perpetrator and identify the circumstances of what occurred prior to, during and after the alleged abuse? If so, describe?
  - o Were visits from the alleged perpetrator supervised? When and where did visits usually occur?
  - o Is access to the alleged victim currently allowed? If so, under what circumstances?
  - o What protections have been put in place (e.g., supervision of visits while the investigation is being conducted); and/or
  - o Has access to other residents been limited? If so, how?
- ☐ For an allegation that a resident was **deprived of goods or services** by staff, ask:
  - o Have you noticed any negative changes (e.g., weight loss, pressure ulcers) with this resident? If so, please describe.
  - o How do staff respond to the resident's requests for assistance? If staff do not respond, what do they say;
  - o Do you have any concerns about the manner in which care is provided to the resident? If yes, describe. Has staff report this concern to you? If so, when and what did you do;
  - o Has the resident had any behavioral symptoms (e.g., combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting care they receive? If so, did staff report this to you? If reported, when and what was your response;
  - o Has the resident had any changes in medication (e.g., antipsychotics) that may be impacting the care that they receive? Note: Determine if the resident may have received unnecessary medications such as chemical restraints; and/or

Abuse Critical Element Pathway

- o If the interventions were not effective in reducing the behaviors, were they revised and if so, what was changed?
- o Did the revised interventions provide the needed protections?
- o What protections have been put in place at this time?
- o Has access to other residents at risk been limited? If so, how?

☐ If the **alleged perpetrator was staff**, ask:

- o Did the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past (e.g., using derogatory language, rough handling, or ignoring residents while giving care)? If yes, describe.
- o Was there a history of resident/family grievances or problems identified with care delivery or services provided? If so, what was the result of the investigation of the concerns, and describe any disciplinary actions and/or training provided related to the complaints/concerns.
- o Did annual performance reviews identify issues with the provision of care, treatment, or other concerns? If so, what was provided to address the concerns.
- o How is monitoring and supervision provided regarding the delivery of care and services by the alleged perpetrator?
- o Who is responsible for supervising and monitoring the delivery of care at the bedside?

Facility Investigator Interview: If the facility investigated the alleged abuse, interview the staff member responsible for the initial reporting and the overall investigation of the alleged abuse. For some facilities, the Administrator may be the Facility Investigator.

- ☐ When (date and time) were you notified of the alleged abuse and by whom?
- ☐ What information was reported to you related to the alleged abuse?
- ☐ When and what actions were taken to protect the alleged victim from further abuse while the investigation was in process?
- ☐ Describe medical interventions, if any, taken in relation to the alleged abuse, (e.g., hospitalization, transfer to ER, onsite visit by attending practitioner).
- ☐ What steps were taken to investigate the allegation? Can you provide me a timeline of events that occurred?
- ☐ Describe interviews conducted, such with the alleged victim/resident representative, witnesses, alleged perpetrator, and practitioner and what information was obtained.
- ☐ Describe record reviews conducted related to the alleged abuse and what information was obtained.
- ☐ Were there any photographs or videos obtained related to the alleged abuse? If yes, describe.
- ☐ When and who received results of the investigation?

Abuse Critical Element Pathway

- ☐ Describe any mental assessments that were conducted pertaining the alleged abuse, and any interventions taken to assist the resident (e.g., counseling).
- ☐ If the allegation relates to sexual abuse, describe the immediate actions of the staff, including preserving evidence, providing medical intervention (e.g., transfer to hospital for sexual assault for rape kit), conducting a physical assessment, and reporting.
- ☐ Who did you notify and when (date/time) of the alleged abuse? Was an outside entity informed about the alleged abuse, and if so, when (date and time)? NOTE: If a suspected crime, note the date and time reported. Obtain copies of the outside entities investigations, if available.
- ☐ What actions were taken as a result of the investigation (e.g., for the alleged victim, the alleged perpetrator, other staff, training, policy revisions)?
- ☐ Is there any related information regarding the allegation that may not be included in the investigation report?

Administrator Interview:

- ☐ When (date and time) were you notified of the allegation and by whom?
- ☐ When (date and time) was the initial report reported to required agencies and law enforcement, as applicable?
- ☐ Who was/is responsible for the investigation? Is the investigation completed or ongoing? If completed, what was the outcome? (if the administrator is the facility investigator, use the questions above to determine how the investigation was conducted.)
- ☐ When (date and time)were the results of the investigation reported to you and to the required agencies?
- ☐ When and what actions were taken to protect the alleged victim and residents at risk from further abuse while the investigation was in process?
- ☐ What happened as a result of the investigation?
- ☐ How do you monitor for potential or actual reported allegations of abuse?
- ☐ If the alleged perpetrator is an employee, were there previous warnings or incidents at the facility? If the alleged abuse was verified, describe actions that were taken.
- ☐ How do you assure retaliation does not occur when staff or a resident reports an allegation of abuse?
- ☐ For an allegation that a resident was **deprived of goods or services**, ask:
  - o Have staff reported any concerns to you about the manner in which care is provided to the resident? If yes, when, what did they report, and what did you do; and
  - o Who is responsible for supervising and monitoring the delivery of care at the bedside?

QAA Responsible Person Interview:

- ☐ How do you monitor reported allegations of abuse?
- ☐ When did the QAA Committee receive the results of the investigation for the allegation of abuse?
- ☐ Did the QAA Committee make any recommendations based on the results of the investigation, such as policy revisions or training to prevent abuse?

Abuse Critical Element Pathway

Review the Alleged Victim's Record:

- ☐ Was the alleged victim was assessed at risk for abuse (e.g., as indicated in the RAI, care plan, progress notes from nurses, social services, practitioners)? If so, how did the facility implement interventions to mitigate risks?
- ☐ When (date/time) did the allegation occur? When was it discovered and by whom?
- ☐ When was the resident's representative, practitioner and other required entities notified?
- ☐ Were physical injuries noted related to the alleged abuse?
- ☐ Are there changes in the alleged victim's mood or demeanor before and after the alleged abuse (e.g., distrust, fear, angry outburst, cowering, tearfulness, agitation, panic attacks, withdrawal, difficulty sleeping, and PTSD symptoms)?
- ☐ Are there potential indicators of sexual abuse (e.g., STD, vaginal or anal bleeding, pain or irritation in genital area, bruising/lacerations on breasts or inner thighs, or recent difficulty with sitting or walking)?
- ☐ Was the resident assessed and the care plan revised as needed? What interventions (e.g., first aid, hospitalization) occurred to address any physical injuries or changes in mental status? (Note: If the resident required medical treatment, you may need to contact the hospital and/or practitioner to obtain related medical records for review.)
- ☐ For an allegation that a resident was **deprived of goods or service**:
  - o Does the record reflect any negative changes (e.g., weight loss, pressure ulcers);
  - o Has the alleged victim had any behavioral symptoms (e.g., combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting the care that they receive? If so, describe; and/or
  - o Determine if the alleged victim may have received unnecessary medications such as chemical restraints and if this impacted the care received.

Review the Alleged Perpetrator's Record, if a Resident:

- ☐ What circumstances are documented (date/time) before, during and after the alleged abuse?
- ☐ Is there a previous history of exhibiting any behaviors that would provoke others? If so: Does the care plan address behaviors, if any, of the alleged perpetrator, and include interventions (e.g., monitoring, staff supervision, redirection?
  - o Were care plan interventions implemented?
  - o If the interventions were not effective in reducing the behaviors, were they revised and if so, what was changed?
- ☐ After the alleged abuse, did staff separate the alleged victim and other residents at risk?
- ☐ What are the plans to monitor and supervise the resident?
- ☐ If interventions were unsuccessful, was the physician notified? Were new interventions implemented?

Abuse Critical Element Pathway

- Did the revised interventions provide the needed protections?
- What protections are currently in place?
- Does the alleged perpetrator have limited access to other residents at risk? If so, how?

Review the Alleged Perpetrator's Personnel File, if Staff:

- ☐ Is there any information related to the alleged abuse? If so, describe.
- ☐ Is there a history of other allegations?
- ☐ Were adverse personnel actions taken? If so, describe.
- ☐ Is there information related to any finding of abuse/neglect/exploitation/misappropriation of property/mistreatment?
- ☐ If a nurse aide:
  - Was training and orientation provided related to dementia management, abuse and neglect prevention?
  - Were annual performance reviews conducted? Was there a history of competency concerns? If so, what disciplinary actions and/or training was provided related to performance deficits?

Investigative Report from Other Investigatory Agencies (APS, Professional Licensing Boards, Law Enforcement):

- ☐ Review a copy of the report if another investigatory agency (e.g., APS, Professional Licensing Board, and Law Enforcement) conducted an investigation.
- ☐ What did the other investigatory agency find? Note: deficient practice is not determined based on another agency's investigation.

Critical Element Decisions:

1) Did the facility protect a resident's right to be free from any type of abuse that results in, or has the likelihood to result in physical harm, pain, or mental anguish?
   If No, cite F600

2) Did the facility hire or engage staff who have:
   - Not been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law?
   - Not had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property?
   - Not had a disciplinary action taken by a state professional licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property?
   - Not had a successful appeal of their disqualification from employment?

Abuse Critical Element Pathway

AND/OR

Did the facility report to the State nurse aide registry or licensing authorities any knowledge of actions taken by a court of law that would indicate unfitness as a staff member of a nursing home?
If No, cite F606
NA, the alleged perpetrator was not staff

3) Did the facility develop and implement written policies and procedures that prohibit and prevent abuse, establish policies and procedures to investigate any such allegations, and include training as required at paragraph §483.95?
If No, cite F607

4) Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training on activities that constitute abuse; procedures for reporting incidents of abuse; and dementia management and resident abuse prevention?
If No, cite F943

5) Does the facility's in-service training for nurse aides include resident abuse prevention?
If No, cite F947

6) Did the facility develop and implement written policies and procedures to ensure reporting of suspected crimes within mandated timeframes, annual notification of covered individuals of reporting obligations, posting of signage stating employee rights related to retaliation against the employee for reporting a suspected crime, and prohibition and prevention of retaliation?
If No, cite F608

7) For alleged violations of abuse, did the facility:
- Identify the situation as an alleged violation involving abuse, including injuries of unknown source?
- Immediately report the allegation to the administrator and to other officials, including to the State survey and certification agency, and APS in accordance with State law?
- Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?

If No to any of the above, cite F609

8) For alleged violations of abuse, did the facility:
- Prevent further potential abuse while the investigation is in progress?
- Initiate and complete a thorough investigation of the alleged violation?
- Maintain documentation that the alleged violation was thoroughly investigated?

Abuse Critical Element Pathway

- Take corrective action following the investigation, if the allegation is verified?

If No to any of the above, cite F610

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Dignity (CA), Visitors F563/F564, Notice of Rights and Rules F572, Privacy (CA), Grievances F585, Reporting Reasonable Suspicion of a Crime F608, Accidents (CA), Social Services F745, Behavioral-Emotional Status (CA), Sufficient and Competent Staffing (Task), QAA/QAPI (Task).

Personal Funds Review

Personal Funds Review: *Complete this review if a resident or representative had concerns with their personal funds account during the initial pool process. Residents should be given the opportunity to manage their own personal funds, and the facility may not require residents to deposit their funds. If residents choose to have the facility manage their funds, the facility may not refuse. If concerns are identified, review additional resident accounts to determine the frequency of identified problems and review the facility's policies, procedures and systems.*

Verify Account: Verify the existence of the resident's account prior to beginning the review. If you determine that the resident does not have an account and this is the only resident causing the task to trigger, remove the Personal Funds task and reconcile the discrepancy before removing the task.

Access to Funds: Review this CE if the resident or representative had concerns about access to their funds.

☐ Interview staff to determine how resident requests for money on weekends or evenings (non-banking hours) are honored and how money is safeguarded until needed.

1. Do residents have ready access to their personal funds managed by the facility? ☐ Yes ☐ **No F567** ☐ **NA**

Quarterly Statements: Review this CE if the resident or representative had concerns about quarterly statements.

☐ Determine how often residents, or their legal representatives, receive statements of personal account activity.

☐ Ask staff to show and describe the system for ensuring that quarterly statements, and statements upon request, are provided.

☐ Determine whether the sampled resident receives his/her own quarterly statements, and statements upon request (unless a legal financial representative has been appointed or the resident has requested another party to receive the information).

2. Does the facility provide quarterly statements and provide statements to residents or legal representatives upon request? ☐ Yes ☐ **No F568** ☐ **NA**

Costs and Services: Review this CE for the residents who caused this task to trigger.

☐ How and when residents are notified of the costs for services and any changes in costs for services.

☐ Whether residents/legal representatives are notified of expected charges at the time of admission, and told in advance when changes will occur in their bills.

☐ Whether residents/legal representatives are notified of any charges for services that are not covered under Medicare or Medicaid or by the facility's per diem rate, such as in-room telephone, haircuts, the daily newspaper, or private room charges.

☐ Whether Medicaid beneficiaries are informed, in writing, at the time of admission or when the resident becomes eligible for Medicaid, of the items and services included in the state plan for which the resident may not be charged.

Personal Funds Review

3. Are residents informed of costs for services and any changes in costs for services? ☐ Yes ☐ **No F582** ☐ **NA**

Separate Accounting Maintained: Review this CE for the residents who caused this task to trigger.

☐ Ask the staff member to show you and describe how separate accounting is maintained.

☐ Are funds in one pooled (combined) resident fund account?

☐ Are funds in a separate account?

☐ Are funds in a combined account for resident funds under $50.00 (not required to be in an interest-bearing account) with an additional separate interest-bearing account for funds in excess of $50.00 for Medicaid residents and in excess of $100.00 for all other residents. (For example, a resident may have a small amount of money in a pooled account and have a large amount of money in an interest-bearing savings account)?

☐ Are funds in a separate accounting, whether or not the funds are pooled (combined), with separate statements maintained showing deposits and withdrawals?

4. Does the facility maintain a separate accounting of each resident's funds? ☐ Yes ☐ **No F568** ☐ **NA**

Accounting Principles: Review this CE for the residents who caused this task to trigger.

☐ Determine whether the record is reconciled and up to date by asking staff to show how the financial account indicates:

- The transactions that have occurred including deposits and withdrawals are accurately recorded.
- The resident's current balance.

5. Does the accounting system follow generally acceptable accounting principles? ☐ Yes ☐ **No F568** ☐ **NA**

Charges: Review this CE for the residents who caused this task to trigger.

☐ Determine how staff ensures that Medicare or Medicaid residents are not charged for services that are covered under the Medicare or Medicaid plan.

☐ Ask staff to review and describe charges and deductions from the account of the Medicare or Medicaid recipient(s).

☐ Follow up on vague entries, unreasonable charges, and any inappropriate charges for covered items. Residents should be allowed to pay for non-covered services that are available to private-pay residents, such as permanents/haircuts, personal reading material, and social events outside the scope of the activities program.

☐ See F571 for examples of items that may be charged to resident's funds. (Medicaid recipients must be informed in writing of items and services

Personal Funds Review

included in the state plan.

6. Are Medicare/Medicaid residents charged only for non-covered services? ☐ Yes ☐ **No F571** ☐ **NA**

Interest: Review this CE for the residents who caused this task to trigger.

☐ Interview staff to determine whether funds in excess of $50.00 for Medicaid residents and $100.00 for all others are kept in an interest-bearing account.

☐ Whether all resident funds are pooled (combined) into one account, that resident money is not co-mingled with facility money, and each resident accrues an appropriate percent of the interest.

☐ Ask staff to show and describe how interest is paid to each entitled resident.

☐ "Applicable interest" means a rate of return equal to or above the passbook savings rate at local banking institutions in the area. If money is in a pooled fund, each resident should receive the applicable interest rate distributed in proper proportion according to individual account balances. Earned interest should be posted to resident accounts within a few business days of the facility's receipt of the bank statement.

7. Is applicable interest paid to each entitled resident? ☐ Yes ☐ **No F567** ☐ **NA**

Medicaid Eligibility Limit: Review this CE if a resident who caused this task to trigger is a Medicaid recipient:

☐ Review the account balance for that resident to see whether the balance is nearing the eligibility limit.

☐ If the balance is within, or approaching, $200.00 of the maximum a Medicaid recipient can have in cash assets (eligibility limit varies from state to state), determine whether the facility has verification that a notice was given to the resident/legal representative.

8. Does the facility notify Medicaid residents when the amount in the resident's account reaches $200 of the eligibility limit? ☐ Yes ☐ **No F569** ☐ **NA**

Surety Bond: Review this CE if the task triggered.

☐ Ask the facility to provide information on how many residents have personal accounts and what total amount (total value) is being managed by the facility.

☐ Determine whether the facility has a surety bond.

☐ Verify that the bank holdings are comparable to the total amount of funds entrusted to the facility.

Personal Funds Review

9. Does the facility have a surety bond or similar protection with the amount of the surety bond equal to at least the current total amount of resident funds? ☐ Yes ☐ **No F570** ☐ **NA**

Extended Survey

Extended Survey: The purpose of the extended survey is to explore the extent to which structure and process factors may have contributed to systemic problems causing SQC. An extended survey includes all of the following:

- Review of a larger sample of resident assessments than the samples used in a standard survey;
- Review of the staffing and in-service training;
- If appropriate, examination of the contracts with consultants;
- A review of the policies and procedures related to the requirements for which deficiencies exist; and
- Investigation of any Requirement for Participation (RfP) at the discretion of the Survey Agency.

An extended survey is conducted when Substandard Quality of Care (SQC) has been verified.

Substandard Quality of Care *is defined as one or more deficiencies with scope/severity levels of F, H, I, J, K, or L in any of the following F tags:*

§ 483.10 Resident Rights	**§ 483.25 Quality of Care**	**§ 483.40 Behavioral Health Services**
F550 – Resident Rights/Exercise of Rights	F684 – Quality of Care	F742 – Treatment/Svc for Mental/Psychosocial Concerns
F558 – Reasonable Accommodation of Needs/Preferences	F685 – Treatment/Devices to Maintain Hearing/Vision	F743 – No Pattern of Behavioral Difficulties Unless Unavoidable
F559 – Choose/Be Notified of Room/Roommate Change	F686 – Treatment/Services to Prevent/Heal Pressure Ulcers	F744 – Treatment/Service for Dementia
F561 – Self Determination	F687 – Foot Care	F745 – Provision of Medically Related Social Services
F565 – Resident/Family Group and Response	F688 – Increase/Prevent Decrease in ROM/Mobility	**§ 483.45 Pharmacy Services**
F584 – Safe/Clean/Comfortable/Homelike Environment	F689 - Free of Accident Hazards/Supervision/Devices	F757 – Drug Regimen is Free From Unnecessary Drugs
§ 483.12 Freedom from Abuse, Neglect, and Exploitation –	F690 – Bowel/Bladder Incontinence, Catheter, UTI	F758 – Free From Unnecessary Psychotropic Meds/PRN Use
F600 – Free from Abuse and Neglect	F691 – Colostomy, Urostomy, or Ileostomy Care	F759 – Free of Medication Error Rates of 5% or More
F602 – Free from Misappropriation/Exploitation	F692 – Nutrition/Hydration Status Maintenance	F760 – Residents are Free of Significant Med Errors
F603 – Free from Involuntary Seclusion	F693 – Tube Feeding Management/Restore Eating Skills	**§ 483.70 Administration**
F604 – Right to be Free from Physical Restraints	F694 – Parenteral/IV Fluids	F850 – Qualification of Social Worker >120 Beds

Extended Survey

F605 – Right to be Free from Chemical Restraints	F695- Respiratory/Tracheostomy Care and Suctioning	**§ 483.80 Infection Control**
F606 – Not Employ/Engage Staff with Adverse Actions	F696 – Prostheses	F883 – Influenza and Pneumococcal Immunizations
F607 – Develop/Implement Abuse/Neglect, etc. Policies	F697 – Pain Management	
F609 – Reporting of Alleged Violations	F698 – Dialysis	
F610 – Investigate/Prevent/Correct Alleged Violation	*F699 – Trauma Informed Care*	
§ 483.24 Quality of Life	*F700 - Bedrails*	
F675 – Quality of Life		
F676 – Activities of Daily Living (ADLs)/Maintain Abilities		
F677 – ADL Care Provided for Dependent Residents		
F678 – Cardio-Pulmonary Resuscitation (CPR)		
F679 – Activities Meet Interest/Needs of Each Resident		
F680 – Qualifications of Activity Professional		

Timing:

☐ The extended survey can be conducted:

- Prior to the exit conference, in which case the facility will be provided with findings from the standard and extended survey; or
- After the standard survey but no later than 14 calendar days after the completion of the standard survey. If the extended survey is completed after the standard survey, documentation of non-compliance should be completed in the same survey shell. Do not upload the survey in ACO until the extended is completed.

Procedures:

☐ Review facility policies and procedures which are related to the deficiencies representing SQC in an effort to identify systemic failures which may have contributed to the SQC.

☐ **§483.35 Nursing Services:** Was the Sufficient and Competent Nurse Staffing Review Facility Task completed for the standard/abbreviated survey in which SQC was found?

☐ Yes – Review findings from this task to determine if there were any structure or process concerns related to written policies/procedures, or sufficient or competent staff which may have contributed to the SQC.

Extended Survey

☐ No – Conduct the Sufficient and Competent Nurse Staffing Review Facility Task with a focus on identifying structure or process concerns which may have contributed to the SQC identified on the survey.

☐ **§483.75 Quality Assurance & Performance Improvement:** Was the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review Facility Task completed for the standard/abbreviated survey in which SQC was found?

☐ Yes – Review findings from this task to determine if there were any structure or process concerns related to the QAPI plan, or QAA committee improvement activities which may have contributed to the SQC.

☐ No – Conduct the QAA/QAPI Plan Review Facility Task with a focus on identifying structure or process concerns which may have contributed to the SQC identified on the survey.

☐ In addition to the above tasks, determine whether structure, process *or staff training* concerns exist by referring to the regulations and guidance in Appendix PP of the SOM for each Ftag below:

☐ **§483.30 Physician Services:**

1. **Is the facility in compliance with Resident's Care Supervised by a Physician?** ☐ Yes ☐ **No, F710**
2. **Is the facility in compliance with Physician Visits – Review Care/Notes/Order?** ☐ Yes ☐ **No, F711**
3. **Is the facility in compliance with Frequency of Physician Visits – Frequency/Timeliness/Alternate NPPs?** ☐ Yes ☐ **No, F712**
4. **Is the facility in compliance with Physician for Emergency Care, Available 24 Hours?** ☐ Yes ☐ **No, F713**
5. **Is the facility in compliance with Physician Delegation of Tasks to NPP?** ☐ Yes ☐ **No, F714**
6. **Is the facility in compliance with Physician Delegation to Dietitian/Therapist?** ☐ Yes ☐ **No, F715**

☐ **§483.70 Administration:**

1. **Is the facility in compliance with Effective Administration?** ☐ Yes ☐ **No, F835**
2. **If a local, state, or other federal authority has taken a final adverse action against the facility or licensed professional currently providing services in the facility, the facility is not in compliance with F836. Is the facility in compliance with F836?** ☐ Yes ☐ **No, F836**
3. **Is the facility in compliance with Governing Body?** ☐ Yes ☐ **No, F837**
4. **Is the facility in compliance with the Facility Assessment?** ☐ Yes ☐ **No, F838**
5. **Is the facility in compliance with Staff Qualifications?** ☐ Yes ☐ **No, F839**
6. **Is the facility in compliance with Use of Outside Resources?** ☐ Yes ☐ **No, F840**
7. **Is the facility in compliance with Responsibilities of Medical Director?** ☐ Yes ☐ **No, F841**

Extended Survey

8. **Is the facility in compliance with Resident Records – Identifiable Information?** ☐ Yes ☐ **No, F842**
9. **Is the facility in compliance with Transfer Agreement?** ☐ Yes ☐ **No, F843**
10. **Is the facility in compliance with Disclosure of Ownership Requirements?** ☐ Yes ☐ **No, F844**
11. **In the event of a pending or potential facility closure, is the facility in compliance with Facility Closure-Administrator?** ☐ Yes ☐ **No, F845** ☐ N/A
12. **In the event of a pending or potential facility closure, is the facility in compliance with Facility Closure?** ☐ Yes ☐ **No, F846** ☐ N/A
13. **Is the facility in compliance with Hospice Services?** ☐ Yes ☐ **No, F849**
14. **Is the facility in compliance with Qualified Social Worker > 120 Beds?** ☐ Yes ☐ **No, F850** ☐ *N/A*

☐ **§483.95 Training Requirements:**

1. ***Is the facility in compliance with an effective training program for all new and existing staff based on the facility assessment?*** ☐ *Yes* ☐ ***No, F940***
2. ***Is the facility in compliance with providing mandatory effective communications training for direct care staff?*** ☐ *Yes* ☐ ***No, F941***
3. ***Is the facility in compliance with ensuring all staff memebers are educated on the rights of the resident and the responsibilities of a facility?*** ☐ *Yes* ☐ ***No, F942***
4. **Is the facility in compliance with Abuse, Neglect, and Exploitation Training?** ☐ Yes ☐ **No, F943**
5. ***Is the facility in compliance with QAPI training?*** ☐ *Yes* ☐ ***No, F944***
6. ***Is the facility in compliance with providing mandatory training that included written standards, policies and procedures for their infection control program?*** ☐ *Yes* ☐ ***No, F945***
7. ***Does the facility effectively communicate standards, policies and procedures of its Compliance and Ethics program to its entire staff?*** ☐ *Yes* ☐ ***No, F946***
8. **Is the facility in compliance with Required In-Service Training for Nurse Aides?** ☐ Yes ☐ **No, F947**
9. **Is the facility in compliance with Training for Feeding Assistants?** ☐ Yes ☐ **No, F948** ☐ N/A
10. ***Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training to meet the resident's behavioral health care needs, as described at §483.95(i)?*** ☐ *Yes* ☐ ***No, F949***

Neglect Critical Element Pathway

Use this pathway for concerns in structures or processes that have led to resident outcome such as unrelieved pain, avoidable pressure injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment. Neglect may be the outcome of systemic or repeated patterns of care delivery failures throughout the nursing home, such as insufficient staffing, or may be the effect of one or more delivery failures involving one resident and one staff person.

If conducting a complaint investigation regarding an allegation of neglect, utilize appropriate Critical Element Pathways for care issues, such as pressure ulcers, injuries, incontinence care, etc., in order to identify whether noncompliance for a care concern exists first. Then if structure or process failures are identified, refer to this pathway. Refer to the Investigative Protocol for F608-Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or an allegation of retaliation against staff for reporting.

Review the Following in Advance:

☐ Identify information from investigation of the relevant care areas to determine whether additional observations, interviews, and record reviews are necessary to evaluate whether the facility has the structures and processes necessary to provide goods and services to residents.

Interviews with Staff Working During the Time the Alleged Neglect Occurred:

☐ Why do you think the alleged neglect occurred?

☐ How did staff respond when the resident requested assistance?

☐ What do you consider as neglect?

☐ What do you do if you suspect that a resident is not receiving necessary care and services?

☐ Were you aware of the care not being provided? If so, who and when did you report it to? What actions were taken by the nursing home? If you did not report your concerns, why not?

☐ Has retaliation occurred as a result of reporting neglect? If so, what actions were taken against staff?

☐ What training have you received from the facility on neglect identification, prevention, and reporting requirements?

Supervisory Staff Interviews from Relevant Departments Related to the Alleged Neglect:

☐ How do you monitor and provide oversight in order to assure care and services are implemented based upon the care plan and the resident's identified needs, and if there is an acute change of condition?

☐ How do you monitor staff/resident interactions?

☐ How do you monitor for the deployment of sufficient numbers of qualified and competent staff across all shifts to meet resident needs?

☐ How do you determine staffing assignments based on the levels and types of care needed for the resident(s)?

☐ How do you and staff communicate across shifts?

☐ How do you monitor for staff burnout, which could contribute to neglect?

☐ How is orientation provided for temporary or pool staff?

☐ Why do you think the alleged neglect occurred?

☐ If there are concerns, such as insufficient staffing or lack of availability of food, medications or supplies, did you report this to administration? Why or why not? If reported, what was the response?

Neglect Critical Element Pathway

Facility Investigator Interview:

- ☐ Were you responsible for the initial reporting and the overall investigation of the alleged neglect? (Obtain a copy of the investigation report, if any.)
- ☐ When were you notified of the allegation and by whom?
- ☐ When and what actions were taken to protect the resident(s) from further potential neglect while the investigation was in process?
- ☐ What steps were taken to investigate the allegation? What was the timeline of events that occurred?
- ☐ What happened as a result of the investigation?
- ☐ Who received the results of the investigation and when?
- ☐ What related information regarding the allegation is not included in the investigation report?

NOTE: Refer to F609 for further investigation if the facility did not have a copy of the investigation report available.

Administrator Interview:

- ☐ When were you notified of the alleged neglect?
- ☐ What deficits in care/services/resources (e.g., insufficient staffing, lack of supplies) were you notified about?
- ☐ If you were notified, what actions did you take to respond to concerns?
- ☐ What actions were taken to prevent further potential neglect during and after the investigation was completed?
- ☐ How do you assure that retaliation does not occur when staff or a resident reports an allegation of neglect?

Quality Assurance Interview:

- ☐ How does the committee provide monitoring and oversight of potential or actual reported allegations of neglect?
- ☐ What recommendations such as policy revision or training to prohibit neglect has the committee made?

Neglect Critical Element Pathway

Record Review:

- ☐ Review policies and procedures that identify the structures and processes in place to provide needed care and services. Review only those policies regarding the neglect that is being investigated.
- ☐ How does the facility determine and monitor sufficient numbers of staff, temporary staff, consultants, contractors, and volunteers?
- ☐ How does the facility determine the type of staff, such as qualified registered, licensed, certified staff (in accordance with State licensing rules) that are competent and have the knowledge and skills necessary for the provision of care and services that they are assigned?
- ☐ What are the duties of direct care staff to meet resident needs? Who is responsible for monitoring the delivery of care at the bedside?
- ☐ What type of orientation and training program exists for staff, including temporary staff, contractors, consultants, and volunteers, including but not limited to policies, specific resident care, services and treatments, neglect, dementia care, abuse and other interventions necessary to meet a resident's needs?
- ☐ How does the facility establish resident care policies and procedures to assure that staff have written direction in accordance with current standards of practice that address resident diagnoses and provide clinical and technical direction to meet the needs of each resident admitted?
- ☐ How does staff communicate relevant resident care information to other staff, health care practitioners, consultants, and the resident or resident representative?
- ☐ How are annual performance evaluations for direct care staff conducted and how is staff performance evaluated?
- ☐ How does the facility provide ongoing maintenance and calibration of resident care equipment and devices, based on manufacturer's instructions?
- ☐ How does the facility ensure a safe and sanitary environment, including all buildings, furnishings, equipment, provision of fire safety, maintenance department, laundry services, dietary services, rehabilitation, and other services?
- ☐ How does the facility provide adequate resident care supplies (e.g., food, medications, linens) to meet resident needs?
- ☐ Review processes including the actual care or services provided:
  - o Were there initial and ongoing assessments that reviewed the clinical needs of the resident including any acute changes in condition? If not, describe;
  - o Was a resident-specific plan of care in place, including the ongoing evaluation and revision of the care plan as necessary;
  - o Was there ongoing monitoring and supervision of staff to ensure the implementation of the care plan as written; and
  - o Was there effective communication between staff, health care practitioners, and the resident or resident representative?
- ☐ Review staff schedules:
  - o Who was working at the time of the alleged neglect;
  - o How is it determined how many staff are required to care for the residents and the actual number of staff assigned to the residents; and
  - o What types of resident care are required, depending on resident acuity, resident needs, and the number of residents?

Neglect Critical Element Pathway

☐ Review personnel records of staff present and directly involved in the allegation of neglect during the time of alleged neglect:

- Do they have a finding of abuse, neglect, misappropriation, exploitation, or mistreatment by a court of law? Have they had a finding entered into the State nurse aide registry? Has there been a disciplinary action in effect against the individual's professional license? If so, describe;
- Were annual performance reviews conducted? Was there a history of problems with care delivery? What disciplinary actions and/or training were provided related to performance deficits;
- How does the facility conduct competency evaluation and training for licensed staff including pool/temporary staff for the types of interventions required, as applicable, such as CPR, IV therapy, oxygen therapy, and mechanical ventilation; and
- What is the scope of practice for staff assigned to provide care and services during the alleged neglect?

☐ If pool/temporary staff were involved in the situation of neglect:

- What type of orientation was provided for pool/temporary staff regarding the facility policies/procedures?
- How does the facility ensure that pool/temporary staff have knowledge of resident-specific interventions as identified in the care plan? How does the facility assure that pool/temporary staff have completed training to perform CPR, as required, to residents in the facility?

Neglect Critical Element Pathway

Critical Elements Decisions:

1) Did the facility protect the resident's right to be free from neglect?
   If No, cite F600

2) Did the facility hire or engage staff who have:
   - Not been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law?
   - Not had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a disciplinary action taken by a state professional licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a successful appeal of their disqualification from employment?

   AND/OR

   Did the facility report to the State nurse aide registry or licensing authorities any knowledge of actions taken by a court of law that would indicate unfitness as a staff member of a nursing home?
   If No, cite F606

3) Did the facility develop and implement written policies and procedures that prohibit and prevent neglect, establish policies and procedures to investigate any such allegations, and include training as required at paragraph §483.95?
   If No, cite F607

4) Did the facility develop and implement written policies and procedures to ensure reporting of suspected crimes within mandated timeframes, annual notification of covered individuals of reporting obligations, posting of signage stating employee rights related to retaliation against the employee for reporting a suspected crime, and prohibition and prevention of retaliation?
   If No, cite F608

5) For alleged violations of neglect, did the facility:
   - Identify the situation as an alleged violation involving neglect, including injuries of unknown source;
   - Report immediately to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law; and
   - Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?

   If No, cite F609.

Neglect Critical Element Pathway

6) For alleged violations of neglect, did the facility:
   - Prevent further potential neglect;
   - Initiate and complete a thorough investigation of the alleged violation;
   - Maintain documentation that the alleged violation was thoroughly investigated; and
   - Take corrective action following the investigation?

   If No, cite F610

7) Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training on activities that constitute neglect, procedures for reporting incidents of neglect, and dementia management and resident abuse prevention?
   If No, cite F943

8) Does the facility's in-service training for nurse aides include resident abuse prevention?
   If No, cite F947

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Grievances F585, Sufficient and Competent Staffing (Task), Administration F835, Governing Body F837, Facility Assessment F838, Medical Director F841, and QAA/QAPI (Task).

Environment

PHYSICAL PLANT ROUNDS - INITIAL TOUR

Facility:_____ Date: _____

TAG #	STANDARD	MET	NOT MET	COMMENTS
	ADMINISTRATIVE			
	802			
	672			
	Facility Assessment			
F-577	Prior Survey available in public area with 3 years?			
F-809	Meal times Posted			
F-803	Menus Posted			
F-679	Activity Calender Posted			
F-585	Grievence Person Contact Information Posted			
F-562	Ombudsman Information			
F-579	MC/MA Info			
F-836	Administrator License			
F-836	Facility License			
F-770-771-772	CLIA Waver			
F-550	Resident Rights Notifications			
F-732	Nurse Staffing sheet visible to public and residents?			
F-576	Private area for resident with phone?			
F-880	MSD current and available to staff			
	Emergency Preparedness			
F-838	Facility Assessment			
	BENEFICIARY NOTICE			
F - 582	Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN)—Form CMS-10055			
F - 582	Notice of Medicare Non-coverage-- Form CMS 10123-NOMNC, also referred to as a “generic notice"			
	RESIDENT FUNDS REVIEW			
F-567	Do residents have ready access to their personal funds managed by the facility?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-568	Provide quarterly statements and provide statements to residents or legal representatives upon request			
F-567	Resident funds are secured in an interest bearing account			
F-567	Is applicable interest paid to each entitled resident			
F-570	Does the facility have a surety bond or similar protection with the amount of the surety bond equal to at least the current total amount of resident funds?			
ENVIRONMENTAL INCLUDING RESIDENT ROOMS				
F-584	Is there an odor upon entering the home?			
F-584, F-880	Are all areas clean?			
F-558	Reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents			
F-584	Surroundings are homelike			
F-812	All refrigerators are clean and have thermometers in both freezer at 0 and refrigerator at 41? Therapy_____ Activities_____Offices_____Utility Room_____Resident Rooms_____			
F-812	Juice/Food labeled, covered, dated less that 72 hours old			
F-812	No employee food unless so designated			
F-761 F-689	OTC drugs stored in room if yes, are drugs secured and have a doctor order			
F-919	Are call systems in all areas functioning properly			
F-689	Functional Call lights and within reach of resident			
F-584	Are comfortable sound levels maintained in all areas			
F-584	Are comfortable and safe temperatures maintained in all areas between 71° and 81°			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-689	Are water temperatures between 105° and 120°			
F-923	Is there adequate ventilation in all areas?			
	Are proper lighting levels maintained in all areas?			
	Are all areas or equipment in good repair? Building, Furniture or Equipment			
F-880 F-775	TF pumps, poles clean and TF labeled - Formula w/start date and time along with rate - initialed			
F-880 F-775	IV pumps, poles clean and IV labeled - Contents w/start date and time along with rate - initialed			
F-584 F-880	Is resident care equipment in safe operating condition ie.. Is lifts, wheelchairs safe and clean			
F-584	Are the residents allowed to have personal belongings, to the extent possible, creating a homelike environment?			
F-584	Are personal items ie.. toothbrushes clearly marked and not co-mingled?			
F-584	Bedpans and Urinals stored properly and covered?			
F-584	Urine graduates labeled for individual resident			
F-584 F-880	Catheters off floor, hanging below bladder covered with a dignity bag			
F-584	Are bed linens, towels, and washcloths available in resident rooms and in good condition?			
F-924	Are handrails accessible and securely affixed to the walls, free from sharp edges?			
F-921	Does the facility provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public?			
F-700	Bed rails are not being used. Are they applied safely; and Are there areas in which the resident could become entrapped (i.e., large openings or gaps), or become injured, such as exposed metal, sharp or damaged edges.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-909	Are there accessible chemicals/other hazards in the resident's bathroom, bathing facilities?			
	Are there chemicals used by facility staff (e.g., housekeeping chemicals), including chemicals or other toxin materials in the resident environment?			
	Are there drugs or other therapeutic agents that pose a safety hazard to a resident?			
	Are there plants or other "natural" materials found in the resident environment or in the outdoor environment?			
	Is there electrical equipment used (e.g., electrical cords, heat lamps, extension cords, power strips, electric blankets, heating pads)?			
F-689	Storage off floors/18" below ceiling			
OXYGEN STORAGE AND USE				
F-880 F-775	Is O_2 tubing dated properly			
F-880 F-775	Tubing off the floor (if really long for independence - Is it Care Planned)			
F-880 F-775	Is O_2 Concentrator clean, is filter clean and installed properly?			
F-689	Oxygen Tank storage. Room is to be secured and have sign to label door.			
F-689	Is room vented?			
F-689	Is there space between full and empty tanks?			
F-689	Is there clear signs designating area for full and empty tanks?			
THERAPY				
F-584	Is linen stored properly and not on floor?			
F-689	Is the hydroculator temperature log up to date?			
F-689	Ultra sound gel or other chemicals properly stored (MSD sheets available)			
F-915	Are O2 tanks secured in cart?			
F-550	Privacy provided during treatment			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-880	No food in patient care areas			
STAFF RESPECTING RESIDENTS				
F-678	Ask staff how they know if resident is CPR or DNR?			
F-550	Offer privacy/no exposure			
F-550	Address resident appropriately			
F-550	Knocks and listens before entering			
F-558/676/688	Positions resident appropriately?			
	Gate Belts used?			
	Wheelchair pedals on when transporting resident?			
F-550	ID Badges are worn?			
PHYSICAL PLANT				
F-921	Trash cans are fire rated			
F-921	No penetration of smoke barriers			
F-584, F-689	Extension cords used properly			
	Evacuation Plan are hanging on each hall with "You Are Here"			
	MSD Material Safety Data available to staff			
F-906	Emergency Power			
F-908	Red electric outlets			
F-921	Corridors unobstructed			
F-908	Doors locked and have appropriate door closures			
F-689	Doors not propped open			
	Are there any gaps on external doors?			
	Is there three feet of clearance in front of electric panel?			
F-689	Shut off Valves are labeled			
	Sharps containers are available for use			
SMOKING OBSERVATIONS				
F-926	Is the resident smoking safely (observe as soon as possible):			
	Is the resident supervised if required?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Does the resident have oxygen on while smoking?			
	Does the resident have a safety equipment if needed?			
	Does the resident have difficulty holding or lighting a cigarette?			
	Are there burned areas in the resident's clothing/body?			
	Does the resident keep his/her cigarettes and lighter?			
	Are cigarette butts disposed of in red self closing trash can?			
	Is the red can marked for cigarette butts only, no trash allowed?			
FOOD SERVICES-KITCHEN/DINING				
	Potentially hazardous foods, such as meat have not been left out to thaw at room temp			
F-812	Food items in the refrigerator(s) are labeled and dated			
	Foods such as uncooked meat, poultry, fish, and eggs are stored separately from other foods (e.g., meat is thawing so that juices are not dripping on other foods).			
	UnPasteurized eggs only are used in foods that are not fully cooked (per observation or interview).			
	Food is prepared, cooked, or stored under appropriate temperatures and with safe food handling techniques.			
	Staff are not touching hair or face without hand washing and then handling food.			
F-880	Hand washing facilities with soap and water are separate from those used for food preparation.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Staff are using hand hygiene and glove use when necessary during food preparation activities, such as between handling raw meat and other foods, to prevent cross-contamination.			
	Are appliances clean?			
	Are counter tops clean?			
	Is red sanitizing bucket being used? Have staff check consistancy.			
	STORAGE TEMPERATURES			
	Freezer temperatures are at or below 0 degrees Fahrenheit (°F)			
	Freezer are clean and odor free?			
F-812	Refrigerator temperatures are at or below 41 degrees Fahrenheit (°F)			
	Refrigerators are clean and odor free?			
	Is all food labeled and dated in all freezers and refrigerators?			
	FOOD STORAGE			
F-812	Frozen foods are thawing at the correct temperature.			
	Foods in the refrigerator/freezer are covered, dated, and shelved to allow circulation.			
	Foods are stored away from soiled surfaces or rust.			
	Canned goods have an uncompromised seal (e.g., punctures).			
	Staff are only using clean utensils when accessing bulk foods and/or ice.			
	Containers of food are stored off the floor, on surfaces that are clean or protected from contamination (e.g., 6 inches above the floor, protected from splash.			
	There are no signs of water damage from sewage lines and/or pipelines.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	There are no signs of negative outcome (e.g., freezer burn, dried out, or change in color).			
	Raw meat is stored so that juices are not dripping onto other foods.			
	Food products are discarded on or before the expiration date.			
	Staff are following the facility's policy for food storage, including leftovers.			
	FOOD PREPARATION AND SERVICE			
	Hot foods are held at 135°F or higher on the steam table.			
	Cold foods are held at 41°F or lower.			
	Food surfaces are thoroughly cleaned and sanitized after preparation of fish, meat, or poultry.			
	Cutting surfaces are sanitized between uses.			
	Equipment (e.g., food grinders, choppers, slicers, and mixers) are cleaned, sanitized, dried, and reassembled after each use.			
	If staff is preparing resident requests for soft cooked and undercooked eggs (i.e., sunny side up, soft scrambled, soft boiled), determine if a pasteurized egg product was used.			
	Proper final internal cooking temperatures (monitoring the food's internal temperature for 15 seconds determines when microorganisms can no longer survive and food is safe for consumption)			
	Foods should reach the following internal temperatures:			
	Poultry and stuffed foods: 165°F; ground beef, pork, fish at least 155°F, eggs at least 155°F			
	Ground meat (ground beef, ground pork, ground fish) and eggs held for service: at least 155°F;			
	Fish and other meats: 145°F for 15 seconds;			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	When cooking raw animal foods in the microwave, foods should be rotated and stirred during the cooking process so that all parts of the food are heated to temperature of at least 165°F, and allowed to stand covered for at least 2 minutes after cooking to obtain temperatue & equilibrium.			
	Fresh, frozen, or canned fruits and vegetables: cooked to a hot holding temperature of 135°F to prevent the growth of pathogenic bacteria.			
	Food itmes that are reheated to the proper temperatures:			
	The potentially hazardous food (PHF) or time/temperature controlled for safety (TCS) food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165°F for at least 15 seconds before holding for hot service; and			
	Ready-to-eat foods that require heating before consumption are best taken directly from a sealed container (secured against the entry of microorganisms) or an intact package from an approved food processing source and heated to at least 135°F for holding for hot service			
	Food is covered during transportation and distribution to residents.			
	Food is cooked in a manner to conserve nutritive value, flavor, appearance, and texture.			
	Snacks that are held at room temperature are served within 4 hours of delivery. Potentially hazardous foods (e.g., milk, milk products, eggs) must be held at appropriate temperatures.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Staff properly wash hands with soap and water to prevent cross-contamination (i.e., between handling raw meat and other foods).			
	Staff utilize hygienic practices (e.g., not touching hair, face, nose, etc.) when handling food.			
	Staff wash hands before serving food to residents after collecting soiled plates and food waste.			
	Opened containers of potentially hazardous foods or leftovers are dated or used within 7 days in the refrigerator or according to facility policy.			
	Proper cooling procedures were observed, such as cooling foods in shallow containers, and not deep or sealed containers, facilitating foods to cool quickly as required.			
	Potentially hazardous foods are cooled from 135°F to 70°F within 2 hours; from 70°F to 41°F within 4 hours; the total time for cooling from 135°F to 41°F should not exceed six hours.			
F-812	Food procured from vendors meets federal, state, or local approval.			
	Review the policies and procedures for maintaining nursing home gardens, if applicable.			
	The time food is put on the steam table and when meal service starts. If unable to observe, determine per interview with the cook.			
	How staff routinely monitors food temperatures on the steam table (review temperature logs).			
	When staff starts cooking the food. If unable to observe, determine per interview with the cook.			
	What cooking methods are available and used (e.g., steamer, batch-style cooking).			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Ensure staff do not compromise food safety when preparing modified consistency (e.g., pureed, mechanical soft) PHF/TCS foods.			
	Ask staff about their knowledge of the food safety practice and facility policy around the particular concern identified.			
	Does the facility have written policies (e.g., eggs) that honor resident preferences safely?			
	Does the facility have a written policy regarding food brought in by family or visitors?			
	Ask staff what the facility practice is for dealing with employees who come to work with symptoms of contagious illness (e.g., coughing, sneezing, nausea, fever, vomiting) or open wounds.			
	If a foodborne illness outbreak occurred, did you report the outbreak to the local health department?			
	Was the facility food service identified as the cause of the outbreak and what remediation steps were taken?			
F-800	Does the facility provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and dietary needs, taking into consideration the preferences of each resident?			
F-804	Does the facility provide food prepared by methods that conserve nutritive value, flavor, and appearance and provide food and drink that is palatable, attractive, and at a safe and appetizing temperature?			
F-805	Is food prepared in a form to meet individual needs of the residents?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-813	Does the facility have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption?			
F-880	During follow-up visits to the kitchen, does the facility handle, prepare, and distribute food in a manner that prevents foodborne illness.			
F-812	**DRY FOOD STORAGE**			
	Pantry clean and orderly?			
	Storage clear of unnecessary items?			
	Items not stored in boxes and put in food grade containers?			
	Is Food labeled and dated?			
	Food rotated?			
F-812	**DINNERWARE SANITIZATION AND STORAGE**			
	For a stationary rack, single temperature machine, 74°C (165°F);			
	For a stationary rack, dual temperature machine, 66°C (150°F);			
	For a single tank, conveyor, dual temperature machine, 71°C (160°F);			
	For a multi-tank, conveyor, multi-temperature machine, 66°C (150°F); or			
	For the wash solution in spray-type washers that use chemicals to sanitize, less than 49°C (120°F)			
	Sanitizing solution must be at level required per manufacturer's instructions.			
	Manual water temperature solution shall be maintained at no less than 110°F. After washing and rinsing, dishes are sanitized by immersion in either:			
	Hot water (at least 171°F) for 30 seconds; or			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	A chemical sanitizing solution. If explicit manufacturer instructions are not provided, the recommended sanitation concentrations are as follows: – Chlorine: 50 – 100 ppm minimum 10 second contact time – Iodine: 12.5 ppm minimum 30 second contact time – QAC space (Quaternary): 150 – 200 ppm concentration and contact time per manufacturer's instructions (Ammonium Compound)			
	Dishes, food preparation equipment, and utensils are air dried. (Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross-contamination.).			
	Wet wiping cloths are stored in an approved sanitizing solution and laundered daily.			
	Clean and soiled work areas are separated.			
	Is dishware allowed to air dry?			
	Dishware is stored in a clean, dry location and not exposed to splash, dust, or other contamination, and covered or inverted.			
	Ask staff how they test for proper chemical sanitization (observe them performing the test).			
	Ask staff how they monitor equipment to ensure that it is functioning properly. (Review temperature/chemical logs.)			
	EQUIPMENT SAFE & CLEAN			
	Are lids on trashcans?			
	Refrigerators, freezers, and ice machines are clean and in safe operating condition.			
	Fans in food prep areas are clean.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Utensils/equipment are cleaned and maintained to prevent foodborne illness.			
	Food trays, dinnerware, and utensils are clean and in good condition (e.g., not cracked or chipped).			
	Appropriate equipment and supplies to evaluate the safe operation of the dish machine and the washing of pots and pans (e.g., maximum registering thermometer, appropriate chemical test strips, and paper thermometers).			
	How does the facility identify problems with time and temperature control of PHF/TCS foods and what are the processes to address those problems			
	Whether the facility has, and follows, a cleaning schedule for the kitchen and food service equipment.			
F-908	If there is a problem with equipment, how staff informs maintenance and follows up to see if the problem is corrected.			
	REFUSE & PEST CONTROL			
F-925, F-813	Is there evidence of pests in the food storage, preparation, or service areas?			
F-814	Is garbage disposed of properly with Dumpster Service? Is Dumpster Secure?			
F-925, F-813	Is there documentation of pest control services that have been provided?			
F-803	**MENUS**			
	Ensure staff are following the menus.			
	Menus meet the nutritional needs of the residents			
	DIETARY STAFF			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-801	Interview dietary staff members to ensure the facility has a full-time qualified dietitian or other clinically qualified professional either full-time, part-time, or on a consultant basis (refer to the regulation for qualification details).			
F-801	If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, interview staff to ensure the person designated as the director of food and nutrition services is qualified (refer to the regulationfor qualification details).			
F-802	Interview staff to ensure they have appropriate competencies and skill set to carry out functions of the food and nutrition services, taking into account resident assessments, care plans, number, acuity, and diagnoses of the facility's population in accordance with the facility assessment.			
	DINING			
F-812	Does staff distribute and serve food under sanitary conditions?			
F-880	Did the facility provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections?			
	Do staff wash hands and use hand sanitizor?			
	Provide meals to all residents at a table at the same time.			
	Provide napkins and nondisposable cutlery and dishware (including cups and glasses).			
	Consider residents' wishes when using clothing protectors.			
	Wait for residents at a table to finish their meals before scraping food from plates at that table.			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Staff sit next to residents while assisting them to eat, rather than standing over them.			
	Staff talk with residents for whom they are providing assistance rather than conducting social conversations with			
	other staff.			
	Residents are allowed adequate time to complete their meal.			
	Staff speak with residents politely, respectfully, and communicate personal information in a way that maintains confidentiality.			
	Respond to residents' requests in a timely manner?			
F-550	Does the facility promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality?			
	Are meals served on trays in a dining room?			
	Medication administration practices that interfere with the quality of the residents' dining experience.			
	Has the facility attempted to provide medications at times and in a manner that does not distract from the dining experience of the resident, such as:			
	Pain medications being given prior to meals so that meals can be eaten in comfort			
	Foods served are not routinely or unnecessarily used as vehicles to administer medications (mixing the medications with potatoes or other entrees)			
F-584	Did the facility provide a homelike dining environment?			
F-561	Does the facility honor the resident's right to make choices about aspects of his/her life in the facility that are significant to the resident?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-676 or F-677	Does the facility provide assistance with meals, assisting with hydration, and nutritional provisions throughout the day?			
F-810	Does the facility provide resident with assistive devices if needed?			
F-675	Is the resident positioned correctly to provide care and services that promote the highest practical well-being?			
F-806	Are residents receiving food that accommodates resident allergies, intolerances, and preferences?			
F-811	Are residents selected based on an IDT assessment? Are paid feeding assistants supervised or used in accordance to State law?			
F-948	Have the paid feeding assistants completed a State-approved training program prior to working in the facility?			
F-804	Does the facility serve meals that conserve nutritive value, flavor, and appearance, and are palatable, attractive, and a safe and appetizing temperature (e.g., provide a variety of textures, colors, seasonings, pureed foods not combined)?			
F-692	Do the residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise?			
F-807	Does the facility provide drinks including water and other liquids consistent with residents' needs and preferences?			
F-808	Does the facility offer an appealing option of similar nutritive value to residents who refuse food being served?			
	Are residents receiving therapeutic diets as prescribed?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
F-920	Does the facility provide one or more rooms designated for dining that are well lighted?			
F-584	Does the facility provide adequate and comfortable lighting levels in the dining areas?			
F-920	Does the facility provide one or more rooms designated for dining that is well ventilated?			
F-584	Does the facility provide comfortable sound levels in the dining areas?			
	Does the facility maintain comfortable and safe temperature levels in the dining areas?			
	Are the dining areas adequately furnished to meet residents' physical and social needs?			
F-920	Do the dining areas have sufficient space to accommodate all dining activities?			
	Does the facility provide at least three meals daily at regular times comparable to mealtimes in the community or in accordance with residents' needs?			
F-809	Does the facility provide sufficient staff to safely and effectively carry out the functions of the food and nutrition services?			
F-802	Does the facility provide meals with no greater than a 14 hour lapse between the evening meal and breakfast?			
F-880	Biohazard waste generating permit			
LAUNDRY				
	Did the facility store, handle, transport, and process linens properly?			
F-880	Using standard precautions (i.e., gloves) and minimal agitation for contaminated linen			
	Holding contaminated linen and laundry bags away from his/her clothing/body during transport			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area			
	Transporting contaminated and clean linens in separate carts. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil.			
	Ensuring mattresses, pillows, bedding, and linens are maintained in good condition and are clean			
	The policies and procedures are reviewed at least annually by laundry personel.			
F-880 F-908	Ceiling and Dryer vents are clean and free of debris			
F-880	PPE available and used as needed ie..Gowns, gloves, goggles			
F-689	Chemicals locked up			
F-880	Doors closed between clean and soiled area			
F-880	Door locked when not attended			
HOUSEKEEPING				
F-880 F-554	Housekeeping carts out of dining room during meal service			
	Are housekeeping carts in sight of housekeeper at all times?			
	No food or drink on Housekeeping cart?			
	Carts are clean and orderly?			
F-689	Wet floor signs in place when mopping floor?			
F-689	Wet floor signs are picked up when floor is dry?			
	Chemicals locked up?			
	Mops clean and stored properly?			
	Corridors clean, waxed, polished and/or corridor carpets clean, free of spots?			
	Ceiling lights clean and bug free?			
	Ceiling vents are clean and free of fuzz?			
	Are walls free of damage?			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	No scuffed paint marks?			
MAINTENANCE DEPARTMENT				
	Weekly Checks by Maintenance			
	Water Temperature Log (105°-120°)			
	Door Alarms			
	Sprinkler Water and Air PSI			
	Sprinkler Valves (Must have 6 extra)			
	Eye Wash Stations			
	Emergency Generator			
	MONTHLY by Maintenance			
	Fire Drill (Each Shift Quarterly)			
F-921	Exit Signs			
	Junction Boxes			
F-921	Fire Extinguishers			
	Emergency Lights 30 Sec			
	QUARTERLY by Maintencance (every 3 months)			
	Quarterly Flow Test			
	Semi Annual (6 Months)			
	Range Hood Suppression System			
	Generator Prevention Maintenance			
	Yearly			
	Rangehood Recharge			
	Fire Alarm System-Annul Semi-Annual Inspection			
F-921	Fire Alarm Panel has tag within last year marked "funtional"			
	Sprinkler System & Backflow Prevention (Fire Line)			
	LP Gas Pressure Test			
	LP Gas Tank Inspection			
	Fire Extinguisher			
	Fire Door Inspection			
	Emergency Lights 1-1/2 hour			

TAG #	STANDARD	MET	NOT MET	COMMENTS
	Emergency Preparedness			
	Fire Safety Consultaion with Fireman			
	Backflow Prevention (Boiler)			
	Bi Annual (2 years)			
	Electric Wiring			
	Boiler and Pressure Vessel (Divison of Fire Safety)			
	Generator Load Test			
	5 Years			
	Internal Pipe Inspection			
GENERAL COMMENTS				

FIRE DRILL GRID

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
7-3												
3-11												
11-7												
Weekend												
Holiday												

Directions:

Plot actual fire drills by shift and month. Minimum compliance is one drill per month, quarterly on each shift. Include weekend drills. Schedule fire drills in advance to assure compliance. You may add internal and external disaster drills to your schedule.

