CHAPTER 16 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Overview

The state has facilities designated to participate in the ICF/IID federal Medicaid program. These facilities are required to meet federal Conditions of Participation (CoP) when providing services to individuals with intellectual disabilities. There are nine CoPs. ICF/IID regulates eight CoPs and the Fire Marshal regulates one CoP: Emergency Preparedness. The ICF regulated CoPs are identified under 42 CFR § 483.420-460 and federal citation tags:

- W102 – Governing Body,
- W122 – Client Protections,
- W158 – Facility Staffing,
- W195 – Active Treatment,
- W266 - Client Behavior and Facility Practices,
- W318 – Health Care Services,
- W406 – Physical Environment, and
- W459 – Dietetic Services.

The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above.

All must qualify for Medicaid assistance financially. Washington has state funded Residential Habilitation Centers (RHC) that house numerous Clients and privately owned ICF/IIDs that house fewer Clients. These facilities provide Interdisciplinary Teams (IDTs) of professionals that support, identify and develop behavior modification techniques to address behavioral difficulties and train those who qualify for extensive training services to gain independent living skills. Thus giving them the opportunity to transition into less restrictive type settings.

CMS uses the term “Clients” and “individuals” interchangeably in the State Operating Manual (SOM). Throughout the ICF/IID Chapter 16 Standard Operating Procedure (SOP), “Client” is used.

Intermediate Care Facilities must comply with the following Revised Code of Washington (RCW), Washington Administrative code (WAC), and the Social Security Act title 19- 1902, Title 42 CFR’s. These chapters give Residential Care Services (RCS) the authority to certify and investigate reports of abandonment, abuse, financial exploitation, and neglect of vulnerable adults.

- Federal: 42 CFR § 483.420-460
  - Requirements for States & LTC Facilities
    - Chapter 388-97-2020 WAC
    - Chapter 74.42 RCW
    - Chapter 74.34 RCW
    - Chapter 70.129 RCW

Subject Matter Experts

- Shana Privett ICF/IID Policy Program Manager, (360) 725-3282 or Shana.privett@dshs.wa.gov
- Gerald Heilinger ICF/IID Field Manager, (360) 725-2484 or Gerald.heilinger@dshs.wa.gov

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16 – ICF/IID Index

This section contains the index to Standard Operating Procedures (SOPs) that ICF/IID Surveyors and Complaint Investigators are required to follow:

Back to Top

Change Log

Washington State Department of Social & Health Services

16A1 – ICF/IID Survey Types

Overview

The Centers for Medicaid Services (CMS) amended the State Operating Manual (SOM) Appendix J (guidelines for surveyors) in 2018. The new guidelines provide for increased observation of Client outcomes. Attention is directed to what actually happens to Clients; whether the facility provides needed services and interventions; whether the facility ensures Clients are free from abuse, mistreatment, or neglect; whether Clients, families and guardians participate in identifying and selecting services; whether the facility promotes greater independence, choice, integration and productivity; how competently and effectively the staff interact with Clients; and whether all health needs are being met. Observation is the primary method of information gathering. The procedures below explain survey types and give general procedures for surveyors to follow. Specific instructions to all tasks are located in Chapter 16B 1-10: Survey Tasks.

Survey types

- Focused fundamental survey
- Extended survey
- Full survey

Each survey type has specific tasks that surveyors must complete.

Task assignments

- Entrance Conference.
- Task 1 – Sample selection.
- Task 2 – Review of facility systems to prevent abuse, negligent/mistreatment and how the facility resolves complaints.
- Task 3 – Focused observation.
- Task 4 – Required interviews with Individuals, family/advocate and direct care staff.
- Task 5 – Drug pass observation.
- Task 6 – Visit each area of the facility serving certified Clients.
- Task 7 – Record review of Clients in the sample.
- Exit Conference.

A. Focused Fundamental Survey (Task 1 - 3)

All ICF/IID recertification surveys utilize the focused fundamental survey. In addition to the entrance and exit, the focused fundamental survey follows the procedures outlined in tasks 1 through 3. The focused fundamental survey process utilizes a system centered on 27 “key regulations” from seven of the eight ICF regulated CoPs. Each of the key regulations has “corresponding regulations” which are looked at if the key regulation is determined to be out of compliance. When the facility is determined to be in substantial compliance with the identified key standard, the standards corresponding from the key standard are automatically determined as “met” since the key standard could not be compliant otherwise.

B. Extended Survey (Tasks 1 – 3)

During a focused fundamental survey, if a key standard of a CoP is found to be out of compliance, then the survey team will review all corresponding standards under that key standard to determine compliance with that condition (i.e., to determine condition-level compliance). If the review of the key standard and corresponding standards could result in a condition-level non-compliance finding, then the team must survey all the standards within that CoP. This review of all the standards within an ICF/IID CoP is known as an extended survey.

C. Full Survey (All 7 Tasks)

All initial certification surveys require a full survey. For recertification surveys, if the review of the key standard and corresponding standards results in a CoP non- compliance finding at 42 CFR 483.420-460:

- (W122) Client Protections,
- (W266) Client Behavior and Facility Practices, or
- (W318) Health Care Services,

The survey must convert from the extended survey to a full survey. Full surveys assess compliance at all eight CoPs.

Focused Fundamental Survey Procedure

Surveyors will:

1. Conduct annual recertification surveys within 12 -15 months of the last survey.
2. During the focused fundamental survey, the primary method of information gathering is observation. Initially spend at least 1 hour of general observations where Clients, using First Hour Observation, Attachment F or Surveyor Notes, Attachment V. Conduct interviews and record reviews to confirm or provide additional information on any concerns identified during observations. Except for the Individual Program Plan (IPP) and the Comprehensive Functional Assessment (CFA) for sample Client(s), do not conduct an in-depth review of progress notes or historical data unless there is suspected non-compliance of a key standard. As a result, the focused fundamental survey requires less onsite survey time than the full survey while still providing sufficient

information regarding the delivery of services by the facility to enable the survey team to determine compliance or noncompliance with the CoPs. Expand the Client sample list at any time as needed.

3. The focused fundamental survey involves the identification of key standards within the ICF/IID CoPs from which all other standards correspond. If indicated during the review of key standards, cite any of the corresponding standards as needed. Conduct Tasks 1 - 3 in addition to the entrance conference and exit conference, (sample selection, review the facilities system to prevent abuse, and observations).
4. **All** surveys will have the required medication observations, Attachment L and the required meal observations, Attachment J.
5. Review the key standard list and if a key standard is out of compliance, review the corresponding regulations associated with each key standard. See Appendix J grid for details. Review the CoP highlighted in **bold** and the key standard(s) under each CoP shaded in gray. The specified W tags under each shaded key standard are the corresponding regulations associated with that key standard. If no significant concerns are identified, the survey may conclude. All key standard citations and corresponding standard citations must have a Statement of Deficiency (SOD) report written. Conduct consensus and the exit conference.

