|  |  |
| --- | --- |
| Slide Number | Presentation Plan |
| Slides and Audio script |
|  | **Cover Slide – Audio Script*** Welcome to today's training! As many of you are aware, CMS has been working hard to develop a single survey process that will be used across the nation. Additionally, CMS has been working to assist providers in understanding and implementing the revised regulatory changes and slowly phase in these revised requirements.
* The new Long-Term Care Survey Process (LTCSP) is in alignment with the revised regulatory requirements and is focused on person-centered care. Person-Centered Care means the focus is on the resident as the locus of control, supports the resident in making their own choices and having control over their daily lives.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 2 - Navigating the Course** |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 3 – Audio script*** This provider training will take the viewer through an overview of the regulatory reform, the rationale behind the changes to the survey process, key changes to the survey process, a comparison of the Traditional, Quality Indicator Survey (QIS) and new LTC survey processes, and basic steps in the survey process that are important to LTC providers.
* The survey process consists of:
* Entrance Conference,
* Day One,
* Day Two,
* Remainder of Survey, and
* Exit Conference.
* Each section will provide the basic information about the specific survey activities, then provide screens that list and outline of the day’s activities, applicable forms, information and interview requests that will be requested throughout the new survey process, when applicable.
* Let's first begin with an overview of the New Regulatory Reform.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 4 – Audio Script*** Overview of Regulatory Reform
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 5 – Audio Script*** Regulation reform has created numerous changes to the regulations that govern long-term care; however, providers should be aware a lot has not changed and include:
* Many of the minimum quality standards from the previous regulations has remained in the new reform,
* Providers will continue to use the minimum data set (MDS) assessments to do assessments and care planning based on resident goals and preferences and include input from the interdisciplinary team,
* Facilities are still required to have a medical director,
* Facilities are still required to have a fulltime nurse, and
* Facilities are still required to conduct medication reviews for their residents.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 6 – Audio Script*** The new regulatory reform implemented several pieces of legislation from the Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, including the following compliance and ethics programs:
* Quality Assurance and Performance Improvement (QAPI),
* Reporting suspicion of a crime,
* Increased discharge planning requirements, and
* Staff training.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 7 – Audio Script*** Phase 1 was implemented November 28, 2016
* Phase 2 will include all Phase 1 requirements, those areas providers need more time to develop, foundational elements and a new survey process to assess compliance. Phase 2 will be implemented on November 28, 2017.
* Phase 2 will include, but is not limited to:
* Behavioral Health Services,
* Quality Assurance and Performance Improvements (QAPI Plan Only),
* Infection Control — Tied to Facility Assessment and Antibiotic Stewardship,
* Physical Environment — smoking policies,
* Resident Rights and Facility Responsibilities (required contact information),
* Freedom from abuse, neglect, and exploitation—1150B Requirements (reporting reasonable suspicion of a crime),
* Admission, transfer, and discharge rights—transfer/discharge documentation,
* Comprehensive Person-Centered Care Planning—baseline care plan,
* Pharmacy Services—drug regimen review and reporting, review of medical chart, definition of psychotropic medications,
* Dental Services—replacing lost dentures, and
* Administration—Facility Assessment—tied to sufficient and competent staff requirements
* As of November 28, 2017, facilities will be responsible for the implementation of all new regulatory reform requirements except for those requirements implemented in phase 3.

* Phase 3 will be implemented on November 28, 2019. All facilities must meet the requirements for all phase 3 requirements. The areas designated in Phase 3 will be the most difficult to implement; therefore, CMS has provided additional time for facilities to meet these requirements.
* Phase 3 includes the following:
	+ QAPI Program Implementation,
	+ Infection Control Preventionist,
	+ Compliance and Ethics Program,
	+ Trauma Informed Care,
	+ Physical Environment (call-lights at resident bedside), and
	+ Training Program.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 8 – Audio Script*** Rationale Behind the Changes to LTC Surveys
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 9 – Audio Script*** Currently there are two different survey processes that exist to review compliance with the Requirements of Participation. These include the Traditional and Quality Indicator Survey (QIS) processes.
* Through workgroups, surveyors identified opportunities to improve the efficiency and effectiveness of both survey processes and identified that the two processes appeared to focus slightly differently on quality of care and quality of life issues. Therefore, CMS set out to build on the best of both the Traditional and QIS processes and establish a single, nationwide survey process that aligns with the revised regulatory requirements and that focuses on the principles of person-centered care.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 10 – Audio Script*** As previously stated, there are currently two survey processes used across the nation. CMS has developed one single survey process that integrated the strengths of both the QIS and Traditional survey processes.
* One strength of the Traditional process was that surveyors could ask resident interview questions as they deemed necessary and appropriate, rather than as a prescriptive set of questions asked verbatim. This strength was retained in the New LTC Survey Process. This approach allows surveyors to conduct conversational interviews with residents and resident representatives through a structured approach. These interviews cover both quality of care and quality of life topics that are person-centered.
