Survey Reports (672 & 802)

User Group Rights to Survey Reports

The 802 and 672 may be accessed via a Write or a View option. In the Write option, a user has the capability to adjust the setups of the report populates the data, make changes to each of the resident's rows of information, print, and view the report. In the View option, a user can only print or view the report. They are unable to make any setup changes or changes to a resident's information.

To grant or remove access to the survey reports, follow the steps below:

1. Click onto American Data – ECS > Setup > Security > User Group.
2. Double click into a user group to access the **Properties** screen.
3. In the **Rights** tree, follow the path **Write > Survey** or **View > Report > Survey** to grant access to either option (with a green checkmark) or remove access (giving a red checkmark).

It is important to be sure any easy access buttons are linked to the appropriate version of the survey report (whether the Write or View version), dependent on the user group needing access. For example, an MDS Coordinator or DON would need the capability to adjust, where as a floor nurse may only need access to print it and therefore could be given the View option.

We are investigating a future enhancement which would split out the Write and Setup options in these reports. This has not yet been programmed but is slated for an update later in 2021 or early 2022.

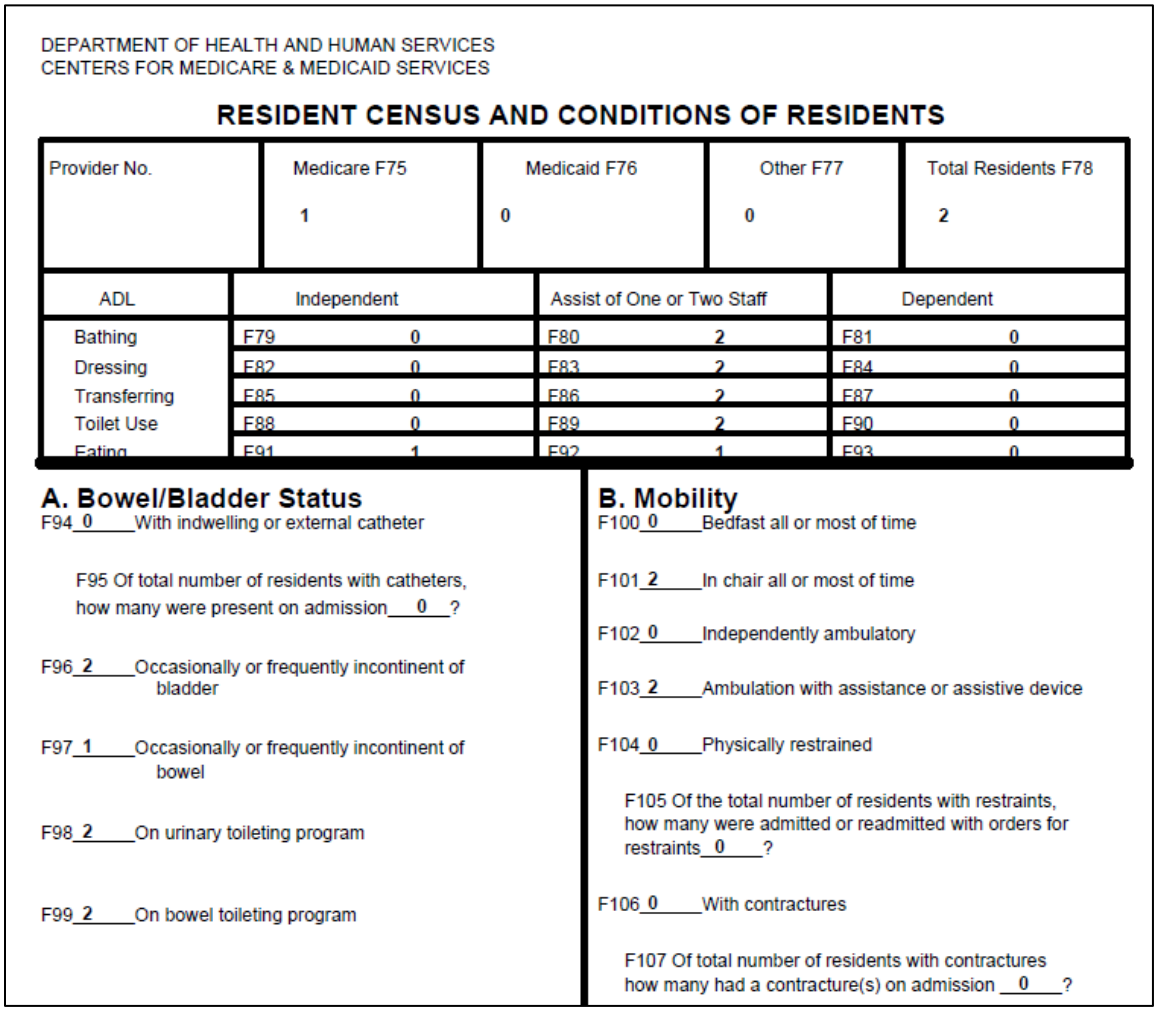
Run the 672 Report

Information can be pulled into the 672 Survey Report from the most recently submitted MDS as well as from charting within ECS.

1. From the MDS/Resident Care Coordinator Access screen, click **672 Census & Condition**.
2. Click the **Name(s)** button, highlight the resident name(s), and click **OK**.
3. Click **Refresh** first if you plan to make changes or viewing the information and verifying it. After clicking Refresh, red boxes will appear for any information that has changed.
    - It is VERY important to click the Refresh button to bring in updated data. We recommend completing this at least once a week when in survey window or monthly when not.
