

MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: LTC-R Regional Directors
Section/Unit Managers

FROM: Marc Gold
Section Manager
Long Term Care-Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #98-18

DATE: February 5, 1999

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 98-18 -- Changes in the Nursing Home Survey and Certification Procedures; Call Elva Longoria, Program Specialist, Professional Services, at (512) 438-2345.

If you have any questions, please direct inquiries to the individuals or sections listed above.

~Original Signature on File~

Marc Gold

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Region VI
1301 Young Street, Room 833
Dallas, Texas 75202

September 22, 1998

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 98-18

To: All State Survey Agencies (Action)
All Title XIX Single State Agencies (Information)

Subject: Changes in the Nursing Home Survey and Certification Procedures

Your agency should have recently received a hardcopy of information which includes new State Operations Manual (SOM) issuances. Included are:

Sections 4145-4156.9.
Appendix P Guidance to Surveyors for F-272 through F-287,
Appendix R "Resident Assessment Instrument for Long Term Care Facilities,"
Appendix R Exhibits 254-258,
The new HCFA Form 672 ("Resident Census and Condition of Residents"),
New provider instructions for the HCFA Forms 672 and HCFA 802 ("Roster/Sample Matrix").

1. Surveyors are to begin using the two new State Operations Manual, Appendix P, F-272 through F-287 immediately. F-286 and F-287 are new tags. They are the resident assessment regulations and Guidance to Surveyors for 42 CFR 483.20(d) *Use* and (f) *Automated data processing requirement*. All the regulations are published requirements. The Guidance is to be used although it is a draft (for grammatical and punctuation review only). There is no change in the standard survey procedure. F-286 and F-287 will not routinely be surveyed unless there is an indication of problems during a standard survey. F-287 is to be handled as specified in the procedures enclosed in the Region VI-Dallas RS&C Letter 98-13. Although the only new regulatory language is at F-286 and F-287, there are changes in all the Guidance for F-272 through F-285 and surveyors **must** read this guidance.

2. The new HCFA 672 incorporates the new tags F-144 and F-145. Surveyors are to begin using the new HCFA 672 as soon as they receive it. By the time this data is ready to be entered in OSCARS that system will accommodate the new tags.

3. The new HCFA 672 and HCFA 802 provider instructions include the correct Minimum Data Set (MDS) crosswalk items. Surveyors should give these to providers as soon as they become available. Providers should be notified that some proprietary MDS software uses incorrect MDS items to automatically generate the HCFA 672 and HCFA 802 for surveys. Surveyors should continue to review the completed HCFA 672 and HCFA 802 for gross accuracy as well as for possible survey concerns.

4. Please inform your surveyors that they will begin to encounter additional full MDSs in the clinical records of Medicare residents. As Skilled Nursing Facilities (SNFs) move into the Prospective Payment System (PPS), additional MDSs are required. These are strictly for reimbursement and are called **Medicare** or **PPS full MDS assessments**. Surveyors should continue to look for and use the most recent Comprehensive Resident Assessment (Resident Assessment Instrument plus any additional needed assessments, e.g. nutrition) along with quarterly assessments and progress notes as they have in the past. Note that in PPS SNFs, the first (and only) quarterly

assessment will be a full MDS. Surveyors are to concern themselves only with the timeliness and accuracy of *clinical* assessments, i.e. annual, quarterly, and significant change assessments.

If you have any questions please contact CDR Daniel McElroy, Rn at 214-767-2077.

Thank you for your assistance.

Sincerely,

-Signature on File-

Molly Crawshaw, Acting Chief
Survey and Certification Operations

Enclosure

Note:

- A. The following attachments are in .pdf format. You will need the Adobe Acrobat Reader (TM) to read the documents.
- B. If you have the Acrobat Reader installed in your pc, just click on the .pdf file to view the document. Or you can click here to return to the document to continue
- C. If you don't have the Adobe Acrobat Reader installed in your pc, click here to download and follow the download instructions.
 - 1. RS&C 98-18c.pdf 14 pages long
 - 2. RS&C 98-18d.pdf 8 pages long
 - 3. RS&C 98-18e.pdf 4 pages long
- D. You will need to use your browser's back button to return to the document.
- E. To print the document, use Acrobat Reader's print icon

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
Refer to F272	<p>§483.20: <u>Resident Assessment.</u></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>	<p><u>§483.20 Intent:</u></p> <p>To provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status. The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to direct observation and communication with the resident, the facility should use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, family members, or outside consultants and review of the resident's record.</p>
F271	<p>(a) <u>Admission Orders.</u></p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p>	<p><u>§483.20(a) Intent:</u></p> <p>To ensure the resident receives necessary care and services.</p> <p><u>§483.20(a) Guidelines:</u></p> <p>"Physician orders for immediate care" are those written orders facility staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. These orders should, at a minimum, include dietary, drugs (if necessary) and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.</p>

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F272	<p>(b) <u>Comprehensive assessments.</u></p> <p>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:</p> <p>(i) Identification and demographic information</p> <p>(ii) Customary routine.</p>	<p><u>§483.20(b) Intent:</u></p> <p>To ensure that the RAI is used in conducting comprehensive assessments as part of an ongoing process through which the facility identifies the resident's functional capacity and health status.</p> <p><u>§483.20(b) Guidelines:</u></p> <p>The information required in §483.20(b)(i-xvi) is incorporated into the MDS, which forms the core of each State's approved RAI. Additional assessment information is also gathered using triggered RAPs.</p> <p>Each facility must use its State specified RAI (which includes both the MDS and utilization guidelines which include the RAPs) to assess newly admitted residents, conduct an annual reassessment and assess those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission.</p> <p>"Identification and demographic information" corresponds to MDS v 2.0 Sections AA, BB and A, and refers to information that uniquely identifies each resident and the facility in which he/she resides, date of entry into the facility and residential history.</p> <p>"Customary routine" corresponds to MDS v 2.0 Section AC, and refers to information regarding the resident's usual community lifestyle and daily routine in the year prior to the date of entry to the nursing home.</p>