* Having a computer-based process and using Critical Element (CE) Pathways to guide investigations were strengths of the QIS process that were carried over to the New LTC Survey Process. Surveyors will use a computer and supported software to guide them throughout the survey, which also provides structure and promotes consistency.
* Surveyors will also use updated Critical Element (CE) Pathways to guide their investigations. The use of CE pathways allows for a consistent, organized, and systematic review of the care area, task, or regulatory requirement. These pathways help surveyors determine facility compliance and cover the provision of person-centered care, services, and care planning.
* Note: Providers can obtain copies of the updated CE pathways at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>.
* The New LTC Survey Process aligns with the new regulatory requirements and maintains a focus on person-centered care. This ensures facilities are incorporating principles of person-centered care and are identifying unique resident needs and preferences.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 11 – Audio Script*** Many changes to the current survey processes have occurred in order to develop a new LTC survey process, which will be discussed in more detail later during the presentation. There are some key changes in the process providers should be aware of:
* The survey sampling process has changed from both the QIS and Traditional survey processes. A portion of the residents included in the survey sample are chosen offsite based on MDS data, while another portion is selected onsite by the survey team.
* The initial pool process, where surveyors identify potential sample residents through interviews, observations, and limited record reviews, begins as soon as the surveyors enter the facility. Surveyors will go room to room, **without staff**, to conduct observations and interviews.
* Since surveyors use a computer and supported software, surveyors are provided more time to engage with residents and will have an increased presence on the units while making observations and conducting interviews with residents and families.
* The new LTC Survey Process is focused on person-centered interventions aimed at enhancing resident's feelings of self-worth, autonomy, and self-esteem; therefore, the new LTC survey process is focused on person-centered care, resident-centered outcomes, quality of care, and quality of life.
* Additionally, a new triggered task, Resident Assessment, has been incorporated into the process. This task reviews and investigates discrepancies identified for residents and their MDS assessment, thus ensuring a person-centered approach to care.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 12 – Audio Script*** So, you might be asking yourself, what makes this process better than the current processes in use today. The new LTC Survey Process will provide consistency among state agencies when surveyors are conducting surveys. All surveyors will be following one survey process and using the same investigative tools to help guide their investigations and determine regulatory compliance.
* This allows for a consistent training model followed by all state agencies and supports changes towards efficiency and improved investigative skills, which will ultimately benefit nursing home residents.
* The new LTC Survey Process has shown to be effective in assisting surveyors conduct consistent and thorough investigations and has been efficient in streamlining the survey process for surveyors and providers.
* The new LTC Survey Process is computer based and software supported and will be used across all states. The software helps guide the survey team through the survey process and covers specific regulatory requirements focused on person-centered care.
* Additionally, the new LTC Survey Process allows surveyors to use their experience and professional expertise in surveying and improves shared processes with CMS, which supports and improves collaboration between state agencies and CMS, ultimately benefiting the residents and providers.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 13 – Audio Script*** All States will use the new LTC Survey Process to conduct LTC surveys beginning **November 28, 2017**
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 14 – Audio Script*** Comparison of the three survey processes
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 15 – Audio Script*** The Traditional survey process is completed on paper while the QIS process is automated. The new LTC Survey Process will be an automated process and surveyors will use a tablet or personal computer throughout the survey process to record findings that are synthesized and organized by new software.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 16 – Audio Script*** The sample size for the new LTC Survey Process will be based on the facility census. The sampling approach for the new survey process is different than either current process. The sample for the new survey process includes 70% of MDS pre-selected residents and 30% surveyor-selected residents.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 17 – Audio Script*** All three of the survey processes review the facility history information to prepare for the survey. In addition, surveyors will review the offsite selected residents and facility rates (e.g., percent of resident that have a condition based on MDS markers and characteristics) during offsite preparation, which is similar to the Traditional process.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 18 – Audio Script*** Similar to the other processes, there will be information requested immediately after entering the facility, which we’ll discuss in detail a little later in the presentation.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 19 – Audio Script*** Unlike the current survey processes, there is no formal tour for the new LTC Survey Process. Surveyors will begin observing and briefly screening every resident in their assigned area. Surveyors will go room to room, **without staff**, to interview and observe residents to include in their initial pool. Surveyors will Identify about eight residents to include in their initial pool.
* The initial pool includes offsite selected residents, new admissions, vulnerable residents, compliant residents, Facility Reported Incidents (FRIs), and other identified concern residents.
* Surveyors may add additional residents to their initial pool based on concerns identified during surveyor observations.
* Surveyors will complete observations, interviews and a limited record review for all residents included in the initial pool. The initial pool selection is based exclusively on surveyor identified information and information documented in the official medical record – which meets the goal for a resident-centered approach.
* Those residents selected in the initial pool are eligible for selection in the final sample. The initial pool process should take surveyors about 8-10 hours to complete.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 20 – Audio Script*** As previously stated, the new LTC Survey Process took into account the strengths of both the Traditional and QIS processes and tried to balance consistency with surveyor autonomy.
