7 Week survey Prep Guide

(Repeat every 7 weeks if no survey)
Negative findings-Do a PIP and increase monitoring frequency.

Weekly Monitoring:

- ☐ Review/audit of Med rooms, med carts, Insulin labeling dated, expired medications, cleanliness.
- ☐ Review of temp logs in all areas.
- ☐ Review of current wounds, weights, Incidents for completion/compliance (May use audit tools).
- ☐ Review of resident restrooms for labeling (if applicable), tubing (if applicable), cleanliness, chemicals.
- ☐ Review of bathing areas for chemicals, locks, cleanliness.
- ☐ Review of areas containing chemicals for locks, labels, and proper storage.
- ☐ Audit of call lights to ensure proper functioning and free of safety concerns.
- ☐ Review of fridges for labeling/dating/temp logs.
- ☐ Review of high-risk kitchen areas: drawers, utensils, scoops.

Week 1:

Update CMS 802 Resident EMR. Take it to morning meeting each day to keep it current and ready for entrance. ***MDS***
Ensure survey readiness book is current and in order. ***Administrator***

- ☐ Visualize your Medicare/Medicaid posting to ensure it is in place. ***Administrator***
- ☐ Visualize your Survey results binders to make sure they are up to date, posted and available. ***Administrator***
- ☐ Ensure all residents have a current CARE assessment and review residents with a current Level II or PASSR determination: Is letter in place? Does the care plan and facility processes show all guidelines listed in Level II (is the letter being followed?) Is MDS coded correctly? Run report to ensure no errors on other residents with Level II/PASSR determinations. ***MDS/Social Services***
- ☐ Audit all clinical records to ensure quarterly assessments are done for each department. ***Nursing***
- ☐ Review all code statuses. Make sure they match care plan/clinical record/POS. Ensure there is system that is an easy visual to identify full code residents (ex: small heart by name on door). ***Social Services***
- ☐ Audit diet orders vs tray cards to ensure they match. ***Dietary/Nursing***
- ☐ Review residents receiving Coumadin. Ensure current PT/INR and side effect monitoring are in place. ***Nursing***
- ☐ Review past 6 months of RD recommendations to ensure follow ups was completed. ***Dietary/Nursing***
- ☐ Review NOMNC process. Ensure all NOMNC's are complete and signed-correct forms being used. Look at past 90 days of discharges. ***Social services/Administrator***
- ☐ Review Education/In-services for past year-skill checks completed per facility assessment? Each CNA has 12 hours of documented training? Individual in-services are noted for each employee? (if not-ongoing with working PIP). ***Administrator/Payroll/Business office***

Week 2:

- ☐ Review past 6 months Pharmacy recommendations to ensure completion and follow-up. ***Nursing***
- ☐ Review past 6 months Fall logs, ensure care plans show intervention(s) after each fall, also ensure room matches interventions in place. Example: low bed, fall mats, etc. (Further recommendation is that investigation summaries and root cause analysis are complete on each fall and that trending is done each month). ***Nursing***
- ☐ Review residents with ***ANY TYPE*** of **side rails**. Ensure measurement of mattresses and rails is being done, ensure rails are tightened routinely and that this is documented. Ensure orders for device use, assessment for use, and care plan current. ***Nursing/Maintenance***
- ☐ Review orders for insulin/accu-checks. Ensure parameters are in place and that notification of physician is being done when result ls out of parameters. ***Nursing***
- ☐ Review residents with pressure ulcers. Ensure the following is in place: ***Nursing/MDS (see number points below)***
    1. Documenting current skin conditions in facility in resident medical record. Wound documentation and rounds should Include measurements and description of wound, classification. Also ensure weekly skin assessments are completed.
    2. Care plan be kept updated with current treatment for any identified skin areas.
    3. PCP and responsible party have been notified and kept up to date with all areas and that this is well documented.
    4. Ensure labs for protein stores are current: Albumin/Pre- albumin.
    5. Supplement and vitamins are in place to promote healing. Further recommend to document a % of amount of supplement consumed dally,
    6. Any Identified skin concerns have been communicated to RD,
    7. Visualizing pressure relief devices in use to ensure they are adequate for the resident.
    8. Education to direct care staff regarding expectations with residents that have pressure ulcers.
    9. Review of RAI manual to determine if a significant change assessment is indicated and that Section M Is correctly coded on MDS.
- ☐ Review past 90 days of discharges including acute transfers. Discharge Assessment and Education done with discharges to community, SNF, ALF, etc? Bed-hold policy and re-admission policy completed with resident and responsible party with acute transfers? If EHR in use are assessments locked. ***Medical Records***
- ☐ Ensure that Ombudsman is being notified monthly of all discharges and notified immediately of emergency discharges. ***Social Services***