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F272	<p>(iii) Cognitive patterns.</p> <p>(iv) Communication.</p> <p>(v) Vision.</p> <p>(vi) Mood and behavior patterns.</p> <p>(vii) Psychosocial well-being</p> <p>(viii) Physical functioning and structural problems.</p> <p>(ix) Continence.</p> <p>(x) Disease diagnosis and health conditions.</p>	<p>“Cognitive patterns” (iii) corresponds to MDS v. 2.0 Section B. “Cognitive patterns” is defined as the resident’s ability to problem solve, decide, remember, and be aware of and respond to safety hazards.</p> <p>“Communication” (iv) corresponds to MDS v. 2.0 Section C, and refers to the resident’s ability to hear, understand others, make him or herself understood (with assistive devices if they are used).</p> <p>“Vision” (v) corresponds to MDS v. 2.0 Section D, and I.1.jj, kk, ll and mm, and refers to the resident’s visual acuity, limitations and difficulties, and appliances used to enhance vision.</p> <p>“Mood and behavior patterns” (vi) corresponds to MDS v. 2.0 Section E, and refers to the resident’s patterns of mood and behavioral symptoms.</p> <p>“Psychosocial well-being” (vii) corresponds to MDS v. 2.0 Sections E1o and p, and F and refers to the resident’s positive or negative feelings about him or herself or his/her social relationships.</p> <p>“Physical functioning and structural problems” (viii) corresponds to MDS v. 2.0 Section G, and refers to the resident’s physical functional status, ability to perform activities of daily living, and the resident’s need for staff assistance and assistive devices or equipment to maintain or improve functional abilities.</p> <p>“Continence” (ix) corresponds to MDS v. 2.0, Section H, and refers to the resident’s patterns of bladder and bowel continence (control), pattern of elimination, and appliances used.</p> <p>“Disease diagnoses and health conditions” (x) corresponds to MDS v. 2.0, Sections AB.9 and 10, I.1 and 2, and J.</p>

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	<p>(xv) Special treatments and procedures.</p> <p>(xvi) Discharge potential.</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.</p> <p>(xviii) Documentation of participation in assessment.</p>	<p>"Special treatments and procedures" (xv) corresponds to MDS v. 2.0 Sections K5, M5, and P1, and Section T, if completed.</p> <p>"Special treatments and procedures" refers to treatments and procedures that are <u>not</u> part of basic services provided. For example, treatment for pressure sores, nasogastric feedings, specialized rehabilitation services, respiratory care, or devices and restraints.</p> <p>"Discharge potential" (xvi) corresponds to MDS v. 2.0 Section Q.</p> <p>"Discharge potential" refers to the facility's expectation of discharging the resident from the facility within the next 3 months.</p> <p>"Documentation of summary information (xvii) regarding the additional assessment performed through the resident assessment protocols (RAPs)" corresponds to MDS v. 2.0 Section V, and refers to documentation concerning which RAPs have been triggered, documentation of assessment information in support of clinical decision making relevant to the RAP, documentation regarding where, in the clinical record, information related to the RAP can be found, and for each triggered RAP, whether the identified problem was included in the care plan.</p> <p>"Documentation of participation in the assessment" corresponds to MDS v. 2.0 Section R, and refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p>
F273	<p>(2) <i>when required</i>. A facility must conduct a comprehensive assessment of a resident as follows:</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p>	<p><u>§483.20(b)(2) Intent:</u></p> <p>To assess residents in a timely manner.</p>

GUIDANCE TO SURVEYORS

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F274	<p>(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p>	<p><u>§483.20(b)(2)(ii) Guidelines:</u></p> <p>The following are the criteria for significant changes:</p> <p>A significant change reassessment is generally indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement:</p> <p><u>Decline:</u></p> <ul style="list-style-type: none"> o Any decline in activities of daily living (ADL) physical functioning where a resident is newly coded as 3, 4 or 8 Extensive assistance, Total dependency, Activity did not occur (note that even if coding in both columns A and B of an ADL category changes, this is considered 1 ADL change); o Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (e.g., an increase in the use of code 1's for E4B); o Resident's decision-making changes from 0 or 1, to 2 or 3; o Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter; o Emergence of sad or anxious mood as a problem that is not easily altered; o Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); o Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before; o Emergence of a condition/disease in which a resident is judged to be unstable;

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		<p>o Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or</p> <p>o Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision making).</p> <p><u>Improvement:</u></p> <p>o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8;</p> <p>o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered;"</p> <p>o Resident's decision making changes from 2 or 3, to 0 or 1;</p> <p>o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or</p> <p>o Overall improvement of resident's condition; resident receives fewer supports.</p> <p>If the resident experiences a significant change in status, the next annual assessment is not due until 366 days after the significant change reassessment has been completed.</p>
F275	(iii) Not less than once every 12 months	<p><u>\$483.20(b)(2)(iii) Guidelines:</u></p> <p>The annual resident assessment must be completed within 366 days after completion of the most recent comprehensive resident assessment.</p> <p><u>\$483.20(b)(2) Probes:</u></p> <p>o Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)?</p>

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		<ul style="list-style-type: none"> o Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or o Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision making). <p><u>Improvement:</u></p> <ul style="list-style-type: none"> o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered;" o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports. <p>If the resident experiences a significant change in status, the next annual assessment is not due until 366 days after the significant change reassessment has been completed.</p>
F275	(iii) Not less than once every 12 months	<p><u>§483.20(b)(2)(iii) Guidelines:</u></p> <p>The annual resident assessment must be completed within 366 days after completion of the most recent comprehensive resident assessment.</p> <p><u>§483.20(b)(2) Probes:</u></p> <ul style="list-style-type: none"> o Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)?

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		<ul style="list-style-type: none"> o Has the facility identified, in a timely manner, those residents who have experienced a change? o Has the facility reassessed residents using the State-specific RAI who had a significant change in status within 14 days after determining the change was significant. o Has the facility gathered supplemental assessment information based on triggered RAPs prior to establishing the care plan? o Does information in the RAI correspond with information obtained during observations of and interviews with the resident, facility staff and resident's family?
F276	<p>(c) <i>Quarterly review assessment.</i> A facility must assess a resident using the quarterly review instrument specified by the State and approved by HCFA not less frequently than once every 3 months.</p>	<p><u>§483.20(c) Intent:</u> To assure that the resident's assessment is updated on at least a quarterly basis.</p> <p><u>§483.20(c) Guidelines:</u> At least each quarter, the facility shall review each resident with respect to those MDS items specified under the State's quarterly review requirement. At a minimum, this would include all items contained in HCFA's standard quarterly review form. If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the significant change reassessment.</p> <p><u>§483.20(c) Probes:</u></p> <ul style="list-style-type: none"> o Is the facility assessing and acting, no less than once every 3 months, on the results of resident's functional and cognitive status examinations? o Is the quarterly review of the resident's condition consistent with information in the progress notes, the plan of care and your resident observations and interviews?

