Lesson 2-F: *Principles of Documentation*

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Understand the purpose of Form CMS-2567, Statement of Deficiencies and Plan of Correction.
- Identify and discuss the key elements of the *Principles of Documentation.*
- Write clear, concise and comprehensive citations.

Lesson Plan

References

Federal

- Survey and Certification letter in September 2000 issuing the revised *Principles of Documentation*

State

(Insert State reference[s] here.)

Other

Highlights

- Brief discussion of the importance of the use of documentation from the survey to complete Form CMS-2567, Statement of Deficiencies and Plan of Correction, using the *Principles of Documentation*
- The principles and information contained in the *Principles of Documentation*, issued in September 2000

Training Techniques

- Lecture
- Group discussion
- Small group and individual exercises

Training Aids

- PowerPoint slides and handouts
- Mandatory web-based training on the *Principles of Documentation* for all surveyors
- Handouts:
  - *Tips for Writing the Statement of Deficiencies*
  - *Owed to the Spell Checker*
  - *Principles of Documentation,* 2000 version
  - *Active-Voice Sentences*
  - *Changing Passive to Active*
  - *Active-Voice Exercises*
  - *Active-Voice Practice #1*
  - *Active-Voice Practice #2*
  - *Principles of Documentation Summary Sheet*
  - *SOD Worksheet*
  - *Principles of Documentation for Statement of Deficiency (CMS-2567) Review*
  - *ICF/MR Practice Sample #1*
  - *ICF/MR Practice Sample #2*
  - *HHA—G277: Scenario and SOD Example*

- *LSC—K038: Scenario and SOD Example*
- *LTC—F314: Scenario and SOD Example*
- *LTC—F316: Scenario and SOD Example*
- *ESRD—V449: SOD Example*
- *HHA—G158: SOD Example*
- *Hospice—L125: SOD Example*
- *Hospital—A350: SOD Example*
- *ICF/MR—W249: SOD Example*
- *LSC—K021: SOD Example*
- *LSC—K051: SOD Example*
- *LTC—F309: SOD Example*
- *OPT—I158: SOD Example*
- *RHC—J70: SOD Example*

Methods of Evaluation

- Verbalization/discussion of understanding
- Completion of skill assessment

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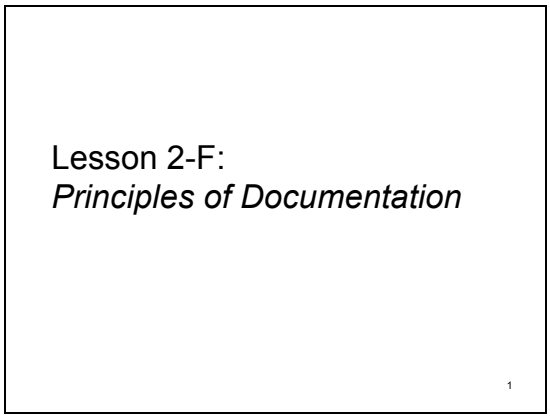
Outline or text of presentation



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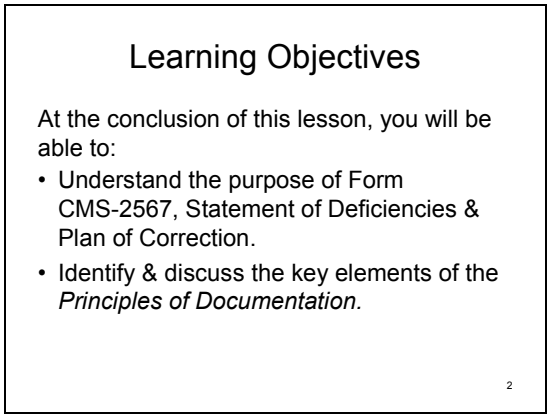

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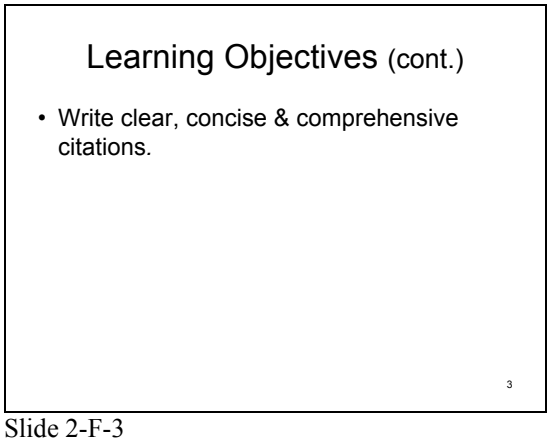
(Inform the students of the objectives.)



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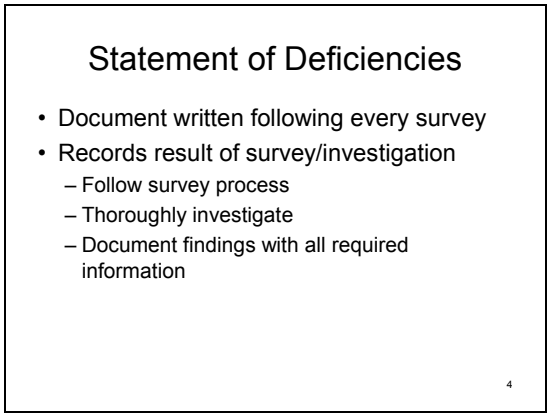

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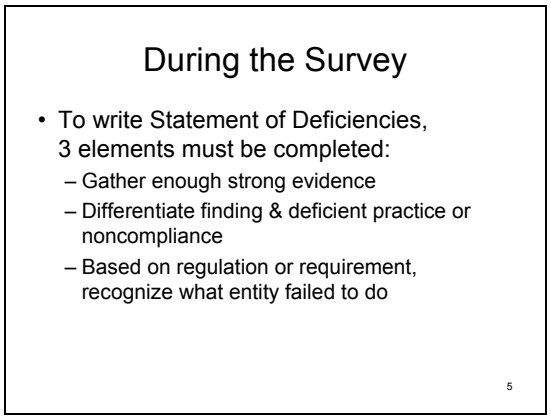

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Outline or text of presentation

The Statement of Deficiencies (SOD) is a document written by surveyors following every survey of a facility. This includes initial, recertification, revisit, and complaint surveys and validation surveys of accredited providers.

This is the document that records the result of your survey—your investigation. Therefore, it cannot be emphasized enough that if you have not followed the survey process and thoroughly investigated and documented your findings with all required information, you will find it extremely frustrating to write the Statement of Deficiencies using the *Principles of Documentation*.

To write a Statement of Deficiencies, three elements must be completed:

- Gather enough strong evidence.
- Differentiate finding and deficient practice or noncompliance.
- Based on a regulation/requirement, recognize what the entity failed to do.

Don't wait until near the end of the survey. If you suspect a problem, get out the regulations, identify the potential deficiency and read the Interpretive Guidelines. Make notes about further investigation. Discuss it with the team and follow through with the investigation.

The problem in completing Form CMS-2567, Statement of Deficiencies and Plan of Correction, is not when you found the entity in compliance with all regulations. The problem is when you found evidence of noncompliance.

The Statement of Deficiencies is not the place to write your assumptions. It is where you write the facts and how those

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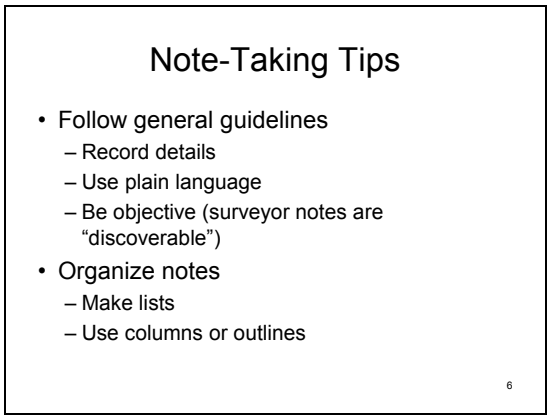

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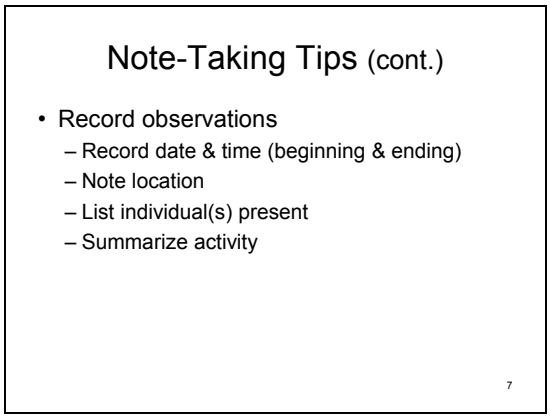

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Outline or text of presentation

facts worked together to show that the facility was not in compliance with the regulation.

Note-Taking Tips

- Follow general guidelines.
  - Record details.
  - Use plain language.
  - Be objective (surveyor notes are "discoverable").
- Organize your notes.
  - Make lists.
  - Use columns or outlines.

- Record observations.
  - Record date and time (beginning and ending).
  - Note location.
  - List individual(s) present.
  - Summarize the activity.

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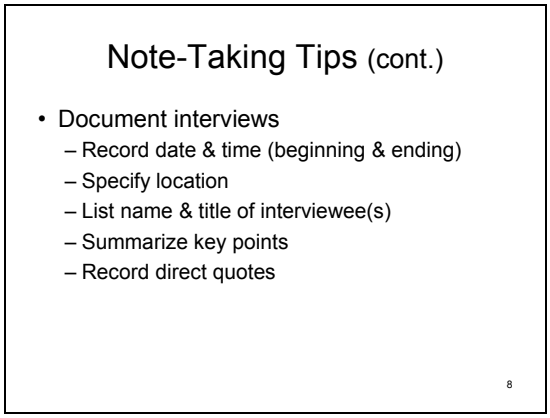
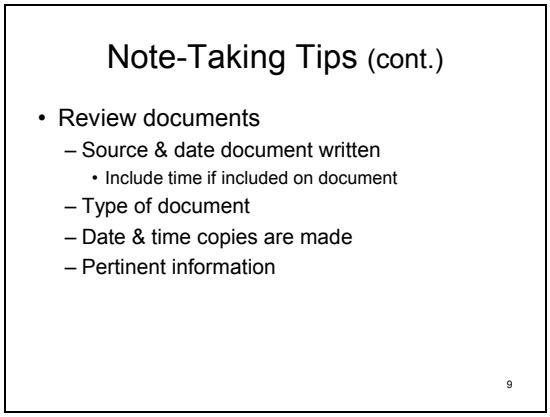


Slide 2-F-8

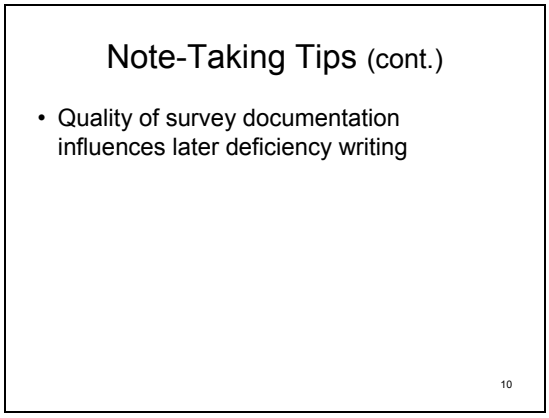
Outline or text of presentation

- Document interviews.
  - Record date and time (beginning and ending).
  - Specify location.
  - List name and title of interviewee(s).
  - Summarize key points.
  - Record direct quotes.



Slide 2-F-9

- Review documents.
  - Source and date document written.
    - Include time if included on document.
  - Type of document.
  - Date/time copies are made.
  - Pertinent information.



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In essence, the quality of your documentation recorded during the survey has a direct relationship to the information you will have to write any deficiency.

When you are finished with a survey, review your notes and ask yourself, "If I had to testify about this survey six months from now, would I be able to review my notes and re-create that survey?" The more strongly you can say, "Yes!" the easier it will be for you to write the Statement of Deficiencies.

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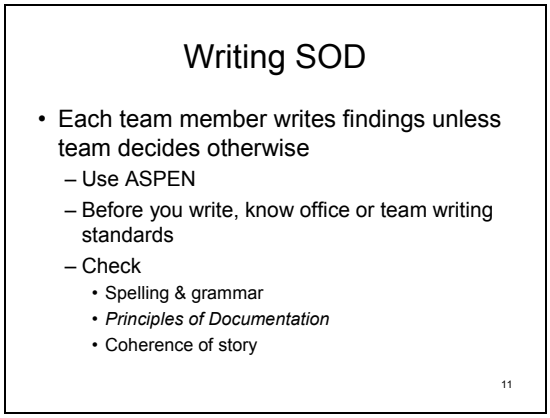

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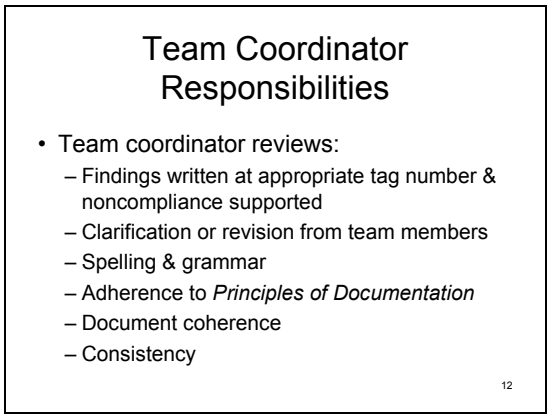

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Outline or text of presentation

Team Members

Each team member writes his/her own findings unless mutually agreed otherwise.

- Use Automated Survey Processing Environment (ASPEN).
- Before you write, know your office or team writing standards. (*Distribute and discuss the handout "Tips for Writing the Statement of Deficiencies" on page 2-F-31.)*
- Check:
  - Spelling and grammar.
  - *Principles of Documentation*.
  - Coherence of story.

(Either divide students into small groups and have them correct a portion of the handout "Owed to the Spell Checker" on page 2-F-33 or have individuals read a portion aloud.)

The Team Coordinator

The team coordinator is then responsible for putting all the pieces together in a coherent manner.

- Ensures findings are written at appropriate tag number and noncompliance is supported.
- Requests clarification or revision from team members.
- Checks spelling and grammar.
- Checks for adherence to the *Principles of Documentation*.
- Ensures document is coherent.
- Ensures consistency.

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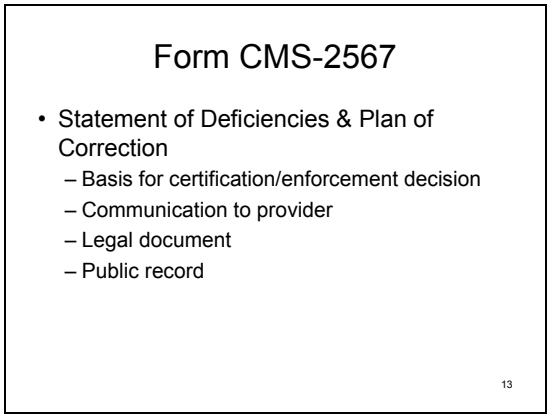

Slide 2-F-13

Outline or text of presentation

Form CMS-2567

- Statement of Deficiencies and Plan of Correction.
  - Basis for certification/enforcement decision.
  - Communication to the provider.
  - Legal document—would be submitted as evidence for a hearing or in court to defend any certification or enforcement action.
  - Public record—the Statement of Deficiencies and Plan of Correction (Form CMS-2567) is available to the public or media (e.g., newspaper and television) under the Freedom of Information Act.

Cause and Effect

The *Principles of Documentation* were written as an answer to a problem.

In 1990, Federal surveyors conducted over 150 surveys in long term care facilities within about a month. Afterward, they submitted all the Statements of Deficiencies to a team for review before they were issued to the facilities. The review team represented Federal surveyors and management staff from Federal Regional Offices throughout the United States. The review found inconsistencies in the manner the surveyors wrote deficiencies. As a result, the Centers for Medicare & Medicaid Services researched and issued the first *Principles of Documentation* reference. It was later modified to the version that was issued in the year 2000.

(Refer students to the "Principles of Documentation," included as a handout on page 2-F-35.)

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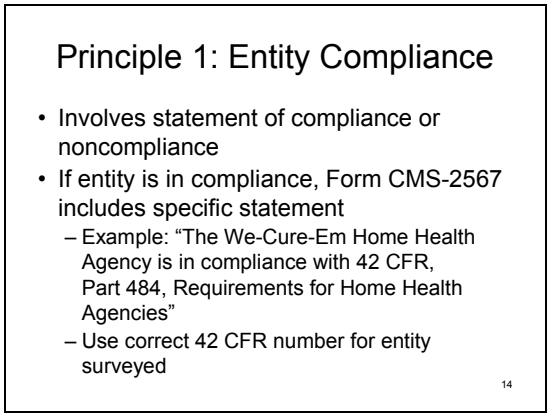

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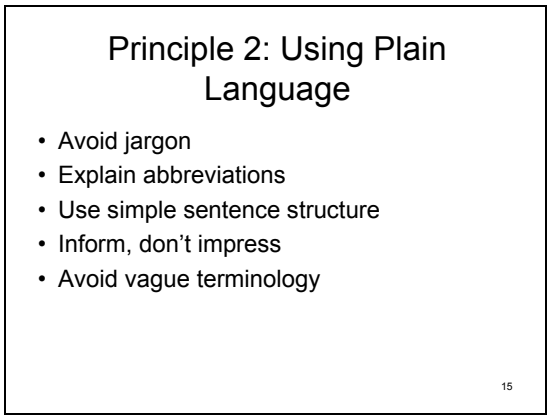

Slide 2-F-15

Outline or text of presentation

Principle 1: Entity Compliance

- Statement of compliance or noncompliance.
- If in compliance, includes specific statement.
  - Example: "The We-Cure-Em Home Health Agency is in compliance with 42 CFR, Part 484, Requirements for Home Health Agencies."
  - Use the correct 42 CFR number for the entity surveyed. For Life Safety Code, the reference changes based on certified entity (e.g., it is different for a hospital and a nursing home).

Principle 2: Using Plain Language

- No jargon—if you use a term not common to the public, give the meaning. For example, what is Alzheimer's disease, a sheet pan or self-abusive behavior?
- Explain abbreviations—the first time a common term appears in *each* deficiency, place the abbreviation behind it in parentheses. Remember to do this for director of nursing, registered nurse, certified nursing aide, etc.
- Use simple sentence structure—use the KISS method (i.e., keep it short and simple).
- Inform, don't impress—again keep it simple.
- Avoid vague terminology: "seems," "appear," "potential."

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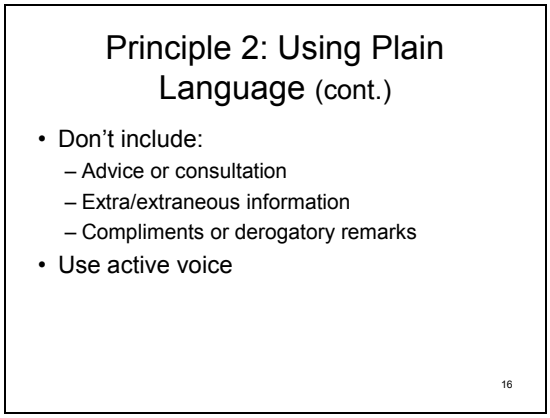

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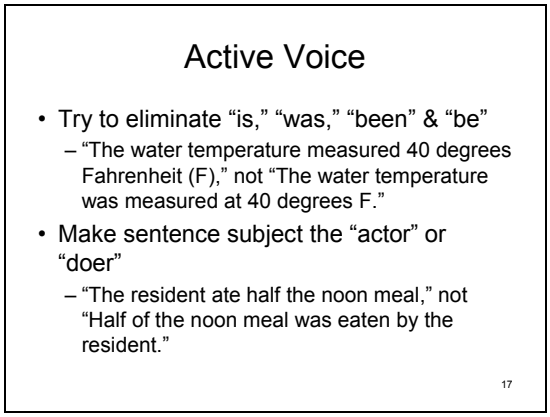

Slide 2-F-17

Outline or text of presentation

- Don't include:
  - Advice or consultation.
  - Extra/extraneous information—for example, if you are writing about a pressure sore, include only pertinent diagnosis—don't include a patient's pacemaker if it isn't directly related to the pressure sore. If the door was unlocked, don't include how many people lived near it—only the number of individuals who could have gone out the door.
  - Compliments or derogatory remarks.
- Use active voice—"X" did something to "Y."

Active Voice

- The tense may be past, present or future.
- Minimize words like "is," "was," "been" and "be."
  - "The water temperature measured 40 degrees Fahrenheit (F)," not "The water temperature was measured at 40 degrees F."
- Make the sentence subject the "actor" or "doer."
  - "The resident ate half the noon meal," not "Half of the noon meal was eaten by the resident."

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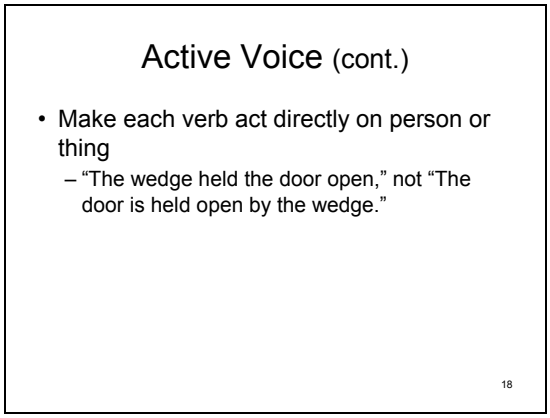
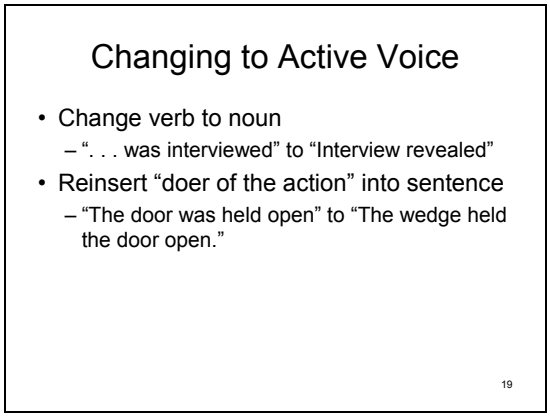


Slide 2-F-18

Outline or text of presentation

- Make each verb act directly on a person/thing.
  - "The wedge held the door open," not "The door was held open by the wedge."



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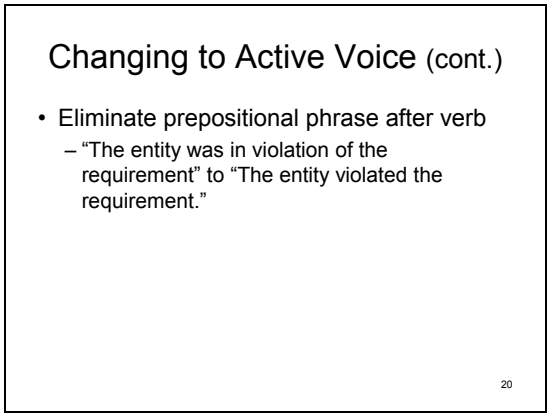
Changing to the Active Voice

- Change a verb to a noun.
  - " . . . was interviewed" to "Interview revealed."
- Reinsert a "doer of the action" into the sentence.
  - "The door was held open" to "The wedge held the door open."



Slide 2-F-20

- Eliminate a prepositional phrase after the verb.
  - "The entity was in violation of the requirement," to "The entity violated the requirement."

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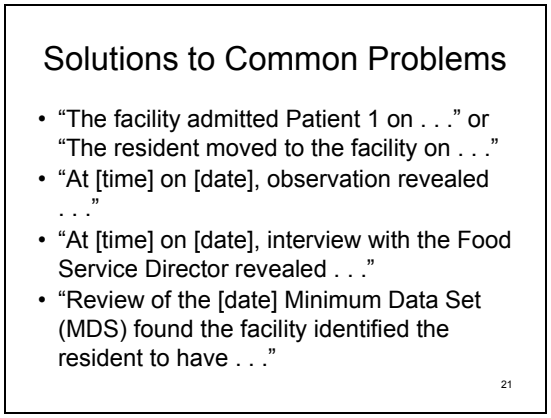

Slide 2-F-21

Outline or text of presentation

- Solutions to common problems:
  - "The facility admitted Patient 1 on . . . ," or "The resident moved to the facility on . . ."
  - "At [time] on [date], observation revealed . . ."
  - "At [time] on [date], interview with the Food Service Director revealed . . ."
  - "Review of the [date] Minimum Data Set (MDS) found that the facility identified the resident to have . . ."

