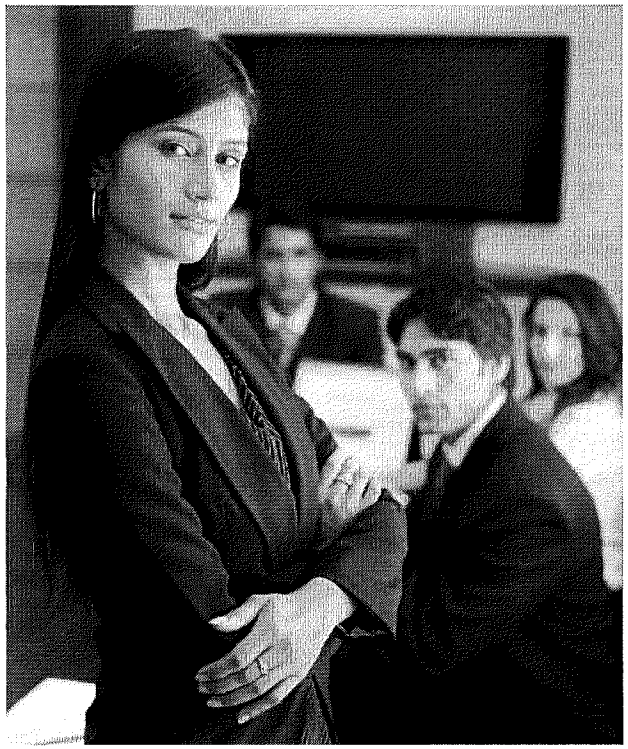
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Assessment and Guidance and Requirements



Speech, Hearing, Vision

Institute of Medicine Presentation

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CMS Expectations: Facilities

Facility Requirements:

1. The facility is required to assess each resident upon admission utilizing the Minimum Data Set.

2. Assessments are done Annually and then three quarterly assessments

3. The facility has to complete the assessment areas and the care area to finish the assessment.

4. The facility has to complete the person centered care plan.

    - within 48 hours and then within 21 days

Minimum Data Set

- All Residents in nursing homes that have certified Medicare/Medicaid Beds receive this assessment:
  - Annual Assessments
  - Quarterly Assessments
- Significant Change Assessments are completed if the resident declines or improves
  - Completed by the appropriate health care professional
  - Signed by an RN as accurate

CMS MDS: Requirements: Attachment 1

- A1100: Language:

A1100. Language

Enter Code ☐

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. Preferred language:

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Steps for Assessment

Steps for Assessment

- 1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
- 2. If the resident is unable to respond, a family member or significant other should be asked.
- 3. If neither source is available, review record for evidence of a need for an interpreter.
- 4. If an interpreter is wanted or needed, ask for preferred language.
- 5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

A1100 Language

Planning for Care

- When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
- Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

Section B: Attachment 2

SECTION B: HEARING, SPEECH, AND VISION

- **Intent:** The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

B 0200: Hearing

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty** - speaker has to increase volume and speak distinctly 3. **Highly impaired** - absence of useful hearing

Steps for Assessment

Steps for Assessment

1. Ensure that the resident is using his or her normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational.

2. Interview the resident and ask about hearing function in different situations (e.g. hearing staff members, talking to visitors, using telephone, watching TV, attending activities).

3. Observe the resident during your verbal interactions and when he or she interacts with others throughout the day.

4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone, speak more slowly or use gestures. The resident may need to see your face to understand what you are saying, or you may need to take the resident to a quieter area for them to hear you. All of these are cues that there is a hearing problem.

5. Review the medical record.

6. Consult the resident's family, direct care staff, activities personnel, and speech or hearing specialists.

B0200: Hearing Planning for Care

Planning for Care

- Address reversible causes of hearing difficulty (such as cerumen impaction).
- Evaluate potential benefit from hearing assistance devices.
- Offer assistance to residents with hearing difficulties to avoid social isolation.
- Consider other communication strategies for persons with hearing loss that is not reversible or is not completely corrected with hearing devices.
- Adjust environment by reducing background noise by lowering the sound volume on televisions or radios, because a noisy environment can inhibit opportunities for effective communication.

