Expansion of MDS & Staffing Focus Survey

Are you prepared?
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OBJECTIVES

• Discuss the regulatory environment leading to the MDS & Staffing Focused Survey process.
• Understand findings from the MDS & Staffing Focused Survey trials and actual surveys in 2015 and 2016.
• Contrast MDS & Staffing Focused Survey protocol with annual survey protocol.
• Identify strategies to minimize risks for regulatory non-compliance in an MDS & Staffing Focused Survey.

Background
Office of Inspector General (OIG) reported that for 37 percent of stays, Skilled Nursing Facilities (SNF) did not develop care plans that met requirements, or did not provide services in accordance with care plans.

OIG, Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements, OEI-02-09-00201, February, 2003.

OIG, Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs, OEI-07-08-00151, July 2012

BACKGROUND

In addition, for 31 percent of stays, SNFs did not meet discharge planning requirements.

Earlier work by the OIG reported that assessment errors are common in nursing homes.

In one report, the OIG stated, "SNFs reported inaccurate information, which was not supported or consistent with the medical record, on at least one MDS item for 47 percent of claims" reviewed in the study.
MDS Focused Survey combined with a review of nursing home staffing

- Intend to strengthen the Nursing Home Five-Star Quality Rating System
- Survey worksheets revised
- Rollout in two phases by CMS regions and states
- Notified of groups in February
- Training began in April (Webinars)
- Deficiencies identified during the surveys will result in relevant citations and enforcement actions.

Purpose of Surveys

- Assess Minimum Data Set, Version 3.0 (MDS 3.0) coding practices and the relationship to resident care in nursing homes
- Volunteer States
  - IL, MD, MN, PA, and VA
  - Expanded to all 50 States in 2015
- Pilot Method
  - 5 surveys in each state conducted over 2 days by State RAI Coordinator and one of two state surveyors
BACKGROUND

- The number of surveys conducted in the pilot and in actual state contracts varies from state to state.
- States were expected to allocate two surveyors for each pilot survey, requiring an estimated 2 days on average.
- Surveyors completed and submitted pilot post-survey information to CMS (e.g., questionnaire about the process and findings).

OBJECTIVES

- Measure:
  - Compliance with RN conducting or coordinating the assessments
  - Compliance with required timelines (OBRA)
  - Agreement between MDS 3.0 assessments and the resident’s medical record
  - Supplemented with observations and interviews

PILOT PROCESS

- CMS provided each of the 5 volunteer State Survey Agencies with a list of possible facilities
  - Based upon QM trends
  - Facility Size usually < 120 residents
  - Survey to be completed in 2 days
PILOT BACKGROUND

- Record review, augmented by resident observations and staff and/or resident interviews, was used by the surveyors to validate MDS 3.0 coding and staffing levels.
- Additionally, while on-site, the surveyors asked a series of questions regarding staffing and MDS related practices of the facility staff, leadership, and others as appropriate.

SURVEY PROCESS

- Disagreement between MDS 3.0 assessments and the resident’s medical record
  - Supplemented with observations and interviews

Staffing Component
Since staffing information is only collected on the annual survey, there is no information available to CMS on how staffing levels may fluctuate throughout the year. Therefore, CMS intends to assess the staffing levels of nursing facilities by expanding the MDS focused surveys to review this information.

"Assessing the accuracy of information on the staffing of nursing homes is critical in order to assure that a facility has the sufficient nursing staff to meet the needs of the residents". (42 CFR 483.30(a) Sufficient Staff).

Skilled nursing facilities and nursing facilities must be in compliance with the requirements in 42 CFR Part 83, Subpart B to receive payment under Medicare or Medicaid, including the completion of the standard survey form CMS-671.