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F286	(d) <i>Use.</i> A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	<p><u>§483.20(d) Intent:</u></p> <p>Facilities are required to maintain 15 months of assessment data in the resident's active clinical record.</p> <p><u>§483.20(d) Guidelines:</u></p> <p>The requirement to maintain 15 months of data in the resident's active clinical record applies regardless of form of storage to all MDS forms, RAP Summary forms, Quarterly Assessment forms, Face Sheet Information and Discharge and Reentry Tracking Forms as required during the previous 15-month period.</p> <p>The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.</p> <p>After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency or HCFA surveyors.</p> <p>If the facility has a "paperless" system in which each resident's clinical record is entirely electronic, the facility does not need to maintain a hard copy of the forms. To qualify for this exception, the facility's MDS system must meet the following minimum criteria:</p> <ul style="list-style-type: none"> o The system must maintain 15 months' worth of assessment, Discharge and Reentry data and must be able to print all assessments, Discharge and Reentry forms for that period upon request; o The facility must have a back-up system to prevent data loss or damage; o The information must always be readily available and accessible to staff and surveyors; o The system must comply with requirements for safeguarding the confidentiality of clinical records; and,

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		<ul style="list-style-type: none"> o The facility must maintain evidence that identifies the Registered Nurse Assessment Coordinator and other staff members that completed a portion of the assessment.
Refer to F279	And use the results of the assessments to develop, review and revise the resident's comprehensive plan of care.	For guidance regarding the use of the results of the assessment (rather than storage), see guidance at F279.
Refer to F285	(e) <i>Coordination</i> . A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	<p><u>§483.20(e) Guidelines:</u></p> <p>With respect to the responsibilities under the PASRR program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.</p>
F287	<p>(f) <i>Automated data processing requirement</i>.</p> <p>(1) <i>Encoding Data</i>. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. 	<p><u>§483.20(f)(1-4) Intent:</u></p> <p>The intent is to enable a facility to better monitor a resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data. The primary purpose of maintaining the assessment data is so a facility can monitor resident progress over time. The information should be readily available at all times.</p> <p><u>§483.20(f)(1-4) Guidelines:</u></p> <p>"Encoding means entering MDS information into a computer.</p> <p>"Transmitting data" refers to electronically sending encoded MDS information, from the facility to the State database, using a modem and communications software.</p>

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	<p>(iv) Quarterly review assessments.</p> <p>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.</p> <p>(vi) Background (face-sheet) information, if there is no admission assessment.</p> <p>(2) <i>Transmitting data.</i> Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State.</p> <p>(3) <i>Monthly transmittal requirements.</i> A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:</p>	<p>"Capable of transmitting" means that the facility has encoded, edited according to HCFA specifications, and locked the record, and the record is ready for transmission.</p> <p>"Passing standard edits" means that the encoded responses to MDS items are consistent and within range, in accordance with HCFA specified standards. In general, inconsistent responses are either not plausible or ignore a skip pattern on the MDS. An example of inconsistency would be if one or more MDS items on a list were checked as present, and the "None of the Above" response was also checked for the same list. Out of range responses are invalid responses, such as using a response code of 2 for an MDS item for which the valid responses are zero or 1.</p> <p>"Monthly" means no more than 31 days.</p> <p>"Accurate" means that the encoded MDS data matches the MDS form in the clinical record.</p> <p>"Complete" means that all items required according to the record type, and in accordance with HCFA's record specifications and State required edits are in effect at the time the record is completed.</p> <p>In accordance with the final rule, facilities will be responsible to edit the encoded MDS data to ensure that it meets the standard edit specifications.</p>

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	<p>(i) Admission assessment.</p> <p>(ii) Annual assessment.</p> <p>(iii) Significant change in status assessment.</p> <p>(iv) Significant correction of prior full assessment.</p> <p>(v) Significant correction of prior quarterly assessment.</p> <p>(vi) Quarterly review.</p> <p>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.</p> <p>(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.</p> <p>(4) <i>Data format.</i> The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.</p>	<p>We encourage facilities to use software that has a programmed capability to automatically edit MDS records according to HCFA's edit specifics.</p> <p>For §483.20(f)(1)(v), the subset of items required upon a resident's transfer, discharge, and death are contained in the Discharge Tracking form and the items required for reentry are contained in the Reentry Tracking form. Refer to Appendix R for further information about the Discharge Tracking and Reentry Tracking forms.</p> <p>All nursing homes must computerize the MDS. Within 7 days of completing the assessment, the facility must:</p> <ul style="list-style-type: none"> o Encode the MDS and RAP summary in a machine readable format; o Run the encoded MDS through edits specified by HCFA. The facility must correct any information on the encoded MDS that does not pass HCFA-specified edits. <p>Within 7 days of completing the assessment, the facility must be able to transmit the edited MDS and RAP Summary form to the State according to State or Federal timeframes. Therefore, the facility must:</p> <ul style="list-style-type: none"> o Lock the edited MDS record; (In accordance with the clinical process, "locking" means that a record has been closed, and no additional changes may be made. Facility software should have an automated way of handling the clinical concept of when records are closed.) o Certify that the MDS meets HCFA-specified edits; and o Print the edited MDS and RAP Summary form and place them in the resident's record. The hard copy of the assessment must match the assessment that the facility transmits to the State. If a hard copy already exists, the facility must correct the hard copy to reflect the changes associated with the edit correction process.

