**Montana Critical Access Hospital:**

**SWING-BED Survey Self-Assessment Tool**

**The Survey Self-Assessment Tool**

This document is part of a series of Survey Self-Assessment Tools created for the Montana Hospital Association specific to Critical Access Hospitals (“CAHs”) and their affiliated facilities and services. Other documents in this series are:

* ***Montana Critical Access Hospital Survey Self-Assessment Tool***
* ***Montana Critical Access Hospital: Rural Health Center Survey Self-Assessment Tool***

Critical Access Hospitals (“CAHs”) and the CAH’s affiliated facilities and services must comply with federal requirements in order to participate in Medicare and be eligible to receive Medicare/Medicaid payment. Swing-bed services are an optional services that may be provided in CAHs that meet the eligibility criteria set forth in the CAH Conditions of Participation (“CoPs”). Swing-bed patients are CAH patients who are situated in the CAH but for whom the CAH is receiving reimbursement for post-acute CAH extended care (skilled nursing services), as opposed to acute-care reimbursement. The goal of a survey is to determine if the CAH is in compliance with the swing-bed CoPs.

Certification of the CAH’s compliance is accomplished through the survey process and involves observations, interviews, and document/record reviews. Surveyors of swing-bed services take direction from two documents:

* The [State Operations Manual, Appendix W](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf), which is applicable to CAHs (“**SOM, Appendix W**”); and
* The [State Operations Manual, Appendix PP](https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf), which is applicable to Long-Term Care Facilities (“**SOM, Appendix PP**”).

Surveyors use unique identifiers called “C-Tags” for CAHs and “F-Tags” for Long-Term Care Facilities to assess compliance with the CoPs. This Survey Self-Assessment Tool (“Tool”) lists each C-Tag and F-Tag which captures the requirements in the CoPs and information from the SOM[[1]](#footnote-1) that details what the surveyors will be assessing. Additionally, below are Survey Preparation Recommendations to assist with considerations prior to a survey being conducted.

**How To Use The Tool[[2]](#footnote-2)**

CAHs may use this Tool to prepare for upcoming surveys or may use the Tool on an ongoing basis to evaluate, identify gaps, and document internal compliance with CAH-specific and Swing-Bed specific requirements. Each row of the Tool describes a C-Tag and/or related F-Tag, the underlying CoP, and guidance from the SOM, Appx. W or SOM, Appx. PP as applicable, on how the CAH can demonstrate compliance with the C-Tag and/or F-Tag. Review each row of the Tool and evaluate whether the CAH does or does not comply with the standard. The review should be dated and initialed by the reviewer. Where appropriate, the reviewer should include information in the Notes/Comments column that indicates where applicable compliance documentation can be found or steps that are being taken to address ongoing compliance with the C-Tag and/or F-Tag. Note that the Tool captures only a summary of the applicable standards, the standard in its entirety may be found in the applicable regulation or SOM cited in the Self-Assessment Questions or Comments column. Note that the requirements for acute-care within a CAH also apply to swing-bed patients and are addressed further in the ***Montana Critical Access Hospital Survey Self-Assessment Tool.*** These two Tools should be used in tandem to evaluate the CAH’s swing-bed services preparedness for survey.

**Limitations of The Tool**

This Tool is intended to address Swing-Bed specific requirements by outlining the Long-Term Care Facility requirements that supplement the CAH-specific requirements addressed in the ***Montana Critical Access Hospital Survey Self-Assessment Tool.***  This Tool is not meant to address all potentially applicable laws and may exclude other relevant requirements (e.g. HIPAA/IT, specialty services, etc.). Please ensure that this Tool is used to supplement existing compliance and operational review activities and documents taking into consideration the CAH’s specific operations. This Tool does not fulfill Swing-Bed specific requirements itself, but rather provides a mechanism for the CAH to check its internal compliance related to the operation of its affiliated Swing-Beds. The content of this Tool may not be current at all times, as changes occur to applicable laws and to the SOM from time to time.