* For the new LTC Survey Process, surveyors will go room to room, **without staff**, to complete thorough interviews and observations of residents included in the initial pool. Surveyors are provided with structured questions (probes) to guide the resident interviews and observations. Surveyors will complete a full interview with residents covering specific quality of life and quality of care areas.
* Surveyors are provided structured questions (probes) to guide theirs interview; however, surveyors are not required to ask questions exactly as written, as previously done during QIS. Surveyors may use their own words when interviewing residents; however, surveyors may not change the intent of the question or lead the resident to give a certain response.   This approach allows surveyors to conduct conversational interviews with residents and resident representatives.
* Additionally, surveyors will complete a limited record review for each resident included in the initial pool. The limited record review focuses on specific situations (e.g. advanced directives, to confirm specific information from interviews and observations, medications and other identified concerns) to optimize surveyor time for observations and interviews.
* For the new LTC Survey Process, the survey team will meet to discuss their findings and select residents to include in the final sample, which is approximately 20% of the facility census.
* Once the final sample is selected, surveyors will spend the remainder of the survey conducting investigations related to resident concerns, facility tasks and three closed records, which includes one hospitalization, one death, and one community discharge.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 21 – Audio Script*** The QIS process conducted an interview with the Resident Council President or Representative. The new LTC Survey Process includes a group interview with residents who are active members of the resident council, similar to the Traditional survey process; however, any resident may attend the meeting.
* Additionally, the questions asked during the group interview are different from both current processes.
 |
|  | **<<INSERT COPY OF SLIDE HERE>>****Slide 22 – Audio Script*** Providers should take time to inform residents of the regulatory changes that govern long-term care. Additionally, providers should inform residents that a new survey process will be implemented starting 11/28/2017.
* Residents should be informed about the survey process and that during the survey surveyors will be:
	+ Asking questions about the care they receive,
	+ Observing staff and residents throughout the survey,
	+ Using computers when speaking with them, and
	+ Using computers when making observations throughout the facility.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 23 – Audio Script*** Overview of the New Survey Process
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 24 – Audio Script*** Let’s begin with the surveyors' entrance into the facility and the entrance conference.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 25 – Audio Script*** Upon entry into the facility the Team Coordinator (TC) will:
	+ Introduce themselves, the survey team and request to see the Administrator and/or Director of Nursing (DON),
	+ Request the facility provides a place where the survey team can work,
	+ Schedule the Entrance Conference with the Administrator and/or DON, and
	+ Request information needed immediately upon entrance, which will be discussed shortly.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 26 – Audio Script*** Here is a copy of the Entrance Conference Worksheets. The TC will provide a copy of these documents to the Administrator/designee during the entrance conference.
* Providers can obtain a copy of the Entrance Conference Worksheets from the CMS website located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 27 – Audio Script*** At the scheduled time the TC will:
	+ Conduct a brief Entrance Conference with the Administrator and/or designee,
	+ Provide the Administrator and/or designee with a copy of the Entrance Conference form. This form outlines needed information and specific timeframes the information is to be provided,
	+ Request information regarding a full-time Director of Nursing (DON),
	+ Request information about the facility's emergency water source (verbal confirmation is acceptable),
	+ Provide signs announcing the survey, which should be posted in high-visibility areas,
	+ Request a copy of an updated facility floor plan, if changes have been made,
	+ Request the name of the Resident Council President, and
	+ Provide the Administrator or designee with a copy of the CASPER 3 report.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 28 – Audio Script*** Information needed from the provider **immediately** upon entrance includes:
	+ Facility census number,
	+ Complete matrix for new admissions in the last 30 days who are still residing in the facility. **Note: Since most new admissions have either not had a completed MDS assessment or an MDS transmitted to the State Agency prior to the survey team entering the facility, it is important to complete the matrix for new admissions Immediately. Providers will complete a matrix for all other residents residing in the facility, which is required within 4 hours upon entrance,**
	+ An alphabetical list of all residents (providers should note any resident out of the facility), and
	+ A list of residents who smoke, designated smoking times and locations.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 29 – Audio Script*** To streamline the survey process for providers and effectively capture those pieces of information the surveyors will require for the survey, CMS has revised the Matrix for Providers and reduced the number of areas that were previously requested. This revision will help reduce the amount time it takes providers to complete and maintain the matrix.