Environmental Observations

Environmental Observation: *Complete this review if environmental concerns were identified through observation, or resident or representative interviews. Investigate the CE(s) applicable to the Initial Pool information that triggered the task as indicated in the table below. If concerns are identified, review the facility's policies, procedures, and systems.*

Triggered From the Initial Pool Process:	CE(s) to be Completed:
☐ Accommodation of Needs (Physical) - RI, RRI, RO	1
☐ Call Light Functioning – RI, RRI, RO	2
☐ Sounds Levels – RI, RRI, RO	3
☐ Temperature Levels – RI, RRI, RO	4
☐ Lighting Levels – RI, RRI, RO	5
☐ Clean Building – RI, RRI, RO	6
☐ Building and Equipment Good Condition – RO	7 and 8
☐ Homelike – RO	9
☐ Lack of Hot Water – RI, RRI, RO	10
☐ Linens – RI, RRI, RO	11
☐ Pest Control – Review if concerns are identified onsite	12
☐ Ventilation – Review if concerns are identified onsite	13
☐ Handrails – Review if concerns are identified onsite	14
☐ Other Environmental Conditions – Review if concerns are identified onsite	15

Accommodation of Needs: Review this CE if there are concerns regarding the resident's accommodation of needs by the resident, representative, or through observations.

☐ Interview staff regarding the identified concern to determine how the facility has addressed the concern:

- Room set up so the resident can get around easily, get to and from the bathroom, use of the sink, or accessing drawers and closets.
- Roommate's personal items taking over the resident's space.
- Call light in reach in the resident's room, toilet, and bathing facilities, and the appropriate type used.
- Enough light in the resident's room to do what the resident wants.
- Adaptive equipment available and used.

1. Do residents receive services with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents? ☐ Yes ☐ **No F558** ☐ **NA**

Environmental Observations

Call Light Functioning: Review this CE if there are concerns with the call lights not functioning by the resident, representative, or through observations.

☐ Interview staff if the resident or representative complained about the call lights not functioning or observations that the call system is not functioning to determine how the facility has addressed the concern.

2. Are call systems in all areas functioning properly? ☐ Yes ☐ **No F919** ☐ **NA**

Sound Levels: Review this CE if there are concerns by the resident, representative, or through observation of uncomfortable sound levels.

☐ Interview staff if the resident or representative complained about comfortable noise levels or observations revealed uncomfortable sound levels to determine how the facility has addressed the concern.

3. Are comfortable sound levels maintained in all areas? ☐ Yes ☐ **No F584** ☐ **NA**

Temperature Levels: Review this CE if there are concerns by the resident, representative, or through observations with comfortable temperature levels maintained

☐ Interview staff if the resident or representative complained about comfortable temperatures or observations revealed uncomfortable room temperatures (too cool or too warm) to determine how the facility has addressed the concern.

4. Are comfortable and safe temperatures maintained in all areas? ☐ Yes ☐ **No F584** ☐ **NA**

Lighting Levels: Review this CE if there are concerns by the resident, representative, or through observations with adequate lighting levels.

☐ Interview staff if the resident or representative complained about proper lighting or observations revealed inadequate lighting to determine how the facility has addressed the concern.

5. Are proper lighting levels maintained in all areas? ☐ Yes ☐ **No F584** ☐ **NA**

Clean Building: Review this CE if there are concerns with the cleanliness of the building by the resident, representative, or through observations.

☐ Interview staff if the resident or representative complained about the cleanliness of their room or building (e.g., walls, floors, ceilings, drapes, resident care equipment, or furniture), or observations revealed an unclean room or building to determine how the facility has addressed the concern.

Environmental Observations

6. Are all areas clean? ☐ Yes ☐ **No F584** ☐ **NA**

Building and Equipment Good Condition: Review this CE if there are concerns with the building being in disrepair through observations.

☐ Interview staff if observations revealed the resident's room, equipment, or building (e.g., transfer equipment, IV pumps, glucometers, thermometers, ventilators, suctioning devices, oxygen equipment, nebulizers, furniture) being in disrepair to determine how the facility has addressed the concern.

7. Are all areas or equipment in good repair? ☐ Yes ☐ **No F584** ☐ **NA**

8. Is resident care equipment in safe operating condition? ☐ Yes ☐ **No F908** ☐ **NA**

Homelike: Review this CE if there are concerns with the resident's room being homelike through observations.

☐ Interview staff if observations revealed the resident's room is not homelike to determine how the facility has addressed the concern.

9. Are the residents allowed to have personal belongings, to the extent possible, creating a homelike environment? ☐ Yes ☐ **No F584** ☐ **NA**

Lack of Hot Water: Review this CE if there are concerns by the resident, representative, or through observations with the hot water being too cool.

☐ Interview staff if the resident or representative complained about the hot water being too cool or observations revealed the hot water in the resident's room, bathroom, or bathing facilities is too cool to determine how the facility has addressed the concern.

10. Are water temperatures comfortable? ☐ Yes ☐ **No F584** ☐ **NA**

Linens: Review this CE if there are concerns by the resident, representative, or through observations with the linens being soiled.

☐ Interview staff if the resident or representative complained about the linens being soiled or observations revealed soiled linens to determine how the facility has addressed the concern.

☐ Refer to the Incontinence or Infection Control pathways, as needed, for additional investigative guidance.

11. Are there clean bed and bath linens in good condition available for the resident? ☐ Yes ☐ **No F584** ☐ **NA**

Environmental Observations

Pest Control: Review this CE if concerns are identified onsite.

☐ Interview staff if there are signs of pests or rodents throughout the facility to determine how the facility has addressed the concern.

☐ Review the facility's pest control program.

☐ Review documentation of pest control intervention (e.g., commercial contractor).

12. Does the facility maintain an effective pest control program so that the facility is free of pests and rodents?
☐ Yes ☐ **No F925** ☐ **NA**

Ventilation: Review this CE if concerns are identified onsite.

☐ Interview staff if there are odors throughout the facility to determine how the facility has addressed the concern.

13. Is there adequate ventilation in all areas? ☐ Yes ☐ **No F923** ☐ **NA**

Handrails: Review this CE if concerns are identified onsite.

☐ Interview staff if there are concerns with handrails being accessible and securely affixed to the walls throughout the facility to determine how the facility has addressed the concern.

14. Are handrails accessible and securely affixed to the walls? ☐ Yes ☐ **No F924** ☐ **NA**

Other Environmental Conditions: Review this CE if concerns are identified onsite.

☐ Interview staff if there are concerns with the environment being safe, functional, sanitary, and comfortable for residents, staff, and the public to determine how the facility has addressed the concern.

15. Does the facility provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public?
☐ Yes ☐ **No F921** ☐ **NA**

Nursing

MDS AUDIT TOOL

Date: _____

Resident Name	Room #	MDS Dates Correct?	Baseline Care Plan complete in accordance with F655	CAA Summary Signed & Dated?	CAA Completed for Each Triggered Area?	Care Plan Addresses Each Problem? (Proceed)	Required Signatures Present?	Location of Info Complete and Correct?	Care Plan Goals Have Timeframes? Measureable?	Change in Condition?

NON-STERILE DRESSING CHANGE

Facility:_____Nurse: _____Date:_____

Objective: To prevent cross contamination and maintain standard infection control techniques.

Item #	Procedure	Met	Not Met	Comments
1	Check treatment order			
2	Gather necessary equipment:			
	- Plastic bag			
	- Bed protector			
	- Clean towel or towel paper for clean field			
	- Dressing supplies			
	- Cleaning solution – check expiration date			
	- Medication ordered of treatment, if any			
	- Gloves			
3	Inform resident of procedure; provide privacy, position resident; place bed protector on bed			
4	Wash hands; put on gloves			
5	Remove dirty dressing and place in plastic bag			
6	Remove gloves and place in plastic bag			
7	Wash hands			
8	Set up clean field; prepare supplies (open dressings, etc.)			
9	Put on gloves			
10	Perform treatment (wound can be measured at this time)			
	a. Clean from inner edge of wound out			
	b. Perform treatment according to orders and apply dressing			
	c. Discard all waste in plastic bag			
11	Remove gloves and place in plastic bag			
12	Wash hands			
13	Reposition resident for comfort			
14	Record treatment and return supplies to proper areas			

General Comments:

CHART AUDIT TOOL

FOCUS REVIEW RELATED TO:

_____Change of condition of _____
_____Focus Documentation (Medicare/Hospice/Dialysis) Incident
_____Admission
_____Discharge

Date: _____

Patient:_____Rm#:_____Admit Date: _____

Area of review	Met	Not Met	N/A	Comments
Resident Physical Assessment				
positioning:				
preventative devices:				
catheter positioning:				
ADL care:				
dated equipment:				
call light:				
water in reach:				
personal care items:				
Consents				
restraints:				
advance directives:				
non-compliance:				
H & P				
signed:				
timely:				
Physicians Orders				
DNR:				
TB testing:				
certification:				
timely:				
Telephone Orders				
written correctly:				
return timely:				
transcribed:				
Nursing Assessment / Summary				
complete:				
timely:				
accurate:				
Nurses Notes				
family / Dr. notified:				
accurate descriptive:				
follow-up evident:				
vital signs:				
MDS 3.0				
MDS				
accurate/CAA:				
date:				
Quality				
updated:				
date timely:				
complete:				

change of condition reassessment:				
Care Plan				
HCP				
goal measurable:				
date:				
Review				
accurate:				
date interdisciplinary:				
resident participates:				
Lab / X-Ray				
drawn timely:				
evaluated:				
follow-up:				
Dr. notified:				
Miscellaneous				
treatment sheet:				
MAR:				
flow sheet:				
weight sheet:				
follow-up intervention:				
timely assessments:				
Social Services				
room moves:				
behavior problems:				
follow-up intervention:				
timely assessments:				
Activities				
patient possessions list:				
timely assessments:				
unusual needs:				
Dietary				
complete diet assessment:				
adequate documentation:				
recommendations follow-up:				
Restorative				
assessment timely:				
complete:				
accurate:				
weekly progress notes:				
monthly summary:				
care planned:				
Rehabilitation				
timely screens:				
assessment timely:				
complete:				
accurate:				
weekly progress notes:				
physician orders clarified / accurate:				
care planned:				

Completed By: _____

Comments: _____

_____

Activities of Daily Living (ADL) Critical Element Pathway

Use this pathway for a resident who requires assistance with or is unable to perform ADLs (Hygiene – bathing, dressing, grooming, and oral care; Elimination – toileting; Dining – eating, including meals and snacks; and Communication including – speech, language, and other functional communication systems) to determine if facility practices are in place to identify, evaluate, and intervene, to maintain, improve, or prevent an avoidable decline in ADLs. Refer to the Positioning/Mobility/ROM pathway, for concerns related to mobility (transfer, ambulation, walking), positioning, contractures, or ROM.

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive assessment and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C, E, F, G*G*, J, and O.
- ☐ Physician's orders (e.g., therapy, restorative, and ADL needs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., ADL assistance, specific care interventions staff will provide, premedication prior to ADLs, environmental approaches and devices used to maximize independence, therapy interventions, or restorative approach).

Observations Across Shifts:

- ☐ Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the resident's choices and preferences.
- ☐ For a resident **receiving assistance with ADLs** observe the following: If concerns are identified, describe.
  - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, based upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
  - Did staff explain all procedures to the resident prior to providing the care? Does the resident require special communication devices? If so, are they being used?
  - Does staff encourage the resident to perform ADLs as much as the resident is able?
  - Did staff provide the necessary level of assistance that meets the resident's current needs?
- ☐ For a resident **who is unable to carry out ADLs** observe for the following: If concerns are identified, describe.
  - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, based upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
  - Did staff explain all procedures to the resident prior to providing the care?
  - If the resident refuses the care, how does staff respond?
  - Is assistance with ADL's provided within a timely manner and per resident preference?
- ☐ Does staff provide assistive devices to maximize independence, including but not limited to the following?
  - Hygiene – assistive grooming devices such as built up grooming aids.
  - Elimination – elevated toilet seat, grab bar, commode.

Activities of Daily Living (ADL) Critical Element Pathway

- Does staff allow sufficient time for the resident to complete tasks independently (e.g., putting on their own shirt)?
- If equipment or devices are used during ADL care, was the equipment clean and in good repair, and was it used correctly?

☐ How are care-planned interventions implemented?

☐ If the resident wears prostheses, are they in place or removed in accordance with the time of day, activities, and resident preference?

- Dining – assistive devices such as built-up utensils, plate guard, nosey cup, three-compartment dish, scoop plate/bowl, weighted or swivel utensils, cup with lid and handles, non-slip materials.
- Communication – communication board, electronic augmentative communication device.

Resident, Resident Representative, or Family Interview:

☐ How did the facility involve you in developing the care plan? Did you talk about your preferences and choices regarding care (e.g., when care should be provided such as bathing)?

☐ If you are aware that the resident has specific ADL concerns, ask: What did staff discuss with you regarding how they would maintain or improve your ability to [ask about specific ADL]?

☐ Are you able to actively participate in ADLs? If so, what is your involvement? How and who instructed you in the interventions? Does staff provide encouragement and revision to the interventions as necessary?

☐ What type of interventions are done? Have assistive devices been provided (e.g., reachers, mobility devices, or communication devices)? If so, were you instructed on how to use them? If not, why not?

☐ How much help do you need from staff with [ask about specific ADL]? If help is needed or the resident is unable to perform ADLs, ask the following:

- Does staff tell you what they are going to do before they do it?
- How does staff encourage you to do as much as you can?
- Does staff allow ample time for you to do as much as you can on your own?
- Does staff provide timely assistance (e.g., toileting needs)?

PT, OT, SLP, or Restorative Manager Interview:

☐ When did therapy/restorative start working with the resident?

☐ How did you identify that the interventions were suitable for this resident?

☐ What are the current goals?

☐ How do you involve the resident or resident representative in decisions regarding treatments?

☐ How often do you meet with the resident?

☐ How often does therapy screen residents? Where are screening results documented?

☐ How much assistance does the resident need with [ADLs]?

☐ How do you promote the resident's participation in [ADLs]?

If the resident is not on a therapy or restorative program: How did you decide that the resident would not benefit from a program?

☐ Does the resident have pain? If so, who do you report it to and how is it being treated?

☐ Does the resident refuse? What do you do if the resident refuses?

☐ Is the resident's [ADL] ability getting worse? If so, did you report it (to whom and when) and did the treatment plan change?

☐ Has the resident had a decline in his/her ability to [ask about specific ADL]? When did the resident's decline in ADLs occur?

☐ What therapy or restorative interventions were in place before the [ADL] decline?

Activities of Daily Living (ADL) Critical Element Pathway

- How does staff consider your preferences when providing care (e.g., shower vs bath, time of the day for care, clothing choices)?

☐ Do you have sufficient time to perform ADLs without being rushed? Does staff complete the ADLs for you rather than letting you perform them yourself?

☐ Do you have discomfort or pain when performing or receiving assistance with any of your ADLs? If so, when does it occur, have you reported it to staff, and how is it being addressed?

☐ If you know the resident independently does exercises: Do you use certain devices to help you with [ADLs]? Do you have them when you need them?

☐ Are you getting PT, OT, or Speech Therapy for any of your ADLs? If so, how often do you receive assistance? If the resident isn't getting therapy, ask: Are aides doing exercises or ADL training (e.g., bed mobility, eating or communication) with you? If so, what exercises are they doing and how often?

☐ If you know the resident has refused specific interventions, ask: Why do you refuse? Did staff attempt alternative approaches? Did staff provide you with education on the risks and benefits of refusing?

☐ Do you feel you've had a decline in [ADLs]? Has your decline caused you to be less involved in activities you enjoy or caused a change in your mood or ability to function?

☐ Has your [ADL] ability improved, been the same, or gotten worse? If the resident has declined, ask: Do you know why you are getting worse? Has your decline caused a change in your mood or ability to function?

☐ Are you included in establishing the type, amount, frequency, and duration of ADL care?

☐ What is therapy/restorative doing to address the resident's [ADL] decline?

☐ How did you train staff to perform the restorative [ADL] program? Is there documentation that nursing staff were trained (ask to see the documentation)?

☐ How do you monitor staff to ensure they are implementing care-planned interventions?

☐ How does staff communicate changes/declines to the rehab department?

☐ When a resident is discharged from therapy, how do you decide whether to start a restorative or maintenance program?

Nurse or DON interviews:

☐ How much assistance does the resident need with [ADLs], how was this determined, and does the resident participate in ADLs?

☐ Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the care plan?

☐ Is the goal to maintain or improve the resident's current level of functioning?

☐ Are all procedures explained and the resident given time to respond to changes in care?

☐ Has the resident had a decline in ability to independently perform any of his/her ADLs?

☐ If the resident experiences a decline or improvement in ADL function, what actions are taken by staff and how is the rest of the staff notified? Did the treatment plan change?

☐ Were any therapy or restorative interventions in place before the [ADL] decline?

☐ What is therapy/restorative doing to address the resident's [ADL] decline?

☐ How did you identify that the interventions were suitable for this resident?

Activities of Daily Living (ADL) Critical Element Pathway

Nursing Aide or Restorative Nurse Aide Interviews:

- ☐ Does the resident receive assistance with ADLs? How much assistance does the resident need?
- ☐ Can you describe the resident's ADL goals? How do you promote the resident's independence with ADLs to the extent possible? What are the resident's choices and preferences for ADLs (shower vs bath, time of day for care)?
- ☐ What interventions are done? What equipment or assistive devices have been provided? How was the resident instructed on how to use them? If not provided, why not?
- ☐ Does the resident have pain with [ADLs]? If so, who do you report it to and how is it treated?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident's [ADL] ability getting worse? If so, who and when did you report it to and did the treatment plan change?
- ☐ If the resident is receiving restorative services:
  - When did restorative start working with the resident?
  - What is the goal of restorative care – to maintain or improve current abilities?
  - If there is a decline: What is being done to address the resident's [ADL] decline?
  - How often do you meet with the resident?
  - How were you trained on the resident's [ADL] restorative program?
- ☐ If a resident is unable to perform any ADLs, ask: What do you provide for ADLs, when and how do you determine what must be provided?
- ☐ If the resident refuses care, do you know why? How does staff provide alternative treatment options and education on any associated risks? If the resident resists care on a repeated basis, how does staff respond?
- ☐ If the resident experiences any pain during ADLs, how does staff respond?
- ☐ Are staff, the resident and resident's representative aware of the programs that the resident is involved in to restore or maintain functional abilities?
- ☐ How do you involve the resident or resident representative in decisions regarding treatments?
- ☐ If the resident is not on a therapy or restorative program: How did you decide that he/she would not benefit from a program?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?

Activities of Daily Living (ADL) Critical Element Pathway

Record Review:

- ☐ Does the assessment identify the resident's: 1) status in all areas of ADLs, 2) inability to perform ADLs, 3) risk for decline in any ADL ability they have, or 4) ability to improve in identified ADLs? If not, describe.
- ☐ Did the record identify potential areas where a resident may benefit from therapy or restorative services given the resident's current status?
- ☐ Has the facility clearly documented the decision-making process used for determining that a resident would not benefit from receiving therapy or restorative services?
- ☐ Was the need for equipment or assistive devices assessed and identified to maximize independence in all areas of ADLs?
- ☐ Is pain related to ADLs assessed and treatment measures documented?
- ☐ Were changes in ADL status or other risks correctly identified and communicated with staff and MD?
- ☐ Are there underlying risk factors identified (e.g., unstable condition, cognition, or visual problems)?
- ☐ Are preventive measures documented prior to a decline?
- ☐ Does your ADL observation match the description of the resident's abilities in the clinical record?
- ☐ Review the therapy assessment, notes, and discharge plan, if applicable.
  - Has the resident's ADL status changed in the last 12 months?
  - Has therapy assessed the ADL decline, provided treatment as often as ordered, and implemented a plan after therapy?
  - Is there documentation that indicates ADLs have improved, been maintained, or declined?
- ☐ Does the care plan address the resident's ADL needs and goals, including the provision of ADLs if the resident is unable to perform ADLs? Has the care plan been revised to reflect any changes in ADL functioning?
- ☐ How did the resident or resident representative participate in the development of the care plan and do the goals and interventions reflect the resident's choices and preferences?
- ☐ Do interventions encourage maintenance or improvement of ADL abilities? Is there evidence that the care plan has been reevaluated and interventions modified according to the resident's lack of improvement or change in ADL functioning?
- ☐ Does the care plan reflect the presence of pain or discomfort related to ADLs, if present, and interventions identified?
- ☐ Was the resident provided with services such as rehabilitative (physical, occupational, speech) or restorative nursing programs designed to restore or maintain functional abilities?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ If concerns are identified, review facility policies and procedures with regard to the provision of ADLs.

Activities of Daily Living (ADL) Critical Element Pathway

Critical Element Decisions:

1) Based on observation, interviews, and record review, did the facility ensure a resident's ADL abilities were maintained or improved and did not diminish unless circumstances of the resident's clinical condition demonstrate that a change was unavoidable?
   If No, cite F676
   NA, the resident is unable to carry out ADLs.

2) Based on observation, interviews, and record review, did the facility provide the resident who is unable to carry out ADLs the necessary services to maintain good nutrition, grooming, and personal and oral hygiene?
   If No, cite F677
   NA, the resident is able to carry out ADLs.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?

If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) or Tasks (Task) to Consider: Dignity (CA), Admission Orders F635, Abuse (CA). Neglect (CA), Professional Standards F658, Communication and Sensory (CA), Bladder and Bowel (CA), Sufficient and Competent Staffing (Task), Eating Assistive Devices F810, Feeding Assistance F811, Rehabilitative and Restorative (CA), Proficiency of Nurse Aides F726, Resident Records F842.

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care Critical Element (CE) Pathway to determine if the facility is providing the necessary care and services for residents living with dementia. Refer to the Communication/Sensory CE Pathway for concerns regarding communication with residents who are non-English speaking.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A, C, D, E, G*G*, I, N, and O.
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., identifies concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident; potential causes or risk factors for the resident's behavior or mood; person-centered non-pharmacological, and pharmacological interventions to support the resident and lessen distress; if pharmacological interventions are in place, how staff track, monitor, and assess the interventions; and alternative approaches if the resident declines treatment; cultural preferences and/or interventions to address a history of trauma, as appropriate).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how did staff address these indications?
- ☐ Are staff implementing interventions in accordance with the care plan to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ Are staff being respectful and responsive to the resident's cultural preferences, health beliefs and practices?
- ☐ Do staff provide culturally competent care (e.g., clothing or food preferences, cultural etiquette, or materials in their preferred language)?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art, massage, essential oils, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment, and access to counseling and therapies) did staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How did staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How did staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Did staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident choices, including cultural preferences (e.g., ADL care, daily routines, activities, etc.)?

Behavioral and Emotional Status Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ☐ Is the facility aware of your/the resident's current conditions or history of conditions or diagnoses?
- ☐ How did the facility involve you/the resident in developing the care plan, including implementing non-pharmacological interventions and goals and identifying triggers that may cause fear or re-traumatize the resident?
- ☐ What non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.
- ☐ How did the facility ensure approaches to care reflect your/the resident's choices and cultural preferences?
- ☐ How are the resident's individual needs being met through person-centered approaches to care?
- ☐ What are your or the resident's concerns, if any, regarding the resident's mood or history of trauma?
- ☐ Have you or the resident had a change in mood? If so, please describe.
- ☐ What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?

Staff Interviews (Interdisciplinary team (IDT) members including social services) across Various Shifts:

- ☐ What are the underlying causes (e.g., history of trauma, mental disorder) of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rationale for each intervention?
- ☐ How do you meet the resident's needs and provide emotional support to a resident who is having difficulty coping with change, loss or coping with stressful events?
- ☐ How do you provide or arrange for needed mental and psychological counseling services?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you know a resident is a trauma survivor and what do you need to do differently for that resident?
- ☐ How did the facility determine cultural preferences which should be honored while the resident is in the facility?
- ☐ What types of behavioral health training have you completed?
- ☐ How do you identify and support individual resident's needs?
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often did the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- ☐ Ask about any other related concerns the surveyor has identified.

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

Behavioral and Emotional Status Critical Element Pathway

☐ How do you know what triggers to avoid for a resident with a history of trauma?

Record Review:

☐ Review therapy notes, social service notes, and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.

☐ Review the admission assessment, History & Physical, and social history/assessment to determine whether the facility identified the resident's history of trauma and the effects of past trauma on the resident.

☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident and cultural preferences, as appropriate.

☐ What is the time, duration, and severity of the resident's expressions or indications of distress?

☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress which may re-traumatize the resident, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?

☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?

☐ What PASARR Level II services or psychosocial services are provided, as applicable?

☐ Did the facility ensure residents with mental or substance use disorders have access to counseling programs or therapies (e.g., 12 step groups)?

☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions, cultural preferences, or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?

☐ Did the facility collaborate with the resident, and/or resident representative, and any other health care professionals to develop an individualized care plan that addresses resident specific triggers.

☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

☐ Was behavioral health training provided to staff in accordance with the facility assessment?

Critical Element Decisions:

1) Did the facility ensure trauma survivors received culturally-competent and/or trauma-informed care which accounted for the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization?

   If No, cite F699

Behavioral and Emotional Status Critical Element Pathway

NA, the comprehensive assessment did not reveal the resident had a history of trauma, PTSD, and/or cultural preferences.

2) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
If No, cite F740

3) Did the facility have sufficient staff who provide direct services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?
If No, cite F741

4) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty?
If No, cite F742
NA, *the comprehensive assessment did not reveal* the resident *displayed or was* diagnosed with a mental or psychosocial adjustment difficulty.

5) Did the facility ensure that the resident whose comprehensive assessment did not reveal or who did not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD did not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable?
If No, cite F743
NA, the resident's comprehensive assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

6) Did the facility provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for this resident?
If No, cite F745

7) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655

Behavioral and Emotional Status Critical Element Pathway

NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

8) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?

   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

9) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

10) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
    If No, cite F641

11) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs (including trauma-informed care) and includes the resident's goals, desired outcomes, and preferences (including cultural preferences)?

    If No, cite F656
    NA, the comprehensive assessment was not completed.

12) Did the facility reassess the effectiveness of the interventions and, review and revise the resident's care plan (with input from the resident, or resident representative, to the extent possible), if necessary, to meet the resident's needs?

    If No, cite F657
    NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Unnecessary/Psychotropic Medications (CA), Resident Records F842, Qualifications of Social Worker >120 Beds F850.

Urinary Catheter or Urinary Tract Infection Critical Element Pathway

Use this pathway for a resident who has a symptomatic urinary tract infection (UTI) and/or an indwelling urinary catheter.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, H, I, and M.
- ☐ Physician's orders (catheter care, UTI, medications).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., interventions specific enough to guide the provision of services and treatment for an indwelling catheter, or current or recurring UTI or Catheter Associated Urinary Tract Infection (CAUTI), interventions to prevent or address complications of the use of an indwelling catheter, such as UTIs, skin irritation/excoriation, leakage around the catheter, catheter-related injury/pain, encrustation, excessive urethral tension, accidental removal, or obstruction of urine outflow, interventions to maintain the resident and the catheter clean of feces to minimize bacterial migration into the urethra and bladder [e.g., cleaning fecal material away from rather than towards the urinary meatus] and keeping the drainage bag below the level of the bladder), and potential psychosocial issues related to urinary catheter use.

Observations:

- ☐ How does staff provide care for a resident with an indwelling urinary catheter (refer to the CDC website for catheter use, management and care):
  - Does staff use appropriate infection control practices with regard to hand hygiene, PPE as needed, urinary catheter maintenance using standard precautions for contact with the catheter, tubing, and the collection bag;
  - Is the urinary catheter tubing free of kinking and secured properly to facilitate unobstructed urine flow? If not, describe;
  - Is the urine collection bag and tubing off the floor at all times? Is the urine collection bag kept below the level of the bladder and emptied using a separate clean collection container for each resident? Ensure the drainage spigot does not touch the collection container. If not, describe;
  - If necessary, how are urine samples obtained (via needleless port and not obtained from the collection bag);
  - How does staff manage/assess urinary leakage, if present, from the point of catheter insertion to the bag;
  - How does staff manage concerns related to the resident's skin, such as urethral tears, maceration, erythema, and erosion;
  - How is the catheter securely anchored to prevent excessive tension on the catheter and how are interventions (such as avoiding tugging on the catheter during transfer and care delivery) used to prevent inadvertent catheter removal or tissue injury from dislodging the catheter;
  - How does staff ensure the resident is provided with and encouraged to take enough fluids to meet the resident's hydration needs, as reflected in various measures of hydration status;
  - How does staff provide care to the resident during catheterization (i.e., appropriate technique), removal, or aspects of catheter care? How does staff afford privacy, reduce embarrassment, and treat the resident with respect and dignity including having a privacy bag for catheters; and
  - What clothing and hygiene products are provided to prevent leakage and enhance socialization?
- ☐ Are there signs of a UTI, which would include a fever (>37.9ºC [100ºF] or a 1.5ºC [2.4ºF] increase above baseline temperature), new

- How does staff assess/manage catheter related pain (e.g., bladder spasms) or other complaints (e.g., ongoing feelings of needing to void);

Resident, Resident Representative, or Family Interview:

- ☐ How has staff involved you in care plan development including whether interventions reflect preferences and choices and if the risks and benefits of a urinary catheter were discussed prior to insertion, to the extent possible?
- ☐ How long has the catheter been in place? Why was the catheter inserted? How long will it be in place?
- ☐ Do you have a UTI now or a history of UTIs? How it is being treated?
- ☐ How frequently is catheter care provided and by whom? Do you have skin issues (such as maceration, erosion)? If so, what type of care is provided for this?
- ☐ Do you have discomfort or pain related to the use of the catheter? Have you reported this to staff? Where is the pain located? What do you think is causing the pain? How is your pain being managed?

Nursing Aide Interviews:

- ☐ What type of training did you receive on how to handle catheters, tubing, drainage bags, and other devices during the provision of care?
- ☐ What, when, and to whom do you report changes or concerns related to catheter use, including potential symptoms for a UTI, such as acute costovertebral angle pain or tenderness, suprapubic pain, or either an acute change in mental status or acute functional decline?

Licensed Nurse Interviews:

- ☐ How do you monitor the implementation of care plan interventions based upon standards of practice including infection control procedures for catheter care, skin integrity, or presence of UTIs?
- ☐ Who is allowed to insert, provide care for, and remove indwelling urinary catheters? What type of training has been provided?
- ☐ How have you assessed and addressed factors affecting the resident's urinary function and identified the clinical rationale for use of a urinary catheter upon admission and as indicated thereafter?
- ☐ What preventive interventions have been implemented to try to minimize complications from a urinary catheter or remove the catheter, if no longer clinically indicated, in accordance with the resident's need and current standards of practice? What were the results of the attempts?
- ☐ What infection assessment tools or management algorithms do you use for antibiotic use for one or more infections (e.g., Situation, Background, Assessment, Recommendation [SBAR] tool for UTI assessment, application of the Loeb minimum criteria for initiation of antibiotics which would include a fever of 100°F or 2.4°F above baseline, suprapubic pain, new costovertebral angle tenderness rigors [shaking chills] with or without identified cause, or new onset of delirium)?
- ☐ What preventive interventions have been implemented to try to minimize the occurrence of symptomatic UTIs and address correctable underlying causes to remain consistent with the resident's assessed need and current standards of practice?
- ☐ What care and treatment is provided to prevent incontinence or improve urinary continence and restore as much normal bladder

Urinary Catheter or Urinary Tract Infection Critical Element Pathway

- ☐ Does the resident currently have a UTI? If so, for how long and how is it being treated?
- ☐ What is the resident risk for UTIs? Does the resident have a history of recurring, persistent, or chronic UTIs? If so, describe.

Record Review:

- ☐ Review the progress notes (nursing, therapy) pharmacist reports, lab reports, and flow sheets/forms that document the resident's continence history, use of an indwelling catheter and/or presence of symptomatic UTIs.
- ☐ If the resident has an indwelling urinary catheter, is there a valid clinical indication consistent with evidence-based guidelines as documented by the attending practitioner for the use of the catheter, which includes ongoing assessment and orders for the removal when the clinical condition demonstrates that catheterization is no longer necessary? If not, describe.
- ☐ What potential alternatives were addressed to prevent the extended use of an indwelling catheter, if possible?
- ☐ Recognize and assess for complications related to the catheter?
- ☐ For a resident who has persistent leakage around the catheter, does the assessment identify factors that may contribute to leakage include irritation by a large balloon or by catheter materials, excessive catheter diameter, fecal impaction, and improper catheter positioning?
- ☐ What risk factors does the resident have for catheter blockage such as alkaline urine, poor urine flow, proteinuria, and/or pre-existing bladder stones?
- ☐ What factors, risks, and history does the resident have with recurring or persistent UTIs?
- ☐ For a resident with an indwelling urinary catheter with recurring UTIs, how does the facility assess for possible impairment of free urine flow through the catheter, assess techniques used for catheter care and for perineal hygiene including the removal of fecal soiling, function as is possible to minimize the resident's risk for the development of UTIs?
- ☐ Was the attending practitioner notified of a change in the resident's condition or development of symptoms that may represent a symptomatic UTI? If so, what interventions were provided?
- ☐ If a resident or resident representative has requested the use of or refused to allow the removal of an indwelling urinary catheter, what is the reason? What counseling was provided to assist the resident in understanding the clinical implications and risks associated with the use of a catheter without an indication for continued use? Was the care plan revised to address the education being provided, including interventions to restore as much urinary function as possible without the use of catheter?
- ☐ Is the care plan comprehensive? Does it address identified needs, strengths, and quantifiable measurable goals with timeframes, resident involvement, treatment preferences, and choices? Has the care plan been revised to reflect any changes?
- ☐ What information and education was provided to the resident/representative on the risks and benefits, the clinical indications for the use of an indwelling catheter, and how long use is anticipated?
- ☐ How has the facility addressed potential psychosocial issues related to the use of an indwelling urinary catheter, such as social withdrawal, embarrassment, shame, humiliation, isolation, and promoted treating the resident with respect and dignity?
- ☐ For a resident with a catheter:
  - What type of care is provided for the indwelling catheter? What type of drainage system is used? What steps are taken for maintaining free flowing urine; and
  - What measures are being used to promote sufficient fluid intake, including alternatives such as food substitutes that have a high liquid content, if there is reduced fluid intake?

Urinary Catheter or Urinary Tract Infection Critical Element Pathway

and to reconsider the relative risks and benefits of continuing the use of an indwelling catheter?

- ☐ What was the assessment for the decision to treat a UTI? Was it based upon a thorough evaluation and assessment of the resident? Is there a rationale for the indication of use of antibiotics for treatment?
- ☐ If concerns are identified, review resident care policies and procedures related to indwelling urinary catheters.
- ☐ After a catheter was removed that was inserted for obstruction or overflow incontinence, what was the assessment for post-void residuals?
- ☐ If concerns are identified, review QAA to determine if they are identifying, assessing, and monitoring:
  - For the presence of indwelling urinary catheters;
  - The presence of UTIs and appropriate treatment based upon standards of practice;
  - Interventions implemented to prevent the unnecessary use of urinary catheters; and Interventions for the prevention, to the extent possible, of UTIs.

Critical Element Decisions:

1) Based on observations, interviews, and record review, did the facility provide appropriate and sufficient services, treatment and care, based upon current standards of practice and the resident's comprehensive assessment and care plan to:
   - Ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
   - Ensure that a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
   - Ensure that a resident receives appropriate treatment and services to prevent urinary tract infections to the extent possible.

   If No, Cite F690

2) Did the facility use appropriate hand hygiene practices and PPE when providing catheter care, and/or handle catheter bag and tubing in accordance with infection control standards of practice?
   If No, cite F880
   NA, the resident did not have an indwelling urinary catheter.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?

If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags,Care Areas (CA), and Tasks (Task) to Consider: Dignity (CA), Right to be Informed and Make Treatment Decisions F552, Notification of Change F580, Accommodation of Needs (Environment Task), Choices (CA), Right to Refuse F578, Professional Standards F658, Pressure Ulcer (CA), Nutrition (CA), Hydration (CA), Unnecessary Medications (CA), Sufficient and Competent Staffing (Task), Infection Control (Task), Medical Director F841, Resident Records F842, QAPI/QAA (Task).

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Use this pathway for a resident having communication difficulty and/or sensory problems (vision and/or hearing).

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections B, C, G*G*, and O.
- ☐ Physician's orders (e.g., communication, hearing or visual aids, pertinent medications, speech therapy, or restorative).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., supportive and assistive devices/equipment to meet visual, hearing, or communication needs, environmental factors to promote vision or hearing).

Observations:

- ☐ How does the resident give cues indicating visual or hearing deficits?
- ☐ What supportive and assistive devices/equipment (telephone with low-high volume switch, hearing aids, magnifying glasses, hand signals, use of pictures, large print books, books on tape, communication boards) are used? Are they used correctly, functioning properly, and in good repair?
- ☐ Are activities and interactions provided in a manner that is responsive to individual hearing, vision, or communication concerns? If not, describe.
- ☐ How is the environment responsive to individual hearing, vision, or communication concerns (e.g., adequate lighting, reduction of glare, removal of clutter, reduction of background noise)?

Resident, Resident Representative, or Family Interview:

- ☐ What is your current communication and/or sensory status?
- ☐ Do you need or have you requested (but don't have) visual or hearing devices? If so, has the facility assisted the resident with making appointments or arranging transportation to/from appointments?
- ☐ How does the facility involve you in the development of the care plan and goals?
- ☐ How does the facility ensure interventions reflect your choices and preferences and staff provide care according to the care plan?
- ☐ If you have refused devices/techniques, what alternatives or other interventions has the facility discussed with you? What did staff talk to you about the risks of refusing?

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Social Services):

- ☐ What specific communication methods and interventions, such as use of communication devices (e.g., sign language, gestures, communication board), any visual devices (e.g., glasses, magnifying lens, contact lenses) or hearing aids, and speech therapy schedules does the resident use?
- ☐ What, when, and to whom do you report changes in communication and/or sensory functioning, including broken assistive devices in need of repair?
- ☐ How do you monitor for the implementation of the care plan?
- ☐ How do you review and evaluate for changes in the resident's communication and sensory functioning?
- ☐ How are appointments and transportation arranged for visual and auditory exams?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.
- ☐ Ask about identified concerns.

Record Review:

- ☐ Review therapy notes, consultations, and other progress notes that may have information regarding the assessment of visual, hearing, and/or communication needs.
- ☐ What was the resident's responsiveness to speech, hearing, or visual services?
- ☐ Did the facility accurately and comprehensively reflect the status of the resident?
- ☐ What causal, contributing, and risk factors for decline or lack of improvement related to limitations in visual or auditory functioning or communication does the resident have?
- ☐ What factors does the resident have that may affect communication (e.g., medical conditions, such as CVA, Parkinson's disease, cerebral palsy or other developmental disabilities, COPD, psychiatric disorders, dysarthria, dysphagia, dysphasia/aphasia, medications, decreased ability to understand how to use communication aids, and hearing/visual limitations).
- ☐ What factors does the resident have that may affect visual functioning (e.g., conditions such as glaucoma, diabetes, macular degeneration, cataracts, eye infections, blurred vision; refusal to wear
- ☐ How did the facility respond to needed assistive devices to promote hearing, vision, or communication?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, strengths, risks, and needs? Does it include measurable objectives and timetables? How did the resident respond to care-planned interventions? If interventions weren't effective, was the care plan revised?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ What scheduled/planned auditory or visual examinations, or speech therapy is the resident receiving?
- ☐ Is the resident at risk for accidents related to visual/auditory impairments, or lack of understanding of safety instructions? If so, how has staff addressed this?
- ☐ If the resident refuses or is resistant to devices or services, what

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

glasses, difficulty adjusting to change in light, poor discrimination of color, sensitivity to sunlight and glare, impaired peripheral and depth perception, impaired edge-contrast sensitivity; and environmental factors such as insufficient lighting).

- ☐ What factors does the resident have that may affect hearing (e.g., background noise, cerumen impaction, infections [colds/congestion], ototoxic medications [ASA, antibiotics], perforation of an eardrum, retrocochlear lesions, tinnitus, poorly fitting or functioning hearing aid, and foreign bodies in the ear canal).

efforts have been made to find alternative means to address the needs identified in the assessment process?

- ☐ How does staff monitor the resident's response to interventions?
- ☐ If the resident experienced an unexpected decline or lack of improvement in hearing or vision, how did staff ensure that proper treatment was obtained in a timely fashion?
- ☐ How did the facility involve the resident or resident representative in the review and revision of the plan?

Critical Element Decisions:

1) Did the facility provide proper care and treatment, including assistive devices, to prevent a decline, maintain, or improve the resident's communication abilities (speech, language, or other functional communication systems)?
   If No, cite F676
   NA, the resident does not have communication needs.

2) Did the facility ensure the resident receives proper treatment and assistive devices to maintain vision and/or hearing abilities?
   If No, cite F685
   NA, the resident does not have vision or hearing needs.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Notice of Rights F552, Dignity (CA), Social Services F745, Accommodation of Needs and/or Sound and Lighting (Environment Task), Admission Orders F635, Professional Standards F658, Rehab or Restorative (CA), Resident Records F842, Physician Supervision F710.

Dental Status and Services Critical Element Pathway

Use this pathway for a resident having oral/dental problems such as broken, carious, or loose teeth; inflamed gums; mouth sores or mouth pain; denture problems; or chewing problems. If mouth or facial pain was identified, the pain care area must be initiated and completed. If oral/dental concerns are determined to be a result of an adverse side effect of a medication, the unnecessary medications care area must be initiated and completed.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, J, K, L, and O.
- ☐ Physician's orders (e.g., mechanically altered diets, assistive oral care devices, medications that have an anticholinergic effect such as antidepressants, antihistamines, and antiarrhythmic agents).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., scheduled/routine dental examinations or referrals, how staff arrange for dental/oral care services, oral/dental/denture care based on the identified problem and relevant conditions [e.g., cancer, end of life], assistive oral care devices, nutritional issues [e.g., mechanically altered diet], efforts to find alternative means to address the needs identified in the assessment process if a resident refuses oral care).

Observations:

- ☐ What signs of dental and oral health concerns does the resident exhibit:
  - Difficulties with chewing;
  - Partial or full dentures that fit improperly;
  - Lack of partial or full dentures if missing natural teeth (partially or totally edentulous);
  - If the resident is not receiving anything by mouth (NPO), lack of special mouth care to maintain the health of oral mucous membranes;
  - Redness, sores, white patches in the mouth, dried cracked lips, dry furrowed tongue, or other manifestations reflecting oral conditions.
- ☐ Are observations of the resident's dental/oral status consistent with the comprehensive assessment? If not, describe.
- ☐ What alternative interventions were attempted if a resident resists dental/oral care?
- ☐ Are sufficient staff available to provide assistance with dental/oral health concerns, as needed? If not, describe.
- ☐ Are standard precautions followed during oral care?
- ☐ Are medications for the oral cavity correctly applied/administered (ensure a qualified surveyor observes)?
- ☐ Are supplies - such as a toothbrush, toothpaste, denture cleaner, denture adhesive - provided to meet the resident's care-planned needs for dental and oral care?

Dental Status and Services Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ Do you have any dental concerns that have not been addressed to your satisfaction? If so, describe.
- ☐ Are you aware of any medications that you are taking that may be contributing to the dental concern, if applicable? If so, describe.
- ☐ Are you experiencing any pain or difficulty eating as a result of the dental/oral concern? What is the facility doing to address it?
- ☐ Did the facility promptly address the dental/oral concern?
- ☐ What alternative options has the facility discussed with you if you have resisted dental/oral care?
- ☐ Have you had lost or damaged partial or full dentures? If so, was a referral made within three business days? If not, was an explanation given to you?
- ☐ How did the facility ensure you were able to continue to eat or drink while waiting for dental services?
- ☐ How did the facility assist you in obtaining dental services that were needed or requested?
- ☐ Do you receive Medicare or Medicaid? If so, were you only charged for services not covered and were you notified of those charges?
- ☐ How did the facility assist you in arranging transportation to dental appointments? Did a staff person accompany you if needed (due to the resident's condition) or requested?

Staff Interviews (Nursing Aides, Nurse, DON, Social Services):

- ☐ Can you explain how oral/dental services, interventions, or treatments should be carried out? How are follow-up visits or recommendations from a dentist provided to the facility? How is this information communicated to direct-care staff including staff from different shifts?
- ☐ What, when, and to whom do you report indications of oral/dental changes, including oral/dental pain or lost or damaged partial or full dentures?
- ☐ How do you monitor for the implementation of the care plan, effectiveness of interventions, and any changes in symptoms that have occurred over time?
- ☐ How does the facility ensure that a dentist is available for residents in accordance with professional standards of quality and timeliness?
- ☐ What potential adverse side effects of the resident's medications may be contributing to the dental/oral concern?
- ☐ How did you involve the resident or resident representative in the review and revision of the care plan?
- ☐ Nursing Aide: What training have you received related to the care of a resident with dental/oral concerns and the resident's routine preventive dental care?
- ☐ Nurse: What training have you received related to the assessment and care of dental/oral concerns?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.

Dental Status and Services Critical Element Pathway

Record Review:

- ☐ Review dental consultations and other interdisciplinary progress notes that may have information regarding assessment of dental and oral needs and the resident responsiveness to dental/oral services.
- ☐ Does the assessment accurately and comprehensively reflect the status of the resident? Are causal, contributing, and risk factors for dental and oral health status identified:
  - Staff identify and address relevant conditions such as broken, fractured, loose, or absence of teeth, inflamed gums, cracking at the corners of the mouth, coated tongue, redness or white patches of the mouth tissue, taste dysfunction, pain due to oral/dental health, or decreased salivation due to medication such as anticholinergic effects of antidepressants, antihistamines, and antiarrhythmic agents. There are many medications that cause dry mouth in addition to common drug classifications listed above;
  - Staff identify medical conditions/treatments that might impact the oral condition of the resident (such as oral cancer, chemotherapy, irradiation, diabetes, terminal health status, or immune compromised conditions);
  - If the resident does not have natural teeth, staff assess the condition of any artificial teeth (dentures); and
  - Risk factors for inadequate oral hygiene potentially leading to a decline in oral/dental health such as manual dexterity or upper extremity flexibility impairments, communication deficits, impaired cognition, impaired vision, and depression.
- ☐ What is the impact of the resident's oral health on his/her ability to consume foods? If the resident requires mechanically altered foods due to oral condition, did staff complete an assessment to determine resident is capable of safely consuming the food? If not, describe.
- ☐ If weight loss occurred, how did staff determine whether weight loss was attributable to the oral/dental condition (e.g., difficulty with chewing foods in the absence of teeth, oral/dental pain, or improperly adjusted/fitted partial or full dentures)?
- ☐ What is the resident's need for, and use of, partial or full dentures or other dental appliances?
- ☐ What regular oral inspections by a practitioner, dentist, dental hygienist, or nursing staff, as appropriate, were completed? What was response to dental care recommendations and/or interventions?
- ☐ If the resident refuses or resists dental/oral care, was an assessment of causal and contributing factors completed? If not, describe.
- ☐ What efforts has the facility made to assist the resident in making appointments and obtaining transportation to and from the dental services location?
- ☐ If concerns are identified with dentures, review facility policy to see if it addresses when the facility would or would not be responsible for lost or damaged partial or full dentures.
- ☐ For lost or damaged partial or full dentures, was a dental referral made within three business days? If not, were the extenuating circumstances for why this did not occur documented? How did the facility ensure the resident was able to eat and drink adequately while waiting?
- ☐ If a resident has difficulty chewing or has lost dentures, how did the interdisciplinary team, dietitian, and/or speech therapist evaluate the resident for appropriate food/fluid texture and consistency so the food/fluid may be safely consumed and the resident may maintain nutritional status?
- ☐ Is the care plan comprehensive and consistent with the resident's specific conditions, risks, needs, goals, behaviors, preferences, and current standards of practice, including measurable objectives and timetables, with specific interventions/services for the management and treatment of dental/oral symptoms, including interventions to address or reduce resistance to care, if appropriate?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

Dental Status and Services Critical Element Pathway

☐ How has staff monitored the resident's response to interventions for prevention and/or treatment? Have they evaluated and revised the care plan based on the resident's response, outcomes, and needs?

Critical Element Decisions:

1) For private-pay or Medicare-funded residents, did the facility promptly provide, or obtain from an outside resource, routine and emergency dental services to meet the resident's needs, including assisting with appointments and transportation arrangements?
   If No, cite F790
   NA, the resident is not private-pay and is not Medicare-funded.

2) For Medicaid-funded residents, did the facility promptly provide, or obtain from an outside resource, routine and emergency dental services to meet the resident's needs, including assisting with appointments and transportation arrangements?
   If No, cite F791
   NA, the resident is not funded by Medicaid.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

Dental Status and Services Critical Element Pathway

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Notification of Change F580, Social Services F745, Admission Orders F635, Professional Standards F658, Quality of Life F675, ADLs (CA), Nutrition (CA), Hydration (CA), Pain (CA), Unnecessary Medications (CA), Infection Control (Task), Sufficient and Competent Staffing (Task), Medical Director F841, Resident Records F842.

Dialysis Critical Element Pathway

Use this pathway for a resident identified as receiving hemodialysis (HD), home hemodialysis (HHD) or peritoneal dialysis (PD) at any location.

Review the following in Advance to Guide Observations and Interviews:

☐ The most current comprehensive *and most recent quarterly* (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, H, J, K, M, N, O.

☐ Physician's orders (dialysis access care, dialysis schedule, individualized dialysis prescription such as the number of treatments per week; length of treatment time, type of dialyzer, specific parameters of the dialysis delivery system [electrolyte composition of the dialysate, blood flow rate, and dialysate flow rate], anticoagulation; fluid restrictions, target weight, blood pressure monitoring).

☐ Pertinent diagnoses.

☐ Care Plan – Has staff evaluated the resident's response to dialysis and developed/revised the care plan in collaboration with the dialysis facility:

- Monitoring vital signs, weights, nutritional, and fluid needs or any restrictions, lab results, and who to notify with concerns;
- Specific type and location of dialysis services, transportation arrangements, and the interventions and goals based upon the type of dialysis;
- If the resident receives Erythropoiesis-Stimulating Agent (ESA) therapy, what to monitor and when and to whom to report results;
- For HD/HHD, which arm to use for blood pressure monitoring;
- For HHD, the number of treatments, length of treatment time, dialyzer, and specific parameters of the dialysis delivery system (e.g., electrolyte composition of the dialysate, blood flow rate, and dialysate flow rate), anticoagulation, the resident's target pre- and post-weights, vital signs, or other monitoring required during the provision of the dialysis treatment and that the trained staff should remain with the resident throughout the treatment and have visual observation of the access site;
- For PD, the number of exchanges or cycles to be done during each dialysis session, the volume of fluid with each exchange, duration of fluid in the peritoneal cavity, the concentration of glucose or other osmotic agent to be used for fluid removal, and the use of an automated, manual, or a combination of the techniques, the target pre- and post-weights, vital signs, or other monitoring required during the provision of the dialysis treatment;
- Who to contact, such as the attending practitioner(s), nephrologist, and dialysis staff, for dialysis-related emergencies, concerns or complications;
- Equipment needed to provide dialysis such as a peritoneal pump and alarm, access catheters, and equipment necessary to address a potential medical complication, and who to contact for equipment problems;
- Monitoring for risk factors and managing complications such as hemorrhage, access site infection, hypotension, and to whom to report concerns;
- Assessment and care of the access site, including the use of PPE as necessary, and other infection control measures;
- Approach to administering medications before, during, or after dialysis according to practitioner's orders; and
- Advance directives, if any, as allowed by State Law.

Observations:

☐ Infection prevention and control policies and procedures should be implemented (i.e., hand hygiene immediately before and after contact

- Dialysis access site dressings are clean, dry, and intact and the dressing is changed with clean (aseptic) technique using clean

with a resident or any equipment used on resident, access site care for hemodialysis and catheter site care for peritoneal dialysis).

☐ Is soap, water, and a sink readily accessible in locations where dialysis care is provided?

☐ Does staff perform hand hygiene (even if gloves are worn) in a manner consistent with the current standards of infection control practices?

☐ Is PPE appropriately implemented?

☐ Are qualified personnel accessing and providing maintenance of central venous catheters (CVCs), shunts, fistulas, or other vascular access catheters using aseptic technique:

- The access insertion date is documented and the indication for use is documented and assessed regularly;
- Only sterile devices are used for dialysis vascular access.

☐ Does the resident require injections related to dialysis care:

- Injections are prepared using aseptic technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids);
- The rubber septum on any med vial, whether unopened or previously accessed, is disinfected with alcohol prior to piercing;
- Med vials are entered with a new needle and a new syringe; and
- Med administration tubing, connectors, and bags of IV solutions are used for only one resident (and not as a source of flush solution for multiple residents).

☐ Are care-planned and ordered interventions in place and followed?

☐ For a resident receiving dialysis **<u>at a certified dialysis facility</u>**, did the nursing home:

- Assess and document vital signs, including the blood pressure in the arm where the access site is not located, weights if ordered and communicate the information including the resident's status with the dialysis facility prior to and post dialysis;
- Provide assistance and safe transportation to and from dialysis;
- Administer meds or meals before or after dialysis as ordered;
- Provide direct visual monitoring of the access site before and after dialysis; and
- Provide ongoing monitoring and care of the resident's vascular access (fistula, graft, or central venous catheter) for HD, catheter for PD as ordered, and provide ongoing monitoring for dialysis related complications (e.g., bleeding, access site infection, or hypotension).

Dialysis Critical Element Pathway

☐ For a resident receiving **HHD or PD in the nursing home provided by staff or other qualified individuals, observe if**:

- There are dialysis trained and qualified staff providing the treatment;
- Staff use appropriate cleaning procedures for furnishings, equipment contaminated with blood or other bodily substances, spills and splashes of blood and effluent based on current standards of infection control practices, and are cleaned after each treatment;
- If there is a roommate, whether access to his/her room or possessions is restricted or if there are concerns related to potential communicable diseases;
- Emergency supplies or equipment are readily available;
- Observe the resident's room and/or designated area for HHD/PD to determine whether it is equipped to afford privacy, has sufficient space, functioning call system within reach; and based upon professional standards of practice, the maintenance of effective infection control practices and measures. This includes ensuring that a resident who is hepatitis B+ is not dialyzed in the same location as resident who is not hepatitis B+.
- Staff respond appropriately in the event of an emergency, a power outage, or other situations in which dialysis may need to be interrupted;
- Safe, secure, and sanitary storage, handling and access of dialysis equipment and supplies; and
- Bio-hazardous waste disposal is available and used.

☐ During the provision of **HHD treatments, the nursing home should ensure that**:

- The HHD treatment is provided according to practitioner and dialysis facility orders and only by trained/qualified caregivers (as allowed by State law and nursing home policy) who received direct training by the dialysis facility trainer;
- Direct observation of the vascular access site and bloodline connection is provided by the dialysis trained caregiver who should be physically present throughout the HHD;
- Infection control practices are implemented, including the use of gloves, masks, and other personal protective equipment, methods for hand hygiene, vascular access and dressing changes;
- The dialysis treatment follows the dialysis prescription;
- Staff recognize, manage, and report vascular access problems, difficulty with cannulation, a change in bruit or thrill;
- Blood pressure (not taken on arm with access site) is taken and monitored prior to, during and after the dialysis treatment and action is taken to address excessively high or low blood pressures during treatment;
- Ongoing assessment and monitoring occurs during the treatment, including vital signs, monitoring level of consciousness, muscle
- Medications are administered as ordered, (if an Erythropoiesis-Stimulating Agent (ESA) is ordered, it is provided, in accordance with State laws and State scope of practice);
- Medical emergencies such as cardiac arrest, air embolism, drug reactions, suspected pyrogen reactions, profound hypotension or hypertension, significant blood loss, hyperkalemia, changes in level of consciousness or pain are recognized, immediately reported, and interventions/actions are provided as ordered;
- After the treatment, staff obtain vital signs, assess the resident's stability and monitor for post-dialysis complications and symptoms such as dizziness, nausea, vomiting, fatigue, or hypotension and symptoms that may be associated with water and dialysate contamination that cannot be readily attributed to other causes (e.g., chills, shaking, fever, vomiting, headache, dizziness, muscle weakness, skin flushing, itching, diarrhea, hyper/hypotension, hemolysis and anemia). If such symptoms are present, determine whether the symptoms are immediately reported to the attending practitioner and nephrologist or dialysis team to determine appropriate action;
- Staff use appropriate infection control cleaning and disinfecting

cramping, itching, comfort or distress and should report identified or suspected complications to the attending practitioner and dialysis staff to enable timely interventions;
- As ordered, the weight is taken prior to and post-treatment;
- Recognize, manage and immediately report to the dialysis facility, power outages, failure of the HD machine, failure of water treatment components (e.g., chlorine/chloramine breakthrough), clotting of the hemodialysis circuit, dialyzer blood leaks, line disconnection, water supply problems or leaks, and problems with supply delivery;
- Use appropriate cleaning procedures for furnishings, equipment contaminated with blood, or other bodily substances, for spills and splashes of blood or effluent; and
- Staff properly dispose of needles, effluents, disposable items, and tubing and to minimize risks of infection or injury to self and others and to prevent environmental contamination (e.g., using impervious puncture resistant containers for disposal of sharps, placing empty dialysate bags and tubing in intact plastic bags before discarding.