**SURVEY PREPARATION RECOMMENDATIONS**

1. ***Create a Survey Team within your CAH***. The team should be responsible for gathering necessary and preferred documentation (and keeping it current), working with department managers and other staff to ensure everyone understands their role in the survey process, and checking for compliance on a regular basis.
2. ***Plan for Surveyor Resources***. To minimize the time and impact of the survey on your facility, plan out the following resources for the survey team[[3]](#footnote-3):
   1. A location (e.g. conference room) at the CAH where the survey team may work privately and conduct interviews, as applicable.
   2. Access to the CAH and Swing-Bed specific policies, procedures, patient care protocols, and medical records and availability of nurses or staff to help provide access.
   3. Access to a copy machine so that the survey team may make copies of records.
   4. Direct access to the EHR and availability of an IT or other experienced EHR users to help provide access.
3. ***Survey documents***. Ensure those documents identified in the ***Montana Critical Access Hospital Survey Self-Assessment Tool*** and specific to the operation of Swing-Bed services are available for surveys.
4. ***Policy documentation and processes***. The CoPs frequently refer to the process taken to review and revise all patient care policies. Although each department should be responsible for the review of their policies, it is important to have a written explanation of how the group described in C-Tag C-1008 (as referenced in ***Montana Critical Access Hospital Survey Self-Assessment Tool***) is involved in this process, as applicable for the required Swing-Bed policies. Both a description of the process and evidence of this group’s involvement must be readily available for a surveyor’s review.
5. ***Environmental walk-through***. Part of the survey process includes a walk-through of the facility. The survey team makes observations and interviews staff during the walk-through. These observations often lead to further policy review. One of the functions of your survey team should be to periodically conduct a walk-through, observing as a surveyor would.

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**Survey Self-Assessment Tool**