- This form requires facilities to list the type of staff working in the facility and the number of hours they worked.
- Surveyors collect this form per Task 2 of the survey process.
(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

Public access to posted nurse staffing data.
The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.
2015 and 2016 Survey Deficiencies

- Staffing Posting
  - Facilities in Virginia and Texas received deficiencies with civil money penalties for inaccessible or absent staffing postings.
  - Multiple deficiencies for staffing posting
  - Multiple deficiencies for retention of staffing posting for required 18 months

Payroll Based Staffing Reporting

CMS has developed a quarterly electronic reporting system that is auditable back to payrolls to verify staffing information.
- new system to increase accuracy and timeliness of data,
- allow for the calculation of quality measures for staff turnover, retention, types of staffing, and levels of different types of staffing.
- Mandatory on July 1, 2016

Pilot Survey Outcomes
Pilot Survey Outcomes

- The MDS 3.0 inaccuracies and insufficient staffing noted during the survey resulted in relevant citations, including those related to quality of care and/or life, or nursing services.
- When patterns of inaccuracies were noted, the case was referred to the CMS RO and CO for follow-up.
- In the event that care concerns were identified during on-site reviews, the concerns may be cited or referred to the SA as a complaint for further review.

Pilot Survey Findings

- Deficiencies were identified and cited on all but one survey (i.e., 24 of 25 surveys).
- Surveyors felt that these surveys enhanced surveyors’ ability to identify errors and deficiencies related to MDS coding and resident care.
- The surveys will be expanded nationwide in 2015.

Survey Process
• 90 Minute Webinar
  – Understand types of assessments (OBRA)
  – Understand why ARD is critical in determining the clinical information captured on the MDS 3.0
  – Understand coding instructions for those items included in the study
  – Understand the criteria for SCSA and how it relates to the assessment process

• Surveyor Training

  – Off-site survey preparation
  – Procedures for entrance to a pilot facility
  – Conducting an entrance conference with facility staff
  – Touring the facility and obtaining direct observation of residents and staff
  – Collection of documents from facility staff
  – Daily team meetings

• Survey Process

  – General guidelines for validating the agreement of the MDS 3.0 assessment
  – Determining compliance with specific (related) regulations
  – Survey team decision making
  – Conducting an exit conference.
Survey Process

- 7 clinical conditions reviewed:
  1. Severity of injury associated with falls
  2. Pressure ulcer status
  3. Restraint use
  4. Late loss ADL status
  5. Indwelling catheters
  6. Antipsychotic medications
  7. UTIs

Pilot Survey Findings

- Findings
  - "Relatively high levels of compliance related to RN coordination and assessment timing”
  - "Room for improvement in 4 of 7 clinical conditions”
- Plan
  - 2015 Expansion of focus surveys
  - All states
  - Add Staffing component

PILOT SURVEY FINDINGS

- Results of the pilot are not generalizable to all nursing facilities
  - Sample was not representative of U.S. nursing facilities (size, rural/urban, etc.)
  - 25 facilities in pilot vs. 16,000 nursing facilities in U.S.
  - About 1,000 MDS 3.0 assessments compared to about 1.6 million submitted to CMS each month
PILOT SURVEY FINDINGS

- Deficiencies in 24 of 25 trial surveys
- 25% disagreement rate for falls with injury
- 18% disagreement rate for pressure ulcer
- 17% disagreement rate for restraints
- 15% disagreement rate for late loss ADLs

Pilot Disagreement Rates

<table>
<thead>
<tr>
<th>Area</th>
<th>PA</th>
<th>MD</th>
<th>VA</th>
<th>IL</th>
<th>MN</th>
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</thead>
<tbody>
<tr>
<td>Late loss ADL</td>
<td>9.5%</td>
<td>28.6%</td>
<td>9.5%</td>
<td>33.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>12.5%</td>
<td>30%</td>
<td>2.5%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>Worsening PU</td>
<td>38.5%</td>
<td>23.1%</td>
<td>0%</td>
<td>38.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Falls w injury</td>
<td>8.3%</td>
<td>37.5%</td>
<td>16.7%</td>
<td>12.5%</td>
<td>25%</td>
</tr>
<tr>
<td>Restraints</td>
<td>0%</td>
<td>6.5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>UTI</td>
<td>18.8%</td>
<td>15.6%</td>
<td>6.3%</td>
<td>18.8%</td>
<td>40.6%</td>
</tr>
<tr>
<td>On Neurogenic Bladder</td>
<td>9.5%</td>
<td>23.8%</td>
<td>42.9%</td>
<td>9.5%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

