Frequently Asked Questions Related to Long Term Care Regulations, Survey Process, and Training

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About this Document

This Frequently Asked Question (FAQ) document contains questions and answers about Long Term Care (LTC) regulations, the survey process, technical questions, and other related LTC areas. Newly added questions and answers are in red font and older questions and answers are in black font.

The Table of Contents (TOC) contains direct links to the various sections of this FAQ document. Also, there is a direct link back to the TOC at the bottom of each page starting on page 1. The direct link to the TOC is only accessible in the PDF format due to the link being in the footer of the document.

This FAQ document will be updated frequently and will be posted on the LTC Final Rule webpage.

A. 483.10 Resident Rights

If a resident is declining to be weighed or has asked that weights be discontinued can the MD write an order for weights to be discontinued? Will the facility incur a citation if we do not obtain weight and are aware that the resident is losing weight?

Per federal requirements at §483.10(c)(6), the resident has "The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive." If a resident declines treatment, the resident may not be treated against his or her wishes. This would include a decline or discontinuation of weights. To meet the requirements at §483.10(c)(6), the resident must be provided with the necessary information, i.e., risks related to the discontinuation of weights, to make an informed decision and the resident's medical record should contain appropriate documentation of this process.

Can we put signs at the head of a resident's bed if they have impaired vision or hearing so staff will know?

Per federal requirements at §483.10(h) - "The resident has a right to personal privacy and confidentiality of his or her personal and medical records." Posting signs in residents' rooms or in areas visible to others that include clinical or personal information could be considered a violation of a resident's privacy. It is allowable to post signs with this type of information in more private locations not visible to the public. An exception can be made in an individual case if a resident or his or her representative requests the posting of information at the bedside (such as instructions to not take blood pressure in right arm). This does not prohibit the display of resident names on their doors nor does it prohibit display of resident memorabilia and/or biographical information in or outside their rooms with their consent or the consent of his or her representative. (This does not include isolation precaution information for public health protection, as long as the sign does not reveal the type of infection).

B. 483.12 Freedom from Abuse, Neglect, and Exploitation

The scenario: A registered nurse received a disciplinary action on her license related to resident abuse back in 2011. She did whatever was called for to keep her license, and in 2017 she is still licensed, free and clear of any restrictions.

The question: Is the registered nurse banned under the new regulations from working at a nursing home, or does the usage of "in effect" mean that she can because the disciplinary action was back in 2011 and is no longer active?

If the disciplinary action is no longer in effect, 483.12(a)(3) (iii) would not prohibit that nurse from working at the facility. Also, the facility would still need to make sure the registered nurse had not "been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a

court of law" or "had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property" per the requirements of 483.12(a)(3(i) and (ii).

Reporting of Abuse

When the regulation refers to reporting immediately but not later than 2 hours, is this reporting internally or externally? For example, does the agency have to report to the appropriate external agencies not later than 2 hours after the allegation is made?

483.12 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

According to 42 CFR 483.12(c)(1), reports must be made to the facility's administrator and to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities and to other officials in accordance with State law.

Which cases of abuse and neglect need to be reported within 2 hours? Within 24 hours?

The following must be reported **immediately** but not later than 2 hours:

1. ***Is there an allegation of abuse?***
   If yes, then the facility must report immediately to the administrator, State Survey Agency, adult protective services and other officials in accordance with State law, but not later than 2 hours.

2. ***Is there an allegation that a resident has suffered serious bodily injury due to neglect, exploitation, mistreatment, or an injury of unknown source?***
   If yes, then the facility must report immediately to the administrator, State Survey Agency, adult protective services and other officials in accordance with State law, but **not later than 2 hours**.

   Is there a reasonable suspicion of a crime involving a resident suffering serious bodily injury?

   If yes, then covered individuals must report immediately to the State Survey Agency and local law enforcement, but not later than two hours.

The following must be reported **not later than 24 hours**:

1. ***Is there a reasonable suspicion of a crime not involving serious bodily injury?***
   If yes, then covered individuals must report to the State Survey Agency and local law enforcement, not later than 24 hours.

2. ***Is there an allegation that doesn't involve serious bodily injury of neglect, misappropriation, exploitation, mistreatment, or injury of unknown source?***
   If yes, then the facility must report to the administrator, State Survey Agency, adult protective services and other officials in accordance with State law, not later than 24 hours.

How do you investigate Abuse if you have a complaint about abuse but a resident is not named in the complaint?

The team should ensure they consider the abuse allegation during the initial pool process. If no residents in the initial pool had concerns with abuse, the TC needs to add a generic placeholder so the abuse care area can still be investigated. To do this the TC will:

- Go to the Resident Manager screen.
- Select the Add New Resident button.
- Enter "Anonymous" for the first name and "Resident" for the last name.
- Do not add a room number or admission date.

You will then be able to add the Abuse care area for the resident (either during the sample meeting or on the investigation screen) and complete the investigation for Abuse.

If a nurse that currently works for a facility has a disciplinary action on her license are we expected to terminate their employment based on the new regulation?

In order to meet the Federal requirement at 42 CFR 483.12(a)(3)(iii), a facility must not employ, or otherwise engage individuals, who have a disciplinary action in effect against his/her professional license as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. If a facility employs a nurse where a probation is in effect on his/her nursing license, as a result of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, then the facility would not be in compliance with Federal requirements. We would encourage you to review the terms of the disciplinary action on the license status to determine this.

Restraints

Does CMS consider bed and chair alarms as restraints and/or abuse?

Determination of the Use of Position Change Alarms as Restraints

Position change alarms are any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors. Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.

While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement. For example, a resident may be afraid to move to avoid setting off the alarm and creating noise that is a nuisance to the resident(s) and staff, or is embarrassing to the resident. For this resident, a position change alarm may have the potential effect of a physical restraint.

Examples of negative potential or actual outcomes which may result from the use of position change alarms as a physical restraint, include:

- Loss of dignity;
- Decreased mobility;
- Bowel and bladder incontinence;
- Sleep disturbances due to the sound of the alarm or because the resident is afraid to move in bed thereby setting off the alarm; and
- Confusion, fear, agitation, anxiety, or irritation in response to the sound of the alarm as residents may mistake the alarm as a warning or as something they need to get away from.

F604 Physical Restraints

Question: Are all bedrails considered to be physical restraints?

Response: No.

A bedrail is considered to be a physical restraint if it meets all of the following criteria:

- Is attached or adjacent to the resident's body;
- Cannot be removed easily by the resident; and
- Restricts the resident's freedom of movement or normal access to his/her body.

To clarify the examples found in Appendix PP of the State Operations Manual found under Tag F604, a bed rail that prevents a resident from voluntarily getting out of bed and the resident cannot lower the bed rail in the same manner as staff would be considered to be a physical restraint.

The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to lower the bedrail.

