

CHAPTER 17: Nursing Homes



Overview


This Standard Operating Procedure (SOP) chapter outlines activities and procedures that Residential Care Services (RCS) staff are required to follow when conducting pre-occupancy, initial certification, recertification, and post surveys at Nursing Homes (NH), also called Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) depending on funding type. These facilities are either Federally Certified and/or State Licensed and employ qualified staff to provide care.

For more information about complaint investigations please refer to [SOP Chapter 20 - Complaint Investigations](#).

NHs are required by law to be surveyed every 9 to 15 months with a 12-month average. If a NH is found out of compliance with regulatory requirements there may be enforcement actions against the facility. For more information about enforcements please refer to [SOP Chapter 7 - Enforcement](#).

These procedures support:

- RCS purpose to promote and protect the rights, security, and wellbeing of individuals living in licensed or certified residential settings.
- The Department of Social and Health Services (DSHS) mission to partner with people to access support, care, and resources.

In this document, the  icon indicates information that is of specific importance to staff that may require additional attention (i.e., documentation requirements, special focus, etc.).

Note: Throughout this document, the terms Administrator, Provider, Licensee, Field Manager (FM), Field Services Administrator (FSA), Regional Administrator (RA), and Administrative Assistant (AA) can also refer to their designee.

Nursing Homes must comply with the following:

- [Long Term Care Survey Process \(LTCSP\) Procedure Guide](#)
- [CMS State Operations Manual \(SOM\), Chapter 2 – The Certification Process](#)
- [CMS State Operations Manual \(SOM\), Chapter 4 – Program Administration and Fiscal Management](#)
- [CMS State Operations Manual \(SOM\), Chapter 5 – Complaint Procedures](#)
- [CMS State Operations Manual \(SOM\), Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities](#)
- [CMS State Operations Manual \(SOM\), Chapter 8 – Standards and Certification](#)
- [CMS State Operations Manual \(SOM\), Appendix PP – Guidance to Surveyors for Long Term Care Facilities](#)
- [CMS State Operations Manual \(SOM\), Appendix Q – Core Guidelines for Determining Immediate Jeopardy](#)
- [Chapter 18.51 RCW – Nursing Homes \(NH\)](#)
- [Chapter 74.42 RCW Nursing Homes – Resident Care, Operating Standards](#)
- [Chapter 388-97 WAC – Nursing Homes \(NH\)](#)
- [Title § 42 eCFR](#)

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RCS partners with the following federal and state agencies and associations to develop NH regulations and policies:

- [CMS](#) – Region 10
- [Department of Health \(DOH\)](#)
- [Washington State Patrol \(WSP\) – State Fire Marshal’s Office \(SFMO\)](#)
- [State Long-Term Care Ombuds Program \(LTCOP\)](#)
- [Washington Health Care Authority \(HCA\)](#)
- [LeadingAge of Washington \(LA\)](#)
- [Washington State Local Health Jurisdictions \(LHJ\)](#)
- [Washington Health Care Association \(WHCA\)](#)

These procedures are in addition to [DSHS Administrative Policies](#), as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years.

Contacts

- [RCS Quality Improvement Unit General Contact](#)
- [RCS Policy Unit General Contact](#) (**internal** RCS use)
- RCSPolicy@dshs.wa.gov (**external** RCS use)
- [RCS Training Unit General Contact](#)



General Guidelines

This document explains the general guidelines for NH Regulators FMs to ensure visits are conducted in a consistent manner.

Survey teams and FMs have some general instructions that apply during regulatory visits.

1. The FM will:
 - a. Ensure regulatory staff are trained to complete this procedure.
 - b. Be available by phone or in person to consult and support the survey team.
 - c. Consult with the Compliance Specialist (CS) in any immediate jeopardy situations.
 - d. Ensure timely completion of the Statement of Deficiencies (SOD).
 - e. Ensure the facility corrects any deficient practice, following state and federal protocols.

2. The survey team will:
 - a. Attend all team meetings.
 - b. Be on time and prepared to discuss identified concerns, findings, and potential noncompliance.
 - c. Be prepared to discuss workload and potential adjustments in workload with other team members.
 - d. Listen attentively to other team members' observations, concerns, or other identified issues.
 - e. Participate in the exit conference as requested by the Team Coordinator (TC).
 - f. Document all findings of deficient practice on the [Statement of Deficiencies \(CMS 2567\)](#) using the [Principles of Documentation \(POD\)](#).

3. The TC will:
 - a. Contact the FM to communicate potential issues and concerns.
 - b. Inform the licensee/administrator to expect frequent contact with the survey team and that the team will interview nursing home staff as needed throughout the visit.
 - c. Provide information on the survey process and establish a tone to encourage and facilitate frequent communication with the licensee/administrator and facility staff.
 - d. Compare the names of the current administrator and Director of Nursing (DON) to the administrator and DON names documented from Internet Quality Improvement and Evaluation system (iQIES).
 - 1) If there is any discrepancy between the actual administrator and/or DON with the names documented in iQIES, notify your FM.

Note: Per [WAC 388-97-1640 \(4\)](#) the nursing home must notify, in writing, the department's aging and disability services administration and each resident, of a loss of, or change in, the nursing home's administrator or director of nursing services at the time the loss or change occurs.



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Part I: Initial State Licensing Process

Note:

- Immediately upon receipt by any RCS personnel that Certificate of Need (CON) and/or Construction Review Services (CRS) have received an application for construction of a new facility, or new construction in an existing facility, this information will be forwarded to the assigned FM. [Residential Care Services Offices/DSHS](#)
- Upon receipt of this information, the assigned FM will contact the facility administrator and provide a copy of “Nursing Home Pre-Occupancy Inspection Checklist – NH Administrator Use” ([DSHS 16-284](#)) and explain it’s use.

A. Initial State Licensing Process

Resources:

- [WAC 388-97-4160 - The process for requesting an initial state license.](#)

1. Steps to process new NH license applications through the Business Analysis Application Unit (BAAU).

a. Prospective NHs will:

- 1) Complete the [Nursing Home Facility License Application \(DSHS 10-670\)](#) with all required forms and documentation and submit to BAAU.

b. BAAU will:

- 1) Send an initial application notification email to the NH Notification Group (see glossary for complete list) when an initial licensing application is received.
- 2) Send a second email notification to the assigned FM and RA when the licensing application is finalized.

Note: If the licensing application remains in pending status for over six months, a revised application must be submitted.



Part II: Federal Enrollment/Certification Process

Note: [Title XVIII of the Social Security Act](#), 42 U.S.C. Sec. 1395, as amended, for a portion of the facility's licensed beds, requires that any nursing home applying to participate in the Medicaid payment system must obtain and maintain Medicare certification. **WAC 388-96-011**

A. Application Submission

Resources:

- [Admin Info: 24-22-ALL MLN9658742 – Medicare Provider Enrollment](#),
- [CMS Enrollment Applications](#),
- [Become a Medicare Provider or Supplier | CMS](#),
- [Tips to Facilitate the Medicare Enrollment Process](#),
- [CMS Provider Enrollment & Certification Roadmap](#),
- [Find and Contact Your MAC](#),
- [Medicare Enrollment Assistance & Contacts | CMS](#),
- [Provider Enrollment Events | CMS](#),
- [Certification | Medicaid](#),
- [Medicaid certification contract](#),
- [Medicaid Provider Enrollment Compendium \(MPEC\)](#),
- [Medicare Program Integrity Manual, Ch 10](#),
- [Manage Your Enrollment | CMS](#);
- [Provider Enrollment, Chain, and Ownership System \(PECOS\)](#),
- [Brief Summaries of Medicare & Medicaid](#).

1. Steps to process a nursing home application

a. The facility must:

- 1) Obtain a type two [National Provider Identifier Standard \(NPI\) | CMS](#) & [NPIs | CMS](#).
- 2) Accurately complete [CMS 855A](#) and submit the application, including all required documentation, to the assigned [Medicare Administrative Contractor \(MAC\)](#) email address.
- 3) Document and retain the application logging and tracking number. This information is necessary when contacting the MAC or updating application information.
 - a) Per [Section 125 of the Consolidated Appropriations Act of 2021](#), an action plan is required to be submitted with the enrollment application.
- 4) Respond to requests for more information within 30 days of receipt.
- 5) Application information can be updated in the Provider Enrollment, Chain, and Ownership System (PECOS), unless the file is locked in review. If this happens, facilities can reach out to the MAC for assistance.

Note: The information across all platforms must match exactly. Facilities should pay particular attention to use of “The” and punctuation.

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2. Process after the nursing home application is submitted

- a. The Assigned MAC must:
 - 1) Review the application packet, ensuring the application is complete, validating the data submitted, and ensuring all required documentation is attached, including:
 - a) [Health Insurance Benefit Agreement \(CMS-1561\)](#); and
 - b) [Assurance of Compliance \(HHS-690\)](#).
 - 2) If corrections or additional documentation are required, the MAC will send the facility a letter identifying what is needed. The facility must respond within 30 days, or the MAC will deny the application and notify the facility.
 - 3) Once the initial application packet has been approved, the MAC sends a “BOX” link containing the initial recommendation of approval documents to both the facility and the department as the designated state agency (SA) at BAAUapplications@dshs.wa.gov.

3. Next steps once the initial recommendation of approval packet is received

- a. BAAU will:
 - 1) Download and review the MAC recommendation of approval documentation; and
 - 2) Contact the MAC with any questions; and
 - 3) Email the following to the assigned field manager (FM) within two business days of receipt:
 - a) The “Initial Recommendation of Approval” letter; and
 - b) CMS forms - [CMS-671](#) and [CMS-690](#).



Part III Pre-Occupancy Inspection Process

A. Preparation

1. Prior to the pre-occupancy inspection

a. The assigned FM will:

- 1) Review the “Initial Recommendation of Approval Letter” from the MAC.
- 2) Ensure receipt of second email notification from BAAU stating the licensing application is finalized.
- 3) Review the status of the facility’s Department of Health (DOH) CON at [Project Status | Washington State Department of Health](#) to confirm approval and the CON is in good standing.
 - a) If there are questions or concerns about the CON, please contact CON at fslcon@doh.wa.gov or 360-236-2955.
- 4) Review the CRS approval packet in Perceptive Content concentrating on the following four areas:
 - a) The “Project Comment Form/Transmittal Letter” received in the CRS approval packet to ensure there are no deficiencies identified.
 - b) The “I-2 Project Details” form, “Notes to Survey” section and “recommendations for survey” and note any items that must be addressed during the inspection.
 - c) Review the “Plan Review Comments and Issues” for follow up by survey staff during inspection.
 - d) Download floor plans and number of beds requested for certification to reference during inspection.
- 5) Once the above actions are completed, contact the NH Administrator, provide a copy of the [Nursing Home Pre-Occupancy Inspection Checklist – NH Administrator Use \(DSHS 16-284\)](#) and explain its use. The FM must inform the Administrator of their requirement to verify that items on the checklist are complete, and the facility is ready for inspection prior to scheduling the inspection.

Note: The timeframe between facility submission of initial licensing and certification applications and pre-occupancy inspection can be lengthy. [DSHS 16-284](#) is provided to facilities both at the time of initial application and prior to the pre-occupancy inspection.

- 6) Upon notification from the NH Administrator that all items on the checklist are complete and the facility is move-in ready, schedule the pre-occupancy inspection in coordination with the State Fire Marshal’s Office (SFMO).

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B. Inspection

Resources:

- [Instructions for locating the Facility “Application Number”](#)
- [Instructions for “Accessing Pre-Occupancy Inspection and Communication Documents Previously Uploaded to Perceptive Content](#)

Note: All other inspections are unannounced. This is the **only** instance in which the State Agency will notify a NH of an inspection.

 The duration of the inspection may vary depending on the facility's size and based on how prepared the NH is at the time of inspection.

1. Preparation

- a. The survey team will:
 - 1) Document the facility’s compliance with each regulatory standard using the [Nursing Home Pre-Occupancy Inspection Checklist – Surveyor Use checklist DSHS 16-287](#).
 - a) Use of the [Pre-Occupancy Worksheet: Resident Room/Bathroom - DSHS 16-288](#) is optional.
 - 2) Within two business days of completion of the site visit, forward a copy of the completed checklist(s) to RCSPC@dshs.wa.gov for upload to Perceptive Content.
 - a) The Subject line must include: “NH Preoccupancy”, the name of the facility, and the facility’s application number.

Example: NH Preoccupancy, ABC Nursing Home, Application number XXXX

2. Upon Completion of the Pre-Occupancy Visit

- a. The assigned FM will:
 - 1) Complete the RCS Nursing Home Pre-Occupancy Inspection Site Visit – Initial Findings – DSHS 16-285 and send it to the facility administrator within two business days.
 - 2) Email a copy of the completed [DSHS 16-285](#) to RCSPC@dshs.wa.gov for upload to Perceptive Content.
 - a) The Subject line must include: “NH Preoccupancy”, the name of the facility, and the facility’s application number.