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		<p>Unless all charting is computerized, the facility should maintain RAI assessments as a part of the resident's clinical record. However, if a facility has a "paperless" system in which each resident's clinical record is entirely electronic, the facility does not need to maintain a hard copy of the MDS. To qualify for this exception, the facility's MDS system must meet the following minimum criteria:</p> <ul style="list-style-type: none"> o The system must maintain 15 months' worth of assessment data (as required in §483.20(k) and must be able to print all assessments for the period upon request; o The facility must have a backup system to prevent data loss or damage; o The information must always be readily available and accessible to staff and surveyors; and o The system must comply with requirements for safeguarding the confidentiality of clinical records. <p>Furthermore, the facility must maintain evidence that identifies the Registered Nurse Assessment Coordinator and other staff members that completed a portion of the assessment.</p> <p>A facility must complete and submit to the State a subset of items when the resident is discharged from the facility (discharge tracking forms), or readmitted to the facility (reentry tracking forms).</p>
Refer to F516	<p>(5) <i>Resident-identifiable information.</i></p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p>	<p><u>§483.20(f)(5) Guidelines</u></p> <p>Automated RAI data are part of a resident's clinical record and as such are protected from improper disclosure by facilities under current law. Facilities are required by sections 1819(c)(1)(A)(iv) and 1919(c)(1)(A)(iv) of the Act and 42 CFR Part 483.75(l)(3) and (l)(4), to keep confidential all information contained in the resident's record and to maintain safeguards against the unauthorized use of a resident's clinical record information, regardless of the storage method of the records.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

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

A. Bowel/Bladder Status

- F94 _____ With indwelling or external catheter
- F95 Of total number of residents with catheters, _____ were present on admission.
- F96 _____ Occasionally or frequently incontinent of bladder -
- F97 _____ Occasionally or frequently incontinent of bowel
- F98 _____ On individually written bladder training program
- F99 _____ On individually written bowel training program

B. Mobility

- F100 _____ Bedfast all or most of time
- F101 _____ In chair all or most of time
- F102 _____ Independently ambulatory
- F103 _____ Ambulation with assistance or assistive device
- F104 _____ Physically restrained
- F105 Of total number of residents restrained, _____ were admitted with orders for restraints.
- F106 _____ With contractures
- F107 Of total number of residents with contractures, _____ had contractures on admission.

C. Mental Status

- F108 _____ With mental retardation
- F109 _____ With documented signs and symptoms of depression
- F110 _____ With documented psychiatric diagnosis (exclude dementias and depression)
- F111 _____ Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type
- F112 _____ With behavioral symptoms
- F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program _____.
- F114 _____ Receiving health rehabilitative services for MI MR

D. Skin Integrity

- F115 _____ With pressure sores (exclude Stage I)
- F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? _____.
- F117 _____ Receiving preventive skin care
- F118 _____ With rashes

Resident Census and Conditions of Residents

E. Special Care	
F119 ___ Receiving hospice care benefit	F127 ___ Receiving suctioning
F120 ___ Receiving radiation therapy	F128 ___ Receiving injections (exclude vitamin B12 injections)
F121 ___ Receiving chemotherapy	F129 ___ Receiving tube feedings
F122 ___ Receiving dialysis	F130 ___ Receiving mechanically altered diets including pureed and all chopped food (not only meat)
F123 ___ Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion	F131 ___ Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)
F124 ___ Receiving respiratory treatment	F132 ___ Assistive devices while eating
F125 ___ Receiving tracheostomy care	
F126 ___ Receiving ostomy care	
<hr/>	
F. Medications	G. Other
F133 ___ Receiving any psychoactive medication	F140 ___ With unplanned significant weight loss/gain
F134 ___ Receiving antipsychotic medications	F141 ___ Who do not communicate in the dominant language of the facility (include those who use sign language)
F135 ___ Receiving antianxiety medications	F142 ___ Who use non-oral communication devices
F136 ___ Receiving antidepressant medications	F143 ___ With advance directives
F137 ___ Receiving hypnotic medications	F144 ___ Received influenza immunization
F138 ___ Receiving antibiotics	F145 ___ Received pneumococcal vaccine
F139 ___ On pain management program	

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

Signature of Person Completing the Form	Title	Date

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? Yes No

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

F148 Medication error rate ___ %

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form HCFA 672)

GENERAL INSTRUCTIONS

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

There is not a federal requirement for automation of the 672 form. The facility may continue to complete the 672 with manual methods. The facility may use the MDS data to start the 672 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the 672 to represent current resident status according to the definitions of the 672. Since the census is designed to be representation of the facility during the survey, it does not directly correspond to the MDS in every item.

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and or Medicaid certified beds). For the purpose of this form "residents" means residents in certified beds regardless of payor source.

Following the definition of each field, the related MDS 2.0 codes and instructions will be noted within square brackets ([]).

Where coding refers to the admission assessment, use the first assessment done after the most recent admission or readmission event.

Complete each item by specifying the number of residents characterized by each category. If no residents fall into a category enter a "0".

INSTRUCTIONS AND DEFINITIONS

Provider No. - Enter the facility's assigned provider number. Leave blank for initial certifications.

Block F75 - Enter the number of facility residents, whose primary payer is Medicare. [code manually]

Block F76 - Enter the number of facility residents, whose primary payer is Medicaid. [code manually]

Block F77 - Enter the number of facility residents, whose primary payer is neither Medicare nor Medicaid. [code manually]

Block F78 - Enter the number of total residents for whom a bed is maintained, on the day the survey begins, including those temporarily away in a hospital or on leave. [Total residents in nursing facility or on bedhold]

ADLS (F79 - F93)

To determine resident status, unless otherwise noted, consider the resident's condition for the 7 days prior to the survey. [Horizontal totals must equal the number in F78; Manually re-code all "8" responses.]

Bathing F79 - F81

The process of bathing the body (excluding back and shampooing hair). This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. [F79: G2A = 0; F80: G2A = 1,2,3; F81: G2A = 4]

Many facilities routinely provide "setup" assistance to all residents such as drawing water for a tub bath or laying out bathing materials. If this is the case and the resident requires no other assistance, count the resident as independent.

Dressing F82 - F84

How the resident puts on, fastens, and takes off all items of street clothing, including donning or removing prostheses (e.g., braces and artificial limbs). [F82: G1Ag = 0; F83: F1Ag = 1,2,3; F84: G1Ag = 4]

Many facilities routinely set out clothes for all residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance with donning a brace, elastic stocking, a prosthesis and so on, securing fasteners, or putting a garment on, count the resident as needing the assistance of 1 or 2 staff.