Extended Survey Process Procedure

Surveyors will:

1. During a focused fundamental survey, if a key standard of a CoP is found to be out of compliance, review all corresponding standards under that key standard to determine compliance with that condition (i.e., to determine condition-level compliance). If the review of the key standard and corresponding standards *could* result in a condition level non-compliance finding, then decide to survey all the standards within that CoP. This review of all the standards within an ICF/IID CoP is the extended survey.
2. Tasks 1 – 3 will have been completed at this point.
3. The Team Leader will inform the facility of the extended status.
4. If there is evidence of non-compliant facility practice, neither the focused fundamental nor the extended survey processes preclude the survey team from review of any other standards.
5. If there are no identified CoPs out of condition, and depending on the Field Manager decision, conduct consensus and the exit conference. Write a SOD for all citations at the standard/key level.
6. If there are CoPs out in 42 CFR 483.420-460:
    - (W158) Facility Staffing,
    - (W195) Active Treatment Services,
    - (W406) Physical Environment and/or

- (W459) Dietetic Services

7. Proceed to write a SOD for citations at any citation level (condition, key, standard) as noted.

Full Survey Process Procedure

Surveyors will:

1. If the review of the key standard and corresponding standards results in a CoP noncompliance finding at 42 CFR 483.420-460:
    - (W122) Client Protections,
    - (W266) Client Behavior and Facility Practices, or
    - (W318) Health Care Services,

    Then the survey team must convert the extended survey to a full survey.
2. Review of all of the standards within all eight ICF/IID CoPs. In addition to the entrance and exit procedure, follow the procedures outlined in all seven tasks. A full survey is the only time CoP Governing Body and Management (W102) is reviewed.
3. Determine if a full survey needs to be conducted when any one or more of the following criteria are met:
    - The survey team is conducting an initial survey;
    - An immediate jeopardy is identified;
    - The survey team determines from the extended survey that Condition-level deficiencies exist at one or more of the specific CoPs at 42 CFR 483.420-460:
        - (W122) Client Protections,
        - (W266) Client Behavior and Facility Practices, or
        - (W318) Health Care Services; or
    - At the discretion of the Field Manager
4. Write a SOD for citations at any level as noted.

Field Manager will:

1. Train new staff and ensure they are able to demonstrate they understand survey types and procedures.
2. Determine facility coverage and appoint a Team Leader for each survey.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from headquarters as needed.

Administrative Assistant 3 will:

1. Maintain a schedule for recertification surveys on all ICF/IID facilities according to CMS guidelines.
2. Prepare a survey packet of needed documents for the Team Leader. See **Appendix A** for a list of ICF/IID forms.
3. Arrange all travel plans for the team.

4. Maintain current facility certification status in the Tracking Tool Survey and Citations.
5. Alert the Fire Marshal of the pending recertification survey.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16A2 - ICF/IID Tracking Tool (Surveys/Complaints)

Overview

To establish a method of documentation for enforcement decisions and actions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The ICF/IID tracking sheet must have all activities below documented.

Procedure

Surveyor/Complaint Investigator will:

1. Document deficiency citations (for all survey and complaint investigations) upon which an enforcement recommendation is warranted in a Statement of Deficiencies (SOD) on CMS form 2567**.**
2. Consult with the Field Manager regarding possible recommendations for enforcement actions.
3. Review the completed SOD with the Field Manager ensuring adequate time for review, prior to the 10 working day requirement for the final SOD delivery to the facility. See timelines in the State Operating Manual SOM Chapter 2: section 2728 and 2720C. Refer to Chapter 16C4: Facility Revisit Surveys for procedures on all ICF/IID timelines.
4. Notify the support staff of all activities and timelines for accurate documentation.

Field Manager will:

1. Review, edit and finalize the SOD using the SOD Review Checklist. (Use Complaint Checklist for ISR review and Reporting Grid)
2. Initiate recommendations for enforcement action when the facility is unable to comply with the plan of correction requirements.
3. If recommended, notify the Office Chief and inform Centers for Medicaid/Medicare Services (CMS) and/or Health Care Authority (HCA) of the need for an alternate enforcement action, within ten (10) working days of the initiation of Denial of Payments, Termination and/or Immediate Jeopardy (IJ). See SOM Chapter 2: section 2141 and Chapter 16D: Alternate Sanctions for procedures.
4. Ensure accurate timelines are enforced and the ICF/IID tracking spreadsheet reflects current actions for all surveys and complaint investigations.

Administrative Assistant 3 will:

1. Document progression of survey activities and/or complaint investigation activities in Tracking Tool Survey and Citations until completion:

- Include all citations, letter delivery dates, plans of corrections, and credible letter of allegations as received.

2. Ensure all survey data is reconciled in ASPEN.
3. Mail letters/documents as required. See AA3 desk manual for details.
4. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.
5. Collect Individual Workload from surveyors monthly.
6. Complete Survey Certification Workload Report monthly.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16A3 - ICF/IID Team Leader Role

Overview

The survey process is complex and time sensitive, requiring structure and leadership. As such, the Field Manager (FM) assigns a Team Leader for each survey to coordinate the survey process, give survey team members direction and the facility a point person of contact. Briefly outlined below are the responsibilities of the Team Leader. Formal procedures for all survey tasks are located in Chapter 16B1-10: Survey Tasks.

Procedure

The Team Leader will:

1. Preparation

- Prior to surveys, develop a Survey Action Plan**,** Attachment A (or for Investigations**,** Attachment AA and Attachment Z) for the team to follow during the course of the survey.
- Collect the ICF/IID survey packet (see Appendix A, ICF/IID Forms) from the Administrative Assistant 3 (AA3).
- Schedule a team meeting to discuss the survey action plan. Include all team members and the Field Manager. The action plan must include the survey type, entrance activities, the estimated exit date and specific information to the facility and team member roles.

2. Entrance

- Responsibilities include taking the lead at the facility entrance conference. Introduce and distribute Team Leader Identification card (ID) (and ID's for team members as applicable). Ensure your DSHS badge is visible. Inform the facility of the type of survey and complete the Entrance Conference Attendance Record, Attachment C. See Chapter 16B1 Entrance Conference or details.
- Give the facility an estimate of the length of time for the survey, request the Required Provider Survey Documents, Attachment D from the facility and present the facility with CMS form 3070G for completion.
- Work with the facility to determine a survey meeting room and ensure team members have keys as needed.
- Complete Sample Selection, Attachment E and assign each surveyor an equal number of sample Clients. See Chapter 16B2: Sample Selection for details.
- If the Field Manager does not accompany the survey team to the facility, check in periodically with the Field Manager or Office Chief, informing them of the progress of the survey, relay any concerns or to ask for direction.

3. Team meetings

- During the survey, conduct team meetings as needed. Use Team Notes, Attachment T or Surveyor Notes, Attachment V to capture the discussion of potential findings each day, as outlined in the survey action plan.
- Take the Lead in communicating with the facility, as needed throughout the survey process.
- For Immediate Jeopardy (IJ) procedures see Chapter 16C9: Immediate Jeopardy (IJ) for details.

4. Consensus

- At the end of the week when observation, interviews and record reviews are completed, facilitate the team in the consensus process (assessment of compliance). See Chapter 16B9: Survey Consensus for details.
- Use the Survey Review Checklist**,** Attachment X and the Team Leader Summary, Attachment Y to ensure all survey tasks are completed and all required documents are collected.
- Respect all team members, giving them the opportunity to voice all viewpoints.
- The role of the Team Leader does **not** include:
- Making decisions for the team, or
- To boss, bully or manage
- After the team consensus process is completed, compose the survey report using CMS form 3070H.
- At the conclusion of the meeting, ensure the facilities conference room is tidy (i.e. removing all documents and/or working papers and trash.) Return keys to the facility.
- Notify the Field Manager of the findings prior to the exit meeting.