4. An Audit Results screen will appear to show any errors and show questions that need to be coded manually. Click **Close**. (To see these audit results again, click on the Errors button.)
5. The survey report will load.

- The information in these reports is pulling directly from either the last submitted MDS assessment for each resident OR directly from charting (if setup manually).
- To manually change the report, double-click on the desired cell containing the information to be changed. Double-clicking on a cell will enter or remove the X in the cell.
- Utilize the Workspace Editor on the right-hand side of the screen to see where the current data is populating from vs. any prior data. Column Description will detail the specifications for that column as well as the MDS crosswalk as to where that data is found. To see the information that is populating into that cell, click onto Show Source. This will either load a view screen (for charted data) or the MDS.

6. Click Print to print the report. This will load the form which is requested by surveyors. Click Print Trigger List to see which residents fall into each category.
7. Click Exit to return to the Access menu. A message will appear: "Save Changes?" Choose Yes, No, or Cancel. If Yes is chosen, the current answers will remain until Refresh is clicked onto or the report is manually edited and saved.



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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
	1	0	0	2

ADL	Independent		Assist of One or Two Staff		Dependent	
Bathing	F79	0	F80	2	F81	0
Dressing	F82	0	F83	2	F84	0
Transferring	F85	0	F86	2	F87	0
Toilet Use	F88	0	F89	2	F90	0
Eating	F91	1	F92	1	F93	0

A. Bowel/Bladder Status

F94_0_With indwelling or external catheter

F95 Of total number of residents with catheters, how many were present on admission_0_?

F96_2_Occasionally or frequently incontinent of bladder

F97_1_Occasionally or frequently incontinent of bowel

F98_2_On urinary toileting program

F99_2_On bowel toileting program

B. Mobility

F100_0_Bedfast all or most of time

F101_2_In chair all or most of time

F102_0_Independently ambulatory

F103_2_Ambulation with assistance or assistive device

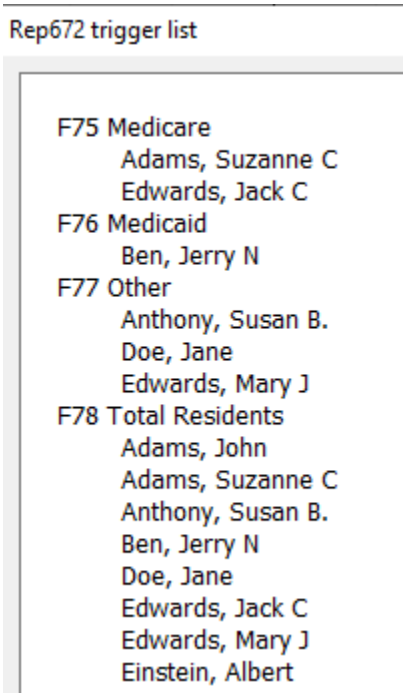
F104_0_Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints_0_?

