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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 42 **Date: APRIL 24, 2009**

SUBJECT: Revision to Appendix P, "Survey Protocol for Long Term Care Facilities - Part I," "Investigative Protocol – Unintended Weight Loss"

I. SUMMARY OF CHANGES: This instruction deletes the section "Investigative Protocol – Unintended Weight Loss." This section has now been moved to Appendix PP, "Guidance to Surveyors for Long Term Care Facilities," §483.25(i), Nutrition, Tag F325.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 24, 2009
IMPLEMENTATION DATE: April 24, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix P/II. The Survey Process/Task 5-Information Gathering/Subtask 5C-Resident Review

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

Unless otherwise specified, the effective date is the date of service.

Sub-Task 5C - Resident Review

(Rev. 42: Issued: 04-24-09; Effective/Implementation Date: 04-24-09)

A. General Objectives

The general objectives of the Resident Review are to determine:

- How resident outcomes and the resident's quality of life are related to the provision of care by the facility;
- If the care provided by the facility has enabled residents to reach or maintain their highest practicable physical, mental, and psychosocial well-being;
- If residents are assisted to have the best quality of life that is possible. The review will include aspects of the environment, staff interactions, and provision of services that affect sampled residents in their daily lives;
- If the facility has properly assessed its residents through the completion of the Resident Assessment Instrument (RAI), including accurate coding and transmitting of the Minimum Data Set (MDS) and has properly assessed care needs, conducted proper care planning, implemented the plan and evaluated care provided to the residents; and
- If there are additional areas of concern that need to be investigated in Phase II of the survey.

B. General Procedures

The team coordinator assigns specific residents in the sample to surveyors.

One surveyor should conduct the entire Resident Review for an assigned resident. If the resident has been chosen for a Quality of Life Assessment protocol (Task 5D), this same surveyor should also complete that protocol. If a surveyor has not passed the Surveyor Minimum Qualifications Test (SMQT) or if the complexity of a resident's care requires expertise of more than one discipline, surveyors should work jointly to complete the review. A surveyor must successfully complete the SMQT to survey independently.

To facilitate the Resident Review, ask the charge nurse for schedules of the following, as appropriate:

1. Meals;
2. Medications;
3. Activities;

4. Tube feedings and special treatments;

5. Specialized rehabilitation therapies; and

6. Physician visits or visits of other health professionals such as dentists, podiatrists, or nurse practitioners.

For all sampled residents except closed records, parts A, B, and C (Resident Room Review, Daily Life Review, and Assessment of Drug Therapies) on the Resident Review Worksheet (Exhibit 93) are completed. The difference between the two reviews is that the focus of the part D Care Review is more extensive for Comprehensive Reviews. Determine, as appropriate, if there has been a decline, maintenance or improvement of the resident in the identified focused care areas and/or Activities of Daily Living (ADL) functioning. If there has been a lack of improvement or a decline, determine if the decline or lack of improvement was avoidable or unavoidable.

C. Comprehensive Care Review

A Comprehensive Review includes observations, interviews, and a record review. After observing and talking with the resident, the surveyor conducts a comprehensive review, which includes the following:

- A check of specific items on the MDS for accurate coding of the resident's condition. The specific items to be checked will be based on QM/QIs identified for the resident on the Resident Level Summary. At least 2 of the QM/QIs identified for the resident must be matched against the QM/QI definitions (see Exhibit 270) and against evidence other than the MDS to verify that the resident's condition is accurately recorded in the MDS. What is being verified is that the resident's condition was accurately assessed at the time the MDS was completed;

- An overall review of the facility's completion of the RAI process including their:

    - Use of the Resident Assessment Protocols (RAPs);

    - Evaluation of assessment information not covered by the RAPs;

    - Identification of risks and causes of resident conditions;

    - Completion of the RAP Summary;

    - Development of a care plan that meets the identified needs of the resident;

- A review of the implementation of the care plan and resident response;

- A review of the relationship of the resident's drug regimen to the resident's condition (see the description of procedures for completing part C below);

- A thorough review of any of the following conditions that apply to the resident: weight loss, dehydration, pressure sores. This review is completed using the investigative protocols found below as a guide. (NOTE: All the residents selected for comprehensive reviews should have one or more of these concerns checked on the QM/QI reports [unless there are no residents with these concerns in the facility]); and

- An evaluation of the resident's dining experience (see Dining Observation Protocol below).

