Appendix A

The following forms were provided by CBC Survey Manager Joan Morris March 2014 as the current forms surveyors are using:

- ❖ CBC Entrance Checklist form
- ❖ CBC Environment Tour Form
- ❖ CBC Kitchen/Food Service Observation Form
- ❖ CBC Review of Systems – Miscellaneous Form
- ❖ CBC Resident Interview Guideline Form
- ❖ CBC Group Interview Guideline Form
- ❖ CBC Family Interview Guideline Form
- ❖ CBC Caregiver Training Record Review & Interview Form
- ❖ CBC Fire Drill Records Review Form
- ❖ CBC Resident Review Form

Joan said the following forms are no longer routinely used but may include good information for providers reviewing their systems:

- ❖ Resident Acuity Report Form
- ❖ Facility Staffing Form
- ❖ Facility Discharge Data Form
- ❖ CBC Criminal History Clearance Interview Form
- ❖ CBC Personal Incidental Fund Management Form
- ❖ CBC Medication Administration Observation Form

CBC Entrance Conference Checklist

Please provide the following information as soon as possible.

Facility Name: Facility #:

Date & time Facility Type ☐ RCF ☐ ALF

☐ 1. Capacity: Beds

Current census:

☐ 2. Facility email address – please by exit

☐ 3. List of residents by room number

☐ 4. Activity calendar (for current month, if available)

☐ 5. Menus (for current week)

☐ 6. Management-team list giving names and titles

☐ 7. List of direct caregivers under the age of 18 years

☐ 8. List of all facility employees, giving first and last name, position and hire date

☐ 9. Resident council minutes for last 3 months

Memory Care Community Endorsed Facilities Only:

☐ 1. Memory Care Community disclosure statement

☐ 2. Weekly staffing schedule for the month

☐ 3. Memory Care Community activity calendar

CBC Environment Tour

Facility Name: _____ Building: _____ Facility #: _____

Surveyor: Dates and Times:

Cleanliness: floors, walls, roofs, ceilings, windows, and furniture) and all equipment clean and in good repair.
Pests: Measures shall be taken to prevent the entry of rodents, flies, mosquitoes, and other insects.
Facility Grounds: The facility grounds shall be kept orderly and free of litter and refuse.
Accident Hazards: toxic materials properly labeled and stored; minimal resistance for passage of wc and ambulation aids.
Hot Water Temperatures: 110 to 120 degrees F
Waste: Garbage stored in covered refuse containers.
Handrails: Handrails shall be installed at one or both sides of resident use corridors.
Odors: The interior of the facility shall be free from unpleasant odors.
Resident Room Heating/Cooling: comfortable for the resident?
Staff Laundry: soiled linen handling
Resident Laundry Facilities: Shall be clean and accessible to residents.
Survey Posted
Staffing Plan and Administrator or designee posted by shift
Emergency: What are you supposed to do if the fire alarm sounds? What would you do if there was an altercation between residents?
Repairs: How is broken equipment reported to maintenance staff? What is the system for ensuring the facility common areas are maintained in good repair and clean?

Notes:

CBC Kitchen / Food Service Observation

Facility Name: _____ Building: _____ Facility Number: _____

Surveyor Name: _____ Observation Dates/Times: _____

Instructions: All questions relate to the requirement to prevent the contamination of food and the spread of food-borne illness. Food shall be prepared and served in accordance with the Oregon Health Services Food Sanitation Rules. C240

Food Storage:

Are the refrigerator, freezer shelves and floors clean and free of spillage?
Foods free of slime & mold?
Are refrigerated foods covered, labeled, dated, and shelved to allow air circulation?
Are foods stored correctly (e.g. cooked foods over raw meat in refrigerator, egg and egg rich foods refrigerated)?
Is dry storage maintained in a manner to prevent rodent and pest infestation?
Is the food in the freezer frozen and the refrigerator 41 degrees F or below? (allow 2-3 degrees variance) Do not check during meal preparation.

Food Preparation:

Are cracked eggs being used only in foods that are thoroughly cooked, such as baked goods or casseroles?
Are frozen raw meats and poultry thawed in the refrigerator on the lowest shelves, or in cold, running water?
___ How is food cooled?

Food Service:

Are hot foods maintained at 140 degrees F or above and cold foods maintained at 41 degrees F or below when served from tray line?
Are the food trays covered until served? Is food protected from contamination during transportation and distribution?
Are food in critical temperature zone, 41 to 140 degrees F, for no longer than 2-4 hours?