* A copy of the Matrix for Providers, including instructions on how to complete the matrix can be found on the CMS website located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>

 * Areas included in the revised Matrix for Providers include:
	+ **Residents Admitted within the Past 30 days:** Resident(s) who were admitted to the facility within the past 30 days and currently residing in the facility,
	+ **Alzheimer's/Dementia:** Resident(s) who have a diagnosis of Alzheimer's disease or dementia of any type,
	+ **Mental Disorder, Intellectual Disability or Related Condition and No PASARR (Pre-Admission Screening and Resident Review) Level II:** Resident(s) who have a serious mental disorder, intellectual disability or related condition but does not have a PASARR level II evaluation and determination. Note: providers should identify residents using the following acronyms on the matrix: (MD) for serious mental disorder, (ID) for intellectual disability, or (RC) for related conditions,
	+ **Medications:** Resident(s) receiving any of the following medications: Insulin, Anticoagulant (e.g. Direct thrombin inhibitors and low weight molecular weight heparin [e.g., Pradaxa, Xarelto, Coumadin, Fragmin]. Do not include Aspirin or Plavix), Antibiotic, Diuretic, Opioid, Hypnotic, Antianxiety, Antipsychotic, Antidepressant, and Respiratory (e.g., inhaler, nebulizer). Note: providers must record medications according to a drug's pharmacological classification, not how it is used. Provider should identify resident medications using the following acronyms on the matrix: (I) for insulin, (AC) for anticoagulant, (ABX) for antibiotics, (D) for diuretics, (O) for opioids, (H) for hypnotics, (AA) for antianxiety, (AP) for antipsychotic, (AD) for antidepressant, and (RESP) for respiratory medications,
	+ **Facility Acquired Pressure Ulcers (any stage):** Resident(s) who have a pressure ulcer at any stage, including suspected deep tissue injury (sDTI) (e.g., I, II, III, IV, unstageable, sDTI),
	+ **Worsened Pressure Ulcer(s) at any stage:** Resident(s) with a pressure ulcer at any stage that have worsened,
	+ **Excessive Weight Loss without Prescribed Weight Loss Program:** Resident(s) with an unintended (not on a prescribed weight loss program) weight loss > 5% within the past 30 days or >10% within the past 180 days. Exclude residents receiving hospice services,
	+ **Tube Feeding:** Resident(s) who receive enteral or parenteral feedings.
	+ **Dehydration:** Resident(s) identified with actual hydration concerns (e.g., receives enteral, parenteral and/or IV feeding/fluids, or is dehydrated) takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups),
	+ **Physical Restraints:** Resident(s) who have a physical restraint in use. A restraint is defined as the use of any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body (e.g., bed rail, trunk restraint, limb restraint, chair prevents rising, mitts on hands, confined to room, etc.). Do not code wander guards as a restraint,
	+ **Fall(s):** Resident(s) who have fallen since admission or within the past 90 days and have incurred an injury or not. A major injury includes bone fractures, joint dislocation, closed head injury with altered consciousness, and subdural hematoma. Note: Providers should use the following acronyms on the matrix: (F) to identify residents with a fall(s), (FI) to identify a resident who has had a fall and sustained an injury excluding major injury, and (FMI) to identify a resident who has sustained a fall(s) with major injury,
	+ **Indwelling Urinary Catheter:** Resident(s) with an indwelling catheter (including suprapubic catheter and nephrostomy tube),
	+ **Dialysis:** Resident(s) who are receiving hemodialysis or peritoneal dialysis either within the facility or offsite. Note: providers should use the following acronyms on the matrix: (H) to identify those residents receiving hemodialysis or (P) for those residents receiving peritoneal dialysis and (F) to identify if the resident receives dialysis within the facility or (O) receives dialysis offsite. For example: a resident who receives hemodialysis at the facility should be listed as HF on the matrix,
	+ **Hospice:** Resident(s) who have elected or are currently receiving hospice services,
	+ **End of Life/Comfort Care/Palliative Care:** Resident(s) who are receiving end of life or palliative care (not including Hospice),
	+ **Tracheostomy:** Resident(s) who have a tracheostomy,
	+ **Ventilator:** Resident(s) who are receiving invasive mechanical ventilation,
	+ **Transmission-Based Precautions:** Resident(s) who are on transmission-based precautions,
	+ **Intravenous Therapy:** Resident(s) who are receiving intravenous therapy through a central line, peripherally inserted central catheter, or another intravenous catheter, and
	+ **Infections:** Resident(s) who have a communicable disease/contagious infection (e.g., MDRO, pneumonia, tuberculosis or viral hepatitis, or c-diff) or has a healthcare-associated infection (e.g., wound infection or urinary tract infection). Providers should use the following acronyms on the matrix: M for MDRO, P for pneumonia, TB for tuberculosis, VH for viral hepatitis, C for c-diff, WI for wound infection, and UTI for urinary tract infection).