3. When Deficiencies are Identified

- a. The facility administrator will:
 - 1) Notify the FM when all deficiencies have been corrected.

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4. Follow Up Visit

- a. The assigned FM will:
 - 1) Schedule the follow up visit.

5. Upon Completion of the Follow Up Visit

- a. The assigned FM will:
 - 1) Complete and forward the [RCS NH Pre-Occupancy Inspection – Follow Up Site Visit - DSHS 16-286](#) to the facility administrator.

Note: The survey team may be required to conduct subsequent inspections, until all licensing requirements are met.

- 2) Provide the state licensing date to BAAU once the facility has demonstrated substantial compliance with all pre-occupancy inspection standards.

C. Admission of a Few Residents Prior to Initial Certification Survey

1. Next Steps

- a. The assigned FM will notify the facility administrator that:
 - 1) A few residents must be admitted prior to the unannounced initial certification survey.
 - 2) Medicare/Medicaid reimbursement will not be available for services provided to these residents prior to the certification effective date; and
 - 3) Reimbursement for services provided to residents admitted prior to certification effective date is either private pay or services provided pro bono.


Note: The facility will NOT receive reimbursement from Medicare/Medicaid until the certification effective date. Payment **cannot** be backdated for services provided prior to that date. Residents admitted to the facility prior to that date must be private pay or services provided pro bono.



D. State Licensing

1. Next Steps

- a. The assigned FM will:
 - 1) Notify the Business Operations and Analysis Unit (BOAU) with the effective date of licensing and the number of approved beds and forwards the application in STARS.
- b. BOAU will:
 - 1) Notify BAAU when state license is approved.
 - 2) Enter the NH into iQIES and notify the assigned FM that the facility is now in iQIES.
[Residential Care Services Offices | DSHS](#).
- c. BAAU will:
 - 1) Send a third email to the NH Notification Group, along with the RA and FM
 - 2) Send the state license to the NH
 - 3) Email the assigned FM stating the facility is licensed

 The initial certification survey **cannot** occur until the new NH has been successfully uploaded into iQIES by BOAU.



Part IV. Initial Certification Survey

A. Preparation

Note: All initial surveys must verify substantial compliance with the regulatory requirements contained in [42 CFR 483.5 through 42 CFR 483.75](#).

*If distinct part status is at issue, determine whether the facility meets the criteria for certification as a distinct part.

1. Scheduling and Initial Certification Survey

- a. The FM will:
 - 1) Schedule the unannounced Initial Certification Survey (this can only be done after BOAU enters the NH into iQIES).
- b. The survey team will:
 - 1) Download the most current Initial Survey ZIP folder from the CMS website.
 - 2) Follow survey and enforcement guidance within [SOM Chapter 7 – Survey & Enforcement Process for SNFs and NFs](#); and [SOM Appendix PP – Guidance to Surveyors for Long-term Care \(LTC\) Facilities](#).
 - 3) Complete certification kits – All required SA accessible fields in iQIES must be completed accurately and any errors that would prevent upload resolved.
 - a) The States do not have access to all required fields. Some of the required fields are to be completed by CMS Provider Enrollment and Oversight Group (PEOG) only.
 - b) When “upload” is selected, check for errors, address the errors as needed, and re-select “upload” until successful upload occurs.
 - c) If issues arise, please reach out to the CMS location.

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B. SA Recommendation of Approval Packet

Recourses:

- [Find and Contact Your MAC](#),
- [Medicare Program Integrity Manual](#)

1. Processing the SA Recommendation of Approval Packet

- Within two (2) days of determining that a facility is in substantial compliance with all CMS conditions of participation, the assigned FM will:
 - Ensure the SA Recommendation of Approval Packet includes all of the following:
 - Email with SA enrollment/certification recommendation,
 - [CMS 1539 \(Revised 6-2021\)](#),
 - [CMS-1539 User Guide for SA \(Revised April 2022\)](#),
 - [CMS-670](#),
 - Instructions at [24-08-CLIA](#); and
 - [CMS-671](#),
 - Proof of electronic submission of [HHS-690](#) to OCR,
 - [CMS – 1561](#)
 - Review all required forms for completeness and accuracy; and
 - When reviewing [CMS-1539](#), ensure:
 - The facility name and address are accurate (Box 3),
 - Box 14 contains the facility’s LTC certified bed breakdown,
 - Box 16, “State Survey Agency Remarks” includes the proposed effective date (In compliance with [42 CFR 489.13](#) for Medicare and [42 CFR 431.108](#) for Medicaid) and any additional required information.
 - Complete form [FM Cover Sheet – SA Recommendation of Approval \(DSHS 10-712\)](#); and
 - Forward the completed [FM Cover Sheet \(DSHS 10-712\)](#) and all required forms, by email to BAAUapplications@dshs.wa.gov

2. Approval not Recommended

- BAAU will:
 - Ensure all required documents are included in the SA Recommendation of Approval Packet.
 - Forward an email to the assigned MAC ([Find and Contact Your MAC](#)) containing statement, “The SA does not recommend initial certification, effective (Date)”

3. Approval is Recommended

- BAAU will:
 - Forward an email to the assigned MAC containing the statement, “The SA recommends initial certification, effective (Date)” and include all required and approved forms.

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C. Enrollment/Certification

Recourses:

- [Medicare Program Integrity Manual](#),
- [Admin Info: 22-02-ALL](#) (Revised 5/19/22)
- [MLN9658742 – Medicare Provider Enrollment](#)

1. MAC Next Steps

- a. The MAC will:
 - 1) Respond to any state inquiry within five business days.
 - 2) If the inquiry involves the need for the MAC to obtain additional data, documentation, or clarification from the NH, the timeframe is 15 business days.
 - 3) If the provider fails to respond to the contractor within this timeframe, the MAC will notify the SA.
 - 4) Order the CMS site visit no later than 5 working days after receipt of the recommendation from the SA.
 - a) [CMS Site visit verification process](#)-Medicare Payment Integrity Manual.
 - If the facility fails the site visit, the MAC will complete denial procedures.
 - If the facility passes the site visit, the MAC will send an email to PEOG at MedicareProviderEnrollment@cms.hhs.gov within three business days with the following attachments:
 - [CMS-855](#) application and all attachments; and
 - [CMS-1539](#) or similar documentation received from the SA; and
 - [CMS-1561](#), signed by provider; and
 - A copy of the draft approval letter, with effective date shown on form [CMS-1539](#) included. ([PIM 10.7.5.1](#) for example letter)

Note: The facility may enroll, make changes, or view existing enrollment information by logging into PECOS at <https://pecos.cms.hhs.gov>

2. PEOG Next Steps

- a. PEOG will:
 - 1) Countersign the provider agreement.
 - 2) Assign an “effective date” (In compliance with [42 CFR 489.13](#) for Medicare and [42 CFR 431.108](#) for Medicaid).
 - 3) Assign a CMS Certification Number (CCN).
 - 4) Enter the applicable data into iQIES.
 - 5) Update the approval letter with any needed edits and finalize.
 - 6) Forward materials to the assigned MAC.

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3. MAC Next Steps

- a. Within 5 business days of receiving the signed provider agreement from PEOG, the MAC will:
 - 1) Send the approval letter and a copy of the CMS-countersigned provider agreement to the facility.
 - 2) Send a copy of both the approval letter and the provider agreement to the BAAU at BAAUapplications@dshs.wa.gov.
 - 3) Switch the PECOS record from “approval recommended” to “approved” consistent with existing instructions.

4. BAAU Next Steps

- a. BAAU will:
 - 1) Forwards a copy of the final approval letter to the assigned FM
 - 2) Send an email containing the certification effective date and the number of beds certified to the following:
 - a) The NH Notification Group
 - b) The assigned FM and RA

5. BOAU Next Steps

- a. BOAU will enter the following information into STARS:
 - 1) The effective date of certification; and
 - 2) The facility’s Medicare ID #; and
 - 3) The facility’s bed count; and
 - 4) The facility’s state vendor ID #; and
 - 5) Changes 49xxxxx (licensed only) to a 41xxxxx (Title 18/19).

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D. State Contracting Process

Resources:

- [Medicaid certification](#); and
- [How Do I Apply for a Medicaid Contract | DSHS \(wa.gov\)](#).

1. How to Apply for a NH Medicaid Contract:

- a. Once the facility license has been issued and Medicaid certification is approved, BAAU will forward a Contract request to the Nursing Facility Services Contract Manager.
- b. The Contract Manager will send a request to the Contractor to prepare and return the following required forms:
 - 1) [Contractor Intake Form](#)
 - 2) [Medicaid Provider Disclosure Statement](#)
 - 3) [W9](#)

Note: The above forms should not be submitted until they are requested by the Contracts Manager.

- c. Once the Contract Manager receives the forms, they will:
 - 1) Enter the information into the Contracts Database.
 - 2) Complete a federal validation for all staff with management, ownership, or controlling interest; and,
 - 3) Upon completion of the federal validation, prepare a facility contract and forward to the contractor for signature.
- d. Once the contract is signed by both parties, the facility is considered approved to accept Medicaid clients.

E. Opt-out” of Medicare:

1. Steps to Opt-out of Medicare

Note: “Opt-out” is a CMS process and is a contract between a provider, beneficiary and Medicare where the provider or beneficiary does not file a claim to Medicare. The physician or practitioner bills the beneficiary directly and is not required to follow the fee-for-service charges determined by Medicare.

- a. The provider must:
 - 1) Submit an [Opt-out Affidavit](#) with Medicare and must keep a [Private Contract](#) with all beneficiaries on file for each two-year period.
 - 2) Make changes within 30 days. After that, the provider may not seek Medicare/Medicaid reimbursement for services provided to any patient, regardless of setting, for two years.



Part V: Recertification Survey

A. Preadmission Screening and Resident Review

This SOP provides instructions to nursing home surveyors regarding investigation of the Preadmission Screening and Resident Review (PASRR) process during the recertification survey.

Note: When PASRR began it was required annually, making it Preadmission Screening and Annual Resident Review or PASARR. However, the annual requirement was discontinued in 1996 and is now known as Preadmission Screening and Resident Review or PASRR.

During the recertification survey, the LTCSP directs the TC to request a matrix from the facility that identifies any resident(s) who have a serious mental illness (SMI) (also referred to as mental disorder [MD]), intellectual disability [ID], or a related condition or both but do not have a PASRR Level II evaluation and determination.

Federal ([42 CFR §483.100-138](#)) and state regulations (WAC [388-97-1910](#) through [388-97-2000](#) and Section [388-834](#)) require Medicaid certified facilities/NF to ensure that individuals with a SMI, ID, or related condition or both are appropriately placed in NFs for long term care. A PASRR Level I evaluation must be completed before admission to the NF and are typically completed by the entity referring the resident for NF admission. If a resident is found to potentially have SMI, ID, or related condition then a Level II evaluation is completed by a PASRR Evaluator.

1. PASRR Investigation Process

a. The Surveyor will:

- 1) Review the list of [PASRR Exempt facilities](#) to determine if the facility requires a PASRR review. The Policy Unit will update this list every January.

Note: Some SNFs are not Medicaid certified and are therefore exempt from the PASRR review.

- 2) According to the [LTCSP procedure guide](#): If a resident has an appropriate diagnosis but is not receiving PASRR Level II services review the record to confirm the information.
- 3) If concerns are found in the PASRR process, follow the CMS-20090 PASRR Critical Element Pathway (CEP) found in the [Survey Resources zip file on CMS website](#).
 - a) In addition to the pathway:
 - The full Level II evaluation does not need to be received prior to admission. However, the determination made by the evaluator needs to be completed and received by the facility, verbally or in writing. If verbal confirmation is received, the facility is required to follow up and ensure the final Level II evaluation is received in writing, placed in the medical record after admission, and that level II recommendations are incorporated into the care plan.

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- When reviewing a Level I form for timeliness, do not consider a Level I form that was not completed timely as failed practice if it was completed prior to the last recertification survey. Complete the rest of the PASRR review for that resident.
- A full Level II evaluation could be completed in a hospital prior to admission if applicable.
- For any resident with a significant change or a newly suspected SMI, ID, or related condition determine if a new Level I form was completed by the NF.
- Regardless, if concerns arise or if no issues are found with the PASRR process, document the PASRR process was reviewed in the unnecessary medication care area in LTCSP.



It is recommended to document in **bold** letters at the top of the unnecessary medication care area that the PASRR review is complete.