PILOT SURVEY FINDINGS

- Non-Compliance with RN conducting or coordinating the assessments
  - 6 of 1,027 assessments
  - 0.6% non-compliance rate
  - "No sign of widespread failure"
  - "Little reason for CMS to focus on RN coordination as an area of concern"
MDS Coding
• Absence of active diagnoses; urinary retention or neurogenic bladder when the resident had an indwelling catheter, new fracture
• Incorrect drug classification – antipsychotic
• Coded a catheter previously discontinued
• Incorrect coding of pressure ulcer stage
• Missed significant change MDS
• Missing interviews
• Wound coding not reflective of wound documentation
• Absence of coded fall in observation period
• Missed coding UTI, UTI coded but did not meet criteria
• Missed antianxiety med

Staffing Posting
– Facilities in Virginia and Texas received deficiencies with civil money penalties for inaccessible or absent staffing postings.
– Multiple cites for staffing posting or retention of staffing posting for required 18 months

Policies and Procedures
– Lack of policies and procedures for coordination of coding and completion of MDS

Care Planning/ care plan revision
– Chair alarm not on care plan, Level g
– Care plan not updated after falls

Medical records
– Inaccurate order transcription, antipsychotic

Quality of care –
– Catheter not anchored
– Resident hospitalized in conflict with MOLST

Free from accident hazards –
– Catheter tubing wrapped around leg,
– Lack of root cause analysis for falls

Unnecessary med –
– Lack of behavior monitoring
– Lack of GDR for antipsychotic

Pressure Ulcers
– Facility acquired pressure ulcer in low risk resident
Surveys Completed in 2015

- North Carolina – 9 (2 deficiency free when State RAI Coordinator was not on the team)
- Virginia – 5 in 2015, 6 in 2016
- Ohio -25
- Massachusetts - 5
- Connecticut – 6
- Wisconsin – 5
- Minnesota - 5

SURVEY FINDINGS

Pilot Findings: Restraints
Disagreement rate of 17%  
• Surveyor observation and investigation identified additional restraint usage  
• Additional guidance and education to ensure correct identification  
  – RAI Manual, Chapter 3, Section P  
  – S&C 07-22

**DEFINITION**

• Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily, which restricts freedom of movement or normal access to one’s body (State Operations Manual, Appendix PP).

Prior to using any physical restraint, the nursing home must
– assess the resident to properly identify the resident’s needs and the medical symptom(s) that the restraint is being employed to address.

• When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use.
When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action,
- a signed physician order that gives the medical symptom supporting the use of the restraint,
- the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected.

“Remove easily” means that the manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident’s physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).

Chairs that prevent rising
- Any type of chair with a locked lap board,
- that places the resident in a recumbent position that restricts rising,
- chairs that are soft and low to the floor,
- chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and
- enclosed-frame wheeled walkers.
For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual.

For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint.

For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.

Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other.

The assessor must consider the effect it has on the resident, not the purpose or intent of its use.

“Medical symptoms/diagnoses”

- an indication or characteristic of a physical or psychological condition.

- Objective findings from the clinical evaluation of the resident’s symptoms and medical diagnoses should be considered when determining the presence of medical symptom(s) that might support restraint use.

- A clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom.

The resident’s subjective symptoms may not be used as the sole basis for using a restraint. They should not be viewed in isolation. The medical symptoms should become the context to determine the most appropriate method of treatment related to the resident's condition, circumstances, and environment, and not a way to justify restraint use.
“Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom.”

Strategies for Success

- Look at assistive devices from a different perspective
- Assess each assistive device to determine if the device restrains the specific resident.
- Document the reason for use, the circumstances for use and amount of time to use each device
- Review the device and its use at any change in resident status

Pilot and Actual Survey Findings: Pressure Ulcers
Pilot Survey Disagreements
- Presence 8.3%
- Staging 18.3%
- Worsening 6.0%
  - Lack of an accurate clinical assessment of the pressure ulcers
  - Head to toe assessment once a week
  - Training/Certification

Actual Survey Deficiencies
- Facility acquired pressure ulcer in low risk resident
- Incorrect coding of pressure ulcer stage

Steps for Assessment
1. Review the medical record: skin care flow sheets, other skin tracking forms, nurses’ notes, and pressure ulcer risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present.