☐ During the provision of PD t**reatments, the nursing home should ensure that**:
- Individuals performing PD, receive dialysis training from the certified dialysis training staff(as allowed by State law and nursing home policy);
- The PD treatment follows the prescription;
- Before, during, and after receiving the PD, obtain and document vital signs and weights based on practitioner and dialysis orders, assess the resident's stability and monitor for emergencies or complications such as dizziness, nausea, fatigue, or hypotension;
- Staff recognize, document, manage, and report dialysis complications, including catheter, tunnel or exit site infection, symptoms of peritonitis, catheter dislodgement, hypotension, hypokalemia, or failure of sufficient dialysate to drain from the peritoneal space;
- Recognize, manage, and report power outages, failure of the PD cycler to the dialysis facility;
- Provide peritoneal catheter care and dressing changes according to the treatment plan and orders;
- The resident's record should include documentation of ongoing evaluation of the peritoneal catheter, including assessment of catheter related infections (e.g., exit site acute and chronic infections) and tunnel for condition, monitoring for patency, leaks, infection, and bleeding at the site. In addition, staff should be monitoring for complications such as peritonitis (e.g., abdominal pain/tenderness/distention, cloudy PD fluid, fever, nausea and vomiting;
- Staff properly dispose of needles, effluents, disposable items, and tubing and to minimize risks of infection or injury to self and others and to prevent environmental contamination (e.g. using impervious puncture resistant containers for disposal of sharps, placing empty dialysate bags and tubing in intact plastic bags before discarding; and
- Use appropriate cleaning procedures for furnishings, equipment contaminated with bodily substances, spills and splashes of effluent based on current standards of infection prevention and control practices.

Dialysis Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How were you involved in the development of the care plan and goals specific to dialysis?
- ☐ Do the interventions reflect your choices and preferences?
- ☐ Do you have any concerns with your dialysis treatment? Do you know who to discuss the concerns with? Were your concerns addressed? If not, why not?
- ☐ Are you on fluid or food restrictions? If so, how does staff monitor your intake? Do you follow your restricted diet and fluids? If not, has staff provided education about the risks and tried to provide alternatives?
- ☐ Are you allowed to have meals or snacks during your dialysis treatments? If so, how are meals or snacks provided? If not, how and when do you receive meals on dialysis days?
- ☐ When do you take your medications on dialysis treatment days? Have you missed any medications on dialysis treatment days?
- ☐ How often do you receive treatments? Have treatments been cancelled or missed? If so, why? Were they rescheduled and by whom?

Dialysis Critical Element Pathway

Staff Interviews (As appropriate, Nurse Aides, Nurse, DON, Practitioner, Dietitian, Pharmacist, Nephrologist, Dialysis Staff, Medical Director):

- ☐ What type of staff training for dialysis care and services did you receive and who provided the training?
- ☐ What type of dialysis is the resident receiving? How do you care for the access sites and dressing changes? When do you monitor vital signs and weights? Are there any restrictions for food or fluids and how is it tracked?
- ☐ What do you do if the resident declines a dialysis treatment, is ill, or if treatments are cancelled?
- ☐ Has the resident had any dialysis-related complications (e.g., dizziness, falls, bleeding)? To whom do you report possible complications or changes in condition?
- ☐ What do you do if there is an emergency or complication including equipment failure?
- ☐ How is care coordinated and communicated between dialysis staff and the facility, including documentation of the resident's status, nutrition, adequate hydration, psychosocial and nursing needs, current dialysis treatment, and the possible need to modify the current interventions?
- ☐ Has the resident had a change in mood or behavior? Has the resident refused to participate in activities that he/she had previously shown interest, expressed feelings of hopelessness or anger over health and need for dialysis treatments? How is this addressed and by whom?
- ☐ Has the resident had pain or anxiety related to dialysis treatments? How is this being addressed?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ How is medication administration monitored to assure meds are administered timely or held according to orders?
- ☐ How and when are diagnostic tests obtained and who is responsible for collecting, reporting, and reviewing the results?
- ☐ If the resident is receiving an ESA, how has the dialysis and facility coordinated obtaining and reporting test results (i.e., hemoglobin and hematocrit) to the practitioner?
- ☐ If the pharmacist reports irregularities of ESA prescribing and potential medication-related adverse consequences, how have the recommendations been coordinated with dialysis?
- ☐ Has the facility established policies and protocols for the dispensing, administration, and storage of ESA?
- ☐ If the interventions or care provided do not appear to be consistent with standards of practice, ask the medical director:
  - How are you involved in developing or implementing policies and procedures regarding HD/HHD/PD, including emergency procedures, medication administration, procedures for use of ESAs, and emergency medications; and
  - Were you asked to address concerns regarding dialysis-related care with the attending practitioner and ESRD practitioners?
- ☐ Ask about identified concerns.

Dialysis Critical Element Pathway

Record Review:

- ☐ If facility staff provide the HHD or PD treatments, request documentation to assure that training meets the current standards of practice, State law and practice acts, and is provided directly by dialysis facility staff to the individual providing the treatment;
- ☐ Did the record reflect the resident's dialysis needs, such as:
  - Identification of individualized risk factors and potential complications related to dialysis (e.g., bleeding, infection, skin integrity, and the effects of dialysis on medication therapy);
  - Choices or preferences including advance directives, if any;
  - Medical status including status of comorbid conditions, frequency of vital signs, weights , and monitoring fluids as ordered;
  - Identification of the type of dialysis, where provided and by whom, how often and if the treatment is in accordance with the dialysis prescription;
  - Supervision and monitoring during HHD or PD, including direct observation of the access site during HHD;
  - Identification of appropriate PPE for type of dialysis treatments and care provided, identification of specific infection control practices to use prior to, during and/or after the treatments, including care of equipment and supplies;
  - Laboratory tests needed to manage and monitor dialysis;
  - Pneumococcal and influenza immunizations, hepatitis immunization, and screening for tuberculosis (per CDC);
  - Communication and coordination with the dialysis team to meet nutrition and hydration needs;
  - Psychosocial needs such as anxiety, depression, confusion or behavioral symptoms that might interfere with treatments and interventions to address the identified needs;
- ☐ Does the record reflect the coordination and collaboration with the dialysis facility including exchange of pertinent information before, during (if HHD provided by the nursing home), and post dialysis?
- ☐ Was there a "significant change" in the resident's condition If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ If concerns are identified related to the provision of dialysis care, review the appropriate facility policies regarding dialysis.

Critical Element Decisions:

NOTE: If at any time during the survey, a concern or issue arises regarding the dialysis services provided by the dialysis facility, the survey team should report this as a complaint to the State Agency survey unit responsible for oversight of the Medicare certified ESRD entity. Identify the specific resident(s) involved and the concerns identified.

1) Did the facility provide dialysis care and services to meet the needs of the resident?
   If No, cite F698

2) Did the facility use appropriate hand hygiene practices and PPE when providing wound/dressing care, central line care, and/or administering IM/IV medications?
   If No, cite F880

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Dialysis Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Dignity (CA), Right to be Informed F552, Right to Refuse F578, Advance Directives (CA), Notification of Change F580, Accommodation of Needs, Call System (Environment Task), Qualified Persons F659, Pressure Ulcer (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Unnecessary Medications (CA), Other Infection Control Concerns (Task), Facility Assessment F838, Medical Director F841, Resident Records F842, QAA/QAPI (Task).

General Critical Element Pathway

Use this pathway to investigate quality of care concerns that are not otherwise covered in the remaining tags of §483.25, Quality of Care, and for which specific pathways have not been established. For investigating concerns regarding care at the end of life, use the Hospice/End of Life CE Pathway.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the concern.
- ☐ Physician's orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan.

Observations Across Various Shifts:

- ☐ Does staff consistently implement the care-planned interventions? If not, describe.
- ☐ Ensure interventions adhere to professional standards of practice.
- ☐ What is the resident's response to interventions? Is the resident's response as intended?
- ☐ Do observations of the resident match the assessment? If not, describe. Are there visual cues of psychosocial distress and harm?

Resident, Resident Representative, or Family Interview:

- ☐ Will you describe your current condition or history of the condition, or diagnosis?
- ☐ How did the facility involve you in the development of the care plan and goals?
- ☐ How effective have the interventions been? If not effective, what alternate approaches have been tried?
- ☐ What are your goals for care? Do you think the facility is meeting them? If not, why do you think that is?
- ☐ For newly admitted residents, did you receive a summary of your (or the resident's) baseline care plan? Did you understand it?

General Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- ☐ Will you describe specific interventions for the resident, including facility-specific guidelines/protocols?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How does the interdisciplinary team monitor for the implementation of the care plan and changes in condition?
- ☐ How is information passed across shifts, and between all disciplines?
- ☐ How are revisions to the comprehensive care plan communicated to staff?
- ☐ How was it determined that the chosen interventions were appropriate?
- ☐ Did the resident have a change in condition that may justify additional or different interventions?
- ☐ How does staff validate the effectiveness of current interventions?

Record Review:

- ☐ Review relevant information such as medication and treatment administration records, interdisciplinary progress notes, and any facility-required assessments that may have been completed. Does the information accurately and comprehensively reflect the resident's condition? If not, describe.
- ☐ Are federally required RAI/MDS assessments completed according to required time frames?
- ☐ For newly admitted residents, is there a baseline care plan, and does it describe the instructions necessary to meet the resident's immediate needs? Does it address the resident's clinical and safety risks?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, preferences, and behaviors? Does it include goals for admission, measureable objectives, timetables, and desired outcomes? How did the resident respond to care planned interventions? Was the care plan revised if interventions weren't effective, the desired outcome was achieved, or if there was a change in condition?
- ☐ Is there evidence of resident or resident representative participation in developing resident-specific, measureable objectives, and interventions? If not, is there an explanation as to why the resident or representative did not participate?
- ☐ Is there evidence that the resident has refused any care or services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment? If so, does the care plan reflect this refusal, and how has the facility addressed this refusal?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

General Critical Element Pathway

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
If No, cite appropriate outcome tag or F684

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

General Critical Element Pathway

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Notification of Change F580, Admission Orders F635, Professional Standards F658, Qualified Staff F659, QOL F675, Foot Care F687, Colostomy/Urostomy/Ileostomy Care F691, Prosthesis F696, Sufficient and Competent Staffing (Task), Physician Services F710, Facility Assessment F838, Medical Director F841, Resident Records F842, QAA/QAPI (Task).

Hospice and End of Life Care and Services Critical Element Pathway

Use this pathway for a resident identified as receiving end of life care (e.g., palliative care, comfort care, or terminal care) or receiving hospice care from a Medicare-certified hospice.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the resident's end of life care, services, and needs.
- ☐ Physician's orders (e.g., hospice or end of life services, advance directives, pain interventions, medications).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., advance directives; provision of ADLs; symptom management including controlling nausea, agitation, pain, uncomfortable breathing; pressure ulcer prevention interventions; nutrition and hydration needs; psychosocial interventions; coordination of care with hospice).

Observations:

- ☐ Are care planned and ordered interventions implemented and meeting the resident's needs? If not, describe the discrepancies.
- ☐ Whether ADLs (including oral care) are provided to address the resident's comfort and dignity.
- ☐ Whether skin integrity interventions are implemented (e.g., repositioning) to ensure the resident is comfortable.
- ☐ Whether the resident's symptoms (e.g., nausea, vomiting, uncomfortable breathing, agitation, or pain) are being managed.
- ☐ Whether supportive/assistive devices are provided as needed.
- ☐ Whether the facility is meeting the resident's choices and preferences (e.g., bathing, toileting, sleep schedule, activities).
- ☐ Whether the resident appears to be agitated, apprehensive, withdrawn, or restless? If so, how are these symptoms being addressed?
- ☐ Whether the type, amount, consistency of food and fluids provided are based on resident's needs, choices and preferences. If not, describe.
- ☐ Whether the environment promotes comfort according to the resident's preferences (e.g., low lighting and minimal background noise)? If not, describe.

Hospice and End of Life Care and Services Critical Element Pathway

Resident, Representative, or Family Interview:

- ☐ Whether the resident/representative is aware of:
  - o The name of the facility interdisciplinary team member/designee who is responsible for working and coordinating with the hospice team for communicating concerns regarding the provision of care; and
  - o How to contact the facility's designated coordinator.
- ☐ If receiving hospice care, have you had any concerns with your hospice care? If so, what are your concerns and do you know who to talk to and how to contact that person?
- ☐ How did the facility involve you in the development of the care plan and goals regarding your care?
- ☐ Do you feel like the care you are receiving reflects your choices and preferences?
- ☐ Were you involved in making choices on the type of care and treatment you are receiving? Do you have an advance directive (according to State law) and is staff aware of your directives? if not, have you or your representative received information on advance directives?
- ☐ Has your care changed recently? If so, were you involved in revisions or changes for care and treatment?
- ☐ Are you experiencing any symptoms (e.g., pain, breathing difficulty, constipation)? How are your symptoms being managed?
- ☐ Have you experienced any anxiety, depression, or grief? How are these needs being addressed?
- ☐ Have you declined any treatments? Why? Did staff find out the reason for the refusal and try to offer alternatives?
- ☐ Do you think the coordination of care between the hospice and facility is meeting your needs? If not, why not? Have you notified staff? Who? What was the resolution?

Staff Interviews (Nursing Aides, Nurse, Hospice Staff, Designated Hospice Coordinator, DON):

- ☐ Can you describe the resident's goals for care and treatment at the end of life?
- ☐ What is the basis for the determination that a resident is approaching the end of life?
- ☐ How do you monitor and document symptoms, implement interventions, and document effectiveness of the interventions? Who do you report any changes to?
- ☐ If the resident is transferred to the ER or hospital, how are the resident's choices and preferences regarding care communicated, including advance directives, if applicable?
- ☐ If the resident is receiving hospice care, determine:
  - o Whether nursing home staff understand the hospice philosophy and practices;
  - o Who is the facility designated IDT member that communicates with hospice and whether he/she meets the qualifications; and
  - o What and how often does the IDT member communicate with hospice.

  NOTE: If concerns, see F849 for the hospice written agreement)
- ☐ Can you describe the ongoing (24/7) communication and coordination process between the facility and hospice?
- ☐ Can you describe your responsibilities compared to what hospice provides?
- ☐ How do you share concerns and responses and who coordinates the resident's care with the hospice?
- ☐ How do you communicate with the resident or resident representative, hospice, and the practitioner any change to the resident's condition that may reflect the need to modify or revise the coordinated care plan?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan. NOTE: If concerns are identified with coordination of care, communication with the hospice, or responses to concerns, interview the facility-delegated coordinator. It may be necessary to interview the designated hospice coordinator regarding resident concerns.

Hospice and End of Life Care and Services Critical Element Pathway

Record Review:

- ☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- ☐ Does the care plan reflect the resident's diagnosis, palliative care and interventions, as appropriate, such as:
  - o End of life or hospice status;
  - o If on hospice:
    - ▪ Identification of the discipline and provider for care plan interventions;
    - ▪ How to contact the hospice 24 hours a day; and
    - ▪ Does the care plan reflect coordination between the hospice and the nursing home.
  - o Identified resident choices, and goals including advance directives as allowed by State law (e.g., directions regarding hospitalization, acute care in the event of an illness or injury, artificial nutrition or hydration, respiratory and cardiac status).
  - o Underlying factors affecting the resident's comfort, cognition, pain, and functional status;
- ☐ Does the record reflect assessment of concerns such as the following:
  - o Nutrition and hydration concerns (e.g., refusal to eat/drink; loss of appetite; alteration in taste and smell; dietary restrictions; food/beverage choices; the amount, type, texture, and frequency for food/fluids; or necessity for ongoing weight measurements)?
  - o Oral health status (e.g., ulcers in mouth; dryness of oral cavity/tongue; or diseases, such as candida or thrush) and how is it being addressed?
  - o Bowel and bladder concerns (constipation, impactions, diarrhea, incontinence)?
  - o Symptoms management (e.g., pain, nausea, vomiting, respiratory concerns, weakness, lethargy, vertigo, skin integrity issues including existing wounds, infections) and interventions?
  - o Level of activities desired including ethnic/cultural practices,
- ☐ Lab/x-ray tests in agreement with the resident's advance directives, if any, including choices, preferences, goals, comfort, and dignity?
- ☐ Does the record reflect a change in treatment to palliative care or hospice?. Was a significant change comprehensive assessment conducted within 14 days of the change?
- ☐ Did the facility identify necessary changes in goals or care approaches to promote comfort and prevent the development or worsening of physical or psychosocial symptoms? Was this communicated with the resident, resident representative, hospice, and attending practitioner?
- ☐ How does the facility monitor the resident's response to interventions for the management of physical and psychosocial needs?
- ☐ Review the facility policy on end of life and hospice care or related policies (e.g., advance directives) if concerns are identified.
- ☐ For a resident receiving hospice services: If the resident is receiving the hospice benefit, is care coordinated between hospice and the facility staff? If not, describe.
- ☐ Does the facility have a current written agreement with the Medicare-certified hospice providing hospice services in the nursing home, and was the agreement developed prior to hospice services beginning. (Refer to F849 – hospice agreement.)
- ☐ If the hospice was advised of resident concerns and failed to resolve issues related to the management of the resident's care, coordination of care, or implementation of appropriate services, review the appropriate portions of the written agreement.

choices regarding when to sleep and awaken?

- Functional/ADL status including mobility?
- Medications used for comfort, symptom control, and desired level of alertness?

Critical Element Decisions:

Referral of Hospice-Specific Concerns: If the resident is receiving Medicare-certified hospice services and 1) the hospice was advised of concerns by the facility and failed to address and resolve issues related to coordination of care or implementation of appropriate services; or 2) the hospice failed to provide services in accordance with the coordinated plan of care, regardless of notice from the facility; or 3) if there is no current written agreement between the nursing home and the hospice; the survey team must refer this as a complaint to the State agency responsible for oversight of hospice, identifying the specific resident involved and the concerns identified.
NOTE: Most noncompliance related to end of life or hospice care and services can be cited at other regulations (e.g., assessment, care planning, accommodation of needs, and physician supervision). Surveyors should evaluate compliance with these regulations and cite deficiencies at F675 only when other regulations do not address the noncompliance.

1) A. Did the facility provide appropriate treatment and services for end of life care?

   B. For a resident receiving hospice services: Did the facility collaborate with the hospice for the development, implementation, and revision of the coordinated plan of care and/or communicate and collaborate with the hospice regarding changes in the resident's condition, including transfer to the emergency department and/or hospital, if applicable?

   If No to A or B, cite F684

2) Did the facility have an agreement to provide hospice services at the facility or with a Medicare-certified hospice, designate staff to the facility's interdisciplinary team who works with the hospice representative to coordinate care, and ensure each resident's care plan includes a description of the care and services provided by the hospice and facility?
   If No, cite F849

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible) if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Right to be Informed Make Treatment Decisions F552, Advance Directives (CA), Choices (CA), Respiratory (CA), Pain (CA), Unnecessary Medications (CA), Behavioral-Emotional Status (CA), QOL F675, Facility Assessment F838, QAA/QAPI (Task).

Death Critical Element Pathway

Use this pathway to 1) investigate circumstances surrounding the death of a resident who was **not** receiving end of life care, hospice, or palliative care, to determine if the facility identified and assessed any change in condition, and intervened as appropriate, or 2) determine if facility practices were in place to identify, assess, and intervene to prevent the rapid decline if the resident died within 30 days of admission and was not receiving end of life services on admission.

Record Review:

- ☐ Review nursing notes, EMT records, hospital and discharge summaries, facility d/c summary, death certificate (noting cause of death), and progress notes/vital signs.
- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections B, C, E, G*G*, H, I, J, and O.
- ☐ Does the comprehensive care plan identify interventions for the risks and conditions related to the resident's death? If not, describe.
- ☐ If the resident expired before the development of the comprehensive care plan, determine what baseline care plan interventions were related to the resident's death, and if they were carried out.
- ☐ Identify pertinent diagnoses.
- ☐ Review physician's orders (e.g., code status).
- ☐ Review laboratory or radiology results pertinent to the resident's death.
- ☐ Was the resident's change in condition or decline assessed, monitored, and documented? Did the facility do a significant change assessment?
- ☐ Review progress notes to determine what interventions were put into place to address the change or decline in condition (e.g., first aid measures, glucose monitoring, cardiopulmonary resuscitation [CPR], and immediate transfer)?
- ☐ Were interventions and preventive measures documented, appropriate, monitored, evaluated, and modified as necessary?
- ☐ Was pain assessed and treatment measures documented, if needed?
- ☐ Was care consistent with the resident's advance directives or goals for care?
- ☐ If concerns are identified, review facility policies and procedures with regard to factors that led to the resident's death.

Family or Resident Representative Interview:

- ☐ Were you made aware of the resident's change in condition? If so, when, and what was the facility going to do to address it?
- ☐ When was the last time you saw the resident? Did the resident appear to be at their baseline, or did you notice a difference? If you noticed a difference, did you notify staff? If so, whom did you notify and when?
- ☐ Were advance directives in place? If so, what were the resident's decisions and were they honored?

Death Critical Element Pathway

Nurse and DON Interviews:

- ☐ Are you familiar with the resident's care?
- ☐ Can you describe the resident's cognitive, functional, and health status before the resident declined and prior to the resident's death?
- ☐ Did the resident have pain? If so, who did you report it to and how was it being treated? How often was the resident being assessed for pain?
- ☐ Did the resident have a change or decline in condition? If so, what interventions were in place to address the problem?
- ☐ When was the practitioner notified? When was the resident's representative notified?
- ☐ When did the resident die and what was the cause of death?
- ☐ How often was the resident's condition assessed while experiencing a change in condition? Where is it documented? Did you report it (to whom and when) and did the treatment plan change?
- ☐ Did the resident refuse any treatments? What did you do if the resident refused?
- ☐ How did you involve the resident in decisions regarding treatment(s)?
- ☐ Were advance directives in place? If so, what were the resident's decisions and were they honored?

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
   If No, cite the relevant outcome tag or F684

2) For newly admitted residents, and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

Death Critical Element Pathway

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status) ?
   If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed F552, Advance Directives (CA), Notification of Change F580, Dignity (CA), Choices (CA), Admission Orders F635, Professional Standards F658, QOL F675, CPR F678, Behavioral-Emotional Status (CA), Advance Directives (CA), Hospice/End of Life (CA), Nutrition (CA), Hydration (CA), Pain (CA), Sufficient and Competent Staffing (Task), Physician Supervision F710, Medical Director F841, Resident Records F842, QAA/QAPI (Task).

Nutrition Critical Element Pathway

Use this pathway for a resident who is not maintaining acceptable parameters of nutritional status or is at risk for impaired nutrition to determine if facility practices are in place to identify, evaluate, and intervene to prevent, maintain, or improve the resident's nutritional status, unless the resident's clinical status demonstrates that this is not possible, or resident preferences indicate otherwise.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, D, G*G*, K, L, and O.
- ☐ Physician's orders (e.g., food allergies/intolerances and preferences, nutritional interventions [e.g., supplements], assistance with meals, type of diet [e.g., mechanically altered], therapeutic diet [e.g., low sodium diet], weight monitoring, meds [e.g., psychotropic meds, diuretics], and labs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., nutritional interventions, assistance with meals, assistive devices needed to eat, type of diet, therapeutic diet, food preferences, or pertinent labs).

Observations:

- ☐ Observe the resident at a minimum of two meals:
  - Are the resident's hands cleaned before the meal if assisted by staff;
  - Is the diet followed (texture, therapeutic, and preferences);
  - Are proper portion sizes given (e.g., small or double portions);
  - Is the resident assisted (with set-up and eating, positioning, supervision, etc.), cued, and encouraged as needed;
  - Are assistive devices in place and used correctly (e.g., plate guard, modified utensils, sippy cups);
  - If the resident isn't eating or refuses: What does staff do (e.g., offer substitutes, encourage, or assist the resident); and
  - How is the dignity of the resident maintained?
- ☐ Are care-planned and ordered interventions in place?
- ☐ Is the call light in reach if the resident is eating in their room?
- ☐ Are there environmental concerns that may affect the resident during meals, such as loud or distracting noises, the inability to reach snacks kept in their room, or other concerns?
- ☐ Does the resident's physical appearance indicate the potential for an altered nutritional status (e.g., cachectic, dental problems, edema, no muscle mass or body fat, decreased ROM, or coordination in the arms/hands)?
- ☐ How physically active is the resident (e.g., pacing or wandering)?
- ☐ Are supplements provided and consumed at times that don't interfere with meal intake (e.g., supplement given right before the meal and the resident doesn't eat the meal)?
- ☐ Are snacks given and consumed as care planned?
- ☐ Is the resident receiving OT, SLP, or restorative therapy services? If so, are staff following their instructions (e.g., head position or food placement to improve swallowing)?
- ☐ Is there any indication that the resident could benefit from therapy services that are not currently being provided (difficulty grasping utensils, difficulty swallowing)?
- ☐ If a resident is receiving nutrition with a feeding tube, observe for positioning, type of tube feeding, whether a pump or gravity is being used, and the rate and amount being provided.

Nutrition Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How did the facility involve you in the development of your care plan and goals?
- ☐ Have you lost weight in the facility? If so, why do you think you've lost weight (e.g., taste, nausea, dental, grief, or depression issues)?
- ☐ What is the facility doing to address your weight loss? (Ask about specific interventions – e.g., supplements.)
- ☐ Do they give you the correct diet, snacks, supplements, and honor your food preferences/allergies? If not, describe.
- ☐ If you don't want the meal, does staff offer you a substitute?
- ☐ Does staff set up your meal, assist with eating, or encourage you as needed? If not, describe.
- ☐ Do you have difficulty chewing or swallowing your food? If so, how is staff addressing this?
- ☐ Do they give you assistive devices so you can be as independent as possible? If not, describe.
- ☐ Do they give you enough time to eat? If not, describe.
- ☐ Do your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances? If not, describe.
- ☐ How does staff involve you in decisions about your diet, food preferences, and where to eat?
- ☐ If you know the resident has refused: What did the staff tell you about what might happen if you don't follow your plan to help maintain your weight?
- ☐ Are you continuing to lose weight? If so, why do you think that is?

Nursing Aide, Dietary Aide or Paid Feeding Assistant:

- ☐ Are you familiar with the resident's care?
- ☐ Where does the resident eat?
- ☐ How much assistance does the resident need with eating?
- ☐ How do you encourage the resident to feed him/herself when possible?
- ☐ Are any supplements given with the meal?
- ☐ How are meal intakes, supplements and weights monitored?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Do you know if the resident has lost weight? Has the treatment plan changed?
- ☐ Have you reported any changes in the resident's weight or intake? Who would you report this to?
- ☐ Ask about identified concerns.

Nurse:

- ☐ Are you familiar with the resident's care?
- ☐ How much assistance does the resident need with eating?
- ☐ How are meal intakes, supplements, and weights monitored? Where is it documented?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Has the resident lost weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Nutrition Critical Element Pathway

Registered Dietitian or Dietary Manager:

- ☐ Who is involved in evaluating and addressing any underlying causes of nutritional risks or impairment?
- ☐ Does the resident require any assistance with meals?
- ☐ Is the resident at risk for impaired nutritional status? If so, what are the risk factors?
- ☐ Has the resident had a loss of appetite, or any GI, or dental issues? If so, what interventions are in place to address the problem?
- ☐ Has the resident lost any weight recently? When did the weight loss occur? What caused it?
- ☐ If the resident's weight loss is recent: Who was notified and when were they notified?
- ☐ Were any interventions in place before the weight loss occurred?
- ☐ Have you seen the resident eat? What meal? Did he/she eat all the meal?
- ☐ What are you doing to address the weight loss?
- ☐ How often is the resident's food/supplement intake, weight, eating ability monitored? Where is it documented?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident/representative in decisions regarding treatments? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident continuing to lose weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you communicate nutritional interventions to the staff?
- ☐ Ask about identified concerns.
- ☐ Who from the Food and Nutrition staff attends the interdisciplinary team meetings?

Practitioner or other Licensed Health Care Practitioner Interviews: If the interventions defined, or the care provided, appear to be inconsistent with current standards of practice, orders, or care plan, interview one or more practitioners or other licensed health care practitioners who can provide information about the resident's nutritional risks and needs.

- ☐ What was the rationale for the chosen interventions?
- ☐ How is the effectiveness of the current interventions evaluated?
- ☐ How have staff managed the interventions?
- ☐ How does the interdisciplinary team decide to maintain or change interventions?
- ☐ What is the rationale for decisions not to intervene to address identified needs?

Nutrition Critical Element Pathway

Record Review:

- ☐ Review the MDS and CAAs, nursing notes, nutritional assessment and notes, rehab, social service, and physician's progress notes.
  - o Have the resident's nutritional needs been assessed (e.g., calories, protein requirement, UBW, weight loss, desired weight range);
  - o Was the cause of the weight loss identified; and/or
  - o Is the rationale for chosen interventions or no interventions documented?
- ☐ Are the underlying risk factors identified (e.g., underlying medical, psychosocial, or functional causes)?
- ☐ Have the medications been reviewed for any impact affecting food intake?
- ☐ Have relevant care plan interventions been identified and implemented to try to stabilize or improve nutritional status?
- ☐ Does the care plan identify the resident's individualized goals, preferences, and choices?
- ☐ How often are food/supplement intakes monitored and documented? Are deviations identified?
- ☐ How often are weights monitored and documented? Are deviations identified?
- ☐ Are preventative measures documented prior to the weight loss?
- ☐ Was a health care provider's order obtained for a therapeutic diet, if applicable?
- ☐ Review laboratory results pertinent to nutritional status (e.g., albumin and pre-albumin) if ordered or available.
- ☐ Has the care plan been revised to reflect any changes in nutritional status?
- ☐ Do your nutritional observations match the description in the clinical record? If no, interview pertinent staff to investigate the potential discrepancy(ies).
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Review the facility policy with regard to nutritional status.
- ☐ If there is a pattern of residents who have not maintained acceptable parameters of nutritional status without adequate clinical justification, determine if Quality Assurance and Performance Improvement (QAPI) activities were initiated to evaluate the facility's approaches to nutrition and weight concerns.

Critical Element Decisions:

1) Did the facility provide care and services to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible, and did the facility ensure that the resident is offered and ordered a therapeutic diet if there is a nutritional problem?
   If No, cite F692

2) If there was a change in the resident's nutritional status, did the physician evaluate and address medical and nutritional issues related to the change?
   If No, cite F710

Nutrition Critical Element Pathway

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Nutrition Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to Refuse F578, Notification of Change F580, Choices (CA), Accommodation of Needs (Environment Task), Parenteral/IV fluids F694, Physician Delegation to a Dietitian F715, Social Services F745, Admission Orders F635, Professional Standards F658, Advance Directives (CA), ADLs (CA), Behavioral-Emotional Status (CA), Accidents (CA), Tube Feeding (CA), Hydration (CA), Unnecessary/Psychotropic Medications (CA), Provides Diet to Meet Needs F800, Qualified Dietary Staff F801, Food in Form to Meet Needs F805, Therapeutic Diet Ordered F808, Assistive Devices F810, Paid Feeding Assistant F811, Physician Services F710, Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

Pain Recognition and Management Critical Element Pathway

Use this pathway for a resident who has pain symptoms or can reasonably be expected to experience pain (i.e., during therapy) to determine whether the facility has provided and the resident has received care and services to address and manage the resident's pain in order to support his or her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences.

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, J, K, L, N, and O.
- ☐ Physician's orders (e.g., pain management interventions, PRN or routine pain medications, type of pain medications [opioid, non-steroidal anti-inflammatory], and route [injectable, oral, topical]).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., measurable goals for pain management, current pain management interventions, pharmacological and non-pharmacological interventions, timeframes, and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions).

Observations:

- ☐ Does the resident exhibit signs or symptoms of pain, verbalize the presence of pain, or request interventions for pain? Does the pain appear to affect the resident's function or ability to participate in routine care or activities? If so, describe.
- ☐ For non-verbal or cognitively-impaired residents who cannot verbalize their pain, how does staff assess for the presence of pain and effectiveness of interventions for pain?
- ☐ If there is evidence of pain, how does staff assess the situation, identify, and implement interventions to try to prevent or address the pain, and evaluate the status of the resident's pain after interventions?
- ☐ If care and services are being provided that reasonably could be anticipated to cause pain, such as therapy, how does staff identify and address these issues, to the extent possible?
- ☐ How does staff respond if there is a report from the resident, family, or staff that the resident is experiencing pain?
- ☐ If there are pain management interventions for the resident, how does staff ensure they are implemented as ordered or care planned?
- ☐ Does the resident exhibit any potential adverse consequences associated with treatment for pain (e.g., respiratory depression)?
- ☐ How does staff respond if the interventions implemented did not reduce the pain consistent with the goals for pain management?
- ☐ How long does the resident wait to receive PRN pain medication after requesting it?

Pain Recognition and Management Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How does the facility involve you in the development of the care plan and defining the approaches and goals?
- ☐ How does the facility ensure the interventions reflect your/the resident's choices and preferences?
- ☐ How are you involved in developing and revising pain management strategies and revisions to the care plan if the interventions did not work?
- ☐ Describe the characteristics of the pain, including the intensity, pain rating, type (e.g., burning, stabbing, tingling, aching), patterns of pain (e.g., constant or intermittent), location, radiation of pain, and frequency, timing, and duration of pain.
- ☐ What factors may precipitate or alleviate the pain?
- ☐ How have you typically expressed pain and responded to various interventions in the past?
- ☐ Who have you told about the pain/discomfort? How has staff responded? How long does it take for you to receive pain medication when you have asked for it?
- ☐ What treatment options (pharmacological and/or non-pharmacological) were discussed and attempted?
- ☐ For a resident with a documented history of addiction or opioid use disorder (OUD): Has the facility used strategies to treat your pain while also addressing the OUD?
- ☐ How effective have the interventions been?
- ☐ Have you refused any interventions (i.e., certain types of medications or nonpharmacological ways to reduce pain without medication)? If so, was there a discussion of the potential impact on you, and what alternatives or other approaches were offered?

Nursing Aide Interview:

- ☐ Does the resident experience any pain during assistance with activities of daily living? If so, what do you do?
- ☐ Does the resident have any complaints, or exhibit any signs or symptoms of pain?
- ☐ Are you aware of the signs and symptoms of adverse side effects of the pain medication this resident is prescribed?
- ☐ To whom do you report the resident's complaints and signs or symptoms?
- ☐ Do you know what interventions are on the resident's care plan for pain/discomfort management (e.g., allowing a period of time for a pain medication to take effect before bathing or dressing)? Do you implement any interventions to relieve the resident's pain?

Nurse, DON, Hospice Nurse, Attending Practitioner, Pharmacist, Medical Director Interviews:

Pain Recognition and Management Critical Element Pathway

- ☐ Is there a tool that is used to assess residents with pain? Is the same tool used for everyone? How is the resident assessed for pain? How and when do staff try to identify circumstances in which pain can be anticipated?
- ☐ Do staff assess for history of addiction and past or ongoing OUD treatment? How is this addressed?
- ☐ For residents receiving pain medication (including PRN and adjuvant medications), how, when, and by whom are the results of medications evaluated (dose, frequency of PRN use, schedule of routine medications, and effectiveness)?
- ☐ How often is the resident's pain regimen reviewed, and what triggers a review?
- ☐ What is done if pain persists or recurs despite treatment? What is the basis for decisions to maintain or modify approaches?
- ☐ How does staff communicate with the prescriber about the resident's pain status, current measures to manage pain, and the possible need to modify the current pain management interventions?
- ☐ How do you monitor for the emergence or presence of adverse events related to opioid medications or the consequences of interventions?
- ☐ Do you keep naloxone on hand to reverse the effects of an opioid overdose?
- ☐ For residents with significant, or difficult to manage pain: How were the interventions developed? What was the basis for selecting them?
- ☐ How do you guide and oversee the selection of pain management interventions?
- ☐ Are you aware of any situation where the resident had pain, but interventions were not utilized? If so, why did this occur? Was there a rationale?
- ☐ Have any of this resident's interventions been ineffective, or caused adverse consequences? If so, when and with whom was this discussed?
- ☐ For a resident who is receiving care under a hospice benefit, how does the hospice and the facility coordinate their approaches and communicate about the resident's needs and monitor the outcomes (both effectiveness and adverse consequences)?

Pain Recognition and Management Critical Element Pathway

Record Review:

- ☐ Review information such as MARs, controlled medication records/count sheets, multidisciplinary progress notes, and any specific assessments regarding pain that may have been completed. Determine whether the information accurately and comprehensively reflects the resident's condition, and extent to which pain is managed.
- ☐ What indicators and characteristics of the resident's pain, including causes and contributing factors related to pain, have been identified, and addressed in the care plan?
- ☐ Did the facility identify the resident's history of pain and related interventions? If not, describe.
- ☐ What was the resident's response to interventions, including efficacy and adverse consequences and any modification of interventions as indicated?
- ☐ Do pain management interventions have a documented rationale and is it consistent with current standards of practice?
- ☐ Does the record show a combination of opioid and benzodiazepine medications for one resident? This combination can increase the risk of respiratory distress -- is there a documented rationale to show these medications are clinically indicated for the resident?
- ☐ What clinically significant medication-related adverse consequences, such as a change in mental status/delirium, falling, constipation, anorexia, or drowsiness, has the resident experienced? What was the plan to try to minimize those adverse consequences?
- ☐ Is the care plan comprehensive? Does it reflect the resident's needs and preferences? How did the resident respond to care-planned interventions? If interventions weren't effective, the pain was not resolved, or the resident experienced a change of condition, was the care plan revised?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ If the resident has elected a hospice benefit, is there evidence that the resident's care is coordinated between the nursing home and the hospice? This includes aspects of pain management, such as:
  - Choice of palliative interventions;
  - Responsibility for assessing pain and providing interventions; and
  - Responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

Pain Recognition and Management Critical Element Pathway

Critical Element Decisions:

1) Did the facility identify, treat, monitor, and manage the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences?
If No, cite F697

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Advance Directives (CA), Choices (CA), Notification of Change F580, Accommodation of Needs (Environment Task), Professional Standards F658, Related Quality of Care (e.g., Dental, Hospice, Pressure Ulcers, Positioning/Mobility/ROM), Unnecessary Medications (CA), Physician Supervision F710, Pharmacy Services F755, Medical Director F841, Resident Records F842.

Physical Restraints Critical Element Pathway

Use this pathway:

- When a resident's clinical record reflects the use of a physical restraint;
- If the survey team observes a position change alarm or device or practice that restricts or potentially restricts a resident's freedom of movement;
- If the resident or other individuals report that a restraint is being used on the resident; or
- If an allegation of inappropriate use of a physical restraint is received.

NOTE: For concerns related to involuntary seclusion, see the Investigative Protocol under Tag F603.

Review the following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, E, G*G*, J, and P.
- ☐ Practitioner's orders (e.g., medical symptom being treated, type of restraint, frequency of releasing the restraint).
- ☐ Care plan (e.g., medical symptoms justifying use of restraint, type of restraint used, frequency, duration, circumstances for when it is to be used, interventions to address potential or actual complications from restraint use such as increased incontinence, decline in ADLs or ROM, increased confusion, agitation, or depression).

Observations:

- ☐ If use of a device is indicated in the care plan, how are care-planned interventions implemented?
- ☐ Is the resident's movement restricted? If so, describe.
- ☐ When was the method used, by whom, and how did staff communicate or respond to the resident during the time of observations? Examples include:
  - Placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed;
  - Tucking in or fastening a sheet, fabric, or clothing tightly so that a resident's freedom of movement is restricted;
  - Placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently;
  - Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and/or that prevent the resident from rising; or
- ☐ Is the restraint used for discipline or results in convenience for staff? Examples include:
  - In response to a resident's wandering behavior, staff become frustrated and restrain a resident to a wheelchair;
  - When a resident is confused and becomes combative when care is provided and staff hold the resident's arms and legs down to complete the care (NOTE: This example differs from an emergency situation where staff briefly hold a resident for the sole purpose of providing necessary immediate medical care ordered by a practitioner); or
  - Staff place a resident in a bean bag chair, in the absence of a medical symptom, and the resident is unable to get out of it, which is potentially more convenient for staff.
- ☐ Are there any physical or psychosocial reactions to the use of any devices/practices? Examples include:

- Holding down a resident in response to a behavioral symptom or during the provision of care.

☐ How does the resident request staff assistance (e.g., access to the call light, calling out to staff for help, grabbing at staff walking by)? How does staff respond to the resident?

☐ How often are staff monitoring the resident?

☐ How often is the resident taken to the bathroom, ambulated, or provided exercises or range of motion?

☐ When the restraint is released, who released the restraint, for how long, and how often?

☐ Is there a position change alarm in use? If so, why? What is the impact to the resident? For example, is the resident hesitant or afraid to move to avoid setting off the alarm?

- Attempts to release/remove a device (e.g., pulling, picking, twisting);
- Verbalizing anger/anxiety due to restricted movement;
- Calling out for help to take a device off;
- Fear of moving since it could trigger the sound of a position change alarm; or
- Attempting to stand up out of a chair (e.g., bean bag, recliner)?

☐ If staff said the resident can remove the restraint, request that staff ask the resident to demonstrate how he/she releases the restraint without staff providing specific instructions for the removal.

☐ During high activity times in the facility (e.g., getting ready in the morning, meal times, bathing), how do staff respond to residents who are wandering or confused?

Resident, Resident Representative, or Family Interview: When conducting interviews, describe the device/practice instead of using the term "restraint" since the interviewee may not recognize that a restraint was/is being used. Note: A resident may have a restraint in place that the facility has stated can be removed by the resident. For safety reasons, do not request that the resident remove the restraint, but rather, request that staff ask the resident to demonstrate how he/she releases the restraint without staff providing specific instructions for the removal.

☐ Can you explain why you have the device?

☐ Who requested the device and why?

☐ Prior to the use of the device, did staff provide you with information regarding:

- Why the device would be used;
- The risks and benefits;
- The effects of the device on your mobility, other activities of daily living, involvement in activities and meals; and
- When and for how long the device would be used?

☐ What was tried before the device was used (e.g., less restrictive alternatives)?

☐ How were you involved in the development of the care plan for the use of the device? Does the care plan reflect your choices and preferences?

☐ How do you contact staff when you need assistance when the device is used? How does staff respond to requests?

☐ If there is a position change alarm in use, can you explain why the alarm is in use? How does it make you feel? Does the use of the alarm change how you move? If so, describe.

☐ Have you had any problems when the device is being used? If so, please describe.

☐ For the resident representative, if a physical restraint was used when imminent danger was present, when did staff notify you? What did staff tell you about the use of the restraint (e.g., type/method)? Did staff explain when the restraint would be discontinued? If not, did staff explain why the restraint continues to be used?

Physical Restraints Critical Element Pathway

Staff Interviews (Nursing Aides, Nurses, DON, as appropriate): When conducting interviews, describe the device/practice instead of using the term "restraint" since the interviewee may not recognize that a restraint was/is being used.

- ☐ Why is this device being used for this resident?
- ☐ Have you had any training on the use of device?
- ☐ How has the use of this device impacted how you provide care to this resident?
- ☐ When did the use of the device begin?
- ☐ What is the rationale (i.e., medical symptoms) for selecting this device?
- ☐ What are the risks and benefits of using the device for this resident?
- ☐ What measures were attempted before the device was started?
- ☐ How often is the device applied, for how long, and under what circumstances is it to be used?
- ☐ How often is the device removed?
- ☐ How do you respond to the resident's request to remove the device?
- ☐ If you observe the resident trying to remove the device, verbalizing anger/anxiety, calling out for help to take the device off, pulling, picking, or twisting at the device; ask staff: How often does this occur? Has this been reported and to whom? Were care plan changes made and implemented?
- ☐ How do you monitor the resident when the device is used?
- ☐ What is the resident's functional ability (e.g., bed mobility and transfer ability to and from bed or chair, and to stand and toilet)?
- ☐ Has the resident had any physical or psychosocial changes related to the use of the device? If so, describe.
- ☐ Are you assigned to provide care for other residents that use devices/restraints? Describe how you manage your time to meet the residents' needs. Describe any training you've received in how to provide care for a resident with behavioral concerns?
- ☐ What are the facility's protocols for the use of the restraint/device (e.g., restraint policy)?
- ☐ If there is a personal alarm or position change alarm in use, why is the alarm used? What is the impact to the resident? For example, is the resident hesitant or afraid to move to avoid setting off the alarm?

For **licensed staff**, ask:

- ☐ How do you supervise staff to assure that the device is applied correctly and released, as ordered?
- ☐ If the resident had any physical or psychosocial changes related to the use of the device, how were care-planned interventions revised to address the changes? Was the attending practitioner notified of changes? What was the response?
- ☐ How often do you evaluate and assess the resident to determine the ongoing need for the use of the restraint for the treatment of the medical symptoms?
- ☐ What is the plan for reducing the use of the device, including ongoing assessment of the resident, revising the plan as necessary, and attempting other interventions to minimize or eliminate the use of the restraint? What was the resident's response to other interventions?
- ☐ How are staff assigned to monitor, care for, and be familiar with residents' behaviors (e.g., the number, location, and consistency of staff assigned across different shifts/units)?

Physical Restraints Critical Element Pathway

Record Review (Review the resident's record to determine):

- ☐ What is the specific medical symptom justifying the use of the restraint or device that restricts the resident's movement (physically or psychosocially).
- ☐ If the assessment identified whether the medical symptom could be eliminated or reduced, without the use of the device.
- ☐ What risks and benefits, if any, were identified for the use of the device.
- ☐ What interventions, including less restrictive alternatives, were attempted and whether the interventions were successful in meeting the resident's assessed needs.
- ☐ What information was provided and when to the resident or representative regarding the identification of a medical symptom requiring the use of the device, the risks and/or benefits, the least restrictive interventions, and when and for how long the device was going to be used.
- ☐ Whether the resident/resident representative was involved in the development of the care plan related to the use of the device in accordance with his/her preferences and choices.
- ☐ What is the resident's current functional ability including strength and balance such as bed mobility, ability to transfer between bed or chair, and to stand or go to the bathroom.
- ☐ Whether there was a decline in physical or psychosocial functioning that may be related to the use of device (e.g., decline in ROM, pain, hydration, weight loss, continence status, muscle strength or balance, confusion, withdrawal, agitation, or depression) and if so, whether the care planned interventions were revised and implemented to address the decline.
- ☐ Whether the resident had any injuries, or potential injuries, that occurred during the use of the device and if so, the facility's response.
- ☐ Whether there was a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan) and if so, if and when the MDS significant change comprehensive assessment was conducted.
- ☐ Who provides monitoring for the use of the device and how monitoring is provided for the implementation of interventions, such as when and how often the device is released and assistance provided for going to the bathroom, ambulation, and ROM.
- ☐ What ongoing assessment and evaluation for the treatment of the medical symptom was conducted related to the use of the device.
- ☐ What interventions have been attempted and evaluated to minimize/eliminate the use of the device and address the medical symptom/underlying problems causing the medical symptom.
- ☐ Whether there is any indication that the device is used for the purpose of discipline or staff convenience.
- ☐ If concerns are identified, review the facility policy related to the use of restraints or the device.
- ☐ If a position change alarm is in use, what is the rationale for its use, and impact on the resident.

Physical Restraints Critical Element Pathway

Critical Element Decisions:

1) Did the facility ensure all of the following:
   - Ensure that the resident is free from physical restraints imposed for discipline or staff convenience;
   - Identify the medical symptom being treated when using a device or a facility practice that meets the definition of physical restraint;
   - Define and implement interventions according to standards of practice during the use of a physical restraint that is used for treatment of a medical symptom;
   - Provide the least restrictive restraint for the least time possible;
   - Provide ongoing monitoring and evaluation for the continued use of a physical restraint to treat a medical symptom; and
   - Develop and implement interventions for reducing or eventually discontinuing the use of the restraint when no longer required to treat a resident's medical symptoms?

   If No, cite F604

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed therefore a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to consider: Dignity (CA), Right to be Informed F552, Right to Participate In Care F553, Accident Hazards (CA), Bed Rails F700, Behavioral-Emotional Status (CA), Unnecessary/Psychotropic Medications (CA), Sufficient and Competent Staffing, Medical Director F841, Resident Records F842, QAA/QAPI (Task).

Pressure Ulcer/Injury Critical Element Pathway

Use this pathway for a resident having, or at risk of developing, a pressure ulcer (PU) or pressure injury (PI) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

Review the following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive *and most recent quarterly (if the comprehensive isn't the most recent)* MDS/CAAs for Sections C, G*G*, H, J, K, M.
- ☐ Physician's orders (e.g., wound treatment) and treatment record (TAR).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection, or pressure injury history).

Observations:

- ☐ Observe wound care and assess the wound (observe as soon as possible)
  - Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan?
  - Is there pain during wound care? If so, what did the nurse do?
  - Does the wound look infected?
  - Use of clean gloves and clean technique for each resident. When treating multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (e.g., in the perineal region).
  - Remove gloves and decontaminate hands between residents.
  - Staff ensure that if perineal or incontinence care is performed gloves are used, then visibly soiled dressing is removed, hand hygiene is performed, and clean gloves are donned before clean dressing is applied.
  - Clean wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications such as ointments, creams should be dedicated to one resident).
  - Is hand hygiene and approved glove use practiced when providing wound care? Are precautions taken to not unnecessarily contaminate the wound or clean equipment and supplies during resident care?
  - Are reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?
  - Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing wet or soiled? What did staff do?
- ☐ How are care planned interventions being implemented?
- ☐ How are staff following the care plan?
- ☐ Is the resident repositioned timely and in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI?
- ☐ Use of proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction.
- ☐ Pressure relief devices are in place and working correctly and are used per the manufacturer's instructions.
- ☐ Does the resident show signs of PU/PI related pain?
- ☐ Are ordered nutritional interventions implemented (e.g., supplements and hydration)?

Pressure Ulcer/Injury Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ Did your wound develop in the facility? If so, do you know how it occurred?
- ☐ Has staff talked to you about your risk for the wound and how they plan to reduce the risk?
- ☐ How are they treating your wound?
- ☐ Is the wound getting better? If not, describe.
- ☐ How has your wound caused you to be less involved in activities you enjoy?
- ☐ How has your wound caused a change in your mood or ability to function?
- ☐ How did the facility ensure you had a choice in how your wound would be treated?
- ☐ How often are dressings changed or treatment applied?
- ☐ Does your wound hurt? Do you have pain with wound care or when the dressings are changed? If so, what does staff do for your pain?
- ☐ What types of interventions are done to help heal your wound? Ask about specific interventions (e.g., positioned q2h, use of pressure redistribution devices or equipment).
- ☐ If you know the resident refused care: Did staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?

Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner):

- ☐ What, when, and to whom do you report changes in skin condition?
- ☐ Does the resident have a PU? If so, where is it located?
- ☐ How are you made aware of the resident's daily care needs?
- ☐ What PU interventions are used?
- ☐ Does the resident have pain? If so, how is it being treated?
- ☐ Has the resident had weight loss, dehydration, or acute illness? If so, what interventions are in place to address the problem?
- ☐ Is the resident currently on any transmission-based precautions?
- ☐ Has there been a change in the resident's overall function and mood?
- ☐ Ask about any observation concerns.
- ☐ Is the resident at risk for the development of PU/PI?
- ☐ How and how often is the resident's skin assessed and where is it documented?
- ☐ When did the current PU/PI develop? What caused the PU/PI?
- ☐ What interventions were in place before the PU/PI developed?
- ☐ Who was notified of the PU/PI and when were they notified?
- ☐ What is the current treatment ordered by the physician?
- ☐ What do you do if the resident refuses care?
- ☐ Is the PU/PI improving?
- ☐ How is pain related to the PU/PI assessed? And how often?
- ☐ How do you inform other staff and the MD about the PU/PI status?
- ☐ How do you monitor staff to ensure they are implementing care planned interventions?
- ☐ How do you determine the appropriate interventions?
- ☐ If there are systemic concerns: What are the facility's policies and procedures regarding care, treatment, prevention, and interventions for pressure ulcers?
- ☐ Is the resident's treatment effective? Have you been contacted with any changes in the PU/PI?
- ☐ How do you monitor the resident's wound progress?
- ☐ How is the effectiveness of wound care or pressure ulcer prevention measures evaluated? And how often and by who?
- ☐ How did you involve the resident in decisions regarding treatments?
- ☐ Are wound care protocols used? If so, describe.

Pressure Ulcer/Injury Critical Element Pathway

Record Review:

- ☐ Review nursing notes and/or skin assessments. Did the resident have any unhealed pressure ulcers? Does the skin assessment include an evaluation of the resident's skin integrity which helps to define prevention strategies?
- ☐ Documentation of the resident's nutritional needs related to wound healing.
- ☐ Have nutrition and hydration interventions been put in place?
- ☐ Review laboratory results pertinent to wound healing.
- ☐ Was the MDS accurately coded to reflect the resident's condition at the time of the assessment? Was a CAA completed to assess the preliminary information gathered in the MDS and determine care planning decisions?
- ☐ Was a baseline care plan in place within 48 hours of admission, for a resident who was admitted at risk for or had a pressure ulcer on admission?
- ☐ Was a comprehensive care plan developed? Does it address identified needs, measurable goals, resident involvement and choice, and interventions to heal/prevent pressure ulcers (e.g., pressure relief devices, treatment, and repositioning)? Has the care plan been revised to reflect any changes in PU?
- ☐ Are interventions and preventive measures for wound healing documented, appropriate, monitored, evaluated, and modified as necessary?
- ☐ If the resident refuses or resists staff interventions, determine if the care plan reflects efforts to find alternatives to address the needs identified in the assessment.
- ☐ Has the physician-ordered treatment been evaluated for effectiveness, modified, or changed as appropriate and/or as needed? Was the IDT involved?
- ☐ Does the wound care documentation reflect the condition of the wound and include the type of dressing, frequency of dressing change, and wound description (e.g., measurement, characteristics)?
- ☐ Is pain related to PU/PI assessed and treatment measures documented?
- ☐ Were changes in PU/PI status or other risks correctly identified and communicated with staff and attending practitioner?
- ☐ Review facility practices, policies, and procedures with regard to identification, prevention, intervention, care, treatment, and correction of factors that can cause PU/PI if concerns are identified.
- ☐ Was there a significant change in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

Critical Element Decisions:

1) Did the facility ensure that a resident:
   - Receives care, consistent with professional standards of practice, to prevent pressure ulcers; and
   - Does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable; and
   - Receives necessary treatment and services to promote the healing of a pressure ulcer, prevent an infection, and prevent new ulcers from developing?

   If No, cite F686

2) Did the physician evaluate and assess medical issues related to the resident's skin status and supervise the management of all associated medical needs, including participation in the comprehensive assessment process, development of a treatment regimen consistent with current standards of practice, monitoring, and response to notification of change in the resident's medical status related to pressure ulcers?
   If No, cite F710

3) Did the facility use appropriate hand hygiene practices and PPE when providing wound care?
   If No, cite F880

4) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

5) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

6) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not require OR the resident did not have a significant change in status.

7) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

8) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

9) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be informed F552, Notification of Change F580, Abuse (CA), Neglect (CA), Choices (CA), Admission Orders F635, General Pathway (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), QAA/QAPI (Task).

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Use this pathway for a resident to ensure the facility obtains and provides necessary rehabilitative or restorative services.

As referenced in 42 CFR §483.65 - Specialized rehabilitative services include but are not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), and are required in the resident's comprehensive plan of care.

As referenced in Section O of the MDS/RAI manual - Restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, H, J, and O.
- ☐ Physician's orders (e.g., therapy which includes type of treatment, frequency and duration, restorative, ADL, and contracture needs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., ADL assistance, premedication prior to therapy, therapy interventions, or restorative approach).

Observations:

- ☐ As soon as possible, observe resident receiving therapy services as required per their assessment and plan of care:
  - Were the services provided as prescribed in the care plan and as ordered?
  - How did the therapy staff take into account the resident's risk factors when providing services (e.g., orthostatic hypotension, hip replacement precautions)?
  - How does staff encourage the resident to participate to the extent possible?
  - How are staff interacting with the resident when providing these services?
  - How much staff assistance is provided to perform tasks?
- ☐ If assistive devices are needed per the care plan and orders, are these devices used correctly and assist the resident to maximize his/her independence? How are residents encouraged to use these devices on a regular basis?
- ☐ If Passive Range of Motion (PROM) exercises are performed, are resident's joints supported and extremities moved in a smooth steady manner to the point of resistance? If not, describe.
- ☐ If a resident expressed that he/she was experiencing pain during these services, how did staff address this?
- ☐ Are therapists treating more than one resident at a time? If so, how is the resident receiving the ordered services needed to improve the resident's function (e.g., therapy is doing exercises in a group and the resident only received two minutes of devoted time)?

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How and by whom were you informed regarding the therapy services you need?
- ☐ What services are your receiving and do you understand why you are receiving these services?
- ☐ With who and how did staff discuss your treatment plan and goals with you and were you allowed to provide input or changes to this plan and the goals?
- ☐ If you refused any of these services, did someone speak with you about the consequences of not receiving these services? If so, who spoke with you?
- ☐ How often and for how long do you receive these services and do you feel you have enough time during therapy to assist you in achieving your goals?
- ☐ Do you feel these services are helping you to improve? If not, why?
- ☐ Do you experience pain during therapy services? If so, what does staff do to help you relieve your pain and is this effective?
- ☐ If staff provided you with assistive devices (e.g., reacher, mobility devices, communication devices, special eating utensils):
  - Did someone show you how to use the device? If so, who?
  - Do you use it? If not, why not?
  - Do you have these devices when you need them? If not, why not?
  - Does staff encourage you to use the device?