- b) Document findings in the Investigation Notes or the Resident Notes in the LTCSP.
 - c) At the survey team’s discretion, expand the sample if failed practice is found related to the PASRR process.
- b. The TC will:
- 1) Verify **all five** PASRR reviews were completed and documented in LTCSP by all surveyors on the survey team. At the conclusion of the recertification survey, alert the FM if failed practice was found.
- c. The FM will:
- 1) Review any PASRR citations to ensure the citation is complete and follows the [POD](#).

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B. Nursing Assistant Training Program Onsite Inspection

According to [42 CFR §483.151\(3\)](#), the State survey agency must, in the course of all surveys, determine whether the nurse aide training and competency evaluation requirements of [§483.35\(c\)](#) and (d) and [483.95\(g\)](#) are met. Surveyors review the information specific to the facility's nursing assistant (NA) training program and provide the findings to the [Nursing Assistant Training and Competency Evaluation Program \(NATCEP\) Manager](#) for action.

1. Off-Site Preparation

- a. The TC will:
 - 1) Ensure the survey team has an electronic or printed copy of [Omnibus Budget Reconciliation Act \(OBRA\) Nursing Assistant Training Onsite Inspection Form for Survey - DSHS 16-168](#) available for use during survey.
 - 2) Check the [Washington State Board of Nursing](#) website to determine if the facility identified for inspection or survey has an approved NA training program.

2. During the Survey

- a. The TC will:
 - 1) Obtain the following information during the entrance conference:
 - a) Determine if there is a facility based approved NA training program.
 - b) Determine if there are any current students doing clinical rotations from any other (non-facility based) NA training program.
 - If non-facility-based NA training is occurring, check the [Sanctioned Facilities](#) list (HCLA intranet) to determine if the facility has sanctions that prohibit facility-based training. If the facility has sanctions, note that in Section 5 of the NATCEP form.
 - A facility with sanctions that prevent them from conducting facility-based training may host non-facility-based NA training under certain circumstances. RCS may authorize this on a case-by-case basis. Contact the [NATCEP/OBRA Registry Unit General Contact](#) to confirm.
 - c) If the facility has an active facility-based program, request the following documents during the entrance conference:
 - Applications for current NA Training Program Director and primary instructors teaching in the NA Training Program.
 - A copy of the most recently approved NA training curriculum. The curriculum is approved by the DOH for a two-year period.
 - Five NA training records from the facility's current training program or from students who have graduated from the program within the past 12 months.
 - A copy of an issued "Certificate of Completion" for the training program, which contains the approved number of hours.
 - d) If the facility has an active program, assign the task to a survey team member. Provide the surveyor with the partially filled out NATCEP form, and the information and documents gathered during the entrance conference.

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- b. The assigned surveyor will:
 - 1) Review the NA training program materials, documenting the review on the NATCEP form.
 - 2) Conduct interview(s) with the program director, the instructor and/or students to resolve any concerns not addressed through record review of the student files.
 - 3) After the survey:
 - a) Email the completed NATCEP form to the [NATCEP manager](#) for filing or further action. Send the form after every survey, whether there is an active program, an inactive program, or no program.
 - b) Include a copy of the completed form with survey working papers.
- c. The FM will:
 - 1) Verify a NATCEP form is completed and sent to NATCEP for each re-certification survey.



C. State Tasks

RCS conducts a periodic survey of each NH to ensure compliance with both state and federal regulations. RCS uses the federal LTCSP to ensure compliance with the minimum standards of federal requirements.

Because most state requirements mirror the federal requirements, RCS conducts the state licensing visit concurrently with the federal survey. Where there are comparable state and federal requirements, the state regulation is reviewed when the equivalent federal requirement is reviewed during the LTCSP, and the more stringent regulation is cited. For those areas where the Washington regulation has a higher standard, or where no comparable federal regulation exists, surveyors review those areas for compliance separately from, but concurrent with the LTCSP. “State Tasks” are the state requirements reviewed in addition to the LTCSP.

All NFs require a review of all state requirements, including State Tasks, except in certain limited circumstances.

! The following facilities will **not** require a review of “state tasks” as these facilities do not have a Medicaid contract that requires adherence to the licensing rules:

- Lakeland Village
- Fircrest School
- Yakima Valley School

Hospitals with free standing SNF/NFs or those with a SNF/NF as a distinct part of the facility require a review of “state tasks” in compliance with [Chapter 388-97 WAC](#).

! The following facilities **require** state tasks:

- Columbia Basin Hospital
- Forks Community Hospital LTC Unit
- North Valley Hospital
- Everett Transitional Care Services

Note: Hospitals with swing beds only are not reviewed by RCS as they are licensed and certified through DOH.

This procedure:

- Identifies which WACs require review as a State Task.
- Provides surveyors with guidance on evaluating compliance of each State Task.

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1. State Task Review

- a. The TC will:
 - 1) Off-site preparation
 - a) Determine if the facility has any current waivers in place (e.g., wireless call light system, retaining wall, resident room size, RN staffing etc.).
 - b) Print a copy of:
 - [Attachment C: State Entrance Conference Letter](#) to provide to the facility during the entrance conference.
 - [Attachment D: State Task Checklist \(DSHS 10-625\)](#) for the survey team members to document completion of review(s) during the survey.
 - [Attachment E: Staffing Pattern \(DSHS 10-626\)](#) to provide to the facility.
 - c) Ensure either printed or electronic copies of the following forms are available to the survey team during the survey:
 - [Attachment F: Liability Insurance Review \(DSHS 10-627\)](#)
 - [Attachment G: Trust Fund Review \(DSHS 10-628\)](#)
 - [Attachment H: Pet Record Review \(DSHS 10-629\)](#)
 - [Attachment J: Paid Feeding Assistant Program Review \(DSHS 10-630\)](#)
 - [Attachment L: Staff Qualification and Background Review \(DSHS 10-631\)](#)
 - [Attachment M: TB Testing Review for Staff \(DSHS 10-632\)](#)
 - [Attachment N: TB Testing Review for Residents \(DSHS 10-633\)](#)
 - [Attachment O: Medication Assistant Endorsement \(DSHS 10-634\)](#)
 - [OBRA NA Training Onsite Inspection for Survey \(NATCEP\) \(DSHS 16-168\)](#)
 - [NH Survey in Progress Poster](#)
 - [Nursing Home State Survey Report \(DSHS 10-207\)](#)
 - 2) During the Survey
 - a) Provide a copy of [Attachment C](#) to the Administrator during the survey entrance conference and review the required information in the letter with the Administrator.
 - b) Provide the Administrator with [Attachment E](#) at the entrance conference. Inform them a surveyor will request documentation to verify the data on the form.
 - c) Ensure the facility provides all required information listed in the State Entrance Conference Letter.
 - d) Assign team members to complete state tasks. Review any waivers with the survey team.
 - e) Ensure completion of all state tasks by the end of the survey.
 - 1) After the Survey
 - a) Consult with the FM regarding any findings or possible failed practice revealed through the State Task review.
 - b) Gather all documentation for state tasks and include in survey working papers.
- b. The FM will:
 - 1) Ensure surveyors review all state tasks during the recertification survey.

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2. Incident Reporting Log


- a. Federal guidelines do not have a specific requirement to keep a log of reported incidents. State regulation ([WAC 388-97-0640](#)) and department [Nursing Home Guidelines](#) (aka, The Purple Book) have specific requirements for facilities to keep an incident reporting log including what types of incidents should be logged, what information the log should contain, and how long the logs should be kept.
- b. Review the facility incident-reporting log(s) for at least the prior six months. Ensure the nursing home is logging incidents, investigating incidents, and reporting to the appropriate state agencies when required. The survey team may expand the lookback to the date of the last survey if concerns are identified.

3. Staffing Patterns for the 30 Days Prior to Survey

- a. State regulations ([WAC 388-97-1080](#)) require more Registered Nurse (RN) hours than the federal regulation ([F727](#)). The state may grant exception. Unlike the federal regulation, the state may not waive the requirement for a full time DON. Please reference [WAC 388-97-1080](#) for state requirements.
- b. Review the completed [Attachment E](#) to ensure required RN staffing.

Note: Surveyors may use information provided on the form as part of the Sufficient Staffing pathway review in the LTCSP.

- 1) Confirm the documented information through observations, and interviews with residents, nursing staff, and/or administrative staff.
- 2) Correlate information on the form with actual nursing schedules.
- 3) If potential issues are identified during documentation review, request and review records, such as timecards or payroll documents to validate the staffing data documented on [Attachment E](#). Verify staffing hours for RNs, Licensed Practical Nurse (LPN), and NAs, Certified or Registered (NA-C/NA-Rs).
- 4) Review any state waivers that permit the facility to have reduced RN hours.

 Waivers related to RN hours are in STARS under the exemptions tab.

4. Medical Test Site Waiver

- a. According to federal regulations ([F770](#)), if a facility provides its own laboratory services or performs any laboratory tests directly (e.g., blood glucose monitoring, etc.), the provisions of [42 CFR Part §493](#) apply and the facility must have a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility. State law ([RCW 70.42.030](#)) provides for a Medical Test Site waiver from the CLIA requirement for facilities that perform only certain low risk testing.
- b. Review the Medical Test Site waiver (or the CLIA certificate, if applicable) and ensure the facility has a valid waiver/certificate that is current.

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5. Liability Insurance

- a. State rules ([WAC 388-97-4166](#), [388-97-4167](#), and [388-97-4168](#)) require the nursing home to maintain liability insurance.

Note: Federal regulations in [Appendix PP](#) of the State Operating Manual have no specific requirement for liability insurance.

- b. Use [Attachment F](#) to document. Verify the facility has liability insurance that covers the items named in the three liability related WACs. Also, verify the amount of the coverage meets or exceeds the requirements in the WACs. If there are concerns with the terms of the liability insurance, interview the Administrator.

6. Trust Fund

- a. Federal regulations ([F567](#), [F568](#), [F569](#) and [F570](#)) and state regulations ([WAC 388-97-0340](#)) have the same requirements for trust funds with a couple exceptions. For the purpose of this State Task use [Attachment G](#).

7. NATCEP Program Review

- a. This review collects information about the NA Training program to ensure compliance with state requirements. The NATCEP Manager evaluates and, if needed, acts on the collected information.
- b. In the entrance conference, the TC will determine if the facility has an active NA Training Program. If the facility has an active program, the TC will request the following records:
 - 1) Applications for current NA Training Program Director, and primary instructors teaching in the NA training program.
 - 2) A copy of the most recently approved NA training curriculum in use by the training program, including the letter approving the program.
 - 3) Training records of five NAs from the facility training program, either past or current students (not necessarily currently employed with the facility).
 - 4) A copy of an issued “Certificate of Completion” for the training program, which contains the approved number of classroom hours.
 - a) The assigned surveyor will review the materials and complete the [OBRA NA Training Onsite Inspection Form for Survey \(NATCEP\) \(DSHS form 16-168\)](#).

8. Paid Feeding Assistant Program

- a. In the entrance conference, the TC will determine if the facility uses paid feeding assistants. If so, the TC will request the following records:
 - 1) A list of names of staff, including agency staff, who have successfully completed training for paid feeding assistants and who are currently assisting selected residents with eating meals and/or snacks.
 - 2) A copy of the paid feeding assistant training curriculum.
 - 3) Use [Attachment J](#) to complete the paid feeding assistant program review.

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9. Call Bell Visible and Audible

- a. State regulation ([WAC 388-97-2280](#)) require a communication system that registers a call by distinctive light at the room door and by distinctive light and audible tone at the staff workstation. The system must be equipped to receive resident calls from bedsides, common areas, toilet, rooms, and bathing areas. Surveyors investigate to make sure there are no changes to the call light system, that it is working effectively, and meets the residents' needs. Some facilities are using wireless systems that send alerts to phones/tablets etc. Verify if waivers are in place when applicable.

Note: This exceeds the federal requirements (F919) that require calls to be relayed to a staff member or a centralized nursing station, and the transmission may be audible, visual or through an electronic device. Both state and federal rules require the facility try to accommodate special needs of residents so they can use a call device.

10. Dementia Unit Egress Signage

- a. State regulation ([WAC 388-97-2920](#)) requires the facility to have directions for releasing the egress control device at each egress-controlled door and gate.
- b. If the facility has a secured dementia unit, observe for the presence of instructions at each entrance and exit of the unit, and for visitors' ability to enter and exit the unit.
- c. Interview visitors and maintenance personnel if signage is not available or directions are not clear.

11. Fresh Fruits and Vegetables

- a. State regulations ([WAC 388-97-1120](#)) require that fresh fruits and vegetables, in season, are available to residents on a daily basis.
- b. Conduct observations of meals and snacks.
- c. Interview residents or resident representatives about availability of fresh produce.
- d. Review menus.
- e. Consult with the surveyor assigned to the kitchen to gather information about the quality and quantity of fresh produce.