(Distribute the handouts you determine are best fitted to your students. Discuss each or have students complete the exercise or practice(s). Choose from the following:

- *"Active-Voice Sentences."*
- *"Changing Passive to Active."*
- *"Active-Voice Exercises."*
- *"Active-Voice Exercises: Answer Sheet."*
- *"Active-Voice Practice #1."*
- *"Active-Voice Practice #1: Corrections."*
- *"Active-Voice Practice #2."*

Since each student will have to write independently, it is recommended that you have each work alone to complete exercises.

When students have completed the exercise(s)/practice(s), ask them to provide active-voice correction.)

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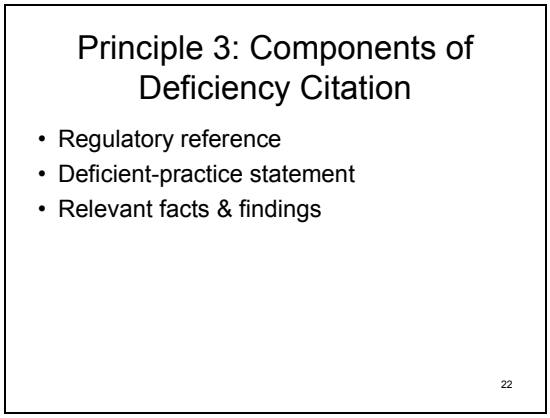

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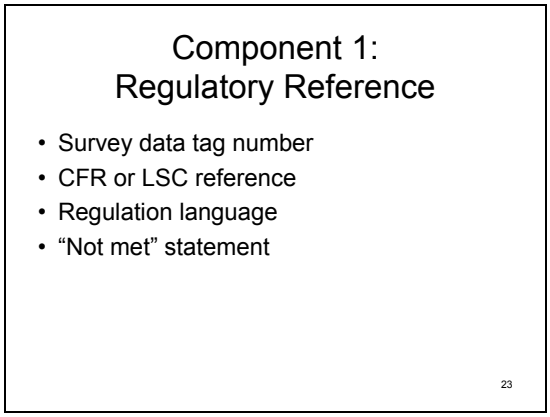
Outline or text of presentation

Principle 3: Components of a Deficiency Citation

- Regulatory reference.
- Deficient-practice statement.
- Relevant facts and findings.



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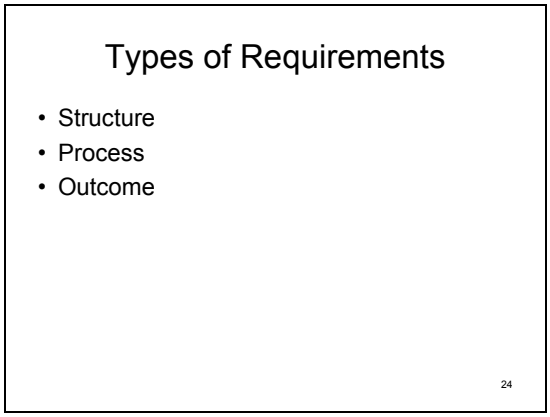
Component 1: Regulatory Reference

The regulatory reference is usually already in ASPEN. However, for new regulations that have been just issued, ASPEN may not yet have been updated. Therefore, you will need to write this information under tag number 9999 in ASPEN.

- Survey data tag number.
- Code of Federal Regulations (CFR) or Life Safety Code (LSC) reference.
- Regulation language.
- "Not met" statement.



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Types of Requirements

- Structure requirements—for example bylaws or policies and procedures.
- Process requirements—how the entity must function (e.g., how often care plans have to be completed in long term care).
- Outcome requirements—results expected to maintain compliance (e.g., "maintain acceptable . . ." or ". . . does not develop . . .")

Knowing the type of requirement will help you know how to investigate it and the evidence needed to cite a deficiency.

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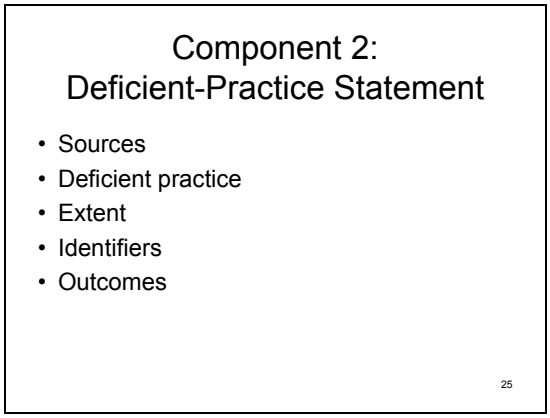


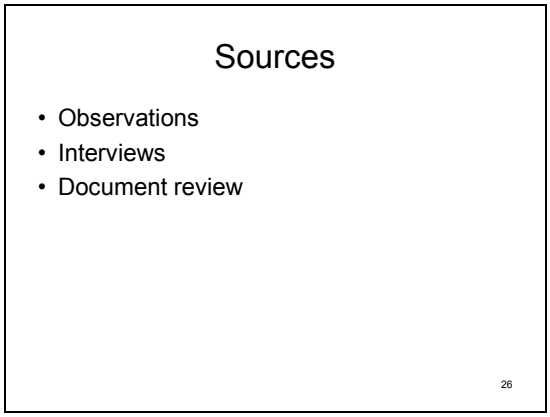
Slide 2-F-25

Outline or text of presentation

Component 2: Deficient-Practice Statement

This may be referred to as the "based on" statement.

- Sources.
- Deficient practice.
- Extent.
- Identifiers.
- Outcomes.



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Sources

- Observations.
- Interviews.
- Document review.

What were the sources of information for the deficiency? It will be extremely rare that you use only one. The more sources the better.

It is important to ask staff if they have any other documents for you to review regarding your concern. If not, record the date, time and title of the individual and include it in the deficiency. Add the source "document review" to the deficient practice statement as a source—you reviewed for it, but did not have any to review.

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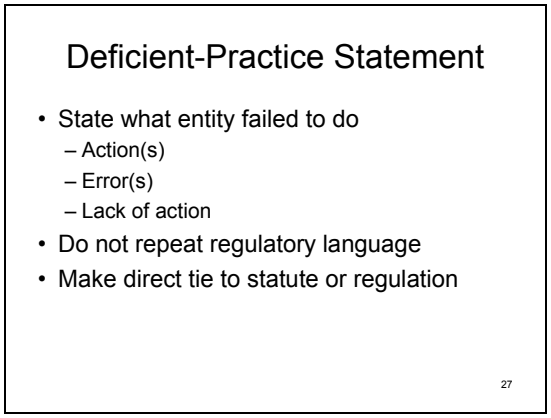

Slide 2-F-27

Outline or text of presentation

Deficient-Practice Statement

- State what the entity failed to do or comply with.
  - Action(s).
  - Error(s).
  - Lack of action.

"Failed to"—provide, assure, prevent, assess, etc.

You can have several different deficient practices under the same regulation. For example, for the long term care regulation, the facility must "store, prepare, distribute and serve food under sanitary conditions." Deficient practices could include:

- "The facility staff failed to wash hands to minimize the potential of food-borne illness, following accepted standards of practice."
- "The facility failed to store foods and beverages in a manner that prevented contamination from rodents."
- "The facility failed to maintain perishable foods and beverages at temperatures that minimized the growth of bacteria."

All potentially could be cited at the same facility during the same survey at the same tag number.

When you have different deficient-practice statements:

- Each is easier to write than jumbling a number of different problems under one deficient practice.
- It makes it easier both for the facility to provide a Plan of Correction and for surveyors to determine compliance at the time of the revisit.
- Do not repeat regulatory language.

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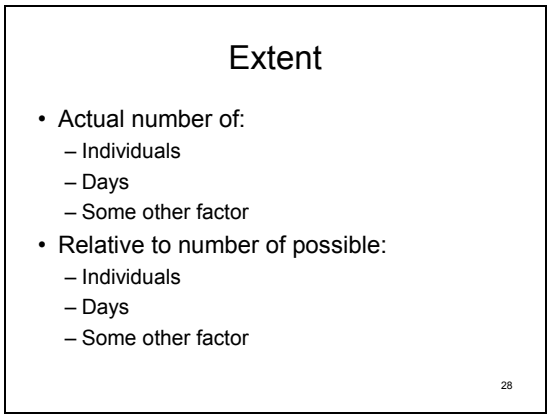

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Outline or text of presentation

For some regulations it is going to be difficult to write the deficient-practice statement. However, sometimes the Interpretive Guidelines may help you think of wording.

Extent

Phrased as the actual number of individuals, days or some other factor relative to the number of possible individuals, days or some other factor.

Extent is with respect to the universe of possible numbers. For example:

- You reviewed a sample of a total of how many individuals?
  - Of those, how many did you review for this issue?
  - With how many did you identify a problem?

The extent or universe could include all three numbers, but must include at least the number you reviewed for this issue and the number for which you identified a problem.

There are a number of regulations that do not address patients or something that is easily counted. Therefore, consider:

- The number of nursing units affected.
- The number of people who live on a unit. For Life Safety Code regulations, it could be the number of individuals who live within a smoke compartment.
- The number of badly maintained doors on a certain number of floors or nursing units or on one day of the survey.
- If it has the potential to affect all individuals, say that and give the number (e.g., failure of the call light

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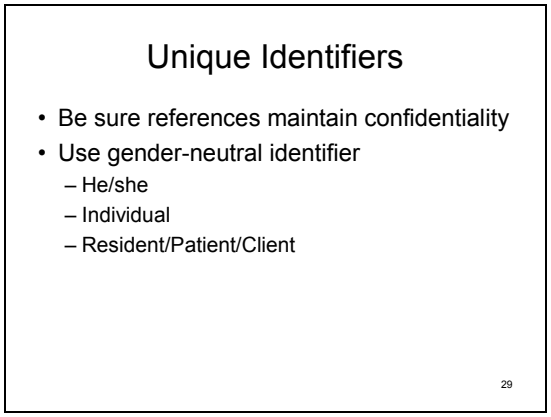

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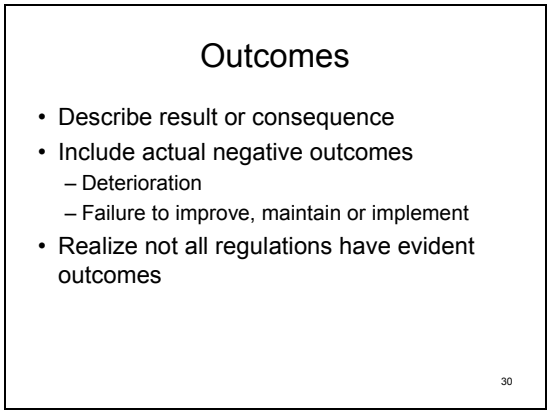

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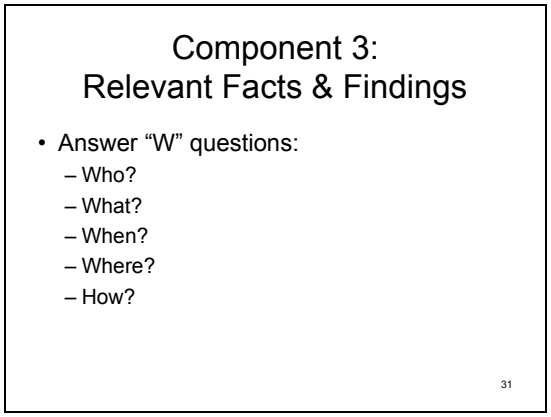

Slide 2-F-31

Outline or text of presentation

system or computers when all medical records are accessible via computer).

Unique Identifiers

- Be sure references maintain confidentiality.
- Use gender-neutral identifiers:
  - He/she.
  - Individual.
  - "The" or "a" resident/patient/client.

Do not use something publicly identifiable, such as a medical record number or social security number. Never refer to a person by the number of the room where he/she is located.

Outcomes

The "So what?" should reflect the actual outcome and the harm the patient/resident received from the failed practice or the potential for harm and outcome.

- Include the result or consequence.
  - Deterioration.
  - Failure to improve, maintain or implement.
- Realize not all regulations have evident outcomes.

Facts and Findings

- Answer the "W" questions:
  - Who?
  - What?
  - When?
  - Where?
  - How?

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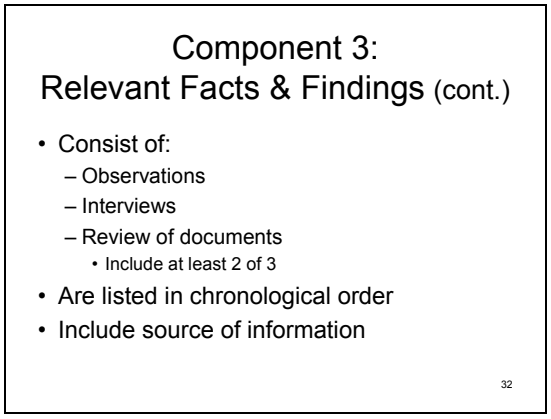


Slide 2-F-32

Outline or text of presentation

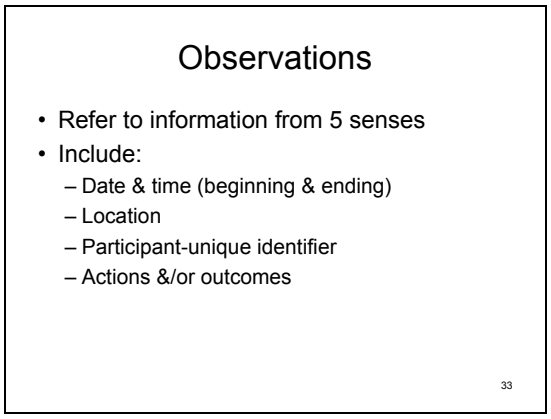
- Consist of:
  - Observations.
  - Interviews.
  - Review of documents.
    - Include at least two of the three.
- Are listed in chronological order, not the order in which you discovered them.
- Include the source of the information for each finding.

The evidence should be self-evident. If you have to reread it because you have forgotten the deficient practice, review and revise it so the evidence is more self-evident.

Organize the examples for different patients/residents by considering:

- Severity: the one with the worst outcome always goes first.
- Topic or concept.
- Unit (e.g., nursing unit or floor).
- Chronological order.

It should be in *logical* order.



Slide 2-F-33

Observations

- Refer to information from the five senses.
- Include:
  - Date and time (beginning and ending).
  - Location: Use the term used by the facility, room number as long as it does not refer to a patient/resident.
  - Participant-unique identifier.
  - Actions and/or outcomes.

If appropriate, ask staff a question to verify what you observed.

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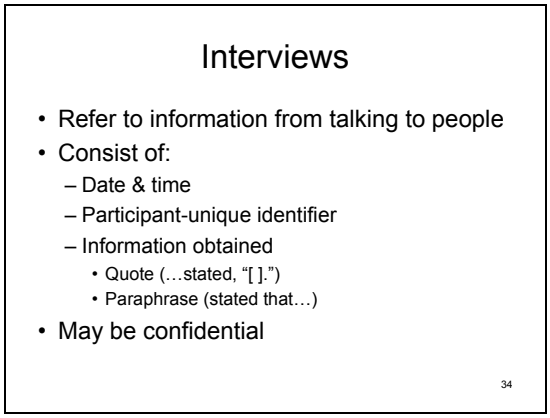
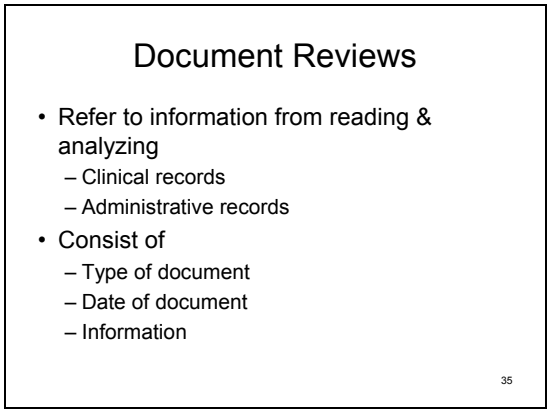


Slide 2-F-34



Slide 2-F-35

Outline or text of presentation

Interviews

- Refer to information from talking to people—patients/residents, family, visitors, staff and management.
- Consist of:
  - Date and time (beginning and ending).
  - Participant-unique identifier.
  - Information obtained.
    - Direct quote: Place the exact quotation in double quotation marks. Example: the supervisor stated, "[ ]."
    - Paraphrase ("stated that . . .")
- May be confidential.

The *Principles of Documentation* state that the surveyor should record the date and time and add, "in a confidential interview . . ." However, if the individual asks not to be identified, ask whether that person knows anyone else who would talk to you about the subject. Furthermore, attempt to validate the information through observations and document review and an interview from another individual.

Document Reviews

- Refer to information from reading and analyzing:
  - Clinical records.
  - Administrative records.
- Consist of:
  - Type of document.
  - Date of document.
  - Information.

You can summarize information, for example, "Review of [name of document] from beginning date] to [ending date] revealed . . ."

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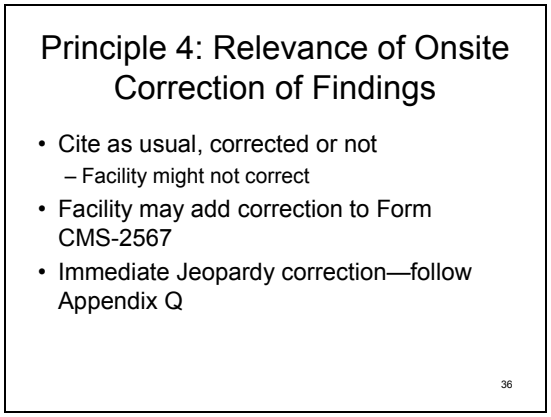

Slide 2-F-36

Outline or text of presentation

If the document is not dated, say it.

SODs are written for a serious audience that may or may not be well informed about the subject manner. Use a *strictly impersonal voice*. SODs should not refer to your opinions or feelings. They should have only the actual observations, interview results and record reviews. They should be deliberately neutral in tone—"let facts speak for themselves."

If the facts cannot "speak for themselves," then perhaps you did not gather enough evidence, or perhaps the evidence gathered was not strong. Review and ask if additional observations or interviews could have provided stronger evidence.

Talk to your teammates. Many times some investigated and have a piece of evidence that will strengthen what you are writing. Remember, a team is always stronger than one individual.

Principle 4: Relevance of Onsite Correction of Findings

- Cite as usual, whether corrected or not.
  – Facility might not correct.
- Facility may add correction to Form CMS-2567.
- Immediate Jeopardy correction—follow Appendix Q.

Facilities are to be in compliance at all times. If you identify a deficiency and tell the facility, cite it regardless of whether the entity corrects it during the survey. The facility can provide the Plan of Correction and the date the deficiency was corrected on Form CMS-2567 when it receives the deficiency.

Audiovisual

Principle 5: Interpretive Guidelines

- Designed for:
  - Better understanding
  - Consistent application
  - Pathways of inquiry
- Not requirements that need to be met
- May include professionally recognized standards
  - Include reference to standard

37

Slide 2-F-37

Outline or text of presentation

Principle 5: Interpretive Guidelines

- Designed for:
  - Better understanding.
  - Consistent application.
  - Pathways of inquiry.
- Not requirements that need to be met.
- May include professionally recognized standards.
  - Include the reference to the standard in the finding.

Principle 6: Citation of State or Local Code Violations

- Cite on Form CMS-2567 if:
  - Federal regulation requires compliance
  - State or local authority determines noncompliance
- Use more restrictive requirement

38

Slide 2-F-38

Principle 6: Citation of State or Local Code Violations

- Cite on Form CMS-2567 if:
  - Federal regulation requires compliance.
  - State or local authority determines noncompliance.
- Use the more restrictive requirement.

Principle 7: Cross-Reference

- Each tag cited must stand alone
- Link to another should:
  - Provide added support
  - Show cause/effect relationship
  - Support Conditions of Participation/Coverage citation

39

Slide 2-F-39

Principle 7: Cross-Reference

- Each tag cited must stand alone.
- Link to another should:
  - Provide added support.
  - Show cause/effect relationship.
  - Support Conditions of Participation/Coverage citation.

Each deficiency must stand alone so that if one is thrown out, it will not result in other deficiencies' also being thrown out.

The deficient practice for each deficiency is different. Therefore, the findings must not be repeated from one citation to

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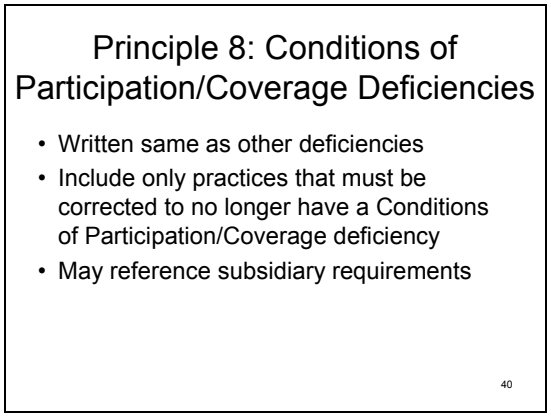

Slide 2-F-40

Outline or text of presentation

another. Although you may copy the findings from one deficiency and paste them into another, you must reevaluate the findings and tailor them to each deficiency.

Principle 8: Conditions of Participation/Conditions of Coverage Deficiencies

- Written same as other deficiencies.
- Include only practices that must be corrected to no longer have a Conditions of Participation/Conditions of Coverage deficiency.
- May reference subsidiary requirements.

(Determine which of the following handouts will meet the needs of your students. Distribute and review as needed. For scenarios, have each student work independently while coaching him/her to write a deficiency.

- *"Principles of Documentation Summary Sheet," page 2-F-97.*
- *"SOD Worksheet," page 2-F-99.*
- *"Principles of Documentation for Statement of Deficiency (CMS-2567) Review," page 2-F-101.*
- *"ICF/MR Practice Sample #1," page 2-F-103.*
- *"ICF/MR Practice Sample #2," page 2-F-105.*
- *"HHA—G277: Scenario and SOD Example," page 2-F-107.*
- *"LSC—K038: Scenario and SOD Example," page 2-F-113.*
- *"LTC—F314: Scenario and SOD Example," page 2-F-117.*
- *"LTC—F316: Scenario and SOD Example," page 2-F-125.*
- *"ESRD—V449: SOD Example," page 2-F-131.*

Audiovisual

Outline or text of presentation

- *"HHA—G158: SOD Example," page 2-F-133.*
- *"Hospice—L125: SOD Example," page 2-F-135.*
- *"Hospital—A350: SOD Example," page 2-F-137.*
- *"ICF/MR—W249: SOD Example," page 2-F-139.*
- *"LSC—K021: SOD Example," page 2-F-141.*
- *"LSC—K051: SOD Example," page 2-F-143.*
- *"LTC—F309: SOD Example," page 2-F-145.*
- *"OPT—I158: SOD Example," page 2-F-147.*
- *"RHC—J70: SOD Example," page 2-F-149.*

When each handout has been completed, have either the student or you, the trainer, review it using either a review form provided or your office form. Optionally, compare it with the State Performance Standard #2 for the current year [see Lesson 2-K].)

Documentation is a challenging task for several reasons.

It is difficult to put perceptions into words. A lot of what you experience on a survey is based upon a combination of senses, and the overall feeling and conclusions that you reach about a facility can be very perceptual in nature.

A surveyor described the task of documentation as "painting a picture in words." You need to relay your gut feelings in a written form and make a convincing case for your citation.

Audiovisual

Outline or text of presentation

Surveyors describe how frequently they spend a large amount of time on the write-up and end by feeling that they have a strong case, only to find out later that the office did not agree. Examples or even whole deficiencies may be deleted and (in long term care) the scope and severity may change if you do not investigate and gather the information to support a deficiency citation.

The surveyors were not able to communicate their feelings effectively in the documentation. Frequently surveyors say, “It’s difficult to relay what we’re feeling on paper.” Writing a “good” Form CMS-2567 can be difficult.

You may inadvertently neglect to include information because certain things were so obvious to you that it did not occur to you to write them down. People reading the citation may have questions that you didn’t even think to address in the citation because you were there and it was so obvious to you.

However, learning to survey is just that—a learning process.

Overall, surveyors feel that documenting immediate-jeopardy cases is the most challenging because of the need to provide sufficient detail to fully support the citation.

It’s difficult to write a jeopardy case. Usually when writing a citation, you want to be as brief and to the point as possible. However, with jeopardy it’s the opposite. You have to include all the details, so deficient-practice statements involving immediate jeopardy are usually very long.