5. Exit

- Arrange and conduct the facility exit conference (findings shared with the facility) from CMS form 3070H and explain pertinent timelines for the Statement of Deficiencies (SOD) arrival and due dates for Plan of Correction (POC). See Chapter 16B10: Exit Conference for details.
- Ensure the facility has a copy of the Client identifier list for reference during the meeting. Collect all survey documents before exiting the facility.
- Ensure all facility staff attending the exit conference sign the Exit Conference Roster, Attachment U.
- Note – At the end of any survey, collect all forms and documents used. Provide a completed packet to the AA3 for storage.

6. Statement of Deficiencies (SOD)

- Once off site, facilitate the process of writing the statement of deficiency, CMS form 2567. Develop and determine a confidential Client and staff list. Complete the ASPEN 0000 page.

- While keeping in mind the required timelines, present the final copy on CMS form 2567 to the Field Manager for review.
- CMS form 2567 must reflect the Field Manager changes and suggestions and the Team Leader is required to record the SOD in ASPEN. Ensure all team members complete the ASPEN 670 page.
- Finalize the CMS form 2567. Print and give the AA 3 a copy, who will send the SOD to the facility and notify them on or before the 10th working day after the survey exit date. See Chapter 16C1: Statement of Deficiencies (SOD) for details.

7. **Plan of Correction (POC)**
   - When the survey unit obtains a POC from the facility for all of the citations noted on the CMS form 2567, ensure it contains the required elements (see Chapter 16C2: Plan of Correction (PoC)) and notify the facility of acceptance of the POC. (Note – the facility is not required to record their POC on the CMS form 2567)
   - If the POC does not contain the required elements, discuss concerns with the Field Manager and notify the facility to ensure they send a corrected version of the POC. See Chapter C3: Unacceptable PoC for details.
8. **Complaint surveys**
   - During complaint surveys, the surveyor who is conducting a complaint survey will carry out all of the responsibilities that are typically the responsibility of the survey team and the survey Team Leader. See RCS SOP **Chapter 20** for details.

Field Manager will:

1. Train new staff and ensure they are able to demonstrate they understand the procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16A4 – ICF/IID Surveyor Conduct

Overview

ICF/IID surveyors represent the Centers for Medicaid Services (CMS) and must act professionally. Facility staff closely monitor surveyor conduct during all surveys and complaint investigations. The following outlined Standard Operating Procedure (SOP) is the expectation for all ICF/IID surveyors while on site, at any facility.

For Clients residing in ICF/IID facilities, having a survey team in their home can be disruptive. To reduce disruption and honor each Client's dignity, follow the procedure outlined below.

Procedure

The ICF/IID Surveyor Professional Guidelines:

1. Dress and communicate professionally at all times. Ensure your DSHS badge is visible. Do not talk "down" to staff or argue. If problems arise, discuss concerns at a private location.
2. Observe Client(s) in all of the areas the Client(s) spend time, including off campus.
3. Schedule time to observe special training programs that are critical to the Client's development. Proper observation procedure:

   Use observation time to determine if the Client's training is consistent at all appropriate times throughout the day. Observations of meal times, Client's communication with staff and others, behavior interventions, and routine activities should reflect a consistent pattern of interactions. Additional observations within similar situations, locations, or activities may be necessary to identify a systemic deficient practice as opposed to an isolated incident.

   - Remain as nonobtrusive as possible.
   - Do not give status updates to staff.
   - Do not assist the direct care staff in activities (i.e., do not assist a Client in a wheelchair to an activity at staff request).
   - Introduce yourself to Clients and staff.
   - Always attempt to be out of the way of Client activities. However, ensure you are able to observe as needed. Do not stand in doorways, or sit where the Client usually sits.
   - Do not accept gifts or snacks.
   - Do not interfere in the activities of the Clients unless they are clearly in danger. Examples may be:

- The nurse is about to give a Client the wrong medicine. (Interfere in the medication process and alert the nurse)
- A Client has fallen and in need of immediate first aid and there is no staff available. (Help the Client, call 911)
- You witness an assault between staff and a Client. (Call for help and remain present until help arrives to protect the Client)
- A Client is about to touch a hot stove unattended. (Attempt to block the area so the Client is protected)

4. Show respect for the Client's home and privacy. As a courtesy, always request permission before entering a bedroom or bathroom, as well as clinical exam rooms and dental offices.

   How to determine permission:

   Clients may or may not be able to give verbal permission. Many Clients are non-verbal. Determine if the Client is indicating a clear "yes" or "no" by nodding their head or using a hand gesture. With permission, enter the room. If not, do not enter the room. Attempt to do the environmental check of the bedroom when the Client is away from the house. If information is available elsewhere, do not observe activities in which Clients are undressed unless that observation is essential to the assessment of facility compliance. If observations of personal care must occur but the facility staff are uncomfortable allowing observations, discuss the issue with the house charge. If difficulties continue, go to the Team Leader outlining the importance of the observation and report to the Field Manager.

   When observing a Client in their room, it is advised to ensure direct care staff are present at all times if possible, however if observing a Client in their room when staff are not present, ensure that sufficient safeguards are present to prevent any appearance of impropriety on the surveyor's part. Refer to the Dignity and Respect examples Attachment DD.

5. For Clients who are working in competitive employment sites, ask the Client's permission to visit that site. If the Client is unable to communicate, discuss with facility staff the advisability of visiting the competitive site. The intent is not to interfere with the Clients work and to be non-intrusive. If the Client works at a restaurant as an example, the surveyor may visit the work site as a "customer" to observe the work environment. If an interview is necessary with the Client's supervisor or support person, conduct the interview in a private area. Upon arriving at the area, introduce yourself to the Client and the staff and explain the purpose of the visit.
6. Remain open minded, respectful of staff and assist other team members as needed.
7. During observations, use forms: 1st Hour Observation, Attachment F; Meal Observation, Attachment J; Medication Pass, Attachment L; and Surveyor Notes, Attachment V.

8. During record reviews, use Surveyor Notes, Attachment V. Do not direct staff to do work for you (i.e.: make copies, retrieve files, etc.). The survey process is a collaborative interaction between surveyors, facilities and their staff.
9. During interviews, use Sample Client Interview and Observation Worksheet, Attachment I or Surveyor Notes, Attachment V.
10. Discuss the facts, do not intimidate staff or argue. Do not give your opinion on how to fix a problem or system. Outline the deficiency giving clear, observational information and record review findings.
11. Maintain a Survey Tracking Log, Attachment B of working hours and complete the ASPEN 670 hours.
12. Develop the Individual Workload Report and give to the AA3.
13. Refer to Chapter 18 For All Settings, for further safety information as needed.

Field Manager will:

1. Train new staff and ensure they are able to demonstrate they understand the procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B – ICF/IID Survey Tasks

Overview

The Centers for Medicaid Services (CMS) provide a methodical survey protocol for surveyors to follow that focuses on the "outcome" of the facilities provision of active treatment. Observation is a key requirement of the survey process. To corroborate observations, the surveyor conducts interviews and records reviews. The survey process has seven tasks. This chapter explains protocols for each of the tasks, in addition to entrance and exit conferences.

All surveyors use these protocols to measure compliance with federal requirements. These protocols identify relevant areas and issues surveyed as specified in each regulation, and, in some cases, the methods used to survey those areas and issues. These protocols promote consistency in the survey process. The process ensures the review of the facility is thorough, efficient and in compliance with the regulations.

Included in the survey protocols are interpretive guidelines Exhibit 355 Probes that serve to clarify standard regulations and Conditions of Participation (CoPs). The guidelines define and explain the relevant Code of Federal Regulations (CFRs) referred to as regulations.