12. Staff Qualification and Background

- a. In addition to the [WAC 388-97-1800](#), [388-97-1820](#), and [388-97-1790](#) see [F606](#) and [F607](#) for federal requirements about screening employees for a history of abuse, neglect, exploitation, or misappropriation of resident property.
- b. Using [Attachment L](#), review the personnel information for each of the sampled staff. Increase the scope of the investigation based on failed practice or concerns observed during the survey.

Note: Do not take any confidential information outside of the facility.

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13. Tuberculosis Review for Residents and Staff

- a. For both staff and residents, the state requirements ([WAC 388-97-1380](#) through [388-97-1580](#)) are specific to the type of TB screening tests, and to the timing and frequency of screening. They also address the required response to a positive test result, and when testing is or is not indicated.
- b. The resident sample will include a minimum of five residents admitted since the last survey. If less than five residents were admitted since the last survey, choose residents admitted prior to last survey and document the reason.
 - 1) Complete [Attachment N](#).

Note: See – Centers for Disease Control and Prevention ([CDC Tuberculin Skin Testing Fact Sheet](#)) for information related to induration.

- c. The staff sample will include a minimum of four staff hired since the last survey and one staff person employed for two years or more by the facility.
 - 1) Complete [Attachment M](#).
- d. For both residents and staff: Interview Infection Control staff to verify a system for adequate TB screening is in place, and to ensure appropriate monitoring and follow up is completed when results indicate.
 - 1) If there are concerns with the TB surveillance program, possible follow up investigation may include:
 - a) Review of facility assessment requirements (F838).
 - b) Review of physical plant requirements.
 - c) Interviews with caregiving staff to determine implementation of infection prevention processes.
 - d) Interview with the Medical Director; and/or
 - e) Interview with personnel from the county or local health district.

14. Pet Records

- a. The state regulation ([WAC 388-97-0980](#)) addresses resident's right to have access to pets and monitoring pet health.
- b. Complete [Attachment H](#).
 - 1) Investigations may include review of the incident log, the grievance log and/or the resident council minutes to review for concerns with pets.

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15. NAC Medication Assistant Program

- a. State [WACs 246-841-586](#) through [246-841-595](#) provides the criteria and mechanism to enable a NA-C to obtain a medication assistant endorsement. This endorsement permits the NA-C to administer certain medications and perform certain treatments under the supervision of a registered nurse (RN). Federal regulation [F755](#) allows unlicensed personnel to administer medication if state law permits, but only under the supervision of a licensed nurse.
- b. The TC will determine at the entrance conference if the facility uses NA-Cs with a medication assistant endorsement to administer medications or perform treatments. If the facility uses medication assistants, the TC will obtain the names of all staff used in that capacity.
- c. For sampled staff, conduct observations of medication administration (may be done as part of the LTCSP medication administration observations) and/or treatment administration and document on [Attachment O](#).



D. Communication Process

Regular communication between facility staff, team members, the FM, and other office staff is crucial to a thorough and effective survey or complaint investigation process.

RCS has established formal expectations for nursing home survey teams regarding communication with licensee/administrator and facility staff during the recertification survey process.

General Communication Principles

- The survey team will follow communication prompts/guidelines within the [LTCS Procedure Guide](#).
- The survey team will not release information related to potential noncompliance until the information gathering is complete and the survey team has determined that a deficiency may be issued. This does not preclude interviewing facility staff for an investigation.
- Communication will not include advice, personal opinions, comments, or directions aimed at the nursing home.
- Prior to beginning a survey, RCS staff will assure that surveys are unannounced by keeping confidential the date, time, and location of surveys, and limiting their communication about survey schedules to those who are required to know.

1. Off-Site Preparation

- a. The TC will:
 - 1) Ensure the SFMO is contacted following their unit specific process to confirm entrance date and time.
 - 2) Ombuds notification:
 - a) Each Region conducts quarterly meetings with ombuds office to gather specific information on facilities in the area, so staff can be aware of resident rights and care issues before going out on a licensing inspection or survey.
 - b) Each Region keeps notes from the quarterly RCS / Ombuds meetings in the Regional Shared Drive or designated place accessible to regulatory staff.
 - c) Regulatory staff review the notes from the RCS/Ombuds regional quarterly meetings during visit preparation prior to going on site for licensing or recertification inspections or surveys.
 - d) Field staff review with the Field Manager any concerns brought up about the home in the quarterly Ombuds meeting before going on site as needed.
 - 3) Share data with survey team members according to the [LTCS Procedures Guide](#).

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2. Upon entrance to the facility:

- a. The TC will:
 - 1) Make introductions and provide appropriate identification (i.e., name tag/badge and business card).
 - 2) Request the information needed immediately according to the Entrance Conference Worksheet within the LTCSP tool.
 - 3) Request a room or access to a power outlet, a place to sit and work, and a means to secure belongings and/or RCS equipment.
 - 4) Contact the AA to notify the ombudsman of the entrance.
 - a) AA staff emails the ombuds that the licensor/surveyor has entered the building.
 - b) The Ombuds office may send an aggregate list of complaints going back one year for the licensor or team awareness.
 - If sent, regulatory staff review the list of Ombuds complaints for themes or concerns to follow up during the inspection.
 - c) Follow the instructions in the [LTCSP Procedure Guide](#).

3. During the survey:

- a. The TC will:
 - 1) Maintain ongoing dialogue throughout the survey, so the administrator is aware of the basic concerns/issues and can provide additional clarification or documentation on identified issues prior to the exit. For example, if the team has completed a task such as medication pass, the administrator should be given a verbal summary of activities completed and general areas of concerns (if any).
 - 2) Provide the licensee/administrator the opportunity to ask questions and/or communicate any information regarding the facility such as recent changes or events that have occurred.
 - 3) Discuss the importance of completing [DSHS form 10-207](#) including completion of the X-5 date when submitting with the plan of correction (POC). Failure to do so could delay the back in compliance (BIC) date of the POC.
 - 4) Consult with the FM regarding any serious issues encountered during the survey process, such as any situation that threatens the health or safety of team members, any situation that significantly affects the expected course of the survey process, or any particularly challenging or stressful communication that occurs.

4. Off-site after the exit conference:

- a. The TC will:
 - 1) Review the findings of the survey team with the FM.
 - 2) If any of the preliminary deficient findings communicated to facility staff during the exit conference change, contact the facility administrator. Explain the changes to the administrator prior to issuing the Statement of Deficiencies.



E. Exit Conference

1. Steps to prepare for and facilitate the exit conference

- a. The TC will:
 - 1) Conduct an exit conference as outlined in the LTCSP Procedure Guide and Chapter 2 of the SOM. In addition:
 - a) Notify the regional ombudsman 24 hours in advance of the start of the exit conference, if possible.
 - b) Avoid using jargon or acronyms, and instead provide general information of what was found.
 - c) Ensure the facility administrator has contact information for the TC and the FM.
 - d) TCs may use [Attachment A](#) to organize the meeting presentation.
- b. The Survey Team will:
 - 1) At the request of the TC:
 - a) Assist with organizing the exit conference presentation.
 - b) Attend the exit conference.
 - c) Present portions of the exit conference as assigned.



F. Off-Hour Surveys

This procedure provides guidelines for conducting required off-hour surveys according to state licensing and federal certification requirements.

Effective June 11, 2020, Engrossed Second Substitute Senate Bill 6515 amended [RCW 18.51.230](#) to revise the state off-hour survey standard. The state standard now aligns with the federal off-hour standard.

Off-hour survey standards for nursing homes:

1. State law, [RCW 18.51.230](#): “The department shall, in addition to any inspections conducted pursuant to complaints filed pursuant to [RCW 18.51.190](#), conduct a periodic general inspection of each nursing home in the state without providing advance notice of such inspection. Such inspections must conform to the federal standards for surveys under [42 C.F.R. Part 488, Subpart E.](#)”
2. Federal regulations [42 CFR §488.307](#) requires all surveys are unannounced, and the State Operations Manual (SOM), [Chapter 7](#), Section 7207, requires that at least 10% of all recertification surveys must be conducted as off-hour surveys and the off-hour surveys must occur on consecutive days.
 - a. CMS released additional guidance for federal off-hour surveys in Quality, Safety & Oversight (QSO) memo [19-02-NH](#). The memo states, “States shall [now be required to] conduct at least fifty percent of the required off-hours surveys on weekends using the list of facilities provided by CMS.”
 - 1) RCS periodically receives a Skilled Facility Candidate list from CMS which identifies facilities that have weekend staffing concerns.
 - 2) FMs pull facilities in their areas from this list and consider which ones to include in weekend/off hour surveys.
3. Off-Hour Survey Requirements:
 - a. The survey must begin on the weekend, a holiday, or the evening/early morning hours before 8:00 AM or after 6:00 PM.
 - 1) A holiday is defined as those days the state recognizes as a state or federal holiday.
 - 2) An off-hour survey initiated on a holiday, or a weekday may not be counted as a required survey for facilities with weekend staffing concerns.
 - b. Once started, the survey must be conducted on consecutive calendar days, including Saturdays, Sundays, and holidays.
 - c. Abbreviated surveys (complaint investigations) conducted during off-hour times are not included in calculating off-hour requirements.

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1. Conducting an evening, early morning, or weekend survey

- a. The Surveyors will:
 - 1) Begin the survey in an off-hour timeframe. Evening surveys must commence after 6 PM; early morning surveys must begin before 8 AM; weekend or holiday surveys must start any time during weekends/holidays. Once started, the survey team will continue the survey on consecutive days until the survey is completed.
 - 2) At least half of the off-hour surveys will be conducted at facilities CMS has identified with weekend staffing concerns. These surveys will begin at any hour on a weekend day and continue for at least six hours during the first day of survey.
 - 3) For off-hour surveys done at facilities that may not be on the weekend staffing concern list:
 - a) If the survey starts during early morning hours (before 8 AM) on a weekday, at least two hours of the survey must occur prior to 8 AM.
 - b) If the survey starts during evening hours (after 6 PM) on a weekday, at least two hours of the survey must occur after 6 PM.
 - c) If the survey is started on a weekend/holiday, the surveys will begin at any hour and continue for at least six hours.

Note: The entire survey team assigned a resident sample must be present during the entire first day of the off-hours survey. The FM may approve a reduction in team size. To count as an off-hour survey, a health survey team of typical size and composition must enter the facility together.

- b. The TC will:
 - 1) Preparing the CMS-2567 Statement of Deficiencies and/or the State of Washington 2567 licensing form, ensuring the initial comments reflect an off-hour survey was conducted. Document the dates(s) of the off-hour data collection. A sample of the first paragraph of the initial comments of an off-hour survey:

Example: “This report is the result of an unannounced Off-Hour Long Term Care Survey [and Complaint Investigation (if appropriate)] conducted at [insert Facility Name] on [insert dates of survey]. The off-hour survey included data collection on [insert dates]. A sample of [insert #] residents was selected from a census of [insert #]. The sample included [insert #] current residents and the records of [insert #] discharged residents.”

- c. The FM will:
 - 1) Ensure that at least 10% of all surveys are conducted as off-hour surveys for the region to satisfy requirements.
 - 2) Ensure at least half of the off-hour surveys are conducted at facilities identified by CMS with weekend staffing concerns ([facilities on the Special Focus Facility \(SFF\) list](#)).
 - a) Off-hour surveys for weekend staffing concerns should be scheduled in an unpredictable manner including varying the start day between Saturday and Sunday and varying the start time of the survey.

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- 3) Ensure that off-hour surveys are unpredictable so that providers are less able to anticipate when a survey will occur. CMS directs that some surveys occur in each targeted timeframe (early morning, evening, and holiday/weekend). Since half of the off-hour surveys (those with staffing concerns) will begin on the weekend, consider beginning the remaining off-hour surveys in early morning or evening hours.
- 4) Be accessible for consultation when the survey team is surveying a facility in off hours.
- 5) Maintain a current list showing which nursing homes are scheduled for an off-hour survey and update the list with changes in schedule. Review current and past off-hour survey lists to ensure that off-hour surveys are distributed among all facilities, unless a facility is identified with concerns that warrant more frequent review (i.e., a facility with significant health and safety concerns occurring in off-hour times).
- 6) Determine and approve the survey team composition for the off-hour survey.
- 7) Update the survey characteristics in the iQIES database if a non-scheduled off-hour survey occurs, or if a scheduled off-hour survey changes to a non-off-hour survey.
- 8) While the state and federal requirements for off-hour surveys represent an annual operational standard that must be met by the department, this requirement should not preclude the FM from adjusting the schedule if there is a reasonable basis to do so.