B0300: Hearing Aide

B0300. Hearing Aid	
Enter Code ☐	**Hearing aid or other hearing appliance used** in completing B0200, Hearing 0. **No** 1. **Yes**

B0300: Hearing Aide

Steps for Assessment

1. Prior to beginning the hearing assessment, ask the resident if he or she owns a hearing aid or other hearing appliance and, if so, whether it is at the nursing home.

2. If the resident cannot respond, write the question down and allow the resident to read it.

3. If the resident is still unable, check with family and care staff about hearing aid or other hearing appliances.

4. Check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded.

5. Ask staff and significant others whether

Facility Requirements

Planning for Care

- Knowing if a hearing aid was used when determining hearing ability allows better identification of evaluation and management needs. • For residents with hearing aids, use and maintenance should be included in care planning.
- Residents who do not have adequate hearing without a hearing aid should be asked about history of hearing aid use.
- Residents who do not have adequate hearing despite wearing a hearing aid might benefit

B0700: Makes Self Understood

B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

Definition

MAKES SELF UNDERSTOOD

- Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

Steps for Assessment

Steps for Assessment

1. Assess using the resident's preferred language.

2. Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing or using cue cards.

3. Observe his or her interactions with others in different settings and circumstances.

4. Consult with the primary nurse assistant

B0700 Makes Self Understood

Planning for Care

- Ability to make self understood can be optimized by not rushing the resident, breaking longer questions into parts and waiting for reply, and maintaining eye contact (if appropriate).

- If a resident has difficulty making self understood:

— Identify the underlying cause or causes.

— Identify the best methods to facilitate

B0800: Ability to Understand Others

B0800. Ability To Understand Others	
Enter Code ☐	**Understanding verbal content, however able** (with hearing aid or device if used) 0. **Understands** - clear comprehension 1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation 2. **Sometimes understands** - responds adequately to simple, direct communication only 3. **Rarely/never understands**

Definition

ABILITY TO UNDERSTAND OTHERS

- Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.

B0800 Ability to Understand Others

Steps for Assessment

1. Assess in the resident's preferred language.

2. If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident's understanding of person-to-person communication.

3. Interact with the resident and observe his or her understanding of other's communication.

4. Consult with direct care staff over all shifts, if possible, the resident's family, and speech-language pathologist (if involved in care).

5. Review the medical record for indications of how well the resident understands others.

B0800

Planning for Care

- Thorough assessment to determine underlying cause or causes is critical in order to develop a care plan to address the individual's specific deficits and needs.
- Every effort should be made by the facility to provide information to the resident in a consistent manner that he or she understands

Care Area Assessment (CAA)

- Attachments: 3 A and B
- The facility utilizes these resources to complete the assessment of the communication area based on the residents individualized needs.
- The facility addresses:
  - The problem including the causal and contributing factors
  - Input form the resident (if capable) or the family or representative
  - Analysis of the findings
  - Risk factors related to the care area
- Then the facility develops a Person Centered Care plan

Surveyor Requirements

- Recertification Surveys or Complaint Surveys that have allegations concerning Hearing issues
- Team of 4 Surveyors
- Team selects 30 % of the Sample based on Information gathered during the first 24 hours of the survey
- LTCSP Software algorithm selects 70 % of the sample based on MDS data and information from the surveyors during first part of the survey.

Surveyor Requirements (Attachment 4)

- When the surveyor either chooses a resident with a hearing deficit, or we have a complaint about the same, or the system choses the resident then the surveyors utilize the:

Communication and Sensory Problems (Includes Hearing and Vision Pathway) Critical Element Pathway

- This pathway requires to the surveyors to do a series of steps which include observations, interviews and record reviews.
- The surveyor does an advanced review to Observations and Interviews to determine how the facility has assessed the resident.
  - Section A 1100 and Sections B Communication, Section C: Cognitive Patterns, Section G: Functional Status, and Section O: Special Treatments and Programs are reviewed.

Surveyor Requirements

- Reviews the Physician's order for hearing aides, visual aides, pertinent medications, speech therapy or restorative needs.
- Pertinent Diagnosis
- Care Plan and whether any type of supportive and assistive devices/equipment to hearing or communication needs, environmental factors to promote vision or hearing.
- Resident, Resident Representative or Family Interview and Staff Interview
- Record Review

Surveyor Requirements

- Specific questions are asked (See attachment 4)

Deficient Areas:

Rights	Professional Standards
Dignity	Rehabilitation and Restorative
Social Services	Resident Records

Accommodations of Needs Sounds/Lighting (Environment)

Physician Supervision

Questions?

