|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Survey Date: | |  | | | Previous Recertification Survey Date: | |  | | Offsite Review Date: | |  |
| Facility Name: | |  | | | | | | | | EventID: |  |
| Administrator Name: | | |  | | | | | | | | |
| Team (List Coordinator First): | | | |  | | | | | | | |
|  |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | Review the CASPER 3 report to determine whether the facility has any patterns of repeat deficiencies. | | | | | | | | | | |
|  | Results from the last Standard survey. | | | | | | | | | | |
|  | Review complaints since the last Standard survey. | | | | | | | | | | |
|  | Review facility reported incidents (FRIs) since the last Standard survey. | | | | | | | | | | |
|  | Review the CASPER PBJ Staffing Data Report for identified concerns regarding staffing.  *Mark all that apply and the applicable quarter.*   |  |  |  |  | | --- | --- | --- | --- | | ***Concern*** | ***Selected*** | ***FY Quarter*** | ***Year*** | | *Low weekend staffing* |  |  |  | | *RN coverage for 8 consecutive hours/day* |  |  |  | | *Licensed nurses for 24 hours/day* |  |  |  | | *1 star staffing rating* |  |  |  | | *Failed to submit PBJ data\** |  |  |  |   *\*If the facility failed to submit PBJ data, F851 (CE1) on the Sufficient and Competent Nurse Staffing pathway cite at Severity/Scope of F.*  *Staffing Notes:*  Note any nurse staffing waiver for onsite review. | | | | | | | | | | |
|  | List active Complaints and FRIs that will be investigated during this survey. Document the following: the complaint/FRI details; whether a complaint/FRI resident is also offsite selected; and link from the ACTS allegation to the LTCSP (i.e., initial pool, facility task, directly to investigation, closed record). Assign a surveyor. | | | | | | | | | | |
|  | Was abuse cited on the prior standard survey or have there been any abuse allegations or citations for complaints? | | | | | | | | | | |
|  | Note any federal waivers/variances for onsite review. | | | | | | | | | | |
|  | Note any active enforcement cases (resident/issues/dates/reason) that shouldn’t be investigated: | | | | | | | | | | |
|  | Ombudsman Name : | | | | | Ombudsman Contact date: | | | | | |
|  | Ombudsman’s Phone Number:  Ombudsman Area(s) of Concern: | | | | | | | | | | |
|  | Mandatory facility task assignments: | | | | | | | | | | |
| 1. Dining Observation | | | | | | | |  | | | |
| 1. Infection Control and Immunizations | | | | | | | |  | | | |
| 1. Kitchen/Food Service Observation | | | | | | | |  | | | |
| 1. Beneficiary Notification Review | | | | | | | |  | | | |
| 1. Medication Administration | | | | | | | |  | | | |
| 1. Med Storage and Labeling | | | | | | | |  | | | |
| 1. QAPI/QAA | | | | | | | |  | | | |
| 1. Resident Council | | | | | | | |  | | | |
| 1. Sufficient and Competent Nurse Staffing | | | | | | | |  | | | |
|  | Team unit assignments: | | | | | | | | | | |