Any identified deficiencies are based on a violation of the regulations. The decision of whether there is a violation of the regulations must be based upon review of the facility's performance, practices, or conditions in the facility.

Where the surveyor believes conditions or practices are not in compliance with a regulation, the surveyor uses observation, record review and interviews to substantiate the existence of non-compliance. At the completion of the survey, the surveyor should have sufficient information to make compliance decisions.

In most cases, the ICF/IID health survey and the Life Safety Code (LSC) survey (conducted by the State Fire Marshal) are scheduled to occur simultaneously.

Authority

State Operating Manual (SOM) Chapter 2, Section 2700c
SOM Appendix J, Exhibit 355 Probes
SOM Chapter 5 - Complaints
Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B – ICF/IID Index

B. Survey Tasks Overview

1. Entrance Conference
2. Task 1: Sample Selection
3. Task 2: Review Systems To Prevent Abuse
    - Phase One
    - Phase Two
4. Task 3: Focused Observation
5. Task 4: Required Interviews
6. Task 5: Drug Administration Observation
7. Task 6: Inspect All Areas
8. Task 7: Record Review
9. Survey Consensus
10. Exit Conference

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B1 – ICF/IID Survey Tasks, Entrance Conference

Overview

It is CMS policy to have unannounced surveys for all ICF/IID facilities. It is extremely important for surveyors to observe the facility and the Clients in their regular, daily routine and not in a staged setting.

The entrance conference sets the tone for the entire survey. The surveyor should be well prepared, courteous, and make requests, not demands.

Procedure

Surveyor will:

1. Upon arrival, be alert and on "observation mode" before entering the facility. Once in the facility, notify the facility administration of your arrival.
2. Present the appropriate business card for identification and introduce other team members (who must also furnish a business card for identification if requested).
3. Conduct the Entrance Conference to include:
   a. Inform the facility administrator and/or director of the purpose of the survey. (Refer to Chapter 16A3: Team Leader Role for Team Leader responsibilities). Secure signatures of the staff present on the Entrance Conference Attendance Record with Attachment C.
   b. For initial and recertification's surveys, present the form Immediate Care Facility for Individuals with Intellectual Disabilities Survey Report CMS Form 3070G to the administrator. If needed, assist the administrator and/or Director with completion of the form. The form must be completed and collected at the end of the survey.
   c. Provide the expected duration and time schedule of the survey completion.
   d. Provide the facility with an overview of the survey and explain the process to include:
      - A physical onsite tour of the facility, inside and outside structures.
      - Direct observations, and interviews with the Clients, families/guardians, and personnel involved in the Clients' care.
      - Review of relevant program, treatments, and Clients' records.
   e. Request loaner keys for any areas that require a key for entry.
   f. Ask the facility to identify which staff will be available for questions/assistance and request a point person.
   g. Provide a prepared list of documents needed immediately, see Required Provider Documents, Attachment D. (Due to the differences in each facility, edit the attachment as needed.) Explain each requested document for clarity.

10. Secure a conference room for team meetings throughout the survey process.
11. When leaving the facility for the night (or lunch break, etc.), ensure the room is locked. Practice confidentiality during all phases of the survey.

Field Manager will:

1. Ensure surveyors understand the entrance process and demonstrate the ability to follow the procedure.

Administrative Assistant 3 will:

1. Prior to the survey, prepare a survey packet for the Team Leader to use during the survey. See ICF/IID Survey Forms. (Surveyors prepare their own documents for complaint surveys)
2. Contact the regional Fire Marshal of the pending survey date.
3. Document survey activity on the Tracking Tool Survey and Citations Spreadsheet.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B2 – ICF/IID Survey Task 1, Sample Selection

Overview

The purpose of drawing a sample of Clients from the facility is to ensure all the focused fundamental regulatory requirements are applied to a proportionate representation of Clients. The sampling methodology outlined below does not intend to create a "statistically valid" sample. The methodology allows for flexibility in the sample selection and ensures that the sample represents most of the focused fundamental tags.

Select the *core* sample of Clients from a list of the facility's current Client list without regard to Client developmental levels or locations in the facility. At a minimum, the core sample should include Clients that meet any one or more of the following criteria:

- Admission within the last six (6) months;
- Participation in a day program;
- On a self-administration program; and/or
- Frequent hospitalizations or ER visits.

The complete sample for the facility will include a core number of Clients selected at the beginning of the survey and additional Clients added during the process of the survey as needed, based on observations and/or interviews. Do not permit the facility staff to select the sample.

Procedure

Surveyor will:

1. The Team Leader usually conducts the sample selection. (See Chapter 16A3: Team Leader Role for Team Leader responsibilities).
2. Use the following guidance to calculate the core sample size:
   Number of Clients residing in the facility / minimum number in core sample

Census:	Sample Ratio:
4 Clients	2 Clients
5-16 Clients	3 Clients
17-50 Clients	4 Clients
51-100 Clients	6 Clients
101-150 Clients	8 Clients
Over 150	10 Clients

3. While selecting the sample, the team members are to begin general observations immediately. Use First Hour Observation Report, Attachment F or Surveyor notes, Attachment V. This initial observation should be no shorter than one hour. (See Chapter 16B4 for Focused observation details.)

4. During the initial observation, identify Client names if areas of concern. Examples may include, but are not limited to:
    a) Clients with significant medical involvement which may be impacting the implementation of their IPP;
    b) Clients with significant behaviors with lack of or inappropriate staff intervention;
    c) Clients that are idle for extended periods of time;
    d) Clients that appear to have strengths but are not encouraged to use those skills or are performing activities below their skill levels; and
    e) Clients who are not provided appropriate medical care.
5. After one hour, return to the team meeting area to determine which core sample Clients each surveyor will be assigned. Surveyors may suggest adding expanded sample Clients at this time as needed.
6. The Team Leader will distribute the Client sample equitably among team members to maximize the advantage of an interdisciplinary survey team. Record the core sample using the Sample Selection form, Attachment E. Ensure the document contains:
    - Summary listing of all Client information comprising the survey sample (including any additions or substitutions to the sample).
    - Any Client-identifier codes used as a reference to protect the Client's confidentiality.
7. After the Client sample selection, additional information about the facility's practices, as well as additional Client information may emerge. Surveyors may add Clients to the sample based on observations or incidents that occur during the survey. Example: Add a Client to the sample based solely on the fact that they are on a self - administration program for medication. Document the reason for adding the Client(s) to the sample using the Sample Selection, Attachment E.
8. If it is determined that a Client is on an extended leave from the facility and/or will be unavailable during the survey process, a Client substitution is acceptable in the core sample. With a substitution made, surveyors must ensure that the Client added to the sample meets the same requirements and criteria listed above.
   Ensure Attachment E also contains a *description* of the representative sample selection:
    - The total number of Clients in the sample.
    - The number, if any, of the Clients added to the sample, including the reason added, e.g., complaint investigation; and
    - The number, if any, of the Clients substituted in the sample, including the reason for withdrawing the original Client.
9. Throughout the survey, each member of the team will share information and possible problematic findings relative to their assigned Client(s). Consult with one another, on a

regular basis during the survey, to maximize sharing of data, knowledge and competencies.

10. A Client added to the core sample, during observations, does not require a full review of their program record. There is no minimum or maximum number of additional Clients required. However, ensure there is the required number of sample core Clients on the list.
11. Conduct a full review (observation, record review and interview) of all Clients in the core sample list.

Field Manager will:

1. Ensure surveyors understand the sample selection process and demonstrate the ability to follow the procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
3. Request training or clarification from headquarters as needed.