F106_0_With contractures

F107 Of total number of residents with contractures how many had a contracture(s) on admission _0_?

Printed view of 672 report



672 Trigger List (displays all residents who triggered in each column)

Run the 802 Report

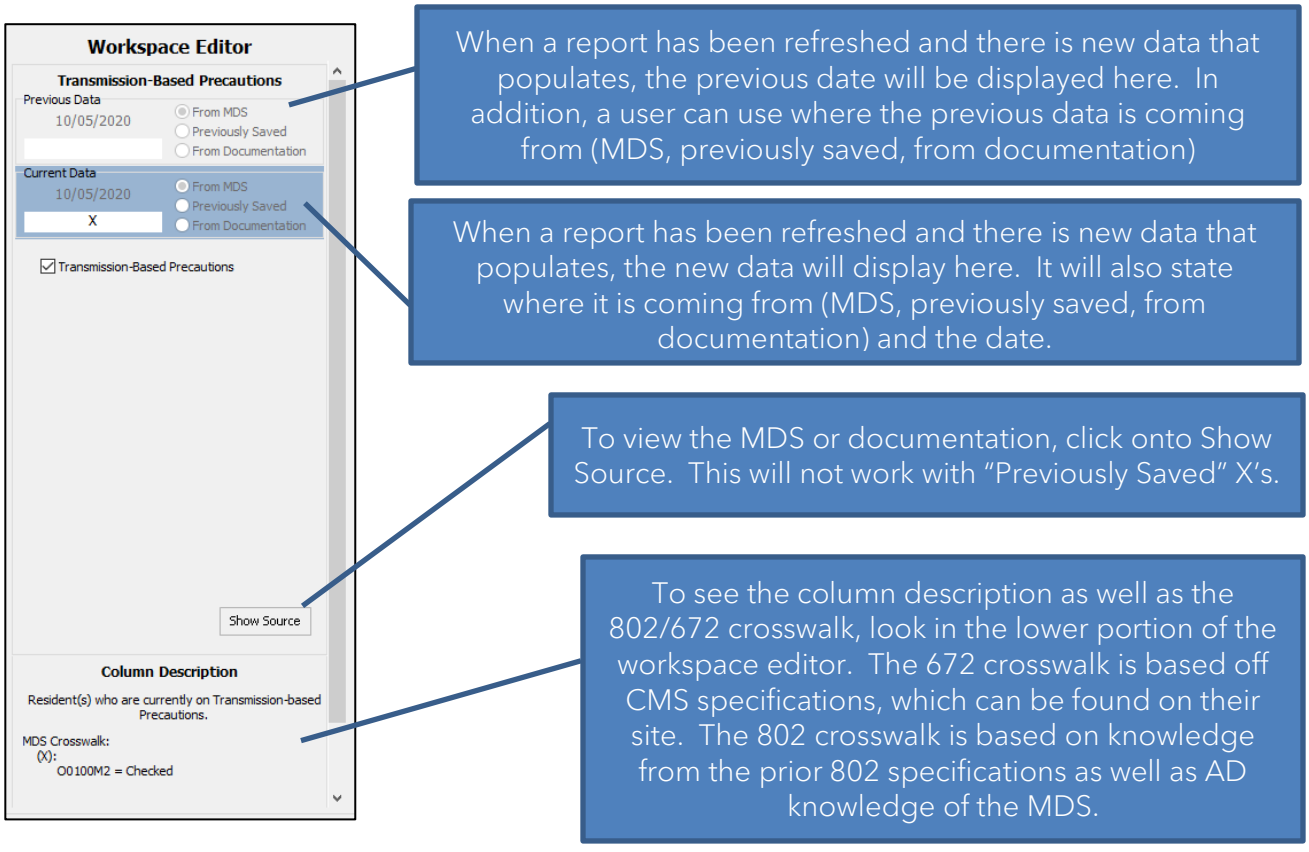
Information can be pulled to the 802 Survey Report from the most recently submitted ECS as well as from charting within ECS.