Sanitation and Equipment:

Are employees washing hands before and after handling food, using clean utensils when necessary and following infection control practices?
Are dishes, utensils and equipment sanitized before going to the clean storage area?
Garbage storage is enclosed and separate from food storage.

Adequate staple food supply?

Dry, staple foods - 1 week supply
Perishable foods - 2 day supply

Special diets:

___ What special diets do you provide?

CBC Review of Systems - Miscellaneous

Facility Name: _____ Provider #: _____

Surveyor Name: _____ Date and time: _____

Abuse Prevention and Response C230, 232, 235 ☐ Please describe how the facility abuse prevention policy and procedure work?	
90 day Review of all meds C304 ☐ Where are RPh or RN review recommendations located?	
Medication Accountability System C302 ☐ What is the system for securing, accounting for and disposing of controlled substances? ☐ Which residents use PRN narcotics or other secured medications frequently?	
Medication Room: ☐ Glucometers ☐ Expired medications ☐ Refrigerator temperatures ☐ Accessability/locked ☐ Medication sink in ALFs or in RCFs with 17+ beds	

Notes:

CBC Resident Interview Guideline

Facility Name: _____ Provider #: _____ Surveyor: _____

Resident Name: _____ Confidential #: _____ Dates & Times: _____

Physical Environment

- What do you like about your apartment/room?
- What would you do in case of fire?
- What do you do if the housekeeping is not done the way you like?
- What happens when something breaks or quits working?
- What is the rest of the building like?
- Is it generally quiet or noisy here?
- Do you have a locked box for valuables?

How things work here:

- How do you get privacy when you want it?
- How is the food?
- Would you like to change anything about the meals?
- What choices do you have if you don't like what is served?
- What time are meals served?

- How do you find out what is happening?
- What do you do on the weekends?
- What activities do you participate in?
- Something you would like to do that is not available here?

- Who usually helps you with things?
- How do they treat you?
- If there was something wrong who would you tell about it?
- Can you get up in the morning and go to bed in the evening when you want?
- How do you get your medicines?
- How do you get help when you need it?
- How do you get to the doctor's office, dentist, bank, shopping?
- Do you receive your mail unopened?

Money management

- Does the facility manage your money?
- Do you get statements?
- When can get money from your account when you want it?

General Satisfaction

- Would you recommend living here to a friend?
- Is there anything else you would like to talk about?

CBC Group Interview Guideline

Facility Name: _____ Provider #: _____

Surveyor Name:_____ Interview Date/Time:_____
Resident(s) Interviewed:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

1. Cleanliness in the facility.
2. Activities:
3. When you ring the bell for staff assistance, how long does it take to get answered?
4. Can you go outside?
5. Are you involved in the service plan process?
6. Are your choices honored?
7. Do any residents come in your rooms and bother your things?
8. How is the food here?
9. Are your funds managed by the facility? Do you get regular reports?
10. Is locked storage available for valuables?

CBC Family Interview Guideline

Resident: _____ Facility: _____ Fac. #: _____

Person Interviewed: _____ Relationship to resident: _____

In person/ by phone: _____ Date/Time: _____ Surveyor: _____

Topics	
Care at the facility / Access to medical care	
Communication with the facility / directing of care	
Involvement in SP / decision making	
Food, nutrition, hydration	
Activities / quality of life	
General environment (common areas)	
Room/apt. environment	
Routines: getting up, hs, getting to/from meals, activities	
Safety issues	
Management of money	
How often do you visit? POA/conservator/guardian	
Is there anything else you would like to tell about this facility and how your relative is treated?	

CBC Caregiver Training Record Review and Interview C370

Facility Name: _____ Provider #: _____

Surveyor Name: _____ Date and time: _____

Name and #	Date started/ hired	Pre-Service Orient	Job Description	Competency demonstrated / documented	Directly supervised until comp demo'd	Abd thrust & first aid	12 hrs annual in-service	Comments

Pre-Service Orientation Topics
- Residents' rights & values of CBC care
- Abuse reporting
- Infection control
- Fire safety, emergency
- Food handler's certificate if job duties include food handling
- Job description

Competency demonstrated & documented
- Service plans
- ADL assistance
- Normal aging
- Identify change of condition
- Conditions to report
- Understanding behavior
- Dementia care

If job duties include
- Food safety
- Med & tx admin
- Other items as facility specifies

Annually in- service training

12 hours on topics related to the provision of care including chronic diseases in the facility population

CBC Staff Training Program Interview (C365, 370)