* Note: Once the matrix for new admissions has been completed and the TC confirms the matrix was completed accurately, the TC will request enough copies for each surveyor. Once the copies are received the TC will deliver a copy of the new admission matrix to each surveyor.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 30 – Audio Script*** Information needed from the provider within **one hour** of entrance includes:
	+ Schedule of meal times, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in from visitors,
	+ Schedule of Medication Administration times,
	+ Number and location of medication storage rooms and medication carts
	+ The actual working schedules for licensed and registered nursing staff for the survey time-period,
	+ List of key personnel, location, and phone numbers. Providers should also note any contract staff (e.g., rehab services),
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 31 – Audio Script*** If the facility employs paid feeding assistants, provide the following information:
* Whether the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training,
* The names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks,
* A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants, if applicable,
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 32 – Audio Script*** Complete matrix for all other residents residing in the facility,
* Admission packet,
* Dialysis contract(s), agreement(s), arrangement(s), and policy and procedures, if applicable,
* List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable,
* Agreement(s) or policies and procedures for transport to and from dialysis treatments, if applicable,
* Whether the facility has an onsite, separately certified, End Stage Renal Disease (ESRD) unit,
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 33 – Audio Script*** Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers),
* Infection Prevention and Control Program Standards, Policies and Procedures, and Antibiotic Stewardship Program. Influenza/Pneumococcal Immunization Policy and Procedures,
* QAA committee information (name of contact, names of members and frequency of meetings), and
* QAPI Plan: Providers must present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2)], which will be implemented beginning November 28, 2017 (Phase 2). Additionally, providers must provide the QAPI Plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

 The QAPI Plan must include policies/protocols describing how it will:* + Track and measure its performance,
	+ Establish goals and thresholds for performance measurements,
	+ Identify and prioritize deviations from performance and other problems and issues,
	+ Systematically investigate and analyze to determine underlying causes of systemic problems and adverse events,
	+ Develop and implement corrective action or performance improvement activities, and
	+ Monitor and evaluate the effectiveness of corrective action/performance improvement activities.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 34 – Audio Script*** Abuse prohibition policy and procedures,
* Description of any experimental research occurring in the facility,
* Facility wide assessment: The facility must conduct and document a facility-wide assessment to determine what resources   are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. [§483.70(e)] and all subparts will be implemented beginning November 28, 2017.

 Note: Surveyors will review the facility assessment during every recertification survey to verify whether the facility conducted and documented a facility-wide assessment to determine what resources are needed to care for its residents competently during both day to day operations and emergencies. Review of the facility assessment is integrated into other survey processes and if systemic concerns are identified, surveyors will review the facility assessment to determine whether or not the facility assessed the needs of the residents and the resources required to provide the necessary care and services. Additionally, surveyors may request to review the facility assessment during a complaint survey, if they need to determine whether or not the facility addressed a specific area they are investigating. The facility assessment must address or include: * The facility’s resident population, including, but not limited to,

(i) Both the number of residents and the facility’s resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. * The facility’s resources, including but not limited to,

(i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies, (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations, andA facility-based and community-based risk assessment, utilizing an all-hazards approach.  * Nurse staffing waivers,
* List of rooms meeting any one of the following conditions that require a variance:
	+ Less than the required square footage
	+ More than four residents
	+ Below ground level
	+ No window to the outside
	+ No direct access to an exit corridor
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 35 – Audio Script*** Information needed from the provider by the **end of the first day** of survey includes:
* Access to all resident electronic health records (EHRs) – do not exclude any information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the EHR outside of the conference room. Providers will complete the attached form on page 2 which is titled "Electronic Health Record (EHR) Information."
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 36 – Audio Script*** Providers will be given the Electronic Health Record (EHR) Information worksheet to complete. This worksheet provides specific instructions on where and how surveyors can access the following information in the EHR (or in the hard copy if using split EHR and hard copy system).
	+ Pressure ulcers
* Dialysis,
* Infections,
* Nutrition,
* Falls,
* ADL (Activities of Daily Living) status,
* Bowel and bladder,
* Hospitalization,
* Elopement,
* Change of condition,
* Medications,
* Diagnoses,
* PASARR (Pre-Admission Screening and Resident Review),
* Advance Directives, and
* Hospice.
* Note: Surveyors require the same access staff members have to residents' EHRs in a read-only format.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 37 – Audio Script*** The information needed from the provider **within 24 hours** of entrance includes the following:
* Completed Medicare/Medicaid Application (CMS-671)
* Completed census and condition information (CMS-672)
* Completed Beneficiary Notice worksheet that identifies those residents discharged from Medicare covered Part A stay with benefit days remaining within the last six months
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 38 – Audio Script*** Providers will also be given a Beneficiary Notice worksheet to complete and return to the survey team within 24 hours.
* Providers will use the worksheet to list those residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past six months.
* Providers will identify whether the resident was discharged home or to lesser care (e.g. independent living, assisted living, etc.) or remained in the facility.
* Providers will exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or who were transferred to an acute care facility or another SNF during the sample date range.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 39 – Audio Script*** Ongoing communication occurs throughout the survey between member of the survey team and facility staff.
* During the first day of the survey, the team will not have completed full investigations related to their preliminary findings. Therefore, the surveyors will not be able to discuss any of their preliminary findings with staff, unless immediate jeopardy is identified by the survey team.
* The survey team will be communicating with all levels of facility staff (e.g., dietary, housekeeping, certified nurse aides, nurses, contractors, management, etc.) throughout the survey.
* Ongoing concerns will be discussed with staff as investigations progress. Staff will have opportunities to clarify issues when brought to their attention. However, surveyors will not release information about ongoing concerns until their investigation is completed.