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Eligibility to Furnish Swing-Bed Services***  ***Note: The CAH’s eligibility to provide Swing-Bed services and to be paid by Medicare for those services is approved by CMS in advance of the CAH furnishing or operating those services. The CAH can assess its compliance with the following eligibility criteria using its Swing-Bed approval documentation from CMS and any supporting documentation it used to obtain Swing-Bed approval. The Survey Agency will confirm the CAH’s compliance with these criteria in advance of the survey.***  ***Note: The following eligibility requirements should be closely reviewed prior to survey particularly if any of the following apply:***   1. ***The CAH has recently increased or changed its bed count to exceed more than 25 inpatient beds;*** 2. ***The CAH experiences any changes in its underlying Medicare provider agreement;*** | | | | | |
| Is the CAH in compliance with specific requirements for Swing-Bed services used to obtain approval from CMS to provide post-CAH SNF care, and to be paid for SNF-level services?  C-1600  42 C.F.R. § 485.645 |  |  |  |  |  |
| Does the CAH meet the following eligibility requirements:   1. The CAH has a Medicare provider agreement; and 2. The CAH does not provide more than 25 inpatient beds.   C-1600  C-1602  42 C.F.R. § 485.645(a) |  |  |  |  |  |
| If the CAH was a rural primary care hospital (RPCH) on September 30, 1997, does it continue to operate and provide post-CAH SNF services under the same terms, conditions, and limitations applicable prior to September 30, 1997?  C-1600  C-1604  42 C.F.R. § 485.645(b) |  |  |  |  | \*No interpretive guidance listed in SOM, Appendix W.  \*Note that if the CAH is relying on its prior RPCH eligibility to furnish post-CAH SNF services, it should maintain documentation of RPCH eligibility and the terms, conditions, and limitations it is subject to. |
| Does the CAH receive payment in accordance with:   1. 42 C.F.R. § 413.70 for inpatient services; or 2. 42 C.F.R. § 413.114 for post-CAH, SNF-level of care services.   Does the CAH meet the following reimbursement criteria for inpatient services:   1. Effective for cost reporting periods beginning on or after 1/1/2004, payment is 101% of the reasonable costs of the CAH in providing CAH services to its inpatients. The following payment principles are excluded when determining payment for CAH inpatient services: (i) lesser of cost or charges; (ii) ceiling on hospital operating costs; (iii) reasonable compensation equivalent (RCE) limits for physician services to providers; and (iv) the payment window provisions for preadmission services.   Does the CAH meet the following reimbursement criteria for post-CAH, SNF-level of care services:   1. For cost reporting periods beginning prior to July 1, 2002, the reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. 2. The CAH does not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient’s physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate   C-1600  C-1606  42 C.F.R. § 485.645(c)  42 C.F.R. § 413.70  42 C.F.R. § 413.114 |  |  |  |  | \*No interpretive guidance listed in SOM, Appendix W.  \*Note that coordination with the CAH’s finance department will be necessary to determine compliance with this requirement. Specifically, confirm that reimbursement for services is appropriately accounted for as the patient shifts from inpatient to post-acute care. |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
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| ***Resident Rights*** | | | | | |
| When a resident is deemed incompetent, do that person’s rights devolve to a representative appointed to act on the resident's behalf within the scope of decision-making authority granted by the State?  Notwithstanding whether a resident has been deemed incompetent:   1. Is the resident extended the right to make decisions outside the representative’s authority? 2. Are the resident’s wishes and preferences considered by the representative? 3. Is the resident provided with opportunities to participate in his or her care? 4. to the extent that the resident understands the risks, benefits, and alternatives to their proposed care and expresses a preference, are the resident’s wishes reasonably considered?   Specifically, does the CAH:   1. Maintain the appropriate legal documentation for a court-appointed resident representative is present in the resident’s medical record. 2. Review court orders or other legal documentation to determine the extent of the court-appointed resident representative’s authority to make decision on behalf of the resident and any limitations on that authority that may have been ordered by the court. 3. Ensure the court-appointed representative is making decisions for the resident within the scope of the resident representative’s decision-making authority (e.g., health care treatment, managing resident funds, discharge decision). 4. Determine if the resident was involved in care planning activities and able to make choices, to the extent possible. 5. Ensure the resident representative is reported under State law when not acting in the best interests of the resident.   (SOM Appendix PP, at 13-14).  C-1608  F-551  42 C.F.R. § 485.645(d)(1)  42 C.F.R.§ 483.10(b)(7) |  |  |  |  | \*Note that more extensive definitions and descriptions of the individuals who constitute “Resident representatives” are discussed in detail in the SOM. (SOM, Appendix PP at 11, Impl. 11-28-2017). |
| Are residents fully informed of their health status or treatment in a language, this includes communicating in plain language, that the resident can understand.  Specifically, does the CAH:   1. Explain technical and medical terminology in a way that makes sense to the resident, 2. Offer language assistance services to residents with limited English proficiency; 3. Provide qualified sign language interpreters or auxiliary aids if hearing is impaired (provision of hearing aids is not required)   (SOM Appendix PP, at 15-16).  C-1608  F-552  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(c)(1) |  |  |  |  |  |
| Are residents and their representative(s) afforded the opportunity to participate in their care planning process by being informed, in advance, of changes to the plan of care?  Specifically, does the CAH:   1. Involve residents and/or representatives in care planning (e.g. inclusion in care planning meetings and scheduling to accommodate residents and their representatives). 2. Provide residents and representatives the right to see the care plan and sign after significant changes are made? 3. Address questions or concerns raised by a resident or representative? 4. If the resident or representative is unable to participate in care planning does the facility staff consult with them in advance about care treatment changes?   (SOM Appendix PP, at 16-17).  C-1608  F-553  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(c)(2)(iii) |  |  |  |  |  |