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HCLA Residential Care Services, Standard Operating Procedures Manual



Part VI: Recertification Survey for State Only Licensed Facilities – Under Construction

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HCLA Residential Care Services, Standard Operating Procedures Manual



Part VII: Post Survey – Under Construction



Part VIII: Special Focus Facilities

Sections [1819\(f\)\(8\)](#) and [1919\(f\)\(10\)](#) of the Social Security Act require CMS to conduct a SFF program which focuses on NHs that have a persistent record of non-compliance leading to poor quality of care. The SFF program is intended to help facilities improve their compliance and quality of care.

CMS revises the [SFF postings](#) monthly. The list includes all current SFFs, graduations, terminations, and program candidates. The information also includes details such as how long the facility spent in the SFF program and most recent standard health survey findings.

Authority

[QSO-23-01-NH](#)

[White House Fact Sheet](#)

A. Candidate List

1. Process for obtaining the candidate list

a. CMS will:

- 1) On a monthly basis, issue a list of NHs identified as SFF candidates to the RCS Director. Candidates are selected for inclusion on the list based on their last three standard health survey cycles and the last three years in complaint survey performance. Each facility is given a numerical score based on the [Health Inspection Rating Methodology](#). Those facilities with the lowest numerical scores in the state are included in the list of candidates.
- 2) Informs the SFF candidates of their inclusion in the monthly preview of the [Five-Star Quality Rating](#) update.

2. Upon receipt of the Candidate List

a. Administrative Assistant 5 (AA5) for the RCS Director will:

- 1) Send the information to the:
 - a) Regional Administrators (RAs)
 - b) Compliance and Enforcement Unit Manager
 - c) Office Chief of Headquarters Operations.



B. Initial Selection

! SFFs are selected from the Candidates List provided monthly by CMS (see '[Candidate List](#)' for more information). When a SFF slot becomes available, RCS must select a new facility from the candidate list **within 21 calendar days (including the notification to the facility)** from the date the slot opens based on the SA notice date to the facility that is no longer in the SFF program. A slot opens once the current SFF either graduates from the program or is terminated. When the former SFF is notified of termination/graduation, RCS must be prepared with a recommendation to CMS for which facility should be moved into the slot.

Given the importance of staffing and its relationship to quality of care, CMS requires staffing levels to be considered when selecting a SFF. For example, if RCS is considering two facilities with similar compliance history for the SFF slot, CMS recommends selecting the facility with lower staffing.

1. Choosing the next SFF

- a. RCS must:
 - 1) Due to the short timeline of choosing the next SFF, begin the process of determining which NH will be recommended to be the next SFF as soon as RCS becomes aware that the current SFF will be recommended for graduation or termination.
- b. The RA will:
 - 1) Upon receipt of the list from the RCS AA5, meet with the FMs who have oversight for any NH included in the candidate list, seeking their input on which facility should be chosen as the next SFF.
- c. The AA5 will:
 - 1) Schedule a meeting with the RCS Director, RAs, Compliance and Enforcement Unit Manager, and the Office Chief of Headquarters Operations to discuss the recommendations and come to a decision which facility to recommend.

! If the group is unable to come to a decision, the RCS Director will have the final determination.

- 2) Schedule a meeting with the CMS Local Office Branch Manager and team, the RCS Director, RAs, Compliance and Enforcement Unit Manager, and the Office Chief of Headquarters Operations to present their recommendation to CMS. The following information will be included in the recommendation:
 - a) anticipated timeline,
 - b) compliance history, and
 - c) staffing.
 - Once CMS approves the selected facility, the meeting attendees will develop a communication plan, about presenting the information to the chosen SFF.

Note: The FM with oversight of the proposed SFF will have a list of accountable parties to be provided to the RCS AA5 once CMS approves the recommendation.



C. Notification to Facility of Initial Selection

Upon CMS approval of the new SFF selection, RCS must provide notice in writing to the NH. The NH has **five working days from receipt of the SFF notice** to provide the SA with contact information of all accountable parties, including but not limited to:

- Administrator
- Chairperson of the governing body
- Holder of the provider agreement
- Any party who owns more than a five percent interest in the facility
- Management company [if applicable]
- Facility landlord(s)
- Mortgage holder
- Corporate owner(s) for chain-operated facilities
- Director of nursing
- Medical director
- CMS

1. Sending the letter to the NH

a. The AA5 will:


- 1) Send notification to the NH via certified letter. A model letter is included in [Appendix C](#).
- 2) Send copies to CMS and all accountable parties.
- 3) Store a copy of the letter in the Q: drive.



D. Meeting to Discuss Significance of SFF Selection

In addition to the written notification to the NH being selected as a SFF, RCS must conduct a teleconference with the NH's accountable parties. The purpose of the meeting is to explain the SFF program, steps necessary to graduate from the program, and conditions by which the facility may be terminated from Medicare and/or Medicaid participation. For additional information, please refer to *page 3* of [QSO-23-01-ALL](#).

1. Communication plan and talking points

 CMS and RCS will develop a communication plan and talking points for the meeting with the NH (see '[Initial Selection](#)' for more information).

a. The AA5 will:

1) Schedule a meeting with the NH's accountable parties, CMS Branch Manager, the RCS Director, Compliance and Enforcement Unit Manager, CS, Office Chief for Headquarters Operations, and the RA/FM who have oversight of the SFF.

a) Topics to be covered must include:

- The seriousness of the designation as a SFF;
- The importance of organizational culture (i.e., leadership behavior, staff approach, and system processes) to drive sustained compliance and protect the health and safety of residents;
- Resources available to SFFs to support quality improvement; and
- CMS expectations for good faith effort by the NH for systemic change to improve quality.

Examples include but are not limited to:

- Regular engagement with CMS Quality Improvement Organization (QIO);
- Hiring an external consultant to support performance improvement;
- Implementation of evidence-based interventions to improve quality; and
- Measurable and sustained operational changes (e.g., leadership or key staffing changes, increased staffing levels, etc.).




E. Progressive Enforcement

While a NH is in the SFF program, RCS will conduct a standard health survey at least once every six months (as unpredictable as possible), as required by [§1819\(f\)\(8\)](#) and [§1919\(f\)\(10\)](#) of the Act. Progressively stronger enforcement actions will be recommended in the event of continued failure to meet the requirements for participation in Medicare and/or Medicaid. Refer to the SOM [Chapter 7](#) for more information on the Survey and Enforcement Process for NH.

1. Reporting all survey outcomes to CMS local office

- a. The FM with oversight of the SFF will:
 - 1) Notify CMS when the CMS-2567 is ready for review for any recertification survey, complaint abbreviated survey, and all revisits.
- b. The RA who has oversight of the SFF must:
 - 1) Provide monthly updates to the CMS Local office by the last week of each month. The report will include a history memo that demonstrates all survey activity and deficiencies, as well as enforcement actions to date.
 - a) Enforcement remedies must be imposed immediately, without an opportunity to correct, when:
 - The SFF has a standard health survey or a complaint survey with deficiencies cited at Scope and Severity (S/S) level of “F” or higher; or
 - Life Safety Code (LSC)/Emergency Preparedness (EP) survey with deficiencies cited at S/S level “G” or higher.
 - b) Subsequent surveys that also result in citations at these levels must have enforcement remedies of increasing severity imposed. This can include:
 - Imposing a higher Civil Monetary Penalty (CMP) than was previously imposed.
 - Increasing from one remedy to more than one remedy being imposed.
 - Denial of Payment for New Admissions (DPNA).
 - State imposed remedies of conditions or stop placement of new admissions.

 CMS considers the good faith efforts of the facility when considering applicable enforcement remedies.

Note: The SFF program does not supersede the three-month mandatory DPNA or the six-month mandatory termination required under [§1819\(h\)\(2\)](#) and [§1919\(h\)\(2\)\(3\)](#) of the Act.



F. Factors Considered for Graduation or Termination Graduation from the SFF Program

CMS may consider using its authority to terminate a SFF provider agreement when it believes it is an appropriate remedy. CMS retains discretion on decisions regarding graduation and termination based on the factors unique to each facility and Medicare/Medicaid programs. In addition, CMS provides specifics about who must be notified and the effective date when a facility has graduated from the program.

Factors considered for graduation or termination include:

- An evaluation of a facility's efforts to improve performance;
- The circumstances or details of any noncompliance that occurred (e.g., a facility that technically meets the criteria to graduate, but due to some of the details related to noncompliance, CMS remains concerned about the facility's quality and does not grant graduation);
- Situations when discretionary termination may potentially cause issues related to access to care.

1. Graduation from the SFF Program

A SFF cannot graduate with pending complaint surveys triaged at Immediate Jeopardy (IJ), or Non-IJ High, or until it has returned to substantial compliance.

- a. The NH **will** graduate from the SFF program once it has completed two consecutive standard health surveys with 12 or fewer deficiencies cited at an S/S of "E" or less on each survey since being selected as the SFF.
- b. The NH will **not** graduate if the following occurs:
 - 1) Any standard health survey results in deficiencies cited at an S/S level of "F" or higher; or
 - 2) Any LSC or EP survey results in deficiencies cited at an S/S level of "G" or higher; or
 - 3) 13 or more total deficiencies cited on any survey (standard health, LSC, EP, or complaint)
 - 4) Intervening complaint surveys with 13 or more total deficiencies, or any deficiencies cited at an S/S level of "F" or higher.

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2. Termination

To avoid situations where a facility remains a SFF for a prolonged period of time, CMS has established criteria that may result in the facility’s discretionary termination from the Medicare and/or Medicaid programs.

- a. SFFs with deficiencies cited at S/S of IJ on any two surveys (standard health, complaint, LSC or EP) while in the SFF program will be considered for discretionary termination.
- b. SFFs that have not yet met program graduation criteria after three standard surveys require a CMS review of their status in the program.
 - 1) The AA5 must schedule a conference call with CMS Branch Manager and team to discuss:
 - a) the efforts the NH has made towards improvement;
 - b) the reasons for continued non-compliance; and
 - c) the likelihood of the NH achieving sustained compliance.
 - 2) The meeting will include the following attendees: CMS Branch Manager, the RCS Director, Compliance and Enforcement Unit Manager, CS, Office Chief for Headquarters Operations, and the RA/FM who have oversight of the SFF.

CMS has the final authority to determine if the facility will move towards discretionary termination or continue to collaborate with RCS to focus on facility improvement. See [Appendix D](#) for questions CMS will pose to RCS when assessing options.

If CMS decides to terminate, the RCS Director, RA, and FM with oversight of the facility, CS, and Compliance and Enforcement Unit Manager must meet to discuss state licensure enforcement action (i.e., revocation, stop placement, need for any temporary manager until facility closure, notifications and planning with HCS on resident discharges, monitoring visits, and notification to Ombuds).



G. Post-Graduation

CMS closely monitors graduates from the SFF program for a period of three years to ensure improvements are sustained. For the SFFs that graduate and demonstrate poor compliance as identified on any survey (e.g., actual harm, substandard quality of care [SQC], or IJ deficiencies), CMS may impose enhanced enforcement options, up to, and including discretionary termination from the Medicare/Medicaid programs.

RCS will also closely monitor SFF graduates for a period of three years, with the focus of early identification of concerns related to quality of care.

- a. After every survey, if a SOD is warranted due to identified noncompliance, the FM responsible for oversight of the NH will:
 - 1) Review the SOD (CMS-2567) for approval following the process outlined in this SOP and [Chapter 20 – Complaint Investigations](#).
 - 2) If concerns about ongoing compliance are apparent, the FM will consult with the RA to determine if the RCS Director needs to be notified.
 - 3) If the RCS Director is notified, they will determine next steps (e.g., continued monitoring, consult with Enforcement and Compliant unit manager and CS, CMS, etc.).



Part IX: Master Survey Schedule

The survey and certification provisions under [§1819\(g\)\(2\)\(A\)\(iii\)](#) and [§1919\(g\)\(2\)\(A\)\(iii\)](#) of the Social Security Act (the Act), under [42 CFR §488.308](#), and under [RCW 18.51.091](#) require that each SNF and NF be subject to a standard survey no later than 15 months after the last day of the previous standard survey; and that the statewide average interval between standard surveys of SNFs and NFs not exceed 12 months.

The NH 15-Month Master Schedule is a fluid 15-Month average of both federal and state NH standard surveys. This process must include several factors to meet the federal standard of 15.9 months and the statewide average standard survey not to exceed 12.9 months. The annual scheduling is completed by each Region using the federal fiscal year calendar from October 1 through September 30 of the following year.

The schedule is subject to change due to multiple factors. When changes occur surveys must still meet all the federal and statewide average components to maintain compliance. Nursing Home standard surveys can occur at a minimum of 9 months and a maximum of 15 months. RCS will make every effort to ensure upcoming standard surveys are unpredictable.