* Surveyors will recommend that facility floor staff report to their supervisor any questions/issues raised by the surveyors.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 40 – Audio Script*** Day One Overview
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 41 – Audio Script*** After the TC has conducted the Entrance Conference with the Administrator and/or designee, the TC will report to their assigned area.
* One surveyor, assigned to the kitchen task, will conduct an initial brief tour of the kitchen. Afterwards, the surveyor will report to their assigned area.
* All other surveyors will report to their assigned areas and immediately begin screening and interviewing residents and or the resident representatives, conduct observations and a limited record review.
* There are no formal staff interview during the first day, unless there are extenuating circumstances (i.e. inability to access electronic health records).
* Additionally, surveyors will observe the first scheduled meal after entering the facility.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 42 – Audio Script*** The new LTC Survey Process is a resident-centered approach; therefore, resident and/or resident representative interviews and observations are a critical component to this resident-centered survey process.
* Once surveyors arrive at their assigned areas, surveyors will:
* Request a list of residents in their assigned area of the facility and request a list of new admissions in the 30 days before conducting the interviews and observations. This list is in addition to the facility matrix for new admissions and allows the surveyors to begin screening newly admitted residents.
* Once surveyors receive the requested information, surveyors will briefly screen residents, in their assigned area, to include in the initial sample and conduct resident/resident representative interviews and observations. Brief resident screenings resident interviews and observations will be conducted by the surveyors independently, **without staff being present**.
* Resident interviews and observations are conducted for the following residents:
* MDS pre-selected residents,
* Vulnerable residents (resident's dependent on staff (i.e. Alzheimer’s or quadriplegic),
* New Admissions,
* Complaints and/or Facility Reported Incidents (FRIs),
* Residents with significant concerns and who do not fall into one of the above categories, and
* Resident representative interviews – a minimum of three resident representative interviews will be conducted. They will include an individual familiar with the resident's care. If surveyors are unable to conduct three resident representative interviews by the end of day one, they should ensure they complete the representative interviews early enough in the survey to follow up on any concerns.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 43 – Audio Script*** Surveyors will conduct limited record reviews for the following reasons, including, but not limited to:
	+ Obtain specific care area information for non-interviewable residents (e.g., falls, wandering, elopement, pressure ulcers, weights, infections, etc.),
	+ Verify information provided by the resident/representative,
	+ Clarify identified discrepancies,
	+ Identify high risk medications, and
	+ Review advanced directives
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 44 – Audio Script*** As previously mentioned, there are no formal staff interviews during the initial pool process. Surveyors will use their resident/resident representative interviews, observations and limited record reviews to obtain needed information; however, under certain circumstances (e.g., inability to access EHRs, time constraints, etc.) surveyors may need to conduct a staff interview in order to obtain information. Therefore, surveyors will require access to the resident EHRs, as soon as possible.
* Staff interviews will be conducted later in the survey, following sample selection.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 45 – Audio Script*** As previously mentioned, surveyors will observe the first scheduled meal after entering the facility.
* Surveyors will cover all dining locations, including room trays
* If there are more dining areas than surveyors, surveyors will observe those dining rooms for residents who require the most assistance.
* Note: Additional dining/room tray observations will be conducted as needed.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 46 – Audio Script*** We have covered a lot of information regarding what providers can expect during the first day of the survey. So, let's briefly review these activities.
* Upon entrance the TC will introduce themselves, the team and request a place to work. The TC will schedule and conduct an entrance conference with the Administrator/designee. One surveyor, will conduct a brief kitchen tour. Surveyors will report to their assigned areas, request a list of new admission residents, briefly screen residents for their initial pool, begin resident/resident representative interviews, observations and limited records reviews, **all without the presence of staff**. Surveyors will also conduct a dining/room tray observation of the first meal after entrance. Providers will begin working on the information needed and outlined on the Entrance Conference Form.
* Note: The matrix for new admission admitted to the facility within the last 30 days is due immediately upon surveyors entering the facility.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 47 – Audio Script**Day Two Overview |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 48 – Audio Script*** On day two of the survey, surveyors will finalize any initial pool items not completed by the end of day one.
* Once the team has completed the initial pool process, the team will meet to discuss their findings from the initial pool. The team will select a sample of residents for in-depth investigations for care areas of concern resulting from Day 1 interviews, observations and record reviews for:
	+ Residents selected off site,
	+ Vulnerable residents (resident's dependent on staff (i.e., Alzheimer's or quadriplegic)),
	+ New admissions,
	+ Harm, SQC if suspected or Immediate Jeopardy (IJ) if identified,
	+ Residents named in complaints or facility reported incidents (FRIs),
	+ Surveyors select the entire sample with active residents – closed records are not included in the total sample number,
	+ There are five residents selected for an Unnecessary Medication review – these residents may or may not be in the sample, and
	+ Three residents selected for closed record reviews (death, hospitalization, and community discharge).