Staff Interviews (Nursing Aides, Nurse, Therapy, DON):

- ☐ What are the current goals and interventions for the resident?
- ☐ How were the interventions determined to ensure they were suitable for the resident's needs?
- ☐ How was the resident/representative involved in decisions regarding their goals, interventions, and treatments?
- ☐ How and by whom were you trained on the resident's therapy or restorative program needs?
- ☐ How and by whom are therapy and nursing staff supervised and monitored to ensure they are implementing care planned interventions?
- ☐ How much assistance from staff does the resident need with their therapy or restorative services?
- ☐ How do you promote and encourage the resident's participation in these services?
- ☐ How often and how is the resident assessed (e.g., quarterly therapy screen) for a change in function and where is it documented?
- ☐ Does the resident have pain or shortness of breath? If so, who do you report it to and how is it being treated?
- ☐ Does the resident ever refuse therapy or restorative services? If so, why and how is this handled?
- ☐ How do you assess if the resident's ability is maintained, improving, or getting worse?
- ☐ If a resident is declining, when did this decline begin? What might have caused this decline? To whom and when was this decline reported and did the treatment plan change?
- ☐ Were there any therapy or restorative interventions in place before the decline developed? If so, what were these interventions and why did they not prove to be effective?
- ☐ Does the resident use any assistive devices? If so, what are these devices and why are they used? How is the resident educated and encouraged to use these devices?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Record Review:

- ☐ How did facility staff assess the resident's therapy and restorative status and needs?
  - Has the resident's progress including improvement or decline been assessed and documented?
  - Were the care plan and interventions revised to reflect any changes needed?
- ☐ Were therapy or restorative services provided and implemented as ordered?
- ☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Does your observation of therapy or restorative services match the level of assistance described in the resident's plan of care and clinical record? If not, describe.
- ☐ Were changes in the resident's status or other risks correctly identified and communicated with the resident, staff, and the attending practitioner?

Critical Element Decisions:

1. Based on observations, interviews, and record review, did the facility provide or obtain the required specialized rehabilitative services?
   If No, cite F825
   NA, the resident does not require specialized rehabilitation services.

2. Based on observations, interviews, and record review, did the facility provide the appropriate treatment and services as outlined in the resident's plan of care to maintain, restore or improve the functional ability for the resident?
   If No, cite F676
   NA, the resident does not have a potential to maintain or improve ADL functioning.

3. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed F552, Choices (CA), Notification of Change F580, Privacy (CA), Abuse (CA), Dignity (CA), Social Services F745, Admission Orders F635, Professional Standards F658, Community Discharge (CA), Pain (CA), Positioning/ROM (CA), ADLs (CA), Behavioral-Emotional Status (CA), Sufficient and Competent Staff (Task), Physician Delegation to Therapist F715, Qualified Rehab Person F826, Infection Control (Task), Resident Records F842, QAA/QAPI (Task).

Respiratory Care Critical Element Pathway

Use this pathway for a resident who requires or receives respiratory care services (i.e., oxygen therapy, breathing exercises, sleep apnea, nebulizers/metered-dose inhalers, tracheostomy, or ventilator) to assure that the resident receives proper treatment and care.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, J, and O.
- ☐ Physician's orders (e.g., nebulizers, inhalers, tracheostomy or ventilator interventions, times of administration, parameters for pulse oximetry).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., respiratory treatment and care, possible complications, communication, advance directives, equipment functioning and cleaning, procedures for emergencies).

Observations:

- ☐ During the provision of any type of respiratory care/services, does staff perform hand hygiene before and after respiratory care or contact with respiratory equipment and ensure appropriate PPE is used? If not, describe.
- ☐ **Respiratory Aerosolized Care (Nebulizer, Inhaler):** If concerns are noted, please describe:
  - Are sterile solutions (e.g., water or saline) used for nebulization;
  - Are single-dose vials used for only one resident;
  - If multi-dose vials are used, are manufacturer's instructions for handling, storing, and dispensing the medications followed;
  - If multi-dose vials are used for more than one resident, are vials dated when initially accessed, stored appropriately, and do not enter the immediate resident treatment area;
  - Are jet nebulizers used for only one resident? Are they cleaned and stored per facility policy, rinsed with sterile water, and air-dried between treatments on the same resident;
  - Are mesh nebulizers that remain in the ventilator circuit cleaned, disinfected, or changed at an interval recommended by manufacturer's instructions; and
  - Are nebulizers/drug combination systems cleaned and disinfected according to the manufacturer's instructions?
- ☐ **Oxygen**:
  - What is the method of delivery (liters, room air or O2);
  - Does the resident have anxiety, distress, or discomfort? How does staff intervene;
  - What type of precautions are observed (e.g., proper handling of oxygen cylinders);
  - Are "No Smoking" signs present wherever oxygen is administered; and
  - How does staff clean and sanitize equipment, tubing, and the humidifier?
- ☐ **Breathing Exercises:**
  - What breathing exercises are provided (coughing/deep breathing)? If therapeutic percussion/vibration or postural drainage is ordered, is it provided as written;
  - How does staff assess the resident's condition before and after the treatments and document respiratory rate, presence of dyspnea, signs of infection, level of cognitive functioning/ability to understand, presence of coughing, vital signs and pulse oximetry at a minimum, and the resident's response to the treatment; and
  - Does the resident's condition preclude the provision of the treatment? What does staff do (e.g., contacts the attending practitioner before providing the treatment)?

Respiratory Care Critical Element Pathway

☐ **Mechanical Ventilation or Tracheostomy:**

- Does the facility:
  - Have sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws;
  - Identify who is authorized to perform each type of respiratory care service, such as mechanical ventilation, suctioning, and tracheostomy care; and
  - Specify the type and amount of supervision required, such as during the delivery of care of a resident receiving mechanical ventilation with or without tracheostomy care.
- How does staff provide direct monitoring of the resident;
- How does the resident make his/her needs known? How does staff respond;
- Does the resident have anxiety, distress, or discomfort? How does staff intervene;
- For a resident on mechanical ventilation, is the resident positioned as ordered;
- What is the condition of the resident's oral cavity, surrounding skin hygiene, and eyes;
- How does staff provide ongoing assessment of respiratory status and response;
- What are the settings of the ventilator, availability of power sources, and condition of emergency equipment including functioning alarms and emergency sterile tracheostomy equipment of the correct size available at the bedside? What is the electrical source for the ventilator? Is a manual resuscitator available;
- How do staff respond when an alarm sounds;
- What is the condition of the tracheostomy site, including cleanliness, signs of infection/inflammation (e.g., redness, swelling, bleeding or purulent discharge, odor and character of secretions), and condition of dressings, if present?
- When changing a tracheostomy tube, does trained, qualified, competent staff (based upon State practice Acts, State law, and professional standards of practice) wear a gown, use aseptic technique, and replace the tube with the correct size and one that has undergone sterilization or high-level disinfection;
- How does staff respond if the resident has signs of an obstructed airway or need for suctioning (e.g., secretions draining from mouth or tracheostomy, inability to cough to clear chest, audible crackles or wheezes, dyspnea, restlessness or agitation);
- Are clean, working suction equipment available to a source of emergency power, available for immediate use, including sterile suction catheters;
- Is sterile water used to fill humidifiers;
- Does staff take precautions not to allow condensate to drain toward the resident;
- Is a single-use open-system suction catheter employed, and a sterile, single-use catheter used with sterile gloves;
- Is sterile fluid used to remove secretions from the suction catheter if the catheter is used for re-entry into the resident's lower respiratory tract; and
- How are machines or equipment maintained and cleaned with an appropriate disinfectant and stored (e.g., in a clean store room with a clear plastic bag or clean tag on equipment)?

Respiratory Care Critical Element Pathway

Resident, Resident Representative, or Family Interview: Determine what method is used for communication with the resident, if it is accessible and used by all staff. Using the communication method, interview the resident.

- ☐ Do you have access to call systems and communication devices? If not, describe.
- ☐ How did the facility involve you in developing care plan decisions for your respiratory care?
- ☐ How does the facility ensure care reflects your preferences and choices?
- ☐ How are your respiratory needs being met?
- ☐ What information has been provided regarding the respiratory interventions used?
- ☐ What complications have you experienced, if any? What did staff do?
- ☐ Does staff wash their hands before and after providing your care?

Staff Interviews (Nurse, DON, Respiratory staff):

- ☐ Who provides ventilation or tracheostomy care? Is it in accordance to state law, State practice Acts, and standards of practice?
- ☐ Will you explain the process for mechanical ventilation including ventilator functioning, settings, use of equipment, troubleshooting, use of emergency equipment, types of airway and care, complications or emergencies, and how to intervene?
- ☐ Who provides supervision? Who provides suctioning and emergency care?
- ☐ What special procedures are used and what do you monitor (e.g., blood pressure, blood gases, respiratory rate, suction needs, and tracheostomy care)?
- ☐ How does the resident respond to respiratory interventions?
- ☐ When and what type of training have you received, and by whom? How often are competencies assessed?
- ☐ Have you received training for:
  - Specific respiratory interventions or care, including oxygen, nebulizer treatments;
  - Emergency interventions and use of equipment (including storage and disposal); and
  - Specific type of modality, including mechanical ventilation, tracheostomy care, suctioning.
- ☐ When and to whom do you communicate changes in the resident's condition, respiratory care, and equipment problems such as the mechanical ventilator, tracheostomy tube?
- ☐ What are the procedures and availability of equipment and staff for emergency situations (e.g., decannulation, cardiac arrest, equipment malfunction) and who responds to alarms?
- ☐ For a resident on mechanical ventilation, is the resident at risk for accidental decannulation? What interventions are in place? Have there been any other ventilator related problems?
- ☐ Who provides ongoing monitoring of equipment, including setting and monitoring ventilation equipment settings and assuring that component alarms are functioning?
- ☐ Who is responsible to assure that machines or equipment used for respiratory care are properly working, maintained, and cleaned with a disinfectant?
- ☐ What procedures are in place for power outages and other environmental emergencies?
- ☐ How are correct settings communicated from one staff person to another?
- ☐ Will you describe infection control practices for respiratory care?

Respiratory Care Critical Element Pathway

Record Review:

- ☐ What is the resident's respiratory status?
- ☐ Does the assessment reflect the resident's status that may be impacted by the respiratory care needs, such as:
  - Medical health status, including comorbidities that may affect the respiratory status, such as cognitive loss, neuromuscular or skeletal disorders, cardiovascular conditions, presence of upper or lower respiratory disorders, chronic infections, central nervous system disorders, and urinary or gastric disorders;
  - Respiratory function and identification of conditions that may be maintained or improved based upon interventions, or conditions that may indicate decline and need for specific comfort measures to meet respiratory needs;
  - Psychosocial needs such as for depression or anxiety;
  - Communication needs;
  - Oral hygiene needs and condition of the eyes;
  - Nutritional needs, bowel or bladder functioning, skin integrity, visual/hearing deficits; and
  - Advance directives.
- ☐ Does the assessment reflect the resident's mechanical ventilation status? Is there a potential for weaning? What is the resident's ADL status related to mechanical ventilation?
- ☐ Is the care plan comprehensive? Does it address identified respiratory care needs and other needs that may be impacted by respiratory care requirements, measureable goals, resident involvement, preferences, and choices? Has the care plan been revised to reflect any changes?
- ☐ Does the care plan record reflect resident specific monitoring of respiratory status, including but not limited to:
  - Type of ventilator equipment, settings, and alarms (refer to physicians orders, and manufacturers specifications for use and care); and
  - Type and size of airway and care of artificial airway.
- ☐ Does the care plan address resident specific risks for complications such as:
  - Unplanned extubation;
  - Aspiration and the potential for respiratory infection (tracheal bronchitis, ventilator associated pneumonia (VAP));
  - Nutritional complications related to tube feedings, gastric distress;
  - Increased or decreased CO2 levels;
  - Development of oral or ocular ulcers,
  - Barotrauma;
  - Deep vein thrombosis due to immobility; and/or
  - Airway complications such as tracheal infections, mucous plugging, tracheal erosion and/or stenosis.
- ☐ Does the record reflect if the resident has experienced any complications? If so, how did staff respond? Were care plan interventions changed if needed?
- ☐ Has the care plan been revised to reflect any changes?

Respiratory Care Critical Element Pathway

Record Review (continued)

☐ For **Mechanical Ventilation**:
- How does staff document equipment function:
  - Appropriate configuration/settings of the ventilator control panel;
  - Alarm function;
  - Cleanliness of filters; and
  - Cleanliness of self-inflating manual resuscitator.
- How does staff document equipment-related problems and responses:
  - Failure or malfunction of the ventilator equipment;
  - Inadequate warming or humidification of the inspired gases;
  - Inadvertent changes in ventilator settings;
  - Accidental disconnection of ventilator; and
  - Accidental decannulation.

☐ Is routine machine maintenance and care completed (e.g., water changes/tubing changes, safety checks on alarms, and machine functioning checks)?

☐ Does documentation include what ventilator equipment is used?
- Type and characteristics;
- Location and type of emergency manual resuscitator;
- Type of ventilator power source including immediate provision of emergency power in case of outage;
- Ventilator circuit (i.e., ventilator tubing, exhalation valve and attached humidifier) description, alarms, cleaning, assembly; and
- Alarms for power failure or dysfunction and for high and low pressure, exhaled volume.

☐ Does the record reflect ventilator details, with physician orders for:
- Times on and off;
- Rate of oxygen;
- Mode of ventilation;
- Changes in relation to activity level such as exercise or sleep;
- Acceptable limits of dialed/measured exhaled volume; and
- Desired pressure ranges.

☐ Does the record reflect ventilator settings used according to physicians orders for:
- Peak pressures;
- Preset tidal volume;
- Frequency of ventilator breaths;
- Verification of oxygen concentration setting;
- Positive End Expiratory Pressure (PEEP) level;
- Appropriate humidification and temperature of inspired gases; and
- Heat and moisture exchanger function.

☐ Does the record reflect the type of airway used according to physician orders (size, type, cuffed or uncuffed, double or single cannula)?

☐ Does the record reflect the care provided for an artificial airway?
- Cuff inflation (conditions for inflation/deflation);
- Airway cleaning, tube changes; and
- Assessment and ongoing monitoring of respiratory functioning including the need for tracheal suctioning and who is allowed to provide tracheal suctioning according to State laws.

☐ Does the record reflect adjunctive interventions used (medications, aerosol [bronchodilator], chest physiotherapy, oxygen therapy, secretion clearance devices)?

☐ If concerns are identified for respiratory care, review the applicable facility policy for mechanical ventilation and other respiratory care provided.

Respiratory Care Critical Element Pathway

Critical Element Decisions:

1. Did the facility provide specialized care needs for the provision of respiratory care including tracheostomy care and tracheal suctioning, in accordance with professional standards of practice, and the resident's care plan, goals, and preferences?
   If No, cite F695

2. Did the staff use appropriate hand hygiene practices and implement appropriate standard precautions?
   If No, cite F880

3. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Dignity (CA), Right to be Informed and Make Treatment Decisions F552, Notification of Change F580, Accommodations of Needs (Environment Task), Choices (CA), Right to Refuse F578, Pressure Ulcer (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Facility Assessment F838, Medical Director F841, QAA/QAPI (Task).

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Use for a resident who has potentially unnecessary medications, is prescribed psychotropic medications or has the potential for an adverse outcome to determine whether facility practices are in place to identify, evaluate, and intervene for potential or actual unnecessary medications. Use also to evaluate the medication regimen review (MRR) process.

NOTE: If the resident has a diagnosis of dementia and is receiving any psychotropic medications (including but not limited to antipsychotic medications) the surveyor should refer to the Dementia Care Critical Element Pathway as a guide to determine the facility's compliance at F744.

Review the Following in Advance to Guide Observations and Interviews:

☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for areas pertinent to the medications ordered such as adverse consequences and behaviors.

☐ Review all medications currently ordered or discontinued going back to the most recent signed recapitulation. Determine if the facility:

- ✓ **Documents an acceptable clinical indication for use.**
  - Medication is prescribed for a diagnosed condition and not being used for convenience or discipline.
  - Medication is clinically indicated to manage a resident's symptoms or condition where other causes have been ruled out.
  - Signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy.
  - Intended or actual benefit is sufficient to justify the potential risk(s) or adverse consequences associated with the medication, dose, and duration.
- ✓ **Demonstrates use of written protocols or resources to guide antibiotic use.**
  - The use of infection assessment tools for antibiotic use for one or more infections (e.g., use of a Situation, Background, Assessment and Recommendation (SBAR) communication tool for UTI assessment, application of the Loeb minimum criteria for initiation of antibiotics).
- ✓ **Demonstrates monitoring for each medication as appropriate.**
  - The following medications pose a high risk for adverse consequences and should be monitored:
    - **Opioids –** assess pain, implement bowel program.
    - **Anticoagulant –** bleeding/bruising, protime/international normalized ratio (PT/INR), interaction with other medications, facility must have policies around monitoring, lab work, communication of lab values, implementation of new orders in response to lab values and/or symptoms.
    - **Diuretics –** edema, potassium level, signs of electrolyte imbalance.
    - **Insulin –** monitoring of blood glucose levels, hemoglobin A1c (HbA1c), and symptoms of hyper/hypoglycemia.
    - **Antibiotics –** interactions with other medications (e.g., warfarin), adverse events (e.g., rash, diarrhea); prescriptions must include documentation of indication, dose, route and duration and be reviewed 2-3 days after antibiotic initiation to assess response and labs, and prescriber should reassess antibiotic selection as appropriate.

- **All psychotropics –** monitor behavioral expressions or indications of distress.

- Facility staff, along with the pharmacist and prescribing practitioner recognize and evaluate the onset or worsening of signs or symptoms, or a change in condition to determine whether these potentially may be related to the medication regimen; and follow up as necessary upon identifying adverse consequences.
- Facility staff monitor the effectiveness of each medication and make changes to the pharmacological intervention, when necessary.

✓ **Demonstrates appropriate dosing for each medication.**

- Is there documentation of a rationale for any medication that exceeds the manufacturer's recommendations, clinical practice guidelines, evidence based guidelines or standards of practice?

✓ **Documents duration for each medication.**

- Medications are not used for an excessive duration.

✓ **Documents clinical rationale for continued use for the medications, as required.**

- Tapering when clinically indicated in an effort to discontinue or reduce the dose.
- Concomitant use of two or more medications in the same pharmacological class.
- Potential incompatibilities between medications.

✓ **Demonstrates a system that monitors and addresses the presence of or potential for adverse consequences.**

- A clear clinical rationale from the attending physician/prescribing practitioner for continuing a medication that may be causing an adverse consequence, including risks and benefits.

✓ **Demonstrates a system for and documents gradual dose reduction (GDR) for psychotropic medications, unless contraindicated.**

- Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication:
  - GDR attempts in two separate quarters with at least one month between the attempts.
  - The GDR must be attempted annually thereafter unless clinically contraindicated.
  - Non-pharmacological approaches must be attempted and documented instead of using psychotropic medications, along with use of psychotropic medications, and while GDR is attempted.

✓ **Demonstrates adherence to requirements for as needed (PRN) psychotropic and antipsychotic medications.**

- Residents do not receive PRN psychotropic medications unless necessary to treat a diagnosed specific condition which must be documented in the record.
- PRN orders for psychotropic medications which **are not** antipsychotic medications are limited to 14 days. The attending physician/prescriber may extend the order beyond 14 days if he or she believes it is appropriate. If the attending physician extends the PRN for the psychotropic medication, the medical record must contain a documented rationale and determined duration.
- PRN orders for psychotropic medications which **are** antipsychotic medications are limited to 14 days. A PRN order for an antipsychotic cannot be renewed unless the attending physician/prescriber evaluates the resident to determine if it is appropriate to write a new PRN order for the antipsychotic medication. The evaluation entails direct evaluation of the resident and assessment of the

resident's current conditions and progress to determine if the PRN antipsychotic medication is still needed. Attending physician/prescribing practitioner documentation of the evaluation should address:
- Whether the antipsychotic medication is still needed on a PRN basis?
- What is the benefit of the medication to the resident?
- Have the resident's expressions or indications of distress improved as a result of the PRN antipsychotic medication?

☐ Review the care plan for medications, especially high risk medications, and individualized approaches to care, including non-pharmacological interventions.

Observations:

☐ Are care planned interventions implemented for medications that pose a high risk for adverse consequences?

☐ What non-pharmacological approaches to care are used? Are they effective?

☐ What pharmacological interventions are used? Why was the medication used and was it effective (e.g., pain is relieved, distress is addressed)?

☐ How does staff respond and interact with the resident?

☐ Does the resident continue to show expressions or indications of distress? If so, how does staff respond?

☐ Are staff using a medication for convenience or discipline? If so, describe. (For concerns related to a medication that involves an inadequate indication for use and evidence shows the medication is also being used for the purpose of discipline or convenience rather than to treat the resident's medical symptoms, surveyors should assess compliance with §483.10(e)(1) and §483.12(a)(2), F605, Right to Be Free From Chemical Restraints.)

☐ Does the resident have psychosocial, behavioral, mental, or physical adverse consequences that may be related to a medication:
- ○ Anorexia/unplanned weight changes, edema;
- ○ Decline in physical functioning (e.g., mobility or activities of daily living (ADLs));
- ○ Rash, pruritus;
- ○ Bleeding or bruising, spontaneous or unexplained;
- ○ Respiratory changes;
- ○ Bowel dysfunction (e.g., cramping abdominal pain);
- ○ Urinary retention, incontinence;
- ○ Dehydration or swallowing difficulty;
- ○ Falls, dizziness, or headaches;
- ○ Muscle/nonspecific pain or unexplained abnormal movement;
- ○ Psychomotor agitation (restlessness, pacing, hand wringing);
- ○ Psychomotor retardation (slowed speech, thinking, movement);
- ○ Subdued, sedated, lethargic, or withdrawn;
- ○ Insomnia or sleep disturbances;
- ○ Mental status changes;
- ○ Behavioral changes or unusual behavior patterns; or
- ○ Depression, apathy or mood disturbance.

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Resident, Family or Resident Representative Interview:

- ☐ What medications do you get and why do you need to take them?
- ☐ What are your goals for your medications?
- ☐ What information on the risk, benefits and potential side effects of medications were you provided?
- ☐ What changes in your medications have occurred, including gradual dose reductions for psychotropic medications?

  NOTE: Permission given by or a request made by the resident and/or representative does not serve as a sole justification for the medication itself.

- ☐ What alternatives to taking some of the medications, including non-pharmacological approaches, has staff told you about?
- ☐ Do you think the medication has helped (e.g., pain control, improvements in function, decrease in edema, mood)? If not, why?
- ☐ What side effects have you had from the medication (ask about specific medications)? Have you experienced any changes in what you are able to do since starting or changing a medication(s)? Do you have allergies to any medication(s)?
- ☐ Have you participated in discussions and/or care plan meetings about your medications?

Staff Interviews (Nursing Aides, Nurse, Director of Nursing (DON), Social Services):

- ☐ What, when, and to whom do you report changes in the resident's status (e.g., indications of distress or pain)?
- ☐ How do you learn what the resident's daily care needs are?
- ☐ What non-pharmacological approaches are used?
- ☐ What is the clinical indication for the medication?
- ☐ How does the facility monitor the medication?
  - ○ What monitoring tools or systems are used?
  - ○ How did the interdisciplinary team (IDT) determine what should be monitored?
  - ○ For psychotropic medications, how did you determine what behavior to monitor?
  - ○ How do you assure orders for medication monitoring are implemented (e.g., HbA1c, PT/INR)?
  - ○ How do you communicate relevant information regarding medication monitoring for this resident to other team members?
- ☐ How do you assess whether each medication is effective?
- ☐ Why does the resident have two medications in the same class?
- ☐ How does the IDT determine what dose and duration is clinically indicated?
- ☐ If the amount of any medication exceeds the manufacturer's recommendations, clinical or evidence-based practice guidelines, or standards of practice, what is the rationale?
- ☐ How do you monitor for significant adverse consequences?
- ☐ Has the resident had a change in condition, diet, weight loss, dehydration, or acute illness? If so, what was done to assess the possible complications for these changes due to medications?
- ☐ Has the resident had an adverse reaction? If so, what and how was the adverse reaction addressed?
- ☐ How do you evaluate whether medications should be initiated, continued, reduced, discontinued, or otherwise modified? How often is the evaluation for modification conducted?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

- ☐ How does the facility ensure a review of medications for GDRs?
- ☐ If the resident is on a psychotropic medication: When did you attempt to reduce the medication in the last year and what were the results?
- ☐ If the practitioner denied a GDR: Did the practitioner provide a risk-benefit statement describing the contraindications for a GDR?
- ☐ How do you monitor staff to ensure they are implementing care planned approaches?
- ☐ What was the rationale for the practitioner's decisions in managing the resident's medications or medication-related concerns?
- ☐ How did you involve the resident in decisions regarding medications?
- ☐ How often is the MRR conducted and are medical charts included in this review?
- ☐ Under what circumstances is the MRR conducted more often than monthly?
- ☐ Are there policies and procedures in place to address issues which include the different steps in the MRR process and steps to take when an identified irregularity requires immediate action?
- ☐ How are medication-related issues communicated to other staff, the attending practitioner or prescribing practitioner, and resident and, if appropriate, resident representative?
- ☐ How is the MRR process conducted for short-stay residents?
- ☐ Has there been a change in the resident's overall function and mood that potentially may indicate unnecessary medications or adverse reactions? If so, describe.
- ☐ If the resident is receiving PRN psychotropic or antipsychotic medication(s): How is this medication monitored and how does the IDT determine if the PRN medication is clinically indicated and ensure the PRN orders are consistent with PRN requirements for psychotropic and antipsychotic medications?
- ☐ Ask about any other related concerns the surveyor has identified.

Pharmacist Interview:

- ☐ Do you perform a monthly MRR (or more frequently if needed)?
- ☐ Do you include each resident's medical record in this monthly review?
- ☐ How do you evaluate PRN medications, specifically PRN psychotropic and antipsychotic medications?
- ☐ What are you reviewing (e.g., adequate indication, dose, continued need, and adverse consequences)?
- ☐ Did you identify and report to the attending physician, medical director, and DON any irregularities with this resident's medication regimen? Did you use a separate, written report?
- ☐ If the pharmacist didn't identify a specific issue, ask why the issue was not identified as an irregularity on the MRR.
- ☐ What is the MRR process for short-stay residents?
- ☐ What protocols to do you have in place (e.g., lab to monitor for adverse events and drug interactions related to use of antibiotics and other high-risk medications)?
- ☐ Are you part of the IDT who reviews this resident's medication?
- ☐ What steps do you take when an irregularity requires immediate action? Are these steps part of facility policy?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Attending Practitioner, Medical Director, and DON Interviews:

- ☐ Did you receive a written report of irregularities identified during the MRR?
- ☐ Did you make a change in the resident's medication in response to the identified irregularity(ies) or document a rationale if you didn't make a change in the medication regimen?
- ☐ What is the rationale behind why the medication is being used (e.g., antipsychotic for dementia or other high risk medications)?
- ☐ What other approaches were attempted prior to the use of a psychotropic medication and/or while attempting a GDR?
- ☐ When was a GDR last completed? What was the result?
- ☐ Are you included in the IDT meeting for this resident?

Record Review:

- ☐ Was the underlying cause (medical, environmental, or psychosocial stressors) of the conditions or symptoms requiring the medication identified?
- ☐ If a medication was discontinued, was there evidence of a GDR, if applicable (e.g., for psychotropic and antipsychotic medications)?
- ☐ Did the pharmacist conduct an MRR for the resident at least once a month that included a review of the resident's medical record?
- ☐ Did the pharmacist identify and report all medication irregularities to the attending physician, medical director, and DON? Were the irregularities documented on a separate, written report? Were the reports acted upon?
- ☐ Did the attending physician document in the medical record that the irregularity was reviewed? What, if any, action was taken? What rationale was documented if no change was made to the medication regimen?
- ☐ If the resident had a change in condition such as, dehydration or acute illness, was the medication regimen reviewed? Did the pharmacist complete a MRR?
- ☐ Is there evidence of actual or potential adverse events, such as allergic reactions, inadequate monitoring? (Refer to the CMS Adverse Drug Event Trigger Tool).
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Is the MAR accurate, complete and followed according to standards of practice?
- ☐ For antibiotics: Are signs or symptoms of infection documented? Have appropriate diagnostic tests been obtained to inform antibiotic selection and continuation?
- ☐ What is the facility response when monitoring indicates a lack of progress toward the therapeutic goal?
- ☐ What individualized, non-pharmacological approaches were documented, specifically for residents who receive psychotropic medications?
- ☐ Review the facility's policies regarding psychotropic medications and MRR. Are they updated and maintained? Does the policy include timeframes for the steps in the process? Does the policy include the steps the licensed pharmacist must take for a medication irregularity that requires urgent action?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Critical Elements Decisions:

1. For the **Medication Regimen Review (MRR)**:
   A. Did the licensed pharmacist:
      - Conduct an MRR, at least monthly, that included a review of the resident's medical record;
      - Conduct an MRR more frequently, as needed; and
      - Report irregularities to the attending physician, medical director, and the DON?

   B. Did the attending physician document:
      - Review of identified irregularity(ies);
      - The action, if any, taken;
      - A rationale if no action is taken?

   C. Has the facility developed and implemented MRR policies and procedures?
      - Do they address, at a minimum:
        - Time frames for steps in the MRR process;
        - Steps the pharmacist must take when an irregularity requires urgent action.

   If No to any of the above, cite F756

2. For **Unnecessary Medications**: Did the facility ensure that each resident's medication regimen was free from unnecessary medications? (Note: If the unnecessary medication is a psychotropic medication, cite F758)
   If No, cite F757

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

3. For **Psychotropic Medications**, did the facility ensure that:
   - they are used only to treat a specific, diagnosed, and documented condition;
   - a GDR was attempted, unless clinically contraindicated, and non-pharmacological approaches to care were implemented;
   - PRN use is only if necessary to treat a specific, diagnosed, and documented condition;
   - PRN orders for psychotropic medications which **are not** for antipsychotic medications are limited to 14 days,unless the attending physician/prescribing practitioner documents a rationale to extend the medication;
   - PRN orders which **are** for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner did not renew the order without first evaluating the resident?

   If No to any of the above, cite F758
   NA, the resident was not prescribed psychotropic medications.

4. Did the facility conduct ongoing review for antibiotic stewardship?
   If No, cite F881

5. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655.
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

6. If the condition or risks related to medications were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

7. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed therefore a significant change in status assessment is not required OR the resident did not have a significant change in status.

8. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

9. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

10. Did the facility reassess the effectiveness of the approaches and review and revise the resident's care plan (with input from the resident and, if appropriate, the resident representative) to meet the resident's needs?
    If No, cite F657
    NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed and Participate F552, F553, Notification of Change F580, Chemical Restraints F605, Choices (CA), Social Services F745, Admission Orders F635, Professional Standards F658, Pain (CA), General Pathway (CA) for Diabetic Management, Dementia Care (CA), ADLs (CA), Urinary Incontinence (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, F711, Pharmacy Services F755, QAA/QAPI (Task).

Hydration Critical Element Pathway

Use this pathway for a resident at risk for or who has experienced dehydration.

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, J, K, L, N, and O.
- ☐ Physician's orders (e.g., fluid restrictions, intake and output monitoring, IV (parenteral) fluids, fluid consistency, labs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., risk factors, preventative care to promote a specific amount of fluid intake each day, monitoring of daily fluid intake and when to report deviations, staff assistance or encouragement needed to meet hydration needs, minimizing aspiration risk, assistive devices needed for drinking skills, hydration interventions to provide fluid intake between and with meals that account for resident preferences and assessment, rehab or restorative to promote improvement in ability to drink, interventions to accommodate fluid restrictions or intolerances, and interventions to address refusals).

Observations:

- ☐ Observe for signs that indicate altered hydration status:
  - Decreased, absent, or concentrated urine output
  - Complaints of dry eyes
  - Poor oral health
  - Poor skin elasticity
  - Dry chapped lips, tongue dryness, longitudinal tongue furrows, dryness of mucous membranes
  - Sunken eyes
- ☐ How are care planned and ordered interventions implemented?
- ☐ Are IV fluids being given? If so, are staff following the order?
- ☐ Are residents able to access fluids (e.g., fluids at the bedside, staff offering and encouraging fluids throughout the day, opening fluids at meals)?
- ☐ Does staff assist the resident to drink fluids if needed during meals and throughout the day? If not, describe.
- ☐ Are assistive drinking cups provided, if needed? If not, describe.
- ☐ How does staff respond if the resident refuses fluids or assistance?
- ☐ Are staff alert to the reduced fluid intake and how do they respond?

Resident, Resident Representative, or Family Interview:

- ☐ Do you have any concerns with persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions, or acute illness? If so, describe.
- ☐ Can you tell me about any recent change in your condition or how you feel (e.g., sudden confusion)?
- ☐ Are you taking meds that affect your taste (e.g., chemotherapy, digoxin, antibiotics)? Have your meds changed recently?
- ☐ How did the facility ensure your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances?
- ☐ Does staff encourage you or help you, as necessary, to drink throughout the day? Please explain.
- ☐ Has your ability to drink changed? Are you getting therapy or restorative to help increase your ability to drink on your own? How is it going?

Hydration Critical Element Pathway

- ☐ Can you tell me about any dental issues, oral pain or other pain that is interfering with your fluid consumption?
- ☐ If the resident was treated for dehydration or has poor fluid intake: Why do you think you were dehydrated or don't drink enough?
- ☐ How did the facility involve you in the development of the care plan and goals?
- ☐ Do they provide you with assistive devices if you need it? If not, what concerns are you having?
- ☐ If you refuse fluids, what does staff do? What education have they provided on consequences of refusing fluids?

Staff Interviews (Nursing Aides, Dietary Staff, Nurses, DON):

- ☐ How do you monitor the resident's fluid intake, including enteral feeding if applicable?
- ☐ What potential hydration deficits has the resident experienced (skin lacks elasticity, persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions or acute illness, reduced sense of thirst, poor fluid intake)?
- ☐ What other limitations or factors impact the resident's hydration (e.g., difficulty getting to the bathroom, medications (diuretics), dialysis, restraint use, fluid restriction, or end of life)?
- ☐ How much assistance or encouragement does the resident need to drink?
- ☐ How do you ensure the resident is provided with adequate fluids?
- ☐ What, when, and to whom do you report changes in fluid intake?
- ☐ What have you done to address the resident's refusal to drink (e.g., provide liquids in a different form like popsicles, or soup)?
- ☐ Who from the dietary staff attends the IDT meetings?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Record Review:

- ☐ What new or existing conditions or diagnoses does the resident have that affect overall intake?
  - Malnutrition, dehydration, cachexia, or failure-to-thrive.
  - Problems with teeth, mouth, gums, or swallowing problems.
  - Decreased kidney function or urine output, renal disease.
  - Decreased thirst perception, increased thirst, change in appetite, anorexia.
  - Cognitive or functional impairment (e.g., dysphagia, dependency on the staff for ADLs, inability to communicate needs).
  - Terminal, irreversible, or progressive conditions (e.g., incurable cancer, severe organ injury or failure, AIDS).
  - Constipation, impactions or diarrhea.
- ☐ Did the facility adequately assess the resident's hydration status?
  - Baseline hydration status (height, weight, BMI).
  - Underlying factors affecting hydration status.
  - Calculation of fluid needs based on clinical condition, including free water for enteral feedings.
  - Adequacy of fluid intake.
- ☐ Do lab values suggest dehydration (ratios of BUN to creatinine of 25 or more, serum sodium level greater than 148 mmol/L)? If so, describe.
- ☐ What interventions were implemented to address the dehydration (e.g., IV fluids)?

Hydration Critical Element Pathway

- Pressure ulcers and other chronic wounds, fractures.
- COPD, pneumonia, diabetes, cancer, hepatic disease, CHF, infection, fever, nausea/vomiting, orthostatic hypotension, hypertension.
- Psychiatric concerns, significant changes in behavior or mood.
- Lethargy or confusion.

☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

☐ Did the facility identify the factors contributing to or causing the resident to refuse? What alternative efforts were made to address hydration needs?

☐ How does staff monitor I&O if the resident is on fluid restrictions and it's ordered?

☐ How are staff monitoring the resident's fluid intake at meals?

☐ Is the resident receiving therapy or restorative as ordered? If not, describe.

☐ Is the care plan comprehensive? How did the resident respond to care planned interventions? If interventions weren't effective, was the care plan revised?

Critical Element Decisions:

1. Based on observation, interviews, and record review, did the facility provide each resident with sufficient fluid intake to maintain proper hydration and health?
   If No, Cite F692

2. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident or resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

6. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Participate in Planning Care F553, Notification of Changes F580, Parenteral/IV Fluids (F694), Advanced Directives (CA), ADLs (CA), Physician Supervision F710, Physician Delegation to Dietitian/Therapist F715, Food and Drink F807, Resident Records F842, QAA/QAPI (Task).

Tube Feeding Status Critical Element Pathway

Use this pathway for a resident who has a feeding tube.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, GG, J, K, and O.
- ☐ Physician's orders (e.g., kind of feeding and its caloric value, volume, rate, duration, and mechanism of administration [e.g., gravity or pump], water flushes, medications, therapy or restorative for swallowing or feeding skills).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., order for tube feeding; oral care; alternatives if the resident refuses or resists staff interventions to consume foods, fluids or enteral feedings; monitoring intake of foods and fluids daily and when to report deviations; how often weights are to be monitored if weight falls out of usual body weight parameters; rehabilitative/restorative interventions and specific measures, such as assistive devices, to promote involvement in improving functional skills; and the necessary interventions to prevent complications from the tube feeding such as aspiration, dislodgment, infection, pneumonia, fluid overload, fecal impaction, diarrhea, nausea, vomiting).

Observations:

- ☐ When does staff initiate, continue, and terminate feedings?
- ☐ Does the resident's level of alertness and functioning permit oral intake? If not, describe.
- ☐ Are assistive devices and call bells available for the resident who is able to use them? How does staff provide assistance for the resident who is dependent?
- ☐ How does staff try to minimize the risk for complications including:
  - Physical complications (aspiration, leaking around the insertion site, intestinal perforation, abdominal wall abscess or erosion at the insertion site);
  - Implementing interventions to minimize the negative psychosocial impact that may occur as a result of tube feeding;
  - Providing mouth care, including teeth, gums, and tongue;
  - Checking that the tubing remains in the correct location consistent with facility protocols;
  - Elevating the head of bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated;
  - Using standard precautions and clean technique and following the manufacturer's recommendations when stopping, starting, flushing, and giving medications through the feeding tube;
  - Ensuring the cleanliness of the feeding tube, insertion site, dressing (if present) and nutritional product;
  - Providing the type, rate, volume, and duration of the feeding as ordered by the practitioner and consistent with the manufacturer's recommendations;
  - Checking gastric residual volumes (GRV) and contacting the resident's physician per facility policy or as ordered;
  - Ensuring that additional water ordered for flushes or additional hydration is administered per order;
  - Staff examining and cleaning the skin site around the feeding tube and equipment;
  - Storing feeding syringes in a clean area. When reused should be labeled with resident's name and date opened; rinsed with hot water after each use; and disposed of within 24 hours.

Tube Feeding Status Critical Element Pathway

- ☐ How does staff respond if there is evidence of possible complications, such as diarrhea, nausea, vomiting, abdominal discomfort, nasal discomfort (if a nasogastric tube is being used); evidence of leakage or skin irritation at the tube insertion site; or risk of inadvertent removal of the tube?
- ☐ During the provision of care, what are staff practices for handling, hang-time, and changing tube-feeding bags? Is it consistent with standards of practice for infection control and manufacturer instructions?
  - Does staff wash hands thoroughly and apply clean gloves before handling the formula, delivery system, or feeding tube;
  - How does staff maintain a clean work area, equipment, and delivery system;
  - Does staff not touch any part of delivery system that comes into contact with the formula? Do they maintain proper storage and handling of the formula;
  - How does staff maintain proper temperature of formula during storage and delivery? Do they cover opened, unused formula, and store it in the refrigerator per facility policy; and
  - Does staff avoid adding water, colorants, medications, or other substances directly to the formula? If not, describe.
- ☐ How are medications administered via the tube? Are staff following physician's orders and standards of practice?
- ☐ How does staff verify the amount of fluid and feeding administered independent of the flow rate established on a feeding pump, if used (e.g., labeling the formula with the date and time the formula was hung and flow rate)?
- ☐ How does staff implement care-planned interventions?
- ☐ How does staff provide therapy or restorative care to improve swallowing or feeding skills, if indicated?
- ☐ Is the resident resistant to assistance or refusing food or liquids? How does staff respond?

Tube Feeding Status Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How does staff involve you in the development of the care plan including goals and approaches?
- ☐ How does staff ensure the interventions reflect your choices and preferences?
- ☐ How have you responded to the tube feeding?
- ☐ How did staff try to maintain your food intake prior to inserting a feeding tube (e.g., identifying underlying causes of anorexia, hand feeding, changing food consistency, texture, form, offering alternate food choices, or providing assistive devices)?
- ☐ What did staff tell you about the relevant benefits and risks of tube feeding? How were you involved in discussing alternatives and making the decision about using a feeding tube?
- ☐ What significant physical, functional, or psychosocial changes have you experienced? What has staff done to address any concerns?
- ☐ Has staff talked to you about the continued necessity of the feeding tube?
- ☐ How have you felt since the feeding tube was placed?
- ☐ Have you had recent nausea, vomiting, diarrhea, abdominal cramping, inadequate nutrition, or aspiration? If so, what did staff do?
- ☐ What is the facility doing to help you eat again, if possible?
- ☐ Has the tube accidentally dislodged? If so, what happened? How did staff respond?
- ☐ If the resident has a naso-gastric tube: How long do you expect to have the naso-gastric tube? What did staff tell you about the possibility of a gastrostomy tube?

Staff Interviews (Nursing Aides, Nurse, DON, Practitioner)

- ☐ What was the cause of the decreased oral intake/weight loss or impaired nutrition? What attempts were made to maintain oral intake prior to the insertion of a feeding tube?
- ☐ What risks and benefits were discussed with the resident or resident representative before consent was obtained to insert tube? What alternatives to the feeding tube were discussed?
- ☐ What are the specific care needs for the resident (e.g., special positioning, personal care, insertion site care, amount of feeding taken in)?
- ☐ How did you determine what the resident's nutritional and hydration needs are? How do you ensure the resident's nutritional and hydration needs are being met, such as periodically weighing the resident? How did you decide whether the tube feeding was adequate to maintain acceptable nutrition and hydration parameters or when to reevaluate and make adjustments?
- ☐ What complaints have been voiced or exhibited by the resident? What physical or psychosocial complications has the resident experienced that may be associated with the tube feeding (e.g., nausea or vomiting, diarrhea, pain associated with the tube, abdominal discomfort, depression, withdrawal)? How have these concerns been addressed?
- ☐ How do you ensure the care plan is implemented correctly?

Tube Feeding Status Critical Element Pathway

- ☐ What periodic reassessment and discussion with the resident or resident representative has occurred regarding the continued appropriateness/necessity of the feeding tube?
- ☐ How do you monitor and check that the feeding tube is in the right location?
- ☐ How do you provide care for the feeding tube (e.g., how to secure a feeding tube externally, provision of needed personal, skin, oral, and nasal care to the resident, how to examine and clean the insertion site, and whether staff can define the frequency and volume used for flushing)?
- ☐ What conditions and circumstances would require a tube to be changed?
- ☐ How do you manage and monitor the rate of flow (e.g., use of gravity flow, use of a pump or period evaluation of the amount of feeding being administered for consistency with orders)?
- ☐ Are staff who are providing care and services to the resident who has a feeding tube aware of, competent in, and utilizing facility protocols regarding feeding tube nutrition and care? If not, describe.
- ☐ What, when, and to whom do you report concerns with tube feedings or potential complications from tube feeding?
- ☐ What do you do if the resident requests food or fluids and they are NPO?

Interview Staff Responsible for Oversight and Training:

- ☐ How did the facility determine the resident was at risk for impaired nutrition, identify and address causes of impaired nutrition, and determine that use of a feeding tube was clinically indicated?
- ☐ What circumstances led to the placement of the feeding tube (e.g., if/when the tube was placed in another facility)?
- ☐ What were the calculated nutritional needs for the resident? How do you ensure that the resident receives close to the calculated amount of nutrition daily?
- ☐ How does staff monitor the resident for the benefits and risks related to a feeding tube? How have you addressed adverse consequences of the feeding tube (e.g., altered mood, nausea and vomiting, pain, or restraint use to try to prevent the resident from removing the feeding tube)?
- ☐ How are staff trained and directed regarding management of feeding tubes, tube feedings in general, and in addressing any specific issues related to this individual resident?
- ☐ How does the facility periodically reassess the resident for the continued appropriateness/necessity of the feeding tube? How do you ensure the care plan was revised and implemented, as necessary, with input from the resident or resident representative?
- ☐ Note: If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.

Tube Feeding Status Critical Element Pathway

Record Review:

- ☐ Review MDS, CAAs, tube feeding records, interdisciplinary progress notes, and any other available assessments regarding the rationale for feeding tube insertion and the potential to restore normal eating skills, including the interventions tried to avoid using the feeding tube before its insertion, restore oral intake after tube insertion, and prevent potential complications.
- ☐ What is the clinically pertinent rationale for using the feeding tube?
  - What was the assessment of the resident's nutritional status, which may include usual food and fluid intake, pertinent laboratory values, appetite, and usual weight and weight changes;
  - What was the assessment of the resident's clinical status, which may include the ability to chew, swallow, and digest food and fluid; underlying conditions affecting those abilities (e.g., coma, stroke, esophageal stricture, potentially correctable malnutrition that cannot be improved sufficiently by oral intake alone); factors affecting appetite and intake (e.g., medications known to affect appetite, taste, or nutrition utilization); and prognosis;
  - What relevant functional and psychosocial factors (e.g., inability to sufficiently feed self, stroke or neurological injury that results in loss of appetite, psychosis that prevents eating) does the resident have;
  - What interventions were tried prior to the decision to use a feeding tube? What was the resident's response to them;
  - What was the calculation of free water for residents being fed by a naso-gastric or gastrostomy tube;
  - Are there plans for removal of a tube, including the functional status of the resident and anticipated level of participation with rehabilitation to improve nutrition, hydration, and restore eating skills? If not, why; and
  - What review has occurred of medications known to cause a drug/nutrient interaction or having side effects potentially affecting food intake or enjoyment by affecting taste or causing anorexia, increasing weight, causing diuresis, or associated with GI bleeding such as Coumadin or NSAIDs?
- ☐ Is there documentation of informed consent? Was the resident or resident representative made aware of the risks and benefits of a feeding tube? Were alternatives to a feeding tube discussed?
- ☐ Prior to inserting a feeding tube, did the prescriber review the resident's choices, instructions, and goals, including all relevant information that may be identified in advance directives?
- ☐ How does staff monitor for actual or potential complications related to the tube feeding and how does staff address the complications?
- ☐ If a resident was admitted with a tube feeding, was a baseline care plan developed within the first 48 hours to meet the needs of the resident?
- ☐ Is the care plan comprehensive? Does it instruct staff on how to check for placement and how often? Does it address identified needs, measureable goals, resident involvement, treatment preferences, choices, and plan to restore eating skills if possible? Has the care plan been revised to reflect any changes?
- ☐ For a resident receiving hospice services, is the most recent hospice care plan included?
- ☐ Did staff notify the practitioner if they suspected or identified a concern with the resident's ability to maintain adequate oral intake or complications related to use of the feeding tube?
- ☐ Was the resident or resident representative notified of any changes in condition in relation to the feeding tube or inability to take nutrition orally?
- ☐ If concerns are identified, review the facility's policies and procedures for tube feedings, staffing, staff training, and functional responsibilities.
- ☐ Review records of incidents and corrective actions related to feeding tubes or documentation of staff knowledge and skills related to the aspects of administering tube feeding.

Tube Feeding Status Critical Element Pathway

Critical Element Decisions:

1) Did the facility provide appropriate treatment and services to:
   - Ensure that a resident is not fed by enteral methods unless the resident's clinical condition demonstrates that use of enteral feeding was unavoidable?
   - Prevent complications for a resident who receives enteral feeding?
   - Restore the resident's normal eating skills, if possible?

   If No, cite F693

2) Did the staff use appropriate hand hygiene practices and implement appropriate standard precautions when assisting with tube feeding?
   If No, cite F880

3) For the newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan, within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

Tube Feeding Status Critical Element Pathway

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Right to be Informed F552, Right to Refuse and Advance Directives F578, Notice of Rights/Rules F572, Choices (CA), Notification of Change F580, Dignity (CA), Professional Standards F658, Nutrition (CA), Hydration (CA), Unnecessary Medications (CA), Sufficient and Competent Staffing (Task), Physician Supervision F710, Pharmacy F755, Resident Records F841, Physician Delegation to Dietitian/Therapist F715, QAA/QAPI (Task).

Positioning, Mobility & Range of Motion (ROM

Use this pathway for a resident with concerns related to ROM, mobility, and/or positioning.

Review the following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C, E, F, G*G*, I, J, and O.
- ☐ Physician's orders (e.g., PT/OT therapy, restorative, pain management, exercises or care for ROM, mobility, or positioning).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., ROM and mobility schedules including types of interventions, positioning interventions, assistance devices, type of splinting [e.g., splint, hand roll, arm trough], pain, care of contracture).

Observations Across Various Shifts:

- ☐ Whether the care plan accurately reflects the resident's condition, including presence of contractures, muscle atrophy, balance, gait, or other ROM/mobility and/or positioning needs. If not, describe;
- ☐ Whether staff provide assistance and interventions, including positioning, exercises, and treatments as ordered including the frequency, number of reps, and direction of movement according to the care plan. If not, describe.
- ☐ Whether the resident participates or is encouraged to participate in the treatments, exercises, therapies, or positioning to the extent possible. If not, describe.
- ☐ If concerns are identified with positioning, exercises, treatments or other interventions, identify who is responsible for monitoring the implementation.
- ☐ When assisting with ROM exercises, whether staff allows sufficient time for the resident to complete tasks. If not, describe.
- ☐ Whether the resident's joints were adequately supported during PROM exercises, and whether the extremities were moved in a smooth, steady manner to the point identified in the care plan. If not, describe.
- ☐ Whether clean and sanitary assistive devices or equipment (such as walkers, wheelchairs, and bedside commodes) are encouraged,
- ☐ For the resident using a wheel chair (w/c) or recliner:
  - The resident is properly positioned in a w/c or recliner to maintain proper body alignment;
  - Seated in a w/c of appropriate size;
  - Whether the resident's chair (e.g., w/c or reclining chair) fits under the dining room table so he/she is properly positioned to be able to access the meal; and
  - If the resident self-propels in the wheelchair, whether the foot pedals are removed, and if the resident cannot self-propel, whether leg rests and foot pedals are in place. If not, describe.
- ☐ If in group therapy (if a concern is identified, describe):
  - Whether the amount of time and intervention provided is based upon the care plan and orders;
  - Whether the resident is participating and if not, whether staff attempts to engage the resident in the group therapy; and
  - Whether group therapy is not meeting the needs according to the resident's interventions.
- ☐ Whether and how staff responds if the resident verbalizes or indicates pain or discomfort, shortness of breath, orthostatic hypotension during the interventions, exercises, mobility, or transfers, or during contracture care.
- ☐ Whether, if required, splints, braces, hand rolls with or without finger separators, hand cones, palm protector, or rolled up

Positioning, Mobility & Range of Motion (ROM

provided and used according to the care plan, for positioning, mobility, ROM treatments or care. If not, describe.

☐ If there are positioning needs for the resident in bed:

- Whether the resident is positioned (according to the assessment and care plan) in bed to maintain proper body alignment including leg's and feet, (i.e., not pressed up against the foot board);
- Whether positioning is provided to prevent complications including during meals; and
- If pillows or other equipment are used for positioning, they are used correctly, (head supports including head rests and straps, back/lumbar support, appropriate height of armrests, trunk/lateral supports, cushions, pillows, appropriate seat depth, and position of feet). If not, describe.

Resident, Resident Representative, or Family Interview:

☐ For a resident with limitations in ROM or the presence of a contracture, ask the resident to describe the amount of limitation present, how long this condition has been present, and how it is being addressed (exercises, equipment)?

☐ Have you had an improvement, or decline in ROM, mobility, or positioning? If so, describe.

☐ Were you involved in developing your care plan for improving or maintaining ROM/mobility and does the plan reflect your preferences and choices?

☐ Is the care plan being implemented as written?

☐ If you need a splint/brace or other adaptive equipment, when is it applied?

☐ Has the facility provided you with assistive devices such as reachers, mobility devices, and/or communication devices? If so, do you use them, and what instructions were you given on how to use them? If not, describe.

washcloths were clean, in good condition, and applied correctly (slowly, gently, fingers stretched out over the splint or hand roll, or arm trough to extend fingers). If not, describe.

☐ If a contracture(s) is present, determine:

- The location of all contractures present;
- The condition of the resident's skin (e.g., clean and properly cared for or evidence of breakdown);
- If the resident's hands are contracted in a fist, whether the nails are clean and trimmed; and
- Whether there are nail prints in the palm of the resident's hand, odor, or signs of moisture. If so, describe.

☐ Do you have any discomfort or pain during treatments, exercise programs, mobility/transfers, application of splints, or positioning? If so, how is this addressed?

☐ Are you able to actively participate in mobility, positioning, treatments, exercises? If not, describe your involvement, instructions received, and whether staff provides encouragement and revision to the interventions as necessary.

☐ Do you have sufficient time to perform the treatments, exercises, mobility or positioning tasks without being rushed? If not, please describe. Does staff complete the task for you, rather than allowing you to perform it by yourself? If so, please describe.

☐ If on PT/OT for ROM, mobility, or positioning needs, did the therapists discuss the treatment plan and goals? If so, what specific interventions (gait, transfer training, exercises, positioning) were provided, how often, and duration or length of the therapy sessions, and are these plans and goals included your preferences and choices? If not, describe.

☐ Are you aware of any skin problems you have developed related to the use of adaptive equipment (e.g., skin breakdown, cleanliness issues)? If so, what is being done?

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- ☐ Do you need assistance with positioning? If so, what is needed and used during positioning? Does it meet your needs for comfort, safety, and proper alignment? If not, how has staff addressed this?
- ☐ Are you comfortable in bed, or in a wheelchair, or recliner? If not, how has staff addressed this?
- ☐ If you have declined specific interventions, why and did the staff discuss or attempt alternatives?

Nurse Aide or Restorative Nurse Aide Interviews

- ☐ Describe your responsibilities for positioning, ROM, or mobility interventions based upon the written care plan.
- ☐ When did you begin working with the resident? Can you identify:
  - Why the resident requires the intervention;
  - What is being provided to address the specific concern for ROM, positioning or mobility;
  - How often and how much assistance the resident requires;
  - What equipment or devices the resident uses for ROM, mobility, or positioning; and
  - The amount of time required to provide the interventions and whether the resident is encouraged to participate and to complete the tasks, to the extent possible.
- ☐ Are you aware of risk factors for developing a contracture, decline in ROM, mobility, or positioning for this resident?
- ☐ Does the resident have complaints of pain or discomfort, shortness of breath or other concerns during treatment/care? If so, how are they addressed and by whom?
- ☐ Are there any skin integrity issues related to the resident's adaptive equipment or positioning? If so, describe what changes have been made to address these issues.
- ☐ If the resident declines to participate, what do you do, and who do you report it to?
- ☐ Has a decline in the resident's condition occurred? If so, was this reported, when, and to whom, and was the care plan changed?
- ☐ What type and amount of training have you received regarding the treatment/services and equipment/devices you are providing?

Licensed Nurse and DON Interviews as appropriate:

- ☐ Was the resident assessed for risks, causes, and treatments to maintain, improve or prevent decline in ROM/positioning or mobility? If not, describe.
- ☐ Have any physical or cognitive limitations been identified that may influence the ability to maintain, improve or prevent decline in ROM/positioning or mobility? If so, describe;
- ☐ Was the resident or resident representative involved in care plan development, including identifying choices and preferences for maintaining, improving or preventing decline in ROM/positioning or mobility? If not, describe.
- ☐ Has a program or interventions to maintain, improve or prevent decline in ROM/positioning or mobility been attempted? If not,
- ☐ What are the resident's risk factors for developing contractures (e.g., stroke, arthritis, immobile), and if any, what is being provided to address the risks?
- ☐ If a contracture is present:
  - When did the contracture develop, who was notified, when were they notified, and what interventions were implemented?
  - What therapy, restorative, or splint interventions were in place before the contracture developed? If not, why not?
  - Whether the contracture worsened, and if so whether the treatment plan changed.
- .☐ Was the resident assessed for pain or discomfort related to ROM/positioning/mobility? If so, when and where does the pain

Positioning, Mobility & Range of Motion (ROM

describe. If this was not done, how was it determined that the resident would not benefit from a program?

- ☐ Was the resident assessed and furnished any equipment or devices for positioning, mobility, and ROM? If not, describe. If the resident is using a transport chair in place of a w/c, ask why.
- ☐ For a resident with positioning/ROM/mobility needs:
  - What needs have been identified and assessed;
  - How were these needs addressed and when;
  - Whether the therapist has been involved in the development of specific interventions to address these needs; and
  - Whether there has been a decline in ROM or mobility related to positioning needs and if so, describe.

occur, was it reported and to whom and what interventions have been put in place to address the pain/discomfort? Do interventions for proper positioning/ROM/mobility improve the resident's pain? If not, describe

- .☐ Have consultations with the attending practitioner and PT/OT been obtained to address areas of concern, such as decline or failure to improve, maintain, or refusal to participate in the treatment interventions?
- ☐ Does the resident decline interventions including positioning and why? If the resident has declined, describe any changes in his or her ROM/positioning or mobility.
- ☐ How and when are staff monitored to ensure they are accurately implementing care-planned interventions?
- ☐ How and who trained staff to provide the treatments/interventions? If concerns were identified with the provision of interventions, request to see the documentation.