Week 3:

- ☐ Review of clinical records of residents receiving anti-psychotic medications to ensure: ***Nursing/MDS/Medical Records***
    1. Appropriate diagnosis for use?
    2. Care Planning of medication use, reasons for use, last GDR's, and potential side effects of use?
    3. AIMS current in past 6 months?
    4. Behavior tracking forms for l behavior per medication used?
    5. Behaviors being tracked are true behaviors?

6. GDR's have been attempted and documented?
7. Physician addresses benefit of medication use in progress notes?
8. Labs are done as indicated with medication use?
9. Consent forms are in clinical records and signed to consent use of medications? (If applicable)

- ☐ Review residents on oxygen. Ensure orders for all oxygen use as follows: ***Nursing/MDS/Medical Records***
  1. Oxygen @ _____ *UNC* or mask(specify which) and is order continuous or PRN?
  2. Check 02 sats every shift and PRN if there is a titration order? (EX: 02 to keep sats >90%)
  3. If order does not contain a titration order, the Check 02 sats PRN/Dyspnea?
  4. Change 02 tubing and rinse filter every week (assign a day) on continuous oxygen use and PRN for PRN oxygen use?
  5. Dating tubing when changed and adding # of Liters ordered for each resident to sticker on tank/sealed baggie?
  6. Review of PRN orders-discontinue orders if the oxygen has not been used.
  7. Are ear protectors being used to prevent skin issues with 02 tubing?
  8. Ensure care plan up to date.
- ☐ Review residents with catheters. Ensure the following: ***Nursing/MDS/Medical Records***
  1. Catheter change PRN (unless otherwise specified by PCP)-include the size of the catheter and the cc's for balloon.
  2. Change drainage bag PRN with catheter change?
  3. Irrigation orders as specified by PCP or PRN for blockage or leaking?
  4. Catheter care every shift and PRN (by whom?)
  5. Output every shift?
  6. Leg strap to anchor tubing to prevent injury?
  7. Cover to ensure dignity-bed and other equipment that might be used?
  8. Diagnosis for catheter use? Care plan matches orders?
- ☐ Review residents with dialysis. Ensure the following: ***Nursing/MDS/Medical Records***
  1. POS/orders show address (location), time of treatment, and phone # of dialysis center?
  2. Orders for shunt care/monitoring? Emergency tourniquet at beside (on wall) for hemorrhage?
  3. Dialysis communication being done between facility and dialysis center-paperwork to show? (Wt before and after treatment, fluid removed, toleration of treatment, and new orders or recommendations)
  4. Meals and medications are addressed for when resident is out of facility?
- ☐ Review residents with hospice. Ensure: *Nursing/MDS/Medical Records*
  1. Orders in place for diagnosis for services?
  2. Family communication in chart with entire IDT Team?
  3. Care plan includes DME and services provided by hospice, pain management, decline in condition?
  4. Significant change MDS completed?
  5. Dr. Progress notes?
  6. Social Services notes?

Week 4:

- ☐ Review residents with enteral feedings. Ensure the following: ***Nursing/MDS/Medical Records***
  1. Type of formula for feedings and amount?

2. Continuous or bolus?
3. Amount of water flushes-how often and how much?
4. Amount of water (flush) between medications?
5. Whether or not any medications can/cannot be crushed and/or given together?
6. Head of bed up during feedings and/or at all times? Degree of elevation?
7. Peg site cleaning/care orders?
8. Checking placement by residual, and amount of residual if noted to hold feeding?
9. POS/Care plan matches orders?