1. Annual Master Schedule Preparation

- a. The FM will:
 - 1) Provide a list of all NHs licensed in the Region to surveyors/complaint investigators.
 - 2) Make the previous year calendar available for review.
- b. The Regulatory staff will:
 - 1) Be prepared to discuss work schedule.
 - 2) Be prepared to discuss annual, sick, and other leave plans for coverage and scheduling purposes.

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2. Annual Final Master Schedule

a. The FM will:

- 1) Finalize the NH 15-Month Master Schedule for distribution by September 10th each year.
- 2) Ensure the NH 15-Month Master Schedule is available to all NH surveyors, NH complaint investigators, the NH Unit AA, and the RA.
- 3) Ensure an electronic copy of the Final NH 15-Month Master Schedule is maintained.
- 4) Ensure an updated copy of the schedule for each month is emailed to RCSCComplianceUnit@dshs.wa.gov by the 10th day of the preceding month.

Example: email the schedule for June to the Compliance Unit by the 10th of May.

Note: If the 10th falls on a weekend or state or federal holiday, the schedule must be emailed by the working day prior (i.e., if the 10th falls on a Saturday, the schedule must be emailed by Friday the 9th)

a) Use a standard form that includes:

- Region and Unit numbers.
- FM name and contact phone number.
- Date each survey starts and ends.
- Facility name.
- Current Census Number
- Number of licensed beds.
- City of facility location.
- TC name.
- Number of survey team members.



Surveyors in training do not count in this number.

- 5) Ensure the monthly emails with the electronic copy are saved per unit process.

b. The NH Compliance AA will:

- 1) Rename each final NH monthly document with correct Region and Unit.
- 2) Email all updated NH monthly schedules to the following:
 - a) CMS,
 - b) SFMO,
 - c) C),
 - d) RCS Training Unit,
 - e) NH Case Mix Manager, and
 - f) RA.
- 3) Save the monthly emails with the forwarded monthly schedules in a shared electronic file.



3. Ongoing 15-Month Master Schedule Maintenance and Updating

- a. The FM will:
 - 1) Ensure accessible copies of the 15-Month Master Schedules are available for changes.
 - 2) If a schedule change(s) needs to be made to the NH 15-Month Master Schedule, ensure the change(s) do not compromise the integrity of the 15-month average requirements. Schedule change(s) can be for one or more reasons, including:
 - a) Facility with significant compliance issues may need to be surveyed sooner.
 - b) Staff emergencies requiring adjusting to the NH 15-Month Master Schedule.
 - c) Facility has an emergent situation (i.e., infectious disease spread) and unsafe for survey staff to enter the facility due to risk of exposure.
 - d) Facility has been identified as a [SFF](#) and needs a survey every six months, or facility graduates from the SFF and may return to standard survey schedule.
 - 3) When a change(s) is made:
 - a) Ensure all parties have adequate notice of the change(s) to maintain the unpredictability of the survey schedule.
- b. The RA will:
 - 1) Conduct a quality assurance (QA) review on a quarterly basis using the 365-day report of completed standard NH surveys to monitor progress toward meeting federal and state averages on the NH 15-Month Master Schedule.
 - 2) Document when quarterly QA reviews are completed.
 - 3) Review and provide oversight of all processes each federal fiscal year to ensure federal and state averages on the NH 15-Month Master Schedule are maintained.

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HCLA Residential Care Services, Standard Operating Procedures Manual



Part X: Change of Ownership (CHOW) – Under Construction

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Part XI: Appendices

A. Resources

1. [Department of Health Nursing Assistant Training Programs](#)
2. [Professional Page for Providers](#)
3. [LTCSP Resources and Guides](#)

B. Forms

1. [Attachment A: Exit Conference Template](#)
2. [Attachment C: State Entrance Conference Letter](#)
3. [Attachment D: State Task Checklist \(DSHS 10-625\)](#)
4. [Attachment E: Staffing Pattern \(DSHS 10-626\)](#)
5. [Attachment F: Liability Insurance Review \(DSHS 10-627\)](#)
6. [Attachment G: Trust Fund Review \(DSHS 10-628\)](#)
7. [Attachment H: Pet Record Review \(DSHS 10-629\)](#)
8. [Attachment J: Paid Feeding Assistant Program Review \(DSHS 10-630\)](#)
9. [Attachment L: Staff Qualification and Background Review \(DSHS 10-631\)](#)
10. [Attachment M: TB Testing Review for Staff \(DSHS 10-632\)](#)
11. [Attachment N: TB Testing Review for Residents \(DSHS 10-633\)](#)
12. [Attachment O: Medication Assistance Endorsement \(DSHS 10-634\)](#)
13. [OBRA NA Training Onsite Inspection Form for Survey \(DSHS 16-168\)](#)



C. Model Letter to Provider Selected as a Special Focus Facility

IMPORTANT NOTICE – PLEASE READ CAREFULLY

(Date)

(Nursing Home Administrator Name)

(Facility Name)

(Address)

(City), WA (Zip)

Dear (Nursing Home Administrator Name)

The purpose of this letter is to inform you that your facility has been selected for the Special Focus Facility (SFF) program based on a persistent pattern of poor compliance history for the past three standard health survey cycles, and during the last three years of complaint surveys. More information on this selection is described below.

What Does This Mean?

You will be subject to at least one standard health survey every six months as required under Section 1819(f)(8)(B) and 1919(f)(10)(B) of the Social Security Act (42 U.S.C. §1395-i3(f)(8)(B) and §1396(f)(10)(B), respectively). The Centers for Medicare & Medicaid Services (CMS) will be closely monitoring your facility with the objective that your facility can attain and maintain substantial compliance with Medicare and/or Medicaid participation requirements.

- You must provide the names, telephone numbers, email addresses, and physical addresses of the accountable parties (e.g., the administrator, chairperson(s) of the Governing Body, holder of the facility's provider agreement, any party who owns more than a five percent interest in the facility, the management company (if applicable), facility landlord(s), the mortgage holder, and corporate owner(s) for chain-operated nursing homes) **within 5 business days** of receipt of the SFF selection notice to the SA;

How Does A Facility Get Removed from the SFF Program?

The facility will graduate from the SFF program once it has met graduation criteria of completing two consecutive standard health surveys, with no intervening complaint, LSC, or EP surveys with 13 or more total deficiencies, or any deficiencies cited at scope and severity (S/S) of "F" or higher; CMS may terminate the facility's provider agreement if the facility is not in substantial compliance, in accordance with 42 CFR §488.456(b) and §489.53.

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The facility will not graduate if the following occurs:

- Any standard health survey results in deficiencies cited at a S/S level of “F” or higher, or
- Any LSC or EP survey results in deficiencies cited at a S/S level of “G” or higher; or
- 13 or more total deficiencies cited on any survey (standard health, LSC, EP, or complaint).
- Intervening complaint surveys with 13 or more total deficiencies, or any deficiencies cited at an S/S level of “F” or higher.
- Additionally, an SFF cannot graduate with pending complaint surveys triaged at Immediate Jeopardy (IJ), or Non-IJ High, and/or until it has returned to substantial compliance.

Involuntary Termination

SFFs with deficiencies cited at S/S of Immediate Jeopardy (IJ) on any two surveys (standard health, complaint, LSC, or EP) while in the SFF program, will be considered for discretionary termination. Additionally, CMS may terminate the facility’s provider agreement if the facility is not in substantial compliance, in accordance with 42 CFR §488.456(b) and §489.53.

The CMS location retains discretion on decisions regarding graduation from the SFF program and discretionary termination based on factors unique to each facility and CMS’ authority to terminate a provider’s participation with the Medicare and/or Medicaid programs. These factors include:

- A facility’s good faith efforts to improve performance;
- The circumstances or details of any noncompliance that occurred (e.g., a facility that technically meets the criteria to graduate, but due to some of the details related to noncompliance, CMS remains concerned about the facility’s quality and does not grant graduation);
- Situations when discretionary termination may potentially cause issues related to access to care.

Progressive Enforcement for Lack of Significant Improvement

CMS will impose immediate sanctions on an SFF that fails to achieve and maintain significant improvement in correcting deficiencies on the first and each subsequent standard health, complaint and LSC/EP survey after a facility becomes an SFF. See 42 CFR §488.400 Subpart F for enforcement remedies under CMS authority. Enforcement sanctions will be of increasing severity for SFFs demonstrating continued noncompliance and failure to demonstrate good faith efforts to improve performance.

Per §§1819(h)(2)(D) and 1919(h)(2)(C), and §§1819(h)(2)(C) and 1919(h)(3)(D) of the Social Security Act (the Act), respectively, CMS is required to impose Denial of Payment for New Admissions if substantial compliance is not achieved within three months and terminate the provider agreement if substantial compliance is not achieved within six months. In addition to the remedies required by the Act, CMS may terminate the facility’s provider agreement at any time if the facility is not in substantial compliance, in accordance with 42 CFR §488.456(b) and §489.53.

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Good Faith Efforts

The CMS location will consider a facility's good faith efforts to improve performance (or lack thereof) when considering enforcement remedies. For example, an SFF with continued noncompliance and little or no demonstrated effort to improve performance will have more severe enforcement remedies than facilities with continued noncompliance but have taken aggressive actions to improve performance. CMS will also consider facilities' good faith efforts to improve when considering discretionary termination from Medicare and/or Medicaid programs. Examples of actions a facility can take to demonstrate a good faith effort include, but are not limited to:

- Regular engagement with the Quality Improvement Organization (QIO)
- Hiring an external consultant(s) to support performance improvement
- Implementation of evidence-based interventions to improve quality
- Measurable and sustained operational changes (e.g., leadership or other key staffing changes, increased staffing levels, etc.).

Where can I find a list of the Special Focus Facilities and how often is the SFF list updated?

The SFF list can be found at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf>. The SFF list is updated and posted on [cms.gov](https://www.cms.gov) monthly.

If you have any questions, please contact ([name, title, address, phone number, fax number, and email address of the appropriate survey agency official](#)).

Additionally, the SA will provide a copy of this notice of your facility SFF selection to the following parties:

- CMS location;
- State Ombudsman's Office;
- State Medicaid Director, and
- The applicable Quality Improvement Organization (QIO).

Sincerely,
(Name and Title)

cc: CMS location
([Name of Quality Improvement Network or Organization](#))
([Name of Owner](#))

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D. CMS Questions to State Agency (SA) on SFF Status

1. What is the total resident census and breakdown. (# of Medicare, # of Medicaid, and # of private pay)		
# of Medicare: _____	# of Medicaid: _____	# of private pay: _____
2. Has the state identified any special care needs or access to care issues that would make it difficult to provide appropriate, alternate placement for residents in the event of termination?		
3. Are staffed beds available in the local area? Where will they go? What is the impact to that community?		
4. Describe the harm/quality of care issues identified during the recertification surveys and/or complaint surveys.		
5. What are the reasons for noncompliance?		
6. Is there a pattern of repeated deficiencies being cited since facility became a SFF candidate and was selected as an SFF?		
7. For repeated deficiencies, has the SA considered imposing a directed plan of correction or directed in service trainings?		
8. How many pending complaint surveys triaged at IJ or Non-IJ high?		
9. Is the SA up to date in investigating complaints and FRIs for SFF?		

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10. What is the likelihood of the facility achieving sustained compliance?	
11. What are issues preventing the facility from graduating?	
12. Who is the Administrator and who is the DON and how long employed?	
Administrator: _____	DON: _____
Length of employment: _____	Length of employment: _____
13. Are key leadership positions filled? Are there increased staffing levels?	
14. Provide a summary/evaluation of facility's efforts to improve performance (examples, engagement with QIO, hiring external consultant to support performance improvement, implementation of evidence-based interventions to improve quality, and measurable and sustained operational changes).	
15. If facility is utilizing external consultants, who are they, what are they focusing on, and what is the frequency of them being onsite at facility?	
16. What other SA contact has occurred besides the onsite surveys?	
17. Besides the nursing home administrator, has the SA had contact and communication with the nursing home accountable parties (chairperson(s) of the Governing Body, holder of the facility's provider agreement, any party who owns more than a five percent interest in the facility, the management company (if applicable), facility landlord(s), the mortgage holder, and corporate owner(s) for chain-operated nursing homes)?	
18. Please list the names, titles, email addresses for the accountable parties.	

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19. Will a potential change of ownership turn into a greater likelihood of quality improvement in the near future?
20. What is the SA's recommendation for the SFF (terminate or allow more time for facility to focus on facility improvement)?
21. Other issues?