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form HCFA 672)

Transferring F85 - F87

How the resident moves between surfaces, such as to and from the bed, chair, wheelchair or to and from a standing position. (EXCLUDE transfers to and from the bath or toilet). [F85: G1Ab = 0; F86: G1Ab = 1,2,3; F87: G1Ab = 4]

Many facilities routinely provide "setup" assistance to all residents, such as handing the equipment (e.g., sliding board) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use F88 - F90

How the resident uses the toilet room (or bedpan, bedside commode, or urinal). How resident transfers on and off toilet, cleans self after elimination, changes sanitary napkins, ostomy, external catheters, and adjusts clothing prior to and after using toilet. If all that is done for the resident is to open a package (e.g., a clean sanitary pad), count the resident as independent. [F88: G1Ai = 0; F89: G1Ai = 1,2,3; F90: G1Ai = 4]

Eating F91 - F93

How resident eats and drinks regardless of skill. Many facilities routinely provide "setup" activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the extent of assistance, count this resident as independent. [F91: G1Ah = 0; F92: G1Ah = 1,2,3; F93: G1Ah = 4]

A. BOWEL/BLADDER STATUS (F94 - F99)

F94 - With an indwelling or an external catheter - The number of residents whose urinary bladder is constantly drained by a catheter (e.g., a Foley catheter, a suprapubic catheter) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., a Texas catheter). [H3c or d = check]

F95 - Of the total number of residents with catheters - The number of residents who had a catheter present on admission. For a resident readmitted from a hospital with a catheter, count this resident as admitted with a catheter. [H3c or d = check and A8a=1 or A8b=1 or 5]

F96 - Occasionally or frequently incontinent of bladder - The number of residents who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. [H1b = 2,3 or 4 and H3c and d are not = check]

F97 - Occasionally or frequently incontinent of bowel - The number of residents who have a loss of bowel control two or more times per week. [H1a = 2,3 or 4]

F98 - On individually written bladder training program - The number of residents with a detailed plan of care to assist the resident to gain and maintain bladder control (e.g., pelvic floor exercises). Count all residents on training programs including those who are incontinent. [H3b = check]

F99 - On individually written bowel training program - The number of residents with a detailed plan of care to assist the resident to gain and maintain bowel control (e.g., use of diet, fluids, and regular schedule for bowel movements). Count all residents on training programs including those who are incontinent. [code manually.]

B. MOBILITY (F100 - F107)

[Total for F100-F103 should = F78; Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.]

F100 - Bedfast all or most of time - The number of residents who were in bed or recliner 22 hours or more per day in the past 7 days. Includes bedfast with bathroom privileges. [G6a = check and G5d is not = check]

F101 - In chair all or most of time - The number of residents who depend on a chair for mobility. Includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. [G5d = check]

F102 - Independently ambulatory - The number of residents who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. [G1ac = 0 and G1Ad = 0 and G5a is not = check]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form HCFA 672)

- F103 - Ambulation with assistance or assistive devices**
- The number of residents who required oversight, cueing, physical assistance or who used a cane, walker, crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. [G1Ac or d = 1, 2 or 3 or G5a = check]
- F104 - Physically restrained** - The number of residents whose freedom of movement and/or normal access to his/her body is restricted by any manual method or physical or mechanical device, material or equipment that is attached or adjacent to his/her body and cannot be easily removed by the resident. [Any P4c, d or e = 1 or 2]
- F105 - Of total number of restrained residents, number admitted or readmitted with an order for restraint.** [Code manually when criteria for F104 is met and P4c, d or e = 1 or 2 and A8a=1 or A8b=1 or 5]
- F106 - With contractures** - The number of residents that have a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc. Includes loss of range of motion in fingers, wrists, elbows, shoulders, hips, knees and ankles. [Any G4Aa, b, c, d, e or f = 1 or 2]
- F107 - Of total of residents with contractures, the number who had a contracture(s) on admission.** [Code when criteria for F106 is met on admission or re-admission assessment and A8a=1 or A8b=1 or 5.]
- C. MENTAL STATUS (F108 - F114)**
- F108 - With mental retardation** - Identify the total number of residents in all of the categories of developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. [Any AB10b, c, e or f = check]
- F109 - With documented signs and symptoms of depression** - The total number of residents with documented signs and symptoms of depression as defined by MDS (Mood and Behavior Section). [11ee = check or E1a, e, l or m > 0]
- F110 - With documented psychiatric diagnosis (exclude dementias and depression)** - The number of residents with primary or secondary psychiatric diagnosis including:
- Schizophrenia
 - Schizo-affective disorder
 - Schizophreniform disorder
 - Delusional disorder
 - Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, and atypical psychosis). [11dd, ff, or gg = check. Code manually for other psychiatric diagnoses listed here]
- F111 - Dementia: Multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type** - The number of residents with a primary or secondary diagnosis of dementia or organic mental syndrome including multi-infarct, senile type, Alzheimer's type, or other than Alzheimer's type. [11q or u = check]
- F112 - With behavioral symptoms** - The number of residents with one or more of the following symptoms: wandering, verbally abusive, physically abusive, socially inappropriate disruptive, resistive to care. (See MDS Section (Mood and Behavioral Patterns)). [Any E4Aa, b, c, d or e = 1, 2 or 3]
- F113 - Of the total number with behavioral symptoms, the number receiving a behavior management program.** The number of residents with behavior symptoms who are receiving an individualized care plan/program designed to address behavioral symptoms (as listed above). [Manually code when criteria for F112 is met and P2a = check and P2c or d = check]
- F114 - Receiving health rehabilitative services for MI/MR** - The number of residents for whom the facility is providing health rehabilitative services for MI/MR as defined at 483.45(a). [Use item for Residents who meet F108 or F110, then code manually]
- D. SKIN INTEGRITY (F115 - F118)**
- F115 - With pressure sores** - The number of residents with ischemic ulcerations and/or necrosis of tissues overlying a bony prominence (exclude Stage I). [Any M1b, c or d > 0 or M2a > 1 Code for first assessment after latest admission or re-admission]
- F116 - Of the total number of residents with pressure sores excluding Stage I, the number who had pressure sores on admission or who were readmitted with a new pressure sore (exclude Stage I).** [Code when criteria for field 115 are met and A8a=1 or A8b=1 or 5.]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form HCFA 672)