Steps for Assessment, cont.
4. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).
5. Examine the resident and determine whether any skin ulcers are present.
   Include skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
Steps to determine deepest anatomical stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

Step 1: 1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.

Step 2: Ulcer staging should be based on the ulcer’s deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer’s tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record.

Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable.
3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable.
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.
### MOST SEVERE TISSUE TYPE

**EPITHELIAL TISSUE**
- New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

**GRANULATION TISSUE**
- Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured.

**SLOUGH TISSUE**
- Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

**ESCHAR**
- Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

### WORSENING ULCERS

- A pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment.

- Review the history of each current pressure ulcer. Compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment.
  - This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.
**Strategies for Success**

- Have an organized comprehensive pressure ulcer documentation system.
- Code the MDS according to the documentation describing the wound not just the Stage that is documented.
- Get clarification when documentation is inconsistent.
- Use an interdisciplinary approach to reassess the resident if a wound worsens.
  - Don’t forget to notify the MD, Family and Wound nurse if you code worsening.

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**Pilot Findings: ADL coding**

Section G Disagreement rate of 15.4%

- One in every seven cases of late loss ADLs was coded differently than would be expected.
- These disagreements directly affect facilities’ QM ratings and 5 Star Ratings and reimbursement.
  - Accuracy of coding at the C.N.A. level
  - Orientation
  - At least quarterly
  - Concurrently with observation period
ADLs – Section G

• “There are many possible reasons for variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment is to capture the total picture of the resident’s ADL self-performance over the 7-day period, 24 hours a day”.

Rule of 3 – Section G

Instructions for the Rule of 3

• Code 0, Code 4, and Code 8 – the definition for these coding levels is very specific and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred.

• Code 7 – this code only applies if the activity occurred fewer than 3 times.

Rule of 3 – Section G

1. When an activity occurs 3 or more times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurred 3 or more times.
3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:
   a. Convert episodes of full staff performance (4) to weight-bearing assistance (3)
   b. For a combination of full staff performance and weight-bearing assistance totals 3 or more times = extensive assistance (3)
   c. For a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that total 3 or more times, = limited assistance (2)
   d. If none of the criteria met, code Supervision (1)
Coding Instructions for G0110, Column 2, ADL Support

- Code for the most support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.
- Make a note for an unusual amount of support provided.

**DEFINITION**

**ADL SUPPORT PROVIDED**

Measures the most support provided by staff over the last 7 days, even if that kind of support only occurred once.

Strategies for Success

- Document at the time of care provided.
- Review ADL charting throughout the observation period.
  - Get clarifications
  - Make corrections
- Watch for 1 time events that may require 2 person assist.
- Remind and frequently re-educate nursing staff about the multiple components of each ADL.
Largest disagreement overall

- 25% of the reviewed assessments (24 out of 94) indicated disagreement for level of injury documented after a fall
- Additional guidance and education to ensure correct identification
  - Nurses notes, progress notes, ER reports, X-rays, incident reports
  - RAI Manual, Chapter 3, Section J
    - Definition of fall
    - Definition of major injury

Falls – Actual Surveys

- Care Plan
  - Care plan not updated after falls
- MDS Accuracy
  - Absence of coded fall in observation period
- Accident Prevention
  - Lack of root cause analysis for falls
Falls

• Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).
• The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
• Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.

Falls

• Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).
• An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

INJURY FROM A FALL

INJURY RELATED TO A FALL

• Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

INJURY (EXCEPT MAJOR)

• Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY

• Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.
• Include MDS Coordinator in morning report to enhance knowledge of residents’ falls.
• Determine how to document intercepted falls.
• Remember for include complaints of pain after a fall and code as "Injury" on the MDS.
• Review Post-fall process to ensure that root cause is identified and care plan is updated.