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Facility Required Attachment 1 A15-16

A1100: Language

A1100. Language	
Enter Code ☐	A. Does the resident need or want an interpreter to communicate with a doctor or health care staff? 0. No → Skip to A1200, Marital Status 1. Yes → Specify in A1100B, Preferred language 9. Unable to determine → Skip to A1200, Marital Status B. Preferred language: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.

Planning for Care

- When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
- Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the resident is unable to respond, a family member or significant other should be asked.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, ask for preferred language.
5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Coding Instructions for A1100A

- **Code 0, no:** if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status.
- **Code 1, yes:** if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.
- **Code 9, unable to determine:** if no source can identify whether the resident wants or needs an interpreter. Skip to A1200, Marital Status.

A1100: Language (cont.)

Coding Instructions for A1100B

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

A1200: Marital Status

A1200. Marital Status	
Enter Code ☐	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.
- Demographic information.

Steps for Assessment

1. Ask the resident about his or her marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither source can report, review the medical record for information.

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:

  1. Never Married
  2. Married
  3. Widowed
  4. Separated
  5. Divorced

Facility Required. Attachment 2 - B1-B-12

SECTION B: HEARING, SPEECH, AND VISION

Intent: The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

B0100: Comatose

B0100. Comatose	
Enter Code ☐	**Persistent vegetative state/no discernible consciousness** 0. **No** → Continue to B0200, Hearing 1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

Item Rationale

Health-related Quality of Life

- Residents who are in a coma or persistent vegetative state are at risk for the complications of immobility, including skin breakdown and joint contractures.

Planning for Care

- Care planning should center on eliminating or minimizing complications and providing care consistent with the resident's health care goals.

DEFINITION

COMATOSE (coma)
A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

Steps for Assessment

1. Review the medical record to determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

Coding Instructions

- **Code 0, no:** if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. Continue to B0200 **Hearing**.
- **Code 1, yes:** if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section G0110, **Activities of Daily Living (ADL) Assistance**.

B0100: Comatose (cont.)

Coding Tips

- Only code if a diagnosis of coma or persistent vegetative state has been assigned. For example, some residents in advanced stages of progressive neurologic disorders such as Alzheimer's disease may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here.

DEFINITION

PERSISTENT VEGETATIVE STATE
Sometimes residents who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.

B0200: Hearing

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty** - speaker has to increase volume and speak distinctly 3. **Highly impaired** - absence of useful hearing

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Planning for Care

- Address reversible causes of hearing difficulty (such as cerumen impaction).
- Evaluate potential benefit from hearing assistance devices.
- Offer assistance to residents with hearing difficulties to avoid social isolation.

B0200: Hearing (cont.)

- Consider other communication strategies for persons with hearing loss that is not reversible or is not completely corrected with hearing devices.
- Adjust environment by reducing background noise by lowering the sound volume on televisions or radios, because a noisy environment can inhibit opportunities for effective communication.

Steps for Assessment

1. Ensure that the resident is using his or her normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational.
2. Interview the resident and ask about hearing function in different situations (e.g. hearing staff members, talking to visitors, using telephone, watching TV, attending activities).
3. Observe the resident during your verbal interactions and when he or she interacts with others throughout the day.
4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone, speak more slowly or use gestures. The resident may need to see your face to understand what you are saying, or you may need to take the resident to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record.
6. Consult the resident's family, direct care staff, activities personnel, and speech or hearing specialists.

Coding Instructions

- **Code 0, adequate:** No difficulty in normal conversation, social interaction, or listening to TV. The resident hears all normal conversational speech and telephone conversation and announcements in group activities.
- **Code 1, minimal difficulty:** Difficulty in some environments (e.g., when a person speaks softly or the setting is noisy). The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The resident's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- **Code 2, moderate difficulty:** Speaker has to increase volume and speak distinctly. Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

B0200: Hearing (cont.)