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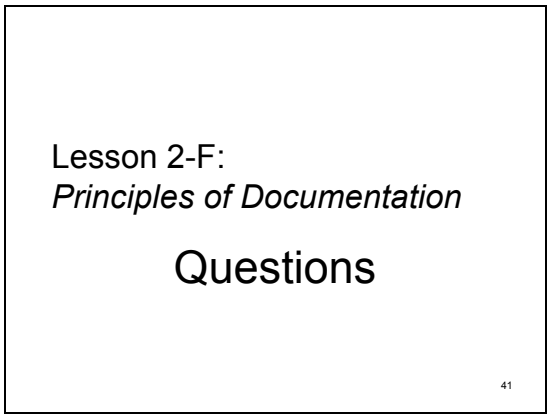

Slide 2-F-41

Outline or text of presentation

Copying Documents

Make a copy of documents that may be helpful in writing a deficiency and supporting facility noncompliance.

(Discuss the office procedures for copying, paying for copies, appropriate charge for each page and documentation of who provided the document at what time and on what date.)

Report writing is a difficult skill for most of us to develop, and it is different from other types of writing you may have done.

Remember:

- Your deficiencies will always be reviewed by the team coordinator and then by a supervisor. New eyes always find it easier to review a deficiency and see information that may be missing or what may be needed to make a stronger deficiency.
- It is normal even for experienced surveyors to be questioned and have to rewrite a deficiency.
- Do not become defensive, but learn what information is needed and vow to do a better job gathering the information next time.

Skill Assessment

Principles of Documentation

Trainee Name _____

Preceptor Name _____

Date _____

OO "Observation Only"
NMSE "Needs More Supervised Experience"
PSS "Performed with Some Supervision"
CMS "Competent with Minimal Supervision"
PI "Performed Independently"
Competent is defined in this context as following survey protocol, policies and procedures.

Provide a comment to support any assessment in shaded boxes.

OO	NMSE	PSS	CMS	PI	Skill	Comment
					1. Wrote deficiencies following the *Principles of Documentation*: A. Clearly documented observations, interviews and record review information for who, what, when, where and how. B. Used language that clearly identified harm or potential harm. C. Followed the *Principles of Documentation* and State/Regional Office–directed format. *Note*: List any specific principle the trainee seems to have a problem with at the time this skill assessment is completed. Include recommendations for improvement if necessary.	

					2. Spelling, punctuation and grammar followed good writing practice.	
					3. Wrote in a manner specific enough to allow a reasonably knowledgeable person to understand the deficient practice and findings that supported noncompliance.	
					4. If information was identified during a confidential interview, the surveyor followed the *Principles of Documentation* when completing Form CMS-2567.	

Comments/Recommendations:

Tips for Writing the Statement of Deficiencies

Determine:

1. Who will write each deficient practice.

2. How to write the following:
   - The deficient practice statement (this includes the portion "Findings include:" or "The findings included:" or other).
   - Dates (e.g., 02/01/2005 or 2/1/05 or February 1, 2005, or other).
   - Time of day (e.g., 2:59 a.m. or 0259 or other).
   - Unique identifiers
     - Patients, residents or other (Patient #2 or patient 2 or other).
     - Staff (Director of Nursing or Licensed Nursing Staff A).

3. Who will read each other's work (if someone other than the team coordinator).

Owed to the Spell Checker

I have a spelling checker—
It came with my PC.
It plane lee marks four my revue
Miss steaks aye can knot sea.

Eye ran this poem threw it.
Your sure reel glad two no
It's vary polished in it's weigh—
My checker tolled me sew.

A checker is a bless sing.
It freeze yew lodes of thyme.
It helps me awl stiles two read,
And aides me when aye rime.

To rite with care is quite a feet
Of which won should be proud.
And we mussed dew the best wee can,
Sew flaws are knot aloud.

And now bee cause my spelling
Is checked with such grate flare,
There are know faults with my cite;
Of non eye am a wear.

Each frays come posed up on my screen
Eye trussed to be a joule.
The checker poured o'er every word
To cheque sum spelling rule.

That's why aye brake in two averse
By righting wants too pleas.
Sow now ewe sea why aye dew prays
Such soft wear for pea seas!

—Anonymous

EXHIBIT 7A

PRINCIPLES OF DOCUMENTATION

NOTE: Principles of Documentation are merely guidance for surveyors and do not impose obligations on either providers or surveyors for the suggestions contained in them.

Table of Contents

Appendix A - Components to be Documented in A Deficiency Citation

Introduction

This appendix provides guidance on how to structure a deficiency statement on the Form CMS-2567 after all the necessary information and evidence have been gathered. These guidelines include a general discussion of the legal aspects of the Statements of Deficiencies and identify and explain the principles considered in the citation of deficiencies to be documented on the Form CMS-2567. The principles are generic and apply to the documentation of survey results regardless of the particular program (Medicare, Medicaid or the Clinical Laboratory Improvement Amendments) or the particular provider or supplier type.

This guide does not replace or supersede the law, regulations, or State Operations Manual (SOM). Rather, this appendix is intended to provide guidance for documenting citations. Therefore, this appendix does not create additional substantive or procedural requirements that must be present to sustain a valid citation.

The CMS-2567 is the record of the survey where the survey team documents and justifies its determination of compliance and informs the provider or supplier of its state of compliance with the requirements for participation in the Federal programs. This information will serve as the basis for the facility to analyze its deficient practices or system failures and to develop plans of correction. The CMS-2567 may also document deficient practices identified by means other than an onsite survey, e.g., a review of compliance with the requirements to transmit comprehensive assessments to the State Agency.

Each principle is discussed in depth and includes an example of that principle. Each example is identified as being effective and is included to illustrate a particular documentation principle and may not represent a complete citation. In each case, there may be other language that may be as effective. The adequacy of any citation can be evaluated only in the context of the particular type and source of evidence, the extent and consequence of deficiency, and other relevant factors.

Definitions

Listed below are definitions that will be used throughout these materials.

COP - an abbreviation that commonly refers to a " condition of participation." COP also is used throughout this manual to refer to a "condition for coverage" relevant to suppliers. The Conditions of Participation are requirements with which an entity must comply in order to participate in the programs.

Deficiency Citation - an entry made on the Form CMS-2567 that includes: (1) the alpha prefix and data tag number, (2) the Code of Federal Regulations (CFR), or Life Safety

Code (LSC) reference, (3) the language from that reference which pinpoints the aspect(s) of the requirement with which the entity failed to comply, (4) an explicit statement that the requirement was "NOT MET" and (5) the evidence (the deficient entity practice statement and relevant individual findings or facts) to support the decision of noncompliance (see Exhibit 0-1).

Deficient Practice - the action(s), error(s), or lack of action on the part of the entity relative to a requirement (and to the extent possible, the resulting outcome). ("practice" and "entity practice" are used interchangeably throughout this manual.)

Deficient Practice Statement - a statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulation.

Entity - a generic term used to describe providers and suppliers under the Social Security Act or laboratories that participate in the CLIA program.

Evidence - an integral part of the citation that begins with a description of the deficient entity practice and identifies the relevant individual findings and facts that substantiate the failure of the entity to comply with the regulation.

Extent of deficient practice - the prevalence or frequency of a deficient entity practice.

Finding - a generic term used to describe each discrete item of information observed or discovered during the survey about practices of an entity relative to the specific requirement being cited as being not met.

Fact - an event known to have actually happened. A truth known by actual experience or observation.

Forms CMS-2567/CMS-2567L Statement of Deficiencies and Plan of Correction - the official document on which citations are recorded (see Appendix A).

Outcome - a result/consequence of entity practices (e.g., development of avoidable pressure sore/ulcer; reaction due to receipt of blood of wrong blood type.).

Recipient - one who receives services (a patient, resident or a client) from an entity regardless of whether or not that person is eligible for, or is receiving, Medicare or Medicaid.

Requirement - any structure, process or outcome that is required by the law, regulations, or the Life Safety Code (LSC).

S/S - In the LTC survey, symbol accompanied by a unique letter (A through L) that illustrates the effect of the noncompliance on the nursing home resident (severity) and the number of residents actually or potentially affected (scope) by the provider's

noncompliance. The symbol with the letter assigned to the noncompliance appears under the tag number on the Form CMS-2567L for nursing homes. (See Appendix P).

Universe - the total number of individuals, records, observations, objects, related to the entity practice or recipients at risk as a result of a deficient practice. Used as the denominator when determining the extent of a deficient practice.

Appendix P - Guidance to Surveyors - Long-Term Care Facilities

Appendix Q - Guidelines for Determining Immediate and Serious Threat to Patient Health and Safety

Legal Aspects of the Statement of Deficiencies

The survey and certification of an entity that participates in Medicare, Medicaid or the Clinical Laboratory Improvement Amendments (CLIA) of the Public Health Service Act, is a process that must adhere to legal requirements. These programs are administered under extensive laws, regulations, operation manuals and other guidelines. Surveys and the documentation from surveys become an important part of subsequent legal proceedings arising out of the certification process.

This section is a brief overview of the legal aspects of surveying and the importance of surveyor documentation to the decision making and appeals process. It is not intended to provide complete and detailed information on the mechanics of the process. Please refer to the State Operations Manual (SOM) for more detailed information.

The survey process determines, and the documentation records, the compliance or noncompliance of providers, suppliers, and CLIA laboratories. The surveyor provides the reasons justifying any resulting enforcement action and the record on which to defend that action in the appeals process. Consistent and accurate documentation is imperative in the entire certification process as it forms the basis for the record and the certification decision. Moreover, the documentation may also be reviewed in any subsequent appeal, i.e., reconsideration, hearing before an Administrative Law Judge (ALJ) of the Departmental Appeals Board (DAB), review by the Board's Appellate Division, and judicial review.

A certification of compliance or noncompliance with the applicable requirements by the State agency or the Federal Government is an official finding and determines whether or not the provider or supplier may participate in the Medicare or Medicaid program or whether a laboratory is issued a certificate to operate under CLIA. It also determines whether any of these entities are subject to other sanctions. The decision-making process and subsequent certifications are based on the documentation of the survey in the Statement of Deficiencies (Form CMS-2567), as well as, other documentation such as surveyor worksheets or notes.

A prospective provider, supplier or clinical laboratory may request a reconsideration of a

determination that it does not qualify to participate in the Medicare/Medicaid program. A formal reconsideration is a thorough, independent review of the prior decision and the entire body of evidence. If the reconsideration determination upholds the initial decision, the entity may request an evidentiary hearing before an ALJ.

If an entity is determined to no longer meet the requirements and is subject to termination or alternate remedies/sanctions, the actual or projected termination or remedy may be appealed through an evidentiary hearing before an ALJ. If a laboratory's certificate is subject to limitation, suspension, revocation, or is actually limited, suspended, or revoked, the actual or projected limitation, suspension or revocation may be appealed through an evidentiary hearing before an ALJ. During a hearing, the government has the responsibility to show why a provider or supplier should be terminated or be subject to alternate remedies, and/or a laboratory's certificate should be limited, suspended or revoked.

The evidence must provide the underlying reason, basis or rationale for the findings of noncompliance with the regulatory requirement(s). Such a hearing is an adversarial proceeding. At the hearing, witnesses testify for both the entity and for CMS, and are subject to cross-examination. The primary evidence is the Form CMS-2567, and any other documentation used to make the determination of survey results (e.g., worksheets, narratives, etc.). The ALJ relies on the testimony of witnesses and the documentation from the survey in making a decision. All documentation used at the hearing becomes part of the public record. The ALJ issues a written decision as to whether or not the entity should be found in compliance with the requirements of the program. The ALJ is usually not a health professional, therefore, it is important that the surveyor present the findings in plain language. For this reason, the Form CMS-2567 does not contain technical jargon or abbreviations that would not be readily understood by a lay person.

If either CMS or the entity is dissatisfied with an ALJ decision or dismissal, it may file a request for review to the DAB Appellate Division. The DAB considers the evidence introduced at the ALJ hearing to determine whether the ALJ's decision had a sound factual basis. An entity dissatisfied with the DAB decision has the right to seek judicial review, CMS does not. The survey documentation again becomes an important document of the proceedings. The review by the Court is limited to the record of the proceedings before the ALJ and the DAB's Appellate Division.

Documentation on the Form CMS-2567 remains the key element in the record to support a determination to certify compliance or noncompliance with applicable requirements and, if necessary, to defend the determination before the public, during the appeals process, or in court. The documentation of each and every survey should be treated as if it will be subject to close scrutiny. The determination of compliance, as well as noncompliance must be based on objective, factual observations and not vague conclusions. A judge will usually rely on surveyor judgment if the documentation is thorough and comprehensive.

If, during the course of the survey, information/evidence involving recipient outcomes is discovered, surveyors should make every effort to relate the deficiencies to the effect on the recipient and recipient's care. Citations must relate to the statutory or regulatory requirements.

In addition, a clear and comprehensive Statement of Deficiencies is necessary to provide the entity with the information necessary to analyze its problems, define appropriate corrective action and come into compliance with the requirements.

Overview

Listed immediately below for easy reference are the principles considered in the development and completion of the Form CMS-2567. Following this listing, each principle is explained in detail in a separate section.

Principle #1 - Entity Compliance and Noncompliance

When an entity complies with the requirements applicable to the survey conducted, the Form CMS-2567 should consist of an explicit statement that the entity is in compliance. If an entity does not comply with one or more applicable requirements, the Form CMS-2567 includes corresponding citations of noncompliance.

Principle #2 - Using Plain Language

The deficiency citation is written clearly, objectively and in a manner that is easily understood. The deficiency citation does not include consultation, advice, comments or direction aimed at the surveyed entity.

Principle #3 - Components of a Deficiency Citation

A deficiency citation consists of (A) a regulatory reference, (B) a deficient practice statement and (C) relevant findings.

A - Regulatory Reference

A Regulatory Reference includes the following components:

1. A survey data tag number,
2. The CFR or LSC reference,
3. The language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant.
4. An explicit statement that the requirement was "NOT MET."

B - Deficient Practice Statement

The statement of deficient practice is one component of the evidence. It includes:

1. The specific action(s),error(s), or lack of action (deficient practice),
2. Outcome(s) relative to the deficient practice, when possible
3. A description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases,
4. The identifier of the individuals or situations referenced in the extent of the deficient practice, and
5. The source(s) of the information through which the evidence was obtained.

C - Relevant Facts and Findings

The facts and findings relevant to the deficient practice, answer the questions: who, what, where, when, and how. They illustrate the entity's noncompliance with the requirement or regulation.

Principle #4 - Relevance of Onsite Correction of Findings

If, during the survey, the entity corrects the situation that resulted in the deficiency, a determination of "NOT MET" must be documented on the Form CMS-2567. The entity may indicate its correction in the right-hand column of the Form CMS-2567. If, during the survey, the entity initiates corrective actions that abate a finding of immediate jeopardy, follow the guidance described in Appendix Q.

Principle #5 - Interpretive Guidelines

The deficiency citation explains how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements.

Principle #6 - Citation of State or Local Code Violations

The entity's failure to comply with State or local laws or regulations is not documented in the Form CMS-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has effectuated an adverse action that has been sustained through the hearing process (such as removal of the license to operate), the Form CMS-2567 should note that the entity no longer has a license.

Principle #7 - Cross-References

The cross-referencing of requirements is an acceptable form of documentation on the Form CMS-2567 only when it is applicable and provides additional strength to the linked citations. Cross-referencing is most effective when the linked citations have a direct cause and effect relationship to the deficient practices described in both citations. In all instances, the linked citation must contain sufficient evidence to demonstrate noncompliance for the referenced regulation at the linked site.

Principle #8 - Condition of Participation Deficiencies

The COP citation includes deficient practice statements and findings to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings.

Principle #1 - Entity Compliance and Noncompliance

When an entity complies with the requirements applicable to the survey conducted, the Form CMS-2567 should consist of an explicit statement that the entity is in compliance for that particular survey. If an entity does not comply with one or more applicable requirements, the Form CMS-2567 includes corresponding citations of noncompliance. The statutes and implementing regulations are the legal authority for determining an entity's compliance with Federal requirements for participation or coverage in Medicare, Medicaid, and CLIA.

The Form CMS-2567 is the official document that communicates the determination of compliance or noncompliance with the Federal requirements. Also, it is the form that an entity uses to submit a plan to achieve compliance. It is an official record and is available to the public on request.

Exhibit 1-1 illustrates how to give official notice to the provider or any other interested parties of the compliance status of the entity when the surveyor has identified no deficiencies. The specific requirements with which the entity must comply, as contained in Title 42 of the Code of Federal Regulations (CFR), are included.

Exhibit 1-1 - Effective Documentation for Principle #1

Tag	Summary Statement of Deficiencies
G 000	The [Name] Home Health Agency is in compliance with 42 CFR Part 848, Requirements for Home Health Agencies.

If a nursing home has no deficiencies identified at the time of the survey, the entry on the Form CMS-2567 would read that the NH is in compliance with 42 CFR Part 483, "Requirements for Long Term Care Facilities."

For SNF/NF, if the provider's noncompliance is isolated and does not pose a risk of more than minimal harm (S/S=A), the deficiency is documented on the "A" Form - "Statement of Isolated Deficiencies Which Cause No Harm With Only A Potential For Minimal Harm for SNFs and NFs." (See Appendix Q?) In addition, the documentation on the Form CMS-2567L would state the SNF/NF is in substantial compliance.

Exhibit 1-2 - Effective CMS-2567L Documentation for Nursing Homes With an A level finding

Tag	Summary Statement of Deficiencies
F 000	The [Name] Nursing Home is in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities

If a nursing home is in substantial compliance but has deficiencies, other than the Isolated Deficiencies which Cause No Harm with Only A Potential For Minimal Harm (S/S=B, C), the deficiencies are documented on the Form CMS-2567L and no additional language regarding substantial compliance is entered on the Form CMS-2567L.

NOTE: The remainder of the principles of documentation address how to document citations, that is, situations in which the entity has been found not to comply with one or more requirements.

Principle #2 - Using Plain Language

The deficiency citation is written clearly, objectively and in a manner that is easily understood. Each deficiency citation relates to a requirement within the CFR or the LSC. The deficiency citation should contain only the evidence to support the determination of noncompliance. Exclude the use of consultation, advice, comments or directions aimed at the surveyed entity. The deficiency citation should contain only the evidence to support the determination of noncompliance.

Inclusion of extraneous comments or consultative remarks in citations may lead to confusion. The entity surveyed and the public may not be able to distinguish between what the survey team would like to see and what is legitimate evidence of noncompliance. To decrease confusion, documentation in the Form CMS-2567 contains only the citation and evidence to support the determination on noncompliance. Extraneous information that is not relevant to demonstrating noncompliance with the specific requirement should be avoided.

An example of an extraneous remark would be: When documenting a deficient practice of failure to complete a care plan, a comment regarding the Resident's lack of knowledge regarding her Medicaid benefits is included. The Resident's knowledge regarding her Medicaid benefits has no relevance to the deficient practice regarding the care plan and only confuses the reader.

The language used to write a deficiency citation should be as clear as possible. Many styles of writing are acceptable, and style is a matter of individual preference; however, surveyors should not use slang, unfamiliar terms and phrases.

Best practice is to:

- Put all relevant facts in chronological order.
- Keep sentences short.
- Use simple sentence structure.
- Use the active voice (e.g. "The DON reprimanded the CNA" not "the CNA was reprimanded by the DON.").
- Avoid undefined abbreviations, initials and technical jargon.
- Write in layman's terms.
- Write to inform, not impress.
- Avoid unnecessary words.
- Avoid vague terminology (such as, seems, appears, did not always).
- Avoid words that imply or state conclusions without including the facts to support them (e.g., "only," "just," "unsatisfactory," "unnecessary," or "inadequate").
- Ensure the accuracy of quoted material.

According to "Strunk and White," When you become hopelessly mired in a sentence, it is best to start fresh; do not try to fight your way through against the terrible odds of syntax. Usually what is wrong is that the construction has become too involved at some point; the sentence needs to be broken apart and replaced by two or more shorter sentences."

Principle #3 - Components of a Deficiency Citation

A deficiency citation consists of (a) a regulatory reference, (b) a statement of deficient practice, and (c) relevant findings. (For SNFs and NFs, the scope and severity decision is documented in the left column under the survey data tag number.). Since all relevant information demonstrating noncompliance have been provided in the deficiency citation, conclusion or summary remarks at the end of the deficiency citation are not necessary and should be avoided.

This principle addresses **all** of the components of a complete citation.

Regulatory Reference

When the entity's practice violates a regulation or requirement, determine the regulation that the entity may have violated. Examine the language of the regulation under which a deficiency could be cited. Determine if the requirement addresses the entity's policies and procedures, actions, or inaction.

A regulatory reference is composed of: (1) a survey data tag number, (2) the CFR or LSC reference, (3) the language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant, and (4) an explicit statement that the requirement was "NOT MET."

Regardless of the computer software used to produce the Form CMS-2567, essential components of the citation: survey data tag, CFR or LSC reference, language of the requirement for that reference, and an explicit statement that the requirement was not met are generated automatically on the Form CMS-2567. Each handwritten citation should include all of those components. The deficient entity practice statement and the relevant findings then follow these components.

If the approved CMS software program for documenting deficiencies does not capture the language of the requirement being cited at a particular data tag or the specific regulatory/statutory requirement, incorporate the language for the specific aspect of the requirement being cited as being deficient.

Federal certification requirements are located at Title 42 of the Code of Federal Regulations (CFR) or in the Life Safety Code. [1] (LSC) The requirements are further coded into a series of alpha numeric data tags (e.g., F201, A53, G156, etc.) that allow essential survey information to be retrieved and analyzed to determine trends and patterns of noncompliance. The numerical order of survey data tags approximates the order of the requirements within the CFR or LSC [1].

Tag	Summary Statement of Deficiencies
F 174 S/S (A-L)	42 CFR 483.10 (k) The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This requirement is NOT MET as evidenced by:

Requirements

Federal requirements for participation or coverage can be categorized as follows:

- **Structure - requirements** that specify the initial conditions that must be present for an entity to be certified to participate and that, in general, are expected to remain as is unless there is a need for major renovation, reorganization or expansion of services. Some examples of structure requirements include:

  The agency has by-laws that **or** Each bedroom measures

- **Process - requirements** that specify the ongoing manner in which an entity must operate. They do not allow the entity discretion to vary from what is specified. Examples of process requirements include:

  The plan of care must be reviewed by **or** The physical examination is conducted on an annual basis

[1] If a LSC chapter references another chapter or NFPA reference document, the referenced chapter or document should also be cited. For instance, 1985 Life Safety Code, 13-3.5.1: Sprinkler systems shall be in accordance with Chapter 7.7-7.1: Sprinkler systems shall comply with NFPA 13, Sprinkler systems… 4-4.1: Buildings shall be sprinkled throughout the premises.

- **Outcome - requirements** that specify the results that must be obtained or events that must occur or not occur following an act. Generally, these requirements are stated in terms of the recipient's response to receipt of needed services or conditions that must result from, or are prevented by, implementing one or more processes. Example of outcome requirements include:

  The facility must ensure that a resident maintains acceptable parameters of....

  F-314: Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates they are unavoidable.

The findings document the outcomes that occurred or failed to occur or failure to assist the individual(s) to achieve optimal improvement in overall functioning or to prevent avoidable regression or loss of function. The citation documents sufficient facts to illustrate the level of harm that has occurred or may occur.

Deficient Practice Statement

The statement of deficient practice must be written in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement that is (are) not met. They are also used to identify the levels of scope and severity of the deficiency. It includes what the entity did or did not do which caused the noncompliance.

The statement of deficient practice must not repeat the regulation, but should state what the facility did that was wrong or failed to do, to let the reader know what to look for in the findings. The statement of deficient practice presents the specific action(s), error(s), or lack of action(s) relative to the requirement.

The evidence for a citation begins with a statement of deficient practice that summarizes the issues that led to the determination that the entity was not in compliance with that requirement and contains all the objective findings. The statement of deficient entity practice includes: (1) the specific action(s), error(s), lack of action (deficient practice); (2) when possible, resultant outcome(s) relative to the deficient practice; (3) a description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases; (4) the code of the individuals or situations referenced in the extent of the practice; and (5) reference to the source(s) of the information through which the evidence was obtained.

Some certification requirements state multiple expectations at a single survey data tag. The entity must maintain compliance with each facet of the requirement in order to continue participation. The failure to comply with only one expectation may be sufficient evidence for a citation of the entire requirement. The deficient practice must be described

in concise clear terms so that the entity can determine which part of the regulation it has NOT MET. The deficient practice statement should be organized and presented in a logical manner and should relate to each part of the regulation with which the entity failed to comply.