Administrative Assistant 3 will:

1. Document survey activity on the Tracking Tool Survey and Citation Spreadsheet.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B3 – ICF/IID Survey Task 2, Review Facility Systems to Prevent Abuse, Neglect and Mistreatment and to Resolve Complaints

Overview

The goal of the federal complaint/incident process is to establish that the facility has a system in place that will assist in promoting and protecting the health, safety, and welfare of Clients receiving services. The complaint/incident management system has three objectives.

1. The first objective and priority for the complaint/incident management system is **protective oversight**. To accomplish this, analyze the complaint allegations and reported incidents received to identify and respond to those that appear to pose the greatest potential for harming beneficiaries (has caused or is likely to cause, serious injury, harm, impairment or death). The facility must immediately investigate complaints/incidents that allege an immediate threat to the health, safety, or welfare of Clients.
2. The second objective is **prevention**. Investigate complaints/incidents that do not allege a threat of serious harm, to determine if a problem exists that could have a negative impact on the services provided. The investigation of these complaints/incidents is designed to identify and correct less serious complaints/incident to prevent the escalation of these problems into more serious situations that would threaten the health, safety, and welfare of the Clients receiving the service. These complaints/incidents are also prioritized and investigated based on the seriousness of the allegations.
3. The third objective is to promote **efficiency and quality** within the facilities delivery system. Complaints/incidents not directly related to federal requirements are forwarded to the appropriate agency(ies) for follow-up and investigation (see Compliant Resolution Unit SOP, Chapter 4 for details). Complaints/incidents in this category may include but are not limited to allegations of abuse, neglect, or mistreatment of Clients, Medicaid fraud, complaints against individual licensed practitioners, and staffing issues. When determining whether the facility has systems in place to prevent abuse, neglect, mistreatment, and to resolve complaints or not, surveyors will use protocols outlined in Task 2.

Task 2 consists of Two Phases. In the absence of pre-existing characteristics, conclude Phase One. If there are pre-existing criteria or if in the course of the survey there are concerns with Client protections identified, the surveyor will extend to the Phase Two review. Any one or more of the following of these pre-existing criteria would initiate a Phase Two review:

- Substantiated (by the facility) complaints or facility reported events in Client Protections since the last recertification survey;
- A survey history of citations at W127, W153-W157; or
- Concerns identified by the survey team that warrant a Phase Two review.

Procedure for Task 2 – *Phase One*

Surveyors will:

1. As determined by the Team Leader and as outlined on the Survey Action Plan Attachment A, assigned staff will begin Task 2.
2. In the absence of any pre-survey information that would indicate the need for a more thorough review, conduct Client **observations** to include staff-to-Client and Client-to-Client interactions, and staff/Client/family interviews. Look for:
    - Any signs of Client injury (e.g., bruising, splints, bandages, scratches, limping or favoring a limb, etc.);
    - Client-to-Client aggression;
    - Inappropriate staff-to-Client interactions (e.g., physical, verbal);
    - Signs of fear in the presence of specific Clients or staff;
    - Signs of mistreatment or punishment by staff such as rudeness, rough handling, restriction of rights, etc.; or
    - Any Clients currently in the hospital or experiencing recent hospitalizations or emergency room visit
3. If Phase One observations identify any concerns with possible abuse, neglect and mistreatment, as well as failure to resolve complaints, then conduct specifically associated interviews. Follow the outlined process on Task 2 Phase One, Attachment G
4. **Interview** the Client first. Do not exclude Clients who use alternate means of communication, such as communication boards or gestures. Most Clients are able to communicate in some manner. See Sample Client Interview and Observation worksheet, Attachment I for examples of questions you might ask and refer to the Dignity and Respect Attachment DD as needed. Document all findings on Survey Notes, Attachment V or Sample Client Interview and Observation worksheet, Attachment I.
5. Interview the family, legal guardian, advocates (if applicable) and close friends (if identified) of each Client for whom a concern was identified either during observations or Client interviews. It is permissible to interview family members, legal guardians, advocates and close friends at the facility or by telephone.

6. Interview facility staff as needed. This includes direct care staff from more than one shift, the applicable Qualified Intellectual Disability Professional (QIDP) and medical personnel. The goals of the interviews are to determine:
    - How often injuries/mistreatment are occurring,
    - What process is the facility using for reporting such instances,
    - The timeliness of notifications,
    - Whether Clients are protected from harm during investigations and
    - Whether the facility implemented process changes to prevent future injuries and/or mistreatment

    Tailor questions during each interview according to the observations made.
7. Carefully document all observations and interviews on Survey Notes, Attachment V or Task 2 Phase One, Attachment G, capturing names, job titles, the date, time and location and summary of the content discussed.
8. These observations and interviews identify the reporting records or investigation records that you will need to review. Request these **records/reports** *after* the observations and interviews have been completed.
9. For any specific injury noted during observations (regardless of whether the Client is in the sample or not), request the documentation associated with the injury (reporting/investigation/disposition). The goal of this documentation review is to verify the information provided by the staff and to ensure the prompt reporting, investigation and protection of Clients with injuries and allegations of mistreatment. Document all findings on Survey Notes, Attachment V or Sample Client Interview and Observation worksheet, Attachment I.
10. Determine if the facility thoroughly investigated the incident. A thorough facility investigation must include at a minimum:
    - The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams;
    - Review of all information related to the allegation;
    - Resolution of any discrepancies;
    - Summary of conclusions; and
    - Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.
11. If the observations, interviews or record reviews during Phase One confirm that the facility is identifying injuries and mistreatment promptly, notifying the appropriate persons, doing appropriate investigations, and doing appropriate interventions, then conclude Phase One. Surveyors may write deficiencies at Phase One without proceeding to Phase Two.

Procedure for Task 2 – *Phase Two*

Surveyors will:

1. If it is determined during Phase One that there is insufficient evidence to find that the facility is in compliance with the CoP for Client protections at 42 CFR 483.420, an extensive review is required. See Task 2 Phase Two, Attachment H to follow the complete process.
2. Request the facility log of Client incidents and reports and select a sample of 5 percent of the incidents from the total Client incidents occurring during the last three (3) months. (Review a minimum of 10, if available. If not, document the justification in the working papers.) Request the investigative reports for these incidents.
3. Review the facility's policy and procedure documents on restraint, seclusion, and time out interventions. The policy must contain information about management and safety intervention and the facility's procedures regarding all the requirements of the CoP.
4. Look for any evidence that suggests Client abuse, neglect or mistreatment. Determine whether in each case the incident was:
    - Reported promptly
    - Investigated thoroughly
    - Safeguards put into place during the investigation
    - Corrective measures taken in order to prevent recurrences
5. If the facility has a system in place to prevent abuse, neglect and mistreatment and to resolve complaints and takes the appropriate corrective measures, then, Task 2, Phase Two (see Attachment H) is complete.
6. If the 5 percent sample review is not determinative as to the compliance with the CoP for Client protections, or the surveyor identifies any patterns of possible abuse, mistreatment or neglect, (or the incident report logs for the past three months indicate an extremely high incident rate), proceed to a full review of the total number of incidents and reports for the past three months to identify any deficient practice by the facility.
7. If issues exist that rise to the level of an Immediate Jeopardy (IJ), investigate and follow procedures in Appendix Q - IJ. Notify the Field Manager immediately. Refer to Chapter 16C9: Immediate Jeopardy (IJ) for details.