C. 483.15 Admission, Transfer, and Discharge

For our long term residents, they may be sent out to the emergency room for some acute issue going on. We do not know if they are going to be admitted or come back from the ER that same day after some treatment. Our intent is to accept them back when their health status is stable. These transfers can happen day, evening or weekends. Do we do the transfer/discharge notification?

Regarding facility-initiated emergency transfers or discharges to an acute care facility our interpretive guidance says: "Emergency Transfers--When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D).

Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis." This requirement also applies in situations where a Medicare beneficiary must be discharged because of admission to an acute care facility.

When we have unplanned discharges to the hospital, say for a UTI, or Altered Mental Status and the hospital treats the resident….then sends them back to our facility….do we have to notify the Ombudsman about this?...or do we only notify the Ombudsman when our facility is NOT ABLE to take the resident back from the hospital?

When a facility transfers or discharges a resident, notification of the ombudsman is required (in addition to the resident and resident representative). CMS has allowed an exception in the timing of providing notice for emergency transfers; notice may be provided as soon as practicable for emergency transfers. Additionally, facilities have the option of notifying the ombudsmen about emergency transfers using a monthly list, which must meet the requirements for content of the notice.

D. 483.20 Resident Assessments

E. 483.21 Comprehensive Resident Centered Care Plans

How long do we have to we have to give the family a written summary baseline careplan? I'm aware the baseline careplan must be made in 48 hours but unclear how much time a written summary of plan to give to family.

At F655, the guidance states, "The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan." This means the resident or their representative must be provided a written summary before the completion of the comprehensive care plan.

Additionally, if the comprehensive assessment identifies changes which would result in a different approach or goal on the comprehensive care plan, these changes must also be reflected in the summary. This is reflected in the following guidance, which goes on to say "Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable."

'Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions."

Can you please confirm that a Care Plan review is required after each assessment for both OBRA and PPS assessments (with the exception of the discharge MDS)? And does this review require documentation that the review was completed.

The regulation at 483.21(b)(2)(iii) (F657) states: "§483.21(b)(2) A comprehensive care plan must be—

… (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments."

Draft interpretive guidance at F657 states, ""After each assessment" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS) as required by §483.20, except discharge assessments."

Additionally, you ask if the care plan review requires documentation. The expectation is that facilities can demonstrate that they have reviewed the care plan, even if no revisions are required. How facilities demonstrate this is up to each facility.

F. 483.24 Quality of Life

G. 483.25 Quality of Care

F700 Bedrails

Question: Does CMS expect bed rails to be removed between residents, given the language in the regulation which says "…prior to installing a side or bed rail." ? For example a resident was discharged and the bed is empty, are we expected to remove the rails?

Response: CMS recognizes that there are many different types of beds, some with bed rails installed, or bed rails with the call button and lights incorporated into the rail, and others without bed rails, for which a separate rail could be installed. CMS regulations do not specify that bed rails must be removed when not in use.

Question: Would the steps of assessment, consent, inspect and maintain bed rails apply whenever a bed has rails, or only when those bed rails are actually used?
The regulations at F700 were intended to address the **use** of bed rails. This means that prior to installing rails for use, or using pre-installed rails, facilities will attempt appropriate alternatives, ensure correct installation, use, and maintenance, which includes:

- assessment for entrapment risk;
- reviewing risks and benefits with the resident or representative, and obtain informed consent prior to installation (or use);
- ensuring bed dimensions are appropriate for resident size/weight; and
- following manufacturers' recommendations and specifications for installing, (using) and maintaining bed rails.

Question: The regulation requires appropriate alternatives be attempted before installing a bed rail. What are some appropriate alternatives?
Response: The guidance at F700 does not specify what appropriate alternatives are, however, CMS would encourage facilities to refer to published information from recognized authorities such as the FDA, which has identified the following alternatives: "Alternatives include: roll guards, foam bumpers, lowering the bed and using concave mattresses that can help reduce rolling off the bed." This and more information may be found at https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362843.htm. This webpage was last updated in December, 2017.

Additionally, the alternative that is attempted should be appropriate for the intended use of the bed rail. For example, a low bed, or concave mattress would not be an appropriate alternative to an enabler for a resident receiving therapy for hip-replacement. If there is no appropriate alternative that would be suitable for the intended use of the bed rail, the medical record would have to include evidence of the following:

- purpose of the bed rail and notation that no suitable alternative exists;
- assessment of the resident, the bed and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight), and
- risks versus benefits were reviewed with the resident and/or representative, and informed consent given.

Question: If bed rails are pre-installed on the bed (purchased as one unit or not easily removed), could they be disabled in some way to ensure they are not used for a resident for whom bed rails are not appropriate?
Response: CMS recognizes that there are many different types of beds, some with bed rails installed, or bed rails with the call button and lights incorporated into the rail, and others without bed rails, for which a separate rail could be installed. CMS regulations do not specify that bed rails must be removed or disabled when not in use.

Facilities should have a process for determining whether beds (and their rails) are appropriate for its residents. For beds with rails that are incorporated or pre-installed, the facility must determine whether or not disabling the bed rail poses a risk for the resident. Could the rail simply be moved to the down position and tucked under the bed frame? When in the down position, does it pose a tripping or entrapment hazard? Would it have to be physically removed to eliminate a tripping or entrapment

hazard? CMS defers to manufacturers' recommendations/instructions regarding disabling or tying rails down. Please note, if bed rails are not appropriate for the resident and the facility chooses to keep the bed rail on the bed, but in the down position, **raising the rail even for episodic use during care, would be considered noncompliance if all of the requirements (assessment, consent, inspection, and maintenance) are not met prior to the episodic bedrail use for the resident.**

Question: Should facilities be cited with noncompliance if bed rails are actually on the bed, even if they are not being used?
Response: The LTC regulations do not require bedrails be removed from beds when not in use. Facilities would not be considered noncompliant for having bed rails on the bed as long as they can safely be lowered or disabled according to manufacturer's specifications, and are not observed in use.

H. 483.30 Physician Services

I. 483.35 Nursing Services

J. 483.40 Behavioral Health Services

K. 483.45 Pharmacy Services

On page two of the CE Pathway for Medication Administration it reads "staff do not crush and combine medication and then give medications all at once either orally (e.g., in pudding or other similar food) or via feeding tube." Does this mean the nurses need to crush each pill and mix it separately for both oral and enteral routes?

CMS has revised interpretive guidance at F759/F760 and the facility task for Medication Administration Observation, CMS 20056 to convey that best practice would be to separately crush and administer each medication with food to address concerns with physical and chemical incompatibility of crushed medications and ensure complete dosaging of each medication. However, separating crushed medications may not be appropriate for all residents and should not be counted as a medication error unless there are instructions not to crush the medication(s). Facilities should use a person-centered, individualized approach to administering all medications. If a surveyor identifies concerns related to crushing and combining oral medications, the surveyor should evaluate whether facility staff have worked with the resident/representative and appropriate clinicians (e.g., the consultant pharmacist, attending physician, medical director) to determine the most appropriate method for administering medications which considers each resident's safety, needs, medication schedule, preferences, and functional ability.