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 49 – Audio Script*** Once the sample has been finalized, surveyors will:
* Begin in-depth investigation for sampled residents of all areas triggered during Initial Pool to determine whether deficient practice exists, document deficiencies, and determine potential scope and severity (S/S),
* Investigate complaints and/or facility-reported incidents, if any,
* Ask questions of non-clinical, clinical and/or administrative staff,
* Make copies of records and policies, as needed, and
* Initiate an investigation of care issues for any resident if the need arises; these residents will be added to the total resident sample.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 50 – Audio Script*** Let's take some time to review the activities surveyors will conduct during day two of the new survey process.
* On day two, surveyors will complete any remaining initial pool interviews, observations and limited records review.
* Once the team has completed the initial pool process, the team will meet to select the final sample of residents for in-depth investigations.
* Once the team has finalized their sample, surveyors will begin their in-depth investigations for care areas and/or resident concerns that warrant further investigation.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 51 – Audio Script*** Remainder of Survey Overview
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 52 – Audio Script*** The remainder of the survey, surveyors will:
* continue to complete their in-depth investigations, as previously discussed during day two of the survey process,
* Complete mandatory facility tasks, which include:
	+ **Dining:** Surveyors will complete a second meal observation if concerns were identified during the first meal.
	+ **Infection Control and Antibiotic Stewardship:** The assigned surveyor will review the Infection Control and Prevention Program.

According to the Centers for Disease Control 75% of nursing home residents receive antibiotics each year. Approximately 40 to 75% of these antibiotics are prescribed incorrectly. Increased use of antibiotics can endanger all residents by promoting the spread of resistant. Additionally, antibiotic-related harms, such as diarrhea from C. difficile, can be severe, difficult to treat, and lead to hospitalizations and deaths, especially among people over age 65.An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use [§483.80(a)(3)] will be implemented beginning November 28, 2017 (Phase 2). Providers must include:* + - Development and implementation with the participation of the medical director, consulting pharmacist, nursing and administration leadership, and infection preventionist (or infection prevention coordinator) to improve antibiotic use,
		- Designation of one or more staff who is responsible for antibiotic stewardship-related duties including training on antibiotic use (stewardship) for all nursing staff and attending practitioners,
		- Development and implementation of written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics, including educational materials on antibiotic stewardship for residents and families,
		- Development and implementation of a system of protocols to review laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infection,
		- A process for a periodic review of antibiotic use by attending practitioners: Review laboratory and medication orders, progress notes and medication administration records to determine whether an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee,
		- A facility-wide system for reporting antibiotic use and the identification of irregularities/incidents and corrective actions taken by the attending practitioner, medical director, and director of nurses (and mechanism for feedback),
		- Policies and protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic, and
		- A system for the provision of feedback on antibiotic use, antibiotic resistance patterns based on laboratory data (i.e., antibiogram), and prescribing practices for the attending practitioner and for the QAA committee.
* **Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review:** The surveyor team will randomly select three residents, who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months, for review. Surveyors will enter the name of each resident on a separate worksheet and return the worksheet to the provider to complete. We will discuss this worksheet shortly,
* **Kitchen:** The assigned surveyor will conduct follow up kitchen observations, interviews with kitchen staff, and review menus, policies, and other documents, as needed,
* **Medication Administration:** The assigned surveyor(s) will observe a minimum of 25 medication opportunities,
* **Medication Storage:** Surveyor will review half of the medication storage rooms, covering different units, half of the medication carts on units where the storage rooms are not observed and reconcile the controlled substance count for two residents on each medication cart reviewed,
* **Resident Council Meeting:** Surveyors will complete an interview with active members of the Resident Council. Surveyors can invite residents (even those not in the Resident Council) they encounter who are able to converse and provide information. Additionally, surveyor will review three months of Resident Council meeting minutes prior to the interview to identify any unresolved areas of concern, with the permission of the Resident Council President,
* **Sufficient and Competent Nurse Staffing:** The assigned surveyor will coordinate the review of the availability of licensed nursing staff to provide and monitor the delivery of care, and
* **Quality Assessment and Assurance (QAA)/Quality Assessment and Performance Improvement (QAPI):** Surveyors will make note of concerns identified during their offsite preparation, which will be further investigated during the survey (e.g., repeat deficiencies, ombudsmen concerns, and complaints/facility reported incidents) and incorporated into the QAA/QAPI review for investigation.
	+ Throughout the survey the surveyors will monitor and identify any potential systematic concerns to be included in the QAA/QAPI review. Once the survey team has thoroughly investigated all issues identified during the survey, the TC/designee will complete the QAA/QAPI review with the facility's QAA/QAPI contact person to determine if the QAA/QAPI committee:
		- Meets at least quarterly,
		- Include the required members,
		- develops and implements appropriate plans of action to correct identified quality deficiencies,
		- Puts forth good faith attempts to identify and correct its own quality deficiencies, and
		- Has a QAA/QAPI plan that contains the necessary policies and protocols describing how they will identify and correct their quality deficiencies.