PT, OT, or Restorative Staff Interviews as appropriate:

- ☐ When did therapy/restorative start working with the resident? How often do you meet with the resident?
- ☐ Did the assessment identify limitations and areas for improvement for ROM/mobility/positioning and plans to maintain, improve, or prevent a decline based upon the resident's clinical condition?
- ☐ How were interventions identified that were suitable for the resident? What are the resident's current goals and how was the resident/representative involved in decisions regarding treatments?
- ☐ Does the resident actively and/or independently participates in the interventions? If not, how much assistance does the resident need?
- ☐ What is therapy doing to address the resident's positioning concerns? When did therapy start working with the resident?
- ☐ How much assistance does the resident need with positioning?
- ☐ Does the resident decline treatment? What do you do if the resident declines to participate in treatment?
- ☐ What assistive devices or adaptive equipment does the resident use? Who provided instructions and what instructions were provided for the staff and resident?
- ☐ Does the resident complain of discomfort, pain, shortness of breath, or other symptoms related to the interventions? If so, what is being done to address the concerns, by whom, and when was the attending practitioner made aware of the concerns?
- ☐ How often is the resident's progress assessed and where is it documented?
- ☐ What risk factors are present that might lead to the development of a contracture?
- ☐ If a contracture is present:
  - When did it develop and when was therapy notified?
  - What interventions are implemented to address the contracture?

Positioning, Mobility & Range of Motion (ROM

- ☐ Were you involved in training staff to position the resident and apply the positioning devices?
- ☐ Is the resident at risk for a decline in function? What may be the cause? What is being done to prevent it?
- ☐ If a decline in function occurred:
  - When did it occur?
  - What caused the decline?
  - Who was notified and when?
  - What therapy or restorative interventions were in place before the decline developed?
  - What is therapy/restorative doing to address the resident's decline?
  - What therapy, restorative, or splint interventions were in place before the contracture developed?
- ☐ If the resident is not on a therapy/restorative program, or it was discontinued, how was it determined that the resident would not benefit from a program?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions as written?
- ☐ Ask about concerns based on your investigation.
- ☐ It may be necessary to interview the attending practitioner regarding declines or failure to improve in ROM/mobility or positioning in order to determine if he/she was aware of the status of the resident's condition and what was done to address the potential or actual decline.

Record Review determine, as appropriate:

- ☐ Do your observations of the therapy/restorative services match the status of the resident's ROM/mobility and level of assistance described in the record? If not, determine if staff can provide documentation regarding the difference.
- ☐ Does the record reflect assessment of risk factors and underlying causes, of identified concerns for ROM/mobility/positioning, and identified interventions/strategies and goals for maintaining, improving or preventing decline in these areas? If not, describe.
- ☐ Does the record identify potential complications that may be related to decreased ROM/Mobility, such as pain, skin integrity issues, deconditioning, unsteady gait/balance, contractures, respiratory/circulatory complications? If so, were interventions developed and implemented to mitigate those risks?
- ☐ How does the facility involve the resident/representative in development of the care plan and ensure it reflects their choices or preferences?
- ☐ Whether necessary services were identified and provided to maintain or improve the resident's ROM, level of mobility, or positioning.
- ☐ Whether the need for equipment or assistive devices was assessed and provided based on need. Whether ROM exercises, treatments,
- ☐ If a resident was assessed as not appropriate for therapy services, were appropriate restorative or maintenance interventions identified and implemented in an attempt, to the degree possible, to prevent further decline in the resident's condition? What instructions did therapy provide regarding restorative or maintenance interventions?
- ☐ Does the record reflect improvement, maintenance, or decline in the resident's abilities for ROM/mobility or positioning and if so, were changes addressed and the care plan revised? If not, describe.
- ☐ If changes in the resident's ROM/mobility or positioning were identified were the changes communicated to appropriate staff and the attending practitioner? If not, describe.
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan) and if so, if and when was the MDS significant change comprehensive assessment conducted.

applications of splints or assistive devices were provided as ordered. If not, describe.

☐ Whether PT/OT assessed and reassessed a resident if a decline or potential decline had been identified, provided treatment as often as ordered, provided devices as necessary and revised interventions to address the actual or potential decline. If not, describe.

☐ If concerns are identified related to the delivery of care and services for ROM/mobility, transfers, positioning, or contracture care, review the applicable policies and procedures.

☐ In some clinical conditions, a decline in ROM/mobility or positioning may occur even though the facility provides ongoing assessment, appropriate resident-specific care planning and provides ongoing preventive care and interventions. Documentation must reflect the attempts made by the facility to implement the plan of care and revise interventions to address the changing needs of the resident. In this type of situation, decline in ROM/mobility may be considered to be unavoidable.

Critical Element Decisions:

1) A. For residents admitted without a limited ROM, and whose clinical condition demonstrates that reduction in ROM is avoidable, did the facility provide services and/or treatment to prevent reduction in range of motion? Were those services/treatment provided in accordance with professional standards of practice and based on the comprehensive assessment, the person-centered care plan, and the resident's preferences?

   B. For residents admitted with a limited ROM and/or mobility, did the facility provide services and/or treatment to increase range of motion/mobility and/or to prevent further decrease in range of motion/mobility, including the provision of equipment for limited mobility?

   If A or B is No, cite F688

   NA, the resident did not have ROM or mobility concerns.

2) Did the facility provide treatment and care to address the resident's positioning needs that were in accordance with professional standards of practice that were based on the comprehensive assessment, person-centered care plan and the resident's choice?
   If No, cite F684
   NA, the resident did not have positioning concerns.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and a comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change in status assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks to Consider: Dignity (CA), Abuse (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, Pain (CA), Pressure Ulcer (CA), Physician Supervision F710, Physician Delegation to Therapist F715, Sufficient and Competent Staffing (Task), Rehabilitative and Restorative (CA), Resident Records F842.

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive *and most recent quarterly (if the comprehensive isn't the most recent)* MDS/CAAs for Sections B, C, E, GG, I, J, N, and O.
- ☐ Physician's orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).
- ☐ Pertinent diagnoses.
- ☐ Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident's hospitalization.
- ☐ Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident's needs, goals, preferences, and assessment).

Observations:

- ☐ Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
  - Physical distress;
  - Mental status changes;
  - A change in condition; and/or
  - Pain?
- ☐ If symptoms are exhibited, what does staff do?
- ☐ Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

- ☐ Why were you sent to the hospital? Has your condition improved? If not, do you know why it's not getting better?
- ☐ When did you start to feel different, sick, or have a change in condition?
- ☐ Do you feel staff responded as quickly as they could have when you had a change in condition?
- ☐ Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?
- ☐ Do you have pain? If so, what does staff do for your pain?
- ☐ Has your health declined since you were in the hospital? If so, what has staff done?
- ☐ What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).
- ☐ Has your hospitalization caused you to be less involved in activities you enjoy?

Hospitalization Critical Element Pathway

- ☐ Were you notified immediately about your change in condition and need for potential hospitalization?
- ☐ Were you involved in the development of the care plan and goals regarding your care before and after you got back from the hospital?
- ☐ Do the interventions reflect your choices and preferences?
- ☐ Did you refuse care related to the symptoms which led to your hospitalization? If so, what was your reason for refusing care? Did the staff provide you with other options for treatment or provide you with education on what might happen if you did not follow the treatment plan?
- ☐ Since your hospitalization, have you had a change in your mood or ability to function? If so, what has staff done?
- ☐ Did you receive a notice of transfer or discharge from the facility?
- ☐ Did the facility give you information about holding your bed for you while you were at the hospital?
- ☐ Were you allowed to return to the facility and to your previous room? If not, do you know why not?

Staff Interviews (Nursing Aides, Nurses, DON, Practitioner):

- ☐ Are you familiar with the resident's care?
- ☐ When did the hospitalization occur? What was the cause (e.g., pain, infection, mental status change, or fall)?
- ☐ Do you have a structured process for identifying and addressing a resident's change in condition (e.g., facility developed tool, Interventions to Reduce Acute Care Transfers [INTERACT])?
- ☐ Prior to the hospitalization, did the resident have a change or decline in condition? If so, when? How often did you assess the resident? Where is it documented?
- ☐ If the resident had a change in condition, who did you notify (e.g., practitioner or representative) and when?
- ☐ Prior to or after the hospitalization, did the resident refuse any treatment? What do you do if the resident refuses?
- ☐ Is the resident at risk for additional hospitalizations?
- ☐ Since the resident returned from the hospital, has the resident had a change or decline in condition? If so, what interventions are in place to address the problem(s)?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ How did you involve the resident/representative in decisions regarding treatments?
- ☐ If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current care plan.
- ☐ Ask about identified concerns.

Hospitalization Critical Element Pathway

Record Review:

- ☐ Was the cause of the hospitalization assessed, monitored, and documented timely (e.g., nursing notes, EMT records, hospital discharge summaries, H&P, progress notes/vital signs)?
- ☐ Did the facility adequately identify and address the resident's change in condition?
- ☐ Were changes in the resident's status or other risks associated with the hospitalization identified as soon as possible?
- ☐ Were changes in the resident's status related to the hospitalization communicated to staff, practitioner, resident and representative immediately after they were identified?
- ☐ Was the transfer to the hospital necessary (e.g., the resident's needs couldn't be met after facility attempts to address the needs, or the health or safety of individuals in the facility would be endangered if the resident stayed in the facility)?
- ☐ If the transfer to the hospital is necessary for the resident's welfare and the resident's needs cannot be met in the facility, did the facility document the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)?
- ☐ Did the facility send all necessary clinical information to the hospital (i.e., practitioner and representative's contact info, advance directive, special instructions or precautions for ongoing care, care plan goals, and all other information needed to care for the resident). Refer to 483.15(c)(2)(iii) for additional guidance on what must be conveyed.
- ☐ Did the appropriate practitioner document the basis for the transfer? [F622, 483.15(c)(2)(ii)]
- ☐ Was the resident/representative provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand?
- ☐ Did the notice meet all the notice requirements at 483.15(c)(3)?
- ☐ Did the resident/representative receive the notice of Bed Hold per 483.15(d)?
- ☐ Did the facility assess and monitor the resident's response to interventions?
- ☐ Did the facility identify necessary changes in interventions to prevent further hospitalizations?
- ☐ Does the resident have a medical condition or receive medications that require monitoring? If so, did the monitoring take place and was it documented (e.g., blood glucose monitored and treated appropriately)?
- ☐ Were there any medication changes that were pertinent to the hospitalization?
- ☐ Were any laboratory results pertinent to the hospitalization?
- ☐ Review facility policies and procedures relevant to the resident's hospitalization (e.g., policy on changes in condition).
- ☐ Review the facility's admission information provided during the Entrance Conference regarding bed holds and transfers.
- ☐ Ensure the resident was provided the policy on returning to the facility in the same room, if possible, and bed holds.
- ☐ Could the transfer to the hospital have been avoided (e.g., had the change in condition been identified and addressed earlier, the condition would not have declined to the point where the resident required a transfer)?
- ☐ **Residents not permitted to return to facility after hospitalization (Discharge):** When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is considered to be a facility-initiated discharge – ensure the facility is in compliance with all discharge requirements at 483.15(c)(1) through (6).

Hospitalization Critical Element Pathway

☐ For any resident whose **transfer to the hospital resulted in a discharge**, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave: [Refer to 483.15(c), (d), and (e) for additional guidance.]

- What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]
- Did the resident/representative receive all appropriate notification (Notice of Transfer, containing the basis for transfer; and Notice of Bed Hold); Was a copy of the notice sent to the ombudsman? [Refer to F623 and F625]
- Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624]
- When the transfer became a discharge, did the facility issue another notice of discharge? If so, what was the basis for the discharge? For residents discharged after a transfer to the hospital because the health or safety of individuals would be endangered, is there evidence that residents with similar health needs, conditions, or symptoms currently reside in the facility, or were admitted after the resident was discharged? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to F623 and F626]
- Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to F626]
- Was the decision to not allow the resident to return based on the resident's care needs at the time of transfer to the hospital/acute care setting or at the time the resident sought return to the facility? Do the resident's records from the nursing home and the acute care facility support this decision (Surveyors may need to review hospital records in this situation)? [Refer to F626]
- Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to F622]

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care to prevent the hospitalization, that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
If No, cite the relevant outcome tag in Quality of Life, Quality of Care, or if no specific outcome tag, cite F684

2) Was the basis for the resident's transfer/discharge consistent with the requirements at 483.15(c)(1)? Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements at 483.15(c)(2)(i)-(ii)? Is there evidence that the information conveyed to the receiving provider met the requirements at 483.15(c)(2)(iii)? Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
If No to any of these questions, cite F622

Hospitalization Critical Element Pathway

N/A, resident was permitted to return and not discharged.

3) Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?
If No, cite F623

4) For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?
If No, cite F623
N/A, resident was permitted to return and not discharged.

5) Was the resident sufficiently prepared and oriented for their transfer to the hospital?
If No, cite F624

6) Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
If No, cite F625

7) Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
If No, cite F626
N/A, resident was permitted to return and not discharged.

8) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

9) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

10) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

Hospitalization Critical Element Pathway

If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change status.

11) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status) ?
If No, cite F641

12) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

13) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAPI/QAA (Task).

Bladder or Bowel Incontinence Critical Element Pathway

Use this pathway for a resident identified with concerns related to bladder or bowel incontinence.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, G*G*, and H.
- ☐ Physician's orders (e.g., incontinence or restorative program, medications affecting continence).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., scheduled toileting or restorative program based on the type of incontinence [retraining, habit training, scheduled voiding, prompted voiding, toileting devices], environment or assistive devices, promotes choice and dignity, psychosocial concerns [social withdrawal or embarrassment], skin integrity, UTI prevention, incontinence products, hydration/nutrition needs).

Observations (if a resident is incontinent of bowel or bladder or is on a program to maintain continence, determine the following):

- ☐ Whether staff uses appropriate hand hygiene and Personal Protective Equipment (PPE) when providing toileting and incontinence care;
- ☐ Whether the staff implements care plan interventions to maintain continence or improve incontinence, and whether staff informs the resident about the incontinence care before providing it;
- ☐ Whether staff maintains the resident's privacy, dignity, and respect during incontinence care. If not, describe. If the resident appears embarrassed or humiliated, how does staff respond?
- ☐ How staff respond to requests for assistance to the bathroom;
- ☐ Whether staff provide timely assistance to the resident to maintain continence (e.g., prompting, assisting to transfer, or stand-by assist to ambulate); and
- ☐ Whether staff provides sufficient fluids based upon the resident's assessed needs?
- ☐ If the resident had an incontinent episode:
  - How long the resident was in wet, soiled clothing, incontinent briefs, or linens before staff changed the resident;
  - The condition of the resident's skin (e.g., reddened, macerated, or irritated);
  - Whether the resident expressed pain or discomfort, and if so, how staff respond;
  - Whether hygiene measures were used (e.g., cleansing, rinsing, drying, applying protective moisture barriers) to prevent skin breakdown and to prevent UTIs; and
  - Whether absorbent products or protective clothing was used to address leakage, odor and enhance socialization and dignity.
- ☐ Whether environmental accommodations have been made to promote continence, such as:
  - Placing the call bell within reach and responding to the call bell promptly;
  - Maintaining a clear pathway and ready access to bathroom facilities;
  - Providing adaptive equipment or devices, based on resident identified needs, such as elevated toilet seats, grab bars, urinals, bedpans, or commodes; and
  - Assuring adequate lighting and assistance as needed to use devices such as urinals, bedpans and commodes.

Resident or Resident Representative, or Family Interview:

- ☐ How long have you had (bladder and/or bowel) incontinence? Do you know what may have caused it?
- ☐ Describe how you were involved in developing your care plan for improving or maintaining continence. Do you believe the plan reflects your preferences and choices?
- ☐ Do you know what the plan is to improve your continence, and what type of interventions are being provided?
- ☐ Do you know if the incontinence is getting better or worse, and if worse, do you know why?
- ☐ Do you have any problems with skin integrity related to the incontinence and if so, please describe and explain what is being done for these problems?
- ☐ Has your incontinence impacted your involvement in activities, mood, or ability to function?
- ☐ What type of assistive devices are provided? Have staff given you instructions on how to use them?
- ☐ What happens when you request staff assistance to go to the bathroom? How do staff respond to you if you have can't make it to the bathroom in time?
- ☐ Do you have a UTI, or a history of UTIs? If so, what interventions are in place to prevent these from occurring, to the extent possible?
- ☐ Do you know if staff have addressed environmental issues that may affect continence (e.g., improved lighting, use of a bedside commode or urinal, reducing the distance to the bathroom if possible, use of grab bars etc.)? Please describe.
- ☐ For surveyor: If you are aware that the resident has declined care to restore continence, what interventions were declined and whether alternatives were suggested?

Nursing Aide Interviews: Interview the nurse aide assigned to provide care to the resident to determine:

- ☐ Can you tell me about the resident's incontinence (e.g., type, whether there is a pattern of incontinence episodes).
- ☐ What interventions are used (restorative/management programs):
  - How often assistance to go to the bathroom is provided;
  - How much assistance the resident requires; and
  - How the resident's participation, to the extent possible, is encouraged.
- ☐ Are there problems with the resident's skin related to incontinence? If so, when it began, whether it was reported, and how it is being addressed?
- ☐ Has the resident declined any interventions to improve or maintain continence? If so, what interventions were declined and why? Do you know what changes have been put in place if the resident declines interventions?
- ☐ Has there been a decline in the resident's continence? If so, who did you report it to, and when? Do you know if care plan interventions have been revised to address the decline, and if so, what was changed?
- ☐ What, when, and to whom do you report changes in status (e.g., hydration status, urine characteristics, and complaints of urinary-related symptoms)?
- ☐ What training have you received on continence programs, skin care, or the use of assistive devices?

Licensed Nurse, DON or Rehabilitative Staff Interviews, as appropriate, to determine:

- ☐ When was the resident's incontinence identified and what was the frequency of the resident's incontinence episodes?
- ☐ Was the resident assessed for risks, causes, types, patterns of incontinence, and potential treatments to address or reverse the incontinence? If not, describe.
- ☐ What physical or cognitive limitations have been identified that may influence potential improvement or maintenance of continence? If so, describe.
- ☐ Was the resident or resident representative involved in care plan development, including identifying choices and preferences for treatment of incontinence? If not, why not?
- ☐ What types of interventions have been attempted to promote continence (e.g., special clothing, devices, types and frequency of assistance, change in toileting schedule, environmental modifications)?
- ☐ What program was developed and implemented to improve, maintain, or correct, to the extent possible, the incontinence? If this was not done, how was it determined that the resident would not benefit from a program?
- ☐ Whether the resident's continence is declining and if so, what changes have been made, implemented and evaluated?
- ☐ Whether a therapy program is in place, as appropriate, (e.g., balance, muscle strengthening, or transfers) to assist in a continence management program.
- ☐ If on a rehabilitative program, the resident's response to the program, including understanding instructions to help improve or maintain continence.
- ☐ Has the resident experienced complications related to incontinence (e.g., skin integrity issues, infections, hydration issues)? If so, how were these addressed?
- ☐ Has the resident been identified to be at risk for UTIs? If so, what are the risk factors and are the risks addressed?
- ☐ Has the resident declined an intervention? What alternatives were offered and put in place?
- ☐ Who monitors staff implementation of the continence program and the impact of the interventions on resident continence status?

Record Review:

- ☐ Does the facility adequately identify the resident's continence history (e.g., nursing or therapy notes, pharmacist reports, lab reports, and flow sheets)?
- ☐ Does the assessment reflect the status of the resident, specifically:
  - Patterns of incontinent episodes, daily voiding/elimination patterns or prior routines;
  - Fluid intake/hydration status, skin integrity and cognitive status;
  - Clinical conditions that may affect continence;
- ☐ Does the care plan identify incontinence interventions, programs, resident choices and preferences? Has the care plan has been revised to reflect any changes?
- ☐ Has there been a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was the MDS significant change comprehensive assessment conducted?

- Medications that may affect continence that could reflect adverse drug reactions;
- Symptoms for bladder incontinence, including the type of incontinence (stress, urge, overflow, mixed, functional, or transient incontinence), potential reversible/irreversible causes and risks;
- Symptoms and type of bowel incontinence including the type, frequency, and amount of stool, potential reversible/irreversible causes and, risks;
- Factors contributing to chronically recurring or persistent UTIs;
- Functional status including balance, muscle strength, transfer and ambulation ability, and the type, frequency and amount of physical assistance necessary to facilitate toileting; and
- Adaptive equipment or accommodations to maintain continence, such as access to the toilet, call bell, type of clothing or continence products, ambulation devices (walkers, canes).

- ☐ How does the facility manage continence if the resident has disabilities or pain, such as due to cancer, arthritis, post-surgical care, fractures, contractures, neurological impairments?
- ☐ How does staff recognize and assess potential evidence of symptomatic UTI, and notify the attending practitioner?
- ☐ What adjustments were considered for medications affecting continence, if possible, (e.g., medication cessation, dose reduction, selection of an alternate medication, or change in time of administration)?
- ☐ How has the resident's condition and effectiveness of the interventions been monitored and revised as necessary?
- ☐ What is the resident's level of participation in, and response to, the continence program?
- ☐ Has the resident had a decline or lack of improvement in continence status? If so, were interventions revised?
- ☐ If concerns are identified, review policies and procedures related to continence care and services.

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care in accordance with professional standards of practice, the resident's comprehensive, person-centered care plan, and the resident's choice in order to maintain continence to the extent possible, prevent urinary tract infections, and restore bladder incontinence and/or bowel function to the extent possible?
   If No, cite F690

2) Did the facility use appropriate hand hygiene practices and PPE, if needed, when providing incontinence care?
   If No, cite F880

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Dignity (CA), Right to be Informed Make Treatment Decisions F552, Notification of Change F580, Accommodations of Needs or Resident Call System (Environment Task), Choices (CA), Right to Refuse F578, Pressure Ulcer (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Medical Director F841, QAA/QAPI (Task).

Accidents Critical Element Pathway

Use this pathway for a resident who requires supervision and/or assistive devices to prevent accidents and to ensure the environment is free from accident hazards as is possible.

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C, E, *G*G, H, J, N, O, and P.
- ☐ Physician's orders.
- ☐ Progress notes related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ If available, investigation report related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ Pertinent diagnoses.
- ☐ Care plan Interventions for the following:
  - Smoking/Use of Electronic Cigarettes;
  - Resident-to-Resident Altercations (also being reviewed under the Abuse pathway);
  - Falls;
  - Wandering and elopement; and/or
  - Safety/Entrapment (e.g., physical restraints, bed rails).

Observations for all areas:

- ☐ What type of supervision is provided to the resident and by whom?
- ☐ How are care-planned interventions implemented?

Wandering and Elopement Observations:

- ☐ Where is wandering behavior observed?
- ☐ What interventions are implemented to ensure the resident's safety?
- ☐ If the resident is exit seeking, what interventions are implemented to prevent elopements?

Smoking/Use of Electronic Cigarette Observations:

- ☐ Is the resident smoking safely (observe as soon as possible):
  - Is the resident supervised if required;
  - Does the resident have oxygen on while smoking;
  - Does the resident have a smoking apron or other safety equipment if needed;
  - Does the resident have difficulty holding or lighting a cigarette;
  - Are there burned areas in the resident's clothing/body; and
  - Does the resident keep his/her cigarettes and lighter?
- ☐ Is the resident using an electronic cigarette in his or her room or in a non-smoking area?
  - Do other residents appear to be bothered by the electronic cigarette use?

Accidents Critical Element Pathway

Resident-to-Resident Altercation Observations:

- ☐ Did the resident have any altercations (e.g., verbal or physical) with any residents? If so, how did staff respond?
- ☐ How does staff supervise/respond to a resident with symptoms such as anger, yelling, exit seeking, rummaging/wandering behaviors, targeting behaviors, inappropriate contact/language, disrobing, pushing, shoving, and striking out?

Fall Observations:

- ☐ How does staff respond to the resident's requests for assistance (e.g., toileting)?
- ☐ What effective interventions are implemented to prevent falls? Examples may include:
  - Responding to the resident's requests timely;
  - Placing the resident in a low bed, or providing a fall mat;
  - Monitoring resident positioning to prevent sliding/falling;
  - Providing proper footwear to prevent slipping;
  - Providing PT/OT/restorative care; and/or
  - Assuring the resident's room is free from accident hazards (e.g., providing adequate lighting, assuring there are no trip hazards, providing assistive devices).
- ☐ Does the resident have a position change alarm in place:
  - What evidence is there that this device has been effective in preventing falls;
  - Is there evidence this device has had the effect of inhibiting or restricting the resident from free movement out of fear of the alarm going off (See Physical Restraints); and
  - Is there evidence that the alarm is used to replace staff supervision?

Entrapment/Safety Observations:

- ☐ If the resident requires assistance with transfers, does staff implement care-planned interventions for transfers? Does the equipment appear to be in good condition, maintained, and used according to manufacturer's instructions?
- ☐ If bed rails are used:
  - Are they applied safely; and
  - Are there areas in which the resident could become entrapped (i.e., large openings or gaps), or become injured, such as exposed metal, sharp, or damaged edges;
- ☐ For a resident with a physical restraint:
  - Does the resident attempt to release/remove the restraint, which could lead to an accident? If so, describe;
  - Who applied the restraint, how was it applied, and how was the resident positioned; and
  - How does the resident request staff assistance (e.g., access to the call light), how do staff respond to resident requests, and how often is monitoring provided?

Accidents Critical Element Pathway

Environmental Hazards Observation:

☐ Handrails
- Are handrails free from sharp edges or other hazards or not installed properly?

☐ Building and Equipment
- Are resident's room, equipment or building (e.g., transfer equipment, IV pumps, glucometers, thermometers, ventilators, suctioning devices, oxygen equipment, nebulizers, furniture) in good condition?
- Are devices for resident care used per manufacturer's recommendations or current standards of practice (e.g., pumps, ventilators, and oxygen equipment)?
- Do staff promptly clean up spilled liquids in a resident area?

☐ Chemicals and Toxins:
- Are there accessible chemicals/other hazards in the resident's bathroom, bathing facilities?
- Are there chemicals used by facility staff (e.g., housekeeping chemicals), including chemicals or other toxin materials in the resident environment?
- Are there drugs or other therapeutic agents that pose a safety hazard to a resident?
- Are there plants or other "natural" materials found in the resident environment or in the outdoor environment?

☐ Unsafe Hot Water:
- For a resident with a concern about the water being too hot or for observations with the water being too hot in the resident's room, bathroom, or bathing facilities;
- Using a thermometer, check the water temperature in the resident room/bathroom/bathing facilities identified with the unsafe hot water;
- Using a thermometer, check the water temperature in resident rooms closest to the hot water tanks/kitchen areas and resident rooms belonging to residents with dementia.

☐ Electrical Safety
- Is there electrical equipment used (e.g., electrical cords, heat lamps, extension cords, power strips, electric blankets, heating pads)?

☐ Lighting
- Do resident rooms have insufficient light or too much light with the potential for glare?

☐ Assistive Devices/Equipment Hazards
- Are assistive devices (e.g., canes, standard and rolling walkers, manual or on-powered wheelchairs and powered wheelchairs) in good repair, safe based on the resident condition, personally fit for the resident, maintained in good repair, and safe staff practices?
- Are assistive devices for transfer (e.g., mechanical lifts, sit to stand devices, transfer or gait belts) are based on the resident condition and maintained in good repair?

Accidents Critical Element Pathway

Resident, Resident Representative, or Family Interview:
Smoking/Electronic Cigarette Use:

- ☐ What instructions have you received from staff regarding smoking, or use of electronic cigarettes?
- ☐ Do you know where the designated smoking areas are located?
- ☐ Are staff available while you are smoking? Do they provide you with any safety equipment?
- ☐ If the resident uses oxygen, do you take your oxygen off when smoking?
- ☐ Do you keep your own cigarettes and lighter?
- ☐ For electronic cigarette use: How do you change your batteries or fill your cartridge?

Wandering and Elopement:

- ☐ For the resident representative, if the resident had attempted to leave the facility, did staff notify you that the resident left or attempted to leave the facility?
- ☐ How is the facility keeping the resident safe?

Resident-to-Resident Altercations:

- ☐ Have you had any confrontations with another resident? If so, what happened? Who was involved? When and where did the confrontation occur?
- ☐ Was there anybody else present when this occurred? If so, who was present? What did they do?
- ☐ Do you feel safe? Are you afraid of anyone?
- ☐ Did you report the confrontation to staff? If so, what was the staff's response? What are staff doing to prevent future altercations?
- ☐ Have you had any past encounters with this resident? If so, what happened?

Falls:

- ☐ Have you fallen in the facility? If so, what happened? Were you injured from the fall?
- ☐ What were you trying to do when you fell?
- ☐ What has staff talked to you about regarding how to prevent future falls?
- ☐ What interventions have been put in place to help prevent future falls? Are they working? If not, why?

Entrapment/Safety:

- ☐ Have you ever been injured during a transfer? If so, what happened? What did staff do?
- ☐ Have you ever been caught between the side rail and mattress? If so, what happened? What did staff do?
- ☐ Have you ever attempted to remove a restraint or get out of your chair/wheelchair/bed without assistance? If so, what happened? What did staff do?

Environmental Hazards:
Unsafe Hot Water:

- ☐ Have you ever sustained a burn due to the water being too hot?
- ☐ How long has the water been too hot?
- ☐ Have you told staff about the water being too hot? Who did you tell? What was their response?

All Other Environmental Hazards:

- ☐ Have you had any concerns [based on specific environmental hazard identified during observation]?
- ☐ Have you told staff? What was their response?

Accidents Critical Element Pathway

Nursing Aide Interviews:

- ☐ Are you familiar with the resident's care?
- ☐ How do you know what interventions or assistance is needed (e.g., for safe smoking, to prevent falls)?
- ☐ Has the resident had a fall/smoking injury/altercation/accident or elopement;
  - When did the accident(s) occur;
  - What were the circumstances around the accident (Ask about any concerns you have – e.g., whether an alarm sounded for a fall/elopement);
  - Did the resident sustain an injury (e.g., smoking, altercations, falls, or transfers); and
  - Was the nurse notified?
- ☐ What interventions were in place before the accident occurred?
- ☐ What interventions were implemented following each accident (e.g., after a fall)?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Ask about concerns based on your investigation.

Therapy and/or Restorative Manager Interviews (for falls, restraints):

- ☐ What therapy/restorative interventions were in place before the accident occurred?
- ☐ What therapy/restorative interventions were implemented following each accident?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident or resident representative in decisions regarding interventions? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ What did you do if the resident fell while going to the restroom?
- ☐ Ask about concerns based on your investigation.

Nurse Interviews:

- ☐ Are you familiar with the resident's care?
- ☐ What are the resident's risk factors for having an accident (e.g., safe smoking, safe side rail use)? How often are they assessed and where is it documented? How do you know what interventions or assistance is needed (e.g., for safe smoking, to prevent falls)?
- ☐ Has the resident had a fall/smoking injury/altercation/accident or elopement;
  - When did the accident(s) occur;
  - What was the resident trying to do;
  - What were the circumstances around the accident? What caused the accident;
  - Did the resident sustain an injury;
  - Who was notified of the accident and when were they notified;
  - What interventions were in place before the accident occurred; and
  - What interventions were implemented following each accident (e.g., after a fall)?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident or resident representative in decisions regarding interventions? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ Ask about concerns based on your investigation.

Social Services Interview:

- ☐ How were you involved in the development of the resident's behavior management plan to address resident altercations, falls, smoking injury, or elopement?
- ☐ Ask about concerns based on your investigation.

Accidents Critical Element Pathway

Record Review:

- ☐ Review nursing notes, therapy notes, and IDT notes. Has the resident's accident risk been assessed (e.g., fall risk, elopement risk, or safe smoking assessment)?
- ☐ Were the underlying risk factors identified?
- ☐ Has the resident had any accidents since admission?
- ☐ Were preventative measures documented prior to an accident:
  - Was the accident a result of an order not being followed? A care intervention not being addressed? A care-planned intervention not implemented?
- ☐ For a resident-to-resident altercation, were interventions reviewed and revised based on the resident's response(s) and evaluated for effectiveness? If not effective, what alternative interventions were implemented?
- ☐ Were the circumstances surrounding an accident thoroughly investigated to determine causal factors:
  - Were the cause and any pattern identified (e.g., falls that occur at night trying to go to/from the bathroom); and
  - Was the resident's accident risk addressed appropriately?
- ☐ Review laboratory results pertinent to accidents.
- ☐ Has the care plan been reviewed and revised if indicated to reflect any changes as a result of an accident(s)?
- ☐ Are injuries related to the accident assessed and treatment measures documented?
- ☐ Are changes in the resident's accident risk correctly identified and communicated with staff and practitioner?
- ☐ Based on a review of the most recent MDS Assessment (J1900), if the resident had a fall(s), is the MDS coded accurately for falls in each category (no injury, injury except major, major injury)?
- ☐ If concerns are identified, review facility policies and procedures with regard to accidents, and relevant policies related to the concern identified.

Critical Element Decisions:

1) Based on observation, interviews, and record review, did the facility ensure the resident's environment is free from accident hazards and each resident receives adequate supervision to prevent accidents?
   If No, cite F689

2) Based on observations, interviews, and record review, did the facility assess each resident for risk of entrapment and only use bed rails after trying other alternatives and explaining the risks and benefits to the resident or the resident's representative?
   If No, cite F700
   NA, bed rails were not investigated.

3) Based on observations, interviews, and record review, did the facility appropriately install and inspect the bed rails, use compatible bed mattresses, bed rails and frames, and identify any risks of entrapment?
If No, cite F909
NA, bed rails were not investigated.

4) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan the care within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident or resident representative receive and understand the baseline care plan?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

5) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

6) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

7) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

8) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

9) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Notification of Change F580, Restraints (CA), Abuse (CA), Right to be Informed F552, Choices (CA), Right to Participate in Planning Care F553, Environment Task, Admission Orders F635, Professional Standards F658, General Pathway (CA), ADLs (CA), Behavioral-Emotional Status (CA), Physician Supervision F710, Unnecessary Medications (CA), Sufficient and Competent Staffing (Task), Physical Environment F906, F907, F909 thru F918, F920, F922, F925, Dementia Care (CA), Rehab and Restorative (CA), QAPI/QAA (Task).

Resident Assessment Critical Element Pathway

Use this pathway for the following: a) when MDS concerns are noted but you are not using a care area pathway (i.e., the care area did not require further investigation), or b) for concerns about the facility's MDS data completion or submission activities.

Record Review:

☐ MDS Accuracy Concerns:

- Does information in the MDS correspond with information obtained during observations and interviews with the resident, facility staff, and resident's family or representative;
- Have appropriate health professionals assessed the resident? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of assessing the resident;
- Based on your total review of the resident, is each portion of the assessment accurate;
- Is there any evidence that an individual willfully and knowingly coded MDS assessment information inaccurately or falsely;
- Is the quarterly review of the resident's condition consistent with information in the progress notes, plan of care, and your resident observations and interviews; and
- Based on the facility documentation, did the facility adhere to the guidelines for conducting a Resident Assessment (e.g., Significant Change in Status Assessment)?
  (Note: Facility documentation is defined as information obtained from the facility that includes resident care and issues that are tracked such as an incident/accident report, clinical record, wound log, transfer log, and ANY other type of documentation that contains evidence of resident issues.)

☐ Completion and Submission Concerns:

- Compare the alphabetical list of residents provided by the facility against the resident listing in the software. Residents on the alpha list and not in the software should be new admissions (admitted in the last 30 days). If they are not new admissions, there may be MDS submission issues (and that's why they are not in the software listing);
- Are the appropriate certifications in place, including the RN Coordinator's certification/signature of completion of an assessment or Correction Request and the certification of individual assessors of the accuracy and completion of portion(s) of the assessment or tracking record completed or corrected;
- Was the assessment completed and submitted timely? If not, why not; and
- What is the assessment type that wasn't completed or submitted timely?

Resident Assessment Critical Element Pathway

Critical Element Decisions:

1) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641
   NA, assessments accurately reflected the resident's status.

2) Did the facility complete a comprehensive assessment, using the CMS-specified Resident Assessment Instrument (RAI) process, within the regulatory timeframes (i.e., within 14 days after admission and at least annually) for each resident?
   If No, cite F636
   NA, the annual assessment or admission assessment was completed timely.

3) Did the facility assess residents, using the CMS-specified quarterly review assessment, no less than once every three months, between comprehensive assessments?
   If No, cite F638
   NA, the quarterly assessment was completed timely.

4) Did the facility transmit the assessment within 14 days after completion?
   If No, cite F640
   NA, assessments were transmitted timely.

5) Did the facility ensure no one willfully and knowingly coded MDS assessment information inaccurately or falsely?
   If No, cite F642

6) Did staff who completed portions of the MDS sign the assessment or tracking record certifying the accuracy and completion of the sections they completed, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request?
   If No, cite F642

Discharge Critical Element Pathway

Use this pathway to evaluate compliance with requirements for Admission, Transfer and Discharge Rights (F622, F623, and F626—only when a resident is not permitted to return after therapeutic leave). For concerns related to not permitting a resident to return after a hospitalization, use the Hospitalization and/or Discharge (F660 and F661) Critical Element (CE) Pathways. Facility-initiated emergency transfers or discharges to acute care should also be reviewed using the Hospitalization CE Pathway.

Review the following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive *and* most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A, C, G*G*, and Q.
- ☐ Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- ☐ Pertinent diagnoses.
- ☐ Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).
- ☐ If investigating a complaint related to discharge, if there are other residents who had further investigation marked for the complaint care area, the team is required to sample three residents. If there weren't any other residents who had concerns regarding the complaint allegation, the team is only required to investigate the complaint resident. If concerns are identified, you may need to expand the sample and ask the facility for a list of facility-initiated discharged residents, as necessary. If the facility cannot provide a list of facility-initiated discharged residents, ask for a list of all discharged residents for the last three months.

Ask facility staff (e.g., Director of Nurses, Social Worker, Attending Physician) whether the discharge was facility- or resident-initiated. Investigate and verify the staff response as to whether the discharge was facility- or resident-initiated using the columns below. For example, if the facility indicates a discharge was facility-initiated, start with Column A.

A. Facility-Initiated Discharges	**B. Resident-Initiated Discharges**
NOTE: Interviewing the resident and/or his or her representative is a critical component of confirming whether the discharge is resident- or facility-initiated. If the resident is no longer in the facility, attempt to contact the resident and/or resident's representative.	
Resident, Resident Representative, or Family Interview:	**Resident, Resident Representative, or Family Interview:**
While conducting the interview, be alert for evidence of psychosocial and/or physical harm resulting from the discharge (e.g., expressions of fear, anxiety, tearfulness, evidence of physical trauma, etc.)	While conducting the interview, be alert for evidence of psychosocial and/or physical harm resulting from the discharge (e.g., expressions of fear, anxiety, tearfulness, evidence of physical trauma, etc.)

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ If the resident has been discharged or issued a notice of discharge, ask: o Where is the resident currently/where is the resident going to be discharged? o Is the resident safe? o Was the resident informed of the location of discharge? o How was the resident involved in selecting the new location? o Does resident have any urgent medical needs? o Where would the resident like to be? o What is the most appropriate setting to meet resident's care needs? o Has the resident experienced any physical or psychosocial harm from the discharge? o Would the resident like to return to the facility from where he or she was discharged? o What did the facility talk to you about regarding post-discharge care (e.g., self-care, caregiver assistance)? ☐ Ask the resident (or his or her representative) to share his or her understanding of the reasons for the discharge and what the facility said as to why the discharge was necessary. ☐ Ask the resident (or his or her representative) to share his or her objections to the discharge that were communicated with the facility. What was the facility response to the objections? ☐ What information did the facility give the resident (or his or her representative) regarding his/her discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable?	☐ If the resident has been or is going to be discharged, ask: o Where is the resident currently/where is the resident going to be discharged? o Is the resident safe? o Does resident have any urgent medical needs? Did the facility fail to provide the resident with services for their medical needs? o Where would the resident like to be? o What is the most appropriate setting to meet resident's care needs? ☐ Is/was it the resident's choice to leave the facility? ☐ Did the resident provide verbal or written notice that he/she wanted to leave the facility? ☐ Did/does the resident feel pressured by the facility to leave? ☐ Was the resident (or his or her representative) involved in discharge planning prior to the discharge? ☐ Is/was the resident interested in returning to the community? If so, was there a referral to the local contact agency or other appropriate entities? ☐ Is/was the resident interested in transferring to another SNF, HHA, IRF, or LTCSH? If so, did the facility help you in selecting another provider? ☐ Does this discharge align with the resident's goals, preferences and choices?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ Did you appeal the discharge? If so, were you allowed to stay in the facility while the appeal was pending?	
Staff Interviews for Facility-initiated Discharges	**Staff Interviews for Resident-initiated Discharges**
☐ Why is the resident being discharged? Based on the reason provided, refer to the appropriate section below: **<u>Inability to meet resident needs:</u>** o What services are you unable to provide to meet the resident's needs? o For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? o What does the new facility offer that can meet the resident's needs that you could not offer? o How did you determine your capability to care for the resident prior to the resident's admission? o Do you serve residents with similar needs? If yes, how do the needs of this resident differ? **<u>Health improved and no longer needs services by the facility:</u>** o What services were you providing to the resident? o How did you determine the resident's health had improved and services were no longer needed? **<u>Endangering the health or safety of others:</u>**	☐ What is the process for determining whether a resident can be discharged back to the community? ☐ How do you involve the resident or resident representative in the discharge planning? ☐ Did the resident indicate an interest in returning to the community? If so, what referrals were made to the Local Contact Agency? ☐ How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated? ☐ What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location or with other service providers (e.g., home health services, primary care physician, etc.)? ☐ How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
○ Describe the resident's clinical or behavioral status that endangered the health or safety of others. ○ How did the clinical or behavioral status endanger the health or safety of others? (Surveyors will need to determine if the reason provided gives adequate justification for discharge.) ○ What does the new facility offer that can meet the resident's needs that you could not offer? ○ How did you determine your capability to care for the resident prior to the resident's admission? ○ If a resident is discharged based on behavioral status: Do you serve residents with similar behaviors? If yes, how does this resident's behavioral status differ? **Non-payment:** ○ When and how did you notify the resident of non-payment? ○ When did the facility notify the resident of a change in payment status, if applicable? ○ How did the facility assist the resident to submit any third-party paperwork, if applicable? ☐ Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible? If so, how did it go? ☐ What, when, and how was necessary healthcare information shared with staff at a new location, if applicable?	
Record Review for Facility-initiated Discharges	**Record Review for Resident-initiated Discharges**

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ What is the basis for the facility-initiated discharge? Review the resident's record to determine if there is adequate evidence to support the basis for the discharge. Use the following probes to guide the review of medical record evidence. **Inability to meet resident needs:** o Has the facility attempted interventions to meet the resident's needs? o Has the facility consulted with the resident's attending physician and other medical professionals and followed orders and care plans appropriately in order to meet the resident's needs? o Is the facility providing care for residents with similar care needs? o Is there evidence in the record that discharge concerns, reasons, and location were discussed with the resident or the resident representative? o Did the physician document the specific needs the facility could not meet; facility efforts to meet those needs; and the specific services the receiving facility will provide that the current facility could not meet? **Improved and no longer needs care:** o What services was the facility providing for the resident that are no longer required? o Does the resident's record support that the resident no longer needs these services?	☐ Is there evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility? ☐ Does the comprehensive care plan contain the resident's goals for admission and desired outcomes, and do these goals and desired outcomes align with an actual or planned discharge? ☐ Were discharge care planning needs updated as needed with the level of care the resident required at the time of discharge? ☐ Is there a discharge care plan and documented discussions with the resident and/or his or her representative containing details of discharge planning and arrangement for post-discharge care (e.g., home health service, physician visits, medication needs, etc.)? ☐ Is there a discharge summary which contains the required elements: o A recapitulation (containing all required components) of the resident's stay? o A final summary of the resident's status that includes the items listed at F661? o A reconciliation of all pre- and post-discharge medications? ☐ Is there evidence that the discharge summary was conveyed to the continuing care provider or receiving facility at the time of discharge?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
○ Did the physician document the basis for the transfer or discharge? **Endangering the health or safety of others:** ○ Has the facility's failure to properly supervise or provide care and services contributed to the resident's dangerous behaviors? ○ If provided with appropriate care and services at the nursing home, would the resident be a danger to self or others? ○ Does the record reflect that the behaviors were truly dangerous rather than just requiring additional staff time and attention? ○ Is there evidence in the record that discharge concerns, reasons, and location were discussed with the resident or the resident representative? ○ Did a physician document the reason for the transfer or discharge? **Non-payment:** ○ Has the resident been given reasonable and appropriate notice to pay for the stay at the facility? ○ Has the facility assisted the resident in applying for Medicaid coverage? ○ Was the application for Medicaid approved or denied? ○ If the resident is eligible for Medicaid coverage, is there a Medicaid bed available in the facility? ○ If not eligible for Medicaid, or there are no Medicaid beds available, has the facility offered the resident an opportunity to pay privately for a bed?	☐ Is there evidence the facility asked the resident about their interest in receiving information regarding returning to the community? ☐ If referrals were made to the local contact agency, did the facility update the discharge plan in response to information received? ☐ If the resident cannot return to the community, who made the determination and why? ☐ Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs? ☐ Who from the IDT was involved in the ongoing process of developing the discharge plan? ☐ What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate? ☐ If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences. ☐ Does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
<u>The facility has or will cease to operate.</u> ☐ Was the transfer or discharge documented in the resident's medical record and appropriate information communicated to the receiving health care institution or provider [see §483.15(c)(2)(i)(ii)(iii)]. ☐ Was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident, resident representative, and a copy to the ombudsman: o Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and o If changes were made to the notice, were recipients of the notice updated? ☐ If a resident was not permitted to return after a planned therapeutic leave, does the medical record contain a basis for the discharge that complies with §483.15(c)(1)?	☐ Is there evidence the resident was provided with a discharge summary with information of the resident's level of care and services required?
At the conclusion of this investigation, the surveyor should determine: • Is this discharge facility-initiated? **Yes or No** • **If Yes,** is there **noncompliance with F622, F623, or F626** (CE3, 4, and 5 below – mark CE1 and CE2 as NA) • **If No,** is there **noncompliance with F660 and/or F661** (CE1 and 2 below – mark CE3, CE4, and CE5 as NA)	**At the conclusion of this investigation, the surveyor should determine:** • Is this discharge resident-initiated? **Yes or No** • **If Yes,** is there **noncompliance with F660 and/or F661** (CE1 and 2 below – mark CE3, CE4, and CE5 as NA) • **If No, evaluate** facility compliance with the **Facility-initiated discharge requirements**

*NOTE: If after completing the investigative pathway, it's determined the resident was discharged **improperly** to an unsafe location, the surveyor should refer to Appendix Q and determine whether Immediate Jeopardy has occurred.

Critical Element Decisions:

1) For a resident-initiated, planned discharge, did the facility:
   - Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support;
   - Document that the resident was asked about their interest in receiving information about returning to the community;
   - Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital); and/or

   If No, cite F660
   N/A, this is a facility-initiated discharge.

2) For a resident-initiated, planned discharge, did the facility:
   a. Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
   b. Develop a post-discharge plan of care, including discharge instructions?

   If No, cite F661
   N/A, this is a facility-initiated discharge.

3) For a facility-initiated discharge, does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., discharge is necessary for the resident's welfare, and the resident's needs could not be met in the facility; the resident no longer requires services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates). Does evidence in the medical record support the basis for this resident's discharge?
   If No, cite F622
   N/A, this is a resident-initiated, planned discharge

4) For a facility-initiated discharge, was required discharge information per 483.15(c)(2)(i)-(ii), documented in the resident's record and appropriate information communicated to the receiving facility per 483.15(c)(2)(iii)?
   If No, cite F622
   N/A, this is a resident-initiated, planned discharge

5) For a facility-initiated discharge, were the resident, resident representative, and ombudsman notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge, or as soon as practicable if the discharge meets one of the exceptions at 483.15(c)(4)(ii)? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)?
   If No, cite F623
   N/A, this is a resident-initiated, planned discharge

6) After a resident's therapeutic leave, did a facility permit the resident to return? If No, was a there a valid basis for the discharge according to 483.15(c)(1)?
   If No, cite F626
   N/A, the resident's transfer or discharge was not related to therapeutic leave

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Participate in Care Plan F553, Notification of Change F580, Professional Standards F658, Medically Related Social Services F745, Resident Records F842, QAPI/QAA (Task), Orientation for Transfer or Discharge F624, Permitting Residents to Return to Facility F626.

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being. If a resident is prescribed psychotropic medications, review the Unnecessary Medication, Psychotropic Medications, and Medication Regimen Review Critical Element (CE) Pathway.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive *and the* most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C, D, E and N.
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided to meet the resident's individual needs? If so, what evidence was observed?
- ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice (e.g., daily routines, dining preferences, mobility, activities, bathing, or use of the bathroom)?
- ☐ Are staff using individualized, non-pharmacological interventions to attain or maintain the resident's well-being? If so, provide examples.
- ☐ How does staff monitor the effectiveness of the resident's care planned interventions?
- ☐ How does the facility modify the environment or facility practices (e.g., ADL care, daily routines, activities) to accommodate the resident's care needs?
- ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
- ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741 using the Behavior-Emotional Status CE pathway.

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
- ☐ How did the facility involve you/the resident in the care plan and goal development process, including the implementation of non-pharmacological approaches to care?
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- ☐ How did the facility consider your/the resident's choices and preferences?

Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to

Dementia Care Critical Element Pathway

- ☐ How were you informed of the risks and benefits of all interventions in your/the resident's care plan?
- ☐ How were you informed of the intended benefits and potential side effects of your/the resident's medication regimen?

Staff Interviews (Interdisciplinary team (IDT) members) Across Various Shifts:

- ☐ Can you tell me about the resident's care plan and his/her condition (including underlying causes)?
- ☐ How do you ensure care is consistent with the care plan?
- ☐ How do you use non-pharmacological interventions to attain or maintain the resident's well-being?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- ☐ What process is used to inform the resident and/or resident representative of the risks and benefits of all interventions in the resident's care plan?
- ☐ What process is used to inform the resident and/or resident representative of the intended benefits and potential side effects of the resident's medication regimen?
- ☐ How do you ensure that pharmaceutical interventions are used only when clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ What are the facility's dementia care guidelines and protocols?
- ☐ What types of dementia management training have you completed?
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and determine what type of social services or referrals have been implemented, also determine compliance with F745.
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ Determine what documentation identifies, in advance of the care to be furnished, the explanation of the risks and benefits of proposed interventions.
- ☐ Was dementia management training provided to staff?

Note: How does the facility inform residents and/or resident representatives, in advance of care, of the risks and benefits and

include measurable objectives and timetables? Has the care plan been revised to reflect any changes?

possible alternatives of treatment (e.g., non-pharmacological approaches to care and treatment other than medications)? Is this process in compliance with requirements at F552?

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measurable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) Did the facility inform the resident and/or resident representative, in advance of care, of the risks and benefits and possible alternatives of treatment?

   If No, cite F552

Dementia Care Critical Element Pathway

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a Significant Change in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant changed in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Dementia Care Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, Resident Rights F550, Choices (CA), QOL F675, Physician Services F710, Social Services F745, Sufficient and Competent Staffing (Task), Activities (CA).