The guidance and facility task will remain unchanged related to separating crushed medications for administration via feeding tube. Separating crushed medications via feeding tube is a standard of practice according to the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) which is referenced in the guidance.

F756

Regulation F428 Drug Regimen Review now states the pharmacist must report any irregularities to the attending physician, the DON and the facility's medical director. What is the timeframe that the pharmacist must report to the attending physician and the medical director? What is the timeframe that the attending physician must respond do the irregularity report?

The new regulations for Drug Regimen Review now state that the pharmacist report irregularities to the attending physician, medical director, and director of nursing or for the attending physician to respond to the report of irregularities. We expect individual facility policy to address these specific

timeframes. An important factor in reporting and responding to irregularities is the potential for or presence of serious adverse consequences. Some irregularities may require immediate notification and response to prevent an adverse consequence to a resident.

Does the pharmacist recommendation have to be placed in the residents chart? Or can it be in a binder located at the nurses' station or DON office?

Per the interpretative guidance for §483.45(c)(4), F756, "The pharmacist is expected to document either that no irregularity was identified or the nature of any identified irregularities. The pharmacist is responsible for reporting any identified irregularities to the attending physician, the facility's medical director, and director of nursing. The timeliness of notification of irregularities depends on factors including the potential for or presence of serious adverse consequences; for example, immediate notification is indicated in cases of bleeding in a resident who is receiving anticoagulants or in cases of possible allergic reactions to antibiotic therapy. The pharmacist must document any identified irregularities in a separate, written report. The report may be in paper or electronic form. If no irregularities were identified during the review, the pharmacist includes a signed and dated statement to that effect."

Additionally the interpretative guidance states, "The pharmacist's findings are considered part of each resident's medical record and as such are available to the resident/representative upon request. If documentation of the findings is not in the active record, it is maintained within the facility and is readily available for review. Establishing a consistent location for the pharmacist's findings and recommendations can facilitate communication with the attending physician, the director of nursing, the remainder of the IDT, the medical director, the resident and his or her legal representative, the ombudsman, and surveyors.

F758

Regulation F758 Unnecessary Drugs talks about requirements for psychotropic medications that are PRN and GDRs for these medications. Will Compazine (which is an antipsychotic according to some medication resources) which residents take for nausea and vomiting on a PRN basis expire every 14 days and have to be renewed every 14 days?

Compazine or prochlorperazine is considered an anti-psychotic, though it can be used to treat nausea and vomiting. Therefore, according to Federal requirements, a PRN order for Compazine would be limited to 14 days. A new PRN order cannot be renewed unless the attending physician or prescribing practitioner first evaluates the resident to determine if entering a new order for the PRN medication is appropriate.

PRN Anti-psychotic medications (specifically Haloperidol) have become a routine order by Hospice physicians. I see no exception to this type of order in the requirements of participation or supporting materials in Appendix PP. The Hospice PRN order may go unused for a period of 14 days, necessitating an in-person reevaluation by the physician, despite the desire of the physician to have the medication available to assist with potential symptoms of dying, particularly delirium associated with hyperactivity at the end of life or for its potent antiemetic properties. Good hospice care, honoring resident's choices and person-centered care, and Hospice clinical best practices all seem to be in conflict with the 14 day limit of PRN orders for anti-psychotic medications for persons receiving Hospice services.

Is there an opportunity, if the medical record indicates the PRN order for Haloperidol is being used to manage end-of-life symptoms for a patient on Hospice care, for an exception to this requirement? These issues were all raised during the comment period, with little to no response.

We understand your concerns and appreciate the importance of promptly addressing the needs of all residents, especially those residents who receive end of life or hospice care. There is no exception to the PRN antipsychotic requirement in the regulations. The intent of this requirement is to address the concern that use of an antipsychotic medication, on a PRN basis beyond 14 days without physician evaluation of the resident, could be detrimental to the resident. We are aware that the current Medicare Hospice requirements under 42 CFR 418.54 require updating of the comprehensive assessment every 15 days or more frequently as needed.

Is melatonin considered a hypnotic to be reduced every ninety days?

Melatonin does not fall under the requirements for psychotropic medications. Melatonin is a natural hormone that is classified as a dietary supplement by the Food and Drug Administration and, therefore, is not subject to the requirements of hypnotics under the new psychotropic medication category at 483.45(c)(3). However, residents should still be monitored with regard to benefits, risks, and potential adverse consequences.

The regulations state that PRN orders for psychotropic drugs are limited to 14 days except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Say a resident takes Restoril (PRN for sleep), would it be acceptable for the physician to document a rationale that indicates the duration for the PRN order to be indefinite? Or is there a max on the duration of time for the PRN order?

There is no maximum duration for PRN orders for psychotropic medications. However, if an attending physician or prescribing practitioner believes it is appropriate to extend a PRN order for a psychotropic medication beyond 14 days, he or she may extend the duration and document the rationale for extending the duration. This requirement was written to address concerns about residents remaining on PRN psychotropic for prolonged periods which may not be appropriate. "Indefinitely" means for an unlimited or unspecified period of time so extending a PRN order indefinitely would not meet the intent of this regulation. It is also unlikely that a rationale could be provided to support an indefinite extension of a PRN order for a psychotropic medication.

Does a resident with a diagnosis of schizophrenia with an order for Seroquel (an on label use) require a 14 day PRN order and continuous 14 day reassessment and PRN order indefinitely?

There are no exceptions to the PRN antipsychotic medication requirements. Use of these medications, on a PRN basis, is limited to 14 days. If the attending physician or prescribing practitioner wishes to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order is appropriate. If deemed appropriate, the new order would, again, be limited to 14 days. If the resident is assessed as needing an antipsychotic on a non-PRN basis, the PRN requirements would not apply.

If a medication such as Morphine Sulfate is ordered for an indication of Anxiety-would this need to have a 14 day stop date for PRN orders even though it is a pain medication?

Morphine sulfate is classified as an opioid pain medication. Opioids do not fall under this definition of psychotropic medications and are not be subject to the associated PRN requirements, however, the facility should monitor and document the benefits and/or any adverse effects of the morphine to ensure the medication is not an unnecessary drug.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Would you clarify what constitutes an evaluation by the attending or prescribing physician? For instance does this suggest that the physician needs to have face to face contact with the resident, or would a review of the medical record and a written summary of the resident's condition sent to the physician be considered evaluation of the appropriateness of the medication? What are surveyors expected to look for in regard to this regulation?

The newly revised advance Interpretive Guidance for surveyors released via a CMS Survey & Certification memo on June 30, 2017 clarifies the required evaluation at F758:

The required evaluation of a resident before writing a new PRN order for an antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record:

- Is the antipsychotic medication 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 medication?