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E. SFF Process Tracking Tool (CMS Job Aide)

Special Focus Facility Process Tracking Sheet
Facility Name:
Facility CCN:
Date of Selection Letter:
Date of Meeting with Facility and Accountable Parties:
Date of Recertification Survey # 1:
---Total # Tags Survey #1
≥ 13 at S/S E = red
s/s \geq F = red
LSC \geq G = red
EP \geq G = red
Intervening Complaint Date
≥ 13 at S/S E = red
s/s \geq F = red
Date of Recertification Survey #2
---Total # Tags Survey #2
≥ 13 at S/S E = red
s/s \geq F = red
LSC \geq G = red
EP \geq G = red
Intervening Complaint Date
≥ 13 at S/S E = red
s/s \geq F = red
Date of Meeting with Facility and Accountable Parties (if ≥ 2 red surveys):
Date of Recertification Survey #3
---Total # Tags Survey #3
≥ 13 at S/S E = red
s/s \geq F = red
LSC \geq G = red
EP \geq G = red
Date of Meeting with State (if ≥ 3 red surveys):

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Graduation Criteria		
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	Two consecutive standard health surveys with 12 or fewer deficiencies cited at scope and severity level (S/S) of "E" or less on each survey.
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	Facility back in compliance
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	No pending complaints at IJ or non IJ high
<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	CMS concurrence with state recommendation
Recommendations		
<input type="checkbox"/> Graduate	<input type="checkbox"/> Terminate	<input type="checkbox"/> Continue in SFF Program



F. Glossary of Terms

Abandonment – as defined in [RCW 74.34.020](#).

Abuse – as defined in [RCW 74.34.020](#).

Active status [OBRA] – means the individual has successfully completed a training and competency program meeting federal requirements. They must have worked in a nursing or nursing related capacity for compensation within the past 24 months and must not have actions or findings that render them ineligible.

Administrator – Includes the various titles of the responsible person(s) for the entity. This list includes but is not limited to superintendent, director, provider, program manager, individual or entity representative, resident manager, administrator, or executive director. Please refer to the WAC relevant to the setting type for more information.

Agency – State agency.

Background check – means a name and date of birth check or a fingerprint-based background check, or both. [WAC 388-113-0010](#).

Background Check Central Unit (BCCU) – means a division within the department that processes background checks for department authorized service providers and department programs who serve vulnerable individuals across Washington State. [WAC 388-113-0010](#).

Basic necessities of life – This means food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen, and medication. [WAC 388-103-0001\(5\)](#).

Certification – The process used by the department to determine if an applicant or service provider complies with federal health, safety, and program standards and is eligible to provide certified community residential services and support to clients.

Character, competence, and suitability (CCS) – the screening and assessment of the potential personal and professional capability of an employee or applicant to work with or serve minor or vulnerable adults based on a review of crimes and negative actions. CCS requirements must meet those in [WAC 388-113-0060](#).

Chemical restraint – as defined in [RCW 74.34.020](#).

Civil monetary penalty (CMP) Letter – the Centers for Medicare & Medicaid Services (CMS) can impose a CMP on Nursing Homes that do not meet the Federal requirements for nursing homes participating in the Medicare or Medicare and Medicaid Programs. This letter is the formal CMS notification of CMP imposition.

CMS State Operations Manual (SOM), Appendix PP – Federal Guidance to Surveyors for Long Term Care Facilities.

CMS State Operations Manual (SOM), Appendix Q – Federal Core Guidelines for Determining Immediate Jeopardy.

Code of Federal Regulation (CFR) – The Departments and Agencies of the Federal Government providing codification of the general and permanent rules published in the Federal Register.

Collateral contact – An external source knowledgeable about the particular situation or concern occurring in the vulnerable adult care setting. The collateral contact typically either corroborates or supports the information of those living in the setting.

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Examples include health care staff not employed by the entity, family members, family friends, resident/client representative, legal guardian, law enforcement, or hospital staff.

Complaint – A report communicated to Residential Care Services’ (RCS) Complaint Resolution Unit (CRU) by anyone NOT acting as an administrator or designee for a provider licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of property for one or more vulnerable adult. The complainant could be a vulnerable adult, a family member, a health care provider, a concerned citizen, other public agencies, or a mandated or permissive reporter. Report sources may be verbal or written.

Complaint investigation – means an onsite investigation as a result of receiving a complaint related to provider practice.

Compliance – The state of an organization that meets prescribed specifications, contract terms, regulations, or standards.

Confidential Identifier – The name, title, or letters/numbers referring to entity staff or those living in the residential setting within a Statement of Deficiency, following guidance contained within [SOP Chapter 18 – Across All Settings, and the Principles of Documentation \(POD\)](#).

Confidential information – A type of information that is protected by state or federal laws, including information about vulnerable adults, DSHS clients, employees, vendors or contractors, and agency systems unavailable to the public without legal authority.

Deficiency citation – Documentation of a violation of statute or regulation, other than those defined as a consultation. Documentation of a deficiency citation includes an entry made on the Statement of Deficiencies that consists of:

- The alpha prefix and data tag number for federal programs;
- The applicable Code of Federal Regulations (CFR) in federal programs;
- The applicable Washington Administrative Code (WAC) and/or the applicable Revised Code of Washington (RCW);
- The language from that reference which pinpoints the aspect(s) of the requirement with which the entity failed to comply;
- An explicit statement that the requirement was “not met”; and
- The evidence to support the decision of noncompliance.

Deficient practice – The action(s), error(s), or inaction on the part of the entity relative to a regulatory requirement and to the extent possible, the resulting outcome.

Deficient practice statement (DPS) – A statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulatory requirement. Also commonly referred to as the “based on” statement.

Denial of payment for new admissions (DPNA) – means an action imposed on an entity by the department that prohibits payment for new Medicaid admissions to the entity after a specified date.

Department – This term refers to the Washington state Department of Social and Health Services (DSHS).

Dually Participating Facility [NH] – means a facility that has a provider agreement in both Medicare and Medicaid programs.

Duty of care – This includes:

- 1) A guardian or conservator appointed under [Chapter 11.130 RCW](#);

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- 2) An agent granted authority under a power of attorney as described under [Chapter 11.125 RCW](#);
or
- 3) A person providing the basic necessities of life to a vulnerable adult where:
 - a) The person is employed by or on behalf of the vulnerable adult; or
 - b) The person voluntarily agrees to provide, or has been providing, the basic necessities of life to the vulnerable adult on a continuing basis.

Electronic medical record (EMR) or Electronic health record (EHR) – a digital version of a chart with resident medical/health information stored in a computer.

Entity – A standard term used throughout this document to depict the long-term care program homes, facilities, and licensees participating in transforming lives of the vulnerable adults living in residential settings.

Entrance date – means the first date RCS staff is on site.

Evidence – Data sources, to include observation, interview and/or record review, described in the findings of the deficiency citation. These data sources within the deficiency citation inform the entity of the failure to comply with regulations. A minimum of two of the three data sources are required to support the citation. Having documentation of all three data sources is optimal for the deficiency citation to be irrefutable.

Exit date – means the last date RCS staff is on site.

Expired status [OBRA Registry] – means the individual has not performed nursing or nursing-related services for a period of 24 consecutive months for monetary compensation. If no work history in the past 24 months is established, the individual with expired status is not eligible to work in the nursing home setting, unless or until, they successfully re-train and re-test, or re-test. If they successfully re-test, the expired status returns to active status.

Extent of deficient practice – The number of deficient cases relative to the total number of sampled cases. This is shown in a numerical format with identifying the number of deficient cases within the universe (e.g., 1 of 3). Please refer to definitions of scope and universe.

Facility – as defined in [RCW 74.34.020](#).

Fact – An event known to have actually happened. A truth that is known by actual experience of observation, interview, and review of records.

Failed provider practice – Describes the action(s), error(s), or inaction(s) on the part of the licensee relative to statute(s) or regulation(s) and, to the extent possible, the resulting negative outcome(s) to vulnerable adult(s). Term includes deficient practice, which is defined as “lacking an essential quality or element, and inadequate in amount or degree.”

Federal programs – This includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Homes (NH).

Financial exploitation – as defined in [RCW 74.34.020](#).

Finding – A term used to describe each item of information found during the regulatory process about entity’s practices relative to a specific requirement cited as being not met.

Fingerprint check – means a fingerprint check is considered a positive identification check. The fingerprints of an applicant are reviewed to match fingerprints taken at the time of an arrest or conviction of a crime.

Food service worker – means according to [Chapter 246-217 WAC](#), an individual who works (or intends to work) with or without pay in a food service establishment and handles unwrapped or

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unpackaged food or who may contribute to the transmission of infectious diseases through the nature of the individual's contact with food products or equipment and facilities. This does not include persons who simply assist residents with meals.

Formal interviews – structured interviews with sample residents, the service provider, staff, family members or representatives, or other collateral contacts.

Forms CMS-2567, CMS 2567B, CMS-2567L Statement of Deficiencies – The official document(s) communicating the determination of compliance or noncompliance with the Federal requirements. In addition, they are the form(s) an entity uses to submit a plan to achieve compliance. Each form is an official, legal record that is available to the public on request.

Gender neutral language – Use of terms to increase the confidentiality and be inclusive of the vulnerable adult(s) in the specific setting. This includes pronouns, which do not associate a gender with the vulnerable adult in order to protect the identity, such as, they, them, or theirs. Emphasize attempts to avoid using gender specific pronouns such as he, him, his or she, her, hers.

Health care – The care, services or supplies related to the health of a vulnerable adult, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling for a physical or mental condition, a prescribed drug, device, or equipment.

Homelike – means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to decorate one's living area and arrange furnishings to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.

Immediate jeopardy (IJ) – means a situation in which immediate corrective action is necessary because the non-compliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a vulnerable adult receiving care in a facility.

Improper use of restraint – as defined in [RCW 74.34.020](#).

Ineligible status [OBRA Registry] – means there is a state disciplinary action or findings of abuse, neglect, or misappropriation of property in WA state or any other state. Individuals with ineligible status are not eligible to work in the nursing home setting unless reassigned by a state nursing home survey and certification agency as eligible based on the finding or action being overturned.

Informal interviews – general conversations or information gathering which may occur during any part of the inspection process.

Internet Quality Improvement Evaluation System (IQIES) – the federal umbrella administrative and computer system that encompasses the MDS and Swing Bed-MDS system, other systems for survey and certification, and home health providers.

Isolate or Isolation – means to restrict a vulnerable adult's ability to communicate, visit, interact, or otherwise associate with persons of his or her choosing. Isolation may be evidenced by acts including but not limited to:

- Acts that prevent a vulnerable adult from sending, making, or receiving his or her personal mail, electronic communications, or telephone calls; or
- Acts that prevent or obstruct the vulnerable adult from meeting with others, such as telling a prospective visitor or caller that a vulnerable adult is not present, or does not wish contact, where the statement is contrary to the express wishes of the vulnerable adult.

The term "isolate" or "isolation" may not be construed in a manner that prevents a guardian or limited guardian from performing his or her fiduciary obligations under [Chapter 11.130 RCW](#) or

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prevents a hospital or facility from providing treatment consistent with the standard of care for delivery of health services.

KN95 and N95 – respirators and surgical masks are examples of personal protective equipment that are used to protect the wearer from the particles or from liquid contaminating the face.

Level I Evaluation – Pre-screen to determine if a resident may have a serious mental illness (SMI), intellectual disability (ID), or related condition and is typically completed by the referring entity.

Level II Evaluation – In-depth evaluation to determine if a resident has a serious mental illness (SMI), intellectual disability (ID), or related condition and is completed by a representative from the state intellectual disability authority or a representative from the state mental illness authority.

Level II Services – Are specialized services or specialized rehabilitative services that the PASRR Evaluator has determined is required to be provided by either the Nursing Facility or the designated state entity as appropriate.

Likely/likelihood – means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.

Long-term care facility – As defined in [RCW 70.129.010\(3\)](#).

Long-term care Quality Improvement Program Specialist (LTC QIPS) – a registered nurse or an allied health professional who performs on- and off-site program visits and activities.

Long-term care workers – includes all persons providing paid, personal care services for the elderly or persons with disabilities, including individual providers of home care services, direct care workers employed by home care agencies, providers of home care services to persons with developmental disabilities under [Title 71A RCW](#), all direct care workers in state-licensed assisted living facilities, adult family homes, respite care providers, community residential service providers, and any other direct care staff providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

Mandated reporter –this is an employee of the Department or the Department of Children, Youth and Families (DCYF); law enforcement officer; social worker; professional school personnel; individual provider; an operator of a facility or a certified residential services and supports agency under [Chapter 71A.12 RCW](#); an employee of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, hospice or certified residential services and supports agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to [Chapter 18.130 RCW](#).

MDS inaccuracy – means that the during the on-site CMAR visit, the CMAR process found a MDS item that was coded incorrectly. The facility’s coding is indicated as the Facility Value (FV) on the RUG Item Category Report. The MDS item is inaccurate and the documentation by the facility in the MDS cannot be substantiated. The FV can impact the assigned RUG or classification category and may decrease or increase the corresponding classification category.