1. From the MDS/Resident Care Coordinator Access screen, click **802 Roster/Sample Matrix**.
2. Click the **Name(s)** button, highlight the resident name(s), and click **OK**.
3. Click **Refresh** first if you plan to make changes or viewing the information and verifying it. After clicking Refresh, red boxes will appear for any information that has changed.
    - It is VERY important to click the Refresh button to bring in updated data. We recommend completing this at least once a week when in survey window or monthly when not.
4. An Audit Results screen will appear to show any errors and show questions that need to be coded manually. Click **Close**. (To see these audit results again, click on the Errors button.)
5. The survey report will load.
    - The information in these reports is pulling directly from either the last submitted MDS assessment for each resident OR directly from charting (if setup manually).
    - To manually change the report, single-click on the desired cell containing the information to be changed. The Workspace Editor on the right-hand side of the

screen will load. In here, check or uncheck boxes to make manual changes to that field.

- Utilize the Workspace Editor on the right-hand side of the screen to see where the current data is populating from vs. any prior data. Column Description will detail the specifications for that column as well as the MDS crosswalk as to where that data is found. To see the information that is populating into that cell, click onto **Show Source**. This will either load a view screen (for charted data) or the MDS.
- On the 802, the Sort button can be used to sort the residents by Resident Name, Resident Number, or Resident Room.

6. Click **Print** to print the report.
7. Click **Exit** to return to the Access menu. A message will appear: "Save Changes?" Choose **Yes**, **No**, or **Cancel**. If Yes is chosen, the current answers will remain until another MDS assessment is submitted or the report is edited and saved.



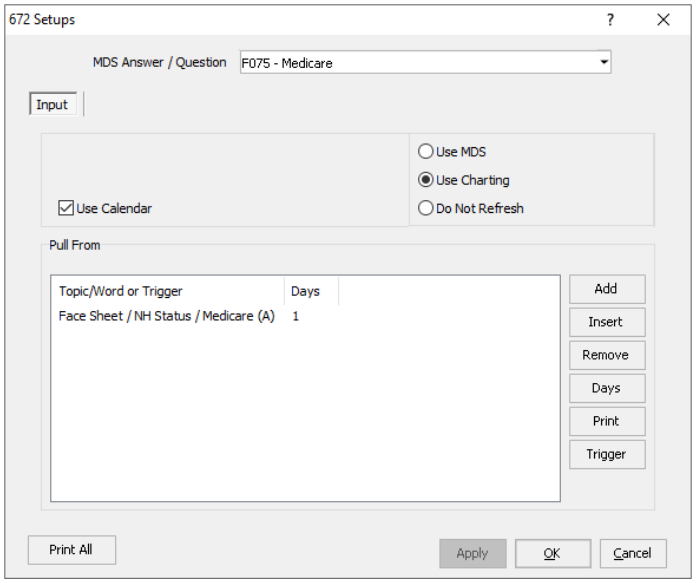
Adjust Setups of 672 or 802

1. From the MDS/Resident Care Coordinator Access screen, click **802 Roster/Sample Matrix** or **672 Census & Condition**.
2. Click onto the Setup button, which loads the setup for that specific report type.

3. In the top portion, click onto the MDS Answer/Question dropdown to select a column to be adjusted.
4. Each question will have three options to select from:
    - Use MDS – will populate the field based on the answers coded on the MDS. This option will be grayed out for columns that must be manually coded as no question that meets the column's parameters exists on the MDS. This option is the most consistent one as it does not need to ever be updated, whereas if the location something is charted changes, then the user needs to remember to also update the survey report setups. This option will gray out all other options on this screen, as this is hard coded.
    - Use Charting – will populate the field based on whatever word(s) are added into the Topic/Word or Trigger box below. If the radio button has Use Charting selected, there must be items filled in below or this field will never know how/when to populate. Utilize the Add button to select word(s) from within the documenting topics. Set the number of days if needed and place a checkmark in Use Calendar if wanting to look at the calendar for this information (i.e., primary payer source). This option must be kept up manually and adjusted if the location of the documentation ever changes.
    - Do Not Refresh – This will leave this column to never pull in any new information based on the MDS or charting. This may be used in a situation where a facility would rather manually keep something updated than have it populate from potentially outdated MDS assessments or from somewhere in the record. This would leave this column to always need to be manually updated by a user for it to change.
5. Dependent on the option selected will determine whether information is added into the "Pull From" location of the screen.
    - If in the 802, note that several columns populate a different value type dependent on the word that triggers. Make sure that when adding in documentation, you also check the Value setups and apply the appropriate one to each piece of charting being added into the "Pull From" location.
6. As changes are made, click onto Apply to save.

