|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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:       |