Exhibit 3-2 - Effective Documentation of Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F 455	42 CFR 483.70 (c)(1) The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care. This requirement was NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a space and the equipment required for physical therapy services for 4 of 10 sampled residents (4, 6, 7, and 10) who needed mat exercises, ambulation in parallel bars, and weight training to improve their physical functioning. Findings include:

Extent

Extent is the prevalence or frequency of a deficient practice and is a numerical quantification of the deficient practice. The extent is expressed in a numerical format by identifying the number of deficient cases within the total number of relevant cases or universe. For example, 4 of 6 residents observed during lunch. The universe may be all of the recipients provided care and services by an entity, if the failed practice affects all the recipients, e.g., when a hospital does not provide adequate maintenance of the fire alarm system. When the failed practice does not affect all the recipients of care and services provided by an entity, the surveyor must attempt to determine the relevant universe or the total number of recipients who could be affected by the failed practice. For instance: The ESRD center does not provide adequate monitoring of anti-coagulant therapy. Only those patients on anti-coagulant therapy would be affected by the deficient practice. Therefore, the universe would be the total number of patients with orders for anti-coagulants.

The surveyor then determines the number of individuals within the sample or expanded sample on anti-coagulant therapy who were harmed or could be harmed by the failed practice. Did the ESRD center fail to monitor all of those patients on anti-coagulant therapy? If not, how many were not monitored? The total number of patients affected by the failed practice divided by the total number of patients that could have been affected

by the failed practice provides a numerical quantification in percent of the extent of the failed practice.

The extent of deficient practice will depend upon whether:

1. The requirement related to all cases or individuals served by the entity;

2. Surveyors had knowledge of all cases to which the requirement applied;

3. The requirement related to a subset of all the cases or individuals served by the entity or only a sample of applicable situations or cases;

4. The deficient practice was determined through only random opportunities for discovery.

    Based on observation, the facility failed to maintain appropriate lighting standards for 7 of 12 emergency exits and failed to test pressure back flows on 2 of 2 water lines. In this example, there are 3 separate expressions of extent: the deficient practice created a potential hazard/impact on the entire recipient population, there were 12 exits and the lighting was insufficient at 7 of those 12, and 2 of 2 water lines were deficient.

- Knowledge of all cases or situations

When the deficiency is based on knowledge obtained about all applicable cases or situations, both this total and the number of cases/situations that evidenced deficiency should be recorded within the body of the citation. The following phrases illustrate a variety of acceptable measures:

> In an interview with the pharmacist at 2:00 p.m. on 5/29/XX he stated that of 98 residents at the facility for whom Haldol had been prescribed, 74 had individual program plans that had not been developed with the participation of…
>
> The hospital's pharmacy committee minutes dated 01/11/XX confirmed that of the 86 patients to whom medications are administered, 45 (approximately 53%) were identified as being unable to...
>
> Nineteen of the 20 residential living units were observed to need the following repairs:
>
> Each of the 5 seclusion rooms used by the facility

- Sample of applicable situations

  When the requirement is not applicable to all of the cases or individuals served by an entity, the extent would be developed by using only the cases or individuals with a negative outcome as a result of the deficient practice divided by the total number of cases or individuals in the sample that could have been impacted by the deficient practice. The extent of deficiency should be reported in numeric, quantified terms. For example:

  Review of records for 10 of the 60 patients who received transfusions between 7/10/XX and 9/30/XX revealed that the facility failed to monitor the vital signs for 6 of the 10 patients...

  Records for 2 of the 4 surgical patients in the recovery room at 9 AM on 1/7/XX and 3 of the additional 9 records reviewed of patients having had surgery between 12/28/XX and 1/6/XX revealed that no history and physical had been documented or dictated.

  Based on record review, and patient and staff interviews, the facility failed to complete an incident and accident report for 1 of 8 sampled patients (#6) reviewed and failed to analyze incident reports for health/safety hazards for 16 of 16 incidents reviewed.

  Based on observation, interview and record review, the facility failed to respond to residents' requests for assistance in a manner that maintained or enhanced their dignity for 5 of 9 sample residents (#5, 9, 12, 18, 24).

  Resident Assessments of 5 residents in the sample of 10 had not been evaluated by...

  For 22 of 50 clients in the sample who have current restraint programs authorized, 19 were...

- Random opportunities for discovery

When the deficiency is based on random opportunities for discovery of the problem, all of the applicable cases or situations may not be known. Surveyors may quantify their observation but may not be able to reference a total number of cases or situations that apply. Even though this procedure does not yield as precise a measure as has been discussed above, the report of measure is valid, particularly when serious outcomes of the deficiency have been observed and reported.

For example:

> In 3 of 4 random observations, the facility failed to honor the resident's requested preference for an alternate meal choice (RS #1, 2, 3).

Based on record review, interview and patient observation, the staff did not recognize and failed to assess the patient for the signs and symptoms of possible fecal impaction.

During the tour of Ward J-7 on XX/XX/XX at 10:00 am, three CNAs were observed addressing residents about their incontinent and personal hygiene in the solarium using extremely loud voices that could be heard down the hall. (RS #1, 2, 3, 4).

Based on observation, on XX/XX/XX the integrity of firewalls located between 1-East and 1-West was breached by a hole measuring 5 inches…

During tour on unit on XX/XX/XX at 2:15 p.m., RS #1 was observed to be mechanically restrained to his bed in locked leather cuffs while he was asleep…

Identifiers

An individual's name must not appear in the Form CMS-2567. The identity of the recipients of deficient practice or any persons, including surveyors, who will be referred to in the report, must remain confidential. They are included in the report by indicating their identifiers, which can be letters, numbers, or a combination or both. These identifiers also appear in the statement of deficient practice and in the findings.

When the person referred to in the report is an entity staff member, the person(s) may be addressed by their position, discipline, or job title, or be assigned an identifier.

Identification of each case found to be deficient provides the entity with information necessary to evaluate the context of the problem. When the evidence refers to individual recipients, the statement of deficient entity practice should reference by identifiers.

The coding system used to indicate the recipients should be decipherable by the entity, and retrievable by the RO or SA. Whenever possible, if a revisit or follow-up survey finds noncompliance for the same individual as in the standard survey, reassign the same identifier code. If it is not possible to use the same identifier, use a different set of numbers for revisits so that in the event of a hearing, the same identifier is not used for two different recipients. Every effort should be made to protect a recipient's privacy especially regarding information gathered during an in-depth interview. Do not identify recipients or family members without their permission. If the interviewee does not wish the entity to know the source of the information provided to you, that information may be recorded on the Form CMS-2567 without an identifier. The CMS-2567 would state, 'During a confidential interview....'' However, the interviewee must be told that there is no guarantee this information will remain confidential as a court may require that confidential information be disclosed. If the interviewee's identity is not disclosed to the

entity, the Form CMS-2567 must contain sufficient information for the entity to correct the deficient practice, and to contest the deficiency, if it desires.

When the deficient entity practice references personnel files or staff training, a separate coding system should be developed to identify the staff affected by the deficient entity practice without using their names.

When random observations or recipients/cases/records beyond the original sample(s) are included in a citation, an identifier should be given to the individual so that the entity may evaluate the extent of the problem or patterns and correct the deficient entity practice.

For example:

> During dining observations in an ICFs/MR, 4 non-sample random clients are observed who were not given an opportunity for incidental training during their dining experience.

After further investigation focused on the identified concern, if a citation is developed, these randomly observed clients need to be assigned an identifier so that the entity may address the deficient practice in its POC.

Examples of identifiers include:

> Sample Recipient identifiers:...for 3 of the 5 clients in the sample (Clients 2340, 5496, and 0429). Staff identifiers: (Title or Position) Based on interview with the ADON responsible for infection control, the entity failed **OR** Staff Identifier Coding System: 7 of 10 CNAs did not receive the 12 hours of in service training (So, 2, 3, 4, 7, 9, 10). Confidential Interview Identifier: Based on record review, the ESRD (entity) failed to allow patient participation in the development of the long term care plan for 4 of 10 patients (#2, 4, 5, 10). In addition a confidential interview revealed...

Sources of the Evidence

The source of evidence is the manner through which the evidence was obtained. Sources of evidence may include: observation, interview, and record review. They contain specific information regarding the who, what, when, where, and how of the events(s) or situation(s) that contributed to the deficiency. It is best to utilize supporting evidence obtained from more than one source of evidence.

The sources of evidence are presented in the statement of deficient practice and are described in detail in the findings portion of the Form CMS-2567 report.

Each statement of deficient practice identifies the source(s) through which the evidence was obtained, that is, from observation, interview, or reviews of records or other documents. Sources identified in the entity practice statement must be represented in the findings. The findings describe the specifics regarding the sources.

For example:

> What was learned from the source; the date, time, and location of the observations; the date and time of the interviews; titles of the interviewed persons and the types and dates of records/documents used in the identification of the deficient practices.

Do not identify the recipients or families when using information from the interview. Use a generic term to identify the person who has been interviewed, e.g., a family member, or a resident. Identify by title those staff who were interviewed. If more than one of the same type is interviewed, then the number of staff should be identified.

Observations

Observation is the process by which a surveyor gathers information in accordance with the requirements, based on input obtained from the five senses. It is what the surveyor sees, hears, touches, smells or tastes during the survey that evidences an entity's deficiency. It must answer the who, what, where, when, and how questions. A surveyor may observe if the actions or outcomes described in a clinical or administrative record actually occur in the daily operation of the entity. Actions or outcomes that are described in a clinical or administrative record and observed are also recorded as an observation.

The surveyor must note the specific date and time the observations were made and describe the observation.

Detailed documentation of observations of deficient practice assists the provider in identifying when and where the deficient practice occurred. Time includes the number of observations in which the deficient practice was observed and, as appropriate, the duration of each observation. For example, a series of observations that identify the failure to deliver service from 4:00 P.M. to 6:00 P.M., may help the entity to identify staffing or supervisory concerns, such as, inadequate supervision or sufficient staffing on a particular shift. Terms such as "throughout the survey," " during observation on the second day of the survey," etc. are vague, too general and should be avoided. Exhibit 3-3 illustrates an appropriate manner to document the evidence that was obtained through observation.

Exhibit 3-3 - Effective Documentation of Observation-Based Findings

Tag	Summary Statement of Deficiencies
K 021	NFPA 101 STANDARD: LIFE SAFETY CODE STANDARD Doors in fire separation walls, hazardous area exposure, horizontal exits, or smoke partitions may be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: (a) The required manual alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed. 13-2.11.5 Based on observations, the facility used a door wedge (an unapproved Device) to hold open 1 of the 9 entry doors included in the facility's fire Safety system. Findings include On facility tour between 2:30 and 3:30PM on xx/xx/xx, a door wedge was Observed at the foot of the West entry door holding the door open. The Door was being held in an open position and could not automatically close in case of fire.

Interviews

The interview process largely consists of talking to individuals (e.g., patients, clients, residents, family, visitors, staff, physicians, ombudsman) to collect information in accordance with requirements about the entity practices. Information obtained through interviews can provide evidence to support a deficiency.

For example:

Surveyors talk with recipients to determine whether the entity fulfills the commitments it has made in records; staff are interviewed to determine their knowledge of the needs of the recipient and of entity polices and procedures. To the greatest extent possible, the surveyor verifies the information obtained from interview through observation or record review. In the absence of other objective validation of information, information may also be confirmed/verified through multiple interview sources.

Exhibit 3-4 - Effective Documentation of Interview Based on Findings

Tag	Summary of Statement of Deficiencies
F 252	42 CFR 483.15 (h)(1) The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This requirement was NOT MET as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for 2 of 15 sampled residents (#5, #6) whose rooms lacked individual decorations and any personal belongings. Findings include: 1. Observations made during the tour at 10 AM on xx/xx/xx, noted that Resident 5's room was barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 3:00 p.m., Resident #5 stated, "I miss my pictures; they are all I have left. I want them with me but no one will get them for me. I want my own toiletries too!" 2. At 10 AM on xx/xx/xx, Resident #6's room was observed to be barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 11:00 a.m., a family member of Resident #6 stated, "My (Resident #6) would like to have a rocking chair. I asked the nurse if I could bring it in and she said she would check on it and let me know. This was about three weeks ago and she has not yet told me if it was acceptable or not." During an interview with the director of nursing (DON) on XX/XX/XX at 1:00 p.m., the DON revealed that the facility was aware of the residents' requests for personal belongings but had tried to discourage displays of any personal items to reduce theft in the facility.

Review of Records and Other Documents

Evidence discovered during review of the entity's documentation is discussed with the staff to determine if additional documentation or other information exists. Record or document review is the process through which administrative (e.g., statements of policy and procedure, committee minutes, injury/incident reports) and clinical (e.g., comprehensive assessments and evaluations, consultations, laboratory reports, plans of care, progress notes) documents are read and analyzed. Through review of recipients' clinical records, surveyors determine the needs of individuals and the extent to which the

entity has addressed those needs. Through review of administrative documents, surveyors assess the entity's compliance with requirements for the maintenance and use of those documents.

When using information obtained through record review, identify the record that contained the information. If the deficiency results from a lack of documentation, make sure the documentation is requested from the staff member who might or who should know where the documentation can be found.

Obtain copies of the records, which show the deficient practice to prove the deficiency, and to show after-the-fact changes that may be made by the entity.

If the regulation requires a policy on specific issues, ascertain that the policy fails to address the necessary issues before determining it is deficient.

Examples of documenting information from records and some of the additional investigation necessary, include:

> Patient Y's medical record contained a urinalysis report dated XX/XX/XX for urine which was sent to a laboratory on XX/XX/XX. The report indicated the sample had been contaminated and recommended that a new sample be submitted. The record did not indicate that another specimen had been sent and the staff on XX/XX/XX were unable to determine if any had been sent.
>
> The medical record did not contain the results of the urinalysis for the sample sent to the lab on XX/XX/XX. Staff were unable to locate the report and reported upon inquiry of the lab that the results had not been sent to the facility.
>
> The initial Minimum Data Set (MDS), dated XX/XX/XX, documented that a resident was readmitted from home on XX/XX/XX with a reddened area. The nurses notes dated XX/XX/XX, documented a "reddened area to left ankle."

Exhibit 3-5 - Effective Documentation of Record Review-Based Findings

Tag	Summary Statement of Deficiencies
V 321	405.2137(b)(4)STANDARD: PATIENT CARE PLAN The care plan for patients whose medical conditions has not stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patient's ongoing needs. This STANDARD is NOT MET as evidenced by: Based on record review, the provider failed to address changes in therapies on the Patient Care Plan (PCP) for 2 of 7 patients (#1, #4). 1. Review of the admission progress note dated 4/10/XX showed that Patient #1 started receiving peritoneal dialysis (in the home) on 4/1/XX. Per the 10/2/XX Social Services note, Patient #1 was switched (at the request of the patient) from peritoneal to hemodialysis (in the dialysis center) on 9/11/XX. Review of the most current PCP dated 12/2/XX revealed that this change in treatment modality was not addressed in the PCP. 2. Patient #4 started hemodialysis (in the dialysis center) on 2/11//xx per the admission assessment. The 9/8/XX Physicians Progress note indicated that Patient #4 received a transplanted kidney on 4/5/XX, but restarted hemodialysis again on 8/1/XX after the transplant was rejected. Review of the PCP dated 12/2/XX revealed that the patient's changes in status were not addressed in the PCP.

Exhibit 3-6 - Effective Documentation of Record Reviews

Tag	Summary Statement of Deficiencies
F 225 S/S	42 CFR 483.13 (c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). This requirement was NOT MET as evidenced by: Based upon staff interview, review of medical records, and review of the policy and procedure manual, facility staff did not report to the administrator bruising of unknown origin for 2 residents in the sample of 20 (#15, 24). The findings include: 1. A record entry dated XX/XX/XX, for resident #24 noted that staff had observed bruises on the resident's genitals and inner thigh. During an interview at 1:00 p.m. on XX/XX/XX, the Director of Nurses stated that the Administrator had been ill for 2 months around that time and she had been acting Administrator. She said, "Staff did not report the bruises to me ...I have not investigated for the cause of the bruises." 2. A record entry, dated XX/XX/XX, for resident #15 noted that staff had discovered that the bridge of the resident's nose was very bruised and no indications of a possible cause were noted. An interview with the charge nurse on the south wing on XX/XX/XX at 10:00 a.m. confirmed that no one knew how the bruise occurred. The injury of unknown origin had not been reported to the administrator and had not been investigated. 3. Review of the policy and procedure manual on XX/XX/XX, did not provide evidence that the facility had established procedures in the manual that specify how allegations of abuse or injuries of unknown origin were to be reported. During interview on XX/XX/XX at 3:00 p.m., the administration confirmed that the facility had no current policy or procedure directing staff regarding when to report possible abuse or injuries of unknown origin.

The following are examples of complete citations that comply with the Principles of Documentation.

Exhibit 3-7 - This example reports the evidence in a way that the entity can understand that the requirement was not met and how the survey team determined that the requirement was not met. The facts are stated clearly, the deficient practice is apparent, and there is no extraneous information within the citation that might cause confusion. All of the components of a complete citation are included.

Exhibit 3-7 - Effective Documentation of Principle #3

Tag	Summary Statement of Deficiencies
L 210	418.94 (a)Standard: Supervision A registered nurse visits the home site at least every two weeks when aide services are being provided, and the visit includes an assessment of the aide services. This STANDARD is NOT MET as evidenced by: Based on review of 4 of 12 medical records (#5, 3, 9, 12) and interviews in 2 of 4 home visits (#5, 12), it was determined that the registered nurse visit did not include an assessment of whether the aide provided grooming services (shampoo and shower) to the patients. The findings include: 1. Review of medical records for Patient #5 revealed that: between 10/20/XX to 12/20/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The son of Patient #5 said, during an interview on 12/28/XX, "The aide never shampoos my Mom's hair and the nurse said that she is supposed to be doing that." During an interview at 10 a.m. on 12/29 with the nurse caring for the patient, the nurse acknowledged that the family member had mentioned the shampoos, the plan of care did indicate the patient was to receive shampoos, but she had not followed up with the aide about not doing them, nor had she verified what was reflected on the aide assignment sheet or what the aide had recorded. 2. Review of medical records for Patient #12 revealed that: between 10/28/XX to 12/28/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The family member of Patient #12 said, during an interview on 12/28/XX, "The aide did not give (my family member) a shower; instead the aide gave (my family member) a very quick bath in bed. I don't know why but the aide always comes late and leaves early."

Tag	Summary Statement of Deficiencies
	3. The same lack of documentation regarding registered nurse visits to the home site to assess aide services was found in medical records for Patients #3 for review period 03/10/XX to 05/07/XX; and #9 for review period 02/11/XX to 03/29/XX.

Each of the three sources may not be necessary to confirm a deficiency. Regardless of the particular avenue(s) through which information about an entity's compliance with requirements is gathered, the Principles of Documentation statement should include how the information was obtained.

Outcomes

To the extent possible, especially where described or anticipated in the requirement(s), the deficient practice indicates outcome(s). The statement of findings describes the specific results and consequences of the entity's deficient practice for the individual cases reported. Negative outcomes include deterioration, failure to improve or maintain, etc. Although no negative outcome may be evident from the deficient practice, a failure to comply with a requirement is a deficiency. Many requirements are not outcome oriented. An example of outcome requirements includes:

A resident who enters the facility without pressure sores does not develop pressure sores.

Exhibit 3-8 - Effective Documentation of Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F 314	42 CFR 483.25 (c) Based on a comprehensive assessment of a resident, the facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable: and This requirement was NOT MET as evidenced by: "Based on observation, staff interview, and record review, the facility failed to provide services to prevent the development of a pressure ulcer, to promote healing and to adhere to infection control measures (universal precautions) designed to prevent cross contamination resulting in the development of an avoidable Stage III pressure ulcer for 1 of 3 sample residents (R#2) with pressure sores. Resident #2 experienced ongoing pain, infection and was unable to continue activities of daily living." Findings include:

This example reports the evidence in a way that the entity can understand that the requirement was not met and how the survey team determined that the requirement was not met. The statement identifies the extent of the deficient entity practice, includes identifiers for the individuals affected by the deficient entity practice, identifies the sources from which the information was obtained, and clearly states the outcomes of the deficient entity practice.

Findings

Findings support or illustrate an entity's noncompliance with a requirement. Cite only findings attributable to the entity. Each statement of deficient practice is followed by the specific findings (**who, what, where, when, how)** that illustrate the entity's noncompliance for each case/issue referenced in the deficient practice statement. The facts are presented in a concise and logical sequence. The findings include the outcomes, descriptions of actions/situations, identifiers, and sources. Any evidence that supports a finding and affects the deficiency determination must be incorporated into the deficiency citation.

When details for a number of individual examples have been described to illustrate a particular deficient practice, a final entry may describe additional similar findings and identifiers to demonstrate the magnitude of the problem.

Facts

A fact is an actual occurrence, something known to exist or have happened. The findings are facts that allow the entity to compare what it did or failed to do, against what is required. The findings support the deficient practice statement. For example, if residents #1, 3, 5, and 7, are discussed in the deficient practice statement, the findings are the facts to support the noncompliance for residents #1, #3, #5,and #7.Without the presence of facts, the evidence can be construed to mean that an assumption was made, rather than a known conclusion about the entity's practice.

Failure to include pertinent facts may prevent the entity from discovering what contributed to the deficient practice. For example, there may be many reasons for the failure of a patient to receive a needed treatment, such as: the patient was not scheduled for a treatment; the staff had not been trained regarding how to provide the treatment; trained staff were not available to provide the treatment; trained staff were available but forgot to provide the treatment; proper authorization for treatment was not provided; or, the patient refused the treatment.

Identification of the pertinent facts gives the entity the means to examine the failure to comply, in light of the specific circumstances or contexts, which the failure occurred.

When writing a deficiency citation, try to provide answers to basic questions - Who?, What?, When?, Where?, and How?. Based on the nature of the deficiency, it may be

impossible or inappropriate to answer each question. However, this approach facilitates inclusion of the pertinent facts. Deficiency citations identify:

How the deficiency was determined, and how the evidence relates to the requirement;

What entity practice was noncompliant;

Who were the residents or staff involved;

Where the deficient practice occurred, e.g., specific locations in the entity or documents; and

When (e.g., for how long) the problem occurred. Include the number of observations and the duration of the observations. Include the specific dates or time period for the noncompliance. The findings also include documentation of verification or request for additional information through interviews with facility staff.

Exhibit 3-9 - The statement of the findings in this example illustrates how the relevant facts answer the basic questions of who, what, when, where and how.

Exhibit 3-9 - Documentation of Facts

Tag	Summary Statement of Deficiencies	
F 369	F369 42 CFR 483.35(g))	
	The facility must provide special eating equipment and utensils for residents who need them.	
	This requirement is NOT MET as evidenced by:	
	Based on record review, observation and interview the facility failed to provide adaptive fork and spoon for a resident (R#7) who was assessed to need these items.	"HOW" "WHAT" "WHO"
	The findings include:	
	1. The care plan, dated XX/XX/XX for Resident #7 indicated that R#7, who has suffered from a recent stroke, needed adaptive utensils to eat meals independently.	"HOW" "WHAT"
	2. R#7 was observed in the dining room during breakfast on XX/XX/XX and XX/XX/XX, lunch on XX/XX/XX and XX/XX/XX, and dinner on XX/XX/XX	"HOW" and "WHERE" "WHEN" "WHEN" "WHEN"

Tag	Summary Statement of Deficiencies	
	struggling to eat, using a regular fork and spoon, and most of the food was falling off the utensils	"WHAT"
	The resident ate only about 25 percent of each meal	"WHAT"
	3. During an interview with the nurse aide on XX/XX/XX at 12:00 p.m., the nurse aide stated, "For a few days R#7 was given special utensils, but I don't know what happened to them	"HOW"
	I haven't seen them for a week or so."	"WHEN"
	4.R#7 said during an interview on XX/XX/XX at 12:25 p.m. "My right hand just doesn't work like it used to since I had this stroke. I was never good at using my left hand, I don't understand	"HOW"
	why they stopped giving me the special fork and spoon, I guess they just want me to eat with regular silverware."	"WHAT"

Organization of Findings

The findings should be organized in a chronological and logical order. Grouping related findings and facts under applicable statements of the deficient practice statement assists the entity in focusing on the development of plans to correct its deficient practices rather that on correction of the findings. The organization of the findings should clearly convey to the reader the sequential order of events that resulted in a citation. For example, situations or cases are presented in a logical sequence to show individual deterioration over time or date.

When setting forth a series of facts and events, start by setting out the relevant background facts (e.g., "Resident #1 was at risk for weight loss as set forth in the MDS dated XX/XX/XX.") Then, if possible, set out the events in chronological order.
The following example, Exhibit 3-10 illustrates a citation from the home health requirements. The citation is written based on two separate requirements contained in the language of the requirement. It includes two statements of deficient practice and organizes the relevant findings/facts under those statements.