Pre-service Orientation – all employees What is the orientation process for all employees? Training materials include: - Resident rights & values of community based care - Abuse and reporting requirements - Standard precautions for infection control - Fire safety and emergency procedures - If duties include preparing food, Food Handlers Certificate or equivalent	
Determining capability What method is used to determine capability (return demonstration & evaluation)? Who is the evaluator of knowledge & performance?	
First 30 days Knowledge & performance demonstrated in first 30 days in at least the following areas: - Service plans in individualized care - Providing assistance with ADLs - Changes associated with aging - Conditions that require assessment, treatment, observation and reporting - Understanding resident actions and behavior as a form of communication - Understanding and providing support for a person with dementia or related condition - General food safety, serving and sanitation - If staff duties include, administration of meds and treatments	
Direct supervision How are staff directly supervised by a qualified person until they have successfully demonstrated satisfactory performance in any task assigned and the provision of individualized resident services? How do you determine a person is qualified to directly supervise a new employee? What does direct supervision mean?	
Abdominal thrust and First Aid How are staff trained in abdominal thrust and first aid?	
Communication and Language Skills How do you determine staff have sufficient communication and language skills?	
In-service training How do you ensure all direct caregivers complete a minimum of 12 hours annually? What topics were covered in the past 12 months?	
Documentation How is training and demonstrated ability documented?	

CBC FIRE DRILL RECORDS REVIEW

FACILITY: _____ REVIEW DATE: _____

SURVEYOR: _____

DATE	TIME/ SHIFT	LOCATION	ESCAPE ROUTE	EVAC TIME	ALARM SYST OPER	COMMENTS RE: RES RESISTED/FAILED TO PARTICIPATE

FIRE LIFE SAFETY TRAINING

DATE	INSERVICE TOPIC	NOTES

Confidential #:

CBC Resident Review Form

Facility _____ Facility # _____ Review date _____

Surveyor _____

Resident name:	Rm #:	Birth date:	Move-in date:

Diagnoses:

Change of Condition, Monitoring, Health Services

- ☐ Staff reported on and documented changes in condition _____
- ☐ Short term change of condition = Intervention determined and communicated to all staff, all shifts, weekly progress notes _____
- ☐ Significant change of condition = Evaluation, referral to RN, RN assessment documented, update service plan _____
- ☐ Monitoring = consistent with needs, changes and interventions reported to all staff in writing _____
- ☐ If needed, further medical action taken timely _____
- ☐ Delegation _____
- ☐ Intermittent Direct Nursing Services provided as needed _____
- ☐ Coordination with on-site and off site services provided by other health care providers _____

Focus areas

- ☐ ER/Hospital visits/Urgent care
- ☐ Self medication
- ☐ Heavy care ADLs
- ☐ 2 person transfer
- ☐ Fall risk/History
- ☐ Recent decline
- ☐ Hospice/HH/Dialysis
- ☐ IDDM/SS/CBGs
- ☐ Skin issues
- ☐ Weight changes
- ☐ Tube feeding/Meal assistance
- ☐ Siderails/Restraints
- ☐ Pain management
- ☐ Behaviors
- ☐ Behavior PRNs/Phych meds
- ☐ Routine coumadin
- ☐ Catheter/Ostomy
- ☐ Incontimence
- ☐ Elopement/Dementia
- ☐ Other

The resident evaluation must address the following elements:	
◊ **Customary routines** – sleep, dietary, social and leisure activities. ◊ **Spiritual, cultural preferences**. ◊ **Physical health status including**: ◊ List of current dx; ◊ List of medications and PRN use; ◊ Visits to health practitioner(s), ER, hospital or NF in the past year; ◊ Vital signs if indicated by dx, health problems, or medications. ◊ **Mental Health issues including**: ◊ Presence of depression, thought disorders or behavioral or mood problems; ◊ History of treatment; and ◊ Effective non-drug interventions. ◊ **Cognition, including**: ◊ Memory, Orientation, Confusion; and ◊ Decision making abilities. ◊ **Communication and sensory including**: ◊ Hearing, Vision, Speech, Assistive devices; and ◊ Ability to understand and be understood. ◊ **Activities of daily living including**: ◊ Toileting, bowel and bladder management; ◊ Dressing, grooming, bathing and personal hygiene; ◊ Mobility – ambulation, transfers, assistive devices; and ◊ Eating, dental status, assistive devices. ◊ **Independent activities of daily living including**: ◊ Ability to manage medications; ◊ Ability to use call system; ◊ Housework and laundry; and ◊ Transportation. ◊ **Pain** – pharmaceutical and non-pharmaceutical interventions. ◊ **Skin condition**. ◊ **Nutrition habits, fluid preferences and weight if indicated.** ◊ **List of treatments** – type, frequency and level of assistance needed. ◊ **Indicators of nursing needs, including potential for delegated nursing tasks.**	