- **Code 3, highly impaired:** Absence of useful hearing. The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Coding Tips for Special Populations

- Residents who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The resident can be observed in their normal environment. Does he or she respond (e.g., turn his or her head) when a noise is made at a normal level? Does the resident seem to respond only to specific noise in a quiet environment? Assess whether the resident responds only to loud noise or do they not respond at all.

B0300: Hearing Aid

B0300. Hearing Aid	
Enter Code ☐	**Hearing aid or other hearing appliance used** in completing B0200, Hearing 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to social isolation and mood and behavior disorders.
- Many residents with impaired hearing could benefit from hearing aids or other hearing appliances.
- Many residents who own hearing aids do not have the hearing aids with them or have nonfunctioning hearing aids upon arrival.

Planning for Care

- Knowing if a hearing aid was used when determining hearing ability allows better identification of evaluation and management needs.
- For residents with hearing aids, use and maintenance should be included in care planning.
- Residents who do not have adequate hearing without a hearing aid should be asked about history of hearing aid use.
- Residents who do not have adequate hearing despite wearing a hearing aid might benefit from a re-evaluation of the device or assessment for new causes of hearing impairment.

Steps for Assessment

1. Prior to beginning the hearing assessment, ask the resident if he or she owns a hearing aid or other hearing appliance and, if so, whether it is at the nursing home.
2. If the resident cannot respond, write the question down and allow the resident to read it.

B0300: Hearing Aid (cont.)

3. If the resident is still unable, check with family and care staff about hearing aid or other hearing appliances.
4. Check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded.
5. Ask staff and significant others whether the resident was using a hearing appliance when they observed hearing ability (above).

Coding Instructions

- **Code 0, no:** if the resident did not use a hearing aid (or other hearing appliance) for the 7-day hearing assessment coded in **B0200, Hearing.**
- **Code 1, yes:** if the resident did use a hearing aid (or other hearing appliance) for the hearing assessment coded in **B0200, Hearing.**

B0600: Speech Clarity

B0600. Speech Clarity	
Enter Code ☐	**Select best description of speech pattern** 0. **Clear speech** - distinct intelligible words 1. **Unclear speech** - slurred or mumbled words 2. **No speech** - absence of spoken words

Item Rationale

DEFINITION

SPEECH
The verbal expression of articulate words.

Health-related Quality of Life

- Unclear speech or absent speech can hinder communication and be very frustrating to an individual.
- Unclear **speech or absent speech can result in physical and psychosocial needs not being met and can contribute to depression and social isolation.**

Planning for Care

- If speech is absent or is not clear enough for the resident to make needs known, other methods of communication should be explored.
- Lack of speech clarity or ability to speak should not be mistaken for cognitive impairment.

Steps for Assessment

1. Listen to the resident.
2. Ask primary assigned caregivers about the resident's speech pattern.
3. Review the medical record.

B0600: Speech Clarity (cont.)

4. Determine the quality of the resident's speech, not the content or appropriateness—just words spoken.

Coding Instructions

- **Code 0, clear speech:** if the resident usually utters distinct, intelligible words.
- **Code 1, unclear speech:** if the resident usually utters slurred or mumbled words.
- **Code 2, no speech:** if there is an absence of spoken words.

B0700: Makes Self Understood

B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

Item Rationale

Health-related Quality of Life

- Problems making self understood can be very frustrating for the resident and can contribute to social isolation and mood and behavior disorders.
- Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.

Planning for Care

- Ability to make self understood can be optimized by not rushing the resident, breaking longer questions into parts and waiting for reply, and maintaining eye contact (if appropriate).
- If a resident has difficulty making self understood:
  - — Identify the underlying cause or causes.
  - — Identify the best methods to facilitate communication for that resident.

DEFINITION

MAKES SELF UNDERSTOOD
Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

B0700: Makes Self Understood (cont.)

Steps for Assessment

1. Assess using the resident's preferred language.
2. Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing or using cue cards.
3. Observe his or her interactions with others in different settings and circumstances.
4. Consult with the primary nurse assistant (over all shifts), if available, the resident's family, and speech-language pathologist.