Mapping for All Areas

	A	B	C	D	E
1	**During sample selection for an initial certification survey, cross off any care area/tag that will be investigated for sample residents. For any remaining area/tag, ensure the review identified in column E has been completed. F684 (QOC) covers edema, constipation, skin conditions, positioning, change of condition, hospitalization and death. The P&P review should address these areas. Infections are covered under the Infection Control Task. Participation in Care Planning is covered for any resident in the sample. Facility Tasks and Unnecessary Medications are excluded from this list since they are covered in the pathway. Refer to Appendix PP for the review, as necessary.**				
2	**Initial Pool Area/Tag Not Mapped to IP**	**Critical Element #**	**Tag #**	**Tag Description**	**Initial Certification Survey Review**
3	Abuse, Neglect, Resident-to-Resident Interaction	1	F600	Free from Abuse and Neglect	P&P
4		2	F606	Not Employ/Engage Staff with Adverse Actions	P&P, Review Personnel Files
5		3	F607	Develop/Implement Abuse/Neglect, etc Policies	P&P
6		4	F943	Abuse, Neglect, and Exploitation Training	P&P
7		5	F947	Required In-Service Training for Nurse Aides	P&P, Proof of In-Service Training
8		6	F608	Reporting of Reasonable Suspicion of a Crime	P&P, Proof of Reporting if applicable
9		7	F609	Reporting of Alleged Violations	P&P, Proof of Reporting if applicable
10		8	F610	Investigate/Prevent/Correct Alleged Violation	P&P, Investigation if applicable
11	Accident Hazards (physical hazards, falls, smoking, elopement, resident-to-resident interaction)	1	F689	Free of Accident Hazards/Supervision/Devices	P&P for all Accident Hazards (physical hazards, falls, smoking, elopement, resident-to-resident interactions)
12		2	F700	Bedrails	P&P, Routine Check Documentation if applicable
13		3	F909	Resident Bed	P&P, Routine Check Documentation if applicable
14	Activities	1	F679	Activities Meet Interest/Needs of Each Resident	P&P
15	ADLs, ADL Decline	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities	P&P
16		2	F677	ADL Care Provided for Dependent Residents	P&P
17	Advance Directives (CPR)	1	F578	Request/Refuse/Discontinue Treatment;Formulate Adv Directives	P&P
18	Bladder and Bowel (P&P) Incontinence	1	F690	Bowel/Bladder Incontinence, Catheter, UTI	P&P
19	Change of Condition	1	F684	Quality of Care	P&P
20	Choices	1	F561	Self Determination	P&P
21	Constipation/Diarrhea	1	F684	Quality Of Care	P&P
22	Dementia Care	1	F744	Treatment/Service for Dementia	P&P Review dementia/Alzheimer's Unit criteria, if applicable
23	Dental	1	F790	Routine/Emergency Dental Services in SNFs	P&P
24		2	F791	Routine/Emergency Dental Services in NFs	P&P
25	Dialysis	1	F698	Dialysis	P&P and contract if applicable In-Facility Dialysis review staff qualifications, training and equipment
26		1	F692	Nutrition/Hydration Status Maintenance	P&P
27		2	F710	Resident's Care Supervised by a Physician	P&P
28	Dignity	1	F550	Resident Rights/Exercise of Rights	P&P
29	Discharge	1	F660	Discharge Planning Process	P&P
30		2	F661	Discharge Summary	P&P
31		3	F622	Transfer and Discharge Requirements: Discharge Appropriate	P&P
32		4	F622	Transfer and Discharge Requirements: Discharge Documentation in Record	P&P
33		5	F623	Notice Requirements Before Transfer/Discharge	P&P, Notice if applicable
34	Edema	1	F684	Quality Of Care	P&P
35	Food	1	F803	Menus Meet Res Needs/Prep in Advance/Followed	P&P
36		2	F804	Nutritive Value/Appear, Palatable/Prefer Temp	P&P
37	Hospice	1(A)	F675	Quality of Life (End of Life care)	P&P
38		1(B)	F675	Quality of Life (receiving Hospice Services)	P&P

	A	B	C	D	E
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2	**Initial Pool Area/Tag Not Mapped to IP**	**Critical Element #**	**Tag #**	**Tag Description**	**Initial Certification Survey Review**
39	Hospice	2	F849	Hospice Services	P&P, Agreement, Contract if applicable
40	Hospitalization	1	F684	Quality of Care	P&P
41		2	F622	Transfer and Discharge Requirements	P&P
42		3	F623	Notice Requirements Before Transfer/Discharge	P&P
43		4	F624	Preparation for Safe/Orderly Transfer/Discharge	P&P
44		5	F625	Notice of Bed Hold Policy Before/Upon Transfer	P&P
45		6	F626	Permitting Residents to Return to Facility	P&P
46	Hydration	1	F692	Nutrition/Hydration Status Maintenance	P&P
47	Language/ Communication	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities	P&P
48		2	F685	Treatment/Devices to Maintain Hearing/Vision	P&P
49	Limited Range of Motion (ROM), Positioning	1(A)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted Without Limited ROM)	P&P
50		1(B)	F688	Increase/Prevent Decrease in ROM/Mobility (Admitted With Limited ROM)	P&P
51		2	F684	Quality of Care	P&P
52	Mood/Behavior	1	F740	Behavioral Health Services	P&P
53		2	F741	Sufficient/Competent Staff-Behav Health Needs	P&P, Proof of In-Service training
54		3	F742	Treatment/Svc for Mental/Psychosocial Concerns	P&P
55		4	F743	No Pattern of Behavioral Difficulties Unless Unavoidable	P&P
56	Notification of Change	1	F580	Notify of Changes (Injury/Decline/Room, Etc.)	P&P
57	Nutrition	1	F692	Nutrition/Hydration Status Maintenance	P&P
58		2	F710	Resident's Care Supervised by a Physician	P&P
59	Pain	1	F697	Pain Management	P&P
60	Personal Property	1	F584	Safe/Clean/Comfortable/Homelike Environment	P&P
61	Preadmission Screening and Resident Review (PASARR)	1	F645	PASARR Screening for MD & ID: Level I Prior to Admission	P&P
62		2	F645	PASARR Screening for MD & ID: Short Stay Longer than 30 Days	P&P
63		3	F645	PASARR Screening for MD & ID: Refer for Level II	P&P
64		4	F644	Coordination of PASARR and Assessments: Refer for Newly Evident Condition	P&P
65		5	F644	Coordination of PASARR and Assessments: Incorporate Level II Recommendations	P&P
66		6	F644	Coordination of PASARR and Assessments: Notify Authority Timely of Newly Evident Condition	P&P
67		7	F646	MD/ID Significant Change Notification	P&P
68	Pressure Ulcers	1	F686	Treatment/Svcs to Prevent/Heal Pressure Ulcers	P&P
69		2	F710	Resident's Care Supervised by a Physician	P&P
70	Privacy	1	F583	Personal Privacy/Confidentiality of Records	P&P
71	Rehab	1	F825	Provide/Obtain Specialized Rehab Services	P&P
72		2	F676	Activities of Daily Living (ADLs)/Maintain Abilities	P&P
73	Respiratory Infection, Oxygen, Vent, Trach	1	F695	Respiratory/Tracheostomy Care and Suctioning	P&P
74	Restraints	1	F604	Right to be Free from Physical Restraints	P&P

	A	B	C	D	E
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2	**Initial Pool Area/Tag Not Mapped to IP**	**Critical Element #**	**Tag #**	**Tag Description**	**Initial Certification Survey Review**
75	Skin Conditions (non-pressure related)	1	F684	Quality Of Care	P&P
76	Tube Feeding	1	F693	Tube Feeding Management/Restore Eating Skills	P&P
77	Vision and Hearing	1	F676	Activities of Daily Living (ADLs)/Maintain Abilities	P&P
78		2	F685	Treatment/Devices to Maintain Hearing/Vision	P&P
79	Death (Closed Record)	1	F684	Quality of Care	P&P
80	F551	1	F551	Rights Exercised by Representative	P&P
81	F552	1	F552	Right to be Informed/Make Treatment Decisions	P&P
82	F553	1	F553	Right to Participate in Planning Care	P&P
83	F554	1	F554	Resident Self-Admin Meds-Clinically Appropriate	P&P
84	F555	1	F555	Right to Choose/Be Informed of Attending Physician	P&P
85	F557	1	F557	Respect, Dignity/Right to have Personal Property	P&P
86	F559	1	F559	Choose/Be Notified of Room/Roommate Change	P&P
87	F560	1	F560	Right to Refuse Certain Transfers	P&P
88	F562	1	F562	Immediate Access to Resident	P&P
89	F564	1	F564	Inform of Visitation Rights/Equal Visitation Privilege	P&P
90	F566	1	F566	Right to Perform Facility Services or Refuse	P&P
91	F575	1	F575	Required Postings	P&P and/or confirm postings
92	F579	1	F579	Posting/Notice of Medicare/Medicaid on Admission	P&P, Copy of notices if available
93	F586	1	F586	Resident Contact with External Entities	P&P
94	F602	1	F602	Free from Misappropriation/Exploitation	P&P
95	F603	1	F603	Free from Involuntary Seclusion	P&P
96	F605	1	F605	Right to be Free from Chemical Restraints	P&P
97	F620	1	F620	Admissions Policy	P&P
98	F621	1	F621	Equal Practices Regardless of Payment Source	P&P
99	F635	1	F635	Admission Physician Orders for Immediate Care	P&P
100	F638	1	F638	Quarterly Assessment At Least Every 3 months	P&P
101	F639	1	F639	Maintain 15 Months of Resident Assessments	P&P
102	F640	1	F640	Encoding/Transmitting Resident Assessment	P&P
103	F642	1	F642	Coordination/Certification of Assessment	P&P
104	F659	1	F659	Qualified Persons	P&P or evidence of qualifications
105	F678	1	F678	Cardio-Pulmonary Resuscitation (CPR)	P&P
106	F680	1	F680	Qualifications of Activity Professional	P&P or evidence of qualifications
107	F687	1	F687	Foot Care	P&P
108	F691	1	F691	Colostomy, Urostomy, or Ileostomy Care	P&P
109	F694	1	F694	Parenteral/IV Fluids	P&P
110	F696	1	F696	Prostheses	P&P
111	F745	1	F745	Provision of Medically Related Social Service	P&P
112	F770	1	F770	Laboratory Services	P&P
113	F771	1	F771	Blood Bank and Transfusion Services	P&P
114	F772	1	F772	Lab Services Not Provided On-Site	P&P
115	F773	1	F773	Lab Svs Physician Order/Notify of Results	P&P
116	F774	1	F774	Assist with Transport Arrangements to Lab Svcs	P&P
117	F775	1	F775	Lab Reports in Record-Lab Name/Address	P&P
118	F776	1	F776	Radiology/Other Diagnostic Services	P&P
119	F777	1	F777	Radiology/Diag. Svcs Ordered/Notify Results	P&P
120	F778	1	F778	Assist with Transport Arrangements in Radiology	P&P
121	F779	1	F779	X-Ray/Diagnostic Report in Record-Sign/Dated	P&P

Mapping for All Areas

	A	B	C	D	E
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2	**Initial Pool Area/Tag Not Mapped to IP**	**Critical Element #**	**Tag #**	**Tag Description**	**Initial Certification Survey Review**
122	F826	1	F826	Rehab Services-Physician Order/Qualified Person	P&P Review therapy qualifications, if applicable
123	F906	1	F906	Emergency Power	P&P
124	F907	1	F907	Space and Equipment	P&P
125	F910	1	F910	Resident Room	P&P and/or review during screening
126	F911	1	F911	Bedroom Number of Residents	P&P and/or review during screening
127	F912	1	F912	Bedrooms Measure at Least 80 Square Ft/Resident	P&P and/or review during screening
128	F913	1	F913	Bedrooms Have Direct Access to Exit Corridor	P&P and/or review during screening
129	F914	1	F914	Bedrooms Assure Full Visual Privacy	P&P and/or review during screening
130	F915	1	F915	Resident Room Window	P&P and/or review during screening
131	F916	1	F916	Resident Room Floor Above Grade	P&P and/or review during screening
132	F917	1	F917	Resident Room Bed/Furniture/Closet	P&P and/or review during screening
133	F918	1	F918	Bedrooms Equipped/Near Lavatory/Toilet	P&P and/or review during screening
134	F922	1	F922	Procedures to Ensure Water Availability	P&P

Psychosocial Outcome Severity Guide

Clarification of Terms

"Anger" refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

"Apathy" refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

"Anxiety" refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper-vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

"Dehumanization" refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.

"Depressed mood" (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

"Humiliation" refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

Purpose

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag. The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome. The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome. For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, *as demonstrated by fear, agitation, and/or isolation*. In this case, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency.

Overview

Psychosocial outcomes (*e.g.*, *changes in* mood and/*or* behavior) may result from a facility's noncompliance with any regulatory requirement. *A* resident may *have* experienced *(or may have the potential or likelihood to experience)* a negative physical outcome *and/*or a negative psychosocial outcome *resulting from facility noncompliance*.

Psychosocial and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level should reflect the most significant negative outcome or highest level of harm/potential harm.

The presence of a given affect (i.e., behavioral manifestation of mood) does not necessarily indicate a psychosocial outcome that is the direct result of noncompliance. A resident's reactions and responses (or lack thereof) also may be affected by *his/her* pre-existing psychosocial issues, illnesses, medication side effects, and/or other factors. Because many nursing home residents have sadness, anger, loss of self-esteem, etc. in reaction to normal life experiences, the survey team must determine that the *negative* psychosocial outcome is a result of the noncompliance and not a pre-existing condition for the resident.

Psychosocial outcomes *may be the result of* facility noncompliance with any regulation. This also includes psychosocial outcomes resulting from facility failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, leading to continuation or worsening of the condition.

Instructions

This Guide is designed to be used separately for each resident included in the deficiency. Each resident's psychosocial response to the noncompliance is the basis for determining psychosocial severity of a deficiency. To determine severity, use the information gathered through the investigative process. Compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) and mood before and after the noncompliance.

If the survey team determines that a facility's noncompliance has resulted in a negative psychosocial outcome to one or more residents, the team should use this Guide to evaluate the severity of the outcome for each resident identified in the deficiency. The team should determine severity based *primarily* on the resident's response, *or if appropriate, apply the reasonable person concept to the deficient practice.*

Application of the Reasonable Person Concept

There are circumstances in which the survey team *should* apply the "reasonable person concept" to determine severity of the deficiency, *such as when a resident's psychosocial outcome may not be readily determined through the investigative process*.

To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance).

NOTE: The reasonable person concept described in this Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes. Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate and is expressly precluded.

Use the reasonable person concept *to determine* a resident's psychosocial outcome, *which* may not be readily determined. *For example:*

- When *a resident may not be able to express their feelings,* there is no discernable response, or when circumstances *may not permit* the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

- When *a* resident's reaction to a deficient practice is markedly incongruent *(or different)* with the level of reaction a reasonable person would have to the deficient practice.

Severity Levels

The following are *examples of severity* levels of negative psychosocial outcomes that *could have* developed, continued, or worsened as a result of *a* facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation *has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.* Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level four* include, but are not limited to:

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).

- Sustained and intense crying, moaning, screaming, or combative behavior.

- Expressions (verbal and/or non-verbal) of severe, unrelenting, excruciating, and unrelieved pain; pain has become all-consuming and overwhelms the resident.

- Recurrent (i.e., more than isolated or fleeting) debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of a specific staff member).

- Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persists regardless of whether the precipitating event(s) has ceased and has resulted in a potentially life-threatening consequence.

- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, impairment, or death to self or others.

- *Extreme changes in social patterns, such as sustained isolation from staff, friends and family for a prolonged period of time.*

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level three* include, but are not limited to:

- Significant decline in former social patterns that does not rise to a level of immediate jeopardy.

- Persistent depressed mood that may be manifested by verbal and nonverbal symptoms such as:
    - Social withdrawal; *apathy*; irritability; anxiety; hopelessness; tearfulness; crying; moaning;
    - Loss of interest or ability to experience or feel pleasure nearly every day for much of the day;
    - Psychomotor agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a bothered or sad expression;
    - Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering);

- Verbal agitation (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), accompanied by sad facial expressions;

- Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care);

- Markedly diminished ability to think or concentrate;

- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead" or "my family would be better off without me").

- Expressions (verbal and/or non-verbal) of persistent pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, weight loss and/or diminished appetite. Pain or physical distress has become a central focus of the resident's attention, but it is not all-consuming or overwhelming (as in Severity Level 4).

- Chronic or recurrent fear/anxiety that has compromised the resident's well-being and that may be manifested as avoidance of the fear-inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization (as in Severity Level 4).

- Ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists regardless of whether the precipitating, dehumanizing event(s) or situation(s) has ceased. The*se* feelings do not result in a life-threatening consequence.
- Sustained distress (e.g., agitation indicative of under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something).
- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, screaming, or cursing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level two* include but are not limited to:

- Intermittent sadness, as reflected in facial expression and/or demeanor, tearfulness, crying, or verbal/vocal agitation (e.g., repeated requests for help, moaning, and sighing).

- Feelings and/or complaints of discomfort or moderate pain. The resident may be irritable and/or express discomfort.

- Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well- being.

- Feeling of shame or embarrassment without a loss of interest in the environment and the self.

- Complaints of boredom and/or reports that there is nothing to do, accompanied by expressions of periodic distress that do not result in maladaptive behaviors (e.g., verbal or physical aggression).

- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm
Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the *following* areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome. *Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:*

483.10 Resident Rights
F557, Respect, Dignity/Right to Have Personal Property;
F558, Reasonable Accommodation of Needs/Preferences;

483.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;
F602 Free from Misappropriation/Exploitation;
F603, Free from Involuntary Seclusion;
F604, Right to be Free from Physical Restraints;
F605, Right to be Free from Chemical Restraints;
F606, Not Employ/Engage Staff with Adverse Actions;
F607, Develop/Implement Abuse/Neglect, etc. Policies;
F608, Reporting of Reasonable Suspicion of a Crime;
F609, Reporting of Alleged Violations;

F610, Investigate/Prevent/Correct Alleged Violation;

483.21 Comprehensive Resident Centered Care Plans
F656, Develop/Implement Comprehensive Care Plan;
F657 Care Plan Timing and Revision;

483.24 Quality of Life
F675, Quality of Life
F679, Activities Meet Interest/Needs of Each Resident;

483.40 Behavioral Health Services
F740, Behavioral Health Services;
F741 Sufficient/Competent Staff – Behavioral Health Needs;
F742, Treatment/Services for Mental/Psychosocial Concerns;
F743, No Pattern of Behavioral Difficulties Unless Unavoidable;
F745, Provision of Medically Related Social Services;

483.45 Pharmacy Services
F757, Drug Regimen is Free From Unnecessary Drugs; and
F758, Free from Unnecessary Psychotropic Medications/PRN Use.

Dietary

DIETARY OBSERVATIONS

1x per month until survey window: then weekly

Place a check under the Yes or No column and N/A if practice not observed	Yes	No	N/A
GENERAL OBSERVATIONS			
Proper uniform per facility policy			
Clean apron			
Closed toed shoes			
Minimal Jewelry (watch, wedding ring, stud earrings)			
Hair restraints covering ALL hair (facial restraint if needed)			
Fingernails short and clean			
Visible wounds gloved at all times			
No eating, drinking or chewing gum			
Name tag worn			
MEAL PREPARATION OBSERVATIONS			
Hands washed before beginning meal preparation			
Hands washed and/or gloves changed when soiled			
Gloves worn when handling ready to eat foods or tongs used (i.e. potato chips, cookies, etc.) Fruits & vegetables (not heated.. carrot sticks, celery, bananas, etc.) Bread/bread products Non-Rethermalized foods (food that won't be reheated, i.e. chicken salad, chief salad)			
Utensils used when ungloved			
STEAM TABLE/SERVING LINE OBSERVATIONS			
Hands washed before beginning meal service			
Utensils/dedicated gloved hand used appropriately			
Hands washed before gloves applied			
Hands washed and/gloves changed when contaminated Changing tasks (refrigerator, dishwasher, trash can) Sneezing or coughing Touching body or someone else Touching unclean equipment or work surface			
Plates handled by edges only			
Bowls, cups, glasses handled by outside only			
Second helpings served on new plate, bowl, etc.			
Meal ticket/card available and used for each resident			
Appropriate scoops used			
PUREED MEAL OBSERVATION			
Recipe available for meal being served			
Recipe followed: Correct Ingredients? Accurate measurements?			
Finished product correct consistency? If not, appropriate corrective action taken? (i.e. change recipe and have R.D. approve)			
Reheated and/or cooled to appropriate temperatures			

Date: _____

Meal observed (circle one): Breakfast Noon Evening

Observation by: _____

Reviewed by: _____

MONTHLY MEAL QUALITY REVIEW

DATE:_____ FACILITY: _____ REVIEWER:_____

AREAS OF OBSERVATION	POINTS			COMMENTS
1. The dining room is neatly arranged, tables have clean, matching, unworn tablecloths and/or center pieces, clean floor, soiled dishes removed.	8	2	0	
2. The meal begins on time according to a posted schedule/menu is posted in dining area(s).	4	2	0	
3. Diet is correctly served, preferences are noted/followed.	4	2	0	
4. FIRST IMPRESSION of prepared trays is favorable – colorful, neatly served, garnished.	8	5	0	
5. Trays are dispersed timely.	3	1	0	
6. Water is served to residents with meals.	3	1	0	
7. Serving in the dining room follows a rotation.	3	1	0	
8. Meal complies with written menu or substitutions are documented/alternates are on the trayline/ pureed items are according to menu.	4	2	0	
9. Hot food is >140F/cold food is <41F on trayline.	4	2	0	
10. Temperatures of food on the line are recorded prior to the beginning of the meal.	3	1	0	
11. Serving utensils are appropriate according to the menu (scoop sizes, ladles, etc.)	4	2	0	
12. Dessert portions, cake squares, cornbread squares, etc. are even/uniform sizes.	3	1	0	
13. A full compliment of utensils is provided unless the reason why not is appropriately documented.	3	1	0	
14. Given glass with milk unless straw requested.	3	1	0	
15. Condiments are available for those eating in their rooms. Appropriate condiments on the dining room table.	3	1	0	
16. Rehab. dining areas are designated and used.	3	1	0	
17. Staff sit while feeding residents.	3	1	0	
18. Residents' faces are kept clean during meals and all residents are adequately assisted. Clothing protectors are available.	3	1	0	
19. There is no loud talking/arguing by staff during meal service.	3	1	0	
20. The dining area is quiet/clean/no odors.	3	1	0	
21. Disruptive residents do not create an unpleasant environment for alert, independent diners.	2	1	0	
22. Food down halls is covered with hot >120 degrees F.	2	1	0	
23. There is adequate food to meet all resident needs at mealtimes.	3	1	0	
24. The dietary manager observes on the line and in all dining areas whenever possible.	4	2	0	
25. Dining room service is completed within 20 minutes.	2	1	0	
26. Residents' meals are not rushed by clean-up crew.	3	1	0	
27. Employees visit with residents, not with each other.	2	1	0	
28. Food has a good taste/regular food is seasoned/rolls are brushed with margarine/beverages have unmelted ice.	4	2	0	
29. A monthly residents' choice meal is provided.	3	1	0	

CIRCLE POINTS ACCORDING TO FINDINGS. COMMENT ON ALL COLUMN 3 FINDINGS.

Column 1 = Excellent; Column 2 = Improvements needed; Column 3 = Unacceptable

RECORD THE SUM OF ALL POINTS CIRCLED _____ (THERE ARE 100 POSSIBLE POINTS.)

A SCORE OF LESS THAN 75 REQUIRES FOLLOW-UP BY ADMINISTRATOR & MANAGER WITHIN 7 DAYS.

MONTHLY SANITATION/INFECTION CONTROL REVIEW

DATE:_____ FACILITY: _____ REVIEWER:_____

AREAS OF OBSERVATION	POINTS			COMMENTS
1. FIRST IMPRESSION of dietary cleanliness from dietary entrance is favorable.	8	4	0	
2. Floor is clear of trash and food particles.	4	2	0	
3. Walls are free of splatters, damage, peeling paint, paper clutter, etc. Papers are all in covers on clean bulletin board(s).	4	2	0	
4. Ceiling is in good repair and appears clean, with clean, unbroken light fixtures - all bulbs working/bulbs covered.	4	2	0	
5. Hood is free of grease, operational, lights work, extinguisher nozzles free of grease/dust, filters clean.	4	2	0	
6. In dry storage, food is off floor by 6", on sanitizable shelves, 18" from ceiling, all food is in enclosed clean containers if opened. Food is neatly arranged/dated and FIFO. No empty boxes and damaged products are grouped for return.	4	2	0	
7. In refrigerated/freezer storage, food is neatly arranged on clean shelving. Thermometers register less than 41 degrees F. or 0 degrees F. for freezer.	4	2	0	
8. All opened food is labeled/dated, and covered.	4	2	0	
9. There are no smudges, fingerprints, dried food particles on refrig./freezer outside surfaces.	2	1	0	
10. Nonfood and chemicals are stored away from food.	3	1	0	
11. Walk-in, floors dry, clean fans, covered lighting.	2	1	0	
12. Inside and outside of all cooking equipment is clean.	4	2	0	
13. All work surfaces, under shelves and legs are free of food/dirt/dust/grease build-up.	3	1	0	
14. All surfaces are free of rust.	2	1	0	
15. Prep. equipment/dishes/utensils are effectively sanitized and properly stored.	4	2	0	
16. Food transport prevents contamination.	3	1	0	
17. Sewage and plumbing meet state or local law.	3	1	0	
18. All refuse containers are covered/clean/adequate.	3	1	0	
19. Frozen foods are thawed properly.	3	1	0	
20. Safe water source with sufficient hot/cold water under pressure.	3	1	0	
21. The can opener is clean/blade not badly worn	3	1	0	
22. There are sufficient cleaning cloths in good condition.	2	1	0	
23. The pot/pan sink is used properly.	3	1	0	
24. Hairnets are on/dress appropriate/no nail polish.	3	1	0	
25. All carts are clean – including wheels.	2	1	0	
26. Manager's office is free of clutter/organized.	3	1	0	
27. Only NSF approved food storage containers are used for leftovers, opened items, etc.	3	1	0	
28. Slicer and mixer bowl are covered when unused.	2	1	0	
29. There is no sign of pest infestation.	3	1	0	
30. All equipment is working properly.	3	1	0	
31. Mops are hung-up, brooms, etc. stored properly.	2	1	0	

CIRCLE POINTS ACCORDING TO FINDINGS. COMMENT ON ALL COLUMN 3 FINDINGS.

Column 1 = Excellent; Column 2 = Improvements needed; Column 3 = Unacceptable

RECORD THE SUM OF ALL POINTS CIRCLED _____ (THERE ARE 100 POSSIBLE POINTS.)

A SCORE OF LESS THAN 75 REQUIRES FOLLOW-UP BY ADMINISTRATOR & MANAGER WITHIN 7 DAYS.

MEAL AUDIT TOOL

Date: _____

Person assigned: _____

Specific area to monitor: _____

Time meal starts: B_____ L_____ D _____

	Breakfast	**Lunch**	**Dinner**
Meals are posted and served per menu.			
Alternate is posted.			
Residents are served in a timely manner.			
Correct diets are served to the residents according to their meal card.			
Staff are assisting residents with meals as needed and not talking over residents to other staff.			
Meal started on time.			
Staff washed hands before passing trays and as needed during meal service.			
Residents are appropriately groomed and ready for meal service.			

Nutrition Critical Element Pathway

Use this pathway for a resident who is not maintaining acceptable parameters of nutritional status or is at risk for impaired nutrition to determine if facility practices are in place to identify, evaluate, and intervene to prevent, maintain, or improve the resident's nutritional status, unless the resident's clinical status demonstrates that this is not possible, or resident preferences indicate otherwise.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, D, G*G*, K, L, and O.
- ☐ Physician's orders (e.g., food allergies/intolerances and preferences, nutritional interventions [e.g., supplements], assistance with meals, type of diet [e.g., mechanically altered], therapeutic diet [e.g., low sodium diet], weight monitoring, meds [e.g., psychotropic meds, diuretics], and labs).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., nutritional interventions, assistance with meals, assistive devices needed to eat, type of diet, therapeutic diet, food preferences, or pertinent labs).

Observations:

- ☐ Observe the resident at a minimum of two meals:
  - Are the resident's hands cleaned before the meal if assisted by staff;
  - Is the diet followed (texture, therapeutic, and preferences);
  - Are proper portion sizes given (e.g., small or double portions);
  - Is the resident assisted (with set-up and eating, positioning, supervision, etc.), cued, and encouraged as needed;
  - Are assistive devices in place and used correctly (e.g., plate guard, modified utensils, sippy cups);
  - If the resident isn't eating or refuses: What does staff do (e.g., offer substitutes, encourage, or assist the resident); and
  - How is the dignity of the resident maintained?
- ☐ Are care-planned and ordered interventions in place?
- ☐ Is the call light in reach if the resident is eating in their room?
- ☐ Are there environmental concerns that may affect the resident during meals, such as loud or distracting noises, the inability to reach snacks kept in their room, or other concerns?
- ☐ Does the resident's physical appearance indicate the potential for an altered nutritional status (e.g., cachectic, dental problems, edema, no muscle mass or body fat, decreased ROM, or coordination in the arms/hands)?
- ☐ How physically active is the resident (e.g., pacing or wandering)?
- ☐ Are supplements provided and consumed at times that don't interfere with meal intake (e.g., supplement given right before the meal and the resident doesn't eat the meal)?
- ☐ Are snacks given and consumed as care planned?
- ☐ Is the resident receiving OT, SLP, or restorative therapy services? If so, are staff following their instructions (e.g., head position or food placement to improve swallowing)?
- ☐ Is there any indication that the resident could benefit from therapy services that are not currently being provided (difficulty grasping utensils, difficulty swallowing)?
- ☐ If a resident is receiving nutrition with a feeding tube, observe for positioning, type of tube feeding, whether a pump or gravity is being used, and the rate and amount being provided.

Nutrition Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How did the facility involve you in the development of your care plan and goals?
- ☐ Have you lost weight in the facility? If so, why do you think you've lost weight (e.g., taste, nausea, dental, grief, or depression issues)?
- ☐ What is the facility doing to address your weight loss? (Ask about specific interventions – e.g., supplements.)
- ☐ Do they give you the correct diet, snacks, supplements, and honor your food preferences/allergies? If not, describe.
- ☐ If you don't want the meal, does staff offer you a substitute?
- ☐ Does staff set up your meal, assist with eating, or encourage you as needed? If not, describe.
- ☐ Do you have difficulty chewing or swallowing your food? If so, how is staff addressing this?
- ☐ Do they give you assistive devices so you can be as independent as possible? If not, describe.
- ☐ Do they give you enough time to eat? If not, describe.
- ☐ Do your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances? If not, describe.
- ☐ How does staff involve you in decisions about your diet, food preferences, and where to eat?
- ☐ If you know the resident has refused: What did the staff tell you about what might happen if you don't follow your plan to help maintain your weight?
- ☐ Are you continuing to lose weight? If so, why do you think that is?

Nursing Aide, Dietary Aide or Paid Feeding Assistant:

- ☐ Are you familiar with the resident's care?
- ☐ Where does the resident eat?
- ☐ How much assistance does the resident need with eating?
- ☐ How do you encourage the resident to feed him/herself when possible?
- ☐ Are any supplements given with the meal?
- ☐ How are meal intakes, supplements and weights monitored?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Do you know if the resident has lost weight? Has the treatment plan changed?
- ☐ Have you reported any changes in the resident's weight or intake? Who would you report this to?
- ☐ Ask about identified concerns.

Nurse:

- ☐ Are you familiar with the resident's care?
- ☐ How much assistance does the resident need with eating?
- ☐ How are meal intakes, supplements, and weights monitored? Where is it documented?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Has the resident lost weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- ☐ Ask about identified concerns.

Nutrition Critical Element Pathway

Registered Dietitian or Dietary Manager:

- ☐ Who is involved in evaluating and addressing any underlying causes of nutritional risks or impairment?
- ☐ Does the resident require any assistance with meals?
- ☐ Is the resident at risk for impaired nutritional status? If so, what are the risk factors?
- ☐ Has the resident had a loss of appetite, or any GI, or dental issues? If so, what interventions are in place to address the problem?
- ☐ Has the resident lost any weight recently? When did the weight loss occur? What caused it?
- ☐ If the resident's weight loss is recent: Who was notified and when were they notified?
- ☐ Were any interventions in place before the weight loss occurred?
- ☐ Have you seen the resident eat? What meal? Did he/she eat all the meal?
- ☐ What are you doing to address the weight loss?
- ☐ How often is the resident's food/supplement intake, weight, eating ability monitored? Where is it documented?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident/representative in decisions regarding treatments? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident continuing to lose weight? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ How do you communicate nutritional interventions to the staff?
- ☐ Ask about identified concerns.
- ☐ Who from the Food and Nutrition staff attends the interdisciplinary team meetings?

Practitioner or other Licensed Health Care Practitioner Interviews: If the interventions defined, or the care provided, appear to be inconsistent with current standards of practice, orders, or care plan, interview one or more practitioners or other licensed health care practitioners who can provide information about the resident's nutritional risks and needs.

- ☐ What was the rationale for the chosen interventions?
- ☐ How is the effectiveness of the current interventions evaluated?
- ☐ How have staff managed the interventions?
- ☐ How does the interdisciplinary team decide to maintain or change interventions?
- ☐ What is the rationale for decisions not to intervene to address identified needs?

Nutrition Critical Element Pathway

Record Review:

- ☐ Review the MDS and CAAs, nursing notes, nutritional assessment and notes, rehab, social service, and physician's progress notes.
  - o Have the resident's nutritional needs been assessed (e.g., calories, protein requirement, UBW, weight loss, desired weight range);
  - o Was the cause of the weight loss identified; and/or
  - o Is the rationale for chosen interventions or no interventions documented?
- ☐ Are the underlying risk factors identified (e.g., underlying medical, psychosocial, or functional causes)?
- ☐ Have the medications been reviewed for any impact affecting food intake?
- ☐ Have relevant care plan interventions been identified and implemented to try to stabilize or improve nutritional status?
- ☐ Does the care plan identify the resident's individualized goals, preferences, and choices?
- ☐ How often are food/supplement intakes monitored and documented? Are deviations identified?
- ☐ How often are weights monitored and documented? Are deviations identified?
- ☐ Are preventative measures documented prior to the weight loss?
- ☐ Was a health care provider's order obtained for a therapeutic diet, if applicable?
- ☐ Review laboratory results pertinent to nutritional status (e.g., albumin and pre-albumin) if ordered or available.
- ☐ Has the care plan been revised to reflect any changes in nutritional status?
- ☐ Do your nutritional observations match the description in the clinical record? If no, interview pertinent staff to investigate the potential discrepancy(ies).
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Review the facility policy with regard to nutritional status.
- ☐ If there is a pattern of residents who have not maintained acceptable parameters of nutritional status without adequate clinical justification, determine if Quality Assurance and Performance Improvement (QAPI) activities were initiated to evaluate the facility's approaches to nutrition and weight concerns.

Critical Element Decisions:

1) Did the facility provide care and services to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible, and did the facility ensure that the resident is offered and ordered a therapeutic diet if there is a nutritional problem?
   If No, cite F692

2) If there was a change in the resident's nutritional status, did the physician evaluate and address medical and nutritional issues related to the change?
   If No, cite F710

Nutrition Critical Element Pathway

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Nutrition Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to Refuse F578, Notification of Change F580, Choices (CA), Accommodation of Needs (Environment Task), Parenteral/IV fluids F694, Physician Delegation to a Dietitian F715, Social Services F745, Admission Orders F635, Professional Standards F658, Advance Directives (CA), ADLs (CA), Behavioral-Emotional Status (CA), Accidents (CA), Tube Feeding (CA), Hydration (CA), Unnecessary/Psychotropic Medications (CA), Provides Diet to Meet Needs F800, Qualified Dietary Staff F801, Food in Form to Meet Needs F805, Therapeutic Diet Ordered F808, Assistive Devices F810, Paid Feeding Assistant F811, Physician Services F710, Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

Social Services

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Choices	• Are you able to make choices about your daily life that are important to you? • I'd like to talk to you about your choices. Are you able to get up and go to bed when you want to? • How about bathing, are you able to choose a bath or shower? Do you choose how often you bathe? • How about food, does the facility honor your preferences or requests regarding meal times, food and fluid choices? • How about activities, are you able to choose when you go to activities? • How about meds, are you able to choose when you receive your medications? • Did you choose your doctor? Do you know their name and how to contact them? • Can you have visitors any time or are there restricted times?	No Issues/NA Further Investigation
Activities	• Do you participate in activities here? If not, why? • Do the activities meet your interests? If not, what type of activities would you like the facility to offer? • Are activities offered on the weekends and evenings? If not, would you like to have activities on the weekends or in the evenings? • Do staff provide activities you can do on your own (cards, books, other)? If resident is in the facility for rehab or is a young resident who says they don't care to participate in the activities, determine: • If it is because the activities don't interest them. or • If they wouldn't participate in activities no matter what was offered. If they don't want to participate in activities (offered or not), then mark activities as No Issues.	No Issues/NA Further Investigation

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Dignity	• Do staff treat you with respect and dignity? • Do you have any concerns about how staff treat you? If so, please describe. • Do you have any concerns about how staff treat other residents in the facility? If so, please describe. • Have you shared with staff any of your concerns about how you or other residents are treated? If so, what happened? NOTE: If abuse is suspected, mark abuse as Further Investigation.	No Issues/NA Further Investigation
Abuse	Describe any instances where staff: o Made you feel afraid or humiliated/degraded o Said mean things to you o Hurt you (hit, slapped, shoved, handled you roughly) o Made you feel uncomfortable (touched you inappropriately) • Have you seen or heard of any residents being treated in any of these ways? • Did you tell anyone about what happened (e.g., staff, family, or other residents)? What was their response? NOTE: If you receive an allegation of abuse, immediately report this to the facility administrator, or his/her designated representative if the administrator is not present. If the concern is dignity related, mark dignity as Further Investigation.	No Issues/NA Further Investigation
Resident-to-Resident Interaction	• Have you had any confrontations with other residents? If so, please describe. • Have you reported this to anyone (e.g., staff, family, or other residents)? If so, what happened afterwards?	No Issues/NA Further Investigation
Privacy	• If the resident has a roommate, ask: Do you feel like you can have a private conversation with your family or a visitor if your roommate is here? • Does staff provide you privacy when they are helping you to bathe or dress, or providing treatments? • Do you have privacy when on the telephone?	No Issues/NA Further Investigation

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Accommoda-tion of Needs (physical)	• Is your room set up so you can easily get around the room, get to and from the bathroom, use the sink? • Do you have any concerns with your roommate's personal items taking over your space? • Does your call light work? Can you reach it? Observe for alternatives to traditional call light systems such as tabs, pads, air puff call lights. Are these devices located in the resident's room, toilet and bathing facilities and working? • Do you have enough light in your room to do what you want or need to do?	No Issues/NA Further Investigation
Personal Funds	• Does the facility hold your money for you? o Can you get your money when you need it, including weekends? o Do you get a quarterly statement from the facility?	No Issues/NA Further Investigation
Personal Property	• Have you had any missing personal items? o How long has it been missing? o What do you think happened? o Did you tell anyone about the missing item(s)? o What happened after you told staff about the missing item? • Did the facility ask you to sign a piece of paper indicating they are not responsible for your lost personal items? • If the room is not personalized, ask: Were you encouraged to bring in any personal items? NOTE: If the resident has not informed staff about the property loss, inform the resident that you will provide the information to the administrator and/or DON so that they may follow up with the resident. Follow up with the facility staff prior to the end of the survey to evaluate the action taken regarding the resident's concerns.	No Issues/NA Further Investigation
Sufficient Staffing	• Do you get the help and care you need without waiting a long time? If not, what happened when you had to wait a long time? • How long would you say it takes staff to come when you use your call light? • How long does it take staff to come when you use your call light to go to the bathroom? • Does this happen often? • Is there a specific time of day or night this happens?	No Issues/NA Further Investigation

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Participation in Care Planning	• Does the staff include you in decisions about your medicine, therapy, or other treatments? • Are you or a person of your choice invited to participate in setting goals and planning your care? • Can you share with me how the meeting went? • Do you receive care according to the plan you developed with the staff to achieve your goals? Only ask for new admissions: • Did you receive a written summary of your initial care plan after you were admitted? If so, did the staff explain your care plan to you? • Did you understand it?	No Issues/NA Further Investigation
Community Discharge	For new admissions and long-stay residents who want to return to the community: • Do your goals for care include discharge to the community? If so, has the facility included you or the person of your choice in the discharge planning? • Do you need referrals to agencies in the community to assist with living arrangements or care after discharge?	No Issues/NA Further Investigation
Environment	• How is the noise level in your room? • How is the temperature in your room and in the building? • Do you feel your room and the building are clean and comfortable? If not, please describe. • Is there-anything else in the building that affects your comfort? • Are the water temperatures too hot or too cold when you wash your hands or take a bath or shower? • Is your bed clean and comfortable?	No Issues/NA Further Investigation
Food	• Does the food taste good and look good? • Are the hot foods served hot and the cold foods served cold? • Does the facility accommodate your food preferences (e.g., cultural, ethnic, or religious), allergies, or sensitivities? • Are you provided a substitution if you don't like what is served? • Do you receive snacks when you request them? • Are they the type of snacks you like to receive?	No Issues/NA Further Investigation

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Dental	• Do you have any problems with your teeth, gums, or dentures? If so, describe. • Have you lost or damaged your dentures? Did you tell staff? Did the staff tell you what they are doing about your dentures? • Do you have difficulty chewing food? If so, how is the staff addressing this? • Does the staff provide you with oral hygiene products you need (e.g. toothbrush, toothpaste, mouthwash, denture tabs/cup/paste)? • Does the staff help you brush your teeth? If so, how often does staff assist you with oral care? • Does the facility help with appointments to the dentist?	No Issues/NA Further Investigation
Nutrition	• Are you on a special diet (which includes an altered consistency)? If so, what is it and how long have you received this diet? • Do you need assistance with eating or dining? • Do you have difficulty swallowing food? • Have you gained weight? • Have you lost weight? • What are staff doing to address your weight loss?	No Issues/NA Further Investigation MDS Discrepancy
Hydration	• Does the staff provide you with water or other beverages throughout the day, evening, and night time? • Do you need assistance to drink the fluids? If so, how often do staff provide you with the fluids? • Have you been dehydrated? • Have you received any IV fluids?	No Issues/NA Further Investigation MDS Discrepancy
Tube Feeding	If you observe that a resident is tube fed, ask: • Why do you receive a tube feeding? • How much do you get? • Do you feel like you have lost/gained weight? • Have you had any issues with it?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Vision and Hearing	• Do you have any problems with your vision or hearing? o Do you wear glasses or use hearing aids? o Are your glasses and/or hearing aids in good repair? If not, what are the facility staff doing to help you with this problem? o Do you need glasses or a hearing aid? o Have you lost your glasses or hearing aids at the facility? o What did the facility do if you lost them? o Does the facility help you make appointments and help with arranging transportation? o If resident has either/both - how are they working for you?	No Issues/NA Further Investigation
ADLs	• Do you get the help you need to get out of bed or to walk? • Do you get the help you need when you need to use the bathroom? • Do you get the help you need to clean your teeth or get dressed? • Do you get the help you need during meals? • If not, please describe.	No Issues/NA Further Investigation
ADL Decline	• Has your ability to dress yourself or to take a bath changed? If so, please describe. • Has your ability to get to the bathroom or use the bathroom changed? If so please, describe. • Do you need more help now to clean your teeth or eat meals? • Do you need more help with getting out of bed or walking now? • Has this been happening for a long time? About how long? • What are staff doing to stop you from getting worse or to help you improve in these areas?	No Issues/NA Further Investigation MDS Discrepancy
Catheter	Only ask for a resident who has a urinary catheter: • Do you know why you have the catheter? • How long have you had it? • Have you had any problems with your catheter? • Have you had any problems such as infections or pain related to the catheter?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Insulin or Blood Thinner	Only ask for residents receiving insulin or an anticoagulant: • Do you get insulin or a blood thinner like Coumadin? • Have you had any problems with your blood sugars such as feeling dizzy or light headed? If so, when did they occur and how did staff respond? • Have you had any bleeding or bruising? • Have you talked to staff about this? • Any other issues?	No Issues/NA Further Investigation MDS Discrepancy
Respiratory Infection	• Do you have easy access to a sink with soap to wash your hands? • Do staff assist you with washing your hands, if needed? • Have you had a fever lately? • Have you had a respiratory infection recently? o Tell me about the infection? o Are you currently having any symptoms?	No Issues/NA Further Investigation MDS Discrepancy
Urinary Tract Infection (UTI)	• Do you have easy access to a sink with soap to wash your hands? • Do staff assist you with washing your hands, if needed? • Have you had a UTI recently? o Tell me about the infection? o Are you currently having any symptoms? o How was it treated? o Are you still being treated?	No Issues/NA Further Investigation MDS Discrepancy
Infections (not UTI, Pressure Ulcer, or Respiratory)	• Have you had any other infections recently (e.g., surgical infection, eye infection, blood infection, or illness with nausea and vomiting)? o Tell me about the infection? o Are you currently having any symptoms?	No Issues/NA Further Investigation MDS Discrepancy
Transmission-Based Precautions	If a resident is on transmission-based precautions, ask the following questions: • Are staff and visitors wearing gowns, gloves, and/or masks when entering your room? If not, please describe what has been occurring. • Are there any restrictions on where you can and can't go in the facility? • Do you know the reason for these restrictions? • Have staff explained why you are on precautions and how long you will be on the precautions? • Are there any restrictions for visitors coming into your room?	No Issue Further Investigation NA

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
	• Have you had any changes in your mood since being placed on precautions, and if so, please describe?	
Hospitaliza-tions	• Have you gone to the hospital or emergency room for treatment recently? o When did you go and why? o Were you able to go back to your same room? o Were you told whether the facility would hold your bed? o How often are you admitted to the hospital?	No Issues/NA Further Investigation MDS Discrepancy
Falls	• Have you fallen recently? If so, when did you fall and what happened? o How many times? o Did you get any injuries from the fall(s)? o What has the facility done to prevent you from falling?	No Issues/NA Further Investigation MDS Discrepancy
Pain	• Do you have any pain or discomfort? o Where is your pain? o How often do you have pain? o What does the facility do to manage your pain (e.g. hot or cold packs, pain medications)? o Were you involved in the management of your pain? o Is your pain relieved? o For opioid use: What did the facility try before starting that medication? o Does the pain prevent you from attending activities or doing other things you would like to do? o Do you receive pain medications when needed such as before therapy or treatment? o Do you receive pain medications in a timely manner when requested? o Do you have any side effects (e.g., constipation or dizziness) related to your pain medications and are they addressed?	No Issues/NA Further Investigation MDS Discrepancy
Pressure Ulcers	• Do you have any sores, open areas, or pressure ulcers? o Where is your pressure ulcer? o When did you get it? o How did you get it? o Are staff here treating it? o How often do they reposition you? o Do you know if it is getting better?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Skin Conditions (non-pressure related)	• Do you have any bruises, burns, or other issues with your skin? o Do you know how you got it? o Are staff aware? o What are they doing to prevent it from happening again?	No Issues/NA Further Investigation
Limited ROM	• Do you have any limitations in your joints like your hands or knees? o What are staff doing to help with your limited range of motion?	No Issues/NA Further Investigation MDS Discrepancy
Rehab	If on a rehab unit or the resident has expressed concerns (e.g., contractures) that should be addressed by rehab, ask: • Are you getting therapy? Tell me about it.	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Dialysis	Only ask if the resident is on dialysis: • What type of dialysis do you receive (hemodialysis or peritoneal dialysis)? For peritoneal or hemodialysis (HHD): • Where and how often do you receive dialysis? • Who administers the dialysis in the facility (e.g., family or staff)? • Where is your access site located? • How often is your access site monitored by facility staff? • Have you had any problems with infections? • For a resident receiving HHD: Have you had any problems with bleeding at the access site? • For a resident receiving HHD: Which arm do staff use for taking your B/P? • Have you had any problems before, during or after dialysis? If so, can you describe what occurred and how staff responded? • How often and when are you weighed and your vital signs taken? • Any issue with your meals and medications on days you receive hemodialysis? • Are you on a fluid restriction or dietary restrictions? • How are you doing with that? • Do you think there is good communication between the dialysis center and the facility? For offsite hemodialysis: • What are the transport arrangements? • Have you had any concerns going from dialysis and back to the facility?	No Issues Further Investigation NA MDS Discrepancy
B&B incontinence	• Are you incontinent? o When did you become incontinent? o Do you know why you are incontinent? o What is the facility doing to try and help you become more continent? • Do you use incontinence briefs? If so, have you ever been instructed to urinate in your briefs and the staff will change you later? • Are you on a program (e.g., scheduled toileting) to help you maintain your level of continence? How is it going? Are there things they could be doing that might help?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Interview

Care Area	Probes	Response Options

Constipation/ Diarrhea	• Are you having any problems with your bowels, including concerns with colostomy?
	• Constipation (longer than 3 days)?
	• Diarrhea?
	  o How long have you had the problems with your bowels?
	  o Are you on a bowel management program? If so, please describe.
	  o Do you feel that the bowel management program helps with your bowel problems? If not, why not?
		No Issues/NA
		
		Further Investigation

Smoking	Only ask if the resident smokes: • Are you able to smoke when you want? If not, what are the smoking times? • Who keeps your cigarettes and lighter? • Do you use oxygen? If so, have you smoked in the facility while using your oxygen? • Where do you put your ashes and cigarette butts? • Does staff supervise you when you smoke? • Do you use devices to help keep you safe while you smoke (e.g., a smoking apron)? • Have you had any accidents or burns while smoking?	No Issues Further Investigation NA
Hospice	Only ask if the resident is receiving hospice services: • How long have you received hospice services? • How often does hospice staff come in to see you or provide care? • What type of care or services do they provide? • Are you involved in care planning decisions with the hospice and the facility? • Did the facility provide you with the name of the person who coordinates care with the hospice? • Has this person been in contact with you? • Do you have any concerns with hospice services? • Do you know who to talk to at the facility concerning your hospice care?	No Issues Further Investigation NA MDS Discrepancy
Other Concerns	• Do you have any other concerns or problems that the facility is not helping you with?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Family member's name, relationship, and phone number if contacted by phone:

_____

Care Area	Probes	Response Options
Choices	• Is [resident's name] able to make choices about his/her daily life that are important to [resident's name]? • I'd like to talk to you about [resident's name] choices. Is [resident' name] able to get up and go to bed when he/she wants to? • How about bathing, is [resident's name] able to choose a bath or shower? Does [resident's name] choose how often he/she bathes? • How about food, does the facility honor [resident's name] preferences or requests regarding meal times, food and fluid choices? • How about activities, is [resident's name] able to choose when he/she goes to activities? • How about meds, is [resident's name] able to choose when he/she receives medications? • Did [resident's name] choose his/her doctor? Does [resident's name] know their name and how to contact them? • Can [resident's name] have visitors any time or are there restricted times?	No Issues/NA Further Investigation
Activities	• Does [resident's name] participate in activities here? If not, why? • Do the activities meet [resident's name] interests? If not, what type of activities would [resident's name] like the facility to offer? • Are activities offered on the weekends and evenings? If not, would [resident's name] like to have activities on the weekends or in the evenings? • Does staff provide activities [resident's name] can do on his/her own (cards, books, other)?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
Dignity	• Does staff treat [resident's name] with respect and dignity? • Do you have any concerns about how staff treat [resident's name]? If so, please describe. • Do you have any concerns about how staff treat other residents in the facility? If so, please describe. • Have you shared with staff any of your concerns about how [resident's name] or other residents are treated? If so, what happened? NOTE: If abuse is suspected, mark abuse as Further Investigation.	No Issues/NA Further Investigation
Abuse	Describe any instances where staff: o Made [resident's name] feel afraid or humiliated/degraded o Said mean things to [resident's name] o Hurt [resident's name] (hit, slapped, shoved, handled [resident's name] roughly) o Made [resident's name] feel uncomfortable (touched [resident's name] inappropriately) • Have you seen or heard of any residents being treated in any of these ways? • Did you tell anyone about what happened (e.g., staff, family, or other residents)? What was their response? NOTE: If you receive an allegation of abuse, immediately report this to the facility administrator, or his/her designated representative if the administrator is not present. If the concern is dignity related, mark dignity as Further Investigation.	No Issues/NA Further Investigation
Resident-to-Resident Interaction	• Has [resident's name] had any confrontations with other residents? If so, please describe. • Have you reported this to anyone (e.g., staff, family, or other residents)? If so, what happened afterwards?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
Privacy	• If the resident has a roommate, ask: Does [resident's name] feel like he/she can have a private conversation with you or a visitor if his/her roommate is here? • Does staff provide [resident's name] privacy when they are helping him/her to bathe or dress, or providing treatments? • Does [resident's name] have privacy when on the telephone?	No Issues/NA Further Investigation
Accommoda-tion of Needs (physical)	• Is [resident's name] room set up so he/she can easily get around the room, get to and from the bathroom, use the sink? • Do you have any concerns with [resident's name] roommate's personal items taking over his/her space? • Does [resident's name] call light work? Can he/she reach it? Observe for alternatives to traditional call light systems such as tabs, pads, air puff call lights. Are these devices located in the resident's room, toilet and bathing facilities and working? • Does [resident's name] have enough light in his/her room to do what he/she wants or needs to do?	No Issues/NA Further Investigation
Personal Funds	• Does the facility hold [resident's name] money? o Can he/she get money when he/she needs it, including weekends? o Do you or [resident's name] get a quarterly statement from the facility?	No Issues/NA Further Investigation
Personal Property	• Has [resident's name] had any missing personal items? o How long has it been missing? o What do you think happened? o Did you tell anyone about the missing item(s)? o What happened after you told staff about the missing item? • Did the facility ask you to sign a piece of paper indicating they are not responsible for [resident's name] lost personal items? • If the room is not personalized, ask: Were you encouraged to bring in any personal items for [resident's name]?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	NOTE: If the representative has not informed staff about the property loss, inform the resident's representative that you will provide the information to the administrator and/or DON so that they may follow up with the resident. Follow up with the facility staff prior to the end of the survey to evaluate the action taken regarding the resident's concerns.	
Sufficient Staffing	• Does [resident's name] get the help and care he/she needs without waiting a long time? If not, what happened when he/she had to wait a long time? • How long would you say it takes staff to come if you put the call light on? • How long does it take staff to come if you put the call light on to take [resident's name] to the bathroom? • Does this happen often? • Is there a specific time of day or night this happens?	No Issues/NA Further Investigation
Participation in Care Planning	• Does the staff include you in decisions about [resident's name] medicine, therapy, or other treatments? • Are you or the responsible party invited to participate in setting goals and planning his/her care? • Can you share with me how the meeting went? • Does [resident's name] receive care according to the plan you or the responsible party developed with the staff to achieve his/her goals? Only ask for new admissions: • Did you or the responsible party receive a written summary of his/her initial care plan after [resident's name] were admitted? If so, did the staff explain the care plan to you? • Did you understand it?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
Community Discharge	For new admissions and long-stay residents who want to return to the community: • Does [resident's name] goals for care include discharge to the community? If so, has the facility included you or the responsible party in the discharge planning? • Do you need referrals to agencies in the community to assist with living arrangements or care after discharge?	No Issues/NA Further Investigation
Environment	• How is the noise level in [resident's name] room? • How is the temperature in [resident's name] room and in the building? • Do you feel his/her room and the building are clean and comfortable? If not, please describe. • Is there-anything else in the building that affects [resident's name] comfort? • Is the water temperatures too hot or too cold when in the bathroom? • Is his/her bed clean and comfortable?	No Issues/NA Further Investigation
Food	• Does the food taste good and look good? • Are the hot foods served hot and the cold foods served cold? • Does the facility accommodate [resident's name] food preferences (e.g., cultural, ethnic, or religious), allergies, or sensitivities? • Is [resident's name] provided a substitution if he/she does not like what is served? • Does [resident's name] receive snacks when he/she request them? • Are they the type of snacks [resident's name] likes to receive?	No Issues/NA Further Investigation
Dental	• Does [resident's name] have any problems with his/her teeth, gums, or dentures? If so, describe. • Has [resident's name] lost or damaged his/her dentures? Did you tell staff? Did the staff tell you what they are doing about his/her dentures? • Does [resident's name] have difficulty chewing food? If so, how is the staff addressing this? • Does the staff provide [resident's name] with oral hygiene products he/she needs (e.g. toothbrush, toothpaste, mouthwash, denture tabs/cup/paste)?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	• Does the staff help [resident's name] brush his/her teeth? If so, how often does staff assist him/her with oral care? • Does the facility help with appointments to the dentist?	
Nutrition	• Is [resident's name] on a special diet (which includes an altered consistency)? If so, what is it and how long has he/she received this diet? • Does [resident's name] need assistance with eating or dining? • Does [resident's name] have difficulty swallowing food? • Has [resident's name] gained weight? • Has [resident's name] lost weight? • What are staff doing to address his/her weight loss?	No Issues/NA Further Investigation MDS Discrepancy
Hydration	• Does the staff provide [resident's name] with water or other beverages throughout the day, evening, and night time? • Does [resident's name] need assistance to drink the fluids? If so, how often do staff provide him/her with the fluids? • Has [resident's name] been dehydrated? • Have [resident's name] received any IV fluids?	No Issues/NA Further Investigation MDS Discrepancy
Tube Feeding	If you observe that a resident is tube fed, ask: • Why does [resident's name] receive a tube feeding? • How much does he/she get? • Do you feel like [resident's name] has lost/gained weight? • Has [resident's name] had any issues with the tube feeding?	No Issues/NA Further Investigation MDS Discrepancy
Vision and Hearing	• Does [resident's name] have any problems with his/her vision or hearing? o Does [resident's name] wear glasses or use hearing aids? o Is [resident's name] glasses and/or hearing aids in good repair? If not, what are the facility staff doing to help with this problem? o Does [resident's name] need glasses or a hearing aid? o Has [resident's name] lost his/her glasses or hearing aids at the facility?	No Issues/NA Further Investigation

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	○ What did the facility do if [resident's name] lost them? ○ Does the facility help make appointments and help with arranging transportation? ○ If resident has either/both - how are they working for [resident's name]?	
ADLs	• Does [resident's name] get the help he/she needs to get out of bed or to walk? • Does [resident's name] get the help he/she needs when using the bathroom? • Does [resident's name] get the help he/she needs to clean his/her teeth or get dressed? • Does [resident's name] get the help needed during meals? • If not, please describe.	No Issues/NA Further Investigation
ADL Decline	• Has [resident's name] ability to dress him/herself or to take a bath changed? If so, please describe. • Has [resident's name] ability to get to the bathroom or use the bathroom changed? If so please, describe. • Does [resident's name] need more help now to clean his/her teeth or eat meals? • Does [resident's name] need more help with getting out of bed or walking now? • Has this been happening for a long time? About how long? • What are staff doing to stop [resident's name] from getting worse or to help him/her improve in these areas?	No Issues/NA Further Investigation MDS Discrepancy
Catheter	Only ask for a resident who has a urinary catheter: • Do you know why [resident's name] has the catheter? • How long has [resident's name] had it? • Has [resident's name] had any problems with his/her catheter? • Has [resident's name] had any problems such as infections or pain related to the catheter?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
Insulin or Blood Thinner	Only ask for residents receiving insulin or an anticoagulant: • Does [resident's name] get insulin or a blood thinner like Coumadin? • Has [resident's name] had any problems with his/her blood sugars such as feeling dizzy or light headed? If so, when did they occur and how did staff respond? • Has [resident's name] had any bleeding or bruising? • Have you talked to staff about this? • Any other issues?	No Issues/NA Further Investigation MDS Discrepancy
Respiratory Infection	• Does [resident's name] have easy access to a sink with soap to wash his/her hands? • Does staff assist [resident's name] with washing his/her hands, if needed? • Has [resident's name] had a fever lately? • Has [resident's name] had a respiratory infection recently? o Tell me about the infection? o Is [resident's name] currently having any symptoms?	No Issues/NA Further Investigation MDS Discrepancy
Urinary Tract Infection (UTI)	• Does [resident's name] have easy access to a sink with soap to wash his/her hands? • Does staff assist [resident's name] with washing his/her hands, if needed? • Has [resident's name] had a UTI recently? o Tell me about the infection? o Is [resident's name] currently having any symptoms? o How was it treated? o Is [resident's name] still being treated?	No Issues/NA Further Investigation MDS Discrepancy
Infections (not UTI, Pressure Ulcer, or Respiratory)	• Has [resident's name] had any other infections recently (e.g., surgical infection, eye infection)? o Tell me about the infection? o Is [resident's name] currently having any symptoms?	No Issues/NA Further Investigation MDS Discrepancy
Transmission-Based Precautions	If a resident is on transmission-based precautions, ask the following questions: • Are staff and visitors wearing gowns, gloves, and/or masks when entering [resident's name]	No Issue Further Investigation NA

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	room? If not, please describe what has been occurring. • Are there any restrictions on where [resident's name] can and can't go in the facility? • Do you know the reason for these restrictions? • Have staff explained why [resident's name] is on precautions and how long he/she will be on the precautions? • Are there any restrictions for visitors coming into [resident's name] room? • Has [resident's name] had any changes in his/her mood since being placed on isolation, and if so, please describe?	
Hospitaliza-tions	• Has [resident's name] gone to the hospital or emergency room for treatment recently? o When did he/she go and why? o Was [resident's name] able to go back to his/her same room? o Were you told whether the facility would hold his/her bed? o How often is [resident's name] admitted to the hospital?	No Issues/NA Further Investigation MDS Discrepancy
Falls	• Has [resident's name] fallen recently? If so, when did he/she fall and what happened? o How many times? o Did [resident's name] get any injuries from the fall(s)? o What has the facility done to prevent [resident's name] from falling?	No Issues/NA Further Investigation MDS Discrepancy
Pain	• Does [resident's name] have any pain or discomfort? o Where is his/her pain? o How often does [resident's name] have pain? o What does the facility do to manage his/her pain (e.g. hot or cold packs, pain medications)? o Were you or the responsible party involved in the management of his/her pain? o Is his/her pain relieved? o For opioid use: What did the facility try before starting that medication?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	○ Does the pain prevent [resident's name] from attending activities or doing other things he/she would like to do? ○ Does [resident's name] receive pain medications when needed such as before therapy or treatment? ○ Does [resident's name] receive pain medications in a timely manner when requested? ○ Does [resident's name] have any side effects (e.g., constipation or dizziness) related to his/her pain medications and are they addressed?	
Pressure Ulcers	• Does [resident's name] have any sores, open areas, or pressure ulcers? ○ Where is his/her pressure ulcer? ○ When did he/she get it? ○ How did he/she get it? ○ Are staff here treating it? ○ How often do they reposition [resident's name]? ○ Do you know if it is getting better?	No Issues/NA Further Investigation MDS Discrepancy
Skin Conditions (non-pressure related)	• Does [resident's name] have any bruises, burns, or other issues with his/her skin? ○ Do you know how he/she got it? ○ Are staff aware? ○ What are they doing to prevent it from happening again?	No Issues/NA Further Investigation
Limited ROM	• Does [resident's name] have any limitations in his/her joints like his/her hands or knees? ○ What are staff doing to help with his/her limited range of motion?	No Issues/NA Further Investigation MDS Discrepancy
Rehab	If on a rehab unit or the resident has expressed concerns (e.g., contractures) that should be addressed by rehab, ask: • Is [resident's name] getting therapy? Tell me about it.	No Issues/NA Further Investigation MDS Discrepancy
Dialysis	Only ask if the resident is on dialysis: • What type of dialysis does [resident's name] receive (hemodialysis or peritoneal dialysis)? For peritoneal or hemodialysis (HHD):	No Issues Further Investigation NA

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	• Where and how often does [resident's name] receive dialysis? • Who administers the dialysis in the facility (e.g., family or staff)? • Where is his/her access site located? • How often is his/her access site monitored by facility staff? • Has [resident's name] had any problems with infections? • For a resident receiving HHD: Has [resident's name] had any problems with bleeding at the access site? • For a resident receiving HHD: Which arm do staff use for taking his/her B/P? • Has [resident's name] had any problems before, during or after dialysis? If so, can you describe what occurred and how staff responded? • How often and when is [resident's name] weighed and his/her vital signs taken? • Any issue with his/her meals and medications on days he/she receive hemodialysis? • Is [resident's name] on a fluid restriction or dietary restrictions? • How is he/she doing with that? • Do you think there is good communication between the dialysis center and the facility? For offsite hemodialysis: • What are the transport arrangements? • Have there been any concerns when [residents' name] goes from dialysis and back to the facility?	MDS Discrepancy
B&B incontinence	• Is [resident's name] incontinent? o When did he/she become incontinent? o Do you know why he/she is incontinent? o What is the facility doing to try and help [resident's name] become more continent? • Does [resident's name] use incontinence briefs? If so, do you know if he/she has ever been instructed to urinate in his/her briefs and the staff will change him/her later? • Is [resident's name] on a program (e.g., scheduled toileting) to help him/her maintain his/her level of	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	continence? How is it going? Are there things they could be doing that might help?	