NOTE: Report of the resident's condition from facility staff to the attending physician or prescribing practitioner does not constitute an evaluation. Therefore, a review of the medical record and a written summary of the resident's condition sent to the physician would not meet the intent of this requirement. When assessing concerns related to PRN antipsychotic medications, surveyors should review the medical record for evidence of the required evaluation and interview staff as appropriate to assess compliance.

L. 483.50 Laboratory, Radiology, and Other Diagnostic Services

M. 483.55 Dental Services

N. 483.60 Food and Nutrition Services

O. 483.65 Specialized Rehabilitative Services

P. 483.70 Administration

F838 Facility Assessment

Is there an expectation that the Surveyors receive the Facility Assessment and leave the Facility with this copy? If yes, is the Facility Assessment to be made available to the public? Must we receive a HIPAA agreement because in some instances our numbers are less than 20 to share the Facility Assessment?

Facility Assessment is a policy. Just like any other policy that a facility may have, if there is non-compliance where the policy is relevant for that area of non-compliance, the surveyor may make a copy as part of the file as documentation to support the deficiency. It would not be routine practice for the surveyor to copy the Facility Assessment unless needed as part of the survey record related to a deficiency.

In general, surveyor documentation is considered part of the surveyor's notes and are not made available to the public. The resulting CMS-2567 is the public document. The Facility Assessment is a policy and is not an individualized care plan pertaining to a specific person. Therefore, HIPAA agreement is not required.

How and where I can get a copy of the sample facility assessment plan template?

You may find a copy here: http://qioprogram.org/facility-assessment-tool

Please provide clarification on what guidance is instructed to surveyors regarding when and how they should evaluate a facility's assessment. There is some concern that surveyors may cite a facility under the facility assessment requirement if an individual resident's care plan is not followed or if staffing decisions on particular days are in question, rather than evaluating the Facility Assessment as an overall planning document to help guide the overall operations and care delivery systems of the facility. Using the facility assessment in any individual decision making or citation seems inappropriate.

You may find a copy here: http://qioprogram.org/facility-assessment-tool .

The survey team will ask for the Facility Assessment on the first day of the Annual Survey. During the survey process if the survey team in their investigation identifies an area where there is evidence of a systemic issues (systems breakdowns) then the team will use the facility assessment to determine how the facility evaluated its resident population and identify the appropriate resources needed to provide the necessary care and services the residents require.

As an example, if it was determined that out of eight residents reviewed two had acquired Pressure Ulcers while in the facility than F 686 (Treatment /Services to Prevent /Heal Pressure Ulcers) would be cited. Under this example the survey team would generally not review the facility's assessment. However, if out of eight residents reviewed, seven had acquired Pressure Ulcers while in the nursing home then the survey team may refer to the facility's assessment. The survey team would review the assessment to determine how the facility evaluated the resident population they were carrying for and if they identified the resources needed to provide the necessary care and services that those residents required.

Q. 483.75 Quality Assurance and Performance Improvement (QAPI)

R. 483.80 Infection Control

S. 483.85 Compliance and Ethics Program

T. 483.90 Physical Environment

F909

Question: What is meant by regular inspection of all bed frames, mattresses and bed rails if any, to identify areas of possible entrapment?

Response: CMS does not define a timeframe for the regular inspection of the bed frames, mattresses and bed rails. Facilities should have a process to determine whether the bed and mattress is safe to use to prevent entrapment. The facility may give consideration to the length of time the bed and/or mattress has been in use and its physical condition, or changes in a resident's condition that may affect the use or condition of the bed and mattress. A change of residents using the bed or mattress may call for an inspection of the bed and mattress to determine if any areas of possible entrapment are present based on the new user of the bed and mattress. Further information and criteria can be found in the FDA publication, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.

U. 483.95 Training Requirements

V. LTC Survey Process Training

W.LTC survey Process

Offsite Prep

Abuse – if it is cited or alleged during the past year, we need to review it. How will we know/review all complaint intakes? How many should be sampled?

The review of information from complaints and facility reported incidents (FRIs) 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 (as described in the Procedure Guide). 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 this is not required, CMS will continue to work with survey agencies on a method to assist states to capture this information in an efficient manner.

If there is a history of abuse, the team will have to review one resident onsite for abuse. This resident might be identified during the initial pool process or the survey team can ask the facility for a list of residents who have been investigated for potential abuse concerns since the last survey to try to identify a resident not already investigated.

What happens to a shell if a survey is postponed?

You will have to update the survey start and exit date in the shell. If the shell was already exported from ACO, you will be asked if you want to recalculate the MDS information. If the start/exit dates have changed, you want to recalculate and then share the updated shell to ensure that the team has the most recent MDS information.

Step 2 in the LTCSP Procedure Guide.

Facility Entrance

We have a dietitian who is a team coordinator. Would it be acceptable for this dietitian to do the Entrance Conference, and then conduct the initial brief visit to the kitchen immediately after the Entrance Conference?

The LTCSP Procedure Guide, Step 12 indicates that while the TC conducts the Entrance Conference, the surveyor assigned to the kitchen conducts the initial brief visit to the kitchen using the kitchen pathway, and the other members of the team go to their assigned areas and begin screening their residents. This is done so that the team members arriving on the floor, and in the kitchen can have an unannounced view of facility practices that are in place as soon as surveyors enter the building. In addition, we believe this is the most efficient use the survey team's time and represents a best practice.

We recommend using the best practice approach of conducting the kitchen review while the Entrance Conference is taking place. However, we recognize the need to be flexible and offer the following option:

The TC conducts the kitchen review before conducting the Entrance Conference – in this scenario, the TC will leave the Entrance Conference form with the Administrator or designee, emphasizing the documents that are needed right away, and will leave to conduct the kitchen review. Upon completion of the kitchen review, the TC returns to conduct the Entrance Conference as quickly as possible.

We do not recommend having the TC conduct the entire Entrance Conference and then do the Kitchen review. This would take too much of the TC's time and not offer an unannounced view of the kitchen.

Can the information given to surveyors on a matrix on a survey be pulled from the most recent MDS data?

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.

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

The information to complete the matrix will come from various places of each resident's clinical record (i.e., physician's orders, laboratory reports, nutrition progress notes, etc.).

We request the facility matrix for New Admissions upon entering the facility. When is the matrix for all other residents requested?

The matrix for all other residents is requested during the Entrance Conference meeting. This is step 12 of the LTCSP procedure guide.

Ask for a **resident roster** for your assigned area with an indicator for the **new admissions** in last 30 days 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.

Why does the TC ask for a list of residents that smoke during the entrance conference?

The TC requests a list of residents who smoke, the designated smoking times and locations to be delivered immediately upon entrance.

The team is required to include at least one resident that smokes (if any) in the initial pool.

Step 13 in the LTCSP Procedure Guide.

What is the survey team supposed to do with the facility assessment that is requested during the entrance conference?