Field Manager will:

1. Ensure surveyors understand the Task 2, Phase One and Phase Two process.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top
Change Log

Washington State Department of Social & Health Services

Chapter 16B4 – ICF/IID Survey Task 3, Focused Observation

Overview

The majority of the time on an ICF/IID focused fundamental survey is spent doing observation, associated interviews, and associated targeted record review. It is critical that observations of sufficient duration occur across the entire survey (i.e. early morning, afternoon, and evening) and occur across the Client's various environments (home, recreation and day program). Observe a minimum of two meals and two medication pass events. (See Chapter 16B6: Drug Administration for details)

With completion of the selected Client core sample list and the when the team obtains copies of the Individual Program Plan (IPP) for each selected Client, the observations should begin. However, do not delay beginning observations awaiting the IPPs. Begin general observations until the facility provides the IPPs.

The purpose of direct observation is to determine the existence of effective therapeutic relationship between the facility staff and the Clients. Staff must respect the rights of the Clients and interact with them in a mutually productive manner. Direct observation also helps to determine how effective staff manages the milieu and efficiency of the application of de-escalation and other behavior management techniques.

Results of these initial observations are critical to the focused fundamental survey process on two levels.

- The surveyor(s) may observe specific issues, which would indicate further investigation or identify additional Clients to add to the core sample.
- The survey team may determine that, based upon the overall initial observation findings, the facility will require an extended or full survey rather than a focused fundamental.

Procedure

Surveyor will:

1. Initially note and record the first general impressions of each area where the Client(s) reside (i.e., the milieu). Conduct these observations, without intruding (unless it is necessary to alert a staff member to a possible risk to a Client) for at least an hour in each initial location. See Chapter 16A4: Surveyor Conduct for details.

2. Use forms: Survey Notes, Attachment V, Sample Client Interview and Observation worksheet, Attachment I, or First Hour Observation Report, Attachment F for observations.
3. Never request the facility to alter a Client's schedule in order to observe the Client during the survey. Observe each sampled Client in as many treatment settings (therapy groups, activities, treatment team meetings, other types of meetings, and milieu interactions in the Client's environment) as possible. Visit as many treatment areas as time permits, and observe Clients' activities during different time periods, including day and evening hours, if possible. Allow sufficient time to observe and assess the sampled Client's responses and behaviors as well as staff responses to Client behaviors. Note things in the general milieu such as:
    - Are all the Clients in the area dressed appropriately but individually according to what appears to be their preferences?
    - What activities are taking place? Note the time of day. Are these activities appropriate for the time of day?
    - How many staff are present?
    - Does the environment appear calm and purposeful?
    - What is the staff doing? How is the staff interacting with the Clients? How are Clients interacting with each other?
    - Are Clients being encouraged by the staff to participate in activities or staff doing things done for them?
    - What types of adaptive equipment or assistive devices are used?
    - Do the staff use teachable moments with the Clients?
    - Behavioral episodes addressed? How?
    - Do Clients appear well nourished? Do they appear sleepy (not early in the morning)?
    - Do any Clients have signs of injury? (Note for subsequent staff interview and Task 2 review.)
4. All Clients in the core sample require a full review (observation, record review and interview).
5. Observe focused areas:
    - **Active Treatment** Each Individual Program Plan (IPP) must be appropriate for the Client based upon a comprehensive assessment and revised with changes in Client program needs. The IPP must correspond to what treatments, programs or services the Client is actually receiving. Programs should be appropriate for the Client (i.e., is the Client able to accomplish/complete the program too easily; have they already accomplished the components of the program; or does the Client have program needs that have not been addressed

by the IPP (e.g., ADL, behavioral, socialization)? If there are discrepancies with the IPP programs after observing the Client in several environments, the surveyor should speak with the Client and/or appropriate staff (QIDP, direct care staff, psychology staff) for additional information on the identified concerns. Do not conduct interviews with staff routinely. If during observations the surveyor(s) determine that the current objectives of the IPP match the strengths and needs of the Client, the staff is familiar with the methodology of accomplishing these programs, and staff apply them as written in the IPP; there is no need to conduct formal staff interviews. The surveyor should ask the direct care staff carrying out the program(s) for records documenting program(s). If the Client is making steady progress, the program data will reflect this. However, if there is no progress made or if there has been a regression, there should be evidence that the QIDP/IDT is aware of the issue and is addressing it. In this case or in the case, where actual programs do not match IPP programs or do not seem appropriate for the Client, based upon the Client's identified skills, it is necessary for the surveyors to interview appropriate staff.

- **Staffing levels** Generally, an inadequate number of staff will result in concerns with Client programming and Client protection. During observations, note how the on duty staffing ratios either promote or prevent a safe and productive active treatment environment. In some instances, surveyors will see the effects of inadequate staffing early (during the first impression observation). These effects may include chaotic environment, Client-to-Client abuse, self-abuse by Clients, Clients sitting unengaged for long periods of time with little or no staff presence, Clients not given the opportunity to assist in ADLs or participate in the rhythms of life due to the need to "get things done" (such as assisting with meal preparation), or programs not being carried out due to inadequate on-duty staffing.
- **Qualified Intellectual Disability Professional (QIDP)** The increased time devoted to observations during the survey provides more of an opportunity to observe the QIDP in action. Observe interactions between the QIDP and the staff and the QIDP and the Clients. Is the QIDP familiar with client programs and Client progress? How much direct interaction is occurring among the QIDP, the staff and the Clients? Is the QIDP intervening when necessary and facilitating revisions to IPP as indicated? If the surveyor has unresolved discrepancies, discuss concerns with the QIDP.
- **Health Care Services** The surveyor should determine from observations whether or not the sampled clients are receiving medical care as indicated. If during observation there is concern about the health of a Client, the nurse

surveyor should talk with the Client and/or the nurse about the issues observed. In the event that there is not a nurse surveyor, the non-clinical surveyor will need to consult with a clinician. See SOP Chapter 18 for details. Determine what interaction is occurring between the Client and the medical staff and whether the situation is improving or deteriorating. Review the pertinent portions of the Client record and discuss with the medical staff as necessary.

- **Physical Environment** During observations, the surveyor should observe the facility for cleanliness, comfortable temperature and any safety hazards (i.e. obstructed walkways, resilient, nonabrasive, and slip- resistant floors).

Field Manager will:

1. Ensure surveyors understand the focused observation process.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
3. Request training or clarification from headquarters as needed.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B5 – ICF/IID Survey Task 4, Required Interviews with Clients and/or Family, Direct Care Staff, and Administrators

Overview

Clients living in the facility, their families/guardians and advocates, and direct care staff are important sources of information about the receipt of active treatment, and the care and services provided on a daily basis. Interviews are conducted for two purposes:

- To determine how the Client perceives the services delivered by the facility
- To clarify information gathered during observations

Surveyors must attempt to interview all sample Clients individually. However, an interview may not be conducted if the Client declines, behavioral difficulties prevent the opportunity or it is inappropriate for the Client's current condition. Staff information and medical record documentation should support the rationale for not interviewing the Client as well as the surveyor's working papers.

Select those Clients who will be able to communicate at least some basic information or those who have actively involved family members, guardians, or advocates. Include interviews with Clients who use alternate means of communication, such as communication boards, sign language, and gestures. Most Clients are able to communicate in some manner.

Conduct interviews and observations of the sampled Clients within the context of the environment in which the Client lives, receives treatment, and spends leisure time. Although focus should be on the sampled Clients, the behavior and interactions of all other Clients and staff within the environment also contributes to the milieu and can be documented as needed.