Exhibit 3-10 - Effective Documentation of Two Deficient Practice Statement and Their Findings

Tag	Summary Statement of Deficiencies
G 108	42 CFR 484.10(c)(1)STANDARD:RIGHT TO BE INFORMED AND PARTICIPATE IN PLANNING CARE AND TREATMENT The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of the visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the agency failed to inform 2 of 12 patients (#3 and #9) reviewed about changes of the frequency of care to be furnished, and the facility failed to inform 2 of 12 patients (#7 and #10) in advance of changes to the plan of care. The findings include: Changes in Frequency of Care: 1. Patient #3 began receiving services on 10/15/XX due to a fractured hip. These services were to include physical therapy (PT) three times a week for 8 weeks for gait and balance training to restore ambulation ability. The PT note, dated 11/1/XX, states, "Increase in case load prohibits three sessions a week of treatment. Frequency to be once a week for reminder of treatment." Observation during the 12/7/XX home visit revealed that the patient is not ambulating. Interview on 12/7/XX during the home visit with Patient #3 indicates that the patient was not informed of the change of frequency of the PT services. Telephone interview with the physical therapist on 12/7/XX confirms that this patient is not ambulating due to the decreased frequency of treatment and that the patient was not informed of the change of frequency. 2. Patient #9 began receiving services on 9/10/XX due to a stiff shoulder....

	Changes in Plan of Care 1. Patient #7 began receiving services on 11/20/XX. The plan of care dated 11/23/XX, indicated that services were to include skilled nursing services for wound care and home health aide assistance for activities of daily living. On 11/28/XX, the nurse's note states: "care plan revised as the home health aide can do wound care. Sufficient healing has occurred so that skilled services are not indicated. Wound needs to be cleansed during bathing." Observation on the 12/8/XX home visit indicated that the wound was healed. Interview with Patient #7 indicated that the patient wondered about the whereabouts of the nurse who used to come to clean the wound. She had not seen her in a long time. Interview with the nurse indicated that as the person was progressing well, there was no need to inform her about the change in the plan of care. 2. Patient #10 was admitted for service on 11/13/XX.The plan of care, dated 11/13/XX, identified an occupational therapy (OT) consultation to determine if environmental modifications to the home were indicated. An OT note of 11/17/XX states: "Consultation not indicated." No additional information was recorded. Interview with Patient #10 on 12/8/XX indicates that he was satisfied with the services received, but, "I hope that the person who is supposed to help with the arrangement of the house gets here soon. It is difficult for me to get around here." Interview with the Director of Services on 12/8/XX confirmed that the person was not informed of the changes to the plan of care."

Principle #4 - Relevance of Onsite Correction of Findings

If, during the survey, a deficiency is found, but the entity corrects the situation as soon as they become aware, a determination of "NOT MET" must be documented on the Form CMS-2567. The entity may indicate its correction in the right-hand column of the Form CMS-2567. If, during the survey, the entity initiates corrective actions that abate a finding of immediate jeopardy, follow the guidance described in Appendix Q. The entity may indicate its correction in the right-hand column of the Form CMS-2567.

If an entity demonstrates practices that cause it to be out of compliance, there may be a system failure. The findings used as part of the evidence illustrate the result of that failure; the findings are not the cause of it. Mere correction of the findings reported to the entity prior to the exit conference would not necessarily assure that the cause of the finding had been addressed. The entity, not the survey team must ascertain the cause and correct the systems failure that caused the deficient entity practice.

Exhibit 4-1 demonstrates how to document a deficient practice even though the entity may have addressed the effects of the practice during the survey.

Exhibit 4-1 - Effective Documentation for Principle #4

Tag	Summary Statement of Deficiencies
G 145	483.14(g)Standard Coordination of patient services A written summary report for each patient is sent to the attending physician at least every 62 days. This standard is NOT MET as evidenced by; Based on record review and staff interview, it was determined the home health agency failed to ensure a written summary report which included a compilation of pertinent factors of patient's clinical progress had been sent to the physicians' office for 2 of 2 sampled patients (#4, and 5) who required a 62 day summary. Findings include: 1. Patient #4 was admitted for home health services on XX/XX/XX. The plans of care for the certification periods XX/XX/XX to XX/XX/XX and XX/XX/XX to XX/XX/XX included goals which stated "Patient will experience stable cardiopulmonary status as evidenced by clear lung sounds, no chest pain, SaO2 (saturation of arterial blood) greater than or equal to 92%." Summary reports addressing the patients progress or lack of progress were not available as part of the Patient's clinical record. 2. Patient #5 was admitted for home health services on XX/XX/XX with the diagnosis of pressure ulcer and congestive heart failure. The plan of care for them certification period XX/XX/XX to XX/XX/XX included goals that stated " Patient will have pressure ulcer healed with no sign or symptoms in 10 weeks." The summary report addressing the status of the patient's wound was not available as part of the clinical record. Staff interview on XX/XX/XX confirmed the HHA had not sent written summary reports to the physicians, until after the surveyor inquiry when summary reports were then completed and faxed to the physician during the survey.

Correction of Immediate Jeopardy (IJ) During Survey

Exhibit 4-2 documents noncompliance with a participation requirement that resulted in a situation of immediate jeopardy. The CMS-2567 includes the facility's actions to remove the immediate jeopardy while the survey team was onsite; however, as stated above, mere correction of the findings does not assure that necessary corrections, at the systems level, have taken place. Follow the directions for immediate jeopardy located in Appendix Q of the State Operations Manual.

Exhibit 4-2 - Effective Documentation for Correction of IJ during Survey-Principle #4

Tag	Summary Statement of Deficiencies
F 223 S/S = J	42 CFR 483.13(b)Requirement Abuse…The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The requirement is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to prevent 1 of 21 sample residents (#5) from being assaulted by staff and failed to report the assault to the appropriate authorities in a timely manner and failed to take actions to prevent further such incidents to residents resulting in immediate jeopardy. Findings include: Interviews with 3 CNAs A, B, C, on duty on 7/10/XX, indicated that they observed a certified nursing assistant (CNA)(E-1) "throw" a resident (R#5)to the ground during a picnic at the facility on 5/26/XX. The CNA, who observed R#5 becoming agitated, went to the resident to bring him back into the facility. When the resident became "uncooperative and irritated" and refused to go into the building, the CNA gave the resident a "bear hug." The resident fell to the ground at which time the CNA dragged the resident by the back of his shirt into the facility, a distance of approximately 30 - 40 feet. Nurses notes on 6/1/XX state that the resident had abrasions on the lower lumbar and upper left thoracic regions, but was not able to say how he got them. During an interview with the facility administrator on 7/11/XX, the administrator said, "I was not aware of the incident until 6/1/XX when a staff member asked for medication to put on [resident #5's[cuts. I notified the health department on 6/1/XX." The administrator acknowledged he did not remove the CNA from providing resident care until questioned by the surveyor on 7/11/XX.

	The administrator was notified of the immediate jeopardy at 2:00 p.m. on 7/11/XX. At 3:00 p.m. the administrator notified the survey team that the involved CNA had been removed from duty and that the CNA would be fired.

Principle #5 - Interpretive Guidelines

The deficiency citation demonstrates how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements. Various appendices to the SOM contain "Interpretive Guidelines" or "Guidance to Surveyors." These Guidelines were designed to assist surveyors to develop a better understanding of the requirements, to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although surveyors must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation, and therefore, may not be used as the basis for a citation. However, they do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist surveyors in making determinations about an entity's compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the surveyor must indicate such on the Form CMS-2567.

Surveyors should carefully consider how the practices of the entity relate to the illustrations within the Interpretive Guidelines, and then compare the entity's practice to the specific language and requirement of the regulation before determining that a deficiency exists.

Exhibit 5-1 - Interpretive Guidelines

Regulation	Guidance To Surveyors
42 CFR 483.35 (h)(2) "Sanitary Conditions." The facility must (2) store, prepare, distribute, and serve food under sanitary conditions; and	Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit, etc... Referenced guidance 1999 FDA Food Code.

Exhibit 5-2 illustrates how material in Interpretive Guidelines can be used to support the citation. The critical factor is whether or not the evidence relates directly to the language and requirement within the regulation.

Exhibit 5-2 - Effective Documentation for Principle #5

Tag	Summary Statement of Deficiencies
W 214	42 CFR 483.440 (c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This Standard is NOT MET as evidenced by: Based on observations, staff interview, and record review, the facility failed to include in the comprehensive functional assessment, the client's cognitive ability for 2 of the 4 clients in the home (#2, #3). The findings include: Review of Client #3's medical records, dated between XX/XX/XX and XX/XX/XX, revealed 11 evaluations conducted by the professional staff. None of the evaluations specified any deficits that may have contributed to his diagnosis or his reported developmental level of functioning. Observations on XX/XX/XX and XX/XX/XX confirmed that...In an interview on XX/XX/XX, LPN1 said, "I am unclear about the client's identified strengths."

Principle #6 - Citation of State or Local Code Violations

The entity's failure to comply with State or local laws or regulations is not documented in the Form CMS-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has effectuated an adverse action that has been sustained through the hearing process (such as removal of the license to operate), the Form CMS-2567 should note that the entity no longer has a license.

Federal certification requirements are uniform throughout the United States. However, States and localities may have additional requirements that the entity must meet in order to continue to operate within those jurisdictions. Some licensing requirements may be more stringent or prescriptive than Federal requirements. Licensure surveys are conducted to determine an entity's compliance with specific State or local laws and regulations. Entities that do not meet the State or local requirements for licensure may not be certified for participation in the Medicare/Medicaid programs.

In the event of a difference in the stringency of a Federal certification requirement and a corresponding State or local (e.g., licensing) requirement, the entity is to comply with the

more stringent of the two. However, when enforcement of the more stringent requirement comes from an authority other than the Federal requirement, the evidence may be recorded on the Form CMS-2567 only in the manner prescribed by CMS.

Failure of the entity to meet State or local requirements is recorded on the Form CMS-2567 at a Federal data tag for one of two reasons:

1. The language of the Federal regulation explicitly requires compliance with State or local laws and codes. Deficiency citations made under these requirements should include a reference to the particular State or local code with which the entity is noncompliant. This insures that there is legal authority to describe any conditions or practices described as deficient. Surveyors always should review their findings relative to the specific Federal requirement to determine if and when an entity's failure to achieve compliance with a licensure requirement is sufficient evidence to cite noncompliance with a Federal certification requirement.

Exhibit 6-1 is consistent with Principle #6. The entity's practice of using LPNs to conduct the health status review was deficient specifically relative to the requirement; or

Exhibit 6-1 - Effective Documentation for Principle #6

Tag	Summary Statement of Deficiencies
W 345	42 CFR 483460(d) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section. This STANDARD was NOT MET as evidenced by: Based on record review, the facility for the period between 7/1/XX and 9/30/XX, utilized Licensed Practical Nurses (LPNs) to review the health status of residents for 4 of 10 sampled records (2, 6, 12, 19).Section 76543 of the Code of Professional Health Practices (State Requirement) requires that this function be performed only by Registered Nurse (RNs).

2. The authority having jurisdiction has made a determination of noncompliance with State or local law, has taken and sustained an adverse action (See Exhibit 6-2.). An adverse action is any procedure taken by a State Agency that goes beyond the approval of a plan of correction, such as, fines, ban on admissions, loss of license, etc. The authority having jurisdiction is the person or persons who have the authority to make a final determination of noncompliance and are responsible for signing the correspondence notifying the facility of the adverse action. A final determination means the determination has not been appealed or is no longer being appealed by the entity.

Exhibit 6-2 - Effective Documentation for Principle #6

Tag	Summary Statement of Deficiencies
F 492	42CFR483.75(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This requirement is NOT MET as evidenced by: Based on evidence in the attached notice of determination of noncompliance, the entity did not meet (state or local) Law #XXX. An adverse action was taken against the entity by (the authority having jurisdiction.) See attached.

Principle #7 - Cross-References

The cross-referencing of requirements is an acceptable form of documentation on the Form CMS-2567 only when it is applicable and provides additional strength to the linked citations. Descriptive evidence (facts and findings) from one citation may be linked into the evidence for a citation at another requirement. The evidence being linked into that requirement must support the determination of noncompliance with that requirement. Each citation must contain all components described in this document independent of the additional information being linked into that citation. Cross-referencing is most effective when the linked citations have a direct cause and effect relationship to the deficient practices described in both citations. In all instances, each citation must contain sufficient evidence to demonstrate noncompliance for the referenced regulation. Additional guidance for cross-referencing for COP level citations is provided in POD #8.

Tag	Summary Statement of Defciencies
G 170	G170 42 CFR 484.30 Skilled Nursing Services The HHA furnishes skilled nursing services in accordance with the plan of care. This requirement is NOT MET as evidenced by: Staff interview and review of seven clinical records requiring RN skilled services revealed that the RN did not comprehensively assess the patients or furnish the frequency of visits required by the Plan of Care for 4 of the 7 patients (H3 H5, H6, H7). See G174 for additional information regarding patients H3, H5, and H7.

	1. Review of H3's clinical record indicated physician orders for twice daily RN visits from 10/01 to 10/08/XX to administer IV antibiotics, assess the stats of and perform a dressing change to the Stage 3 ulcer of the left heel. The aide sheet for 10/04 reflected that the aide had changed the heel dressing that a.m. The record shows two LPN visits and an evening dressing change by the LPN on 10/04 but does not contain information of an RN visit, assessment or dressing change on 10/04/XX. Interview at 10:30 a.m. on 11/10/XX with supervising nurse confirmed that on 10/04/XX an aide had performed the a.m. dressing change on H3's Stage 3 pressure ulcer of the heel. The supervising nurse reported that although the RN was ill and had not made the planned a.m. or p.m. visits that day, the agency's LPN had performed the visits and supervised the aide. 2. Review of H5's clinical record indicated that the Plan of Care for H5 required RN visits from 4 to 5 times the week of 10/07/XX and 3 times a week for 3 weeks beginning 10/4/XX to assess the patient's response to changes in the medication to control her angina and blood pressure. The RN visited only 3 times (10/07, 10/08 and 10/10) during the week of 10/07 and limited her assessment to checking breath sounds and blood pressure. The RN did not evaluate for signs and symptoms or complications of either hypo or hypertension or for compliance with dietary restrictions or known side effects which accompany the use of calcium channel blockers. 3. Review of H6's clinical record indicated the RN did not visit H6 twice daily as required by the Plan of Care to monitor the institution of sliding scale insulin for the newly diagnosed brittle diabetic. The Plan of Care required twice daily visits from --- to ---. The actual visit frequency was ---.

Tag	Summary Statement of Deficiencies
G 170	G170 42 CFR 484.30 (Cont.) 4. Review of H7's clinical record indicated the RN did not assess, record, and report to the physician the change in the status of the suture line of the hip wound on 10/21/XX.The Plan of Care required RN visits 5 times a week for 1 week then 3-5 times a week for 2 weeks or until the wound healed to change the dressing and assess the character of the post operative wound. The therapist's progress notes from the therapy visit on 10/21 at 10 a.m. (3 hours prior to the RN visit) reflect that the patient complained to the therapist of burning and dampness at the suture line.

Principle #8 - COP Deficiencies

The evidence for the citation of noncompliance with a Condition of Participation explains how the extent or severity of deficient practices justifies a conclusion of noncompliance at the COP level. The COP citation includes a statement(s) of deficient entity practice(s) and findings to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings. The COP citation includes ONLY those requirements that must be corrected to achieve compliance with the COP.

The determination that an entity is not in compliance with an applicable COP is one of the most serious decisions the RO or SA can make. The decision as to whether there is compliance with a particular COP depends upon the manner and degree to which the entity satisfies the various requirements and standards within each COP. If a COP is determined to be deficient, the Form CMS-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these subsidiary requirements may be referenced under the COP citation.

For certain provider and supplier types, a COP may stand alone at a single survey data tag without accompanying standards or other requirements. The text of the particular COP may have multiple components. Based on the evaluation of the evidence, an entity can be cited at a COP level even if it violates only one component of multi-component regulations.

For example, in the Ambulatory Surgery Center program, 42 CFR 416.43 Condition for Coverage Evaluation of Quality (tag Q 9) has multiple requirements: (1) conduct an ongoing , comprehensive self-assessment of the quality of care provided, (2) include active participation of the medical staff, (3) include review of the medical necessity of the procedures performed and appropriateness of care, (4)

use the findings, when appropriate, in the revision of the center policies and (5) use the findings, when appropriate, in the consideration of clinical privileges.

There may be entity practices relevant to standards that are deficient, yet not essential for a determination of compliance with the COP. Most likely it is because the nature of these practices, individually or collectively, does not justify a conclusion of noncompliance and warrant an adverse action. Such requirements are not referenced at the COP citation. They are included at the appropriate tag number and corresponding CFR reference in the Form CMS-2567.

Exhibit 8-1 - Effective Documentation for Principle #8

Tag	Summary Statement of Deficiencies
Q 003	416.41 Condition Governing Body and Management The ambulatory surgical center must have a governing body, that assumes full responsibility for determining, implementing and monitoring policies governing the centers total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these services are provided in a safe and effective manner. This Condition is NOT MET as evidenced by: Based on staff interview and review of administrative records, policies and procedures, and infection control and quality assurance documentation, it was determined that the ambulatory surgery center's governing body failed to assume full responsibility for determining, implementing and monitoring policies governing the center's total operation. The governing body failed to ensure that practitioners had been appointed to the medical staff and had been granted privileges to practice at the ASC (refer to Q19, Q20, Q21, and Q22), failed to ensure that a comprehensive quality assurance program was in place (refer to Q9); failed to ensure that an effective infection control program had been established (refer to Q14). The cumulative effect of these systemic problems resulted in the surgery center's inability to ensure the provision of quality health care in a safe environment.

Conclusion

All requirements are binding. The structures, processes and outcomes required by the regulations are necessary for the entity to provide quality care, prevent negative outcomes, and facilitate positive outcomes. Failure of the entity to provide any of the

required services or to meet required conditions constitutes evidence of noncompliance regardless of the presence of outcomes. The purpose of these Principles of Documentation is to provide structure and consistency to the construction of a citation.

Correctly documenting the "Statement of Deficiencies and Plan of Correction" (Form CMS-2567) is the key to the success of the survey and certification process. Effective documentation of the survey signals the provision or denial of financial participation in the Medicare/Medicaid program, as well as the provision of or lack of quality care in health care settings.

Keep in mind that one of the roles of the surveyor is to ensure that quality health care is provided by those entities participating in the Medicare/Medicaid program. It is the surveyor's knowledge of the regulations and how to interpret and apply these regulations in a consistent manner during the survey that will produce a clear description of the entity's deficient practice. When the deficient practices are resolved by the entity, quality of care and quality of life can be a reality in health care settings.

Appendix A - Components to be Documented in A Deficiency Citation

COMPONENTS TO BE DOCUMENTED IN A DEFICIENCY CITATION

Data Tag				
In CFR/LSC/CLIA order				
CFR/LSC/CLIA Reference				
CFR/LSC/CLIA Requirement				
Statement that requirement is "Not Met"				
Evidence: Each Statement of deficient practice with corresponding findings (repeat each practice)	**YES(Y)**	**NO (N)**	N/A	
Extent of deficient practice				
Identifiers (confidential)				
Description of violation of regulation				
Source of evidence				
State/local code reference, if applicable				
Findings/Facts:				
Who				
What				
When				
Where				
How				
Outcome				
Observations: date, time, location				
Record/document reviews: date(s), record type				
Sequential organization of facts				
Is the Deficiency Citation…	**Yes**	**No**	N/A	
Applicable to requirement cited?				
Written in plain language?				
Free of extraneous remarks and advice				

Active-Voice Sentences

Active-Voice Rule

The voice of a verb refers to the relationship between verb and subject . . . who or what is performing the action or agent doing it and is the subject of the verb. There are two voices in English: active and passive.

The most basic active-voice sentence takes the pattern: subject + verb + object.

Subject: the *actor* or doer in the sentence.
Verb: the *"doing"* word; a word for actions or processes.
Object: the person or thing that is *acted upon* or has the action done to it.

For example:

Hercules was strong.
Hercules had a bad temper.
Hercules went to Hades to find Cerberus.

Ask yourself:

(1) Who or what is the *doer* of the action?
(2) Which is the *action* word?
(3) Who or what is the *object* of the action?

Be aware that a subject or an object can consist of more than one word.

Examples

Find the doer of the action and make it the subject.

The meeting <u>was opened</u> by the president. (Passive)
The president opened the meeting. (Active)

The book <u>was read</u> by most of the class. (Passive)
Most of the class read the book. (Active)

Comparison of Paragraphs (a) and (b)

(a) When passive voice <u>is used</u>, sentences <u>are robbed</u> of powers. Strong verbs <u>are weakened</u> by this construction, and awkwardness <u>is caused</u>. Although there are reasons to use passive voice, it <u>is often employed</u> unintentionally and unnecessarily by beginning writers.

(b) When journalists use passive voice, they rob their sentences of power. This construction weakens strong verbs and causes awkwardness. Although passive voice has its place, novice writers often use it unintentionally and unnecessarily.

Read Paragraph (a) again. Do the sentences sound awkward? Look at the verbs. Are they powerful words that propel their sentences? In the first paragraph all three sentences use passive-voice constructions.

In Paragraph (b) each sentence is in the active voice. Compare both versions. If you recognize the awkwardness and false formality of the first paragraph and if you can see the lifeless verbs, then you are on your way to recognizing and avoiding passive-voice construction.

Don't confuse tense and voice. Verbs can be present, past or future tense. The same verbs can appear in active voice or passive voice.

Exercise

Revise these passive voice sentences to make them active.

1. The computer class was attended by many students.
2. The issues were clouded and the listeners inflamed by the irate speakers.
3. The call to arms was responded to eagerly by many who were motivated by a thirst for liberty.
4. For a violinist to be a success, many types of bowing and scales must be mastered.
5. The fact that the town was obliterated by the hurricane was bad enough, but it was also further victimized by looters.

Active vs. Passive Sentence Construction

Consider the following examples.

1. The brilliant essay was written by John.
2. John wrote the brilliant essay.

John is the person who wrote the essay, so he is the agent in both of these sentences. Sentence 1 is passive because the agent is "disguised" as the object of a preposition and the receiver of the action is occupying the subject slot. Sentence 2 is active because the agent is also the grammatical subject of the sentence. Notice that the active sentence is shorter and more direct than the passive sentence.

1. A book can be read in which Caesar was killed by Brutus.
2. You can read a book detailing how Brutus killed Caesar.

Differentiating between the Active and Passive Voice

In the active voice the subject of the sentence performs the action of the verb. For example, "The dog bit the boy." The dog, the subject of the sentence, is performing the action of biting.

In the passive voice the subject of the sentence receives the action of the verb**.** For example, "The boy was bitten by the dog." The doer of the action in the passive voice may either appear in a prepositional ("by the…") phrase or be left out.

Spotting the Passive Voice

Look at the verb phrase. The passive voice will always include a form of the "to be" verb, such as "is," "are," "was," or "is being." Look for a prepositional phrase ("by the . . ."). The doer of the action, if named, is in this "by the . . . " phrase.

Suggestions for Choosing the Active Voice

The active verb is often easier to understand than the passive because the active voice states specifically who or what is doing the action.

- Less clear: The entrance exam was failed by over one-third of the applicants to the school.
- Revised: Over one-third of the applicants to the school failed the entrance exam.

The active verb is more concise than the passive verb because fewer words are needed.

- Wordy: The action on the bill was considered by the committee.
- Better: The committee considered acting on the bill.

The active voice emphasizes the doer of the action and is often more direct and dramatic.

- Less direct and dramatic: The brakes of the car were slammed on by the driver as her car sped down the hill.
- Direct and dramatic: She slammed on the brakes as her car sped downhill.

The passive voice is useful when the doer of the action is unknown or unimportant.

- The lock was broken when the police arrived on the scene of the crime.
- The experimental liver transplant was performed successfully.

The passive voice focuses attention on the action rather than on the doer of the action.

- "Rules are made to be broken," he said defiantly.

The passive verb is sometimes preferred in scientific writing—but not always.

- The hydrogen experiment was used to verify the previous results.

Some Further Suggestions

Avoid starting the sentence in the active voice and switching to the passive voice.

Many customers in the restaurant found the coffee too bitter to drink, but it was still ordered frequently.

Revised: Many customers in the restaurant found the coffee too bitter to drink, but they still ordered it frequently.

Avoid dangling modifiers caused by shifts to the passive voice.

To save time, the paper was written on a computer.

Revised: To save time, Kristin wrote the paper on a computer.

Don't trust grammar checkers on computers. Many grammar checkers will flag all passives, and you may want to keep some passive phrasing.

Changing Passive to Active

If you want to change a passive-voice sentence to an active-voice one, find the agent in a "by the..." phrase or consider carefully who or what is performing the action expressed by the verb. Make that agent the subject of the sentence and change the verb accordingly.