The facility assessment should be provided to the TC within four hours after the entrance conference.

According to F838 §483.70(e), If systemic care concerns are identified that are related to the facility's planning, review the facility assessment to determine if these concerns were considered as part of the facility's assessment process.

Facility Task

Am I correct in understanding that ALL surveyors, including the one assigned to the kitchen task must observe dining AND all surveyors fill out the Dining Observation Critical Element (CE) Pathway

Any surveyor assigned to a dining room or room trays will observe dining. There may be a situation where there are more surveyors than dining areas/room trays – in that case, it is conceivable that a surveyor wouldn't have to complete the dining observation task. The surveyor assigned primary responsibility has to answer all CEs. The other surveyors will answer CEs of concern or those CEs related to their dining observation. Any "No" response to a CE will overwrite any "Yes" response in the LTCSP software application. The "No" response to any CE will then display on the potential citations screen at the end of the survey (Step 23 in the LTCSP Procedure Guide).

Step 20 in the LTCSP Procedure Guide

It is more efficient if the person assigned to the Kitchen also takes the responsibility for answering all the Dining questions, since both these tasks are closely related any follow up with staff interviews, policies etc. can be done by that one person**.**

How do I add residents for the Beneficiary Notices and Infection Control Tasks?

If you want to add a resident the LTCSP software , click on the Add Resident icon in the upper right corner OR if the resident is already listed in the LTCSP resident list, add the resident's ID in the Notes field using Alt+R or the person icon (next to the clock icon).

In the Resident Council Facility Task, why does the software not skip question #7 when question #6 is answered as Yes?

At this time if the "Yes" box is checked for question #6, the software does not skip question #7. Therefore, a fix was made to question #7 that gives an additional option of selecting "N/A" in addition to "Yes" and "No".

Initial Pool Process

Is it possible that a surveyor will have 8 or more offsite selected (i.e., from the MDS triggers) and, if so, how many more should be chosen to review when on the unit?

While it is possible, it is unlikely that one surveyor will have the majority of offsite selected residents. During the initial pool process, in addition to offsite selected residents, the surveyor is also including complaint/FRI residents (up to five maximum across the team) and identifying onsite selected residents (vulnerable, new admissions, or residents with identified issues that don't fit into any other subgroup) to include in the initial pool of about eight residents per surveyor. If any surveyor identifies more than eight residents who are appropriate for the initial pool, he/she will have to discuss with the team what to do (e.g., have others help or increase the amount of time it takes to finish the initial pool).

Where would you document random observations? Example: If you see staff transfer a resident (who is in the initial pool or sampled incorrectly who is under another team member's name?

You should use Surveyor Notes (click on the clipboard and pen icon on the far right of the screen). Surveyor notes are available in the software for general concerns. However, the concerns documented in surveyor notes should be moved to the appropriate area to cite deficient practice. Reviewing your surveyor notes at the end of each day is a good practice. You'll be reminded of the observation or interview and will be able to copy and paste the information onto the appropriate investigative documentation screen.

Explain the 8 interviews – is it to attempt 8 interviews with the knowledge that not all residents are interviewable?

Each surveyor is required to screen every resident in their assigned area to identify about eight **residents** (not interviews) to include in the initial pool. All residents included in the initial pool will have a formal observation and limited record review. Remember, the residents in the initial pool will potentially be included in the finalized sample. The surveyor will only interview those residents in the initial pool who are interviewable. The team will try to complete at least three RRI/family interviews for the non-interviewable initial pool residents.

Step 13 in the LTCSP Procedure Guide.

When can offsite selected residents be removed?

They cannot be removed from the *initial pool* unless discharged from the facility. When the team meets to select the finale sample (after the initial pool process is complete) the offsite selected resident may be removed from the *sample* if you were able to rule out their concerns.

Step 11 in the LTCSP Procedure Guide.

If you have no issues with an observation and you mark that, do you have to document your observation in the box?

The focus of doing observations is to identify deficient practice for example staff not following the care plan. It is important to have evidence that multiple observations were made to determine if staff were consistently following the care plan. If concerns are identified those observations would need more details and specifics as opposed to observations that did not identify a concern. It is recommended that there is some documentation of all observations.

Facility Reported Incidents (FRIs) – please clarify if you have active 10 FRI/Complaints, 5 are added in addition to your sample and the other 5 are included in the initial pool and sample?

If the team has 10 complaint/FRI residents that will be included with the recertification survey, five of the complaint/FRI residents can be included in the initial pool and sample. The other five complaint/FRI residents are in addition to the sample (i.e., the sample size indicated on the *Sample Size Grid*).

Refer to Attachment B of the Procedure Guide.

A Resident was added to the resident list in the LTCSP software application but was already in the list. Is there a way to delete the second entry?

Before adding a resident to the resident list search for the resident in the search box to make sure they are not already in the list before adding them to avoid duplication.

Currently there is no way to remove a duplicate resident.

Do we need to do a RI, RO and RR for all residents? How much documentation is necessary during the screening process?

It is not required to document any information for the residents you have screened out and not included in the initial pool. The RI, RO and RR are only done for the residents included in the initial pool.

Initial Pool Process Step 13 of the Procedure Guide

To screen residents for the initial pool, review their MDS indicators and/or matrix information before entering the room to give you a more complete picture. Introduce yourself and briefly converse with the resident (e.g., ask how they are doing) while you complete a brief head-to-toe observation of the resident and their surroundings. If there are concerns, consider whether they should be included in the initial pool.

The first eight to ten hours onsite are primarily spent completing the initial pool process. This process entails screening all residents in the facility and narrowing down all 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 who should be in the sample

For clarification regarding residents who have "Identified Concerns," as determined during the Initial Pool screening process: Do these residents need to be in the Sample, even if they trigger for nothing else? i.e. In the Traditional survey process people who were unhappy with the food, or had concerns about missing equipment they owned, would be considered Random Residents and their concerns investigated, outside of the sample and findings written. Are we now including them in the sample?

During the screening process if a surveyor determines a resident has an identified concern then the surveyor would select that category and include them in the initial pool. The surveyor would then do observations, interviews and a limited record review to determine if the concern needs further investigation (FI). If FI is marked for a care area then during sample selection the team will decide either to include the resident in the sample or not. There may be times another resident with the same care area may be a better candidate for the sample.

One team member was finishing up their initial pool activities while the other members of the team began the sample finalization process. When the surveyor was finished gathering their initial pool information they shared the data with the TC however the data was not transferred to the TCs computer. Is there a bug with the software?

Step 16 of the LTCSP Procedure Guide states that "**All data must be shared before selecting the sample**". Step 17 states "Once the initial pool process is finished and the data is shared with the TC, meet for an hour, on average, to select the sample.