| Does the facility provide information to residents, at a time in which they are able to receive such information, regarding their right to:   1. request (if medically necessary or appropriate), refuse, and/or discontinue treatment; 2. participate in or refuse to participate in experimental research; and 3. formulate an advance directive?   Specifically,   1. If a resident or representative requests, refuses, or discontinues treatment, does the facility honor that decision? 2. Maintain a current copy of the resident’s advance directive in the resident’s medical record? 3. Does the facility establish, maintain, and implement written policies and procedures regarding the residents’ rights to formulate and advance directive and refuse medical or surgical treatment? 4. Document in the comprehensive care planning process the resident’s wishes? 5. Establish mechanisms for documenting and communicating the resident’s choices to the interdisciplinary team and staff responsible for the resident’s care?   (SOM Appendix PP, at 51-55)  C-1608  F-578  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(c)(6) |  |  |  |  | \*Note, the SOM provides definitions for the following terms: “advance care planning”; “advance directive”; “physician orders for life-sustaining treatment paradigm form”; “experimental research”; “health care decision-making”; and “health care decision-making capacity.” (SOM Appendix PP at 50-51, Impl. 11-28-2017).  \*Note, the SOM provides significantly more detail than is provided here. (SOM, Appendix PP at 50-54, Impl. 11-28-2017). |
| Are residents given the right to choose his or her attending physician?  C-1608  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(d) |  |  |  |  |  |
| Are the all attending physicians chosen by patients licensed to practice?  C-1608  F-555  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(d)(1) |  |  |  |  |  |
| Are residents informed of the name, specialty, and way of contacting their chosen physician or other primary care professionals that are responsible for his or her care?    C-1608  F-555  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(d)(3) |  |  |  |  |  |
| In the event that the physician chosen by the resident does not meet licensure or qualification requirements or is unable or unwilling to provide care, does the facility discuss alternative physician participation with the resident?  C-1608  F-555  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(d)(2),(4) |  |  |  |  |  |
| In the event that the resident selects another attending physician, does the facility honor the resident’s choice?  C-1608  F-555  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(d)(2), (5) |  |  |  |  |  |
| Are residents given the right to retain and use personal possessions, including furnishings, and clothing, as space permits, and to the extent that such would not infringe upon the rights or health and safety of other residents?  C-1608  F-557  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(e)(2) |  |  |  |  |  |
| Are residents given the right to share a room with their spouse (including same-sex spouses) when both residents live in the same facility and both consent to the arrangement?  C-1608  F-559  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(e)(4) |  |  |  |  |  |
| Subject to the resident’s right to deny or withdraw consent at any time and providing that it would not impose on the rights of another resident or unreasonably affect clinical and safety restrictions, does the facility provide the following persons with immediate access to a resident:   1. Immediate family and other relatives of the resident? 2. Others who are visiting with the consent of the resident?   C-1608  F-563  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(f)(4)(ii) and (iii) |  |  |  |  | \*Note that further guidance on the circumstances constituting “Reasonable clinical and safety restrictions” related to resident access is addressed in the SOM. (SOM Appendix PP, at 28-29, Impl. 11-28-17).  \*Note, there is significantly more detail included in the SOM than is listed here. (SOM Appendix PP, at 28-30, Impl. 11-28-17). |
| Are residents given the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service including the right to:   1. Privacy of such communications; and 2. Access to stationery, postage, and writing implements at the resident’s own expense?   C-1608  F-576  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(g)(8) |  |  |  |  |  |
| Does the facility notify each Medicaid-eligible resident, in writing, at the time of admission and when the resident becomes eligible for Medicaid, of the items and services which are and are not covered under Medicaid or by the facility’s per diem rate?  C-1608  F-582  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(g)(17)  ARM 37.106.330 |  |  |  |  |  |
| Does the facility inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility, of any changes to the items and services covered, and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate?  In the event that a resident died, was hospitalized, or transferred and did not return to the facility, does the facility refund applicable funds to the resident, representative, or estate?  C-1608  F-582  42 C.F.R. § 485.645(d)(1)  42 C.F.R. § 483.10(g)(18)  ARM 37.106.330 |  |  |  |  |  |
| Are residents given the right to privacy and confidentiality in all aspects of their care, including   1. Personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; 2. Personal privacy including the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service; and 3. Secure and confidential personal and medical records, including the right to refuse the release of such records in accordance with applicable federal and state laws.   Does the facility allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident’s medical social, and administrative records in accordance with State law?  C-1608  F-583  42 C.F.R. § 485.645(d)(1)  42 C.F.R.§ 483.10(h)(1)-(3)  ARM 37.106.314 |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. (SOM, Appendix PP at 60-62, Impl. 11-28-2017). |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
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| ***Admission, Transfer, and Discharge Rights*** | | | | | |
| Does the CAH:   1. Permit each resident to remain in the facility and not transfer/discharge the resident from the facility unless:    * the transfer/discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the CAH;    * the transfer/discharge is appropriate because the resident’s health has improved sufficiently;    * the safety or health of individuals in the facility is at risk due to the clinical/behavioral status of the resident;    * the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility;    * the facility ceases to operate. 2. Pause transfer or discharge activities while a resident appeal is pending. 3. Provide the resident with at least thirty (30) notice before the facility transfers or discharges the resident. 4. Provide residents with notice in advance of facility closure.   C-1610  F-621  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(1) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 168-173, Impl. 11-28-17) |