Procedure for Client Interviews

Surveyor will:

1. When possible, interview Clients to verify participation in service planning and in making choices about matters important to them.
2. Ensure the Clients name, date, time of interview, location and summary of the interview are clearly documented using First Hour Observation Attachment F, Sample Client Interview and Observation Attachment I as a guide, and/or Surveyor Notes, Attachment V.
3. Respect the Client's rights and ensure the setting of the interview is conducive and non-restrictive:
    a. Request permission of the Client to talk with them individually.
    b. Provide the Client with information, such as your name, the purpose of the survey, and what your role is. To put the person at ease you may want to begin

with some general conversation, e.g., about the weather or a special event coming up.

c. Ensure Client privacy by conducting the interview in an appropriate location (low stimulus, on or off unit depending on Client restrictions, staff visible for surveyor and Client protection, *if necessary*). Staff should be easily available and may be present in the room, but should not be able to overhear conversation unless the Client makes a request for staff to remain in close proximity. Refer to Dignity and Respect Attachment DD as needed.

4. Take into consideration the Client's age and diagnosed condition(s). Interviews with Clients consist of questions directed at determining their understanding of the treatment services indicated in their individual program plan, progress towards goals, and the type and quality of relationship with program staff.
5. The questions and communication method will vary from person to person. For Clients who use a specialized communication method, attempt to begin the interview on a one to one basis. If you find you are unable to communicate with the Client, ask someone familiar with the person to assist you (e.g., a family member or a staff person.). For this Client, pay close attention to how the staff communicates with them. If the person uses sign language or a communication board, do staff understand and interact with the Client using the same method? If the Client uses gestures, does staff take time to determine their needs?
6. Determine if the Client responds better to questions that can be answered "yes" or "no" versus open-ended questions. Adjust questions accordingly.
7. Be sensitive to signs that the Client is tiring or becoming uncomfortable and either end the interview or continue it at a later time.
8. The wording to the questions may be modified, based on the Client being interviewed and on the communication skills of that Client. It is not necessary to ask every question in the guide, but ask at least one question related from each topic area.
9. Ask questions related to:
   a. **Choice and Community Participation** (W136, W147, W247):
      - What sorts of things do you like to do for fun?
      - Do you go out to activities or events in the community (like shopping, movies, or church)?
      - How often do you do this? How do you get there? Who chooses where you go?
      - Do you go to visit family members or take vacations?
      - Is there something you would like to do more often?
   b. **Personal Finances and Possessions** (W126, W137):
      - Do you earn money when you work for your job (at your day program)?
      - What do you like to buy with your money?
      - Do you have enough money to buy the things you want or need?
      - Does someone help you with spending or saving your money?
      - When you go to the store, do you pay for items or does a staff person pay for them?
      - Do you have enough clothes and shoes?

- Do you always have enough deodorant and toothpaste, etc.?
- What do you do if you need to buy something?

c. **Personal Relationships and Privacy** (W129-W130, W133, W143 - W148):
- Do you have family or friends who visit you?
- Does your family write to you or telephone you?
- Does someone help you read their letters/ call them on the phone?
- If you feel like being alone or spending private time with a friend or family, where do you go?
- Does staff knock on your door before they come into the room?

d. **Client's and Family's Participation in the IPP Process** (W209, W247):
- Do you go to (team) meetings with the staff where they talk about the services you get?
- Does your family/advocate come to these meetings? Were you asked if the date and time of the meeting were OK with you? What would you like to learn to do for yourself?
- Does the staff ask you what you want? Who chooses what you do? Does the staff listen to you and make changes based on what you want?

e. **Service Delivery** (W242, W249, W436):
- What help do you need from staff to dress, eat, bathe, etc.?
- Do you get any special therapy (e.g., speech or physical therapy)?
- What new things are you learning to do?
- What chores do you help with around the house?
- Who helps you when you do not know how to do something?
- What special equipment do you use?

f. **Client Rights and Protections** (W124-W125, W127, W153-W157, W127-W128, W263):
- Who do you tell if you do not like something, or something is wrong?
- Are there rules that everyone who lives here must follow?
- What sorts of things are you allowed to do or not do?
- How does the staff treat you?
- Are staff loud? Does staff yell, swear or hit?
- Do you ever do things you are not supposed to do? What happens then?
- Were you ever asked to give consent for any treatments or services?
- Were you told the benefits, risks, and alternatives?

g. **Health Status** (W322, W356):
- How often do you see a doctor? A dentist?
- Do you have any health problems?
- Do you take any medicines? Do you know what they are for?

h. Wrap-up Questions:
- Is there anything you especially like about living here?
- Anything you especially dislike?
- Is there anything else you think I should know about what it is like to live here?

10. At the end of the interview, if you think you may need to discuss or confirm personal information with staff or family, ask the Client if it is OK to share that information. Honor the Clients request when possible.
11. Thank the Client for talking with you.
12. Use the following hierarchy of sources in the order shown:
    - Client
    - Families, Legal Guardian, or Advocate
    - Direct Care Staff
    - Qualified Intellectual Disabilities Professional (QIDP) and/or Professional Staff
    - Managers, Administrators, or Department Heads

Procedure for Family, Legal Guardian, or Advocate Interviews

Surveyor will:

1. Interviews with family members, legal guardians, or advocates can be conducted as needed or in place of the sampled Clients. Family members, guardian, or advocate can be interviewed at the facility, at a location convenient to both the surveyor and the interviewee, or by telephone.
2. All interviews should be conducted in private locations and scheduled at mutually agreed upon times in order to minimize disruptions to family members', legal guardians' or advocates' activities. Amend the questions below as needed for each interviewee:
    - How do you learn about things like the services your family member receives, an illness, or a change in medication?
    - Are there any restrictions for when you can visit your family member or where you can go within the home?
    - Does the facility inform you of locked cabinets, refrigerators, and alarms on doors and windows for the sake of other Individuals' behaviors? Does the facility require you to give consent?
    - How do you feel about the services your son/daughter receives at the facility?
    - Do you feel that they should be receiving services that they are not presently receiving?
    - If you have any concerns about the care your son/daughter are receiving, do you inform the facility about your concerns?
3. Thank the family member, legal guardian, or advocate for speaking with you.
4. Ensure you document the relationship to the Client, the method of interview (face-to-face or telephone contact), number of contacts attempted, and a summary of information obtained. Document clearly using Surveyor Notes, Attachment V.

Procedure for Interviews with Direct Care Staff

Surveyor will:

1. Interviews with staff are not done routinely. If during observations the surveyor(s) determine that the current objectives of the Individual Program Plan (IPP) match the

strengths and needs of the Client, direct care staff is familiar with the methodology of accomplishing these programs, and they are being carried out as written in the IPP, there is no need to conduct formal staff interviews.