To further explain this, surveyors should understand that **clicking the "Start Sample Finalization" button in the LTCSP software application closes the door on the opportunity to include any information gathered by the team during the Initial Pool process**. Any Initial Pool information shared by any team member after the button has been selected **will not be included in the sample finalization process**. Furthermore, any pertinent information gathered during the Initial Pool process that might lead to a resident being selected for a full medication review will not be considered either.

Sample Selection

If you mark "further investigate" for a resident in the initial pool & you don't pick them for your sample, do you have to go back & settle that information?

If a resident is not included in the sample, any areas marked for further investigation require no further follow up. The areas included in the sample will be representative of any resident not sampled (i.e., so the general area of concern will be investigated for a sampled resident).

Step 17 in the LTCSP Procedure Guide.

Do you need only pick a Hospice or Dialysis or pick all on the list?

The team is required to select at least one resident for the initial pool and sample receiving each of the following: hospice, dialysis, ventilator and transmission-based precautions.

Step 17 in the LTCSP Procedure Guide.

If there is a concern with a resident's Insulin but that resident wasn't selected for unnecessary medications review, can you replace one of the 5 with the resident with Insulin concerns or this resident would need to be added?

No, you cannot alter the residents selected by the system for the unnecessary medication review since those residents had the most concerns with the high risk medications and adverse consequences. If you identify specific medication concerns for a sampled resident, you will still follow up on that specific medication concern. For example, the resident with an insulin concern will be followed up on during your investigation.

Step 17 in the LTCSP Procedure Guide.

How do we select residents for a closed record review?

The LTCSP software application selects 3 residents for closed record review. One resident that died, one resident that was discharged to the hospital and one resident that was discharged to the community. The survey team needs to review one resident for each area, if available. If there are no residents that fit either of the tree categories the team does not have to complete the review.

Step 17 in the LTCSP Procedure Guide.

If there is a history of abuse but no residents are marked as FRI for abuse or bruises of unknown origin and the facility has no other residents that they have investigated for abuse besides the complaint or FRI resident already investigated, do we still review abuse? If so, for whom?

No, you are not required to complete a review if:

- There are no onsite concerns of abuse during the initial pool process AND
- The team asked the facility for a list of allegations that have been investigated since the previous survey and there are none that have not already been investigated by the facility.

When do we add a resident on PASARR to the sample?

You would only add a resident for PASARR if you marked them for further investigation during the initial pool process, if you identified a concern when you reviewed the matrix or if you identified concerns during the offsite preparation.

When a complaint resident is added to the sample does the complaint require a sample of 3?

It depends. If there are other residents who had further investigation marked for the complaint allegation/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 the complaint allegation is not covered by the interview, observation, or record review areas addressed in the initial pool process (e.g., record keeping), then the team is required to sample three residents to investigate the area

Step 17 in the LTCSP Procedure Guide.

How does the sample get picked, is it based on # of certified beds or census?

The sample size is based on the actual facility census not the number of beds Please see Attachment A in the LTCSP Procedure Guide.

Investigation

What is the difference between Investigative Protocols (IPs) and Critical Element (CE) Pathways?

Both CE pathways and IPs are tools the surveyor should use to help guide their investigation to ensure a thorough and complete investigation is conducted. The pathways and IPs cover different care areas. The pathways are included in the software, while the IPs are a part of Appendix PP and cover fewer areas (e.g., paid feeding assistants, CPR).

Ongoing and Other Survey Activities

Potential Citations

Will the team be able to see what each surveyor identified in the potential citations screen?

If the team shares their completed investigation data with the TC, then there will be a consolidated list of potential citations on the TC's computer. The TC could then conduct a data share with each surveyor so they have all surveyors' potential citations.

Step 23 in the LTCSP Procedure Guide.

How do you select a tag for an identified deficient practice during deficiency determination on the potential citation screen?

On the Potential Citation screen, select the "Do Not Cite" option. Then select "Move to another tag" under the reason for not citing the tag, select the correct tag and scope and severity, and note the appropriate citation category. After the TC loads final citations in Citation Manager, the system will automatically move the information to the new tag.

X. Complaints/Facility Reported Incidents

If you have 100 bed facility. Sample is 20. We include 5 FRI/Complaint residents in the sample. We also have 5 more resident complaints. If we add in those 5 additional residents...our sample will now be 25....those 5 extra residents can we simply complete the complaint review on them or must I complete all the RI, RO, RR for all areas for those 5 residents?

If the SSA includes complaints or FRIs with the recertification survey, they may only include up to 5 residents in the initial pool. The SSA would conduct full interviews, observations, and limited record reviews for these first 5 residents. Any additional complaints or FRIs would be above the recommended sample size, and the team would include these residents after the final sample was selected. When these residents are included in the sample after the final sample is determined, the SSA would only be required to look at the specific complaint/allegations for those residents.

Are there a limited number of residents who may be added to the initial sample from complaints? May additional names be added to a supplemental sample if there are multiple complaints to be done at the same time as the annual?

There are a limited number of residents that can be added to the survey sample; up to 5 residents can be included in the survey sample without adding additional time or resources to the survey. This is to ensure the sample for the annual recertification survey is case mix stratified and not that of an abbreviated complaint survey. You can add additional residents at any time to go above and beyond the identified sample number for either complaint investigation or to rule out SQC or other.

Y. Software Questions

Where do we indicate who the family representative is? i.e. Son, daughter, guardian, neighbor, etc.? And how often they visit?

This information may be entered into the notes section in the resident representative interview. This information would be saved for future reference.

How does the new survey process and software handle extended survey?

When substandard quality of care is identified and an extended survey must be conducted, you would go to the Navigation Menu; select Investigation/Facility tasks, , and assign the Extended Survey task to the team member(s) who will be assigned to complete the task by following the Extended Survey Pathway.

How do resident numbers get assigned in the LTCSP software? How does it differ for residents that have MDS submitted and those that do not?

The resident numbers in the software are assigned randomly for residents that have an MDS submitted. The surveyors should use the numbers assigned to each resident by the software. Surveyors should first make sure the resident is not in the resident list by using the search function in the resident manager screen to avoid duplication. If the surveyor adds a resident that is not in the software, the system will automatically assign a number to that resident, each surveyor gets assigned a range of 50 numbers by the software. These numbers will not be chronological because the number assigned to the resident is dependent on which surveyor added the resident to the list.

Investigation

In the investigation area what is the difference between resident notes and investigation notes. We know that the resident notes area can be seen across all the notes area and that is convenient.

The resident notes is information that is common across all care areas for example their BIMS, and MDS information like cognition and ADL status, Diagnoses etc. The investigation notes should be specific to the care area for example, relevant MDS information, care plan, physician orders, observations and interviews. The investigation notes will display any Initial Pool notes entered for that care area. (Surveyors

may choose to primarily use the Resident Notes as it may be easier to have one ongoing notes field per resident. This is separate from the Surveyor Notes which are a temporary location for documentation.)