D. Focused Care Review Phase 1

This focused review includes observations, interviews, and a record review. This review focuses on care areas that were checked for the resident on the Resident Level Summary and any additional care items checked by the team as pertinent to the resident, e.g., all areas that are checked on the Roster/Sample Matrix by the team for the resident are reviewed, whether or not they have been highlighted as concerns for the survey. The dining observation is done for a resident if the resident has any checkmarks related to dining or the investigating team member has any concerns about the resident related to dining, e.g., such as weight loss.

The Phase 1 focused care review includes all care areas the team has checked for the resident: a review of the MDS, the facility's use of the RAPs, care planning, implementation of the care plan, and the resident's response to the care provided.

E. Focused Care Review Phase 2

This focused review includes observations, interviews and a record review, which concentrates only on those areas of concern for which the team requires additional information. For example, if the team needs additional information concerning facility compliance with the requirements for tube feeding, review only those RAI areas related to tube feeding; make observations of nutritional status, complications, and techniques of tube feeding, and interview residents, family and staff concerning related areas.

F. Closed Record Review

This includes a record review of the resident's care issues and transfer and discharge requirements. It may be possible to select some or all of the closed records from the preselected list of residents for the Phase 1 sample, if any of these preselected residents were noted onsite to be discharged or deceased.

Assess quality of care and quality of life requirements that relate to the identified care areas for the sampled resident. While assessing these, note and investigate concerns with any other requirements.

G. Conducting the Resident Review

The Resident Review consists of 4 main sections: Resident Room Review, Daily Life Review, Assessment of Drug Therapies, and Care Review. See Resident Review Worksheet and instructions (Form CMS-805, Exhibit 93) for specific areas to review.

1. Section A - The Resident Room Review assesses aspects of accommodation of needs, environmental quality, and quality of life in the resident's room. Through observations and interviews, evaluate how the resident's environment affects his/her quality of life.

2. Section B - The Daily Life Review is a review of the resident's daily quality of life, especially in the areas of staff responsiveness to resident grooming and other needs, staff interactions, choices, and activities. Through ongoing observations and interviews, evaluate the resident's daily life routines and interactions with staff.

3. Section C - The Assessment of Drug Therapies is a review of the medications the resident is receiving to evaluate whether the effectiveness of the therapeutic regimen, including all drugs that may play a significant role in the resident's everyday life, is being monitored and assessed. Record the information on the Resident Review Worksheet, Form CMS-805. Review and record, as pertinent, all non-prescription and prescription medications taken by the resident during the past 7 days. In addition follow the guidance in Appendix PP, Tag F329 for the determination of unnecessary medications.

4. Section D -- The care review is an assessment of those quality of care areas (see 42 CFR 483.25) that are pertinent to the sampled resident. The survey team, through use of the Roster/Sample Matrix, determines what care areas will be reviewed for each sampled resident. Additional areas for evaluation may be identified during the review.

   There are a designated number of comprehensive, focused and closed record care reviews completed, depending on the size of the sample.

H. Care Observations and Interviews -- Make resident observations and conduct interviews, which include those factors or care areas as determined by the Roster/Sample Matrix. For example, if the resident was chosen because he/she is receiving tube feedings, observe the care and the outcomes of the interventions, facility monitoring and assessment, and nutritional needs/adequacy related to tube feeding.

Complete the following tasks:

- Observe the resident and caregivers during care and treatments, at meals, and various times of the day, including early morning and evening, over the entire survey period. Observe residents in both informal and structured settings, e.g., receiving specialized rehabilitation services, participating in formal and informal activities. Also, observe staff-resident interactions;

- Gather resident-specific information, including information on the resident's functional ability, potential for increasing ability, and any complications concerning special care needs;

- Evaluate implementation of the care plan. Determine if the care plan is consistently implemented by all personnel at all times of the day, and if the care plan is working for the resident. If the care plan is not working, look for evidence that the facility has identified this and acted on it even if the care plan has not formally been revised;

- Determine if there is a significant difference between the facility's assessment of the resident and observations; and

- Evaluate the adequacy of care provided to the resident using the Guidance to Surveyors.