| When the facility transfers or discharges a resident, does the facility ensure that the transfer or discharge is documented in the resident’s medical record, and appropriate information is communicated to the receiving healthcare institution, or provider?  Does the documentation in the resident’s medical record include the basis for the transfer, or the specific resident needs that cannot be met?  Is the documentation in the resident’s medical record made by the resident’s physician when transfer or discharge is necessary for any reason other than nonpayment or facility closure?  Does the information provided to the receiving provider include the following:   1. Contact information of the practitioner responsible for the resident; 2. Resident representative information including contact information; 3. Advance directive information; 4. All special instructions or precautions for ongoing care, as appropriate; 5. Comprehensive care plan goals; and 6. All other necessary information to meet the resident’s needs, including a copy of the resident’s discharge summary.   C-1610  F-622  42 C.F.R. § 485.645(d)(2)  42 C.F.R. 483.15(c)(2) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 168-173, Impl. 11-28-17) |
| Before the facility transfers or discharges a resident, does the facility:   1. Provide notice to the resident and the resident’s representatives of the transfer or discharge and the reasons for the move in writing in a language that they understand? 2. Record the reasons for the transfer or discharge in the resident’s medical record? 3. Send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman?   C-1610  F-623  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(3) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 174-178, Impl. 11-28-17) |
| Before the facility transfers or discharges a resident, does the facility provide timely notice, specifically:   1. At least 30 days before the resident is transferred or discharged; or 2. As soon as practicable before the transfer or discharge when:    1. The health or safety of individuals in the facility would be endangered;    2. The resident’s health improves sufficient to allow a more immediate transfer or discharge;    3. An immediate transfer or discharge is needed to address the resident’s urgent medical needs; or    4. The resident has not resided in the facility for 30 days.   C-1610  F-623  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(4) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 174-178, Impl. 11-28-17) |
| Does the written notice provided by the facility contain the following information:   1. The reason for the transfer or discharge; 2. The effective date of the transfer or discharge; 3. The location to which the resident is transferred or discharged; 4. A statement of the resident’s appeal rights; 5. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman; 6. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities; 7. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder;   C-1610  F-623  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(5) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 174-178, Impl. 11-28-17) |
| Before the facility transfers or discharges a resident, does the facility provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer and discharge, and in a form and manner that the resident can understand?  Specifically, does the CAH:   1. Document the preparation an orientation in nursing notes prior to discharge? 2. Ensure that the resident’s needed/requested possessions are transferred with the resident to the new location? 3. Ask the resident or representative if they understand why the transfer or discharge occurred?   (SOM Appendix PP, at 178-179)  C-1610  F-624  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(7) |  |  |  |  |  |
| In the case of facility closure, does the individual who is the administrator of the CAH provide written notification prior to the impending closure as well as the plan for the transfer and adequate relocation of the residents to:   1. the State Survey Agency, 2. the Office of the State Long-Term Care Ombudsman, 3. residents of the facility, and the resident representatives.   C-1610  F-623  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(8)  42 C.F.R. § 483.70(l) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 174-178, Impl. 11-28-17) |
| If the resident is changing rooms in a facility that is a composite distinct part (a distinct part of a facility consisting of two or more noncontiguous components that are not located within the same campus) does the facility only move the resident within the same building in which the resident currently resides, unless the resident voluntarily agrees to move to another location?  C-1610  F-621  42 C.F.R. § 485.645(d)(2)  42 C.F.R. § 483.15(c)(9). |  |  |  |  | \*Note there is more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 165-166, Impl. 11-28-17) |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
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| ***Freedom from Abuse, Neglect, and Exploitation*** | | | | | |
| Does the facility protect a resident’s right to be free from:   1. Verbal, mental, sexual, or physical abuse 2. Neglect 3. Misappropriation of resident property 4. Exploitation 5. Corporal punishment 6. Involuntary seclusion 7. Physical or chemical restraint not required to treat the resident’s medical symptoms. 8. Any other conduct that results in, or has the likelihood to result in physical harm, pain, or mental anguish.   C-1612  F-600  F-602  F-603  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(a)(1) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM provides detailed guidance for different categories of abuse and neglect. (SOM Appendix PP at 70-90, Impl. 11-28-2017).  \*Note, SOM F-603 extensively details guidance for “involuntary seclusion.” (SOM Appendix PP at 100-110, Impl. 11-28-2017). |
| Does the facility ensure residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms?  When restraints are used, does the facility   1. use the least restrictive alternative for the least amount of time, 2. identify the medical symptoms being treated with the use of any chemical restraints, 3. document ongoing re-evaluation of the need for restraints, and 4. discontinue the use of any chemical restraint when the medical symptom is no longer being treated?   C-1612  F-602  F-604  F-605  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(a)(2) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here, including the risks associated with the use of restraints, assessment, care planning and documentation guidance, the use of restraints during periods of imminent danger to the safety and well-being of residents, the use of bed rails, and the use of position change alarms. (SOM Appendix PP at 110-121, Impl. 11-28-2017)  \*Note, SOM F-605 details guidance for indications that medicine was not used to treat a resident’s medical symptoms. (SOM, Appendix PP at 121-132). |