Coding Instructions

- **Code 0, understood:** if the resident expresses requests and ideas clearly.
- **Code 1, usually understood:** if the resident has difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood.
- **Code 2, sometimes understood:** if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
- **Code 3, rarely or never understood:** if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

B0800: Ability to Understand Others

B0800. Ability To Understand Others	
Enter Code ☐	**Understanding verbal content, however able** (with hearing aid or device if used) 0. **Understands** - clear comprehension 1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation 2. **Sometimes understands** - responds adequately to simple, direct communication only 3. **Rarely/never understands**

Item Rationale

Health-related Quality of Life

- Inability to understand direct person-to-person communication
  - — Can severely limit association with others.
  - — Can inhibit the individual's ability to follow instructions that can affect health and safety.

B0800: Ability to Understand Others (cont.)

Planning for Care

- Thorough assessment to determine underlying cause or causes is critical in order to develop a care plan to address the individual's specific deficits and needs.
- Every effort should be made by the facility to provide information to the resident in a consistent manner that he or she understands based on an individualized assessment.

DEFINITION

ABILITY TO UNDERSTAND OTHERS
Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.

Steps for Assessment

1. Assess in the resident's preferred language.
2. If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident's understanding of person-to-person communication.
3. Interact with the resident and observe his or her understanding of other's communication.
4. Consult with direct care staff over all shifts, if possible, the resident's family, and speech-language pathologist (if involved in care).
5. Review the medical record for indications of how well the resident understands others.

Coding Instructions

- **Code 0, understands:** if the resident clearly **comprehends** the message(s) and demonstrates comprehension by words or actions/behaviors.
- **Code 1, usually understands:** if the resident misses some part or intent of the message **but** comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2, sometimes understands:** if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.
- **Code 3, rarely/never understands:** if the resident demonstrates very limited ability to understand communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

B1000: Vision

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** - sees fine detail, including regular print in newspapers/books 1. **Impaired** - sees large print, but not regular print in newspapers/books 2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** - object identification in question, but eyes appear to follow objects 4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Item Rationale

DEFINITION

ADEQUATE LIGHT
Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

Health-related Quality of Life

- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Planning for Care

- Reversible causes of vision impairment should be sought.
- Consider whether simple environmental changes such as better lighting or magnifiers would improve ability to see.
- Consider large print reading materials for persons with impaired vision.
- For residents with moderate, high, or severe impairment, consider alternative ways of providing access to content of desired reading materials or hobbies.

Steps for Assessment

1. Ask direct care staff over all shifts if possible about the resident's usual vision patterns during the 7-day look-back period (e.g., is the resident able to see newsprint, menus, greeting cards?).
2. Then ask the resident about his or her visual abilities.
3. Test the accuracy of your findings:
   - Ensure that the resident's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
   - Ensure adequate lighting.

B1000: Vision (cont.)

- Ask the resident to look at regular-size print in a book or newspaper. Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.
- When the resident is unable to read out loud (e.g. due to aphasia, illiteracy), you should test this by another means such as, but not limited to:
  - — Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).

Coding Instructions

- **Code 0, adequate:** if the resident sees fine detail, including regular print in newspapers/books.
- **Code 1, impaired:** if the resident sees large print, but not regular print in newspapers/books.
- **Code 2, moderately impaired:** if the resident has limited vision and is not able to see newspaper headlines but can identify objects in his or her environment.
- **Code 3, highly impaired:** if the resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).
- **Code 4, severely impaired:** if the resident has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes.

Coding Tips and Special Populations

- Some residents have never learned to read or are unable to read English. In such cases, ask the resident to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).
- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement of objects or people. These gross measures of visual acuity may assist you in assessing whether or not the resident has any visual ability. For residents who appear to do this, **code 3, highly impaired.**

B1200: Corrective Lenses

B1200. Corrective Lenses	
Enter Code ☐	**Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision 0. **No** 1. **Yes**

B1200: Corrective Lenses (cont.)

Item Rationale

Health-related Quality of Life

- Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.
- Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.
- Many persons who benefit from and own visual aids do not have them on arrival at the nursing home.

Planning for Care

- Knowing if corrective lenses were used when determining ability to see allows better identification of evaluation and management needs.
- Residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning.
- Residents who do not have adequate vision without eyeglasses or other visual appliances should be asked about history of corrective lens use.
- Residents who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment.