- F117 - Receiving preventive skin care** - The number of residents receiving non-routine skin care provided according to a physician's order, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.) [Any M5a,b,c,d,e,f,g,h, or i = check]
- F118 - With rashes** - Enter the number of residents who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., but not limited to antifungals, corticosteroids, emollients, diphenhydramines or scabidulids, etc.) [M4d = check]
- E. SPECIAL CARE (F119 - F132)**
- F119 - Receiving hospice care** - Number of residents who have elected or are currently receiving the hospice benefit. [P1ao = check]
- F120 - Receiving radiation therapy** - The number of residents who are under a treatment plan involving radiation therapy. [P1ah = check]
- F121 - Receiving chemotherapy** - The number of residents under a specific treatment plan involving chemotherapy. [P1aa = check]
- F122 - Receiving dialysis** - The number of residents receiving hemodialysis or peritoneal dialysis either within the facility or offsite. [P1ab = check]
- F123 - Receiving intravenous therapy, IV nutritional feedings and/or blood transfusion** - The number of residents receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. [K5a = check or P1ac = check or P1ak = check]
- F124 - Receiving respiratory treatment** - The number of residents receiving treatment by the use of respirators, ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheotomy care or respiratory suctioning. [P1ag = check or P1al = check or P1bdA > 0]
- F125 - Receiving tracheotomy care** - The number of residents receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. [P1aj = check]
- F126 - Receiving ostomy care** - The number of residents receiving care for a colostomy, ileostomy, uretostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheotomy. [P1af = check]
- F127 - Receiving suctioning** - The number of residents that require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the mouth, nasal passage, or tracheotomy stoma. [P1ai = check]
- F128 - Receiving injections** - The number of residents that have received one or more injections within the past 7 days. (Exclude injections of Vitamin B12.) [Review residents for whom O3 = 1,2,3,4,5,6 or 7. Omit from count any resident whose only injection currently is B12.]
- F129 - Receiving tube feeding** - The number of residents who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). [K5b = check]
- F130 - Receiving mechanically altered diets** - The number of residents receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). [K5c = check]
- F131 - Receiving rehabilitative services** - The number of residents receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist. (Exclude health rehab. for MI/MR.)) [P1baA or P1bbA or P1bcA > 0]
- F132 - Assistive devices with eating** - The number of residents who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). [K5g = check]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form HCFA 672)

F. MEDICATIONS (F133-F139)

F133 - Receiving psychoactive drugs - The number of residents that receive drugs classified as anti-depressants, anti-anxiety, sedative and hypnotics, and anti-psychotics. [Any O4a,b,c or d = 1,2,3,4,5,6 or 7]
Use the following lists to assist you in determining the number of residents receiving psychoactive drugs. These lists are not meant to be all inclusive, therefore, a resident receiving a psychoactive drug not on this list, should be counted under F133 and any other drug category that applies - F134, F135, F136, and/or F137.

F134 - Receiving Antipsychotic medications [O4a = 1,2,3,4,5,6 or 7]
Clorazil (Clozapine)
Haldol (Haloperidol)
Haldol Deconate (Haloperidol Deconate) -
Inapsine (Droperidol)
Loxitane (Loxapine)
Mellaril (Thioridazine)
Moban (Molindone)
Navane (Theothixene)
Olazapine (Zyprexa)
Orap (Pimozide)
Prolixin, Deconoate (Fluphenazine Deconate)
Prolixin, Permitil (Fluphenazine)
Quetiapine (Seroquel)
Risperdal (Risperidone)
Serentil (Mesoridazine)
Sparine (Promazine)
Stelazine (Trifluoperazine)
Taractan (Chlorprothixene)
Thorazine (Chlorpromazine)
Tindal (Acetophenazine)
Trilat, Perphenazine)

F135 - Receiving Antianxiety medications [O4b = 1,2,3,4,5,6 or 7]
Ativan (Lorazepam) Serax (Oxazepam)
Centrax (Prazepam) Valium (Diazepam)
Klonopin (Clonazepam) Vistaril, Atarax (Hydrox-
Librium (Chlordiazepoxide) yzine)
Paxipam (Halazepam) Xanax (Alprazolam)

F136 - Receiving Antidepressant medications [O4c = 1,2,3,4,5,6,7]
Asendin (Amoxapine)
Aventyl, Pamelor (Nortriptyline)

Bupropion (Wellbutrin)
Desyrel (Trazodone)
Effexor (Venlafaxine)
Elavil (Amtriptyline)
Lithonate, Lithane (Lithium)
Ludiomil (Maprotiline)
Marplan (Isocarboxazid)
Nardil (Phenelzine)
Nefazodone (Serzone)
Norpramin (Desipramine)
Parnate (Tranylcypromine)
Paroxetine (Paxil)
Prozac (Fluoxetine)
Sertraline (Zoloft)
Sinequan (Doxepin)
Tofranil (Imipramine)
Vivactil (Protriptyline)

F137 - Receiving Hypnotic medications [O4d = 1,2,3,4,5,6 or 7]
Dalmane (Flurazepam) Quazepam (Doral)
Estazolam (ProSom) Restoril (Temazepam)
Halcion (Triazolam) Zolpidem (Ambien)

F138 - Receiving antibiotics - The number of residents receiving sulfonamides, antibiotics etc. either for prophylaxis or treatment. [Code manually]

F139 - On a pain management program - The number of residents with a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with alternative approaches (e.g., massages, heat, etc.). [Code manually when any J3a,b,c,d,e,f,g,h,i or j = check]

G. OTHER RESIDENT CHARACTERISTICS (F140-F146)

F140 - With unplanned or significant weight loss/gain - The number of residents who have experienced gain or loss of 5% in one month or 10% over six months. [K3a or K3b = 1 and K5h is not = check]

F141 - Who do not communicate in the dominant language at the facility - The number of residents who only express themselves in a language not dominant at the facility (e.g., this would include residents who speak only Spanish, but the majority of staff that care for the residents speak only English). [code manually]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form HCFA 672)