Constipation/Diarrhea	• Is [resident's name] having any problems with his/her bowels?
	• Constipation (longer than 3 days)?
	• Diarrhea?
	  o How long has [resident's name] had the problems with his/her bowels?
	  o Is [resident's name] on a bowel management program? If so, please describe.
	  o Do you feel that the bowel management program helps with his/her bowel problems? If not, why not?
		No Issues/NA
		
		Further Investigation

Smoking	Only ask if the resident smokes: • Is [resident's name] able to smoke when he/she wants? If not, what are the smoking times? • Who keeps his/her cigarettes and lighter? • Does [resident's name] use oxygen? If so, has he/she smoked in the facility while using his/her oxygen? • Where does [resident's name] put his/her ashes and cigarette butts? • Does staff supervise [resident's name] when he/she smokes? • Does [resident's name] use devices to help keep him/her safe while he/she smokes (e.g., a smoking apron)? • Has [resident's name] had any accidents or burns while smoking?	No Issues Further Investigation NA
Hospice	Only ask if the resident is receiving hospice services: • How long has [resident's name] received hospice services? • How often does hospice staff come in to see him/her or provide care? • What type of care or services do they provide? • Are you or the responsible party involved in care planning decisions with the hospice and the facility? • Did the facility provide you or the responsible party with the name of the person who coordinates care with the hospice?	No Issues Further Investigation NA MDS Discrepancy

Initial Pool Process: Resident Representative Interview

Care Area	Probes	Response Options
	• Has this person been in contact with you or the responsible party? • Do you have any concerns with hospice services? • Do you know who to talk to at the facility concerning his/her hospice care?	
Notification of Change	• Are you the person who would be notified of a change in condition or an accident involving [resident's name]? • Has there been a change in [resident's name]'s condition within the past several months? • Did the staff notify you promptly? • Are you notified when [resident's name]'s treatment is changed?	No Issues/NA Further Investigation
Other Concerns	• Do you have any other concerns or problems that the facility is not helping [resident's name] with?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Activities	• Did you observe the resident in activities? • Is the resident actively participating or engaged in activities? • Do staff encourage the resident to participate? • Is a younger resident engaged in age appropriate activities? • Are there a variety of activities available for all residents?	No Issues/NA Further Investigation
Dignity	• Observe to determine whether staff failed to: o Knock/ask permission to enter room or wait to enter until permission given o Explain service or care to be provided o Include resident in conversations while providing care or services o Provide visual privacy of resident's body while transporting through common areas, or uncovered in their room but visible to others o Cover a urinary catheter bag/other body fluid collection device o Respond to the resident's call for assistance in a timely manner o Clothing and face soiled after meals o Poorly fitting clothing • Staff did the following: o Used a label for resident (e.g., "feeder" or "honey") o Posted confidential clinical/personal care instructions in viewable areas o Dressed resident in institutional fashion (e.g., hospital type gown during day) o Labeled clothes with resident's name visible • Any other identified dignity concerns?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Abuse	• Is there evidence of indicators of possible abuse? o Fractures, sprains or dislocations o Burns, blisters, or scalds on the hands or torso o Bite marks, scratches, skin tears, and lacerations including those that are in locations that would unlikely result from an accident o Bruises or injuries, including those found in unusual locations such as the head (e.g., black eye, broken /missing teeth), neck, lateral locations on the arms, posterior torso and trunk, or shapes (e.g., finger imprints) o Fear of others • Is the resident exhibiting any aggressive behavior (verbal or physical) to other residents? o Hitting, striking out at others, kicking, pushing o Threatening others Note: If you witness an act of abuse, you must immediately report this observation to the administrator, or his/her designated representative if the administrator is not present.	No Issues/NA Further Investigation
Privacy	• Bedrooms are not equipped to assure full privacy (e.g., ceiling suspended curtains, moveable screens, private rooms, etc.) • Is personal privacy assured for: o Electronic communications o Personal care o Medical treatments o Communication to residents and representatives regarding the resident's condition that cannot be overheard	No Issues/NA Further Investigation
Accommo-dation of Needs (physical)	• Are any of the following observed? o Difficulty opening and closing drawers and turning faucets on and off o Unable to see him/herself in a mirror and have items easily within reach while using the sink o Difficulty opening and closing bedroom and bathroom doors, accessing areas of their room and bath, and operating room lighting o Difficulty performing other desired tasks such as turning a table light on and off o Difficulty or inability to use the call bell • Is adaptive equipment available and used? • Do any accommodations that you observed place this, or any other resident at risk?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Language/ Communi-cation	• Does the resident speak a different language, use sign language or other alternative communication means? • Does staff know how to communicate with the resident? • Are there communication systems available at the bedside (cards, note pad, others)?	No Issues/NA Further Investigation
Mood/ Behavior	• Does the resident: o Appear depressed or anxious (e.g., sad, teary, non-communicative, anxious movements) o Appear socially withdrawn, isolated, fatigued, not eating o Appear to lack emotional affect, short tempered, easily annoyed • Does staff recognize expressions, indications of distress, or behaviors and respond through a person-centered approach to care? • Does the resident appear to exhibit hallucinations (e.g., hearing voices or seeing things not present)? • Does the resident appear to exhibit any physical expressions of distress directed towards others - Hitting, striking out at others, kicking, pushing, scratching, and grabbing • Does the resident appear to exhibit any verbal expressions of distress directed towards others - threatening others, screaming at others, cursing at others, crying • Does the resident appear to exhibit any other expressions of distress not directed toward others - physical such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, sounds that are distressing to other residents, constant vocalizations • Wandering, ambulating in and out of resident's rooms, rummaging in other resident's belongings • Appear angry, frustrated, combative, confrontational • How do staff interact with resident(s) during these occurrences?	No Issues/NA Further Investigation MDS Discrepancy
Restraints	• Is there anything that restricts a resident's movement or access to his/her body? • If so, describe the device or practice that restricts the resident's movement (e.g., trunk restraint, limb restraint, bed rails, chair that prevents rising, mitts, or personal alarms). • Are restraints applied correctly?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Accident Hazards	• Are any of the following observed? o Are bed rails (full, half, quarter, or grab bars) in use? If so, are they properly installed (e.g., are the bed rails loose or broken) and do they fit the bed properly so the resident can't get caught between the bed rails and mattress? o Is the mattress of proper size and fit for the bed to prevent the resident from becoming entrapped? o Is the resident's restraint/device properly applied? If not, does the restraint/device have the risk or likelihood of causing serious injury, harm or death? o Are electric cords, extension cords, or outlets in disrepair/used in unsafe manner? o Is safety equipment in bedroom/bathroom inadequate (grab bars, slip surface)? o Are there accessible chemicals/other hazards in bedroom/bathroom? o Is there unsafe hot water in the room? o Is there exposure to unsafe heating unit surfaces? o Is ambulation, transfer, or therapy equipment in unsafe condition? o Are locks disabled, fire doors propped open, irregular walking surfaces, handrails in good repair, inadequate lighting? o Are residents adequately supervised? o On a secured unit, is there sufficient staff to supervise the residents? • Are there any other environmental hazards or risks observed? Note: Each surveyor should check water temperature with their hand held under the hot water in two resident rooms (on opposite sides of the hall) per unit. Use a thermometer if there is concern that water is too hot and could potentially scald or harm residents. Target resident rooms closest to the hot water tanks/kitchen areas and resident rooms belonging to residents with dementia who may use sinks/bathtubs/showers independently.	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Unsafe Wandering/ Elopement	• Is the resident exit seeking? • Is the resident wandering into other residents' rooms? • Does a resident attempt to follow visitors or other residents to other parts of the facility? • Is the resident redirected by staff? • Are staff supervising residents who wander? • Does the resident appear anxious, frustrated, bored, or hungry which is displayed as wandering or lack of supervision by staff? • If you observe the resident attempting to leave the building, is the wandering alarm system functioning correctly?	No Issues/NA Further Investigation MDS Discrepancy
Call light in reach, call system functioning	• Is the call light within reach if the resident is capable of using it? • Is the call system functioning in the resident's room, toilet, and bathing areas?	No Issues/NA Further Investigation
Environ-ment	• Are any of the following observed in the resident's rooms? o Walls, floors, ceilings, drapes, or furniture are not clean or are in disrepair o Bed linens and fixtures visibly soiled o Resident care equipment (e.g., mechanical lift, commode, hemodialysis or peritoneal equipment) is unclean, in disrepair, or stored in an improper or unsanitary manner o Hot water is too cold o Room not homelike o Lighting levels inadequate o Uncomfortable sound levels o Uncomfortable room temperatures (e.g., too cool or too warm) o Stains from water damage that could lead to mold • For residents on transmission-based precautions, is dedicated or disposable noncritical resident care equipment (e.g., blood pressure cuffs) used?	No Issues/NA Further Investigation
Dental	• Does the resident have broken, missing, lose or ill-fitting dentures? • Does the resident have broken or loose teeth, or inflamed or bleeding gums?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Nutrition	• Is the resident assisted (with meal setup and eating), cued, and encouraged to eat as needed? • Are assistive devices utilized and used correctly (e.g., plate guard, lipped plate or bowl, modified utensils, sippy cups, nosey cups, cues, hand over hand)? • If the resident refuses or isn't eating (e.g., pacing), what does staff do? Do they offer substitutes, encourage or assist the resident? • Does the resident's physical appearance indicate the potential for an altered nutritional status (e.g., cachectic)? • Are supplements provided at times that don't interfere with meal intake and consumed (e.g., supplement given right before or during the meal and the resident doesn't eat)? • Are snacks given and consumed?	No Issues/NA Further Investigation MDS Discrepancy
Edema	• Are the resident's legs/feet or arms/hands swollen? • Are the resident's legs/feet or arms/hands elevated or support stockings in place, if needed?	No Issues/NA Further Investigation
Hydration	• Does the resident have dry, cracked lips, dry mouth, sunken eyes and signs of thirst? • Is there a water pitcher by the bedside and is it accessible to the resident? • Do staff offer the resident fluids throughout the day? • Are fluids provided at meal times and is the resident encouraged to drink them? • Is the meal tray accessible and cups and cartons opened and accessible to the resident? • Does staff assist the resident during meals if needed? • If the resident is resistant to assistance or refuses liquids how do staff respond? • Is the resident receiving IV fluids?	No Issues/NA Further Investigation MDS Discrepancy
Tube Feeding	• Does the resident receive tube feedings (e.g., g-tube, peg tube, total parenteral nutrition (TPN), naso-gastric)? • If tube feeding is infusing, is the head of the bed elevated at least 30-45 degrees? • Is the feeding properly labeled (e.g., date, time initiated, nurses' initials)? • Does the amount remaining seem reasonable? • Is the site clean and free from signs and symptoms of infection (e.g., redness, drainage, odors)?	No Issues/NA Further Investigation MDS Discrepancy
Vision and Hearing	• Are the resident's hearing aids in and working, if needed? • Are the resident's glasses on, clean, and not broken, if needed?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
ADLs	• Are any of the following observed? o Hair disheveled, uncombed or greasy o Facial hair unkempt or present on a female resident o Face, clothing or hands unclean or with food debris o Fingernails untrimmed, jagged or dirty o Body or mouth odor o Teeth or dentures not brushed o Clothing visibly soiled or in disrepair o Dentures stored in an unsanitary manner, if visible • If the situation presents itself, are there other concerns with the assistance provided for other ADLs (e.g., dressing or transfers)?	No Issues/NA Further Investigation
Catheter	• Does the resident have a urinary catheter in place? o Is the catheter tubing properly secured, unobstructed and free of kinks? o Is the catheter drainage bag maintained below the level of the bladder? o Is the catheter drainage bag off the floor at all times (i.e., do not place directly on the floor without protection from the floor surface)? o Are there signs and symptoms of infection (e.g., foul smelling urine, sediment, blood or mucus)? • If the situation presents itself, is the catheter drainage bag emptied using a separate, clean collection container for each resident, and does the drainage spigot touches the collection container?	No Issues/NA Further Investigation MDS Discrepancy
Psych Med Side Effects	• Are any of the following observed? o Tongue thrusting or rolling? o Lip puckering or lip smacking o Rapid eye blinking/eyebrow raising o Pill rolling o Tremors	No Issues/NA Further Investigation MDS Discrepancy
Psych/ Opioid Med Side Effects	• Are any of the following observed? o Excessive sedation (e.g. difficult to rouse, always sleeping) o Dizziness	No Issues/NA Further Investigation MDS Discrepancy
AC Med Side Effects	• Are any of the following observed? o Bruising o Bleeding	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Respiratory Infection	• Does the resident have signs or symptoms of a respiratory infection (e.g., wheezing, altered breathing such as rapid breathing, coughing with yellow phlegm)?	No Issues/NA Further Investigation MDS Discrepancy
Urinary Tract Infection (UTI)	• Does the resident have signs or symptoms of an infection (e.g., confusion, delirium)?	No Issues/NA Further Investigation MDS Discrepancy
Infections (other than UTI, Pressure Ulcer, or Respiratory)	• Does the resident have signs or symptoms of an infection (e.g., rigors with confusion or delirium, matted eyes, redness and swelling of skin)? • If visible, does the resident's medical device insertion site have redness, swelling or drainage? If drainage present (document color/amount/type/odor).	No Issues/NA Further Investigation MDS Discrepancy
Transmission-Based Precautions	• Are personal protective equipment/PPE (e.g., gloves, gowns, masks) readily accessible in resident areas (e.g., nursing units, therapy rooms)? • If a resident is on transmission-based precautions, are appropriate PPE supplies outside of the resident's room and signage indicating the resident is on transmission-based precautions clear and visible prior to entering the room (signage must also comply with confidentiality and privacy)?	No Issue Further Investigation NA
Oxygen	• Is the resident receiving O2? • Is the mask/tubing properly placed? • Is there a date on the tubing and humidification? • Observe the liters/minute? • Are there signs that the resident has discomfort? Is he/she in respiratory distress (mouth breathing, short of breath, gasping)?	No Issues/NA Further Investigation

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Positioning	If a resident is unable to position him or herself, are any of the following observed? o Lack of arm/shoulder support o Head lolling to one side, awkward angle o Hyperflexion of the neck o Leaning to the side without support to maintain an upright position o Lack of needed torso or head support o Uncomfortable Geri-chair positioning, sliding down in the chair o Wheelchair too big or too small (seat too long/short, seat too high/low) o Dangling legs and feet that do not comfortably reach the floor and/or without needed foot pedals in place o Sagging mattress while lying in bed o Bed sheets tucked tightly over toes holding feet in plantar flexion o Legs and/or feet hanging off the end of a too short mattress	No Issues/NA Further Investigation
Falls	• Did you observe any concerns with the resident falling or almost falling? If so, what did staff do? • Does the resident have any fall prevention devices in use and functioning correctly? • Does the resident have on inappropriate foot covering – shoes/socks without non-skid soles?	No Issues/NA Further Investigation MDS Discrepancy
Pain	• Does the resident have a pained facial expression – clenched jaw, troubled/distorted face, or crying? • Is the resident muttering, moaning, or groaning? • Is the resident's breathing strenuous, labored, negative noise on inhalation/expiration? • Is the resident in a strained and inflexible position, rocking, restless movement, guarding, forceful touching or rubbing body parts? • Does the resident have an altered gait, strained/inflexible position, forceful touching/rubbing body parts?	No Issues/NA Further Investigation MDS Discrepancy
Pressure Ulcers	For residents at risk (e.g., vulnerable residents) or who have a pressure ulcer, are any of the following observed? • If visible, is the wound covered with a dressing, and is drainage present on the dressing (document color/amount/type/odor)? • Is the resident positioned off the pressure ulcer?	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
	• Are pressure relieving devices observed (e.g., heel protectors, w/c cushion, padding between bony prominences)? • If so, are they used correctly? • Is the resident in the same position for long periods of time when in the w/c or bed (resident is not repositioned in chair at least every hour and in bed at least every two hours)?	
Skin conditions (non-pressure related)	• Are any of the following observed? o Abrasions o Lacerations o Bruises o Skin tears o Burns o Rash/hives o Dry skin	No Issues/NA Further Investigation
Limited ROM	• Does the resident have a limitation in ROM or a contracture? • Is a splint device in place and correctly applied? Note: ROM limitation = Limited extent of movement of a joint. Contracture = Condition of fixed high resistance to passive stretch of a muscle.	No Issues/NA Further Investigation MDS Discrepancy
Hospice	For a resident who is receiving hospice services: • Does the resident appear comfortable or show any signs of agitation or distress? • Does the resident show signs of respiratory distress? • Is there room for family to visit in private?	No Issues Further Investigation NA MDS Discrepancy
Vent/Trach	<u>For a resident on a ventilator:</u> • Are there signs of anxiety, distress or labored breathing? • Is the head of bed elevated 30-45 degrees? • Is suction equipment immediately accessible? • If the alarm sounds, does staff respond timely? <u>For a resident with a trach</u>: • Is the tracheostomy site clean? • Is there emergency tracheostomy equipment, ambu bag, and functional suction equipment readily assessable in the room?	No Issues Further Investigation NA MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
B&B incontinence	• Does the resident have a urine or BM odor? • Is the resident wet? • Does the resident have soiled clothes or linens with urine or BM? • Is the resident provided incontinence care timely? • Are staff implementing maintenance programs (e.g., prompted or scheduled voiding) appropriately, if known?	No Issues/NA Further Investigation MDS Discrepancy
Smoking	For residents who smoke: • Is the resident smoking in an appropriate place? • Is the resident smoking safely? • Are safety precautions used (e.g., no oxygen, smoking apron, supervision if unsafe, or access to safe or appropriate ashtrays)? • Are smoking materials safely stored? • Are there burn marks on the resident's clothing, furnishings or wheelchair?	No Issues Further Investigation NA
Other Concerns	• Are there any other concerns observed for this resident?	No Issues/NA Further Investigation

Psychosocial Outcome Severity Guide

Clarification of Terms

"Anger" refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

"Apathy" refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

"Anxiety" refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper-vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

"Dehumanization" refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.

"Depressed mood" (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

"Humiliation" refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

Purpose

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag. The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome. The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome. For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, *as demonstrated by fear, agitation, and/or isolation*. In this case, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency.

Overview

Psychosocial outcomes (*e.g.*, *changes in* mood and/*or* behavior) may result from a facility's noncompliance with any regulatory requirement. *A* resident may *have* experienced *(or may have the potential or likelihood to experience)* a negative physical outcome *and/*or a negative psychosocial outcome *resulting from facility noncompliance*.

Psychosocial and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level should reflect the most significant negative outcome or highest level of harm/potential harm.

The presence of a given affect (i.e., behavioral manifestation of mood) does not necessarily indicate a psychosocial outcome that is the direct result of noncompliance. A resident's reactions and responses (or lack thereof) also may be affected by *his/her* pre-existing psychosocial issues, illnesses, medication side effects, and/or other factors. Because many nursing home residents have sadness, anger, loss of self-esteem, etc. in reaction to normal life experiences, the survey team must determine that the *negative* psychosocial outcome is a result of the noncompliance and not a pre-existing condition for the resident.

Psychosocial outcomes *may be the result of* facility noncompliance with any regulation. This also includes psychosocial outcomes resulting from facility failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, leading to continuation or worsening of the condition.

Instructions

This Guide is designed to be used separately for each resident included in the deficiency. Each resident's psychosocial response to the noncompliance is the basis for determining psychosocial severity of a deficiency. To determine severity, use the information gathered through the investigative process. Compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) and mood before and after the noncompliance.

If the survey team determines that a facility's noncompliance has resulted in a negative psychosocial outcome to one or more residents, the team should use this Guide to evaluate the severity of the outcome for each resident identified in the deficiency. The team should determine severity based *primarily* on the resident's response, *or if appropriate, apply the reasonable person concept to the deficient practice.*

Application of the Reasonable Person Concept

There are circumstances in which the survey team *should* apply the "reasonable person concept" to determine severity of the deficiency, *such as when a resident's psychosocial outcome may not be readily determined through the investigative process*.

To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance).

NOTE: The reasonable person concept described in this Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes. Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate and is expressly precluded.

Use the reasonable person concept *to determine* a resident's psychosocial outcome, *which* may not be readily determined. *For example:*

- When *a resident may not be able to express their feelings,* there is no discernable response, or when circumstances *may not permit* the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

- When *a* resident's reaction to a deficient practice is markedly incongruent *(or different)* with the level of reaction a reasonable person would have to the deficient practice.

Severity Levels

The following are *examples of severity* levels of negative psychosocial outcomes that *could have* developed, continued, or worsened as a result of *a* facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation *has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.* Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level four* include, but are not limited to:

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).

- Sustained and intense crying, moaning, screaming, or combative behavior.

- Expressions (verbal and/or non-verbal) of severe, unrelenting, excruciating, and unrelieved pain; pain has become all-consuming and overwhelms the resident.

- Recurrent (i.e., more than isolated or fleeting) debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of a specific staff member).

- Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persists regardless of whether the precipitating event(s) has ceased and has resulted in a potentially life-threatening consequence.

- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, impairment, or death to self or others.

- *Extreme changes in social patterns, such as sustained isolation from staff, friends and family for a prolonged period of time.*

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level three* include, but are not limited to:

- Significant decline in former social patterns that does not rise to a level of immediate jeopardy.

- Persistent depressed mood that may be manifested by verbal and nonverbal symptoms such as:
    - Social withdrawal; *apathy*; irritability; anxiety; hopelessness; tearfulness; crying; moaning;
    - Loss of interest or ability to experience or feel pleasure nearly every day for much of the day;
    - Psychomotor agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a bothered or sad expression;
    - Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering);

- Verbal agitation (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), accompanied by sad facial expressions;

- Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care);

- Markedly diminished ability to think or concentrate;

- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead" or "my family would be better off without me").

- Expressions (verbal and/or non-verbal) of persistent pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, weight loss and/or diminished appetite. Pain or physical distress has become a central focus of the resident's attention, but it is not all-consuming or overwhelming (as in Severity Level 4).

- Chronic or recurrent fear/anxiety that has compromised the resident's well-being and that may be manifested as avoidance of the fear-inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization (as in Severity Level 4).

- Ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists regardless of whether the precipitating, dehumanizing event(s) or situation(s) has ceased. The*se* feelings do not result in a life-threatening consequence.
- Sustained distress (e.g., agitation indicative of under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something).
- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, screaming, or cursing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level two* include but are not limited to:

- Intermittent sadness, as reflected in facial expression and/or demeanor, tearfulness, crying, or verbal/vocal agitation (e.g., repeated requests for help, moaning, and sighing).

- Feelings and/or complaints of discomfort or moderate pain. The resident may be irritable and/or express discomfort.

- Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well- being.

- Feeling of shame or embarrassment without a loss of interest in the environment and the self.

- Complaints of boredom and/or reports that there is nothing to do, accompanied by expressions of periodic distress that do not result in maladaptive behaviors (e.g., verbal or physical aggression).

- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm
Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the *following* areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome. *Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:*

483.10 Resident Rights
F557, Respect, Dignity/Right to Have Personal Property;
F558, Reasonable Accommodation of Needs/Preferences;

483.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;
F602 Free from Misappropriation/Exploitation;
F603, Free from Involuntary Seclusion;
F604, Right to be Free from Physical Restraints;
F605, Right to be Free from Chemical Restraints;
F606, Not Employ/Engage Staff with Adverse Actions;
F607, Develop/Implement Abuse/Neglect, etc. Policies;
F608, Reporting of Reasonable Suspicion of a Crime;
F609, Reporting of Alleged Violations;

F610, Investigate/Prevent/Correct Alleged Violation;

483.21 Comprehensive Resident Centered Care Plans
F656, Develop/Implement Comprehensive Care Plan;
F657 Care Plan Timing and Revision;

483.24 Quality of Life
F675, Quality of Life
F679, Activities Meet Interest/Needs of Each Resident;

483.40 Behavioral Health Services
F740, Behavioral Health Services;
F741 Sufficient/Competent Staff – Behavioral Health Needs;
F742, Treatment/Services for Mental/Psychosocial Concerns;
F743, No Pattern of Behavioral Difficulties Unless Unavoidable;
F745, Provision of Medically Related Social Services;

483.45 Pharmacy Services
F757, Drug Regimen is Free From Unnecessary Drugs; and
F758, Free from Unnecessary Psychotropic Medications/PRN Use.

SNF Beneficiary Notification Review

Beneficiary Notification Review: Complete the review for residents who received Medicare Part A Services. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. This protocol is intended to evaluate a nursing home's compliance with the requirements to notify Medicare beneficiaries when the provider determines that *Medicare Part A coverage is ending or when services may no longer be covered*. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare **Part A** skilled services when the resident has not used all the Medicare benefit days for that episode. This review does not include Admission notifications or Medicare Part B only notifications.

The two forms of notification that are evaluated in this review are:

1. **Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN)—Form CMS-10055**; *and*
2. **Notice of Medicare Non-coverage *(NOMNC)* -- Form CMS-10123.**

Entrance Conference Worksheet: The following information was requested during the Entrance Conference:

☐ A list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Exclude the following residents from this review:

- Beneficiaries who received Medicare Part B benefits only.
- Beneficiaries covered under Medicare Advantage insurance.
- Beneficiaries who expired during the sample date range.
- Beneficiaries who were transferred to an acute care facility or another SNF.

Review Three Notices:

☐ Randomly select 3 residents from that list. We recommend selecting one resident who went home and two residents who remained in the facility, if available.

☐ Fill in the name of the selected residents at the top of each Beneficiary Notification Checklist.

☐ Give the provider one Beneficiary Notification Checklist for each of the three residents to complete and return to the surveyor.

☐ The provider completes one checklist for each of the three residents in this sample and returns the checklist and notices to the survey team.

☐ Review the checklists and notices with the provider.

1. Were appropriate notices given to the residents reviewed? ☐ Yes ☐ **No F582** ☐ NA

SNF Beneficiary Notification Review for Residents who Received Medicare Part A Services

Facility Representative: *Please complete* all fields of this form. The intent of the checklist is to provide the surveyor with all copies of the forms issued to the resident, and if the notification was not required, an explanation of why the form was not issued.

Resident Name: _____

Medicare Part A Skilled Services Episode Start Date: _____

Last covered day of Part A Service: _____

SNF Beneficiary Notification Review

(Part A terminated/denied or resident was discharged)

How was the Medicare Part A Service Termination/Discharge determined?

☐ Voluntary, i.e., self-initiated in consultation with physician, family, or AMA.

☐ The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.

☐ Other (explain):

1. Was a SNF ABN, Form CMS-10055 provided to the resident?	☐ Yes →If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No →If no, explain why the form was not provided: ☐ The resident was discharged from the facility and did not receive non-covered services. ☐ Other Explain: ☐ ***If NOT issued and should have been: *cite* F582**
2. Was a NOMNC, *Form* CMS-10123 provided to the resident?	☐ Yes→ If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary's representative. ☐ No → If no, explain why the form was not provided: ☐ 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA). ☐ 2. Other Explain: ☐ ***If NOT issued and should have been: *cite* F582**

Beneficiary Notice Scenarios for Surveyors

Scenario	SNF ABN	Notice of Medicare Non-Coverage (NOMNC)	Notice(s) Not Required
Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day. *This does not apply to NOMNC if beneficiary initiated discharge.		X	
Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility. *This does not apply to NOMNC if beneficiary initiated discharge.	X	X	
Resident has skilled benefit days remaining and elects the Hospice benefit.			X
Resident discharges self as an unplanned discharge.			X
Resident has an unplanned discharge to the hospital.			X
Resident discharges to another SNF for continued skilled care.			X
Resident exhausts their skilled Part A benefit (has no days remaining).			X

Resident Council Interview

Resident Council Interview - *Complete an interview with active members of the Resident Council early enough in the survey to afford the team enough time to investigate any concerns. If there is not a resident council, determine whether residents have attempted to form one and have been unsuccessful, and if so, why.*

☐ Introduce yourself to the president of the council and ask for assistance in arranging the meeting. If there is no president, ask for a list of active resident council participants and select a resident to assist in arranging the meeting. Try to keep the group manageable, no more than 12 residents. Explain the survey process and the purpose of the interview using the following concepts. It is not necessary to use the exact wording.

> **"*[Name of facility]* is inspected periodically by a team from the *[Name of State Survey Agency]* to ensure that residents receive quality care. While we are here, we make observations, review the nursing home's records, and talk to the residents and family members or friends who can help us understand what it's like to live in this nursing home. We appreciate that you are taking the time to talk with us. We would like to know more about the Resident Council and interactions of the group and staff."**

☐ At all times, be cognizant of resident confidentiality. Obtain permission from the Resident Council President or Officer to review the Resident Council minutes and become familiar with some of the issues that have been discussed. Review three months of minutes prior to the interview to identify any unresolved areas of concern.

☐ Review the grievance policy to ensure prompt resolution of all grievances and that the facility has maintained results of grievances for a minimum of 3 years.

☐ It is suggested that the interview begin with some discussion of issues that have been discussed during the most recent Council meeting and how the facility has responded. For example, "I read in the minutes that you had discussed noise at night during the last meeting. Has the facility responded to your concern?" or "During the last meeting, several participants brought up an issue with food being cold. Has that situation been resolved to your satisfaction?" This initial discussion of current issues before the Council may prove helpful to establish a rapport with the Resident Council President (or Officer) and help make the remainder of the interview more informative.

☐ Document the names of residents in the meeting.

☐ Follow up on any concerns that are within the scope of the long-term care requirements with reference to specific F-tags identified on this pathway. Further investigation should include interviews with appropriate staff members to determine how concerns are resolved.

☐ Team meetings will provide opportunities to share concerns and focus on particular problematic areas. Any potential concerns noted during the interview should be shared with all team members.

Resident Council Interview

Interview		
Council		
	Resident Council Response	**Is the Facility in Compliance?**
1. Does the Resident Council meet on a regular basis?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
2. Does the facility help with arrangements for council meetings?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
3. Is there enough space for everyone who wants to attend?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
4. Can you meet without staff present, if you desire?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
Grievances		
	Resident Council Response	**Is the Facility in Compliance?**
5. Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
6. Does the Grievance Official respond to the resident or family group's concerns?	☐ Yes ☐ **No** (If Yes, Skip Question #7)	☐ Yes ☐ **No F565**
7. If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**
8. Do you know how to file a grievance?	☐ Yes ☐ **No**	☐ Yes ☐ **No F585**
9. Do you feel a resident or family group can complain about care without worrying that someone will 'get back' at them?	☐ Yes ☐ **No**	☐ Yes ☐ **No F585**

Resident Council Interview

Resident Specific Areas		
	Resident Council Response	**Is the Facility in Compliance?**
10. Do staff treat you with respect and dignity so that you do not feel afraid, humiliated, or degraded? (If concerns are identified, refer to the Abuse Pathway)	☐ Yes ☐ **No**	☐ Yes ☐ **No F600**
11. Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely? (If concerns are identified, refer to the Sufficient Staffing Pathway)	☐ Yes ☐ **No**	☐ Yes ☐ **No F725**
12. Do you receive snacks at bedtime or when you request them?	☐ Yes ☐ **No**	☐ Yes ☐ **No F809**
13. Ask about concerns identified during survey:		

Rules		
	Resident Council Response	**Is the Facility in Compliance?**
14. Have you (residents) been informed of the rules at the facility (such as are there restrictions on visiting hours)?	☐ Yes ☐ **No**	☐ Yes ☐ **No F563**
15. If the Resident Council makes suggestions about some of the rules, does the facility act on those suggestions?	☐ Yes ☐ **No**	☐ Yes ☐ **No F565**

Resident Council Interview

Rights		
	Resident Council Response	**Is the Facility in Compliance?**
16. Does staff talk about and review the rights of residents in the facility?	☐ Yes ☐ **No**	☐ Yes ☐ **No F572**
17. Are residents able to exercise their rights?	☐ Yes ☐ **No**	☐ Yes ☐ **No F550**
18. Do you feel that the rights of residents at this facility are respected and encouraged?	☐ Yes ☐ **No**	☐ Yes ☐ **No F561**
19. Is mail delivered unopened and on Saturdays?	☐ Yes ☐ **No**	☐ Yes ☐ **No F576**
20. Without having to ask, are the results of the State inspection available to read?	☐ Yes ☐ **No**	☐ Yes ☐ **No F577**
21. Do residents know where the ombudsman's contact information is posted?	☐ Yes ☐ **No**	☐ Yes ☐ **No F574**
22. Does the facility allow you to see your medical records if you ask?	☐ Yes ☐ **No**	☐ Yes ☐ **No F573**
23. Have residents been informed of their right (and given information on how) to formally complain to the State about the care they are receiving?	☐ Yes ☐ **No**	☐ Yes ☐ **No F574**
Other		
Investigation of responses from this question should be conducted through initiation of a care area, if available. If an applicable care area is not available, a direct F-tag initiation is appropriate.		
24. Do you have any questions, or is there anything else you would like to tell me about the Resident Council?	☐ **Yes** ☐ No	☐ Yes ☐ **No (Display all F-tags)**

Abuse Critical Element Pathway

Use this pathway for investigating an alleged violation of abuse to a resident. This would include allegations where a resident was deprived of goods or services by an individual, necessary to attain or maintain physical, mental and psychosocial well-being. If photographic documentation is obtained during the survey, refer to S&C-06-33. In addition, for investigating other concerns:

- Refer to the Investigative Protocol found at F603 for concerns related to involuntary seclusion;
- Refer to the Neglect CE Pathway to investigate concerns about structures or processes leading to a resident(s) with an outcome, for example, unrelieved pain, avoidable pressure ulcers/injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment; or
- Refer to the Investigative Protocol for F608-Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or for an allegation of retaliation.

NOTE: If you witness an act of abuse or receive an unreported allegation of abuse, you must immediately report it to the facility administrator, or his/her designated representative if the administrator is not present. The survey team would then determine whether the facility takes appropriate action in accordance with the requirements at F608, F609 and F610, including implementing safeguards to prevent further potential abuse. If you witness an act of abuse, you must document who committed the abusive act, the nature of the abuse, where and when it occurred, and potential witnesses.

Review the following in Advance to Guide Observations and Interviews*:*

☐ Information related to an alleged violation of abuse, such as:

- Date, time, and location (e.g., unit, room, floor) where alleged abuse occurred;
- Name of alleged victim(s), alleged perpetrator(s) and witnesses, if any;
- Narrative/specifics of the alleged abuse(s) including frequency and pervasiveness of the allegation; and
- Whether the allegation was reported by the facility and/or to other agencies, such as Adult Protective Services or law enforcement.

☐ Sources for this information may include:

- Resident, representative, or family interviews, observations or record review;
- Reports from the long-term care ombudsman or other State Agencies;
- Deficiencies related to abuse (CASPER 3 Report); and
- Complaints and facility-reported allegations of abuse, including any facility investigation reports, received since the last standard survey.

☐ Facility's abuse prohibition policies and procedures provided during the Entrance Conference (review only those components necessary during the investigation to determine if staff are implementing the policies as written). Refer to F607.

Abuse Critical Element Pathway

Observation across Various Shifts:. Request staff assistance to make observations, as needed. Only if you are a licensed nurse or practitioner can you observe the resident's private areas.

- ☐ Observe whether the alleged perpetrator (staff, other resident, or visitor) is present in the facility. What access does the alleged perpetrator have to the alleged victim and other residents?
- ☐ Describe the alleged victim's reaction, if any, when the alleged perpetrator, or a specific resident(s) or staff person(s) is present:
  - o Avoids or withdraws from conversations or activities;
  - o Displays fear of, or shies away from being touched; and/or
  - o Exhibits behaviors such as angry outbursts, tearfulness, or stress (agitation, trembling, cowering)?
- ☐ Describe physical injuries, if any, related to the alleged abuse, such as:
  - o Fractures, sprains or dislocations;
  - o Burns, blisters, or scalds;
  - o Bite marks, scratches, skin tears, and lacerations with or without bleeding, including those that would be unlikely to result from an accident;
  - o Bruises, including those forming shapes (e.g., finger imprints) or found in unusual locations such as the head, neck, lateral locations on the arms, posterior torso and trunk, inner thigh, genital area and/or breasts; and/or
  - o Facial injuries, including but not limited to, broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks.
- ☐ Observe and describe:
  - o If the alleged perpetrator is a resident, whether he/she displays symptoms, such as
    - ▪ Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;
    - ▪ Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
    - ▪ Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;
    - ▪ Taking, touching, or rummaging through other's property;
    - ▪ Wandering into other's rooms/space; or
    - ▪ Resistive to care and services.
  - o If the alleged perpetrator is staff, whether he/she displays rough handling of residents, appears rushed, dismisses requests for assistance, expresses anxiety, or frustration regarding work and lack of staffing.
- ☐ Observe for possible environmental factors related to the alleged abuse, such as:
  - o If in a resident's room, the room configuration, presence of privacy curtains, and the availability of a working call light/call bell;
  - o Lighting levels; or
  - o Location in relation to the nurse's station, staff lounges, or outside access such as windows, doors, or hallways.
- ☐ For an allegation that a resident was deprived of goods or services by staff, observe for physical/psychosocial outcomes related to care deficits.

Abuse Critical Element Pathway

Interviews: Be impartial, use discretion, and non-judgmental language. Use an interpreter as needed to obtain as accurate information as possible. Attempt to interview the alleged victim and witnesses as soon as possible.

Alleged Victim or Representative and Witness(es) Interview: Conduct private interviews unless the alleged victim requests the presence of another person. Observe the alleged victim's emotions and tone, as well as any nonverbal expressions or gesturing to a particular body area, in response to the questions. Maintain the confidentiality of witnesses and the person who reported the allegation (e.g., change the order of the interviews, location or time), to the extent possible. During the interview with the witnesses, the surveyor may ask him/her to re-create or re-enact the alleged incident, to better understand the sequence of events.

☐ For the **alleged victim/resident representative/witness**, ask, as applicable:

- What occurred prior to, during, and immediately following the alleged abuse?
- When and where did the alleged abuse occur?
- Could he/she identify the alleged perpetrator and any witnesses? Who?
- What was said? What was the tone of the alleged perpetrator's voice or volume?
- Did you report the alleged abuse? Who did you report it to? What was their response? If not reported, what prevented you from reporting the alleged abuse?
- Did you report the alleged abuse to any external entities (e.g., police, physician, ombudsman, and other state agencies)? Who did you report it to? What was their response?
- Do you think retaliation has occurred since you reported the alleged abuse? If so, what actions were taken?

☐ For the **alleged victim/resident representative**, document as applicable:

- Did you suffer any injuries (e.g., bruises, cuts, fractures) from the alleged abuse? Please describe, including the alleged victim's response to the injuries (e.g., pain, new difficulty sitting or walking).
- Did you go to the hospital or physician's clinic for evaluation and treatment? When and which facility?
- Do you feel safe?
- Have there been past encounters with the alleged perpetrator?
- Have there been past instances of abuse?

☐ For the **resident's representative**, ask, as applicable:

- Have you observed any changes in the alleged victim's behavior, and if so, describe?

☐ For an **allegation that a resident was deprived of goods or services by staff, for the alleged victim/resident representative**, ask, as applicable:

- How do staff respond to your requests for assistance? If staff do not respond, what happens?
- Do you have any concerns about the manner in which care is provided to you? If so, describe. Did you report this to anyone? If so, to whom, when, and what was the response?
- Do you feel that you have had any negative changes (e.g., weight loss, pressure ulcers) because of the failure to receive the care that you need?
- Have you had any changes in medication (e.g., antipsychotics) that may be impacting the care you receive?

Abuse Critical Element Pathway

Alleged Perpetrator Interview: If the alleged perpetrator is a staff member, the staff member may have been suspended or re-assigned until the facility's investigation is completed and in some situations, the facility may have terminated the employment of the individual. In some cases the alleged perpetrator may not be in the facility or may refuse to be interviewed. If possible, interview the alleged perpetrator in person or by phone even if the alleged perpetrator is no longer working in the facility. In addition, the alleged perpetrator may be a resident or visitor. Interview the alleged perpetrator to determine the following, to the extent possible, and include information regarding inability, if any, to conduct the interview:

- ☐ What information can you provide regarding the alleged abuse?
- ☐ Were you present in the facility at the time of the alleged abuse? If so, where were you at?
- ☐ What is your relationship, if any, to the alleged victim?
- ☐ For an allegation that a resident was **deprived of goods or services**, ask the staff member:
  - How do you respond to the resident's requests for assistance;
  - Have you had any concerns when you have been assigned to this resident? If so, describe. Did you report this to anyone? If so, to whom, when, and what was the response?
  - Have you noticed any negative changes (e.g., weight loss, pressure ulcers) with this resident? If so, describe; and
  - Has the resident had any behavioral symptoms (e.g. combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting the care that they receive? If so, have you reported this? If reported, to whom, when, and what was the response?
- ☐ If the **alleged perpetrator is a staff member**:
  - What is your position?
  - Describe any contact that you have with the alleged victim.
  - Do you continue to have access to the alleged victim? If not, why?
  - How long have you worked in the facility?
  - What type of orientation, training, work assignments, and supervision did you receive?
  - What training have you received related to abuse prevention, reporting abuse, and the facility's abuse policy and procedures?
- ☐ Do you have any other information you wish to share in regard to the investigation?

Abuse Critical Element Pathway

Staff Interviews: Interview the most appropriate direct care staff member. Review staff schedules from all departments to determine who was working at the time of the alleged abuse and who may have had contact with the alleged perpetrator or alleged victim. Interview the most appropriate direct care staff member:

- ☐ Did you have knowledge of the alleged abuse? If so, describe.
- ☐ What actions, if any, did you take in response to the allegation?
- ☐ If you're familiar with the alleged victim, have you noticed any changes in the alleged victim's behavior as a result of the alleged abuse? If so, describe.
- ☐ How did the alleged perpetrator and victim act towards one another prior to and after the incident?
- ☐ Did the alleged perpetrator and/or victim exhibit any behaviors that would provoke one another? If so, what actions were taken to address this?
- ☐ If the alleged perpetrator was staff, had the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past, such as using derogatory language, rough handling, or ignoring residents while giving care?
- ☐ If the alleged perpetrator was a visitor, did the visitor exhibit any inappropriate behaviors in the past or have any indication of risk to the resident(s)?
- ☐ Did you report the alleged abuse to any supervisors/administration? Who did you report it to? What was their response?
  - o If reported, do you think retaliation has occurred since you reported the alleged abuse? If so, describe. Do you fear retaliation?
  - o If not reported, what prevented you from reporting the alleged abuse?
- ☐ Did you report the alleged abuse to any external entities (e.g., police, physician, ombudsman, and other state agencies)? Who did you report it to? What was their response?
- ☐ Have you received training on abuse identification, prevention, and reporting requirements?
- ☐ For an allegation that a resident was **deprived of goods or services** by staff, ask:
  - o How do staff respond to the resident's requests for assistance? If staff do not respond, what do they say;
  - o Do you have any concerns about the manner in which care is provided to the resident? If yes, describe. Did you report this to anyone? If so, to whom, when, and what was the response;
  - o Has the resident had any negative changes (e.g., weight loss, pressure ulcers) because of the failure to receive the care that he/she needs;
  - o Has the resident had any changes in medication (e.g., antipsychotics) that may be impacting the care that they receive? Note: Determine if the resident may have received unnecessary medications such as chemical restraints.

Abuse Critical Element Pathway

Other Healthcare Professionals (DON, Social Worker, Attending Practitioner) Interviews, as Appropriate Ask the appropriate personnel:

- ☐ Do you have knowledge of the alleged abuse? If so, describe.
- ☐ When and by whom were you notified of the alleged abuse?
- ☐ Did you conduct an assessment of the alleged victim for potential injuries or a change in mental status? What interventions or treatment (e.g., counseling) were provided, if any?
- ☐ Was the alleged victim assessed and/or treated at a hospital after the alleged incident? NOTE: Attempt to interview the practitioner from the hospital who examined the alleged victim to determine physical findings and mental status at the time.
- ☐ Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses?
- ☐ If there are discrepancies in injuries based on the alleged victim's description, how was this investigated?
- ☐ Did the alleged perpetrator and/or victim exhibit any behaviors that would provoke one another? If so, what actions were taken to address this?
- ☐ Did you report the alleged abuse to administration? Who did you report it to? What was their response? If not reported, what prevented you from reporting the alleged abuse? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)?
- ☐ Were any external entities (e.g., APS or law enforcement) contacted? If so, who made the report, to whom, and when?
- ☐ If the **alleged perpetrator was a resident**:
  - o Did you conduct any interviews related to the alleged abuse and identify the circumstances of what occurred prior to, during and after the alleged abuse?
  - o Does the care plan identify interventions to address any behaviors of the alleged perpetrator?
  - o Was the care plan implemented?
- ☐ If the **alleged perpetrator is a visitor**:
  - o Was there any indication of a prior history of abuse, aggression, or other inappropriate behaviors?
  - o Was there any indication of a physical or psychosocial change in the alleged victim after a visit with the alleged perpetrator, whether onsite or outside of the facility?
  - o Did you interview the alleged perpetrator and identify the circumstances of what occurred prior to, during and after the alleged abuse? If so, describe?
  - o Were visits from the alleged perpetrator supervised? When and where did visits usually occur?
  - o Is access to the alleged victim currently allowed? If so, under what circumstances?
  - o What protections have been put in place (e.g., supervision of visits while the investigation is being conducted); and/or
  - o Has access to other residents been limited? If so, how?
- ☐ For an allegation that a resident was **deprived of goods or services** by staff, ask:
  - o Have you noticed any negative changes (e.g., weight loss, pressure ulcers) with this resident? If so, please describe.
  - o How do staff respond to the resident's requests for assistance? If staff do not respond, what do they say;
  - o Do you have any concerns about the manner in which care is provided to the resident? If yes, describe. Has staff report this concern to you? If so, when and what did you do;
  - o Has the resident had any behavioral symptoms (e.g., combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting care they receive? If so, did staff report this to you? If reported, when and what was your response;
  - o Has the resident had any changes in medication (e.g., antipsychotics) that may be impacting the care that they receive? Note: Determine if the resident may have received unnecessary medications such as chemical restraints; and/or

Abuse Critical Element Pathway

- o If the interventions were not effective in reducing the behaviors, were they revised and if so, what was changed?
- o Did the revised interventions provide the needed protections?
- o What protections have been put in place at this time?
- o Has access to other residents at risk been limited? If so, how?

☐ If the **alleged perpetrator was staff**, ask:

- o Did the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past (e.g., using derogatory language, rough handling, or ignoring residents while giving care)? If yes, describe.
- o Was there a history of resident/family grievances or problems identified with care delivery or services provided? If so, what was the result of the investigation of the concerns, and describe any disciplinary actions and/or training provided related to the complaints/concerns.
- o Did annual performance reviews identify issues with the provision of care, treatment, or other concerns? If so, what was provided to address the concerns.
- o How is monitoring and supervision provided regarding the delivery of care and services by the alleged perpetrator?
- o Who is responsible for supervising and monitoring the delivery of care at the bedside?

Facility Investigator Interview: If the facility investigated the alleged abuse, interview the staff member responsible for the initial reporting and the overall investigation of the alleged abuse. For some facilities, the Administrator may be the Facility Investigator.

- ☐ When (date and time) were you notified of the alleged abuse and by whom?
- ☐ What information was reported to you related to the alleged abuse?
- ☐ When and what actions were taken to protect the alleged victim from further abuse while the investigation was in process?
- ☐ Describe medical interventions, if any, taken in relation to the alleged abuse, (e.g., hospitalization, transfer to ER, onsite visit by attending practitioner).
- ☐ What steps were taken to investigate the allegation? Can you provide me a timeline of events that occurred?
- ☐ Describe interviews conducted, such with the alleged victim/resident representative, witnesses, alleged perpetrator, and practitioner and what information was obtained.
- ☐ Describe record reviews conducted related to the alleged abuse and what information was obtained.
- ☐ Were there any photographs or videos obtained related to the alleged abuse? If yes, describe.
- ☐ When and who received results of the investigation?

Abuse Critical Element Pathway

- ☐ Describe any mental assessments that were conducted pertaining the alleged abuse, and any interventions taken to assist the resident (e.g., counseling).
- ☐ If the allegation relates to sexual abuse, describe the immediate actions of the staff, including preserving evidence, providing medical intervention (e.g., transfer to hospital for sexual assault for rape kit), conducting a physical assessment, and reporting.
- ☐ Who did you notify and when (date/time) of the alleged abuse? Was an outside entity informed about the alleged abuse, and if so, when (date and time)? NOTE: If a suspected crime, note the date and time reported. Obtain copies of the outside entities investigations, if available.
- ☐ What actions were taken as a result of the investigation (e.g., for the alleged victim, the alleged perpetrator, other staff, training, policy revisions)?
- ☐ Is there any related information regarding the allegation that may not be included in the investigation report?

Administrator Interview:

- ☐ When (date and time) were you notified of the allegation and by whom?
- ☐ When (date and time) was the initial report reported to required agencies and law enforcement, as applicable?
- ☐ Who was/is responsible for the investigation? Is the investigation completed or ongoing? If completed, what was the outcome? (if the administrator is the facility investigator, use the questions above to determine how the investigation was conducted.)
- ☐ When (date and time)were the results of the investigation reported to you and to the required agencies?
- ☐ When and what actions were taken to protect the alleged victim and residents at risk from further abuse while the investigation was in process?
- ☐ What happened as a result of the investigation?
- ☐ How do you monitor for potential or actual reported allegations of abuse?
- ☐ If the alleged perpetrator is an employee, were there previous warnings or incidents at the facility? If the alleged abuse was verified, describe actions that were taken.
- ☐ How do you assure retaliation does not occur when staff or a resident reports an allegation of abuse?
- ☐ For an allegation that a resident was **deprived of goods or services**, ask:
  - o Have staff reported any concerns to you about the manner in which care is provided to the resident? If yes, when, what did they report, and what did you do; and
  - o Who is responsible for supervising and monitoring the delivery of care at the bedside?

QAA Responsible Person Interview:

- ☐ How do you monitor reported allegations of abuse?
- ☐ When did the QAA Committee receive the results of the investigation for the allegation of abuse?
- ☐ Did the QAA Committee make any recommendations based on the results of the investigation, such as policy revisions or training to prevent abuse?

Abuse Critical Element Pathway

Review the Alleged Victim's Record:

- ☐ Was the alleged victim was assessed at risk for abuse (e.g., as indicated in the RAI, care plan, progress notes from nurses, social services, practitioners)? If so, how did the facility implement interventions to mitigate risks?
- ☐ When (date/time) did the allegation occur? When was it discovered and by whom?
- ☐ When was the resident's representative, practitioner and other required entities notified?
- ☐ Were physical injuries noted related to the alleged abuse?
- ☐ Are there changes in the alleged victim's mood or demeanor before and after the alleged abuse (e.g., distrust, fear, angry outburst, cowering, tearfulness, agitation, panic attacks, withdrawal, difficulty sleeping, and PTSD symptoms)?
- ☐ Are there potential indicators of sexual abuse (e.g., STD, vaginal or anal bleeding, pain or irritation in genital area, bruising/lacerations on breasts or inner thighs, or recent difficulty with sitting or walking)?
- ☐ Was the resident assessed and the care plan revised as needed? What interventions (e.g., first aid, hospitalization) occurred to address any physical injuries or changes in mental status? (Note: If the resident required medical treatment, you may need to contact the hospital and/or practitioner to obtain related medical records for review.)
- ☐ For an allegation that a resident was **deprived of goods or service**:
  - o Does the record reflect any negative changes (e.g., weight loss, pressure ulcers);
  - o Has the alleged victim had any behavioral symptoms (e.g., combative behavior, frequent requests for assistance, calling out, grabbing) that may be impacting the care that they receive? If so, describe; and/or
  - o Determine if the alleged victim may have received unnecessary medications such as chemical restraints and if this impacted the care received.

Review the Alleged Perpetrator's Record, if a Resident:

- ☐ What circumstances are documented (date/time) before, during and after the alleged abuse?
- ☐ Is there a previous history of exhibiting any behaviors that would provoke others? If so: Does the care plan address behaviors, if any, of the alleged perpetrator, and include interventions (e.g., monitoring, staff supervision, redirection?
  - o Were care plan interventions implemented?
  - o If the interventions were not effective in reducing the behaviors, were they revised and if so, what was changed?
- ☐ After the alleged abuse, did staff separate the alleged victim and other residents at risk?
- ☐ What are the plans to monitor and supervise the resident?
- ☐ If interventions were unsuccessful, was the physician notified? Were new interventions implemented?

Abuse Critical Element Pathway

- Did the revised interventions provide the needed protections?
- What protections are currently in place?
- Does the alleged perpetrator have limited access to other residents at risk? If so, how?

Review the Alleged Perpetrator's Personnel File, if Staff:

- ☐ Is there any information related to the alleged abuse? If so, describe.
- ☐ Is there a history of other allegations?
- ☐ Were adverse personnel actions taken? If so, describe.
- ☐ Is there information related to any finding of abuse/neglect/exploitation/misappropriation of property/mistreatment?
- ☐ If a nurse aide:
  - Was training and orientation provided related to dementia management, abuse and neglect prevention?
  - Were annual performance reviews conducted? Was there a history of competency concerns? If so, what disciplinary actions and/or training was provided related to performance deficits?

Investigative Report from Other Investigatory Agencies (APS, Professional Licensing Boards, Law Enforcement):

- ☐ Review a copy of the report if another investigatory agency (e.g., APS, Professional Licensing Board, and Law Enforcement) conducted an investigation.
- ☐ What did the other investigatory agency find? Note: deficient practice is not determined based on another agency's investigation.

Critical Element Decisions:

1) Did the facility protect a resident's right to be free from any type of abuse that results in, or has the likelihood to result in physical harm, pain, or mental anguish?
   If No, cite F600

2) Did the facility hire or engage staff who have:
   - Not been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law?
   - Not had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property?
   - Not had a disciplinary action taken by a state professional licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property?
   - Not had a successful appeal of their disqualification from employment?

Abuse Critical Element Pathway

AND/OR

Did the facility report to the State nurse aide registry or licensing authorities any knowledge of actions taken by a court of law that would indicate unfitness as a staff member of a nursing home?
If No, cite F606
NA, the alleged perpetrator was not staff

3) Did the facility develop and implement written policies and procedures that prohibit and prevent abuse, establish policies and procedures to investigate any such allegations, and include training as required at paragraph §483.95?
If No, cite F607

4) Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training on activities that constitute abuse; procedures for reporting incidents of abuse; and dementia management and resident abuse prevention?
If No, cite F943

5) Does the facility's in-service training for nurse aides include resident abuse prevention?
If No, cite F947

6) Did the facility develop and implement written policies and procedures to ensure reporting of suspected crimes within mandated timeframes, annual notification of covered individuals of reporting obligations, posting of signage stating employee rights related to retaliation against the employee for reporting a suspected crime, and prohibition and prevention of retaliation?
If No, cite F608

7) For alleged violations of abuse, did the facility:
- Identify the situation as an alleged violation involving abuse, including injuries of unknown source?
- Immediately report the allegation to the administrator and to other officials, including to the State survey and certification agency, and APS in accordance with State law?
- Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?