Steps for Assessment

1. Prior to beginning the assessment, ask the resident whether he or she uses eyeglasses or other vision aids and whether the eyeglasses or vision aids are at the nursing home. Visual aids do not include surgical lens implants.
2. If the resident cannot respond, check with family and care staff about the resident's use of vision aids during the 7-day look-back period.
3. Observe whether the resident used eyeglasses or other vision aids during reading vision test (B1000).
4. Check the medical record for evidence that the resident used corrective lenses when ability to see was recorded.
5. Ask staff and significant others whether the resident was using corrective lenses when they observed the resident's ability to see.

B1200: Corrective Lenses (cont.)

Coding Instructions

- **Code 0, no:** if the resident did not use eyeglasses or other vision aid during the **B1000, Vision** assessment.
- **Code 1, yes:** if corrective lenses or other visual aids were used when visual ability was assessed in completing **B1000, Vision.**

Facility Required.

Attachment 3. (A)
C 18-20

✓	**Characteristics of the communication impairment** (from clinical record)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Expressive communication (B0700)	
☐	—Speaks different language (A1100)	
☐	—Disruption in ability to speak (B0600, clinical record)	
☐	—Problem with voice production, low volume (B0600, clinical record)	
☐	—Word-finding problems (clinical record)	
☐	—Difficulty putting sentence together (B0700, C1310C, clinical record)	
☐	—Problem describing objects and events (B0700, clinical record)	
☐	—Pronouncing words incorrectly (B0600, clinical record)	
☐	—Stuttering (B0700, clinical record)	
☐	—Hoarse or distorted voice (clinical record)	
☐	• Receptive communication (B0800)	
☐	—Does not understand English (A1100)	
☐	—Hearing impairment (B0200, B0300 = 1, B0800)	
☐	—Speech discrimination problems (clinical record)	
☐	—Decreased vocabulary comprehension (clinical record) (A1100A-B)	
☐	—Difficulty reading and interpreting facial expressions (clinical record, direct observation)	
☐	• Communication is more successful with some individuals than with others. Identify and build on the successful approaches (clinical record, interviews, observation)	
☐	• Limited opportunities for communication due to social isolation or need for communication devices (clinical record, interviews)	
☐	• Communication problem may be mistaken as cognitive impairment	

✓	**Confounding problems** that may need to be resolved before communication will improve	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Decline in cognitive status (clinical record) and BIMS decline (C0500, V0100D)	
☐	• Mood problem, increase in PHQ-9 score (D0300, D0600, V0100E)	
☐	• Increased dependence in Activities of Daily Living (ADLs) (clinical record, changes in G0110, G0120)	
☐	• Deterioration in respiratory status (clinical record)	
☐	• Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100, clinical record)	
✓	**Use of communication devices** (from clinical record, observation)	**Supporting Documentation**
☐	• Hearing aid (B0300)	
☐	• Written communication	
☐	• Sign language	
☐	• Braille	
☐	• Signs, gestures, sounds	
☐	• Communication board	
☐	• Electronic assistive devices	
☐	• Other	

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Facility Resource. Attachment 3 (B)

4. COMMUNICATION

Review of Indicators of Communication

✓	**Diseases and conditions** that may be related to communication problems	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Alzheimer's Disease or other dementias (I4200, I4800, I8000)	
☐	• Aphasia (I4300) following a cerebrovascular accident (I4500)	
☐	• Parkinson's disease (I5300)	
☐	• Mental health problems (I5700 – I6100)	
☐	• Conditions that can cause voice production deficits, such as	
☐	—Asthma (I6200)	
☐	—Emphysema/COPD (I6200)	
☐	—Cancer (I0100) —Poor-fitting dentures (L0200)	
☐	• Transitory conditions, such as	
☐	—Delirium (C1310, I8000, clinical record)	
☐	—Infection (I1700 – I2500) —Acute illness (I8000, clinical record)	
☐	• Other (I8000, clinical record)	
✓	**Medications** (consultant pharmacist review of medication regimen can be very helpful)	**Supporting Documentation**
☐	• Narcotic analgesics (medication administration record)	
☐	• Antipsychotics (N0410A)	
☐	• Antianxiety (N0410B)	
☐	• Antidepressants (N0410C)	
☐	• Parkinson's medications (medication administration record)	
☐	• Hypnotics (N0410D)	
☐	• Gentamycin (N0410F) (medication administration record)	
☐	• Tobramycin(N0410F) (medication administration record)	
☐	• Aspirin (medication administration record)	
☐	• Other (clinical record)	

Performance Log Finishers

P.O. Box 702854 New Smyrna Beach, FL 32170
WeFixLogHomes.com
1-800-781-2551

Thank you for choosing Performance Log Finishers for your log home project. We have over 20 years of experience in the log home industry. As a company we strive to provide the highest level of customer service. Our professional technicians insure satisfaction from start to finish. Our applied restoration techniques will meet manufacturer's warranties.