Passive:

The book is being read by most of the class.
Results will be published in the next issue of the journal.
A policy of whitewashing has been pursued.
Mistakes were made.

Active:

Most of the class is reading the book.
The researchers will publish their results in the next issue of the journal.
The CIA director and his close advisors have pursued a policy of whitewashing.
We made mistakes.

Advantages of Using the Active Voice

Clearly defined agent action by verbs creates immediacy and strong declarative structure.

There are two primary reasons to avoid the passive voice. First, the passive voice is impersonal. Second, the passive voice generally leads to more complex grammatical constructions which are more challenging to read.

Using the Passive Voice

Passive sentence structure sometimes occurs when the agent is unknown, in business and social settings, to avoid the appearance of blame or unfair accusation or to emphasize the receiver of the action. In certain instances, the recipient of the action is more important (or more newsworthy) than the performer of the action. So, in all fairness, there may be a time and a place for passive-voice construction, but it usually has no place in writing deficiency reports.

Changing Passive to Active

Usually—but not always—when these forms of the verb "to be" are in front of the verb, the sentence becomes passive. Note that these forms used with the present participle (*-ing* form) of a verb usually indicate active voice.

Singular	**Plural**
Is	Are
Has been	Have been
Was	Were
Had been	Had been
Will be	Will be
Will have been	Will have been
Is being	Are being
Was being	Were being

Examples:

1. Resident 2 *was being transferred* by Nurse C and Nurse H. (passive)

Nurse C and Nurse H transferred Resident 2. (active)

Nurse C and Nurse H were transferring Resident 2. (active)

2. The fire alarm system *was observed* on 3/21/XX at 9:05 a.m. (passive)

Observation of the fire alarm system on 3/21/XX at 9:05 a.m. revealed . . . (active)

3. On 6/2/XX, at 10:15 a.m., an interview was conducted with Staff F. (passive)

On 6/2/XX, at 10:15 a.m., interview with Staff F revealed . . . (active)

Placing "am," "is," "was," "were," "are," "be," "being," and "been" in front of a verb usually—but not always—makes it passive. Be careful with "*-ing*" forms of verbs. When used with a form of "to be," they usually are active voice. So use "helpers" carefully.

Active-Voice Exercises

Name_____ Date_____

In the space below each passive-voice sentence, rewrite the sentence in the active voice.

1. The resident‘s back and thighs were lying against the urine-soaked pads and sheets. The resident’s urine-soaked pads and sheets had not been changed by the duty nurse.

2. The hot water temperature was tested by the maintenance person with the facility‘s thermometer.

3. At 4:00 p.m. on XX/XX/XX, a home visit was conducted at Client 8’s apartment. Registered Nurse Staff B was observed to clean the wound, which had purulent drainage.

4. No written physician‘s orders for the medications were contained in the medical record.

5. The patient was ordered intravenous replacement with antibiotics.

6. A door wedge was observed at the foot of the door holding the door open.

7. Dialysis was initiated on XX/XX/XX.

8. On XX/XX/XX at 9:00 a.m., the written preventive maintenance program was reviewed. The written program lacked evidence that preventive maintenance had been completed.

9. The patient was moved to the nursing facility.

10. The patient needing rehabilitative therapy was identified by the facility staff because the patient was contracted in the upper extremities.

Active-Voice Exercises: Answer Sheet

Name_____ Date_____

In the space below each passive voice sentence, rewrite the sentence in the active voice.

1. The resident's back and thighs were lying against the urine-soaked pads and sheets.
   Observation revealed the resident's back and thighs lying on urine-soaked pads and sheets.

   The resident's urine-soaked pads and sheets had not been changed by the duty nurse.
   The duty nurse had not changed the resident's urine-soaked pads and sheets.

2. The hot water temperature was tested by the maintenance person with the facility's thermometer.
   The maintenance person tested the hot water temperature using the facility's thermometer.

3. At 4:00 p.m. on XX/XX/XX, a home visit was conducted at Client 8's apartment. Registered Nurse Staff B was observed to clean the wound, which had purulent drainage.
   Beginning at 4:00 p.m. on XX/XX/XX during the home visit to Client 8, observation revealed Registered Nurse B cleaning the client's [part of body] wound, which had purulent (that is, odorous) drainage.

4. No written physician's orders for the medications were contained in the medical record.
   Review of the medical record found no physician's orders for medications.

5. The patient was ordered intravenous replacement with antibiotics.
   Review of the medical record revealed the physician had ordered intravenous replacement with antibiotics on [date].

6. A door wedge was observed at the foot of the door holding the door open.
   Observation found a wedge at the bottom of a door holding it open.

7. Dialysis was initiated on XX/XX/XX.
   The patient started dialysis on XX/XX/XX.

8. On XX/XX/XX at 9:00 a.m., the written preventive maintenance program was reviewed. The written program lacked evidence that preventive maintenance had been completed.
   On XX/XX/XX at 9:00 a.m., review of the written preventive maintenance program found a lack of evidence that it had been completed.

9. The patient was moved to the nursing facility.
   The facility transferred the patient to the nursing facility.

10. The patient needing rehabilitative therapy was identified by the facility staff because the patient was contracted in the upper extremities.
    Facility staff identified the patient needing rehabilitative therapy because the patient was contracted in the upper extremities.

Active-Voice Practice #1

Use the *Principles of Documentation* and revise the following deficiency report. Be sure to check for use of *all* the elements in Principles #2 and #3.

Tag

F282: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

Statement of Deficient Practice

Based on observation and record review, the facility failed to provide services in accordance with the resident's written plan of care. Facility census was thirty-nine residents. The sample was nine residents, with six additional residents included for interviews. Concerns were identified for one resident.

Findings

When the NA toileted Resident 2, she said the resident should have been toileted before lunch but was not because she did not get back from her lunch break in time to do it.

Resident 2 was identified on her 1/21/00 MDS as requiring total staff assistance to transfer and toilet.

The resident was monitored on 2/29/00 from 9:55 a.m. until 2:52 p.m. She was not toileted, checked or changed until 2:52 p.m., making it at least 5 hours between checks.

The 1/21/00 care plan had directed staff to check the resident every 1½ to 2 hours to ensure the resident was clean and dry. The care plan was not observed to be followed.

Active-Voice Practice #1: Corrections

Use the *Principles of Documentation* and revise the following deficiency. Be sure to check for use of *all* the elements in Principles #2 and #3.

Tag

F282: The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

Statement of Deficient Practice

Based on observation and record review, the facility failed to provide services in accordance with the resident's written plan of care. Facility census was 39 residents. The sample was nine residents, with six additional residents included for interviews. Concerns were identified for one resident.

Comments
Interview source not included. Statement of Deficient Practice repeats the regulatory language. You cannot remove the passive voice until you write the extent as an equation. Resident identifier not included. Extraneous information included.

Revision
Based on observation, record review, and interview, the facility failed to toilet 1 of 9 sampled residents (Resident 2) in accordance with the resident's written plan of care. Facility census was 39.

Findings

When the NA toileted Resident 2, she said the resident should have been toileted before lunch but was not because she did not get back from her lunch break in time to do it.

Comments
This should be the last finding listed. No identification of source included. No date and time of interview included. Abbreviation "NA" not defined. Feminine pronoun "she" used. Written in passive voice. Extraneous information included.

Revision
In an interview on 2/29/00 at 2:52 p.m., Nursing Assistant (NA) B confirmed that staff should have toileted Resident 2 before lunch but had not.

Resident 2 was identified on her 1/21/00 MDS as requiring total staff assistance to transfer and toilet.

Comments
This should be the first finding listed. No identification of source included. Written in passive voice. Gender pronoun "her" used. Abbreviation "MDS" not identified. "MDS" might also be considered jargon and, therefore, might need defining.

Revision
Review of Resident 2's Minimum Data Set (MDS) (a federally mandated comprehensive assessment tool used for care planning) dated 1/21/00 revealed the resident required total staff assistance to transfer and toilet.

The resident was monitored on 2/29/00 from 9:55 a.m. until 2:52 p.m. She was not toileted, checked or changed until 2:52 p.m., making it at least 5 hours between checks.

Comments
This should be the third finding. No identification of source included. Gender-related pronoun "she" used. Both sentences written in passive voice.

Revision
Observation on 2/29/00 showed that Resident 2 received no toileting, checking, or changing from 9:55 a.m. until 2:52 p.m., which is a time span of almost 5 hours.

The 1/21/00 care plan had directed staff to check the resident every 1½ to 2 hours to ensure the resident was clean and dry. The care plan was not observed to be followed.

Comments
This should be the second finding listed. No identification of source included. Second sentence written in passive voice.

Revision
Review of Resident 2's care plan dated 1/21/00 revealed direction for staff to check the resident every 1½ to 2 hours to keep the resident clean and dry.

Information to Strengthen the Deficiency Statement

- Was the resident wet or dry?
- What was the resident's continence status (continent or incontinent)?
- Was there a recent change in continence (continent to incontinent or increase in incontinence)?
- Was the resident interviewable and, if so, how did the resident feel about not being toileted?
- Was toileting offered and how many times? Did she refuse? Has this occurred before, etc.? (Listing the times checked rather than a time span might be better.)
- Did this occur more than one time in the survey?
- Is this the correct tag for this deficiency or is there a better one?

Active-Voice Practice #2

Use the *Principles of Documentation* and revise the following deficiency report.

The following deficiencies relate to the Iowa Administrative Code (IAC), Chapter 63.

Tag

63.9(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

Employees shall have a physical exam at least every four years, including an assessment of tuberculosis status.

Statements of Deficient Practice

Based on record review and staff interview, it was determined that one of two staff employed at this house did not have a current physical and tuberculin status. Findings include:

_____
_____
_____
_____
_____

Staff S1's file had 12/22/95 as the date of the last physical and tuberculin test. This was longer than four years.

_____
_____
_____
_____
_____

Principles of Documentation Summary Sheet

PRINCIPLE OF DOCUMENTATION	COMPONENT/ELEMENT
Principle 1: Entity Compliance	Include an **"In Compliance"** statement if you find no deficiency.
Principle 2: Using Plain Language	**Clear Style:** Include an explanation of abbreviations.
	Exclude jargon, extraneous information, and advice.
	Write in the **active voice**.
Principle 3: Components of a Deficiency Citation	**Regulatory Reference.** Include: • The Survey Data Tag Number. • A CFR or LSC reference. • The language of the regulation. • A "NOT MET" statement.
	Deficient Practice Statement. Include: • The sources of evidence. • The clearly identified deficient practice, not a repeat of the wording of the regulation. • The extent: Both the number deficient and the possible universe. • The identifiers of the recipients. • The outcomes, if applicable.
	Facts and Findings. Include: • Items written in chronological order of occurrence. • Observation facts: Date, time, location, identifiers and information. (Use numbers for recipients and letters for staff.) • Interview facts: Date, time, identifiers and information. (Use numbers for recipients and letters for staff.) • Confidential interview facts: Date, time, wording "in a confidential interview" and information. • Record review facts: Date, time of record and record type.
Principle 4: Relevance of Onsite Correction	Write as for any other deficiency. Do not state the correction(s) unless there is an immediate jeopardy finding.
Principle 5: Interpretive Guidelines	State how the regulation is not met, not how the guidelines are not met.
Principle 6: Citation of State/Local Code Violation	Include only if required by the Federal regulations.
Principle 7: Cross-Referencing	Cross-reference a Quality of Care Tag to an Assessment of Care Planning Tag
	Cross-reference a Condition of Participation Deficiency to each subsidiary requirement deficiency.
Principle 8: Condition of Participation Deficiencies	A deficient practice and findings must support the Condition of Participation citation.

SOD Worksheet

Page 1 of the SOD:

1. The term "unannounced" and the type of inspections were identified.
2. The start date and end date, the name of the home and address of the home along with the sample size and the home's census were identified.
3. The surveyor/investigator/licensor's initials were included.
4. The unit information was included.

The failed practice and the findings reflect the regulation.

The "based on" statement:

The failed practice in the "based on" statement was clear and specific about the issue.

The scope was clearly identified.

The correct universe was identified.

Resident identifiers were used.

Findings:

Sources of evidence identified in the "based on" statement reflected what was found in the findings.

The citation had multiple sources of information and verification of the issues.

The most severe example was listed first.

Findings supported the failed practice statement.

Findings painted a clear picture of the failed practice.

Extraneous information was not present. All information was relevant to the issue.

Findings were neutral in tone and mood was used only to describe emotions that were observed. Gender was neutral.

Past tense and active voice were used. Lay terminology was used and medical and other terminology were defined when necessary.

Cross-references were used where needed, but each citation stood on its own.

Grammar and text style were correct and consistent throughout the document.

Principles of Documentation for Statement of Deficiency (CMS-2567) Review

Principle of Documentation	ELEMENT	YES	NO	N/A	COMMENTS
Principle 1: Entity Compliance	Includes **"in compliance" statement** if there are no deficiencies?				
Principle 2: Using Plain Language	**Clear style**: explains abbreviations and contains no jargon, extraneous information, and/or advice?				
	Uses **active voice** throughout the entire deficiency?				
Principle 3: Components of a Deficiency Citation	Regulatory reference: Includes **CFR or LSC reference** (e.g., 42 CFR 483.35(g), 42 CFR 483.70(a), etc.)?				
	Regulatory reference: cites the **correct tag** number (e.g., F214, K029)?				
	Regulatory reference: Would you delete this deficiency?				
	Includes the statement of **"not met"**?				
	Deficient practice statement: Are **extent, universe, identifiers, sources** included?				
	Deficient practice statement: Is the **deficient practice clearly identified** not just a restatement of the regulation?				
	Facts/findings: **Who, what, when, where, how** are included?				
	Facts/findings: Are they written in a **sequence that is easy to follow** (i.e., in order of how the events occurred)?				
	Observations: Are **date, time, and location** included?				
	Interviews: Are **date, time, and identifiers** (1, 2, 3 for residents; A, B, C for staff) included?				
	Record/document review: Are **date, time, record type** included?				
Principle 4: Relevance of On-site Correction of Findings	Is **"not met" statement for all findings** included, even if findings corrected during survey?				
Principle 5: Interpretive Guidelines	Explains **how regulation was not met**, not how the Interpretive Guidelines were not met?				
Principle 6: Citation of State/Local Code Violation	Does the deficiency **include federal not just state/local** regulation violations?				
Principle 7: Cross Reference	Cross-reference: Does the deficiency **reference care tag to assessment or care plan tag?**				
	Cross-reference: Is **each tag supportable on its own** if the other tag is deleted?				
	Do findings cross-referenced support the COP citation?				
Principle 8: Condition of Participation Deficiencies	Do deficient practice and findings support COP citation?				

TAG NUMBER: _____ **DATE OF REVIEW:** _____ **TEAM MEMBERS:**

ICF/MR Practice Sample #1

Revise the following deficiency report to meet the requirements of the *Principles of Documentation*. Be sure to check for *all* of the elements in Principles #2 and #3. At the end or on the back of the sheet, list any additional information that could have strengthened the deficiency report.

Statement of Deficient Practice

For two of three bathrooms in the residence, hot water used by four of four clients (1, 2, 3, and 4) for bathing and hand washing exceeded 115 degrees F. There was a potential for burns. Findings are based on observation, interview and record review.

Revision

In two of three bathrooms in the residence (west and north bathrooms), the hot water used by four of four clients (1, 2, 3, and 4) for bathing and hand washing exceeded 115 degrees Fahrenheit (F.), causing a potential for burns. Observation, interview and record review are the basis of the findings.

Statement of Deficient Practice

Hot water temperatures were taken by the surveyor on X/XX/XX at 4:45 p.m. in the west bathroom and 6:00 p.m. in the north bathroom. The west bathroom sink was 152 degrees F. and the north bathroom sink and bathtub was 154 degrees F.

Revision

Hot water temperature measurements on X/XX/XX revealed the hot water in the west bathroom sink at 152 degrees F at 4:45 p.m. and in the north bathroom sink at 154 degrees F. at 6:00 p.m.

Statement of Deficient Practice

When interviewed during the testing of the west bathroom water temperatures, Client 3 stated he had never been burned by hot water but the bathroom water was too hot to stick his hand into at times.

Revision

An interview with Client 3 on X/XX/XX at 4:45 p.m. revealed that although never burned by the hot water in the bathroom, the client found the water was at times too hot for washing.

Statement of Deficient Practice

Records were reviewed for Clients 1 and 2 (residential assessments for each dated XX/XX) and showed that each could regulate water temperatures independently. However, Client 1's Individual Program Plan (IPP) dated XX/XX/XX documented he had a history of seizures. Incident reports showed he had seizured within the last two months.

Revision
A record review of the Residential Assessments dated XX/XX for Clients 1 and 2 revealed each client's ability to regulate water temperatures independently. A review of Client 1's Individual Program Plan (IPP) dated XX/XX/XX revealed a history of seizures. A review of Incident Reports revealed seizure activity for Client 1 within the last two months.

Statement of Deficient Practice

When interviewed during testing of north bathroom water temperatures, the residential supervisor was not sure that all of the clients at the residence could adequately monitor and adjust the hot water independently and agreed that the hot water temperature should be turned down to ensure the clients' safety.

Revision
An interview with the Residential Supervisor on X/XX/XX at 6:00 p.m. revealed the supervisor did not know the clients could monitor temperatures and independently adjust the hot water. There was agreement that the hot water temperature needed lowering to ensure client safety.

Information to Strengthen the Deficiency Statement

- Second temperature readings to demonstrate the temperatures were routine and not a one-time occurrence. If the agency kept a temperature log, information from the log could support the continued, elevated readings.
- Evidence to show that Client 3 was capable of making believable statements.
- The connection between Client 1's seizure activity and the increased risk for burns.
- The dates of the Incident Reports reviewed and whether any of the incident reports recorded burns or not.
- Evidence related to Client 4 who appears in the deficient practice statement but not in the evidence.

ICF/MR Practice Sample #2

Revise the following deficiency report to meet the requirements of the *Principles of Documentation*. Be sure to check for *all* of the elements in Principles #2 and #3. At the end or on the back of the sheet, list any additional information that could have strengthened the deficiency report.

Tag

W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Statements of Deficient Practice

One of four clients reviewed was not always receiving an active treatment program at the Day Service. This finding was based on observation and staff interview.

Client 1 was observed on XX/XX/XX from 8:30 a.m. until 10:57 a.m. and from 1:40 p.m. until 2:26 p.m. Out of 13 observed opportunities to be encouraged by staff to move his wheelchair, only one time did the DSS direct Client 1 to move his wheelchair.

Out of six observed opportunities for him to go get training supplies, only one time did the DSS direct Client 1 to go to a shelf to choose an activity. At the other opportunities, staff were either observed giving him materials that he had asked for or placing materials in front of Client 1 that had not been asked for.

When interviewed during the p.m. observation, the DSS on duty said they had been trained to implement Client 1's training programs, which were to propel his own wheelchair and gather his own training supplies. It was also stated that, when training the "gathering supplies" program, Client 1 would tell staff what he wanted to do and the staff would go get the supplies.

When the DS Director was interviewed after completion of observations, it was stated that Client 1 was to be encouraged to move his wheelchair at every opportunity to increase his independence. Also, Client 1 was to go to a shelf in the training area and get what he wanted to work on.

Record review was conducted and verified the management staff's version of the training program. However, as previously mentioned, these programs were not being implemented consistently and at every opportunity.

HHA—G227: Scenario and SOD Example

Scenario

Tag

G227, 42 CFR 484.36(c): Assignment and duties of the home health aide. Duties include completing appropriate records.

Surveyor's Notes

1. Sample size was 15 with five home visits and a current agency census of 44.

2. Surveyor notes:
    a. Patient 2—Plan of Care dated 05/01/XX to 06/30/XX lists tasks to be completed by the aide on each visit as AROM to upper and lower extremities × 15 reps, empty urinary drainage bag and change over to the urinary leg bag, assist the patient to a standing position 5 repetitions, transfer with gait belt and apply right-hand splint after bath.

    36 Aide Treatment forms reviewed from dates 05/01/XX to 06/27/XX. No documentation found on 11 visits for AROM, 27 visits for assist the patient to a standing position 5 repetitions, 2 visits for emptying of the urinary drainage bag and changing over to the urinary leg bag, 34 visits for right-hand splint being applied.

    Interview with patient—During home visit on 6/27/XX at 11 a.m., all tasks were being completed. Pleased with care and services.

    b. Patient 3—Plan of Care dated 04/04XX to 06/03/XX lists tasks to be completed by aide on each visit as AROM to lower extremities every visit, empty urinary drainage bag every visit and position the hospital bed in low position with side rails up before leaving.

    45 Aide Treatment forms reviewed from 04/04/XX to 06/03/XX. No documentation found on 35 visits for AROM, 26 visits for emptying urinary drainage bag and 22 visits for hospital bed in low position with side rails up before leaving.

    Surveyor observation—6/26/XX at 1:00 p.m., all tasks completed as listed on the Plan of Care by Jean HHA. Catheter bag contained 600 cc of cloudy urine. Lower extremities stiff during ROM exercises and aide unable to completely straighten legs at knees. Patient repeatedly stated "that it hurts so much" during the exercises.

    Staff interview with Jean—6/26/XX at 1:30 p.m., assigned duties correctly without referring to written instructions. Stated has "so many to care for, does not always have time to chart. Sometimes forgets." When questioned regarding

AROM exercises, aide stated "has been getting stiffer over the last several visits. Probably should let the nurse know to see if therapy needs to get involved."

c. Patient 4—Plan of Care 04/03/XX to 06/02/XX lists tasks to be completed by aide on each visit as assist with transfers, AROM exercises to left upper extremity, ambulate with quad cane, hospital bed to be in low position with side rails up before leaving.

26 Aide Treatment forms reviewed from 04/03/XX to 06/02/XX. No documentation found on 4 visits for assist with transfers, 26 visits for AROM exercises, and 24 visits for hospital bed to be in low position with side rails up before leaving.

Patient interview—6/26/XX at 10 a.m., states exercises and walking is done each time the aides come and the aide does place the hospital bed in low position with the side rails up before leaving.

d. Patient 6—Plan of Care 04/28/XX to 06/28/XX lists tasks to be completed by aide on each visit as skin massage to back and legs with lotion every visit, assist with patient transfers and PROM exercise to left hand, fingers and wrist × 10 repetitions.

18 Aide Treatment forms reviewed from 04/28/XX to 06/27/XX. No documentation found on 14 visits for skin care, 17 visits for assist with transfers, and 1 visit for PROM exercises.

Surveyor observation—6/27/XX at 2 p.m., all tasks completed by John HHA except lotion applied only to legs and PROM exercises were done to all extremities. Patient refused to have lotion applied to his back.

Staff interview with John—6/27/XX 2:30 p.m., "know that I'm supposed to put lotion on his back but he always refuses. Says it's too much trouble." Also stated, "I exercise everything to stimulate the circulation" regarding questions about the PROM exercises.

Interview with wife as patient confused and does not respond appropriately to questions—via phone 6/27/XX at 3 p.m., "I wish they'd rub his back when they're here. I know it feels good and sometimes the skin is red from sitting so long when I finally get him to bed, but sometimes my husband just refuses."

e. Patient 10—Plan of Care 05/10/XX to 07/10/XX lists tasks to be completed by aide on each visit as assist with transfers and ambulate with walker and gait belt.

20 Aide Treatment forms reviewed from dates 05/10/XX to 06/28/XX. No documentation found on 10 visits for assist with transfers and 3 visits for ambulate with walker with gait belt.

Surveyor observation—06/28/XX at 9 a.m., John completed all tasks as ordered.

SOD Example

Tag

G227, 42 CFR 484.36(c): Assignment and duties of the home health aide. Duties include completing appropriate records.

Findings

This requirement is NOT MET as evidenced by:

Based on clinical record reviews, observations, patient and staff interviews, the agency failed to ensure the home health aide (HHA) documentation followed the written HHA plan of care as ordered by the physicians for 5 of 15 sampled patients (Patient 2, 3, 4, 6 and 10.)

A. Review of clinical record for Patient 2 revealed physician certification orders dated 05/01/XX to 06/30/XX required the HHA to provide the following care every visit:
- Active range of motion (AROM) for 15 repetitions to the upper and lower extremities.
- Assist the patient to a standing position for 5 repetitions.
- Assist the patient with transfers using a gait belt.
- Empty the patient's urinary drainage bag and change the bag to a urinary leg bag after the bath.
- Apply the patient's right hand splint after the bath.