Do not continue to follow residents once enough information has been accrued to determine whether the resident has received care in accordance with the regulatory requirements.

If there are indicators to suggest the presence of a quality of care problem that is not readily observable, e.g., a leg ulcer covered with a dressing, or a sacral pressure sore, ask facility staff to assist in making observations by removing, for example, a dressing or bedclothes.

Resident care observations should be made by those persons who have the clinical knowledge and skills to evaluate compliance.

When observing residents, respect their right to privacy, including the privacy of their bodies. If the resident's genital or rectal area or female breast area must be observed in order to document and confirm suspicions of a care problem, a member of the nursing staff must be present at this observation, and the resident must give clear consent.

If the resident is unable to give consent, e.g., is unresponsive, incompetent, and a legal surrogate (family member who can act on the resident's behalf or legal representative as provided by State law) is present, ask this individual to give consent.

An observation of a resident's rectal or genital area (and for females, the breast area) may be made without a resident's or legal surrogate's consent, under the following conditions:

1. It is determined that there is a strong possibility that the resident is receiving less than adequate care, which can only be confirmed by direct observation;

2. The resident is unable to give clear consent; and

3. A legal surrogate is not present in the facility.

Only a surveyor who is a licensed nurse, a physician's assistant or a physician may make an observation of a resident's genitals, rectal area, or, for females, the breast area.

I. Record Review

Conduct a record review to provide a picture of the current status of the resident as assessed by the facility; information on changes in the resident's status over the last 12 months for those areas identified for review; and information on planned care, resident goals, and expected outcomes.

Use the record review to help determine whether the assessments accurately reflect the resident's status and are internally consistent. An example of inconsistency may be that the facility assessed the resident's ADLs as being independently performed yet had indicated that the resident requires task segmentation for performing ADLs.

For sampled residents selected for either a comprehensive or a focused review, conduct a review of the RAI information including:

- The face sheet of the MDS for background information including customary routines and demographic information to provide an understanding of the resident prior to admission. This assists in assessing the quality of life of the resident.

- The latest MDS to determine which RAPS were triggered. For a sampled resident receiving a comprehensive review, note all triggered areas. Also, review the facility's assessment of the resident's level of functioning and note particularly drug therapy and cognitive, behavior, and ADL function. For a resident receiving a focused review in Phase I of the survey, review both the areas of concern specific to the resident and the other care areas that have been identified with the Roster/Sample Matrix. For Phase 2 residents, review only those areas that have been identified by the team as areas of concern.

If the RAI is less than 9 months old, review and compare with the previous RAI and the most recent quarterly review. If the RAI is 9 months or older, compare the current RAI with the most recent quarterly review. Review the following:

- The RAP summary sheet to see where the assessment documentation is located for any RAP triggered;

- The information summarizing the assessments (RAPS) and decision to proceed or not to proceed to care planning. Determine if the assessments indicate that the facility used the RAPs and considered the nature of the problem, the causal and risk factors, the need for referrals, complications, and decisions for care planning. If this is a reassessment, review whether the facility determined if the care plan required revision or was effective in moving the resident toward his/her goals;

- The care plan to identify whether the facility used the RAI to make sound care planning decisions. Determine whether the facility identified resident strengths, needs, and problems which needed to be addressed to assist the resident to maintain or improve his/her current functional status. Determine whether the facility identified resident-

centered, measurable goals and specific interventions to achieve those goals. With observations, interviews, and record review, determine if the facility implemented the interventions defined; and

- Determine whether the facility documentation and resident status as observed indicate the decision to proceed or not to proceed to care planning was appropriate. This information will assist in determining whether a resident's decline or failure to improve was avoidable or unavoidable.

- It is not necessary to review the entire resident record. Review only those sections that are necessary to verify and clarify the information necessary to make compliance decisions. These sections may include, for example, laboratory reports, progress notes, and drug regimen review reports.