The resident evaluation must address the following elements:	
◊ **Review of risk indicators including:** ◊ Fall Risk or history; ◊ Emergency evacuation ability; ◊ Complex medication regimen; ◊ History of dehydration or unexplained weight loss or gain; ◊ Recent losses; ◊ Unsuccessful prior placements; ◊ Elopement risk or history; and ◊ Smoking, ability to smoke safely and alcohol use or drug abuse. ◊ **If the information has not changed from the previous evaluation period, the information does not need to be repeated. A dated and initialed notation of no changes is sufficient. *The prior evaluation must then be kept in the current resident record for reference.*** ◊ **Resident service plan date ____** ◊ **Time frames** ◊ Quarterly evaluations, changes dated and initialed, historical info must be maintained, significant change of condition. ◊ ***General*** ◊ reflect the resident's needs, based on eval, resident preferences, support dignity, privacy, choice, individuality, independence, readily available, provides clear direction to staff; ◊ who, what, when, how, how often service provided; and ◊ changes & entries dated & initialed ◊ **Service Planning Team**	

Notes

Appendix A

Per CBC Survey Manager Joan Morris in March 2014, the following forms are no longer routinely used but may include good information for providers reviewing their systems:

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DHS Oregon Department of Human Services Seniors and People with Disabilities

Resident Acuity Report

Facility: _____ Facility #: _____ Date: _____

See Page 2 for instructions and definitions.

Resident Name →									**Totals**
Dementia									R50
Psychoactive medications									R51
Behaviors									R52
Transfer assistance									R53
Recent falls / high risk									R54
Siderails, restraints									R55
Recent decline, ER, hosp., urgent care visits									R56
Skin issues									R57
Hospice / HH / Dialysis									R58
Diabetics: Indicate if SS / IDDM / CBGs									R59
Meal assistance									R60
Weight gain, loss									R61
Pain issues									R62
Incontinence									R63
Urinary catheters									R64
Anticoagulant therapy / blood thinners									R65

SDS 0823 8/05

Instructions for completing the Resident Acuity Report

Enter the facility name, provider or CCMU number and the date of completion across the top of the form. List resident names across the top of the chart. Below each name, place a check mark in each row if the condition applies to the resident. Total the number of checkmarks per condition in the far right column. (The "R" codes in this column are for DHS use only.)

Definitions of conditions listed on the form:

Dementia: A cognitive deficit which impacts a resident's ability to independently direct their daily life; can be from any cause.

Psychoactive medications: Includes either scheduled or PRN anti-psychotic, anti-anxiety or sleep-inducing medications.

Behaviors: Those which can adversely affect the resident or others, such as wandering, intrusions, elopement, combativeness.

Transfer assistance: Unable to transfer without the physical help of at least one other person.

Recent falls / high risk: Residents who have either fallen within the past month or who are very prone to falls.

Side rails, restraints: Any device used to keep a resident in place; can include such devices as half or full length bed rails, tray tables, lap buddies, seat belts and pommel cushions.

Recent decline, ER/hosp./urgent care visits: Residents whose needs have increased, requiring changes in their service plans, or who have visited the emergency room, hospital or urgent care center for care in past month.

Skin issues: Residents with current or recent pressure ulcers, bedsores, rashes, stasis ulcers, skin tears, abrasions, bruises, etc.

Hospice/Home Health / Dialysis: Residents currently receiving such services or having received them within the past two weeks.

Diabetics: Residents with a diagnosis of diabetes, either type 1 or type 2. In addition to checking this box, indicate those with SS (Sliding scale insulin orders), IDDM (insulin dependent diabetes mellitus) or CBGs (Capillary blood glucose).

Meal assistance: Residents who need frequent cueing, physical assistance or both to eat their meals.

Weight gain, loss: Residents who have shown either a rapid or ongoing gradual weight change.

Pain issues: Frequent or daily pain which impacts a resident's function.

Incontinence: Residents with incontinence which is being managed by the facility.

Urinary Catheters: Residents with urinary catheters managed by the facility.

Anticoagulant therapy / blood thinners: Residents taking blood thinning medications such as Coumadin, Warfarin and daily full-strength aspirin.