- ☐ Review weight loss for past 30, 90, and 180 days (5%, 7.5% and l0%) *Recommend weekly calculation and setting proactive benchmark at (3%, 5%, and 7.5%). ***Nursing/MDS/Medical Records/Dietary***
    1. Orders obtained and care plans are updated with interventions?
    2. Dr and responsible parties have been notified?
    3. Need for expected wt loss letter and that this is well documented?
    4. Orders for labs on residents with weight loss (albumin/ pre-albumin)?
    5. Any supplements used have % of Intake being recorded?
    6. RD for facility is notified and communication in chart for interventions?
    7. Review of RAI manual to determine if a significant change assessment is indicated?
- ☐ Review all residents with daily weight orders. Ensure weight is done same timeframe every day, and completion of measurement daily. If weight does not get completed notification of Dr, family, and nursing team for follow-up. ***Nursing/MDS/Medical Records/Dietary***
- ☐ Review all residents with orders for fluid restrictions. Are there specific amounts designated per shift and with meals? Ensure care plans are updated and that staff are aware of restrictions and that they are being followed. ***Nursing/MDS/Medical Records/Dietary***

Week 5:

- ☐ Match Care Plans with CAA triggers, POS's, and assessments to ensure they are all accurate and updated. Ensure if a resident has a diagnosis for Dementia that there is a dementia care plan. ***MDS***
- ☐ Review Bath records, skin assessments, MAR/TAR. Ensure all are current and no holes are noted. ***Nursing***
- ☐ Review infection control book. Ensure it is complete and that infections are trended each month with action plans to reduce number of infections in facility. Each month should include: ***Nursing***
    1. Monthly Summary (Electronic workbook)
    2. Monthly line listing
    3. Map
    4. Antibiogram
    5. Surveillance form
    6. Variance report.
- ☐ Ensure glucometers are being cleaned between use appropriately. ***Nursing***
- ☐ Review TB testing on Residents AND employees. Ensure these are current with policies. ***Nursing***
- ☐ Review immunizations. Ensure all residents have immunizations record, even historical data received outside of center. ***Nursing/Medical Records***
- ☐ Review CNA kardex. Ensure they are current with the most up to date information on how to care for each resident. Further, ensure that there is a process for communication of changes to CNA staff, especially with transfers, infections, and fall interventions. ***Nursing***

Week 6:

- ☐ Look at residents who smoke. Ensure assessment is current, contract is signed, and care plan is current. ***Nursing***
- ☐ Look at residents with orders to keep medications at bedside or self-administer medications. Ensure assessment is current and care plan is current. ***Nursing***
- ☐ Review Grievance log and individual forms. Ensure all follow-up is completed and that signatures are present on each form. Ensure any trends in complaints that have not been addressed. ***Social Services/Administrator***
- ☐ Review Resident council minutes and concerns. Ensure follow-up is complete with any concerns and that any repeat concerns are addressed. ***Administrator/Activity Director***
- ☐ Review triggers for each resident on QM/CASPER report. Review clinical records in triggered areas. **MDS**
- ☐ Review resident preferences: get up (wake-up) times, bath days/times, activity preferences. Ensure CNA kardex and care plans show these preferences and that facility schedules show these preferences are being followed. Include this in Resident council discussions. ***Nursing***

Week: 7

- ☐ Review bowel records. Make sure no resident is going more than 3 days without a bowel movement without having an intervention documented. ***Nursing***
- ☐ Review your Bowel and Bladder assessments. Does each resident have a current assessment? (Upon admit, annually, and with a change of continence status). If indicated, has a 72-hour voiding diary been done? Does the care plan reflect individual toileting plans and are the staff following these? ***Nursing***
- ☐ Review all residents to ensure they have a current wandering risk assessment. Ensure the elopement book is up to date and that care plans match the assessments. These are due quarterly. ***Nursing***
- ☐ Review personal property inventories. Make sure they are current annually. Social Services
- ☐ Ensure that housekeeping is aware of cleaners being used and wet times recommended (make a quick guide for all carts) ***Housekeeping***
- ☐ Review residents for pain. Focus on short term residents that are receiving therapy. Make sure no resident is having continued complaints of pain without review or change to regimen. ***Nursing/MDS***

COMMON QUESTIONS STATE SURVEYORS MIGHT ASK CNA's

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