- In any care area in which it is determined that there has been a lack of improvement, a decline, or failure to reach highest practicable well being, assess if the change for the resident was avoidable or unavoidable. Note both the faulty facility practice and its effect on resident(s). Determine if a reassessment based on significant change should have been conducted, and if the absence of reassessment contributed to the resident's decline or lack of improvement.

- Verify that the information needed has been obtained to determine if the facility fulfilled its obligation to provide care that allowed the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

NOTE: When conducting either a focused or comprehensive review, if there are areas of concern which fall outside the care areas identified, investigate these, as necessary.

The following are special investigative protocols which should be used in Task 5C to gather information and in Task 6, to determine facility compliance in the care areas of pressure sore/ulcer(s), hydration, unintended weight loss, sufficient nursing staffing, and dining and food services.

NOTE: "Although the RAI assessments discussed in the following [investigative protocols] must occur at specific times, by Federal regulation, a facility's obligation to meet each resident's needs through ongoing assessment is not neatly confined to these mandated time frames. Likewise, completion of the RAI in the prescribed time frame does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facility's are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI." ("CMS Long-Term Care Facility Resident Assessment Instrument User's Manual," Version 2.0.)

Investigative Protocol

Hydration

Objectives:

- To determine if the facility identified risk factors which lead to dehydration and developed an appropriate preventative care plan; and

- To determine if the facility provided the resident with sufficient fluid intake to maintain proper hydration and health.

Task 5C: Use:

Use this protocol for the following situations:

- A sampled resident who flagged for the sentinel event of dehydration (QM/QI 7.3);

- A sampled resident who has one or more of the following QM/QI conditions:

    - 5.4 – Prevalence of fecal impaction;

    - 6.1 – Residents with a urinary tract infection;

    - 7.1 – Residents who lose too much weight;

    - 7.2 – Prevalence of tube feeding;

    - 9.1 – Residents whose need for help with daily activities has increased; and

    - Any of the three pressure ulcer QM/QIs: 12.1, 12.2, or 13.3.

- A sampled resident who was discovered to have any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious processes, dependence on staff for the provision of fluid intake, use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphagia, a history of refusing fluids, limited fluid intake or lacking the sensation of thirst.

Procedures:

- Observations/interviews conducted as part of this procedure should be recorded on the Forms CMS-805 and/or the Form CMS-807.

- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and whether there were abnormal laboratory test values which may be an indicator of dehydration.

    NOTE: A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for

residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires. If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?

- Observe the care delivery to determine if the interventions identified in the care plan have been implemented as described.

    - What is the resident's response to the interventions? Does staff provide the necessary fluids as described in the plan? Do the fluids provided contribute to dehydration, e.g., caffeinated beverages, alcohol? Was the correct type of fluid provided with a resident with dysphagia?

    - Is the resident able to reach, pour and drink fluids without assistance and is the resident consuming sufficient fluids? If not, are staff providing the fluids according to the care plan?

    - Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?

    - If the resident refuses water, are alternative fluids offered that are tolerable to the resident?

    - Are the resident's beverage preferences identified and honored at meals?

    - Does staff encourage the resident to drink? Are they aware of the resident's fluid needs? Are staff providing fluids during and between meals?

    - Determine how the facility monitors to assure that the resident maintains fluid parameters as planned. If the facility is monitoring the intake and output of the resident, review the record to determine if the fluid goals or calculated fluid needs were met consistently.

- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident, should know of, or be able to provide information about the causes of a resident's condition or problem.

    NOTE: If a resident is at an end of life stage and has an advance directive, according to State law, (or a decision has been made by the resident's surrogate or representative, in accordance with State law) or the resident has reached an end

of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute noncompliance with the requirement for hydration. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with 42 CFR 483.25, F309, Quality of Care.

- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.25(j), F327, Hydration:
    - For this resident, the facility is compliant with this requirement to maintain proper hydration if they properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, cite at F327.

- Compliance with 42 CFR 483.20(b)(1) & (2), F272, Comprehensive Assessments:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they assessed factors that put the resident at risk for dehydration, whether chronic or acute. If not, cite at F272.