Review of 36 aide treatment forms for Patient 2 completed for the dates 05/01/XX to 06/27/XX revealed the HHA failed to document the following:
- AROM during 11 visits.
- Assisting the patient to a standing position for the ordered 5 repetitions during 27 visits.
- Emptying the urinary drainage bag and changing to the urinary leg bag during 2 visits.
- Application of the patient's right hand splint during 34 visits.

During a home visit on 06/27/XX, interview at 11:00 a.m. with Patient 2 confirmed that the HHA provided all cares as ordered by the physician.

B. Review of clinical record for Patient 3 revealed the physician certification orders dated 04/04/XX to 06/03/XX required the HHA to provide the following care every visit:
- AROM to the lower extremities.
- Empty the urinary drainage bag.
- Position the hospital bed in low position with the side rails up before leaving.

Review of 45 aide treatment forms for Patient 3 completed for the dates 04/04/XX to 06/03/XX revealed the HHA failed to document the following:
- AROM during 35 visits.
- Emptying the urinary drainage bag during 26 visits.
- Positioning the hospital bed in a low position with the side rails up before leaving during 22 visits.

During a home visit on 06/26/XX at 1:00 p.m., observation showed that the HHA 'A' provided all cares as ordered by the physician.

In an interview during the home visit on 06/26/XX at 1:30 p.m., HHA A stated that there is not always enough time to chart and sometimes charting is forgotten.

C. Review of clinical record for Patient 4 revealed the physician certification orders dated 04/03/XX to 06/02/XX required the HHA to provide the following care every visit:

- Assist with patient transfers.
- AROM exercises to upper left extremity.
- Ambulate the patient with a quad cane.
- Position the hospital bed in low position with the side rails up before leaving.

Review of 26 aide treatment forms for Patient 4 completed from 04/03/XX to 06/02/XX revealed the HHA failed to document the following:

- AROM during 26 visits.
- Assisting with patient transfers during 4 visits.
- Positioning the hospital bed in a low position with the side rails up before leaving during 24 visits.

During the home visit on 06/26/XX, interview with Patient 4 at 10:00 a.m. confirmed that the HHA provided all cares as ordered by the physician.

D. Review of clinical record for Patient 6 revealed the physician certification orders dated 04/28/XX to 06/28/XX required the HHA to provide the following care every visit:

- Skin massage to the patient's back and legs with lotion.
- Assist with patient transfers.
- Passive range of motion (PROM) to the patient's left hand, fingers and wrist for 10 repetitions.

Review of 18 aide treatment forms for Patient 6 completed from 04/28/XX to 06/27/XX revealed the HHA failed to document the following:

- Skin massage to the patient's back and legs with lotion during 14 visits.
- Assisting with patient transfers during 17 visits.
- PROM to the patient's left hand, fingers and wrist for the ordered 10 repetitions during 1 visit.

E. Review of clinical record for Patient 10 revealed the physician certification orders dated 05/10/XX to 07/10/XX required the HHA to provide the following care every visit:

- Assist with patient transfers.
- Ambulate with a walker and a gait belt.

Review of 20 aide treatment forms for Patient 10 completed from 05/10/XX to 06/28/XX revealed the HHA failed to document the following:

- Assisting the patient with transfers during 10 visits.
- Ambulating the patient with a walker and gait belt during 3 visits.

During the home visit on 06/28/XX, observation of HHA B at 9:00 a.m. revealed Patient 10 received all cares as ordered by the physician.

LSC—K038: Scenario and SOD Example

Scenario

Tag

K038, NFPA 101: Exit access is so arranged that exits are readily accessible at all times. LSC 5-5, 13-2.1.

Surveyor's Notes

Name: Bob Fireman, LSC Specialist
Date & time: 5/22/XX, from 1:00 p.m. to 3:00 p.m.

History of the building:
Bedrest Care Center is a one-story brick building built in 1954. The building is not sprinklered. Total census of the building is 56. There are three exit doors from the building. There is one nursing station with 3 halls: 100 Hallway (24 beds), 200 Hallway (8 beds), and 300 Hallway (24 beds.)

Observations during tour of building:
At 1:10 p.m., Bob saw 5 boxes of canned food stacked on the floor in the hallway outside the kitchen. In the 200 Hallway, Bob also saw a metal cart with a missing wheel, a bed mattress and 2 wheelchairs in the hallway. Fred told Bob that the larger broken items always accumulated there because their tool shed was too small. Fred complained that the administrator went and bought a rider mower and that stupid thing has to be kept indoors all the time so there's no space in there to make repairs.

At 1:18 p.m., Bob noticed that both laundry doors were held open with doorstops. These laundry doors had automatic closing devices. Lucy Laundry told Bob that it gets so hot in the laundry area that they prop the doors open to cool it down.

At 1:32 p.m., Bob noticed that the door to the linen room on the 300 Hallway, which was a converted closet, would not latch. Fred Fixit, the maintenance supervisor, told Bob during the tour that he didn't know what had happened to the door or where the door was. At 2:45 p.m., Bob went back and still saw the items were still in the hallway.

Staff interviews:
At 1:15 p.m., Winnie Whiner, RN, told Bob during his tour that the med room had a squeaky door. She whined to Bob that she can't understand why things were just let go. She also complained that the sweet rolls didn't have enough frosting like they used to.

At 1:40 p.m., Molly Mop, the housekeeper who is also the supervisor for the department of two, asked Bob if it would be OK to lock the main door when she mops the floor so people wouldn't track on her clean floors. Molly told Bob those boxes of food in the hallway by the kitchen were a nuisance, too. She said she likes things just so and they got in the way whenever they were there.

Record reviews:
At 2:15 p.m., Bob looked at the logbook for the emergency generator and the tests were okay.

At 2:30 p.m., Bob looked at the record book for the fire drills. Bob found a note on the page for the 2/1/XX fire drills that said, “Drill slowed due to rear service exit clutter! Staff should stop storing furniture there.”

At 2:35 p.m., Bob then looked at the preventive maintenance records of the equipment. Bob found that the facility had a contract with a group that routinely came out to the facility to check the range hood.

SOD Example

Tag

K038, NFPA 101: Exit access is so arranged that exits are readily accessible at all times. LSC 5-5, 13-2.1 S/S = D.

Findings

This requirement is NOT MET as evidenced by:

Based on observations, record review and interview with facility staff, the facility failed to ensure that one of 3 exits areas (200 Hallway) of the building was cleared at all times to provide readily accessible exits. Failure to maintain exit corridors free from obstruction puts the residents at risk during a fire or other emergency requiring evacuation since the obstruction can delay or hinder the escape of the residents from the building. The resident census was 56.

1. On 5/22/XX at 1:10 p.m., observation revealed 5 boxes of canned food stacked on the floor outside the kitchen, a metal cart with a missing wheel, a bed mattress and 2 wheelchairs obstructing the 200 Hallway exit corridor. Eight residents use the 200 Hallway exit corridor should they need to evacuate the building during a fire or other emergency.

2. On 5/22/XX at 2:45 p.m., observation showed the boxes of canned food, the metal cart, the bed mattress and the two wheelchairs continued to obstruct the 200 Hallway exit corridor.

3. On 5/22/XX at 1:10 p.m., during the tour of the nursing home, the maintenance supervisor verified that items needing repairs were stored in the 200 Hallway exit corridor because there is not enough space in the tool shed to repair large items.

4. Review of the facility fire drill records dated 2/1/XX recorded: “Drill slowed due to rear exit clutter! Staff should stop storing furniture there.”

LTC—F314: Scenario and SOD Example

Scenario

Tag

F314, 42 CFR 483.25(c): Based on the comprehensive assessment of a resident, the facility must ensure that:

1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infections and prevent new sores from developing.

Survey Packet Information

Survey dates are 3/21/XX through 3/24/XX and survey sample size was 16 from a census of 78. 2 of the sampled residents had pressure sores. For 1 of those 2, the surveyor identified concerns.

Medical record information for Sarah Jane Jones (Resident 1):

Minimum Data Set (Full) Dated 8/9/XX	Minimum Data Set (Quarterly) Dated 11/4/XX	Minimum Data Set (Quarterly) Dated 2/20/XX
Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs (activities of daily living) except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days."	Diagnoses: Alzheimer's, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." "Rashes" was checked for skin problems. Skin treatments included pressure-relieving devices for bed and chair, application of ointments and other preventative skin care.	Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair-bound. Occasionally incontinent of bowel and has a Foley catheter. "Did not consume all/most all liquids provided in last 3 days" was checked. Stage II pressure ulcer was marked "1." Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments and other preventative skin care.

Physician's orders:
12/20/XX—Cleanse wound on coccyx with NS and apply Duoderm. Change PRN to keep area covered.
1/15/XX—Bactrim DS 1 BID × 10 days for UTI. Obtain follow-up UA.
1/21/XX—Change diet to regular with ground meat.

Care Plan with latest update 2/20/XX:
1) Problem—Potential for alter nutrition related to lack of dentures. Goal—Will consume 100% of diet. Approaches—Monitor food intake, obtain dental referral to fix broken dentures, give ground meat and soft, easy-to-chew foods.
2) Problem—Potential for skin breakdown. Goal—Will have no open areas × 90 days. Approaches—Egg crate mattress/pad in both bed and w/c, repo q 2 hrs with massage to boney prominence, treat open areas per MD orders.
3) Problem—Recurrent UTI. Goal—Will have no UTI × 90 days. Approaches—Follow aseptic technique for cath care, encourage fluids, give cranberry juice TID with meals.

Surveyor observation notes:

1. 3/22/XX: At 6:45 a.m. NAs, Sally and Rita, transferred Sarah Jane to w/c with mechanical lift. Bed remained at lowest position during entire procedure. They rolled Sarah Jane to left side and positioned lift seat under her. They then rolled Sarah Jane to right side, straightened lift seat beneath her, and rolled her on to back. Bottom edge of lift seat was at level of mid-buttocks. Each NA grabbed a leg strap of the seat and tugged it down into position. Sally then unhooked cath bag from side of bed and hooked it to her uniform pocket. Rita connected the lift seat to the lift frame and raised Sarah Jane into air. Sally swung Sarah Jane around and Rita pushed lift frame to position her over the chair. Rita lowered Sarah Jane into the w/c. As Sally made the bed (which was covered with a blue foam mattress overlay), Rita provided oral care to Sarah Jane and took her to the dining room for breakfast. Sarah Jane remained in the dining room until after lunch. At 9:00 a.m., another resident, John Henry, conducted devotions in the dining room. Then there was group exercise conducted by Maude Hurry, Activities Director, at 10:00. Then the kindergarten class from Jeff Davis Public School came at 11:00 and sang for the residents. Maude said, “Sarah Jane doesn’t care much for John’s devotional services. He had a run-in with her husband several years ago and they’ve been enemies even since. She’s kind of lazy and won’t exercise either but we keep her out for the socialization. But she sure enjoys the kids.” At 12:30 p.m., same 2 NAs transferred Sarah Jane from the w/c back into bed using the mechanical lift. When they removed Sarah Jane’s incontinent brief, no dressing covered the wound on her coccyx, which was about the size of a quarter and staged at a II. Sally said, “Boy, that looks nasty! It’s bigger than when I saw it last week!” Rita said, “Yeah, I told Betty that the dressing was off this morning and she said they couldn’t put a new one on until tomorrow.” Sarah Jane remained in bed on left side until observations ended at 4:30 p.m.

2. 3/23/XX: At 8:30 a.m., Sarah Jane was in the dining room eating breakfast which consisted of scrambled eggs, oatmeal, toast with butter and strawberry jelly, 6 oz glass of milk, 4 oz glass of orange juice, and cup of coffee. At 8:40 a.m., Jane (NA) took Sarah Jane from the dining room and returned her to her room. Sarah Jane had eaten ½ of her oatmeal and drank only her coffee. Sarah Jane remained seated in her w/c in her room watching TV throughout morning until taken to dining room for lunch at 11:30 a.m. At 1:00 p.m., Betty Bopp (RN) requested that Jane lay Sarah Jane down so she could do the wound treatment. Betty did Sarah Jane’s wound treatment at 1:30 p.m. She turned Sarah Jane onto her left side and exposed Sarah Jane from the waist down. Betty said,

"Tsk, Tsk. This looks redder than when we have it covered with a dressing. I wish they'd let us order dressings more than once a week. We always seem to run out and have to wait for a new supply to come in." Betty then washed wound with soap and water and applied Duoderm dressing. Sarah Jane remained on left side until observation ended at 4:00 p.m.

SOD Example

Tag

F314, 42 CFR 483.25(c): Based on the comprehensive assessment of a resident, the facility must ensure that:

1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infections and prevent new sores from developing.

Findings

This requirement is NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to provide repositioning, treatment, and nutritional interventions to promote the healing of pressure sores for 1 of 2 sampled residents (Resident 1) with pressure sores from a sample size of 16. Facility census was 78.

1. Record review of Resident 1's latest Minimum Data Set (MDS), a federally mandated comprehensive assessment tool, dated 2/20/XX showed the following information:
   - Diagnoses of Alzheimer's disease and recent stroke with paralysis, wheelchair bound with no ambulation.
   - A stage II pressure sore (a partial thickness loss of skin layers either dermis or epidermis that presents clinically as an abrasion, blister or shallow crater).
   - Skin treatments including pressure-relieving devices for bed and chair, application of dressing, application of ointments and other preventative skin care.

Review of Resident 1's Care Plan updated 2/20/XX documented the identified problem of "potential for skin breakdown" with approaches consisting of egg crate mattress on bed and in wheelchair, reposition every 2 hours, and treat open areas per physician's orders.

Observation showed Resident 1 sat in the wheelchair on 3/22/XX from 6:45 a.m. until 12:30 p.m. without change of position to relieve pressure on the buttocks and coccyx. On 3/23/XX, Resident 1 sat in the wheelchair from 8:30 a.m. until 1:00 p.m. Observation also showed Resident 1 remained in bed positioned on left side without benefit of repositioning from 12:30 p.m. until observation ended at 4:30 p.m. on 3/22/XX and again from 1:00 p.m. until observation ended at 4:00 p.m. on 3/23/XX. (Routine repositioning relieves the pressure from areas where bones are close to the skin surface. Unrelieved pressure causes a decrease in circulation, which results in death of skin tissue and the development of pressure sores.)

Review of physician's orders showed an order dated 12/20/XX to cleanse the coccyx wound with normal saline (NS) and keep covered with a Duoderm dressing. Observation showed that the coccyx wound remained uncovered from 12:30 p.m. on 3/22/XX until RN A

completed the wound treatment at 1:30 p.m. on 3/23/XX. Interview with RN A on 3/23/XX at 1:30 p.m. confirmed deterioration in the wound due to the wound being uncovered.

Review of the latest diet order dated 1/21/XX showed Resident 1's diet to be a regular diet with ground meat. Review of the Care Plan updated 2/20/XX showed no nutritional interventions identified to address the need for increased protein for wound healing. Observation of breakfast meal on 3/23/00 showed consumption of less than ½ the diet without intake of protein foods.

F314: Points for Questions Related to SOD

CMS Representative (Pro)	Facility Representative (Con)
AHCPR Guidelines for Treatment Ulcers show the need for pressure-reducing devices in bed and chair (foam mattresses/pads need to be 3–4 inches thick, which blue egg crates are not).	No interview with Sarah Jane or staff related to whether she refused to go to bed and wanted to stay up through the morning.
AHCPR Guidelines for Treatment Ulcers show to avoid sitting for long periods if the sore is in areas affected by sitting. The coccyx would be.	No interview with Sarah Jane or staff related to whether she preferred the left side and refused to lay any other way.
AHCPR Guidelines for Treatment Ulcers show low protein and nutrient intake contributes to pressure sore development and delays healing.	No observation of pressure relief in the wheelchair.
Care plan identifies only a "potential" for skin breakdown and does not address the actual breakdown.	No interview with Sarah Jane or staff related to food preferences and what was offered to increase protein.
Staff is aware that the wound should be covered but is not because of the ordering policies of the facility and the lack of dressing material.	No exact measurements were taken of the wound and no review of wound care documentation done.
	No additional meal observations besides breakfast on 3/23/XX.

LTC—F316: Scenario and SOD Example

Scenario

Tag

F316, 42 CFR 483.25(d)(2): A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Survey Packet Information

Sample size was 16 from a census of 78. 2 of the sampled residents had indwelling catheters. The surveyor identified concerns for 1 of those 2 residents.

Resident 44:

Minimum Data Set (Full) Dated 8/9/XX	Minimum Data Set (Quarterly) Dated 11/4/XX	Minimum Data Set (Quarterly) Dated 2/20/XX
Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs (activities of daily living) except eats independently, does not ambulate and is wheelchair bound. Occasionally incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." Stage IV pressure ulcer was marked with "1" and "Rashes" was checked. Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.	Diagnoses: Alzheimer's, decubitus ulcer, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair bound. Occasionally incontinent of bowel and has a Foley catheter. "Did not consume all/most all liquids provided in last 3 days" was checked. Stage II pressure ulcer was marked "1" and Stage IV "0." Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.	Diagnoses: Alzheimer's, Parkinson's, and recent CVA with paralysis. Short- and long-term memory problems with poor decision making and supervision required. Understands speaking but has difficulty finding words or finishing thoughts. Needs limited assist with most ADLs except eats independently, does not ambulate and is wheelchair bound. Occasional incontinent of bowel and has a Foley catheter. "Urinary tract infection in last 30 days" was checked as well as "Did not consume all/most all liquids provided in last 3 days." "Rashes" was checked for skin problems. Skin treatments included pressure-relieving devices for bed and chair, application of dressing, application of ointments, other preventative skin care.

Surveyor observation notes:

1. 3/22/XX at 11:45 a.m. 2 NAs transferred resident to wheelchair with mechanical lift. Bed remained at its lowest height during entire procedure. Catheter bag that contained 500 cc urine removed from far side of bed by NA (Sally) and handed across resident to NA (Rita) on near side of bed who hooked it to pocket of uniform. No strap or tape was securing catheter to thigh. Resident rolled to face far side of bed and lift seat positioned under resident. Resident rolled to face near side and lift seat straightened. Lift seat connected to lift frame, raised and transfer made to wheelchair. Resident positioned in wheelchair. While NA (Sally) straightened bed, other NA (Rita) unhooked catheter bag from pocket and laid it on floor under wheelchair. NA (Rita) went around back of wheelchair and reached from behind wheelchair to pick up bag. NA (Rita) place bag in cover while holding bag behind resident at resident shoulder level then attached bag to cord running from one side of back to other at seat level. Drainage tubing looped from front of chair seat to drainage bag hanging in back and touching on the floor. Catheter bag did not have antireflux valve.

2. 3/22/XX at 1:30 p.m. Same 2 NAs transferred resident from wheelchair to bed. Drainage tubing was still touching the floor. Bed remained at its lowest height during entire procedure. While one NA (Rita) pulled back covers to open bed, other NA (Sally) removed catheter bag from back of wheelchair and laid it on floor under chair. NA (Sally) then went around to front of wheelchair, picked bag up from floor, removed cover and hooked to pocket of uniform. Lift seat was attached to lift frame, resident raised and transferred to bed. With NA on each side of bed, resident was rolled to face near side and lift seat rolled up under resident. Resident was rolled to face far side of bed, lift seat removed and positioned on that side. NA (Sally) removed catheter bag hook from pocket and handed bag across resident to other NA (Rita). Catheter bag was hooked to bed frame and tubing left dangling from edge of bed.

3. 3/23/XX at 6:00 a.m. provision of pericare. NA (Jane) brought washcloths and towel from linen room. Knocked on door, entered, placed linen on bed stand and washed hands. Then got washbasin from resident's bed stand and filled with water in bathroom. Placed basin with linen on bed stand and put on gloves. Told resident was going to "clean around catheter" and pulled back covers exposing resident. Moistened washcloth, applied soap, and formed mitt around hand. Spread labia with fingers of one hand and wiped front-to-back with washcloth on each side of labia. While still holding labia apart, dipped mitt in basin of water, squeezed water out, and wiped each side of labia using same motion. Labia released, mitt dipped in basin, rubbed on soap bar, and each side of outside of labia wiped front-to-back. Rinse process repeated. Mitt placed in basin, towel picked up and outer labia patted dry. Powder sprinkled liberally on peri-area.

Resident interview:
3/23/XX at 9:30 a.m. The "catheter sometimes pulls during transfers or repositioning. At times it feels like I have to go bad and it burns down there." Likes staff. Has no complaints about treatment or care. Doesn't like to drink water, never has. Prefers coffee.

Additional chart review:
Urine analysis on 2/17/XX: Cloudy, WBC 120, nitrate + leukocyte esterase + bacteria large.
Culture results: E. coli; sensitive to all tested antibiotics.
Physician's order on 2/18/XX for antibiotic for 10 days with UA 2 days after antibiotic finished. Diagnosis: UTI (urinary tract infection).

Staff interviews:
NA (Rita) on 3/22/XX at 12:15 p.m. Catheter straps kept in utility room but a nuisance when used because need to be moved and repositioned to prevent skin irritation. Procedure is to keep catheter bag below bladder level at all times.

Director of Nursing on 3/23/XX at 2:30 p.m. Catheter bags facility uses do not have anti-reflux device. Policy is to keep catheter bag below bladder level at all times so reflux does not occur. Catheter bags and tubing are not to touch the floor.

Policy and procedure review:

a. Policy/procedure for "Caring for a Foley Catheter" dated June XXXX states catheter bags are to be positioned below bladder level with tubing coiled and placed at or below bladder level at all times to prevent reflux of urine from the tubing and/or drainage bag into the bladder which could cause a UTI. To prevent contamination, the drainage bag and tubing should never touch the floor. Drainage tubing is to be attached to the upper thigh using a catheter strap to prevent tension on the catheter.

b. Policy/procedure for "Catheter Care" dated June XXXX states it is to be provided twice daily, with a.m. and HS cares. The labia are to be spread and the urinary meatus and 4 inches down the catheter to be washed with soap and water and rinsed first. Then the inside of the labia is to be washed with soap and water using a different portion of the washcloth for each stroke, then rinsed. A front-to-back cleansing motion is to be used. The labia are then released and the outside of the labia should be washed and rinsed in the same manner. A clean washcloth is to be used whenever the cloth becomes soiled. The labia are to be patted dry. The insides of the thighs are to be cleaned in the same manner. The resident is then to be turned on the side and the rectal area cleansed in the same manner. Powders and lotions are not to be used unless ordered as a moisture barrier.

SOD Example

Tag

F316, 42 CFR 483.25(d)(2): A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Findings

This requirement is NOT MET as evidenced by:

Based on observations, staff interview, and record review, the facility failed to provide treatment and services to prevent urinary tract infections for 1 of 2 sampled residents with indwelling catheters (Residents 44 and 57). Total sample size was 16 in a facility with a census of 78.

Record review conducted on 3/21/XX for Resident 44 revealed diagnoses of Alzheimer's disease, Parkinson's disease, recent cerebrovascular accident (CVA) with paralysis, and history of decubitus ulcer. Review of the last three Minimum Data Sets (MDSs) completed for Resident 44 documented the resident has an indwelling catheter.

Laboratory report dated 2/17/XX showed the following results: appearance cloudy, WBCs (white blood cells) 120 (normal is 3 to 4), nitrates positive (normal is negative), leukocyte esterase positive (normal is negative), and large amount of bacteria (normal is negative). A physician's order dated 2/18/XX documented a diagnosis of urinary tract infection (UTI) and prescribed a 10-day course of antibiotics.

During observation of transfer of Resident 44 from bed to wheelchair on 3/22/XX at 11:45 a.m., NA C (a nursing assistant) lifted catheter drainage bag over top of resident lying in bed to hand it to NA B, who hooked it to uniform pocket. Resident 44's bed was at its lowest height, causing the drainage bag to be suspended above bladder level prior to the transfer. After the transfer was completed, NA B placed the catheter bag on the floor underneath the wheelchair, went around to the back of the wheelchair, and picked up the bag from behind the wheelchair. NA B then placed catheter drainage bag in a cover holding the bag at the height of the resident's shoulders. NA B then hooked the drainage bag to the back of the wheelchair below bladder level with the tubing looped under the wheelchair from front to back with the tubing touching the floor. Check of the catheter drainage bag at the time of observation revealed that the bag did not contain an antireflux valve between bag and drainage tubing.

Observation of another transfer of Resident 44 on 3/22/XX at 1:30 p.m. revealed NA B and NA C again hooking the catheter bag to a pocket, above the level of the resident's bladder. During the transfer, the catheter tubing again came in contact with the floor.

3/23/XX at 9:30 a.m. During interview, Resident 44 said the "catheter sometimes pulls during transfers or repositioning. At times it feels like I have to go bad and it burns down there."
In an interview conducted on 3/23/XX at 2:30 p.m., the Director of Nursing confirmed that the catheter drainage bags used by the facility do not contain antireflux valves. The Director of Nursing stated that, due to the bags' not containing antireflux valves, it is the policy of the facility to keep the catheter tubing and drainage bags below the residents' bladder level at all times.