A surveyor added a resident to the survey and the same resident was already included in the original MDS list of residents. During the final sample selection both were selected (e.g., the original resident was selected for unnecessary meds and the added resident had at least one further investigation and was selected for the final sample). What do we do?

You should have only one record for the resident, so you will have to combine all investigations into one. Best practice is to use the original MDS resident; if a new resident was added more than once, select one to combine all investigations. To combine resident investigations:

1. Initiate any investigations for the resident record you will work with.
2. Copy all investigation notes from the other resident investigation(s).
3. Paste investigation notes into the appropriate initiated investigations.
4. Update the resident name that you will not be using to clearly show that it is the duplicate.

Sample Finalization

I have residents with FIs marked that are not in the list of final sample candidates. Why not?

It is possible that the FIs marked were for care areas that are only mapped to facility tasks. Once you have finalized the sample, these residents appear in the appropriate facility task list of residents. Each facility task when you open it should show you the list of residents identified to investigate for that task.

If a resident was marked for Further Investigate under care areas that are mapped to facility level tasks only then they will not appear as candidates for the Final Sample in the LTC software application. However, if you are investigation concerns for these residents they are part of your overall sample. We are continuing to collaborate with all parties to address this question.

I started sample finalization before the team was ready. How do I reset the Start Sample Finalization?

It is important to wait until all interviews, observations, and record reviews have been completed by the team and all data has been transferred to the team coordinator. This ensures that all the information is available to make final sample decisions, including any unnecessary meds candidates determined from the limited record review.

If, however, you do click Start Sample Finalization before you wanted to, you can reset the sample. Press Alt + U to return the data to the state it was before beginning the sample finalization. This function:

- Activates the Start Sample Finalization button (changes back from Finalize Sample).
- Resets sample selections—any selections you made will not be retained.
- Recalculates the unnecessary meds residents when you start sample finalization again ensuring that any unnecessary meds candidates determined through the limited record review will be included.

Note: This function ONLY works to reset the begin sample finalization; once the sample is finalized, the sample cannot be reset and finalized again.

Resident Manager

I discharged an offsite resident with the reason (Expired, Discharged to Community or Hospitalized) but they still show up in the resident list. Why is that?

The application does not remove any residents from the resident list even if they are marked as being discharged.

Interviews, Observations, and Record Review

Why do green checkmarks show up on the interview and observations page right-hand care area menu even though I selected "Further Investigate" for that care area?

The Interview and Observations screen lists **both** interview and observations probes since it is often simpler to answer observation questions at the same time. If the surveyor marks an area as further investigate for an observation based question the surveyor will not see the orange exclamation point unless they select the RO icon at the top right of the screen. Keep in mind when selecting this icon the surveyor will only see the Observation Care

Areas. Also, if any care area is marked as "Further Investigate" for either RI, RO or RR a blue circle will appear on the Resident Manager screen.

Sample Finalization I get a timeout error when finalizing the sample, what do I do?

If you receive this message when finalizing the sample: Unexpected Error

The request channel timed out while waiting for a reply after 00:00:59:8271291. Increase the timeout value passed to the call to Request or increase the Send Timeout value on the Binding. The time allotted to this operation may have been a portion of a longer timeout.

The HTTP request to 'https://localhost:8443/ws/investigation' has exceeded the allotted timeout of 00:01:00. The time allotted to this operation may have been a portion of a longer timeout.

The operation has timed out.

Take these steps:

1. Close all other applications open on your PC.
2. Close ASE-Q and re-open the survey.
3. Try again.
4. If after trying a few times with no success, export the survey shell from ASE-Q and email to the ASPEN helpdesk. They can finalize the sample for the team and return the shell.

Data Sharing

What data does not currently get shared as part of data sharing?

The following is the list of data items that are not being shared during data sharing:

- Attachments
- Facility Census number from the Sample Finalization page

To share attachments the team members will need to export the survey from ASPEN and send to the TC. After the survey is complete and Load Cites has been done, survey team members can share their attachments by exporting the survey from ASPEN (ASEQ) and sending to the TC. The TC can then import the survey received from the team members. When importing the survey shell received from the team members, the TC should be mindful of the "source and destination" screens.

My team coordinator tried to unassign me from a facility task but after data sharing the assignment is still there.

Once you have been assigned a facility task you should be the only one to unassign yourself. This prevents any work that has been completed from being lost unintentionally.

Why is my resident assignment and interview data not showing up on other team members' machines?

Check to see if Sample Finalization has been started by the Team Coordinator. If the TC has already started sample finalization, any resident assignments, Interview, Observations and Record Review responses from the team members will no longer be shared with the team. This is because once Sample Finalization has begun additional changes to the assignments or sample are performed by the leader.

Why do I receive an error when changing data on a screen?

If you are using wired or wireless data sharing, data may have been changed that impacts the screen you are working on requiring the screen to be refreshed. We recommend that when sharing data, all team members go to the Data Sharing screen even when using the wired and wireless methods.

Z. General Questions

Does the software allow us to transfer just a portion of what was documented from one resident to another?

If you have entered information under the wrong resident and you click on the transfer Interview Answers to Other Resident button, all of the interview answers as well as the record review and observation information will be transferred to the selected resident as long as the selected resident is completely blank.

Step 13 in the LTCSP Procedure Guide.

If you need to transfer a portion (e.g., interview responses) you will have to manually enter the information under the correct resident and delete the information from the incorrect resident.

Can you change the TC in the middle of the survey?

Yes you can, the software steps are located at Step 10 in the LTCSP Procedure Guide will be provided in the procedure guide.

Step 10 Procedure Guide.

Does the software automatically save?

The auto save for entering documentation is set to two minutes. For all other changes that are not documentation, they are saved as soon as the change is made. For example, on the investigation screen, if the surveyor is entering a lot of investigative documentation, it will be saved every two minutes, but when they answer the critical element (CE), it will be saved right away.

Are bed-holds included in the census pool or do we "discharge" them even though they aren't technically discharged?

Any resident on a bed hold should not be included in the facility census number.

Refer to step 12 in the LTCSP Procedure Guide: The facility should exclude bed holds from the facility census number (item 1).

What is the expectation for documentation IF THERE ARE NO CONCERNS? Should we document to "prove" we did the interview or observation?

Documentation is extremely important to surveyors, leads to an effective and efficient investigation, and could be included in a potential deficient practice statement. If a concern warrants further investigation, surveyors should place a check mark in the "further investigation" box and document the specifics of the concerns in the notes field. If there are no concerns, surveyors should simply mark the "no issues" box and move on to the next care area.

However, it is important to have evidence that multiple observations were made to determine if staff were consistently following the care plan. If concerns are identified those observations would need more details and specifics as opposed to observations that did not identify a concern. It is recommended that there is some documentation of all observations.

Why is there no need to ask for a list of residents on Psych meds?

