

LONG TERM CARE SURVEY

SURVEY AREA	OBSERVATION	INTERVIEWING	RECORD REVIEW	EVALUATION FACTORS	CROSS REFERENCE
<p><b>Patient Care Management</b></p> <p>F167 SNF 405.1124(d)</p> <p>F168 ICF 442.341</p>	<p>Observe resident level of physical, mental, emotional and social functioning. Note problems, potential problems, needs, using observation/interview/record review work sheet.</p>	<p><b>Ask Resident:</b></p> <ul style="list-style-type: none"> <li>- Are you aware that you have a plan of care?</li> <li>- Did you participate in developing a plan of care?</li> <li>- Do you/your family know what the plan is and details? (e.g., diet, ambulation, dressing, etc.)</li> <li>- Do you attend and participate in plan of care meetings?</li> <li>- Who else attends the plan of care meetings?</li> <li>- When did you last attend the meeting for your plan of care?</li> <li>- Does the staff assist you in achieving the goals on the plan of care? If not, who does or why not?</li> <li>- Do you have all necessary assistive devices and equipment?</li> <li>- Is there anything that is not part of your plan of care that you think should be included?</li> <li>- What happens if you question any treatment or procedure? Can you give an example?</li> </ul>	<p><b>Review:</b></p> <ul style="list-style-type: none"> <li>- Plan of care</li> </ul> <p>The content of the plan of care is of primary importance rather than the format. Separate care plans are not required for each discipline, but may be accepted if there is evidence that the various disciplines coordinate their planning.</p> <ul style="list-style-type: none"> <li>- Nursing assessment/re-assessments and notes.</li> <li>- Physician orders.</li> <li>- Physician notes.</li> <li>- Assessments/evaluations and progress notes from all professional disciplines as appropriate.</li> <li>- Medication and treatment records as applicable.</li> <li>- Lab reports, as applicable.</li> </ul>	<ul style="list-style-type: none"> <li>- Are all resident's needs/problems identified?</li> <li>- Is the plan developed to meet these needs?</li> <li>- Does the plan demonstrate an interdisciplinary approach, and include:               <ul style="list-style-type: none"> <li>+ Goals stated in measurable/observable terms?</li> <li>+ Approaches (staff action) to meet the resident action goals?</li> <li>+ Responsible disciplines/staff</li> <li>- responsible for approaching to assist resident in achieving goal/goals?</li> <li>+ Is plan being reassessed and changed as needed to reflect current status?</li> <li>+ Does plan of care accurately reflect information gained from observation, interview and record review?</li> </ul> </li> </ul>	<p><u>Physician Services</u> 405.1123 442.346</p> <p><u>Medical Records</u> 405.1132 442.318</p> <p><u>Resident Rights</u> 405.1121(k) 442.311</p> <p><u>24 Hour Nursing Service</u> 405.1124 442.338</p> <p><u>Specialized Rehabilitation Services</u> 405.1126 442.343</p> <p><u>Training</u> 405.1121(h) 442.314</p> <p><u>Resident Rooms</u> 405.1134(e)</p> <p>442.325 442.326</p> <p><u>Infection Control</u> 405.1135 442.328 442.324</p>
<p>F169</p> <p>A. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of medical care, and is implemented shortly after admission.</p> <p>F170</p> <p>B. Each professional service identifies needs,</p>					