- Compliance with 42 CFR 483.20(k)(1), F279, Comprehensive Care Plans:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they developed a care plan that includes measurable objectives and timetables to meet the resident's needs as identified in the resident's assessment. If not, cite at F279.

- Compliance with 42 CFR 483.20(k)(3)(ii), F 282, Provision of care in accordance with the care plan:
    - For this resident in the area of hydration, the facility is compliant with this requirement if qualified persons implemented the resident's care plan. If not, cite at F282.

Investigative Protocol

Dining and Food Service

Objectives:

- To determine if each resident is provided with nourishing, palatable, attractive meals that meet the resident's daily nutritional and special dietary needs;

- To determine if each resident is provided services to maintain or improve eating skills; and

- To determine if the dining experience enhances the resident's quality of life and is supportive of the resident's needs, including food service and staff support during dining.

Task 5C: Use

This protocol will be used for:

- All sampled residents identified with malnutrition, unintended weight loss, mechanically altered diet, pressure sores/ulcers, and hydration concerns; and

- Food complaints received from residents, families and others.

General Considerations:

- Use this protocol at two meals during the survey, preferably the noon and evening meals.

- Record information on the Form CMS-805 if it pertains to a specific sampled resident, or on the Form CMS-807 if it relates to the general observations of the dining service/dining room.

    - Discretely observe all residents, including sampled residents, during meals keeping questions to a minimum to prevent disruption in the meal service.

- For each sampled resident being observed, identify any special needs and the interventions planned to meet their needs. Using the facility's menu, record in writing what is planned in writing to be served to the resident at the meal observed.

- Conduct observations of food preparation and quality of meals.

Procedures:

1. During the meal service, observe the dining room and/or resident's room for the following:

    - Comfortable sound levels;

    - Adequate illumination, furnishings, ventilation; absence of odors; and sufficient space;

- Tables adjusted to accommodate wheelchairs, etc.; and

- Appropriate hygiene provided prior to meals.

2. Observe whether each resident is properly prepared for meals. For example:

    - Resident's eyeglasses, dentures, and/or hearing aids are in place;

    - Proper positioning in chair, wheelchair, gerichair, etc., at an appropriate distance from the table (tray table and bed at appropriate height and position); and

    - Assistive devices/utensils identified in care plans provided and used as planned.

3. Observe the food service for:

    - Appropriateness of dishes and flatware for each resident. Single use disposable dining ware is not used except in an emergency and, other appropriate dining activities. Except those with fluid restriction, each resident has an appropriate place setting with water and napkin;

    - Whether meals are attractive, palatable, served at appropriate temperatures and are delivered to residents in a timely fashion.

        - Did the meals arrive 30 minutes or more past the scheduled mealtime?

        - If a substitute was needed, did it arrive more than 15 minutes after the request for a substitute?

    - Are diet cards, portion sizes, preferences, and condiment requests being honored?

4. Determine whether residents are being promptly assisted to eat or provided necessary assistance/cueing in a timely manner after their meal is served.
    - Note whether residents at the same table or in resident rooms, are being served and assisted concurrently.

    - If you observe a resident who is being assisted by a staff member to eat or drink, and the resident is having problems with eating or drinking, inquire if the staff member who is assisting them is a paid feeding assistant. If so, follow the procedures at tag F373.

5. Determine if the meals served were palatable, attractive, nutritious and met the needs of the resident. Note the following:

    - Whether the resident voiced concerns regarding the taste, temperature, quality, quantity and appearance of the meal served;

- Whether mechanically altered diets, such as pureed, were prepared and served as separate entree items (except when combined food, e.g., stews, casseroles, etc.);

- Whether attempts to determine the reason(s) for the refusal and a substitute of equal nutritive value was provided, if the resident refused/rejected food served; and

- Whether food placement, colors, and textures were in keeping with the resident's needs or deficits, e.g., residents with vision or swallowing deficits.

Sample Tray Procedure

If residents complain about the palatability/temperature of food served, the survey team coordinator may request a test meal to obtain quantitative data to assess the complaints. Send the meal to the unit that is the greatest distance from the kitchen or to the affected unit or dining room. Check food temperature and palatability of the test meal at about the time the last resident on the unit is served and begins eating.

6. Observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does not prohibit the administration of medications during meal service for medications that are necessary to be given at a meal, nor does this prohibit a medication to be given during a meal upon request of a resident who is accustomed to taking the medication with the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

    - Has the facility attempted to provide medications at times and in a manner to support the dining experience of the resident, such as:

        - Pain medications being given prior to meals so that meals could be eaten in comfort;

        - Foods served are not routinely or unnecessarily used as a vehicle to administer medications (mixing the medications with potatoes or other entrees).

7. Determine if the sampled resident consumed adequate amounts of food as planned.

    - Determine if the facility is monitoring the foods/fluids consumed. Procedures used by the facility may be used to determine percentage of food consumed, if available; otherwise, determine the percentage of food consumed using the following point system:

        - Each food item served except for water, coffee, tea, or condiments equals one point. Example: Breakfast: juice, cereal, milk, bread and butter, coffee (no points) equals four points. If the resident consumes all four items in the amount served, the resident consumes 100% of breakfast. If the resident consumes two of the four food items served, then 50% of the breakfast would have been consumed.

If three-quarters of a food item is consumed, give one point; for one-half consumed, give .5 points; for one- fourth or less, give no points. Total the points consumed x 100 and divide by the number of points given for that meal to give the percentage of meal consumed. Use these measurements when determining the amount of liquids consumed: Liquid measurements: 8 oz. cup = 240 cc, 6 oz. cup = 180 cc, 4 oz. cup = 120 cc, 1 oz. cup = 30 cc.

- Compare these findings with the facility's documentation to determine if the facility has accurately recorded the intake. Ask the staff if these findings are consistent with the resident's usual intake; and

- Note whether plates are being returned to the kitchen with 75% or more of food not eaten.

8. If concerns are noted with meal service, preparation, quality of meals, etc., interview the person(s) responsible for dietary services to determine how the staff are assigned and monitored to assure meals are prepared according to the menu, that the meals are delivered to residents in a timely fashion, and at proper temperature, both in the dining rooms/areas and in resident rooms.

NOTE: If concerns are identified in providing monitoring by supervisory staff during dining or concerns with assistance for residents to eat, evaluate nursing staffing in accord with 42 CFR 483.30(a), F353, and quality of care at 42 CFR 483.25(a)(2) and (3).

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.35(d)(1)(2), F364, Food

  - The facility is compliant with this requirement when each resident receives food prepared by methods that conserve nutritive value, palatable, attractive and at the proper temperatures. If not, cite F364.

- Compliance with 42 CFR 483.35(b), F362, Dietary services, sufficient staff

  - The facility is compliant with this requirement if they have sufficient staff to prepare and serve palatable and attractive, nutritionally adequate meals at proper temperatures. If not, cite F362.

  NOTE: If serving food is a function of the nursing service rather than dietary, refer to 42 CFR 483.30(a), F353.

- Compliance with 42 CFR 483.15(h)(1), F252, Environment

- The facility is compliant with this requirement if they provide a homelike environment during the dining services that enhances the resident's quality of life. If not, cite F252.

- Compliance with 42 CFR 483.70(g)(1)(2)(3)(4), F464, Dining and Resident Activities

  - The facility is compliant with this requirement if they provide adequate lighting, ventilation, furnishings and space during the dining services. If not, cite F464.

Investigative Protocol

Nursing Services, Sufficient Staffing

Objectives:

- To determine if the facility has sufficient nursing staff available to meet the residents' needs.

- To determine if the facility has licensed registered nurses and licensed nursing staff available to provide and monitor the delivery of resident care.

Task 5C: Use:

NOTE: This protocol is not required during the standard survey, unless it is triggered in the event of care concerns/problems which may be associated with sufficiency of nursing staff. It is required to be completed for an extended survey.