DEFIENCIES
• Non-Compliance with required timelines (OBRA)
  – 23 of 1,027 assessments
  – 2.2%
  – Includes failures to initiate the assessment and/or complete the assessment in a timely manner
  – Overall rate of compliance is high
  – Non-compliance issues were high in 3 of 5 states with a total of 6 facilities (24%)

Actual MDS Coding Deficiencies
• Section H
  – Coded a catheter previously discontinued
• Section I
  – Absence of active diagnoses; urinary retention or neurogenic bladder when the resident had an indwelling catheter,
  – new fracture
  – Missed coding UTI,
  – UTI coded but did not meet criteria
• Section J
  – Absence of coded fall in observation period
Actual MDS Coding Deficiencies

- **Section M**
  - Incorrect coding of pressure ulcer stage
  - Wound coding not reflective of wound documentation
- **Section N**
  - Incorrect drug classification – antipsychotic
  - Missed antianxiety med

Strategies for Success

- Consider whether “copy prior MDS” is a worthwhile function to continue.
- Review identification and coding of diagnoses in Section I.
- Have a handy reference for drug classification
  - GlobalRPh Drug Reference, [http://globalrph.com/drug-4.htm](http://globalrph.com/drug-4.htm)

Other Deficiencies

- **MDS Process/Accuracy**
  - Missing interviews
  
  *Recommendation: Have trained backup staff for each department that completes MDS sections*
- **Significant Change**
  - Missed significant change MDS
  
  *Recommendation: Make Sign change discussion part of daily stand-up meeting, an IDT process. Document a progress note about why/why not.*
Other Deficiencies

- Unnecessary med –
  - Lack of behavior monitoring
  - Lack of GDR for antipsychotic

Recommendation: Establish a psychoactive medication committee. Include a review of all new admissions and re-entries each month. Include the MDS section in every chart review for any purpose.

HOW TO PREPARE

1. Know what to expect

ENTRANCE CONFERENCE

1. Identification of a Wound Care Nurse (and if he/she is available during survey process), wound team, wound care facility, etc. Who coordinates wound care in the facility? How is wound care tracked?
2. Identification of whom in the facility is responsible for staffing and if they are available to provide information and questions during the survey process.
3. 10 most recently completed MDSs
4. List of correction requests submitted, if any
5. List of schedules of people involved in MDS coding
6. All facility Policies and Procedures related to Staffing and scheduling.
   a. There are no Federal requirements for having a policy and procedure for staffing,
      – There are requirements that a center has certain designated positions (i.e., DON, Administrator).
      – Review each section of the regulation relative to minimal requirements.
      – There is a requirement for posting the total number of actual hours worked.

7. Completed Medicare Medicaid application (Form CMS 671).
   a. This must be provided to surveyors within 24 hours of entrance conference.
   b. Be certain the individual completing the Form 671 understands how to accurately complete the Form – how to report staff hours worked in the designated time period.
      Read the instructions on the form carefully to capture direct staff as defined by CMS

MDS-Focused Survey Tip Sheet March 20, 2015
AHCA Workgroup comprised of members of Clinical Practice and Survey/Regulatory Committees
1. Have an audit system in place
   - Peer audits of MDS coding
   - ADL coding reviews just prior to and in first 2
days of observation period.
   - Audit pressure ulcer charting at least monthly
   - Peer audits of physical devices
   - Review of Pressure Ulcer documentation at
least monthly

2. Note the reason for MDS code when
   supporting documentation is variable
   or different than MDS.

3. Use the RAI instructions for coding
   the MDS.
   - Investigate further if documentation is
   variable.
   - Most instructions say “assess” not just review
the record.

4. Educate the staff about high risk
   error documentation areas.
   - ADL review at least quarterly
   - Wound assessments
   - Restraints

5. Use Care Area Assessment (CAA)
   worksheets to show decision-making
   process for care planning and the
   involvement of the resident, family and
   other representatives as appropriate.

6. Ensure that documentation is
   consistent and care provided matches
   the care plan.
   - Care observations by charge nurses
   and supervisors
   - Comfortable communication between nurses
   and nursing assistants about residents’ abilities
   and changes.
MDS SURVEY AND 5 STAR

- MDS Focus Survey is weighted as a complaint survey for the 5 Star Report.
  - An additional survey for the year
  - Less weight than annual but still impacts score.

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