- F142 - Who use non-oral communication devices** (e.g., picture board, computers, sign-language). [Any C3b.c.d.e.or f = check]
- F143 - Who have advanced directives** (living will durable power of attorney). The number of residents who have advanced directives, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated. [Any A10a.b.c.f.g.or h = check]
- F144 - Received influenza immunization** - The number of residents known to have received the influenza immunization within the last 12 months. [code manually]
- F145 - Received pneumococcal vaccine** - The number of residents known to have received the pneumococcal vaccine. [code manually]
- F146 - Ombudsman notice - LEAVE BLANK.** This will be completed by survey team. Indicate yes or no whether Ombudsman office was notified prior to survey.
- F147 - LEAVE BLANK.** This will be completed by the survey team. Indicate whether Ombudsman was present at any time during the survey. 1 (yes) or 2 (no).
- F148 - Medication error rate - LEAVE BLANK.** This will be completed by the survey team.

ROSTER/SAMPLE MATRIX PROVIDER INSTRUCTIONS

(use with HCFA FORM 802)

The Roster Sample Matrix form (HCFA 802) is used by the facility to list all current residents including residents on bedhold, and to note pertinent care categories. **The facility completes the following: resident name, resident room, and columns 9-29, which are described below.** All remaining columns are for Surveyor Use Only.

There is not a federal requirement for automation of the 802 form. The facility may continue to complete the 802 with manual methods. The facility may use the MDS data to start the 802 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the 802 to represent current resident status according to the definitions of the 802.

Following the definition of each field, the related MDS 2.0 codes and instructions will be noted in the "crosswalk" section indicated by square brackets ([]).

For each resident mark all columns that are pertinent.

- 9. Language/Communication** - The resident uses a language other than the dominant language of the facility or exhibits difficulty communicating his/her needs. This must be individually determined. Some facilities predominant language is other than English, such as Spanish, Navaho, or French. If the resident uses a language other than the predominant language of the nursing facility, then code L.
- Mark L if resident uses a language other than the dominant language and C if the resident has communication difficulties. It is possible to have two flags (L and C) for an individual resident.
[Code manually for L: if C3d,e or f = check then 802-9 = C; if C4 = 2 or 3 then 802-9 = C; if C5 = 1 or 2 then 802-9 = C; if I1r = check then 802-9 = C]
- 10. Vision/Hearing/Sensory** - The resident has a significant impairment of vision, hearing or other senses.
- Mark V if the resident has a visual impairment, H for hearing impairment and S for other sensory impairments. It is possible to code up to 3 results for an individual resident.
[D1 = 3 or 4 then 802-10 = V; D2 = a or b then 802-10 = V; C1 = 2 or 3 then 802-10 = H]
- 11. Abrasions/Bruises/Fx** - The resident has abrasions, bruises or fractures.
- Mark A if a resident has abrasions, B for bruises and F for fractures.
[If M4a = check then 802-11 = F; If J4c or d = check then 802-11 = F; If I1m or p = check then 802-11 = F]
- 12. Restraints** - If the resident has a restraint, check this column. [If P4a or b > 0 and G6b is not checked, then check column 12 or If P4c,d,e > 0, then check column 12]
- 13. Adm./Transfer/Discharge** - The resident was admitted within the past 30 days or is scheduled to be transferred or discharged within the next 30 days.
- Mark A for an admission, T for a transfer and D for a discharge. Code for first assessment after initial admission (or readmission after discharge without expectation of return).
[If (Today's date - AB1) <= 30 days then 802-13 = A; Code transfer and discharge manually.]
- 14. MR/MI (Non Dementia)** - The resident has a diagnosis of mental retardation or mental illness.
- Mark MR for mental retardation or MI for mental illness. [If AB10 b,e or f = check, then 802-14 = MR; if I1 dd ee ff gg = check then 802-14 = MI]
- 15. Behavioral Symptoms** - If the resident has any behavioral symptoms, as listed in MDS, check this column.
[If E4A a,b,c,d or e are > 0 then Column 802-15 = check]
- 16. Psychoactive Meds** - If the resident receives any psychoactive medications, check this column.
[If O4 = a,b,c or d > 0 then 802-16 = check]
- 17. Non-Responsiveness** - If the resident is non-responsive (comatose), check this column.
[If B1 = 1, then check.]
- 18. Incontinence/Toileting Programs** - If the resident is incontinent, check this column.
[If H1b = 3 or 4, then check.]
- 19. Catheter** - If the resident has an indwelling urinary catheter, check this column.
[If H3d = check, then check.]
- 20. Tube Feedings** - If the resident receives tube feedings, check this column.
[If K5b = check, then check.]

ROSTER/SAMPLE MATRIX PROVIDER INSTRUCTIONS

(use with HCFA FORM 802)

- 21. Weight Change/Nutrition Needs** - If the resident has had a weight loss/gain of 5% in one month or 10% in six months, check this column. Note: Presence of a weight loss program is Not to be considered in this item. [If K3a = 1 or K3b = 1 then check.]
- 22. Hydration/Electrolyte** - If a resident has problems with hydration/electrolytes identified on the care plan, mark H for hydration, or E for electrolytes. [If J1c or d = check and A8a = 1 or A8b = 1 or 5 or hydration goals are on care plan then 802-22 = H; Code manually for electrolyte problems]
- 23. Assistive Devices** - If the resident uses special devices to assist the resident with eating or mobility (e.g., tables, utensils, hand splints, dentures, etc.) and other assistive devices, check this column. [K5g = check or L1b = check or G5a = check or P3c > 0 then check]
- 24. Swallow/Dining Program** - If the resident is in a restorative dining program or has swallowing problems that may affect dietary intake, check this column. [Swallowing can be crosswalked to: K1b = check or P3h > 0, then check. Dining Program - no crosswalk possible]
- 25. Antibiotics/Infections** - If the resident has an infection, check this column. [Since this information is very time sensitive, crosswalk to the MDS is NOT sufficient. Its m12 = a b c d e f g h i j k l may be used to sensitize this item. This item must be answered on the day of the survey.]
- 26. Pressure Sores** - If the resident has pressure sore(s), check this column. [If M2a = 1, 2, 3 or 4 then check]
- 27. ROM/Contractures/Posit.** - If the resident has contractures, check this column. [Only contractures are to be coded: G4A a, b, c, d, e or f = 1 or 2, then check]
- 28. Specialized Rehab** - For residents receiving specialized rehabilitative services, mark the following:
 P for physical therapy
 S for speech language pathology
 O for occupational therapy
 H for health rehabilitative services for MI/MR
 [P1bAc > 0 then P; P1bAa > 0 then S; P1bAb > 0 then O. H has no crosswalk.]
- 29. Respiratory Care** - If the resident has a tracheotomy, ventilator, resident needs suctioning, etc., check this column. [P1a.i, j, or l = check, then check.]