| Does the facility ensure it does not hire or engage individuals who:   1. Have been found guilty of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property by a court of law; 2. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property?   C-1612  F-602  F-606  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(a)(3)(i), (ii) |  |  |  |  |  |
| Does the facility report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff?  C-1612  F-602  F-606  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(a)(4) |  |  |  |  |  |
| Does the facility develop and implement written policies and procedures to prevent abuse, neglect, and exploitation of residents and misappropriation of resident property that includes the following components:   1. screening potential employees for a history of such conduct; 2. training for new and existing employees on prohibiting, preventing, identifying, and reporting such conduct; 3. identification of such conduct 4. investigation of such conduct; 5. the protection of residents during an investigation; and 6. reporting/responding to such conduct?   C-1612  F-602  F-607  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(b)(1), (2) |  |  |  |  | \*Note, the SOM provide guidance on each component that must be included in a facility’s policies and procedures. (SOM, Appendix PP at 135-141, Imp. 11-28-2017). |
| Does the facility ensure through its procedures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown sources, are reported immediately to the administrator of the facility and to other officials?   1. Within 2 hours for allegations of abuse or result in serious bodily injury. 2. Within 24 hours for allegations not involving abuse and do not result in serious bodily injury.   C-1612  F-602  F-609  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(c)(1) |  |  |  |  | \*Note, the SOM provides detailed guidance on how to report abuse, including a chart of what needs to be reported, who needs to report, to whom, and when. (SOM, Appendix PP at 150-155, Impl. 11-28-2017). |
| Does the facility initiate and complete thorough investigations of alleged violations of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, maintain evidence/documentation of that an investigation?  C-1612  F-610  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(c)(2) |  |  |  |  | \*Note, the SOM provides detailed guidance on how to investigate, prevent, and correct misconduct. (SOM, Appendix PP at 155-158, Impl. 11-28-2017). |
| While investigations of alleged violations of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property are in progress, does the facility take steps to prevent any further misconduct?  C-1612  F-602  F-610  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(c)(3) |  |  |  |  | \*Note, the SOM provides detailed guidance on how to investigate, prevent, and correct misconduct. (SOM, Appendix PP at 155-158, Impl. 11-28-2017). |
| Does the facility report the results of all investigations to the administrator or a designated representative and to other officials in accordance with State law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, does the facility take appropriate corrective action?  C-1612  F-602  F-609  F-610  42 C.F.R. § 485.645(d)(3)  42 C.F.R. § 483.12(c)(4) |  |  |  |  | \*Note, the SOM provides detailed guidance on how to report abuse, including a chart of what needs to be reported, who needs to report, to whom, and when. (SOM, Appendix PP at 150-155, Impl. 11-28-2017). |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Social Services*** | | | | | |
| Does the CAH provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident?  Specifically, does the CAH:   1. Identify the need for medically-related social services through care planning processes and ensure that these services are provided (It is not required that a qualified social worker necessarily provide all of these services, unless required by State law). 2. Assist or arrange for a resident to obtain needed items and services from outside entities, including psychosocial and mental counseling services; 3. Promoting non-pharmacological approaches to care; 4. Addressing grief and stressful events; 5. Assist residents with financial and legal matter including advance care planning; 6. Provide social services or obtain needed services from outside entities when the resident experiences or exhibits:    * Lack of effective support;    * Psychological or mental distress,    * Abuse of any kind,    * Difficulty coping with change or loss, or    * Need for emotional support.   (SOM Appendix PP, at 478-480)  C-1616  42 C.F.R. § 485.645(d)(4)  42 C.F.R. § 483.40(d) |  |  |  |  |  |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Comprehensive Assessment, Care Plan, and Discharge Planning*** | | | | | |
| Does the CAH make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences that includes at least the following information:   1. Identification and demographic information. 2. Customary routine. 3. Cognitive patterns. 4. Communication. 5. Vision. 6. Mood and behavior patterns. 7. Psychosocial well-being. 8. Physical functioning and structural problems. 9. Continence. 10. Disease diagnoses and health conditions. 11. Dental and nutritional status. 12. Skin condition. 13. Activity pursuit. 14. Medications. 15. Special treatments and procedures 16. Discharge planning. 17. Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). 18. Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.   C-1620  F-636  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.20(b)(1) |  |  |  |  | \*Note that for Survey purposes, the SOM Appendix W advises that ***CAHs are not required to use the resident assessment instrument specified by the State or CMS***. (SOM Appendix W, at 249, Impl. 02-21-20.). Notwithstanding this exception, the applicable CoP is included in its entirety in the SOM Appendix W and is included here for reference as a recommended best practice.  \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 188-194, Impl. 11-28-17) |
| Does the facility conduct a comprehensive assessment of a resident in accordance within the following timeframes:   1. Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition; 2. within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition; or 3. Not less than once every 12 months.   C-1620  F-636  F-637  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.20(b)(2) |  |  |  |  | \*Note that for Survey purposes, the SOM Appendix W advises ***that CAHs are not required to comply with the requirements applicable to the frequency, scope, and number of assessments***. (SOM Appendix W, at 249, Impl. 02-21-20.) Notwithstanding this exception, the applicable CoP is included in its entirety in the SOM Appendix W and is included here for reference as a recommended best practice.  \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 188-194, Impl. 11-28-17) |