Review of facility policy titled "Caring for a Foley Catheter" dated June XXXX confirmed "catheter bags are to be positioned below bladder level with tubing coiled and placed at or below bladder level at all times to prevent reflux of urine from the tubing and/or drainage bag into the bladder which could cause a UTI (urinary tract infection)."

During observation of catheter care for Resident 44 on 3/23/XX, at 6:00 a.m., NA D did not cleanse the urinary meatus, the Foley catheter tubing, or the thighs and rectal area. NA D sprinkled the perineal area liberally with powder.

Review of the facility policy and procedure titled "Catheter Care" dated June XXXX directed staff to wash around the urinary meatus and up to four inches of the catheter, followed by the outer labia, thighs, and finally the rectal area.

ESRD—V449: SOD Example

Tag

42 CFR 405.2163(d): The dietitian, in consultation with the attending physician, is responsible for assessing the nutritional and dietetic needs for each patient, recommending therapeutic diets, counseling patients and their families on prescribed diets, and monitoring adherence and response to diets.

Findings

This requirement is NOT MET as evidenced by:

Based on record review, facility policy and procedure review, and interview with facility staff, the facility failed to ensure dietitian services for 2 of 2 sampled ESRD (end stage renal disease) patients (Patients 3 and 4) diagnosed with ESRD, diabetes and hypertension.

1. Review of facility policy #949 titled "Dietetic Services" revision date 1/5/XX, stated that the "Dietitian shall assess each new patient in the facility within the first 4 weeks after initiation of dialysis." Further review of facility policy #949 recorded the dietitian is to evaluate and educate the new patient for knowledge level and understanding of diet related to diabetes, hypertension, ESRD and fluid restrictions within the first week after initiation of dialysis.

2. Review of the 9/4/XX history and physical of Patient 3 revealed an 82-year-old patient with diagnosis of diabetes, hypertension and ESRD. Review of the comprehensive Care Plan revealed dialysis began on 9/4/XX and the patient's diet order stated: 1500 calorie ADA (American Dietetics Association), 60 gram protein, 2 gram sodium, 2 gram potassium, less than 1 gram phosphorus, 1200 cc (cubic centimeters) fluid restriction per day. Review of social services evaluation and Care Plan notes revealed the patient moved to a skilled nursing home on 9/20/XX due to transportation difficulties from home to the dialysis facility. Review of the patient's medical record showed no dietitian evaluation of Patient 3.

   During an interview on 10/8/XX at 2:00 p.m., the charge nurse confirmed that the dietitian did not evaluate Patient 3. Further interview with the charge nurse revealed that the dietitian was scheduled to consult with Patient 3 on 9/25/XX.

3. Review of the 9/10/XX history and physical of Patient 4 revealed a 76-year-old patient with diagnosis of diabetes, hypertension and ESRD. Review of the comprehensive Care Plan revealed dialysis began on 9/10/XX and the patient's diet order stated: 1800 calorie ADA, 60–75 gram protein, 2 gram sodium, 2 gram potassium, less than 1 gram phosphorus, 1500 cc (cubic centimeters) fluid restriction per day. Review of the dietary evaluation and Care Plan notes showed no dietitian evaluation of Patient 4.

During interview on 10/8/XX at 2:00 p.m., the charge nurse confirmed that the dietitian had not evaluated Patient 4. Further interview with the charge nurse revealed that the dietitian was scheduled to consult Patient 4 on 9/25/XX.

HHA—G158: SOD Example

Tag

42 CFR 484.18: Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

Findings

This Standard is NOT MET as evidenced by:

Based on observation, patient interview, agency staff interview and clinical record reviews, the agency failed to develop and/or follow written physician plans of care for 3 of 11 patients (Patients 1, 2, and 5) related to cares in regards to medication changes, elevated blood sugars and wound care.

1. Patient 2's clinical record review on 5/8/XX revealed the following. The skilled nurse (SN) documented a change of physician on 4/6/XX. The clinical record failed to contain orders from the new attending physician. On 4/6/XX, the SN documented that the new attending physician discontinued the patient's Theophylline and started Atrovent (both bronchodilating medications). The patient's clinical record contained no written physician's orders for these medication changes.

   Interview on 5/9/XX at 7:45 a.m. with the SN case manager for Patient 2 confirmed that the new attending physician did not write orders for Patient 2.

2. Patient 5's clinical record review on 5/8/XX revealed the following. The primary diagnosis for Patient 5 is diabetes mellitus. Physician certification orders dated 3/24/XX to 5/24/XX included that the skilled nurse is to visit the patient two times a week. During these visits, the SN is to perform a blood glucose fingerstick in the morning before meals and the administration of the morning medications. The SN is to notify the physician if the patient's blood sugar exceeds 200 mg/dl (milligrams per deciliter)

   Review of Patient 5's clinical record further revealed that the SN documented on 3/27/XX that the patient's blood sugar as 321 mg/dl at 8:00 a.m. before the patient consumed meals and medications. On 3/30/XX, the SN documented the patient's blood sugar as 279 mg/dl at 8:00 a.m. before the patient consumed meals and medications. On 4/3/XX, the SN documented the patient's blood sugar as 282 mg/dl at 7:45 a.m. before the patient consumed meals and medications. There was no documentation the SN notified the physician of the elevated blood sugars on 3/27, 3/20 or 4/3/XX. On 4/6/XX, the SN documented that "Patient did not answer the door." On 4/7/XX the SN documented a transfer OASIS (Outcome Assessment and Information Set) assessment, a federally mandatory comprehensive assessment document, recording the patient's admission to an acute care facility on 4/6/XX for treatment of hyperglycemia (high blood sugar level).

Interview with the SN case manager for Patient 5 on 5/9/XX at 8:00 a.m. confirmed that the physician was not notified of the elevated blood sugars as ordered by the physician.

3. Patient 1's clinical record review on 5/8/XX revealed the following. Diagnosis of diabetes mellitus and a physician order of 4/11/XX included the SN is to provide wound care every other day to the patient's right foot. This wound order stated " Use Skintegrity to cleanse the wound then rinse the wound with sterile normal saline, apply a Strasorb dressing to the wound, then apply an abdominal dressing securing the dressing with paper tape." Review of the wound treatment record showed the SN documented cleansing the patient's right foot with hydrogen peroxide then applying a Duoderm dressing on 4/12, 4/14, 4/16, 4/18, 4/20, and 4/22/XX.

   During a home visit on 5/8/XX at 4:00 p.m., observation revealed the SN cleansed Patient 1's right foot wound with hydrogen peroxide then applied a Duoderm dressing to the wound. During interview at 4:30 p.m., Patient 1 revealed that today's wound care procedure was "no different than any other day." Patient further stated: "I don't like the burning and it's not getting any better."

Hospice—L125: SOD Example

Tag

42 CFR 418.56(d): The hospice retains the responsibility for payment for services.

Findings

The Standard is NOT MET as evidenced by:

Based on interviews, and review of clinical record, written agreement and billing records, the hospice failed to develop a written agreement that did not limit its financial responsibility. In addition, the hospice failed to retain payment for hospice-related services including supplies, diagnostic tests and medications for 1 of 1 hospice patient (Patient 3) that resided in a skilled nursing facility.

1. Review of the hospice written agreement between the hospice and the SNF (skilled nursing facility) dated and signed by both contracting parties on 12/9/XX revealed the following. The agreement at Exhibit C.II.(b)(i) states: "Hospice will: (i) Provide the following supply items identified to be appropriate according to the Hospice plan of care . . . disposable diapers (36 per week); blue pads (28 per week); Depends (15 per week); ostomy bags if ostomy is the result of terminal diagnosis (7 per week); Foley catheter (one change per month); wound care supplies." This written agreement between the SNF and the hospice limits the financial responsibility of the hospice for the medical supplies of its terminal patients.

2. Review of physician's progress notes in the SNF clinical record for Patient 3 revealed the following. Patient admitted to hospice services on 12/13/XX with the admitting diagnosis of multiple sclerosis. Patient had an indwelling catheter. The physician orders of 9/1/XX stated: "Catheter to be changed monthly or as needed if leaking or pulled out. Catheter bag to be changed every two weeks."

Interview with hospice director on 1/22/XX at 3:00 p.m. revealed that the hospice did not have billing records of Patient 3's catheter supplies. Upon request by the hospice director after the surveyor requested billing information, the SNF faxed to the hospice copies of health insurance claim forms submitted to Medicare by the SNF for the following catheter supplies.

a. Dates of service 12/10/XX to 12/31/XX documented charges for one catheter tray at a cost of $39.30.
b. Dates of service 1/1/XX to 1/9/XX documented charges for two urinary draining bags at $10.49 each for a total cost of $20.98.
c. Dates of service 1/10/XX to 2/9/XX documented charges for insertion catheter tray for $39.30 and a urinary drainage bag for $10.49.

Further interview with the hospice director on 1/22/XX at 4:00 p.m. revealed the hospice will pay the bill for the catheter supplies and will not bill Medicare.

3. Review of SNF clinical record for Patient 3 revealed the following. History and physical dated 10/6/XX that included: "Respiratory difficulties secondary to the multiple sclerosis." On 12/28/XX, the physician ordered a chest X-ray for the patient. The X-ray summary report dated 12/28/XX stated: "Left base pneumonia, mild. The recurrence and/or persistence of this pneumonia does suggest underlying pathology and definitive follow-up is recommended to rule out pathology." Because of the chest X-ray diagnosis of pneumonia on 12/28/XX, the physician ordered intravenous replacement with antibiotic treatment. The patient received the treatment of D5NS (5% Dextrose solution) at 75 cc (cubic centimeters) per hour for 7 days with Levaquin 500 mg (milligrams), an antibiotic, every 24 hours for 7 days. The patient began on oxygen at 2 liters per nasal cannula when the patient's oxygen level dropped below 90% blood saturation levels. The hospice medication sheet included the physician order dated 1/3/XX for Albuterol 0.5 cc with Atrovent 2.5 cc (both bronchodilator drugs) three times per day via nebulizer. A copy of the hospice ongoing plan of care documented that the Albuterol, Atrovent and nebulizer treatments were "non-covered items."

On 1/20/XX at 11:00 a.m., interview with the SNF Director of Nurses revealed that she was unaware who was to be billed for Patient 3's 12/28/XX pneumonia care. The care for Patient 3's pneumonia included the following charges: chest X-ray, intravenous therapy treatments for fluid replacement and intravenous antibiotic treatments, oxygen, and nebulizer treatments.

Interview with hospice Director of Nurses on 1/20/XX at 1:00 p.m. confirmed that no one had contacted the physician but would do so on 1/20/XX to verify if the patient's 12/28/XX diagnosis of pneumonia is related to the terminal diagnosis of multiple sclerosis for Patient 3. Review of a fax from the physician dated 1/20/XX at 1:30 p.m. confirmed the diagnosis of pneumonia on 12/28/XX had a relationship to the patient's terminal diagnosis of multiple sclerosis.

Hospital—A350: SOD Example

Tag

42 CFR 482.43(a): Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Findings

This standard is NOT MET as evidenced by:

Based on patient and staff interviews, review of facility policies, and review of 2 of 10 patients' medical records (Patients 10 and 25), the facility failed to identify and implement patient needs for home health care and colostomy teaching prior to discharge.

1. The hospital policy and procedure #9999 entitled "Discharge Planning" reviewed on 6/2/XX at 10:30 a.m. stated that "A Discharge Plan is to be initiated by the social worker and the nursing staff within 24 hours of admission on every patient who is over the age of 62, . . . anyone living alone, or anyone likely to need postdischarge care."

   Medical record review of Patient 25 on 6/2/XX at 8:30 a.m. revealed patient had surgery for a permanent colostomy on 5/26/XX due to cancer of the colon. Interview with the patient on 6/2/XX at 1:00 p.m. revealed that the patient was worried because the patient lives alone and feels very weak. During the interview, the patient revealed anticipating discharge in a couple of days. Patient 25 further stated, "I'm not sure how I will manage the colostomy at home," and needs to know how to take care of the colostomy before going home.

   Review of nursing policy #999A "Colostomy Training" effective on 1/1/XX showed that "Colostomy training must be initiated within 24 hours postoperatively so as to make sure the patient is able and willing to take care of the colostomy at home."

   Review of Patient 25's medical record on 6/2/XX at 5:30 p.m. seven days after Patient 25's surgery revealed no evidence in Patient 25's medical record of initiation of colostomy teaching.

   On 6/3/XX at 9:00 a.m., the unit manager revealed in interview that the nursing staff should have initiated colostomy training with Patient 25 to prepare the patient for discharge. The unit manager stated that colostomy training for Patient 25 would start immediately. Clinical record review on 6/3/XX at 5:30 p.m. revealed no evidence of colostomy teaching by hospital staff with Patient 25. During interview with Patient 25 on 6/3/XX at 6:00 p.m., the patient stated: "They haven't talked to me yet about my colostomy."

2. On 6/2/XX at 9:00 a.m., record review of Patient 10's closed medical record revealed the following from the 4/30/XX history and physical. Patient 10 is a 75-year-old admitted on 4/30/XX with abdominal pain. Patient 10 diagnosed with cholecystitis had a cholecystectomy (removal of gallbladder) performed on the same day. Three days later the patient developed a surgical wound infection. The wound required packing with gauze moistened with normal saline three times a day. Review of the physician's progress notes dated 5/4/XX further revealed that Patient 10's discharge occurred on 5/4/XX with a physician's order to continue with the dressing changes at home under the care of a home health agency. There was no documented evidence in Patient 10's medical record that demonstrated coordination of care with a home health agency.

   During an interview on 6/3/XX at 9:00 a.m., the unit manager confirmed that the social worker failed to coordinate the discharge plans with the home health agency. In an interview on 6/3/XX at 11:00 a.m., the social worker assigned to the unit that cared for Patient 10 stated: "I am aware of the policy but I have been very busy and unable to evaluate every patient on my assigned unit. Sometimes, by the time I realize it, the patients have gone home without a discharge plan."

ICF/MR—W249: SOD Example

Tag

42 CFR 482.440(d)(1): As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Findings

This requirement is NOT MET as evidenced by:

Based on observation, record review and staff interview, the facility failed to assure that 1 of 58 clients (Client 34) sampled received continuous active treatment programs to support the behavioral needs of each client.

On 2/22/XX at 6:20 p.m., observation revealed Client 34 sat in the dining room, away from the table facing the TV (television). The TV was off. The client's back was to the other clients who were at the table. A radio played quietly as other clients finished supper. Client 34 sat with two beanie babies in the wheelchair, head down, and eyes closed.

During an interview on 2/22/XX at 6:20 p.m., the developmental aide on duty (DA I) said Client 34 received tube feedings and nothing by mouth. DA I also said Client 34 came to the dining room during meals for the social time. At 6:30 p.m. DA I gave Client 34 a child's driving simulator toy (Tiny Tot Driver). The client immediately began pushing buttons on the toy. The client still sat facing the TV with back to the other clients. This continued until 7:00 p.m. (30 minutes).

During observation on 2/29/XX at 5:30 p.m., Client 34 sat facing the TV away from the table. The TV was not on. Client 34 continued to sit there until 6:40 p.m. (70 minutes).

On 3/1/XX at 5:00 p.m., observation revealed that Client 34 sat in the dining room away from the table facing the TV. The TV was not on, and the client engaged in no activity. At 5:05 p.m. DA I turned Client 34 around to face the table, but did not push the client up to the table (approximately 6 feet away). At that time, DA I stated the clients go to the dining room after the afternoon programming. The clients stay in the dining room and do activities until the serving of the evening meal. At 5:25 p.m. (20 minutes had passed), Client 34 still sat back from the table with no activity and continued to sit there until 6:10 p.m. (65 minutes) with no activity. At 6:10 p.m. DA I gave Client 34 a toy (Tiny Tot Driver). The client immediately began pushing the buttons on the toy.

On 3/2/XX at 9:00 a.m. observation revealed Client 34 sitting in the dining room back from the table and not engaged in any activity. The client sat with a stuffed brown bear in the wheelchair, head down and eyes closed. At 9:05 a.m. the DA K said Client 34 came to the dining room for social activity. Client 34 continued to sit back from the table and engaged in

no activity until 9:30 a.m. (30 minutes). The other clients were at the door, lined up to leave the dining room.

The PCP (person-centered plan) dated 1/20/XX documented interventions for Client 34 were visual/tactile and/or audio/visual stimulation during social time at meals (e.g., peg boards, tactile stimulation, etc.)

LSC—K021: SOD Example

TAG	SUMMARY STATEMENT OF DEFICIENCIES
K021	NFPA 101 STANDARD: Life Safety Code Standard Doors in fire separation walls, hazardous area exposure, horizontal exits, or smoke partitions may be held open only by devices arranged to automatically close such doors by zone or throughout the facility upon activation of: a) the required manual system and b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and c) the automatic sprinkler if installed. 13-2.11.5 This requirement was NOT MET as evidenced by: Based on observation and staff interview, the facility failed to allow the automatic closure of 1 of 9 fire separation doors (West Fire Door) included in the facility's fire safety system by use of a door wedge (an unapproved device which prevents automatic door closure). Findings are: On facility tour between 2:30 and 3:30 p.m. on XX/XX/XX, observation revealed a door wedge at the foot of the West Entry door holding the door open. The door wedge held the door in the open position and prevented automatic closure in case of fire, which breaks the fire separation barrier and allows the spread of smoke and fire into and out of that fire containment zone. In an interview conducted at the time of observation (between 2:30 and 3:30 p.m. on XX/XX/XX), custodial staff member D stated that during the summer wedges routinely held open the West Entry door to allow for air flow in the laundry area when the dryers are running.

LSC—K051: SOD Example

Tag

A fire alarm system, not a presignal type, with approved component devices or equipments installed to provide effective warning of fire in any part of the building. Pull stations in patient sleeping area may be omitted at exits if located at all nurses stations, are visible and continuously accessible and travel distances of 7-6.2.4 are not exceeded. Required sprinklers, detectors, etc. are arranged to activate the fire alarm system and operate devices such as dampers, door holders, etc. Fixed extinguishment protective systems protecting commercial cooking equipment in kitchens protected by a complete automatic sprinklers need not initiate the building fire alarm system. The fire alarm system is connected to automatically transmit an alarm to summon the local fire department. (13-3.4.2, 13-3.4.3, 13-3.4.4)

Findings

This requirement is NOT MET as evidenced by:

Based on observation, staff interviews and record reviews, the facility failed to provide a fire alarm that was audible in 6 of 6 fire zones which placed all 112 residents at risk for unsafe evacuation in case of fire.

An interview with the administrator conducted on 3/21/XX at 9:05 a.m. revealed the fire alarm company updated the facility fire alarm system with work completion on 3/1/XX.

A review of the facility "Fire Drills and Safety" records for the year XXXX confirmed, on 3/1/XX, the update to the facility's fire alarm system.

Observation and testing of the fire alarm system on 3/21/XX, at 9:30 a.m., revealed that the 6 horizontal exit doors closed but the fire alarm horns did not sound.

An interview with the maintenance supervisor on 3/21/XX, at 9:50 a.m., revealed that the maintenance department conducted no testing of the fire alarm system since the fire alarm company completed work on 3/1/XX.

An interview with the administrator on 3/21/XX, at 1:00 p.m., revealed contact with the fire alarm company and reactivation of the fire alarm audible signal resulting in the facility having no audible fire alarm signal for at least 20 days.

LTC—F309: SOD Example

Tag

42 CFR 483.25: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Use F309 for quality of care deficiencies not covered by 42 CFR 483.25(a)–(m).

Findings

Severity and Scope: G

This requirement was NOT MET as evidenced by:

Based on observations, interviews and record review, the facility failed to assess, monitor, and provide timely interventions after a fall for 1 of 8 residents (25) facility staff assessed as at risk for falling. The facility census was 39 residents.

Review of Resident 25's Minimum Data Set (MDS), dated 9/5/XX, documented the following:

- Diagnoses of osteoarthritis and Parkinson's disease.
- No long-term memory problems.
- Modified independence with decision-making abilities (some difficulty with new situations only).
- Confusion.
- No history of pain.
- Dependent on staff assistance for personal hygiene, transfers and walking.

During an interview on 10/12/XX, at 1:30 p.m., Resident 25's family member revealed the following information:

- Upon arrival at the facility on 10/6/XX at 10:45 a.m. to prepare Resident 25 for a 2:00 p.m. previously scheduled visit to the physician, found Resident 25 in bed, moaning and grimacing.
- Resident 25 said, "I hurt and nobody believes me. I fell to the floor during the night and stayed there until I could crawl back into bed."
- Upon examining the resident's room, two broken picture frames were on the nightstand. The frames were intact the day before.
- Because the resident continued to complain of pain in the back area, the family member checked Resident 25 and discovered a large crescent shaped bruise on the resident's back.
- Staff was immediately summoned and the DON (Director of Nursing) entered the resident's room. The family member told the DON that the resident fell and was in great pain. The DON said the resident did not fall, but only dreamt of falling. The family member showed the DON the large bruise on the resident's right side of back and the DON said the bruise was new.

- At the family member's insistence, facility staff notified the resident's physician at 11:15 a.m.
- Resident 25 continued to moan with severe pain. The resident kept repeating, "I fell, could get no one to help, and had to crawl back into bed alone."
- At 11:30 a.m. the family member followed up with a call to the physician's office, reporting the resident's fall, the bruise, and pain.

Review of physician orders dated 10/6/XX revealed an order for an immediate transfer to the hospital for X-rays. Review of a copy of the X-ray report dated 10/6/XX in the resident's medical record revealed that Resident 25 had new fractures of four ribs and three vertebrae.

During an interview on 10/12/XX at 4:30 p.m., the physician revealed the following information:

- The call from the facility staff indicated no urgency or need for transfer because there was no report of pain or injury.
- On first examination of the resident in the hospital, the resident's injured areas were quite tender. The resident described the pain as "jump-out-of-bed" kind.
- Resident 25 developed pneumonia as a direct result of the fractured ribs.

Review of the nurses' notes showed only one note for 10/6/XX at 12:00 midnight and documented that Resident 25 had dreamt of falling.

On 10/13/XX at 10:00 a.m., observation of Resident 25's bath revealed the presence of a fading yellow bruise (2 × 4 inches in size) on the right lower rib area of the back. During the observation, Resident 25 complained of pain in the side and back area upon movement, when coughing, and when staff touched the area.

OPT—I158: SOD Example

Tag

42 CFR 485.713(c): The organization establishes a written preventive maintenance program to ensure that:

(1) The equipment is operative and is properly calibrated and
(2) The interior and exterior of the building are clean and orderly and maintained free of any defects, which are a potential hazard to patients, personnel and the public.

Findings

The Standard is NOT MET as evidenced by:

Based on review of the OPT's (outpatient physical therapist's) written preventive maintenance program and staff interview, the OPT failed to ensure that 2 of 3 machines (1 of 2 ultrasound machines and the electrical stimulation machine) received equipment maintenance and/or calibration.

1. On 6/15/XX at 9:00 a.m., review of the written preventive maintenance program revealed a lack of documentation for completion of the preventive maintenance and calibration review for ultrasound machine #2 and the electrical stimulation machine.

2. During interview on 6/15/XX at 10:00 a.m., the physical therapist director confirmed an absence of preventive maintenance checks and calibrations for ultrasound machine #2 or for the electrical stimulation machine.

RHC—J70: SOD Example

Tag

42 CFR 481.10(a)(3) For each patient receiving health care services, the clinic maintains a record that includes, as applicable:

(i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;

(ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;

(iii) All physician's orders reports of treatments and medications and other pertinent information necessary to monitor the patient's progress;

(iv) Signatures of the physician or other health care professional.

Findings

This requirement is NOT MET as evidenced by:

Based on record review and staff interview, the clinic failed to maintain consent for treatment forms for 3 of 6 patient clinical records (Patient 1, 3, 5).

1. Review of the policy titled "Content of Clinical Records" with the office manager revealed that clinical records are to include consent forms signed by the patient.

2. On 6/2/XX review of the clinical records revealed the following:
   - Patient 1's record revealed an absence of consent for treatment signed by the patient.
   - Patient 3's record revealed a diagnosis of senile dementia and an absence of a signed consent for treatment by the patient or a responsible party.
   - Patient 5's record revealed an absence of consent for treatment signed by the patient.

3. On 6/2/XX at 10:15 a.m., interview with the office manager confirmed that Patients 1, 3, and 5 did not have signed consent forms for treatment and were currently receiving services. Further interview with the office manager revealed that the clinic staff needed to work on ensuring that all patients signed consents for treatment.