* Note: Information obtained from disclosure of the QAA committee documents may not be used to cite new issues not already identified by the survey team or to expand the scope and severity of concerns identified on the current survey
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 53 – Audio Script*** Additionally, surveyors will complete any tasks that triggered if the survey team has identified concerns. These triggered tasks include:
* **Personal Funds:** Surveyors will complete this review when there are identified concerns with sampled residents not having access to funds or not receiving a quarterly statement,
* **Environment:** All surveyors are responsible for environmental factors identified with concerns in their area. One surveyor will coordinate the task and complete with the facility staff as necessary. Surveyors will conduct the environmental tour with facility staff and conduct necessary staff and resident interviews and pertinent record reviews, and
* **Resident Assessment:** This is a new triggered facility task. Surveyors will complete this review if there were concerns with:
	+ A delay with the completion and/or submission of MDS assessments; and/or
	+ MDS discrepancies for care areas that weren't marked for further investigation
	+ Note: Each surveyor will review their own residents who had MDS discrepancy concerns.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 54 – Audio Script*** Now, let's take a look at the Skilled Nursing Beneficiary Protection Review worksheet. As previously stated, surveyor will randomly select three residents to include in the review, enter the resident's name on each worksheet and return the worksheet to the provider to complete. The provider will complete the following questions for each resident beneficiary notice review:
	+ Medicare Part A skilled services episode start date,
	+ Last covered day of Part A services (Part A services terminated/denied or resident was discharged),
	+ How the Medicare Part A termination/discharge was determined (e.g. voluntary, facility/provider initiated when days were not exhausted or other),
	+ Whether an SNF ABN form CMS-10055 or any of the 5 alternative denial notices were provided to the resident,
	+ Whether a NOMNC (CMS\_10123) was provided to the resident,
* Surveyors will then review the completed forms and supporting documents with the provider.
* The objective of the Beneficiary Liability Protection Notices Review is to determine if the facility issues notices as required under 42 CFR Part 405.1200-1204 and §1879(a)(1) of the Social Security Act. This protocol is intended to evaluate a nursing home’s compliance with the requirements to notify Original (Fee-For-Service) Medicare beneficiaries when the provider determines that the beneficiary no longer meets the skilled care requirement. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare Part A skilled services, when the resident has not used all the Medicare benefit days for that episode.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 55 – Audio Script*** Once the survey team has completed their in-depth investigation and facility tasks the survey team will conduct one final team meeting. During the team meeting, the team will discuss pertinent survey findings, discuss each area of potential non-compliance and determine potential citations.
* Once the surveyors complete their final team meeting the TC/designee will schedule an exit conference with the Administrator/designee
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 56 – Audio Script*** We have provided an in-depth review of the activities surveyors will complete during the remainder of the survey. Let's take a moment to briefly review these activities.
* During the remainder of the survey, surveyors will continue their in-depth investigations, request additional information and request interviews as needed.
* Surveyors will complete all mandatory and triggered facility tasks.
* Once the team has completed all investigations, mandatory and triggered tasks the team will meet to discuss pertinent survey findings, discuss each area of potential non-compliance and determine potential citations.
* After the final team meeting the TC will schedule an exit conference with the Administrator/designee.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 57 – Audio Script*** Exit Conference Overview
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 58 – Audio Script*** The exit conference is held in the same manner as previous surveys.
* The individuals requested to attend the exit conference include: the Administrator and/or the Director of Nursing (DON), the resident council president and up to two interested residents, if applicable, and the Ombudsman

 * Note: the surveyors will contact the Ombudsman upon entrance to advise them of the survey and prior to exiting the facility and invite them to join the exit conference
* During the exit conference the TC will report on potential findings of non-compliance under regulatory headings (upon request, specific F-tags, if possible), identify the facts related to the non-compliance (such as number of residents), report on preliminary findings, avoiding specific scope and severity determination, unless immediate jeopardy was identified and advise the provider that these are preliminary finding, which are not finalized until receipt of the statement of deficiency, the CMS-2567.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 59 – Audio Script*** In conclusion, the training has provided you with an in-depth overview of the new regulatory reform, the rationale behind the changes to the survey process, key changes to the LTC survey process, a comparison of the Traditional, Quality Indicator Survey (QIS) and New LTC Survey Processes, and the basic steps in the survey process that are important to a LTC Providers. We hope providers find this information helpful as they implement the new regulatory reform and participate in the new LTC survey process.
* Providers may obtain all documents and forms discussed in this presentation at:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>   |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 60 – Audio Script*** For further questions, providers can submit questions about the new survey process to NH Survey Development mailbox at:

NHSurveyDevelopment@cms.hhs.gov.  |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 61 – Audio Script*** Congratulations!
* You have completed the Provider Training for the New LTC Survey Process.If you would like to watch this presentation again please click the FORWARD button. To exit, click the X in the upper right-hand corner of your screen.
 |
|  | **<< INSERT COPY OF SLIDE HERE>>****Slide 62 – Audio Script*** No Audio Script for this slide.
 |