Cindy Deporter
3759 US Hwy 15
Oxford, NC 27565

October 23rd, 2017

Exterior Options

Check Maintenance: Will apply Check Mate 2 to all log checks greater than ¼". It is the job of the Clear Coat to maintain the checks smaller than ¼".

Log End Sealing: Will grind all log ends and seal with Perma-Chink Log End Seal. This provides a durable, water repellent barrier against excessive cracks and checks, it will also prevent the ends from wicking moisture and creating rot.

Total Contracted Amount: $1,736.43

100% Payment on contract signing **$1,736.43**

Initial below to acknowledge that you have read and understand all terms and conditions.

_____ All payment processed via Credit or Debit Card are subject to an 3% processing fee.

_____ All change orders or add on work is subjected to $65.00 per man hour; excluding materials.

_____ This proposal is valid for 30 days from date listed above. After this period options will be reevaluated due to possible price increases.

_____ Performance Log Finishers reserves the right to put a lien onto the home addressed above if total amount agreed upon signing of contract is not received within 15 days of job completion.

_____ If contract is cancelled after signing is completed; A minimum of 50% of contract signing may be held for possible restock fees, time, and cost into job. Refunds will be determined per option.

_____ Performance Log Finishers will protect plants and bushes around the home to the best of our ability. The customer is responsible for all bushes / shrubs to trimmed at least 2 - 3 feet from the home before their estimated start date to ensure the crews will be able to work on the home in a safe and productive manor. Performance Log Finishers cannot guarantee against damage or loss of plants and will not be held responsible.

_____ During the media blasting process, media can enter the exterior heating and cooling unit. If this is a concern to the customer, Performance Log Finishers will provide coverage for the exterior unit. The customer is responsible for switching the power to the unit both ON and OFF. Performance Log Finishers is not responsible for damage to the homes heating and cooling unit.

_____ Performance Log Finisher will cover any large objects on decks of home that cannot be removed, to include but not limited to Jacuzzi, or hot tubs. Prior to project start up customer is required cover, protect, and unplug items for extra precautionary measures to prevent any media or debris entering said items. Performance Log Finishers is not responsible for any debris entering pools.

_____ Any warranties of the product manufacturer are the manufacturers responsibility alone and not the dealers. Performance Log Finishers gives a 120 day warranty for labor from job completion date.

Whose signature appears below, acknowledges that they have read and understand this contract and finds all terms herein to be reasonable and fair.

Print Name Cindy Gallaher **Date** 10-23-17

Signature _____ **Date** 10-23-17

Thank you for choosing Performance Log Finishers. We value your business and look forward to working with you.

Surveyor

Attachment 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Use this pathway for a resident having communication difficulty and/or sensory problems (vision and/or hearing).

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections B – Hearing, Speech, Vision, C – Cognitive Patterns, G – Functional Status, and O – Spec Treatment/Proc/Prog - SLP (O0400A) and restorative nursing (O0500).
- ☐ Physician's orders (e.g., communication, hearing or visual aids, pertinent medications, speech therapy, or restorative).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., supportive and assistive devices/equipment to meet visual, hearing, or communication needs, environmental factors to promote vision or hearing).

Observations:

- ☐ How does the resident give cues indicating visual or hearing deficits?
- ☐ What supportive and assistive devices/equipment (telephone with low-high volume switch, hearing aids, magnifying glasses, hand signals, use of pictures, large print books, books on tape, communication boards) are used? Are they used correctly, functioning properly, and in good repair?
- ☐ Are activities and interactions provided in a manner that is responsive to individual hearing, vision, or communication concerns? If not, describe.
- ☐ How is the environment responsive to individual hearing, vision, or communication concerns (e.g., adequate lighting, reduction of glare, removal of clutter, reduction of background noise)?