In American Data's default system, all questions are setup to populate from the MDS, except for the ones below. The ones below are setup differently as they are payer sources, which change frequently, or are required to be manually coded as they are not found on the MDS.

- 672 Report "Use Charting" or "Do Not Refresh" Setups:
  - F075 [Medicare] > Use Charting > Use Calendar checked > Face Sheet/NH Status/Medicare (A) > 1 day.
  - F076 [Medicaid] > Use Charting > Use Calendar checked > Face Sheet/NH Status/Medicaid > 1 day.
  - F077 [Other] > Use Charting > Use Calendar checked > Face Sheet/NH Status/Self Pay, Medicaid MCO, Medicare Advantage (A), Medicaid Pending, Insurance, Managed Care, Hospice Medicaid, Hospice Self Pay, Optum (A), VA > 1 day.



  - F100 [Bedfast] > Use Charting > CAA/16 – Pressure Ulcer(s)/Bedfast or wheelchair bound, CAA/19 – Pain/bedfast, Department Notes/Dietary Notes/bedfast (1.2), Assessments/Skin Breakdown Risk/bedfast (1) > 90 days.
  - F113 [Behavior Management] > Do Not Refresh.
  - F114 [Rehab Service MI/MR] > Do Not Refresh.
  - F118 [Rash] > Use Charting > Nursing/NH Admission Note/rash, Nursing/NH Summary Note/open lesion(s) not ulcer/rash, Nursing/LOA/Rm Change/DC/Transfer/rash(es) and rash, CNA/AM Skin/rash, CNA/PM Skin/rash, CNA/Night Skin/rash > 30 days.
  - F142 [non-oral communication] > Use Charting > Nursing/NH Admission Note/non-verbal, Assessments/Pain/PAINAD SCALE.
  - F143 [Advanced Directive] > Use Charting > Face Sheet/Personal Information/any of the options listed in the ADVANCED DIRECTIVE column (except for No Directives), and Physician Orders/Code Status/POLST.
- 802 Report "Use Charting" or "Do Not Refresh" Setups:
  - 00 [Resident Room Number] > Use Charting > Use Calendar checked > Face Sheet/Rooms/SNF ROOM > 1 day.
  - 01 [Date of Admission if in the past 30 days] > Use Charting > Use Calendar checked > Face Sheet/NH Status/ADMISSION DATE and READMISSION DATE > 30 days.
  - 04 [Medications] > Use Charting > Medi-Span drug category for the following with the corresponding value setup: Antianxiety agents (AA), Amebicides (ABX),

Aminoglycosides (ABX), Anthelmintics (ABX), Anti-infective agents – misc. (ABX), Antimycobacterial agents (ABX), Cephalosporins (ABX), Fluoroquinolones (ABX), Macrolides (ABX), Penicillins (ABX), Sulfonamides (ABX), Tetracyclines (ABX), Antibiotics – topical (ABX), Ophthalmic anti-infectives (ABX), Otic anti-infectives (ABX), Anticoagulants (AC), Antidepressants (AD), Antipsychotics/Antimanic agents (AP), Diuretics (D), Hypnotics/Sedatives/Sleep disorder agents (H), Insulin (I), Analgesics – Opioid (O), and Respiratory Agents – misc. (RESP).

- 06 [Worsened Pressure Ulcer(s)] > Use Charting > Nursing/Pressure Injury Assessment/worsened > 7 days.
- 13 [Dialysis] > Use Charting > Physician Orders/Treatments/hemodialysis (H) and peritoneal dialysis (P). In facility and Offsite would be coded manually by the user.
- 15 [End of Life/Comfort/Palliative Care] > Do Not Refresh. As this field excludes hospice care and it is typically charted in conjunction with end of life, it is best if a user manually determines when this field applies.
- 19 [Intravenous] > Use Charting > Physician Orders/Medications/intravenous.