Information regarding the medications residents are receiving come from a few different areas. Some information is gained from the MDS data and some information is obtained through the initial pool process activities (limited record review). The LTCSP application will provide the team with a list of 5

residents that will require a full medication review based on this information. In addition, the facility matrix requests a list of residents receiving all forms of psychotropic medications.

What if you mistakenly think a resident is interviewable, click that option, then during or after the interview you realize the answers are non-comprehensible, the resident is delusional, etc.

There are two ways to handle this situation. If the surveyor has marked the resident as interviewable and begins the interview, and part way through the interview determines the resident is not interviewable the surveyor should stop the interview and mark the resident as non-interviewable.

Is there a back-up plan if electronic fails for some reason?

There is a back-up plan for how surveyors can address any potential software/hardware issues. Refer to the document titled, "Survey Instructions if you Encounter Software or Hardware Issues" which can be found in the Survey Resources folder that should be saved to everyone's desktop and can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

However some States have developed their own back-up procedures based on available resources and support. For instance, some states plan to have back-up computers available in the event a computer malfunctions. Other states may choose to carry paper copies of the CE and Facility Task Pathways and surveyor notes worksheets as a back- up method.

Do we contact the Ombudsman prior to entrance to the facility?

Yes, information from the Ombudsman should be used to complete the offsite preparation.

How can a supervisor review a survey in ACO?

The supervisor cannot review the LTCSP data in ACO. They would have to transfer the shell into ASE-Q to review the LTCSP data. In ASE-Q they will activate the TC as the active surveyor to be able to review the LTCSP data.

Is an IDR Report available?

The IDR report is not available at this time but should be available in a few weeks. In the meantime if SAs or ROs need information for an IDR, Alpine will be able to provide the information needed if requested.

Are "cut letters/denial letters acceptable" at this time for the SNF Beneficiary Protection Notification Review task?

CMS is in the process of getting final clearance on the newly revised SNFABN. With this newly revised SNFABN, CMS will be discontinuing the SNF's use of the 5 Denial Letters as well as the NEMB-SNF. At this time, we are unable to give a definitive date as to when this new form will go into effect. We do know that once the clearance process concludes, we will notify the public and will allow a 90 day transition time to accommodate the SNFs in using this new form. In the interim, please note that the SNFs will still be using the 5 Denial Letters, the SNFABN and the NEMB-SNF. Therefore, the SNFs should not be cited for using any of these forms. It may take some time to get Appendix PP and the facility task in the software updated to reflect this current situation that is dependent upon the final clearance process.

Are there instructions for editing and finalizing 2567"s?

Yes, Editing and Finalizing the Statement of Deficient Practice can be located in the Survey resources folder on the CMS DNH website. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

How do I identify Scope and severity data? The "Resident's reviewed by care area" report could be improved in determining exactly how many residents were reviewed for "X" issue.

On the sample screen you will be able to see other residents being reviewed for the same care area. Click on the sample by care area button on the top right hand corner of the screen. This is how you will know how many other residents were reviewed for that particular care area. You will have to toggle back to the sample screen to get this number. The report "Residents Marked for FI by Care Area" does not give the residents included in the sample it gives you a list of all residents that were marked with an FI for a care area. In the near future we will be able to get an Investigation Workload report that will show the number of residents being investigated for each care area.

Scenario: facility where each resident has their medication in their own room – How many do we review? The question came about because in the new process if we have 60 rooms and each has their own medication storage and we put 60 in the number of locations, the system will ask us to complete 30 reviews. Is that the expectation?

In general, yes, resident rooms count if they store medicine in resident rooms versus a common storage area. We would ask that they review storage in resident rooms, we will look at this area for further guidance needed in terms of the number of rooms needed and whether or not there will be any variation from the current instructions to review 50 percent of medication storage areas.

Can take the SMQT without attending the required prerequisite Basic Long Term Care Course since it's not offered at this time?

The training division at CMS announced earlier in the year the Basic Long Term Care Course (BLTCC) would only be available as a self-paced web based training. The BLTCC previously conducted in person was suspended after the June 2017 offering to afford for revisions to be made to the training that would reflect the changes to the Long Term Survey Process (LTCSP) and the revised Nursing Home regulations that were implemented in 2016 and the upcoming phase 2 implementation of November 2017. CMS and the Division of Nursing Homes (DNH) anticipate the revised BLTCC will be available in March of 2018.

You are correct in that the SMQT remains open for to afford the surveyors that attended the BLTCC especially those that attended in June 2017 ample time to successfully complete the SMQT. After October 2017 the SMQT will no longer be available. The SMQT will be revised to reflect the new LTCSP and the revised nursing home regulations.

Chapter 4 of the State Operation Manual (SOM) states at 4009.1B, "Prior to taking the SMQT, a LTC surveyor must complete the CMS Orientation Program, and the Basic Long Term Care Health Facility Surveyor Training Course". Furthermore at 4009.1D Chapter 4 states "An individual must successfully complete the SMQT in order to survey independently. A surveyor can serve as a member of a survey team with at least one surveyor who has successfully completed the required training, but cannot survey independently until the surveyor has successfully completed the SMQT".

At this time CMS does not intend to change the requirements listed in Chapter 4, therefore the surveyor must complete the required training prerequisites, which includes the BLTCC, in preparation for successful completion of the SMQT. Newly hired surveyors should continue to participate as members of a survey team as your survey agency permits during this important time of training.

Where do I document screening information gathered during the initial pool process?

There is **no** requirement in the LTCSP to document the results for the screen process during the Initial Pool. If the surveyor would like to document information that may potentially be important as the survey proceeds, they can do so by using the Surveyor Notes screen within the LTCSP software

application. Taking the time to document the result of each resident screening will take time away from the conducting Initial Pool activities for those residents identified with potential care concerns.

Which regulation set do I use to conduct a complaint survey after November 28, 2017 when investigating a complaint allegation received prior to November 28, 2017?

Survey Agencies should use the current regulation set that is in effect as of November 28, 2017 even if the situation or issue specified in the complaint allegations took place prior to November 28, 2017. When determining potential deficiencies, surveyors should take into consideration if the investigation revealed concerns with requirements that would have been in place prior to November 28, 2017 as well as if there is existing current non-compliance based on the revised regulatory requirements.

When conducting a Post Survey Revisit (PSR) for a survey conducted prior to November 28, 2017, which regulation set should be used?

When conducting a PSR for a survey conducted prior to November 28, 2017 the State Survey Agency should use the regulation set in effect during the survey for which the revisit is being conducted. The reason for the PSR is to ensure the facility has corrected areas of noncompliance found during the previous survey.

Some Considerations:

- If the survey team is conducting a complaint survey alongside the revisit survey, there should be two separate shells created. A revisit shell with the regulation set used to conduct the previous survey that is driving the revisit and a second shell for the complaint that includes the current regulation set.
- If the survey team identifies newly discovered areas of concern during the revisit survey that are serious in nature, a new survey event should be created in ACO (new shell) that includes the current regulation set as of November 28, 2017.