Mechanical restraint – as defined in [RCW 74.34.020](#).

Medicaid Fraud Control Division (MFCD) – means the statewide division that is responsible for both criminal and civil investigations and prosecution of healthcare provider fraud committed against the State’s Medicaid program. The division also investigates and prosecutes complaints of resident abuse or neglect in healthcare facilities and residential settings.

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Medication dose – Multiple tablets or capsules required to deliver a dose of a single medication count as one dose.

Medication pass – The process through which medication is administered to patients.

Mental abuse – as defined in [RCW 74.34.020](#).

Mental disorder – means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

Minimal harm – means violations that result in little to no negative outcome or little or no potential harm for a resident.

Minimum Data Set (MDS) – a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.

Misappropriation of resident property – means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money.

Moderate harm – means violations that result in negative outcome and actual or potential harm for a resident.

Neglect – as defined in [RCW 74.34.020](#).

Noncompliance [NH] – means any deficiency that causes a facility not to be in substantial compliance. ([42 § CFR 488.301](#))

Nurse's Aide or Nursing Assistant-Certified (NA-C) – refers to the individuals on the OBRA Registry or applying to be on the registry. The terms are interchangeable.

Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under [section 1919\(a\) of the federal Social Security Act](#). All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

Nursing home (NH) – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

Omnibus Budget Reconciliation Act (OBRA) of 1987 – Provisions set forth in law regarding the use of nurse's aides. In addition to nurse aide training requirements, the act specifies that each state must have a registry for nurse aides.

Omnibus Budget Reconciliation Act (OBRA) Registry – A registry containing information related to all individuals who have successfully completed a nurse aide training and competency evaluation program and found by the State to be competent to function as a nurse aide or who may function as a nurse aide because of meeting criteria in [42 CFR §483.150](#).

Opportunity to correct [NH] – means the entity is allowed an opportunity to correct identified deficiencies before remedies are imposed.

Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the entity (e.g., development of avoidable pressure injury; reaction due to receipt of blood; lack of monitors for anticoagulant). Harm to vulnerable

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adults unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.

Outcome of care measures – means criteria to evaluate the care provided to residents/clients, based on the results of care which indicates the result of the performance (or non-performance) of a function or process.

Paid feeding assistant - an individual who meets the requirements specified at [42 CFR §483.60\(h\)\(1\)\(i\)](#) and who is paid by the facility to feed residents, or who is used under an arrangement with another agency or organization.

PASRR Evaluator - is a representative from the state intellectual disability authority who evaluates for individuals with intellectual disabilities and/or related conditions or a representative from the state mental illness authority who evaluates for individuals with mental illness.

Past Noncompliance [NH] – means a deficiency citation at a specific survey data tag (F-tag or K-tag), that meets all of the following three criteria:

- 1) The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
- 2) The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and
- 3) There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Personal exploitation – as defined in [RCW 74.34.020](#).

Physical abuse – as defined in [RCW 74.34.020](#).

Physical restraint – as defined in [RCW 74.34.020](#).

Plan of correction (POC) – means an entity's written response to cited deficiencies that explains how it will correct the deficiencies and how it will prevent their reoccurrence.

Process – The specification of the ongoing manner that the entity must operate. The process requirements do not allow the entity to vary from what is specified.

Examples include the reviewing, revising and/or updating the plan of care; policies and procedures such as, infection control procedures for cleaning/maintaining glucometers; or annual assessments for the vulnerable adults in the residential settings.

Referral – when a report includes other jurisdictions outside of RCS, including but not limited to Adult Protective Services (APS), Department of Children, Youth and Families (DCYF), Department of Health (DOH), Department of Licensing (DOL), Medicaid Fraud Control Division (MFCD), or Law Enforcement (LE). Send the intake to the other agency as a referral.

Regional Office (RO) - CMS has 10 ROs that work closely together with Medicare contractors in their assigned geographical areas on a day-to-day basis. Four of these Ros monitor Network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

Regulatory process – Regulatory staff evaluate current entity compliance with statutes and regulations. Types of regulatory processes include pre-occupancy, abbreviated complaint

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investigations; full inspection/recertification surveys; initial certification surveys; follow-up or post surveys; initial licensing and relicensing, and monitoring visits.

Regulatory staff/Regulator – RCS staff responsible for enforcing the rights, safety, and health regulations of individuals living in Washington’s licensed or certified residential settings.

Reporter [also referred to as Complainant] – means the individual making the report of alleged abuse, neglect, financial exploitation, or other non-compliance with regulatory requirements to the CRU. Reporter types are *Public, Facility, State Employees, Law Enforcement or Anonymous*.

- **Public** – are generally residents or clients, family of residents or clients, Long Term Care Ombudsman staff, facility staff when it is clear they are not making an official facility report or are reporting as whistle blowers, hospital staff, and teachers.
- **Facility** – are generally facility or agency Administrators or other management staff making a report as the official “facility” or provider report, staff who leave the facility/agency phone number and give permission to call them back, staff who state they reported their call to the hotline to their management.
- **State Employees** – are generally DSHS staff who are making a report in the natural course of their job duties.

Requirement – Any structure, process, or outcome that is required by law or regulation.

Resident Assessment Instrument (RAI) – an assessment tool, which consists of three basic components: the MDS Version 3.0, the Care Area Assessment process, and the RAI utilization guidelines.

Revised Code of Washington (RCW) – The compilation of all permanent laws now in force. It is a collection of Session Laws (enacted by the Legislature, and signed by the Governor, or enacted via the initiative process), arranged by topic, with amendments added and repealed laws removed. It does not include temporary laws such as appropriation acts.

Scope and severity (S/S) [NH] – The effect of the deficient practice on resident outcome (severity level) and the number of residents potentially or actually affected (scope level), using the [decision matrix grid guidance](#) provided by CMS.

Serious adverse outcome or Likely serious adverse outcome – means serious injury, harm, impairment, or death has occurred, is occurring, or is likely to occur to one of more vulnerable adult receiving care in a facility due to the facility’s noncompliance with health, safety, or quality regulations.

Service animal – means any dog or miniature horse that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability, as defined in [RCW 49.60.040](#).

Sexual abuse – as defined in [RCW 74.34.020](#).

Significant change [NH] – based on MDS/RAI manual.

Skilled nursing facility (SNF) – a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under [section 1819\(a\) of the federal Social Security Act](#).

State agency (SA) – A permanent or semi-permanent organization in government that is responsible for the oversight and administration of specific functions.

State Tasks – are the (14) state requirements reviewed in all facilities that have a Medicaid contract, in addition to the LTCSP.

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Statement of deficiencies (SOD) – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date for the cited deficient practice. The SOD is a legal document available to the public on request.

Structure – Requirements specifying the initial conditions, which must be present for an entity to be certified to participate. They are expected to remain as is unless there is a need for major renovation, re-organization, or expansion of services.

Examples include updating to new windows/carpet/paint; changing the number of bedrooms; changing the size of a room.

Substantial bodily harm/injury – means:

- A substantial impairment of a person's physical condition requiring professional medical treatment.
- Loss of consciousness, concussion, bone fracture, muscle tears, disfiguring lacerations, or wounds requiring multiple sutures.
- Injury requiring corrective or cosmetic surgery.
- Substantial bodily injury involves temporary but substantial disfigurement or loss/impairment of bodily function.
- Injury that creates a substantial risk of death, serious permanent disfigurement, or prolonged loss/impairment of body function.

Substantial compliance [NH] – means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements ([42 § CFR 488.301](#))

Universe – The prevalence or frequency of deficient cases (scope) relative to the total number of actual and potential cases (universe). The extent is expressed in a numerical format. The universe is used as the denominator when determining the extent of deficient practice.

Unsupervised access – means not in the presence of:

- Another employee or volunteer from the same business or organization; or
- Any relative or guardian of any of the children or individuals with a developmental disability or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization ([RCW 43.43.830](#)).

Volunteer – an individual who interacts with residents without reimbursement.

Vulnerable adult – as defined in [RCW 74.34.020](#).

Waiver – means a temporary situation granted by CMS which waives an entity's requirement to comply with a specific regulatory requirement.

Washington Administrative Code (WAC) – Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.

Willful – as defined in [RCW 74.34.020](#) (related to abuse, neglect, or exploitation).

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HCLA Residential Care Services, Standard Operating Procedures Manual



Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

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G. Acronym List

AA	Administrative Assistant
AKA	Also known as
BAAU	Business Analysis Application Unit
BAOU	Business Operations and Analysis Unit
BGI	Background Inquiry
BIC	Back In Compliance
CASPER	Certification and Survey Provider Enhanced Reports
CC	Carbon Copy (in emails)
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CE	Certification Evaluation
CEP	Critical Element Pathways
CFR	Code of Federal Regulations
CHOW	Change in Ownership
CLIA	Certified Laboratory Improvement Amendment
CMAR	Case Mix Accuracy Review
CMP	Civil Monetary Penalty
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CRS	Construction Review Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DCAT	Deficiency Citation Analysis Tool
DOH	Department of Health
DON	Director of Nursing
DPNA	Denial of Payment for New Admissions
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
eFax	Electronic Facsimile
EHR	Electronic Health Record
EMR	Electronic Medical Record
EP	Emergency Preparedness
ePOC	Electronic Plan of Correction
FM	Field Manager
FP	Fingerprint
FSA	Field Services Administrator
GDR	Gradual Dose Reduction
HCA	Health Care Authority
HIPAA	Health Insurance Portability and Accountability Act
ID	Intellectual Disability

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IJ	Immediate Jeopardy
IPC	Infection Prevention and Control
iQIES	Internet Quality Improvement Evaluation System
LA	LeadingAge of Washington
LHJ	Local Health Jurisdiction
LN	Licensed Nurse (includes both RNs and LPNs)
LPN	Licensed Practical Nurse
LSC	Life Safety Code
LTC	Long-Term Care
LTCO	Long-Term Care Ombuds
LTCOP	Long-Term Care Ombuds Program
LTCSP	Long-Term Care Survey Process
MAC	Medicare Administrative Contractor
MB	Management Bulletin
MD	Mental Disorder
MDS	Minimum Data Set
MFCD	Medicaid Fraud Control Division
MI	Mental Illness
NA	Nurse's Aide/Nurse's Assistant
N/A	Not Applicable
NA-C	Nursing Assistant Certified
NA-R	Nursing Assistant Registered
NATCEP	Nursing Aide Training and Competency Evaluation Program
NF	Nursing Facility
NH	Nursing Homes
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
PASRR	Pre-Admission Screening and Resident Review
PECOS	Provider Enrollment, Chain, and Ownership System
PEOG	Provider Enrollment and Oversight Group
POC	Plan of Correction
POD	Principles of Documentation
POLST	Physician's Order for Life Sustaining Treatment
PPE	Personal Protective Equipment
QA	Quality Assurance
QAPI	Quality Assurance and Performance Improvement
QIO	Quality Improvement Organization
QSO	Quality, Safety and Oversight
RA	Regional Administrator
RC	Related Condition
RCS	Residential Care Services
RCW	Revised Code of Washington

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RN	Registered Nurse
RO	Regional Office
RPP	Respiratory Protection Program
SA	State Agency
SFF	Special Focus Facility
SFM	State Fire Marshal
SFMO	State Fire Marshal's Office
SMI	Serious Mental Illness
SMQT	Surveyor Minimum Qualifications Test
SNF	Skilled Nursing Facility
SOD	Statement of Deficiency
SOM	State Operations Manual
SOP	Standard Operating Procedures
SQC	Substandard Quality of Care
S/S	Scope and Severity
TB	Tuberculosis/Tuberculin
TC	Team Coordinator
The Act	Social Security Act
VASOR	Vulnerable Adult Statement of Rights
WAC	Washington Administrative Code
WD	Working Day
WNOB	Washington State Name and Date of Birth
WSP	Washington State Patrol

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H. Change Log

Eff. Date	Chapter/Section #	Description of Change	Reason for Change	Communication and Training Plan
01/17/2025	Part VII Master Survey Schedule	Added guidance for due dates that fall on weekends or holidays	Incorporated current guidance to staff for clarification	N/A
01/17/2025	Entire Chapter	Formatting updates	Comply with new DSHS branding	N/A
06/14/2024	Full Chapter	Sunset Review update to capture current systems	Provide current guidance to staff	MB R24-053
06/14/2024	Full Chapter	Updated to new formatting	Provide for easier document navigation	MB R24-053
05/08/2023	Part VI added Special Focus Facilities (SFF)	Established subchapter Part VI	Added to provide guidance for SFF process	MB R23-046
01/04/2023	17G NH Master Survey Schedule	Established subchapter 17G	Adopted in response to SAO Audit finding and related CAP	MB R23-002
08/03/2020	17C11 Recertification Off-Hour Surveys	Established subchapter 17C11		MB R20-090