ROSTER/SAMPLE MATRIX INSTRUCTIONS FOR SURVEYORS
(use with FORM HCFA 802)

The Roster/Sample Matrix (HCFA 802) is used as a tool for selecting the resident sample. The vertical columns are highlighted to identify potential facility concerns. The horizontal rows list residents chosen for review.

The following describes each column. Use the horizontal rows to list residents.

Resident Number - Number each line sequentially down the rows. The numbering sequence should be continued to additional pages of the form. These numbers may be used as resident identifiers for the sample.

Resident Room - List the room number of the resident listed on the row.

Surveyor Assigned - List initials or surveyor number of surveyor assigned to review each resident.

Resident Name - List the name of the resident.

Individual Interview - Check this box for any resident receiving a Quality of Life Assessment Resident Interview.

Family Interview/Observation - Check this box for any non-interviewable resident receiving a Quality of Life Assessment Family Interview/Observation.

The following three columns must equal the total number of residents listed for Phase 1 and Phase 2 in sample table.

Closed Record Review - Check this box for any resident receiving a closed record review.

Comprehensive Review - Check this box for any resident receiving a comprehensive review.

Focused Review - Check this box for any resident receiving a focused review.

INDICATOR COLUMN Highlight each column that is an area of concern. For each resident entered on the roster/sample matrix, check all columns that pertain to the resident whether or not that column has been highlighted.

1. **Privacy/Dignity Issues** - Concerns about residents' right to privacy (accommodations, written and telephone communication, visitation, personal care) or if there are concerns that the facility does not maintain or enhance residents' dignity.
2. **Social Services** - Concerns about medically related social services.
3. **Choices** - Concerns about residents' ability to exercise their rights as citizens; be free from coercion, discrimination or reprisal; participation in care planning and treatment changes and participation in resident and family groups and other community activities.
4. **Abuse/Neglect** - Concerns about resident abuse, neglect or misappropriation of resident property, or how the facility investigates and responds to allegations of abuse, neglect or misappropriation of personal property.
5. **Clean/Comfort/Homelike** - Concerns about the facility environment including cleanliness, lighting levels, temperature, comfortable sound levels, or homelike environment. (The resident's ability to use their personal belongings and individualize their room to the extent possible.)
6. **Activities** - Concerns about activities meeting the interests, preferences and needs of residents.
7. **Pain/Comfort** - Concerns about timely assessment and intervention with residents needing pain or comfort measures.
8. **ADL Concerns** - Concerns that the resident is not given appropriate treatment and services to maintain or improve abilities in ADL's.
9. **Language/Communication** - Concerns about the facility assisting those residents with communication difficulties to communicate at their highest practicable level.
10. **Vision/Hearing/Sensory** - Concerns about the facility assisting those residents with visual or hearing impairments to function at their highest practicable level.
11. **Abrasions/Bruises/Fx** - Concerns about the presence and/or prevalence of abrasions, bruises or fractures.
12. **Restraints** - Concerns about inappropriate use of physical restraints.

Roster /Sample Matrix Instructions for Surveyors

13. **Adm/Transfer/Discharge** - Concerns about resident transfer or discharge procedures; and care/tx for residents recently admitted and those preparing for discharge/transfer.
14. **MR/MI (Non Dementia)** - Concerns related to the care and treatment of mentally retarded or mentally ill (non-demented) residents.
15. **Behavioral Symptoms** - Concerns about presence or prevalence of resident behaviors that need to be addressed by the facility. (e.g. verbal or physical outbursts, wandering, etc.)
16. **Psychoactive Meds** - Concerns about the use of psychoactive medications.
17. **Non-Responsiveness** - Concerns regarding residents who are non-responsive.
18. **Incontinence/Toileting Programs** - Concerns related to resident incontinence and facility toileting programs and the presence and/or prevalence of incontinent residents.
19. **Catheter** - Concerns related to catheter use in the facility.
20. **Tube Feedings** - Concerns related to tube feedings.
21. **Weight Change/Nutrition Needs** - Concerns about residents with weight changes and/or nutritional needs.
22. **Hydration/Electrolyte** - Concerns about resident dehydration or electrolyte imbalance.
23. **Assistive Devices/Dentures** - Concerns about the need for, absence of or use of special devices to assist residents in eating. (e.g. tables, utensils, hand splints, dentures, etc.) or concerns about any other assistive devices.
24. **Swallow/Dining Program** - Concerns about the need for restorative dining programs or residents with swallowing problems that may affect dietary intake.
25. **Antibiotics/Infections** - Concerns about presence or prevalence of resident infections and facility infection control procedures or with antibiotic use patterns.
26. **Pressure Sores** - Concerns about the occurrence, assessment, prevention or treatment of pressure ulcers or other necessary skin care.
27. **ROM/Contractures/Posit.** - Concerns about the occurrence, prevention or treatment of contractures. Concerns with staff provision or lack of provision of ROM or the incorrect positioning of residents.
28. **Specialized Rehab** - Concerns about the facility's provision or lack of provision of Specialized Rehabilitative Services including:
 - Physical therapy
 - Speech/language pathology
 - Occupational therapy
 - Health rehabilitative services for MI/MR
29. **Respiratory Care** - Concerns about care provided to residents with tracheotomies, ventilators, residents needing suctioning, etc.
30. **Special Needs** - Note any special care areas (e.g. prosthesis, ostomy, injection, special foot care and IV's, including total parenteral nutrition) that may be of concern in the column and highlight the column.