| Does the facility develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment?  Does the comprehensive care plan describe the following:   1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; 2. Any services that would otherwise be required but are not provided due to the resident’s refusal of treatment (as a protected exercise of the resident’s rights). 3. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. 4. In consultation with the resident and/or representative:    1. Goals for admission and desired outcomes,    2. Preferences and potential for future discharge    3. Documentation of whether the resident’s desire to return to the community was assessed and referrals made to local contact agencies for this purpose.    4. Discharge plans.   C-1620  F-656  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.21(b)(1) |  |  |  |  | \*Note that for Survey purposes, ***CAHs are not independently required to complete a PASARR***, but to the extent the resident had a PASARR completed by a facility required to do so prior to admission into a CAH swing-bed, the recommendations from the PASARR should be included in the CAH’s comprehensive care plan for the resident. (SOM Appendix W, at 249, Impl. 02-21-20.) Notwithstanding this exception, the applicable CoP is included in its entirety in the SOM Appendix W and is included here for reference as a recommended best practice.  \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 219-225, Impl. 11-28-17) |
| Are the CAH’s comprehensive care plans:   1. Developed within 7 days after completion of the comprehensive assessment; 2. Prepared by an interdisciplinary team, that includes but is not limited to the following:    1. the attending physician,    2. a registered nurse with responsibility for the resident;    3. a nurse aide with responsibility for the resident;    4. a member of food and nutrition services staff;    5. to the extent practicable, the participation of the resident and the resident's representative(s);    6. other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. 3. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment.   C-1620  F-657  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.21(b)(2) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details what should be included in the provisions listed here and should be reviewed for evaluation of compliance with this section (SOM, Appendix PP, at 225-229, Impl. 11-28-17) |
| Does the CAH ensure that the services provided or arranged by the CAH, as outlined in the comprehensive care plan:   1. Meet the professional standards of quality; 2. Are provided by qualified persons in accordance with the written care plan; and 3. Are culturally-competent and trauma-informed?   C-1620  F-658  F-659  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.21(b)(3) |  |  |  |  | \*Note that the SOM provides possible reference sources for professional standards of quality, including   * Current manuals or textbooks on nursing, social work, physical therapy, etc. * Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc. * Clinical practice guidelines published by the Agency for Healthcare Research and Quality. * Current professional journal articles.   (SOM, Appendix PP, at 230, Impl. 11-28-17) |
| When the facility anticipates discharge of a resident, does the facility have a discharge summary that includes, but is not limited to, the following:   1. A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; 2. A final summary of a resident’s status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident’s representative; 3. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); 4. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.   C-1620  F-661  42 C.F.R. § 485.645(d)(5)  42 C.F.R. § 483.21(c)(2) |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details requirements and recommendations specific to each listed element included in the discharge summary. (SOM, Appendix PP, at 239-243, Impl. 11-28-17) |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Specialized Rehabilitative Services*** | | | | | |
| If specialized rehabilitative services are required in the resident’s comprehensive plan of care, has the facility provided the required services; or obtained the required services from an outside resource that is a provider of specialized rehabilitative services?  Are specialized rehabilitative services provided under the written order of a physician by qualified personnel?  Additionally, does the CAH:   1. Monitor specialized rehabilitative services for their effectiveness 2. Assist residents to attain or maintain their highest practicable level of physical, mental, functional, and psychosocial well-being or to prevent or slow a decline in condition.   (SOM Appendix PP, at 610-611)  C-1622  F-825  F-826  42 C.F.R. § 485.645(d)(6)  42 C.F.R. § 483.65 |  |  |  |  | \*Note, there is significantly more detail included in the SOM than is listed here. The SOM details requirements and recommendations specific to the type of specialized rehabilitative services offered (e.g. PT, OT, SLP, and respiratory therapy). (SOM, Appendix PP, at 608-613, Impl. 11-28-17) |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Dental Services*** | | | | | |
| Does the CAH assist residents in obtaining, provide, or obtain from outside providers routine and 24 hour emergency dental care?  C-1624  F-790  F-791  42 C.F.R. § 485.645(d)(7)  42 C.F.R. § 483.55(a)(2)  42 C.F.R. §483.55(b)(1) |  |  |  |  | \*Note, the CAH may charge a Medicare resident an additional amount for routine and emergency dental services. 42 C.F.R. § 483.55(a)(2) |
| Does the CAH have a policy identifying those circumstances when the loss or damage of dentures is the facility’s responsibility, so that they may not charge a resident for the loss or damage of dentures?  C-1624  F-790  F-791  42 C.F.R. § 485.645(d)(7)  42 C.F.R. § 483.55(a)(3)  42 C.F.R. § 483.55(b)(4) |  |  |  |  |  |
| If necessary or if requested, does the CAH assist the resident in making appointments and by arranging for transportation to and from the dental services location?  C-1624  F-790  F-791  42 C.F.R. § 485.645(d)(7)  42 C.F.R. § 483.55(a)(4)  42 C.F.R. § 483.55(b)(2) |  |  |  |  |  |
| Does the CAH refer residents with lost or damaged dentures for dental services within 3 days?  If not within 3 days, does the facility provide documentation of what the facility did to ensure that the resident could still eat and drink adequately while awaiting dental services, and the extenuating circumstances that led to the delay?  C-1624  F-790  F-791  42 C.F.R. § 485.645(d)(7)  42 C.F.R. § 483.55(a)(5)  42 C.F.R. § 483.55(b)(3) |  |  |  |  |  |
| Does the CAH assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State Plan (including Medicaid)?  C-1624  F-791  42 C.F.R. § 485.645(d)(7)  42 C.F.R. § 483.55(b)(5) |  |  |  |  |  |