This protocol is to be used when:

- Quality of care problems have been identified, e.g., residents not receiving the care and services to prevent pressure sore/ulcer(s), unintended weight loss and dehydration, and to prevent declines in their condition as described in their comprehensive plans of care, such as bathing, dressing, grooming, transferring, ambulation, toileting, and eating; and

- Complaints have been received from residents, families or other resident representatives concerning services, e.g., care not being provided, call lights not being answered in a timely fashion, and residents not being assisted to eat.

Procedures:

- Determine if the registered/licensed nursing staff are available to:

  - Supervise and monitor the delivery of care by nursing assistants according to residents' care plans;

  - Assess resident condition changes;

- Monitor dining activities to identify concerns or changes in residents' needs;
- Respond to nursing assistants' requests for assistance;
- Correct inappropriate or unsafe nursing assistants techniques; and
- Identify training needs for the nursing assistants.

- If problems were identified with care plans/services not provided as needed by the resident, focus the discussion with supervisory staff on the situations which led to using the protocol: how do they assure that there are adequate staff to meet the needs of the residents; how do they assure that staff are knowledgeable about the needs of the residents and are capable of delivering the care as planned; how do they assure that staff are appropriately deployed to meet the needs of the residents; how do they provide orientation for new or temporary staff regarding the resident needs and the interventions to meet those needs; and how do they assure that staff are advised of changes in the care plan?

- Determine if nursing assistants and other nursing staff are knowledgeable regarding the residents' care needs, e.g., the provision of fluids and foods for residents who are unable to provide these services for themselves; the provision of turning, positioning and skin care for those residents identified at risk for pressure sore/ulcers; and the provision of incontinence care as needed;

- If necessary, review nursing assistant assignments in relation to the care and or services the resident requires to meet his/her needs;

- In interviews with residents, families and/or other resident representatives, inquire about the staff's response to requests for assistance, and the timeliness of call lights being answered; and

- Determine if the problems are facility-wide, cover all shifts or if they are limited to certain units or shifts, or days of the week. This can be based on information already gathered by the team with additional interviews of residents, families, and staff, as necessary.

Task 6: Determination of Compliance:

NOTE: Meeting the State-mandated staffing ratio, if any, does not preclude a deficiency of insufficient staff if the facility is not providing needed care and services to residents.

- Compliance with 42 CFR 483.30(a), F353, Sufficient Staff:

- The facility is compliant with this requirement if the facility has provided a sufficient number of licensed nurses and other nursing personnel to meet the needs of the residents on a 24-hour basis. If not, cite F353.

J. Closed Record Reviews

Closed records are included in the total resident sample. If possible, select closed records of residents who have been identified through the use of offsite information concerning a particular care issue. If there is a care area that is an identified concern, try to obtain the closed records of residents who had the same care needs before death, discharge, or transfer. Document information on the Form CMS-805, Sections C and D, as appropriate.

Look for information to determine compliance with quality of care and other requirements such as:

- Assessment and care of infections;
- Pressure sores;
- Significant weight loss;
- Restraints;
- Multiple falls or injuries;
- Discharge planning; and
- Transfer and discharge requirements.

Unless there is a reason to review the entire record, focus the review on the appropriateness of care and treatment surrounding the resident's discharge or transfer, and the events leading up to that discharge or transfer. For example, if the survey team has identified a concern with inadequate identification and care of residents with infections, and several residents have recently been hospitalized with serious infections, the review would be a focused review on the care and assessment these residents received before they were hospitalized. In addition:

- Look for documentation related to transfer, discharge, and bed-hold, including facility's discharge planning, notices, and reasons for facility-initiated moves, e.g., proper planning and transferring subsequent to a change in payor or care needs; and
- Determine if within 30 days of the death of a resident, the facility conveyed the deceased resident's personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate as provided by State law (see 42 CFR 483.10(c)(6), F160).

K. Review of Influenza and Pneumococcal Immunizations

Use the Investigative Protocol contained at Tag F334 to complete a review of the implementation of the facility's immunization policies and procedures.

L. Liability Notices and Beneficiary Appeal Rights

Medicare-participating long term care facilities are obligated to inform Medicare Part A and B beneficiaries about specific rights related to billing, and to submit bills to the Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) when requested by the beneficiary. In a Medicare-participating long term care facility, verify compliance with these requirements.