Resident, Resident Representative, or Family Interview:

- ☐ What is your current communication and/or sensory status?
- ☐ Do you need or have you requested (but don't have) visual or hearing devices? If so, has the facility assisted the resident with making appointments or arranging transportation to/from appointments?
- ☐ How does the facility involve you in the development of the care plan and goals?
- ☐ How does the facility ensure interventions reflect your choices and preferences and staff provide care according to the care plan?
- ☐ If you have refused devices/techniques, what alternatives or other interventions has the facility discussed with you? What did staff talk to you about the risks of refusing?

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Social Services):

- ☐ What specific communication methods and interventions, such as use of communication devices (e.g., sign language, gestures, communication board), any visual devices (e.g., glasses, magnifying lens, contact lenses) or hearing aids, and speech therapy schedules does the resident use?
- ☐ What, when, and to whom do you report changes in communication and/or sensory functioning, including broken assistive devices in need of repair?
- ☐ How do you monitor for the implementation of the care plan?
- ☐ How do you review and evaluate for changes in the resident's communication and sensory functioning?
- ☐ How are appointments and transportation arranged for visual and auditory exams?
- ☐ If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.
- ☐ Ask about identified concerns.

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Record Review:

- ☐ Review therapy notes, consultations, and other progress notes that may have information regarding the assessment of visual, hearing, and/or communication needs.
- ☐ What was the resident's responsiveness to speech, hearing, or visual services?
- ☐ Did the facility accurately and comprehensively reflect the status of the resident?
- ☐ What causal, contributing, and risk factors for decline or lack of improvement related to limitations in visual or auditory functioning or communication does the resident have?
- ☐ What factors does the resident have that may affect communication (e.g., medical conditions, such as CVA, Parkinson's disease, cerebral palsy or other developmental disabilities, COPD, psychiatric disorders, dysarthria, dysphagia, dysphasia/aphasia, medications, decreased ability to understand how to use communication aids, and hearing/visual limitations).
- ☐ What factors does the resident have that may affect visual functioning (e.g., conditions such as glaucoma, diabetes, macular degeneration, cataracts, eye infections, blurred vision; refusal to wear glasses, difficulty adjusting to change in light, poor discrimination of color, sensitivity to sunlight and glare, impaired peripheral and depth perception, impaired edge-contrast sensitivity; and environmental factors such as insufficient lighting).
- ☐ What factors does the resident have that may affect hearing (e.g., background noise, cerumen impaction, infections [colds/congestion], ototoxic medications [ASA, antibiotics], perforation of an eardrum, retrocochlear lesions, tinnitus, poorly fitting or functioning hearing aid, and foreign bodies in the ear canal).
- ☐ How did the facility respond to needed assistive devices to promote hearing, vision, or communication?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, strengths, risks, and needs? Does it include measurable objectives and timetables? How did the resident respond to care-planned interventions? If interventions weren't effective, was the care plan revised?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ What scheduled/planned auditory or visual examinations, or speech therapy is the resident receiving?
- ☐ Is the resident at risk for accidents related to visual/auditory impairments, or lack of understanding of safety instructions? If so, how has staff addressed this?
- ☐ If the resident refuses or is resistant to devices or services, what efforts have been made to find alternative means to address the needs identified in the assessment process?
- ☐ How does staff monitor the resident's response to interventions?
- ☐ If the resident experienced an unexpected decline or lack of improvement in hearing or vision, how did staff ensure that proper treatment was obtained in a timely fashion?
- ☐ How did the facility involve the resident or resident representative in the review and revision of the plan?

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

Critical Element Decisions:

1) Did the facility provide proper care and treatment, including assistive devices, to prevent a decline, maintain, or improve the resident's communication abilities (speech, language, or other functional communication systems)?
   If No, cite F676
   NA, the resident does not have communication needs.

2) Did the facility ensure the resident receives proper treatment and assistive devices to maintain vision and/or hearing abilities?
   If No, cite F685
   NA, the resident does not have vision or hearing needs.

3) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

4) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

5) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

6) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway

7) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

8) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Notice of Rights F552, Dignity (CA), Social Services F745, Accommodation of Needs and/or Sound and Lighting (Environment Task), Admission Orders F635, Professional Standards F658, Rehab or Restorative (CA), Resident Records F842, Physician Supervision F710.