If No to any of the above, cite F609

8) For alleged violations of abuse, did the facility:
- Prevent further potential abuse while the investigation is in progress?
- Initiate and complete a thorough investigation of the alleged violation?
- Maintain documentation that the alleged violation was thoroughly investigated?

Abuse Critical Element Pathway

- Take corrective action following the investigation, if the allegation is verified?

If No to any of the above, cite F610

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Dignity (CA), Visitors F563/F564, Notice of Rights and Rules F572, Privacy (CA), Grievances F585, Reporting Reasonable Suspicion of a Crime F608, Accidents (CA), Social Services F745, Behavioral-Emotional Status (CA), Sufficient and Competent Staffing (Task), QAA/QAPI (Task).

Personal Funds Review

Personal Funds Review: *Complete this review if a resident or representative had concerns with their personal funds account during the initial pool process. Residents should be given the opportunity to manage their own personal funds, and the facility may not require residents to deposit their funds. If residents choose to have the facility manage their funds, the facility may not refuse. If concerns are identified, review additional resident accounts to determine the frequency of identified problems and review the facility's policies, procedures and systems.*

Verify Account: Verify the existence of the resident's account prior to beginning the review. If you determine that the resident does not have an account and this is the only resident causing the task to trigger, remove the Personal Funds task and reconcile the discrepancy before removing the task.

Access to Funds: Review this CE if the resident or representative had concerns about access to their funds.

☐ Interview staff to determine how resident requests for money on weekends or evenings (non-banking hours) are honored and how money is safeguarded until needed.

1. Do residents have ready access to their personal funds managed by the facility? ☐ Yes ☐ **No F567** ☐ **NA**

Quarterly Statements: Review this CE if the resident or representative had concerns about quarterly statements.

☐ Determine how often residents, or their legal representatives, receive statements of personal account activity.

☐ Ask staff to show and describe the system for ensuring that quarterly statements, and statements upon request, are provided.

☐ Determine whether the sampled resident receives his/her own quarterly statements, and statements upon request (unless a legal financial representative has been appointed or the resident has requested another party to receive the information).

2. Does the facility provide quarterly statements and provide statements to residents or legal representatives upon request? ☐ Yes ☐ **No F568** ☐ **NA**

Costs and Services: Review this CE for the residents who caused this task to trigger.

☐ How and when residents are notified of the costs for services and any changes in costs for services.

☐ Whether residents/legal representatives are notified of expected charges at the time of admission, and told in advance when changes will occur in their bills.

☐ Whether residents/legal representatives are notified of any charges for services that are not covered under Medicare or Medicaid or by the facility's per diem rate, such as in-room telephone, haircuts, the daily newspaper, or private room charges.

☐ Whether Medicaid beneficiaries are informed, in writing, at the time of admission or when the resident becomes eligible for Medicaid, of the items and services included in the state plan for which the resident may not be charged.

Personal Funds Review

3. Are residents informed of costs for services and any changes in costs for services? ☐ Yes ☐ **No F582** ☐ **NA**

Separate Accounting Maintained: Review this CE for the residents who caused this task to trigger.

☐ Ask the staff member to show you and describe how separate accounting is maintained.

☐ Are funds in one pooled (combined) resident fund account?

☐ Are funds in a separate account?

☐ Are funds in a combined account for resident funds under $50.00 (not required to be in an interest-bearing account) with an additional separate interest-bearing account for funds in excess of $50.00 for Medicaid residents and in excess of $100.00 for all other residents. (For example, a resident may have a small amount of money in a pooled account and have a large amount of money in an interest-bearing savings account)?

☐ Are funds in a separate accounting, whether or not the funds are pooled (combined), with separate statements maintained showing deposits and withdrawals?

4. Does the facility maintain a separate accounting of each resident's funds? ☐ Yes ☐ **No F568** ☐ **NA**

Accounting Principles: Review this CE for the residents who caused this task to trigger.

☐ Determine whether the record is reconciled and up to date by asking staff to show how the financial account indicates:

- The transactions that have occurred including deposits and withdrawals are accurately recorded.
- The resident's current balance.

5. Does the accounting system follow generally acceptable accounting principles? ☐ Yes ☐ **No F568** ☐ **NA**

Charges: Review this CE for the residents who caused this task to trigger.

☐ Determine how staff ensures that Medicare or Medicaid residents are not charged for services that are covered under the Medicare or Medicaid plan.

☐ Ask staff to review and describe charges and deductions from the account of the Medicare or Medicaid recipient(s).

☐ Follow up on vague entries, unreasonable charges, and any inappropriate charges for covered items. Residents should be allowed to pay for non-covered services that are available to private-pay residents, such as permanents/haircuts, personal reading material, and social events outside the scope of the activities program.

☐ See F571 for examples of items that may be charged to resident's funds. (Medicaid recipients must be informed in writing of items and services

Personal Funds Review

included in the state plan.

6. Are Medicare/Medicaid residents charged only for non-covered services? ☐ Yes ☐ **No F571** ☐ **NA**

Interest: Review this CE for the residents who caused this task to trigger.

☐ Interview staff to determine whether funds in excess of $50.00 for Medicaid residents and $100.00 for all others are kept in an interest-bearing account.

☐ Whether all resident funds are pooled (combined) into one account, that resident money is not co-mingled with facility money, and each resident accrues an appropriate percent of the interest.

☐ Ask staff to show and describe how interest is paid to each entitled resident.

☐ "Applicable interest" means a rate of return equal to or above the passbook savings rate at local banking institutions in the area. If money is in a pooled fund, each resident should receive the applicable interest rate distributed in proper proportion according to individual account balances. Earned interest should be posted to resident accounts within a few business days of the facility's receipt of the bank statement.

7. Is applicable interest paid to each entitled resident? ☐ Yes ☐ **No F567** ☐ **NA**

Medicaid Eligibility Limit: Review this CE if a resident who caused this task to trigger is a Medicaid recipient:

☐ Review the account balance for that resident to see whether the balance is nearing the eligibility limit.

☐ If the balance is within, or approaching, $200.00 of the maximum a Medicaid recipient can have in cash assets (eligibility limit varies from state to state), determine whether the facility has verification that a notice was given to the resident/legal representative.

8. Does the facility notify Medicaid residents when the amount in the resident's account reaches $200 of the eligibility limit? ☐ Yes ☐ **No F569** ☐ **NA**

Surety Bond: Review this CE if the task triggered.

☐ Ask the facility to provide information on how many residents have personal accounts and what total amount (total value) is being managed by the facility.

☐ Determine whether the facility has a surety bond.

☐ Verify that the bank holdings are comparable to the total amount of funds entrusted to the facility.

Personal Funds Review

9. Does the facility have a surety bond or similar protection with the amount of the surety bond equal to at least the current total amount of resident funds? ☐ Yes ☐ **No F570** ☐ **NA**

Activities Critical Element Pathway

Use this pathway if there are activity concerns for a resident to determine if the facility is meeting the resident's activity needs.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, F, and GG.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., activity plan in the facility and community, continuation of life roles consistent with preferences and functional capacity, adaptations needed for activity participation, needed transportation assistance, and who is to provide the assistance to attend preferred activities).

Observations:

☐ For a resident whose care plan includes group activities:

- How does staff inform the resident of the activity program schedule?
- How does the facility provide timely transportation, if needed, for the resident to attend in-facility activities, and help the resident access transportation for out-of-facility and community activities?
- Are the activities compatible with the resident's individual physical and mental capabilities? If not, describe.
- How are the activities compatible with known interest and preferences?
- How are the activities adapted, as needed (such as large print, holders if resident lacks hand strength, task segmentation)?
- Are the activities person-appropriate? If not, describe.

☐ For a resident who participates in individual activities:

- How has the facility provided any needed assistance, equipment, and supplies?
- Does the room have sufficient light and space for the resident to complete the activity? If not, describe.

Activities Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How did the facility involve you in care plan development, including defining the approaches and goals?
- ☐ Do the activities offered here reflect your (or the resident's) preferences and choices? If not, please explain.
- ☐ In what activities do you participate? If none, why don't you participate?
- ☐ Do you need any assistance, such as set up of activity materials or adaptation? If so, what is needed? How is the facility providing it to facilitate your participation in activities of choice?
- ☐ How are you notified of upcoming activities? Are you offered transportation assistance to attend the activities, both inside and outside of the facility?
- ☐ How has the facility made efforts to provide your scheduled care, such as bathing and therapy services, so they don't conflict with the activities you want to do?
- ☐ What equipment and supplies do you receive to complete activities?
- ☐ What assistance do you receive during group activities (e.g., toileting, eating assistance, ambulation assistance)?
- ☐ Are planned activity programs occurring on a regular basis? If not, describe. Are scheduled activities often cancelled? If so, do you know why that is?
- ☐ Are there activities that you like that the facility does not provide? If so, describe.

Activity Staff Interviews:

- ☐ What is the resident's program of activities and what are the goals?
- ☐ What assistance do you provide in the activities that are part of the resident's care plan?
- ☐ How regularly does the resident participate?
- ☐ How do you make sure the resident is informed and transported to group activities of choice?
- ☐ How are special dietary needs and restrictions handled during activities involving food?
- ☐ How do you make sure the resident has sufficient supplies, proper lighting, and sufficient space for individual activities?

Nurse Interviews:

- ☐ How do you assist the resident in participating in activities of choice?
- ☐ How do you coordinate schedules for ADLs, medications, and therapies, to the extent possible, to maximize the resident's ability to participate?
- ☐ How do you make nursing staff available to assist with activities in and out of the facility?
- ☐ If the resident is refusing to participate in activities, how do you try to identify and address the reasons?
- ☐ What role, if any, does nursing play when activity staff are not available to provide care-planned activities?

Activities Critical Element Pathway

Social Service Interviews:

- ☐ How do you facilitate resident participation in activities of choice?
- ☐ What role do you play in obtaining equipment or supplies needed by the resident in order to participate in activities of choice (obtaining audio books; assisting the resident to obtain new glasses or hearing aids, if needed; providing needed assistance to the resident for the purchase of music, crafts, and other supplies)?
- ☐ What role do you play in the resident accessing his/her funds for participation in activities of choice that require funds, such as restaurant dining events? (If redirected to a different staff member, interview that staff member).

Record Review:

- ☐ Review activity documentation, social history, discharge information from a previous setting, and other disciplines' documentation that may have information regarding the assessment of the resident's activity interests, preferences, and needed adaptations.
- ☐ Does the most recent RAI assessment accurately and comprehensively reflect the status of the resident:
  - Longstanding interests/customary routine and how the resident's current physical, mental, and psychosocial health status affects either the resident's choice of activities or ability to participate;
  - Specific information about how the resident prefers to participate in activities of interest (for example, if music is an interest --what kinds of music, does the resident play an instrument; if the resident listens -- does the resident have the music of choice available, does the resident have the functional skills to participate independently, such as putting a CD into a player);
  - Have any recent significant changes in activity pattern occurred prior to or after admission;
  - The resident's current need for special adaptations in order to participate in desired activities (e.g., auditory enhancement, equipment to compensate for physical difficulties, such as use of only one hand);
  - The resident's need, if any, for time-limited participation (e.g., due to short attention span, illness that permits only limited time out of bed);
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ How does the facility encourage and support the development of new interests, hobbies, and skills?
- ☐ How does the facility provide activities to help the resident reach the goal?
- ☐ For a resident who is constantly mobile, how does the facility accommodate the resident's need to move about in a safe, supervised area?
- ☐ For a resident with severely limited attention span or who is medically compromised, how does the facility ensure activities are time-limited or low-energy programs and address pertinent medical, nursing, dietary, or therapy recommendations or restrictions?
- ☐ For a resident who is confined to his/her room, what is the plan for room-based activities?
- ☐ For a resident who is on a toileting program or special nutrition/hydration program, what is the plan for coordination among activity, dietary, and nursing staff so that needs are met?
- ☐ How does the facility monitor the resident's condition and effectiveness of interventions?

Activities Critical Element Pathway

- The resident's desired daily routine and availability for activities; and
- The resident's choices for group, one-to-one, or self-directed activities.

☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, preferences, and choices? Has the care plan been revised to reflect any changes?

☐ How does staff accommodate activity changes because of the time of year (e.g., gardening in the summer)?

☐ If the resident refuses, resists, or complains about some chosen activities, what was the reason and what alternative interventions were offered?

Critical Element Decisions:

1) Did the facility provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of the resident?
If No, cite F679

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

Activities Critical Element Pathway

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Access and Visitation Rights F563, Choices (CA), Privacy (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, Activity Director Qualifications F680, Social Services F745, Sufficient and Competent Staffing (Task), Dining (Task) and Activity Rooms F920, Facility Assessment F838, Staff Qualifications F839, Resident Records F842.

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ☐ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How does staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Behavioral and Emotional Status Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ☐ Awareness of current conditions or history of conditions or diagnoses.
- ☐ How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?
- ☐ How does the facility ensure approaches to care reflect your/the resident's choices and preferences?
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- ☐ How are the resident's individual needs being met through person-centered approaches to care?
- ☐ What are your or the resident's concerns, if any, regarding the resident's mood?
- ☐ Have you or the resident had a change in mood? If so, please describe.
- ☐ What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- ☐ What other non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ☐ What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rational for each intervention?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is provided that is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ What types of behavioral health training have you completed?
- ☐ Ask about any other related concerns the surveyor has identified.
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

Behavioral and Emotional Status Critical Element Pathway

Record Review:

- ☐ Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ What PASARR Level II services or psychosocial services are provided, as applicable?
- ☐ Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Was behavioral health training provided to staff?

Critical Element Decisions:

1) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
If No, cite F740

2) Does the facility have sufficient and competent direct care staff to provide nursing and related services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?
If No, cite F741

Behavioral and Emotional Status Critical Element Pathway

3) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD)?

   If No, cite F742
   NA, the resident does not display or is not diagnosed with a mental or psychosocial adjustment difficulty, or does not have a history of trauma and/or PTSD.

4) Did the facility ensure that the resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable?

   If No, cite F743
   NA, the resident's assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

5) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?

   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

6) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?

   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

7) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

Behavioral and Emotional Status Critical Element Pathway

8) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

9) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

10) Did the facility reassess the effectiveness of the interventions and, review and revise the resident's care plan (with input from the resident, or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Social Services F745, Unnecessary/Psychotropic Medications (CA), Resident Records F842.

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Use this pathway for a resident having communication difficulty and/or sensory problems (vision and/or hearing).

Review the Following in Advance to Guide Observations and Interviews*:*

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections B – Hearing, Speech, Vision, C – Cognitive Patterns, G – Functional Status, and O – Spec Treatment/Proc/Prog - SLP (O0400A) and restorative nursing (O0500).
- ☐ Physician's orders (e.g., communication, hearing or visual aids, pertinent medications, speech therapy, or restorative).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., supportive and assistive devices/equipment to meet visual, hearing, or communication needs, environmental factors to promote vision or hearing).

Observations:

- ☐ How does the resident give cues indicating visual or hearing deficits?
- ☐ What supportive and assistive devices/equipment (telephone with low-high volume switch, hearing aids, magnifying glasses, hand signals, use of pictures, large print books, books on tape, communication boards) are used? Are they used correctly, functioning properly, and in good repair?
- ☐ Are activities and interactions provided in a manner that is responsive to individual hearing, vision, or communication concerns? If not, describe.
- ☐ How is the environment responsive to individual hearing, vision, or communication concerns (e.g., adequate lighting, reduction of glare, removal of clutter, reduction of background noise)?

Resident, Resident Representative, or Family Interview:

- ☐ What is your current communication and/or sensory status?
- ☐ Do you need or have you requested (but don't have) visual or hearing devices? If so, has the facility assisted the resident with making appointments or arranging transportation to/from appointments?
- ☐ How does the facility involve you in the development of the care plan and goals?
- ☐ How does the facility ensure interventions reflect your choices and preferences and staff provide care according to the care plan?
- ☐ If you have refused devices/techniques, what alternatives or other interventions has the facility discussed with you? What did staff talk to you about the risks of refusing?

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Social Services):

- ☐ What specific communication methods and interventions, such as use of communication devices (e.g., sign language, gestures, communication board), any visual devices (e.g., glasses, magnifying lens, contact lenses) or hearing aids, and speech therapy schedules does the resident use?
- ☐ What, when, and to whom do you report changes in communication and/or sensory functioning, including broken assistive devices in need of repair?
- ☐ How do you monitor for the implementation of the care plan?
- ☐ How do you review and evaluate for changes in the resident's communication and sensory functioning?
- ☐ How are appointments and transportation arranged for visual and auditory exams?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.
- ☐ Ask about identified concerns.

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Record Review:

- ☐ Review therapy notes, consultations, and other progress notes that may have information regarding the assessment of visual, hearing, and/or communication needs.
- ☐ What was the resident's responsiveness to speech, hearing, or visual services?
- ☐ Did the facility accurately and comprehensively reflect the status of the resident?
- ☐ What causal, contributing, and risk factors for decline or lack of improvement related to limitations in visual or auditory functioning or communication does the resident have?
- ☐ What factors does the resident have that may affect communication (e.g., medical conditions, such as CVA, Parkinson's disease, cerebral palsy or other developmental disabilities, COPD, psychiatric disorders, dysarthria, dysphagia, dysphasia/aphasia, medications, decreased ability to understand how to use communication aids, and hearing/visual limitations).
- ☐ What factors does the resident have that may affect visual functioning (e.g., conditions such as glaucoma, diabetes, macular degeneration, cataracts, eye infections, blurred vision; refusal to wear glasses, difficulty adjusting to change in light, poor discrimination of color, sensitivity to sunlight and glare, impaired peripheral and depth perception, impaired edge-contrast sensitivity; and environmental factors such as insufficient lighting).
- ☐ What factors does the resident have that may affect hearing (e.g., background noise, cerumen impaction, infections [colds/congestion], ototoxic medications [ASA, antibiotics], perforation of an eardrum, retrocochlear lesions, tinnitus, poorly fitting or functioning hearing aid, and foreign bodies in the ear canal).
- ☐ How did the facility respond to needed assistive devices to promote hearing, vision, or communication?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, strengths, risks, and needs? Does it include measurable objectives and timetables? How did the resident respond to care-planned interventions? If interventions weren't effective, was the care plan revised?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ What scheduled/planned auditory or visual examinations, or speech therapy is the resident receiving?
- ☐ Is the resident at risk for accidents related to visual/auditory impairments, or lack of understanding of safety instructions? If so, how has staff addressed this?
- ☐ If the resident refuses or is resistant to devices or services, what efforts have been made to find alternative means to address the needs identified in the assessment process?
- ☐ How does staff monitor the resident's response to interventions?
- ☐ If the resident experienced an unexpected decline or lack of improvement in hearing or vision, how did staff ensure that proper treatment was obtained in a timely fashion?
- ☐ How did the facility involve the resident or resident representative in the review and revision of the plan?

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Critical Element Decisions:

1) Did the facility provide proper care and treatment, including assistive devices, to prevent a decline, maintain, or improve the resident's communication abilities (speech, language, or other functional communication systems)?
   If No, cite F676
   NA, the resident does not have communication needs.

2) Did the facility ensure the resident receives proper treatment and assistive devices to maintain vision and/or hearing abilities?
   If No, cite F685
   NA, the resident does not have vision or hearing needs.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Notice of Rights F552, Dignity (CA), Social Services F745, Accommodation of Needs and/or Sound and Lighting (Environment Task), Admission Orders F635, Professional Standards F658, Rehab or Restorative (CA), Resident Records F842, Physician Supervision F710.

Hospice and End of Life Care and Services Critical Element Pathway

Use this pathway for a resident identified as receiving end of life care (e.g., palliative care, comfort care, or terminal care) or receiving hospice care from a Medicare-certified hospice.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the resident's end of life care, services, and needs.
- ☐ Physician's orders (e.g., hospice or end of life services, advance directives, pain interventions, medications).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., advance directives; provision of ADLs; symptom management including controlling nausea, agitation, pain, uncomfortable breathing; pressure ulcer prevention interventions; nutrition and hydration needs; psychosocial interventions; coordination of care with hospice).

Observations:

- ☐ Are care planned and ordered interventions implemented and meeting the resident's needs? If not, describe the discrepancies.
- ☐ Whether ADLs (including oral care) are provided to address the resident's comfort and dignity.
- ☐ Whether skin integrity interventions are implemented (e.g., repositioning) to ensure the resident is comfortable.
- ☐ Whether the resident's symptoms (e.g., nausea, vomiting, uncomfortable breathing, agitation, or pain) are being managed.
- ☐ Whether supportive/assistive devices are provided as needed.
- ☐ Whether the facility is meeting the resident's choices and preferences (e.g., bathing, toileting, sleep schedule, activities).
- ☐ Whether the resident appears to be agitated, apprehensive, withdrawn, or restless? If so, how are these symptoms being addressed?
- ☐ Whether the type, amount, consistency of food and fluids provided are based on resident's needs, choices and preferences. If not, describe.
- ☐ Whether the environment promotes comfort according to the resident's preferences (e.g., low lighting and minimal background noise)? If not, describe.

Hospice and End of Life Care and Services Critical Element Pathway

Resident, Representative, or Family Interview:

- ☐ Whether the resident/representative is aware of:
  - o The name of the facility interdisciplinary team member/designee who is responsible for working and coordinating with the hospice team for communicating concerns regarding the provision of care; and
  - o How to contact the facility's designated coordinator.
- ☐ If receiving hospice care, have you had any concerns with your hospice care? If so, what are your concerns and do you know who to talk to and how to contact that person?
- ☐ How did the facility involve you in the development of the care plan and goals regarding your care?
- ☐ Do you feel like the care you are receiving reflects your choices and preferences?
- ☐ Were you involved in making choices on the type of care and treatment you are receiving? Do you have an advance directive (according to State law) and is staff aware of your directives? if not, have you or your representative received information on advance directives?
- ☐ Has your care changed recently? If so, were you involved in revisions or changes for care and treatment?
- ☐ Are you experiencing any symptoms (e.g., pain, breathing difficulty, constipation)? How are your symptoms being managed?
- ☐ Have you experienced any anxiety, depression, or grief? How are these needs being addressed?
- ☐ Have you declined any treatments? Why? Did staff find out the reason for the refusal and try to offer alternatives?
- ☐ Do you think the coordination of care between the hospice and facility is meeting your needs? If not, why not? Have you notified staff? Who? What was the resolution?

Staff Interviews (Nursing Aides, Nurse, Hospice Staff, Designated Hospice Coordinator, DON):

- ☐ Can you describe the resident's goals for care and treatment at the end of life?
- ☐ What is the basis for the determination that a resident is approaching the end of life?
- ☐ How do you monitor and document symptoms, implement interventions, and document effectiveness of the interventions? Who do you report any changes to?
- ☐ If the resident is transferred to the ER or hospital, how are the resident's choices and preferences regarding care communicated, including advance directives, if applicable?
- ☐ If the resident is receiving hospice care, determine:
  - o Whether nursing home staff understand the hospice philosophy and practices;
  - o Who is the facility designated IDT member that communicates with hospice and whether he/she meets the qualifications; and
  - o What and how often does the IDT member communicate with hospice.

  NOTE: If concerns, see F849 for the hospice written agreement)
- ☐ Can you describe the ongoing (24/7) communication and coordination process between the facility and hospice?
- ☐ Can you describe your responsibilities compared to what hospice provides?
- ☐ How do you share concerns and responses and who coordinates the resident's care with the hospice?
- ☐ How do you communicate with the resident or resident representative, hospice, and the practitioner any change to the resident's condition that may reflect the need to modify or revise the coordinated care plan?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan. NOTE: If concerns are identified with coordination of care, communication with the hospice, or responses to concerns, interview the facility-delegated coordinator. It may be necessary to interview the designated hospice coordinator regarding resident concerns.

Hospice and End of Life Care and Services Critical Element Pathway

Record Review:

- ☐ Is the care plan comprehensive? Does it address identified needs, measureable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- ☐ Does the care plan reflect the resident's diagnosis, palliative care and interventions, as appropriate, such as:
  - o End of life or hospice status;
  - o If on hospice:
    - ▪ Identification of the discipline and provider for care plan interventions;
    - ▪ How to contact the hospice 24 hours a day; and
    - ▪ Does the care plan reflect coordination between the hospice and the nursing home.
  - o Identified resident choices, and goals including advance directives as allowed by State law (e.g., directions regarding hospitalization, acute care in the event of an illness or injury, artificial nutrition or hydration, respiratory and cardiac status).
  - o Underlying factors affecting the resident's comfort, cognition, pain, and functional status;
- ☐ Does the record reflect assessment of concerns such as the following:
  - o Nutrition and hydration concerns (e.g., refusal to eat/drink; loss of appetite; alteration in taste and smell; dietary restrictions; food/beverage choices; the amount, type, texture, and frequency for food/fluids; or necessity for ongoing weight measurements)?
  - o Oral health status (e.g., ulcers in mouth; dryness of oral cavity/tongue; or diseases, such as candida or thrush) and how is it being addressed?
  - o Bowel and bladder concerns (constipation, impactions, diarrhea, incontinence)?
  - o Symptoms management (e.g., pain, nausea, vomiting, respiratory concerns, weakness, lethargy, vertigo, skin integrity issues including existing wounds, infections) and interventions?
  - o Level of activities desired including ethnic/cultural practices,
- ☐ Lab/x-ray tests in agreement with the resident's advance directives, if any, including choices, preferences, goals, comfort, and dignity?
- ☐ Does the record reflect a change in treatment to palliative care or hospice?. Was a significant change comprehensive assessment conducted within 14 days of the change?
- ☐ Did the facility identify necessary changes in goals or care approaches to promote comfort and prevent the development or worsening of physical or psychosocial symptoms? Was this communicated with the resident, resident representative, hospice, and attending practitioner?
- ☐ How does the facility monitor the resident's response to interventions for the management of physical and psychosocial needs?
- ☐ Review the facility policy on end of life and hospice care or related policies (e.g., advance directives) if concerns are identified.
- ☐ For a resident receiving hospice services: If the resident is receiving the hospice benefit, is care coordinated between hospice and the facility staff? If not, describe.
- ☐ Does the facility have a current written agreement with the Medicare-certified hospice providing hospice services in the nursing home, and was the agreement developed prior to hospice services beginning. (Refer to F849 – hospice agreement.)
- ☐ If the hospice was advised of resident concerns and failed to resolve issues related to the management of the resident's care, coordination of care, or implementation of appropriate services, review the appropriate portions of the written agreement.

choices regarding when to sleep and awaken?

- Functional/ADL status including mobility?
- Medications used for comfort, symptom control, and desired level of alertness?

Critical Element Decisions:

Referral of Hospice-Specific Concerns: If the resident is receiving Medicare-certified hospice services and 1) the hospice was advised of concerns by the facility and failed to address and resolve issues related to coordination of care or implementation of appropriate services; or 2) the hospice failed to provide services in accordance with the coordinated plan of care, regardless of notice from the facility; or 3) if there is no current written agreement between the nursing home and the hospice; the survey team must refer this as a complaint to the State agency responsible for oversight of hospice, identifying the specific resident involved and the concerns identified.
NOTE: Most noncompliance related to end of life or hospice care and services can be cited at other regulations (e.g., assessment, care planning, accommodation of needs, and physician supervision). Surveyors should evaluate compliance with these regulations and cite deficiencies at F675 only when other regulations do not address the noncompliance.

1) A. Did the facility provide appropriate treatment and services for end of life care?

   B. For a resident receiving hospice services: Did the facility collaborate with the hospice for the development, implementation, and revision of the coordinated plan of care and/or communicate and collaborate with the hospice regarding changes in the resident's condition, including transfer to the emergency department and/or hospital, if applicable?

   If No to A or B, cite F684

2) Did the facility have an agreement to provide hospice services at the facility or with a Medicare-certified hospice, designate staff to the facility's interdisciplinary team who works with the hospice representative to coordinate care, and ensure each resident's care plan includes a description of the care and services provided by the hospice and facility?
   If No, cite F849

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible) if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Right to be Informed Make Treatment Decisions F552, Advance Directives (CA), Choices (CA), Respiratory (CA), Pain (CA), Unnecessary Medications (CA), Behavioral-Emotional Status (CA), QOL F675, Facility Assessment F838, QAA/QAPI (Task).

Preadmission Screening and Resident Review Critical Element Pathway

Use this pathway for a resident who has or may have a serious Mental Disorder (MD), Intellectual Disability (ID) or a Related Condition to determine if facility practices are in place to identify residents with one of these conditions and to determine if Level I PASARR screening has been conducted and referrals have been made to the appropriate state-designated authority for Level II PASARR evaluation and determination.

Review the following to Guide Observations and Interviews:

- ☐ The most current comprehensive *and most recent quarterly (if the comprehensive isn't the most recent)* MDS/CAAs for Sections A, I, N, and O.
- ☐ Physician's orders (e.g., psychoactive medications).
- ☐ Pertinent diagnoses/conditions.
- ☐ Level I PASARR screening results and Level II PASARR evaluation and determination, if appropriate.

Resident, Representative, or Family Interview:

- ☐ Can you tell me about your current diagnosis/condition (e.g., MD, ID, or mood concerns)?
- ☐ Did you have this diagnosis/condition prior to your admission to this facility?
- ☐ Do you receive any specialized services to help with your mental health or disability concerns? If not, why not? If so, describe.
- ☐ What are they doing to address your mental health or disability concerns (e.g., behavior management plan, ID interventions, meds, level II recommended interventions)?

Staff Interviews (Nurses, DON, Social Worker):

- ☐ What is the facility's process for identifying residents with a possible MD, ID or a related condition prior to admission to the facility?
- ☐ How does the facility identify residents with newly evident or possible serious MD, ID or a related condition after admission to the facility?
- ☐ Who is responsible for making the referral to the appropriate state-designated authority when a resident is identified as having an evident or possible MD, ID or related condition?
- ☐ If a resident is identified as having newly-evident or possible MD, ID or a related condition after admission, what is the facility's process for referring the resident to the appropriate state-designated authority?
- ☐ If the resident was identified as having evident or possible MD, ID or a related condition, and a referral to the appropriate state-authority was not made, ask why.

Preadmission Screening and Resident Review Critical Element Pathway

Record Review:

- ☐ Did the resident have an MD, ID or related condition at the time of admission or was the condition identified after admission?
- ☐ Was a Level I screen for possible MD, ID or a related condition completed prior to admission OR if the resident was expected to be in the facility less than 30 days and remained in the facility more than 30 days (as allowed by the State) was a Level 1 screen performed?
- ☐ If the Level I screening process identified evident or possible MD, ID or a related condition, was a referral made to appropriate state-designated authority for Level II PASARR evaluation and determination?
- ☐ Review facility policies and procedures regarding Level I screening (e.g., the criteria that would require a Level II evaluation) and referral for Level II PASARR evaluation and determination.
- ☐ If a Level II evaluation should have been done but wasn't, what mental health or disability services are being provided (e.g., social service interactions or counseling)? [If concerns are identified, initiate the Behavior pathway.]
- ☐ Was there a "significant change" in the resident's condition (i.e., a decline in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting, and impacts more than one area of health and requires IDT review, and/or revision of the care plan)?
- ☐ If yes, was a significant change in status assessment conducted within 14 days of determining the change was significant?
- ☐ If the significant change in status was related to a new or possible MD, ID or related condition, did the facility notify the state-designated mental health or ID authority timely?
- ☐ Did the facility incorporate the recommendations from the PASARR Level II determination and evaluation report into the resident's assessment and care plan?

Critical Elements Decisions:

1) Is there evidence of Level I pre-screening of the resident to determine if the newly admitted resident had or may have had a MD, ID or a related condition prior to admission to the facility?
   If No, cite F645
   NA, the resident entered the facility as an exception (an exempted hospital discharge), in accordance with the State PASARR process, and has been in the facility less than 30 days.

2) If pre-admission screening of residents expected to be in the facility 30 days or less is not performed, in accordance with the State PASARR process, and the presumed short-stay resident was not screened prior to admission to the facility and remained in the facility longer than 30 days, did the facility screen the resident to determine if the resident had or may have had an MD, ID or a related condition?
   If No, cite F645
   NA, Level I pre-screening of the resident was performed prior to admission to the facility or the resident was in the facility less than 30 days.

Preadmission Screening and Resident Review Critical Element Pathway

3) If the Level I pre-screening of the resident, either prior to admission or within 30 days, in accordance with the state PASARR process, identified that the resident had or may have had an MD, ID or related condition, did the facility refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination?
If No, cite F645

4) For a resident who had a negative Level I pre-screen, who was later identified with newly evident or possible serious MD, ID or a related condition, did the facility refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination?
If No, cite F644
NA, the resident was not later identified with newly evident or possible serious MD, ID or a related condition.

5) For a resident with a Level II, did the facility coordinate assessments with the PASARR program by incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's assessment, care planning, and transitions of care?
If No, cite F644
NA, the resident did not have a Level II.

6) If the resident's significant change in status was related to newly evident or possible MD, ID or related condition, did the facility notify the appropriate state-designated mental health or ID authority for a Level II evaluation as soon as the criteria indicative of a significant change in status was evident?
If No, cite F644
NA, the resident did not have a signicant change in status related to newly evident or possible MD, ID or related condition.

7) Did the facility notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for a review?
If No, cite F646
NA, the resident did not have a signicant change in mental or physical condition.

8) For the newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

9) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

10) If there was a significant change in the resident's status, did the facility complete a significant change in status assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

11) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

12) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

13) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: QOL F675, Behavior and Emotional (CA), Social Services F745, Rehab and Restorative (CA), Rehab Services Qualified Staff F826, Qualification of Social Worker F850, Facility Assessment F838, Resident Record F842, QAA/QAPI (Task).

Neglect Critical Element Pathway

Use this pathway for concerns in structures or processes that have led to resident outcome such as unrelieved pain, avoidable pressure injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment. Neglect may be the outcome of systemic or repeated patterns of care delivery failures throughout the nursing home, such as insufficient staffing, or may be the effect of one or more delivery failures involving one resident and one staff person.

If conducting a complaint investigation regarding an allegation of neglect, utilize appropriate Critical Element Pathways for care issues, such as pressure ulcers, injuries, incontinence care, etc., in order to identify whether noncompliance for a care concern exists first. Then if structure or process failures are identified, refer to this pathway.

Refer to the Investigative Protocol*s* for *F607/F609*-Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or an allegation of retaliation against staff for reporting. *If the surveyor discovers a reasonable suspicion of a crime committed against a resident of, or an individual receiving services from, the facility and it has not been reported by a covered individual, the surveyor reminds the facility of the covered individuals' obligation to report suspected crimes to the appropriate agencies within the required timeframes. "Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility. If a covered individual reports the suspected crime to local law enforcement, the surveyor must verify that the report was made (e.g., obtain time/date of report, name of person who received report, case number, etc.). If the covered individual refuses to report, or the surveyor cannot verify that a report was done, the surveyor must consult with his/her supervisor immediately, and the SA must report the potential criminal incident to law enforcement immediately.*

Review the Following in Advance:

☐ Identify information from investigation of the relevant care areas to determine whether additional observations, interviews, and record reviews are necessary to evaluate whether the facility has the structures and processes necessary to provide goods and services to residents.

Interviews with Staff Working During the Time the Alleged Neglect Occurred:

☐ Why do you think the alleged neglect occurred?

☐ How did staff respond when the resident requested assistance?

☐ What do you consider as neglect?

☐ What do you do if you suspect that a resident is not receiving necessary care and services?

☐ Were you aware of the care not being provided? If so, who and when did you report it to? What actions were taken by the nursing home? If you did not report your concerns, why not?

☐ Has retaliation occurred as a result of reporting neglect? If so, what actions were taken against staff?

☐ What training have you received from the facility on neglect identification, prevention, and reporting requirements? *NOTE: If the staff member has not received training, ask other staff members whether they have received training.*

Neglect Critical Element Pathway

Supervisory Staff Interviews from Relevant Departments Related to the Alleged Neglect:

- ☐ How do you monitor and provide oversight in order to assure care and services are implemented based upon the care plan and the resident's identified needs, and if there is an acute change of condition?
- ☐ How do you monitor staff/resident interactions?
- ☐ How do you monitor for the deployment of sufficient numbers of qualified and competent staff across all shifts to meet resident needs?
- ☐ How do you determine staffing assignments based on the levels and types of care needed for the resident(s)?
- ☐ How do you and staff communicate across shifts?
- ☐ How do you monitor for staff burnout, which could contribute to neglect?
- ☐ How is orientation provided for temporary or pool staff?
- ☐ Why do you think the alleged neglect occurred?
- ☐ If there are concerns, such as insufficient staffing or lack of availability of food, medications or supplies, did you report this to administration? Why or why not? If reported, what was the response?

Facility Investigator Interview:

- ☐ Were you responsible for the initial reporting and the overall investigation of the alleged neglect? (Obtain a copy of the investigation report, if any.)
- ☐ When were you notified of the allegation and by whom?
- ☐ When and what actions were taken to protect the resident(s) from further potential neglect while the investigation was in process?
- ☐ What steps were taken to investigate the allegation? What was the timeline of events that occurred?
- ☐ What happened as a result of the investigation?
- ☐ Who received the results of the investigation and when?
- ☐ What related information regarding the allegation is not included in the investigation report?

NOTE: Refer to F609 for further investigation if the facility did not have a copy of the investigation report available.

Administrator Interview:

- ☐ When were you notified of the alleged neglect?
- ☐ What deficits in care/services/resources (e.g., insufficient staffing, lack of supplies) were you notified about?
- ☐ If you were notified, what actions did you take to respond to concerns?
- ☐ What actions were taken to prevent further potential neglect during and after the investigation was completed?
- ☐ How do you assure that retaliation does not occur when staff or a resident reports an allegation of neglect?

Quality Assurance Interview:

- ☐ How does the committee provide monitoring and oversight of *cases of verified neglect*?
- ☐ *Did the QAA Committee make any recommendations and/or take any corrective actions based on the results of the investigation, such as policy revisions or training to prevent neglect?*

Neglect Critical Element Pathway

☐ *When did the QAA Committee receive the results of the investigation for the verified case of neglect?*

Record Review:

☐ Review policies and procedures that identify the structures and processes in place to provide needed care and services. Review only those policies regarding the neglect that is being investigated.

☐ How does the facility determine and monitor sufficient numbers of staff, temporary staff, consultants, contractors, and volunteers?

☐ How does the facility determine the type of staff, such as qualified registered, licensed, certified staff (in accordance with State licensing rules) that are competent and have the knowledge and skills necessary for the provision of care and services that they are assigned?

☐ What are the duties of direct care staff to meet resident needs? Who is responsible for monitoring the delivery of care at the bedside?

☐ What type of orientation and training program exists for staff, including temporary staff, contractors, consultants, and volunteers, including but not limited to policies, specific resident care, services and treatments, neglect, dementia care, abuse and other interventions necessary to meet a resident's needs?

☐ How does the facility establish resident care policies and procedures to assure that staff have written direction in accordance with current standards of practice that address resident diagnoses and provide clinical and technical direction to meet the needs of each resident admitted?

☐ How does staff communicate relevant resident care information to other staff, health care practitioners, consultants, and the resident or resident representative?

☐ How are annual performance evaluations for direct care staff conducted and how is staff performance evaluated?

☐ How does the facility provide ongoing maintenance and calibration of resident care equipment and devices, based on manufacturer's instructions?

☐ How does the facility ensure a safe and sanitary environment, including all buildings, furnishings, equipment, provision of fire safety, maintenance department, laundry services, dietary services, rehabilitation, and other services?

☐ How does the facility provide adequate resident care supplies (e.g., food, medications, linens) to meet resident needs?

☐ Review processes including the actual care or services provided:

- Were there initial and ongoing assessments that reviewed the clinical needs of the resident including any acute changes in condition? If not, describe;
- Was a resident-specific plan of care in place, including the ongoing evaluation and revision of the care plan as necessary;
- Was there ongoing monitoring and supervision of staff to ensure the implementation of the care plan as written; and
- Was there effective communication between staff, health care practitioners, and the resident or resident representative?

☐ Review staff schedules:

- Who was working at the time of the alleged neglect;
- How is it determined how many staff are required to care for the residents and the actual number of staff assigned to the residents; and
- What types of resident care are required, depending on resident acuity, resident needs, and the number of residents?

Neglect Critical Element Pathway

☐ Review personnel records of staff present and directly involved in the allegation of neglect during the time of alleged neglect:

- Do they have a finding of abuse, neglect, misappropriation, exploitation, or mistreatment by a court of law? Have they had a finding entered into the State nurse aide registry? Has there been a disciplinary action in effect against the individual's professional license? If so, describe;
- Were annual performance reviews conducted? Was there a history of problems with care delivery? What disciplinary actions and/or training were provided related to performance deficits;
- How does the facility conduct competency evaluation and training for licensed staff including pool/temporary staff for the types of interventions required, as applicable, such as CPR, IV therapy, oxygen therapy, and mechanical ventilation; and
- What is the scope of practice for staff assigned to provide care and services during the alleged neglect?

☐ If pool/temporary staff were involved in the situation of neglect:

- What type of orientation was provided for pool/temporary staff regarding the facility policies/procedures?
- How does the facility ensure that pool/temporary staff have knowledge of resident-specific interventions as identified in the care plan? How does the facility assure that pool/temporary staff have completed training to perform CPR, as required, to residents in the facility?

Neglect Critical Element Pathway

Critical Elements Decisions:

1) Did the facility protect the resident's right to be free from neglect?
If No, cite F600

2) Did the facility hire or engage staff who have:
   - Not been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law?
   - Not had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a disciplinary action taken by a state professional licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a successful appeal of their disqualification from employment?

   AND/OR

   Did the facility report to the State nurse aide registry or licensing authorities any knowledge of actions taken by a court of law that would indicate unfitness as a staff member of a nursing home?
   If No, cite F606

3) Did the facility develop and implement written policies and procedures that prohibit and prevent neglect, establish policies and procedures to investigate any such allegations, include training as required at paragraph §483.95, *establish coordination with the QAPI program required under §483.75, and post signage of employee rights related to retaliation against the employee for reporting a suspected crime*?
If No, cite F607

4) For alleged violations of neglect, did the facility:
   - *Develop policies and procedures related to ensuring the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases) and notifying covered individuals annually of their reporting obligations;*
   - Identify the situation as an alleged violation involving neglect, including injuries of unknown source;
   - Report immediately to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law; and
   - Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?

   If No, cite F609

5) For alleged violations of neglect, did the facility:
   - Prevent further potential neglect;
   - Initiate and complete a thorough investigation of the alleged violation;
   - Maintain documentation that the alleged violation was thoroughly investigated; and
   - Take corrective action following the investigation?

   If No, cite F610

6) Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training on activities that constitute neglect, procedures for reporting incidents of neglect, and dementia management and resident abuse prevention?
   If No, cite F943

7) Does the facility's in-service training for nurse aides include resident abuse prevention?
   If No, cite F947

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Grievances F585, Sufficient and Competent Staffing (Task), Administration F835, Governing Body F837, Facility Assessment F838, Medical Director F841, and *QAPI/QAA* (Task).

Discharge Critical Element Pathway

Use this pathway to evaluate compliance with requirements for Admission, Transfer and Discharge Rights (F622, F623, and F626—only when a resident is not permitted to return after therapeutic leave). For concerns related to not permitting a resident to return after a hospitalization, use the Hospitalization and/or Discharge (F660 and F661) Critical Element (CE) Pathways. Facility-initiated emergency transfers or discharges to acute care should also be reviewed using the Hospitalization CE Pathway.

Review the following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive *and* most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A, C, G*G*, and Q.
- ☐ Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- ☐ Pertinent diagnoses.
- ☐ Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).
- ☐ If investigating a complaint related to discharge, if there are other residents who had further investigation marked for the complaint care area, the team is required to sample three residents. If there weren't any other residents who had concerns regarding the complaint allegation, the team is only required to investigate the complaint resident. If concerns are identified, you may need to expand the sample and ask the facility for a list of facility-initiated discharged residents, as necessary. If the facility cannot provide a list of facility-initiated discharged residents, ask for a list of all discharged residents for the last three months.

Ask facility staff (e.g., Director of Nurses, Social Worker, Attending Physician) whether the discharge was facility- or resident-initiated. Investigate and verify the staff response as to whether the discharge was facility- or resident-initiated using the columns below. For example, if the facility indicates a discharge was facility-initiated, start with Column A.

A. Facility-Initiated Discharges	**B. Resident-Initiated Discharges**
NOTE: Interviewing the resident and/or his or her representative is a critical component of confirming whether the discharge is resident- or facility-initiated. If the resident is no longer in the facility, attempt to contact the resident and/or resident's representative.	
Resident, Resident Representative, or Family Interview:	**Resident, Resident Representative, or Family Interview:**
While conducting the interview, be alert for evidence of psychosocial and/or physical harm resulting from the discharge (e.g., expressions of fear, anxiety, tearfulness, evidence of physical trauma, etc.)	While conducting the interview, be alert for evidence of psychosocial and/or physical harm resulting from the discharge (e.g., expressions of fear, anxiety, tearfulness, evidence of physical trauma, etc.)

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ If the resident has been discharged or issued a notice of discharge, ask: o Where is the resident currently/where is the resident going to be discharged? o Is the resident safe? o Was the resident informed of the location of discharge? o How was the resident involved in selecting the new location? o Does resident have any urgent medical needs? o Where would the resident like to be? o What is the most appropriate setting to meet resident's care needs? o Has the resident experienced any physical or psychosocial harm from the discharge? o Would the resident like to return to the facility from where he or she was discharged? o What did the facility talk to you about regarding post-discharge care (e.g., self-care, caregiver assistance)? ☐ Ask the resident (or his or her representative) to share his or her understanding of the reasons for the discharge and what the facility said as to why the discharge was necessary. ☐ Ask the resident (or his or her representative) to share his or her objections to the discharge that were communicated with the facility. What was the facility response to the objections? ☐ What information did the facility give the resident (or his or her representative) regarding his/her discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable?	☐ If the resident has been or is going to be discharged, ask: o Where is the resident currently/where is the resident going to be discharged? o Is the resident safe? o Does resident have any urgent medical needs? Did the facility fail to provide the resident with services for their medical needs? o Where would the resident like to be? o What is the most appropriate setting to meet resident's care needs? ☐ Is/was it the resident's choice to leave the facility? ☐ Did the resident provide verbal or written notice that he/she wanted to leave the facility? ☐ Did/does the resident feel pressured by the facility to leave? ☐ Was the resident (or his or her representative) involved in discharge planning prior to the discharge? ☐ Is/was the resident interested in returning to the community? If so, was there a referral to the local contact agency or other appropriate entities? ☐ Is/was the resident interested in transferring to another SNF, HHA, IRF, or LTCSH? If so, did the facility help you in selecting another provider? ☐ Does this discharge align with the resident's goals, preferences and choices?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ Did you appeal the discharge? If so, were you allowed to stay in the facility while the appeal was pending?	
Staff Interviews for Facility-initiated Discharges	**Staff Interviews for Resident-initiated Discharges**
☐ Why is the resident being discharged? Based on the reason provided, refer to the appropriate section below: **<u>Inability to meet resident needs:</u>** o What services are you unable to provide to meet the resident's needs? o For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? o What does the new facility offer that can meet the resident's needs that you could not offer? o How did you determine your capability to care for the resident prior to the resident's admission? o Do you serve residents with similar needs? If yes, how do the needs of this resident differ? **<u>Health improved and no longer needs services by the facility:</u>** o What services were you providing to the resident? o How did you determine the resident's health had improved and services were no longer needed? **<u>Endangering the health or safety of others:</u>**	☐ What is the process for determining whether a resident can be discharged back to the community? ☐ How do you involve the resident or resident representative in the discharge planning? ☐ Did the resident indicate an interest in returning to the community? If so, what referrals were made to the Local Contact Agency? ☐ How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated? ☐ What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location or with other service providers (e.g., home health services, primary care physician, etc.)? ☐ How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
○ Describe the resident's clinical or behavioral status that endangered the health or safety of others. ○ How did the clinical or behavioral status endanger the health or safety of others? (Surveyors will need to determine if the reason provided gives adequate justification for discharge.) ○ What does the new facility offer that can meet the resident's needs that you could not offer? ○ How did you determine your capability to care for the resident prior to the resident's admission? ○ If a resident is discharged based on behavioral status: Do you serve residents with similar behaviors? If yes, how does this resident's behavioral status differ? **Non-payment:** ○ When and how did you notify the resident of non-payment? ○ When did the facility notify the resident of a change in payment status, if applicable? ○ How did the facility assist the resident to submit any third-party paperwork, if applicable? ☐ Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible? If so, how did it go? ☐ What, when, and how was necessary healthcare information shared with staff at a new location, if applicable?	
Record Review for Facility-initiated Discharges	**Record Review for Resident-initiated Discharges**

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
☐ What is the basis for the facility-initiated discharge? Review the resident's record to determine if there is adequate evidence to support the basis for the discharge. Use the following probes to guide the review of medical record evidence. **Inability to meet resident needs:** o Has the facility attempted interventions to meet the resident's needs? o Has the facility consulted with the resident's attending physician and other medical professionals and followed orders and care plans appropriately in order to meet the resident's needs? o Is the facility providing care for residents with similar care needs? o Is there evidence in the record that discharge concerns, reasons, and location were discussed with the resident or the resident representative? o Did the physician document the specific needs the facility could not meet; facility efforts to meet those needs; and the specific services the receiving facility will provide that the current facility could not meet? **Improved and no longer needs care:** o What services was the facility providing for the resident that are no longer required? o Does the resident's record support that the resident no longer needs these services?	☐ Is there evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility? ☐ Does the comprehensive care plan contain the resident's goals for admission and desired outcomes, and do these goals and desired outcomes align with an actual or planned discharge? ☐ Were discharge care planning needs updated as needed with the level of care the resident required at the time of discharge? ☐ Is there a discharge care plan and documented discussions with the resident and/or his or her representative containing details of discharge planning and arrangement for post-discharge care (e.g., home health service, physician visits, medication needs, etc.)? ☐ Is there a discharge summary which contains the required elements: o A recapitulation (containing all required components) of the resident's stay? o A final summary of the resident's status that includes the items listed at F661? o A reconciliation of all pre- and post-discharge medications? ☐ Is there evidence that the discharge summary was conveyed to the continuing care provider or receiving facility at the time of discharge?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
○ Did the physician document the basis for the transfer or discharge? **Endangering the health or safety of others:** ○ Has the facility's failure to properly supervise or provide care and services contributed to the resident's dangerous behaviors? ○ If provided with appropriate care and services at the nursing home, would the resident be a danger to self or others? ○ Does the record reflect that the behaviors were truly dangerous rather than just requiring additional staff time and attention? ○ Is there evidence in the record that discharge concerns, reasons, and location were discussed with the resident or the resident representative? ○ Did a physician document the reason for the transfer or discharge? **Non-payment:** ○ Has the resident been given reasonable and appropriate notice to pay for the stay at the facility? ○ Has the facility assisted the resident in applying for Medicaid coverage? ○ Was the application for Medicaid approved or denied? ○ If the resident is eligible for Medicaid coverage, is there a Medicaid bed available in the facility? ○ If not eligible for Medicaid, or there are no Medicaid beds available, has the facility offered the resident an opportunity to pay privately for a bed?	☐ Is there evidence the facility asked the resident about their interest in receiving information regarding returning to the community? ☐ If referrals were made to the local contact agency, did the facility update the discharge plan in response to information received? ☐ If the resident cannot return to the community, who made the determination and why? ☐ Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs? ☐ Who from the IDT was involved in the ongoing process of developing the discharge plan? ☐ What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate? ☐ If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences. ☐ Does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

Discharge Critical Element Pathway

A. Facility-Initiated Discharges	B. Resident-Initiated Discharges
<u>The facility has or will cease to operate.</u> ☐ Was the transfer or discharge documented in the resident's medical record and appropriate information communicated to the receiving health care institution or provider [see §483.15(c)(2)(i)(ii)(iii)]. ☐ Was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident, resident representative, and a copy to the ombudsman: o Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and o If changes were made to the notice, were recipients of the notice updated? ☐ If a resident was not permitted to return after a planned therapeutic leave, does the medical record contain a basis for the discharge that complies with §483.15(c)(1)?	☐ Is there evidence the resident was provided with a discharge summary with information of the resident's level of care and services required?
At the conclusion of this investigation, the surveyor should determine: • Is this discharge facility-initiated? **Yes or No** • **If Yes,** is there **noncompliance with F622, F623, or F626** (CE3, 4, and 5 below – mark CE1 and CE2 as NA) • **If No,** is there **noncompliance with F660 and/or F661** (CE1 and 2 below – mark CE3, CE4, and CE5 as NA)	**At the conclusion of this investigation, the surveyor should determine:** • Is this discharge resident-initiated? **Yes or No** • **If Yes,** is there **noncompliance with F660 and/or F661** (CE1 and 2 below – mark CE3, CE4, and CE5 as NA) • **If No, evaluate** facility compliance with the **Facility-initiated discharge requirements**

*NOTE: If after completing the investigative pathway, it's determined the resident was discharged **improperly** to an unsafe location, the surveyor should refer to Appendix Q and determine whether Immediate Jeopardy has occurred.

Critical Element Decisions:

1) For a resident-initiated, planned discharge, did the facility:
   - Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support;
   - Document that the resident was asked about their interest in receiving information about returning to the community;
   - Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital); and/or

   If No, cite F660
   N/A, this is a facility-initiated discharge.

2) For a resident-initiated, planned discharge, did the facility:
   a. Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
   b. Develop a post-discharge plan of care, including discharge instructions?

   If No, cite F661
   N/A, this is a facility-initiated discharge.

3) For a facility-initiated discharge, does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., discharge is necessary for the resident's welfare, and the resident's needs could not be met in the facility; the resident no longer requires services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates). Does evidence in the medical record support the basis for this resident's discharge?
   If No, cite F622
   N/A, this is a resident-initiated, planned discharge

4) For a facility-initiated discharge, was required discharge information per 483.15(c)(2)(i)-(ii), documented in the resident's record and appropriate information communicated to the receiving facility per 483.15(c)(2)(iii)?
   If No, cite F622
   N/A, this is a resident-initiated, planned discharge

5) For a facility-initiated discharge, were the resident, resident representative, and ombudsman notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge, or as soon as practicable if the discharge meets one of the exceptions at 483.15(c)(4)(ii)? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)?
   If No, cite F623
   N/A, this is a resident-initiated, planned discharge

6) After a resident's therapeutic leave, did a facility permit the resident to return? If No, was a there a valid basis for the discharge according to 483.15(c)(1)?
   If No, cite F626
   N/A, the resident's transfer or discharge was not related to therapeutic leave

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Participate in Care Plan F553, Notification of Change F580, Professional Standards F658, Medically Related Social Services F745, Resident Records F842, QAPI/QAA (Task), Orientation for Transfer or Discharge F624, Permitting Residents to Return to Facility F626.

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being. If a resident is prescribed psychotropic medications, review the Unnecessary Medication, Psychotropic Medications, and Medication Regimen Review Critical Element (CE) Pathway.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive *and the* most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C, D, E and N.
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided to meet the resident's individual needs? If so, what evidence was observed?
- ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice (e.g., daily routines, dining preferences, mobility, activities, bathing, or use of the bathroom)?
- ☐ Are staff using individualized, non-pharmacological interventions to attain or maintain the resident's well-being? If so, provide examples.
- ☐ How does staff monitor the effectiveness of the resident's care planned interventions?
- ☐ How does the facility modify the environment or facility practices (e.g., ADL care, daily routines, activities) to accommodate the resident's care needs?
- ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
- ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741 using the Behavior-Emotional Status CE pathway.

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
- ☐ How did the facility involve you/the resident in the care plan and goal development process, including the implementation of non-pharmacological approaches to care?
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- ☐ How did the facility consider your/the resident's choices and preferences?

Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to

Dementia Care Critical Element Pathway

- ☐ How were you informed of the risks and benefits of all interventions in your/the resident's care plan?
- ☐ How were you informed of the intended benefits and potential side effects of your/the resident's medication regimen?

Staff Interviews (Interdisciplinary team (IDT) members) Across Various Shifts:

- ☐ Can you tell me about the resident's care plan and his/her condition (including underlying causes)?
- ☐ How do you ensure care is consistent with the care plan?
- ☐ How do you use non-pharmacological interventions to attain or maintain the resident's well-being?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- ☐ What process is used to inform the resident and/or resident representative of the risks and benefits of all interventions in the resident's care plan?
- ☐ What process is used to inform the resident and/or resident representative of the intended benefits and potential side effects of the resident's medication regimen?
- ☐ How do you ensure that pharmaceutical interventions are used only when clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ What are the facility's dementia care guidelines and protocols?
- ☐ What types of dementia management training have you completed?
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and determine what type of social services or referrals have been implemented, also determine compliance with F745.
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ Determine what documentation identifies, in advance of the care to be furnished, the explanation of the risks and benefits of proposed interventions.
- ☐ Was dementia management training provided to staff?

Note: How does the facility inform residents and/or resident representatives, in advance of care, of the risks and benefits and

include measurable objectives and timetables? Has the care plan been revised to reflect any changes?

possible alternatives of treatment (e.g., non-pharmacological approaches to care and treatment other than medications)? Is this process in compliance with requirements at F552?

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measurable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) Did the facility inform the resident and/or resident representative, in advance of care, of the risks and benefits and possible alternatives of treatment?

   If No, cite F552

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3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a Significant Change in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant changed in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

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Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, Resident Rights F550, Choices (CA), QOL F675, Physician Services F710, Social Services F745, Sufficient and Competent Staffing (Task), Activities (CA).

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