Listed below are the requirements of the Skilled Nursing Facility (SNF).

1. If a SNF provider believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services, and that an otherwise covered item or service may be denied as not reasonable and necessary, the facility must notify the resident or his/her legal representative in writing and explain:

    - Why these specific services may not be covered;
    - The beneficiary's potential liability for payment for the non-covered services;
    - The beneficiary right to have a claim submitted to Medicare; and
    - The beneficiary's standard claim appeal rights that apply if the claim is denied by Medicare.

    This notice requirement may be fulfilled by use of either the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (Form CMS-10055) **or** one of the five uniform Denial Letters. The SNFABN and the Denial Letters inform the beneficiary of his/her right to have a claim submitted to Medicare and advises them of the standard claim appeal rights that apply if the claim is denied by Medicare. These claims are often referred to as "demand bills" and are reviewed by the FI or MAC. (See Chapter 1, §60.3 of the Medicare Claims Processing Manual, Pub. 100-04 for detailed instructions on submitting institutional demand bills.) The SNF:

    - Must keep a copy of the SNFABN or Denial Notice on file;
    - Must file a claim when requested by the beneficiary; and
    - May not charge the resident for Medicare covered Part A services while a decision is pending.

2. The SNF must issue the Notice of Medicare Provider Non-coverage (Form CMS-10123) when there is a termination of all Medicare Part A services for coverage reasons. The Notice of Medicare Provider Non-coverage informs the beneficiary of his/her right to an expedited review of a service termination by the Quality Improvement Organization (QIO). The Notice to Medicare Provider Non-coverage is sometimes referred to as an "Expedited Appeal Notice" or a "Generic Notice." The SNF should not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the QIO cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for "coverage" reasons. The SNF:

    - Must keep a copy of the Notice of Medicare Provider Non-coverage on file;
    - Must file a claim when requested by the beneficiary; and
    - May not charge the resident for Medicare covered Part A services while a decision is pending.

    Failure to provide written liability of payment and/or appeal notice(s), to submit the bill (if requested by a resident), or to charge the resident for Medicare covered Part A services while a decision is pending may constitute a violation of the facility's provider agreement. Refer to S&C-09-20 or go to http://www.cms.hhs.gov/bni/ for more details about liability notices and resident appeal rights.

Procedure to Determine Compliance

1. During the entrance conference, obtain a list of Medicare beneficiaries who requested demand bills in the past 6 months. From the list, randomly select one resident's file to determine if the facility submitted the bill to the FI or MAC. In general, Medicare claims must be filed within one full calendar year following the year in which the services were provided. (For more information, refer to 42 CFR 424.44 and the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, General Billing Requirements, §70.1.) If the facility failed to submit the bill to the FI or MAC within the required time frame or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite Tag F492, 42 CFR 483.75(b), Compliance with Federal, State and local laws and professional standards, and refer to 42 CFR 489.21, Specific limitations on charges.

    NOTE: If no Medicare beneficiaries requested a demand bill in the past 6 months, this portion of the review is complete, and the surveyor should continue with the closed record review.

2. During closed record review, review three charts of discharged Medicare beneficiaries from the SNF. If the current closed record review sample does not include three Medicare beneficiaries discharged from the SNF, expand the sample. Look for a copy of appropriate liability and appeal notice(s). If the facility failed to provide the resident the appropriate

liability and/or appeal notice(s), the facility is in violation of the notice requirements. Cite Tag F156, 42 CFR 483.10, Resident Rights.

If the record indicates the resident requested the facility submit the bill for appeal, determine if the facility submitted the bill to the FI or MAC within the required time frame. In general, Medicare claims must be filed within one full calendar year following the year in which the services were provided. (For more information refer to 42 CFR 424.44 and the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, General Billing Requirements, §70.1.) If the facility failed to submit the bill to the FI or MAC within the required timeframe or charged the resident while the decision was pending, the facility is in violation of the provider agreement with respect to resident billing requirements. Cite Tag F492, 42 CFR 483.75(b), Compliance with Federal, State and local laws and professional standards, and refer to 42 CFR 489.21, Specific Limitations on Charges.