| **Self-Assessment Questions** | **Yes** | **No** | **N/A** | **Date/Name of Reviewer** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| ***Nutrition*** | | | | | |
| Does the facility, based on the resident’s comprehensive assessment, ensure that the resident maintains acceptable parameters of nutritional status and that the resident is offered sufficient fluid intake to maintain proper hydration and health?  Does the facility, based on the resident’s comprehensive assessment, ensure that the resident is offered sufficient fluid intake to maintain proper hydration and health?  Additionally, does the CAH:   1. Accurately and consistently assess a resident’s nutritional status on admission and as needed thereafter; 2. Identify a resident at nutritional risk and address risk factors for impaired nutritional status, to the extent possible; 3. Identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident’s assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status; 4. Notify the physician as appropriate in evaluating and managing causes of the resident’s nutritional risks and impaired nutritional status; 5. Identify and apply relevant approaches to maintain acceptable parameters of residents’ nutritional status, including fluids; 6. Provide a therapeutic diet when ordered; 7. Offer sufficient fluid intake to maintain proper hydration and health.   (SOM Appendix PP, at 352-353).  C-1626  F-692  42 C.F.R. § 485.645(d)(8)  42 C.F.R. § 483.25(g)(1) & (2) |  |  |  |  | \*Note that nutrition includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids. 42 C.F.R. § 483.25.  \*Note, there is significantly more detail included in the SOM than is listed here, including definitions relevant to the application of this condition and how to assess the resident for nutritional status. (SOM, Appendix PP, at 342-353, Impl. 11-28-17) |

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1. Although there are multiple appendices to the State Operations Manual, for purposes of this Tool, references to SOM, Appendix W refer to [State Operations Manual, Appendix W](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf), applicable to CAHs (as linked) or as found at the following web address: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf>. References to the SOM, Appendix PP refer to the [State Operations Manual, Appendix PP](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf), which is applicable to Long-Term Care Facilities (as linked) or as found at the following web address: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> . [↑](#footnote-ref-1)
2. Completion of this Tool in its entirety and ongoing holistic review of the organization’s compliance with the standards captured in the Tool is a best practice and will ensure that the organization is optimally prepared for survey.  However, given time and resource limitations, it may be desirable to prioritize certain categories for self-assessment based on historical survey results or ongoing areas of concern.  [↑](#footnote-ref-2)
3. This level of access is permitted and in fact required by the CAH’s provider agreement with Medicare. [↑](#footnote-ref-3)