DHS Oregon Department of Human Services Seniors and People with Disabilities

Facility Staffing

Facility Name: _____ Facility #:_____

Staff person completing this form: _____Date:_____

This form asks for information about the number of hours worked in providing certain types of services in your facility. First, fill in the information above. Then complete the two charts below, showing actual hours worked by RNs and Caregivers. *(Note: "R" codes in both charts are for SPD use only.)*

RN HOURS

In the space below, show the *actual* number of hours worked by RNs in your facility each day for the past seven-day period. Round hours to the quarter hour.

Date:							
RN hours in facility:	R40	R41	R42	R43	R44	R45	R46

CAREGIVER HOURS

In the space below, show the actual (not *scheduled*) number of hours worked on each of the past seven days by staff whose primary responsibility is caregiving. Do not show hours for RN, administrative, maintenance, housekeeping or food-service employees.

Date:							
Day Shift:	R47	R48	R49	R50	R51	R52	R53
Evening Shift:	R54	R55	R56	R57	R58	R59	R60
Night Shift:	R61	R62	R63	R64	R65	R66	R67

Comments: _____

DHS
Oregon Department of Human Services

Seniors and People with Disabilities

Facility Discharge Data

for the past 12 months

Name of Facility: _____ ☐ RCF ☐ ALF

Date of Review: _____

Number of discharges between: _____ and _____
(date) (date)

Destinations:

_____Nursing Home

_____Adult Foster Home

_____Assisted Living Facility

_____Hospital

_____Death

_____Residential Care Facility

_____Alzheimer's Care Unit

_____Independent living arrangement

CBC Criminal History Clearance Interview

Facility Name: _____ Provider # _____ Who was interviewed? _____ AD or CP (Circle one)

Surveyor Name: _____ Date and time: _____

Review of sample of recently hired staff, volunteers, any person residing in facility (not residents)

Staff, Volunteer, Person residing in building Name position shift	Confidential #	Hire date/ resident contact date	Prelim fitness date / Actively supervised ?	301 Date sent / date returned	Potentially disqualifying history? If yes, weighing test documented?	Final fitness date	Comments

OAR 407 - Criminal History Checks Rules - Effective 7/2007
407-007-310 & 320 Prior to working with residents, subject individuals (SI) must have **criminal history request** form (Form 301) completed and preliminary fitness determination completed. If **fingerprints** are required, they must be submitted within 21 days of request. SI must be **actively supervised** until final fitness determination is completed. Active supervision is defined as being in the same building or within line of sight, knowing what the SI is doing and where, and periodically observing the actions of the SI. **Final fitness** must be completed with 21 days of receiving the history (411-007-270). The AD is required to perform a **weighing test** for final fitness unless the history shows no potentially disqualifying history. Weighing test is defined as a process in which known negative and positive information is considered to determine if a SI is approved or denied.

CBC Personal Incidental Fund (PIF) Management C410

Facility Name:_____ Provider #:_____

Surveyor Name:_____ Date & time _____

Sample 4 Residents receiving Medicaid whose PIF are managed by the facility – Expand as needed to verify compliance

1 - Resident authorized facility to manage funds
2 - Resident Account (SDS 713) or comparable form used
  A. Detail with supporting documentation, all monies received,
  B. Disposition of funds with description, price of items purchased & receipts
  C. Copy of individual financial record provided to resident quarterly
3 - Funds over $150 maintained in interest-bearing account with appropriate interest credited to each resident's account; not co-mingled with facility funds
4 – Resident access to funds, at a minimum within 1 day of request excluding weekends and holidays

Legend: Yes = meets rule No = doesn't meet rule, explain in comment section

Resident Name	1 Facility Authorized	2A&B Acct Details – Received/ disbursed	2C Resident provided quarterly record	3A Interest bearing acct; not co-mingled	4 Resident access	Comments
	Yes No	Yes No	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	Yes No	Yes No	

(If resident dies, monies are to be forwarded within 10 days to estate or to DHS, Estates Division.)

CBC Medication Administration Observation

Facility Name:_____ Provider #:_____ Surveyor:_____

Staff member observed: _____ Date/Time:_____

Recommended sample size is at least 5 residents and at least 20 medications.

Resident	Medication, Dose, Route	How prepared? Crushed? Whole? With/without food/fluids? Where stored until administration? Resident observed taking med?	Reconciled with PO in record

Resident	Medication, Dose, Route	How prepared? Crushed? Whole? With/without food/fluids? Where stored until administration? Resident observed taking med?	Reconciled with PO in record