2. However, it is often necessary to ask impromptu questions during observations for clarification. If possible, interview staff following the interval in which the Client was observed with the particular staff member. For example, if you have just observed Client A engaging in stereotypical behaviors, ask: "Can you tell me what, if anything, you do when he rocks back and forth?" Ask open- ended questions in order to confirm observations, obtain additional information, or corroborate information, e.g., accidents, odors, apparent inappropriate dress, adequacy, and appropriateness of training activities.
3. Document staff names, job title, date, time, reason for the interview and summary of the interview using Surveyor Notes, Attachment V.
4. In the absence of finding interaction between staff and Clients during observations, it may be necessary to judge whether or not staff is knowledgeable about Client objectives and techniques for implementation of programs.
5. Ask questions that elicit information about how staff learn what to do with Clients across the spectrum of support and programming activities they are expected to perform. Questions to ask may be:
    - Do you participate in the interdisciplinary treatment team; if yes, what role do you play?
    - Did you contribute to IPP objectives/goals for the sample Client and updates?
    - Give examples of de-escalation techniques you were taught and how you utilize them when dealing with Clients?
    - Do you feel you are adequately prepared (through education and training) to handle behavioral safety situations and emergencies related to Clients' care?
6. During the course of observations and interviews, consider the following:
    - Are staff competent to carry out the Client's choices and skill development activity?
    - Is there evidence that programs are in fact being carried out throughout the Client's waking hours?
    - Are interventions revised based on changes in the Client's progress toward goals?
    - If staff cannot demonstrate the skills necessary to implement the individual's programs and choices, if interventions are not being carried out consistently, or if revisions to interventions do not occur, is active treatment delivered?

Procedure for Conducting Interviews with Professional and Administrative Staff

Surveyor will:

1. Interview Interdisciplinary Team Members (IDT) who have assigned active treatment responsibilities for each Client, if concerns arise.

2. Conduct these interviews near the end of the survey and base the interviews on information that was gathered during observations and direct interviews with Clients and direct care staff.
3. If needed, conduct interviews to determine what the facility does to provide individualized services and supports. Questions to consider:
    - Are individuals treated with respect and dignity?
    - Does the facility attempt to help the person set and attain individual goals?
    - Are there consistent opportunities for making choices?
    - When a choice is not an option, how is the Client assisted to understand?
        - For example, if a planned activity is to go to a restaurant for dinner, who chooses the restaurant?
        - If one group of people does not want to go, how is this choice accommodated?
        - Is the accommodation based on individual choice, staff convenience, or a reasonable justification if a choice is not an option?
4. For medical concerns, consider the questions below to determine if the Clients are receiving proper medical care:
    - Do any of the Clients have acute or chronic medical issues? How are these issues being addressed by the medical staff at the facility?
    - Do the Clients seem alert and energetic?
    - Are Clients at a healthy weight?
    - Do the Clients have good oral health? Have any dental problems been dealt with promptly and appropriately?
    - Are the staff trained on first aid and reporting of medical issues?
5. Document staff names, position/job title, date, time, and reason for the interview with a summary of the interview, using Surveyor Notes, Attachment V.
6. It is imperative to remember that when concerns arise that may indicate non-compliance with federal regulations, the surveyor will need at least two of three sources of information to be well documented: observations, interviews, and record reviews, for solid confirmation of non-compliance. Having three sources of distinct evidence is ideal as it reduces the chances of challenged citations.

Field Manager will:

1. Ensure surveyors understand the interview process and demonstrate the ability to follow the procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B6 – ICF/IID Survey Task 5, Drug Administration Pass

Overview

Observe and record the administration of medications ("pass"). The purpose of the medication review is to direct the facility's attention to assuring an error free drug distribution system, and away from the paper, processes that often do not represent actual errors in medication administration. Observations and interviews with the Client and staff focus on the medication administration. A medication error is an observed discrepancy during the medication pass between what is ordered by the physician and what is administered to the Client. 42 CFR 483.460(k)(2)

If there are Clients on a self-administration of medications program, the evaluation of the program should be part of the active treatment observations. The medication administration pass observed during the observations may or may not be for Clients in the survey sample.

Medication administration pass: One observation of medication administration on a particular shift that captures half of the required drug doses.
Drug dose: Multiple tablets or capsules required to deliver a dose of a single medication, count as one dose.

- For small facilities (up to 16 beds), the **medication administration pass** will encompass a total of eight (8) **drug doses**. The observations should be split between two separate drug passes 4/4 (one in the morning and one in the late afternoon or early evening).

- For large facilities (17 beds or more), the **medication administration pass** will encompass a total of 12 **drug doses**. The observations should be split between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). The record of observation should be reconciled (with the most current signed physician's orders), soon after the observation to allow for interviewing the administrating nurse if questions arise.

Procedure

Surveyor will:
Medication Preparation

1. Record on the Medication Pass Observation Worksheet, Attachment L, the Client's name (or identified letter), the name of the medication, dose, route, expiration date, and time to be administered.
2. Identify the product by its size, shape, color, and number of pills.
3. This is often done by requesting to read either the medication bottle or package and/or medication "Punch card". Alert the nurse that you will be observing the medication pass and will need to document the information.

Observation

1. Remain non-obtrusive as possible. Observe the preparation and administration of medications to Clients. Findings at this juncture should be focused on what the surveyor **observes**, not what the medication administration record states.
2. If there are Clients at the facility who self-administer medications, attempt to observe the self-administration. Respect the Client's right to privacy by verbally asking the Client for permission to observe.
3. Document if medications are crushed prior to administration.
4. Observe infection prevention practices by staff administering the medications. If the staff administering medications fail to use infection prevention, this would lead to a deficiency.

Documentation

1. Record your observations in Medication Pass Observation Worksheet, Attachment L and any additional comments in Surveyor Notes, Attachment V if needed. If applicable, document administrative actions. Did the nurse shake the liquid, pour at eye level, or offer water? Follow the person administering medications and observe the Clients receiving drugs.
2. When observing staff administering medications to a Client, plan to watch the entire process to include all doses.
3. Complete the Medication Pass Observation Worksheet, Attachment L for each dose given for each Client observed.
4. Note every detail about drug administration in your notes. Example: "eye drops administered to both eyes" or "nurse took pulse" or "all drugs crushed and administered in applesauce."

Reconcile

1. Record review may help identify possible errors, however detection of blank spaces on a Medication Administration Record (MAR) does not alone constitute the occurrence of actual medication errors. The surveyor(s) conducting medication observation will need to follow-up on any observed concerns through additional record review and interviews.
2. Reconcile the record of observation with the prescriber's medication orders to determine whether or not medication errors have occurred. It is best to review the MAR *and* the most current physician orders to ensure accuracy. For each medication on the Medication Pass Observation Worksheet, Attachment L, determine if the medication was administered:
    - According to a valid prescriber's order(s)
    - To the correct Client
    - At the correct time
    - In the correct dose
    - By the correct route
    - According to correct accepted standards of practice and manufacturer's specifications

3. For medications not on the surveyor's list, examine the record for medication orders that were not administered and should have been. Such circumstances may represent omitted doses, one of the most frequent types of errors.
4. Before concluding that an error has occurred, discuss the apparent error, if possible, with the person who administered the medications, as there may be a logical explanation for an apparent error. Document the interview.
5. The surveyor should now have a complete record of what was observed and what should have occurred according to the prescribers' orders.

Intervening During Medication Administration

1. There may be times when the surveyor should intervene before the person administering the medication makes a suspected medication error. This would occur in the event the surveyor becomes aware of the concern before reconciling the medication administration observations with the physician's orders.
2. Examples of this may include situations where the surveyor understands that the resident is about to receive:
    - An unusually large dose of medication;
    - A medication via the wrong route, such as ear drops in the eyes; or
    - An inaccurate amount of medication (difference in what was seen prepared versus what the staff member stated they were preparing, such as amount of insulin).
3. When the surveyor encounters such a situation, bring it to the attention of the person about to administer the medication. The timing of this would take place at the point in which that person has committed to administering the medication, such as upon entering the Client's room or approaching the Client. The surveyor should question the person away from the Client, such as at the medication cart or in the medication room, in a way that is respectful of the person administering medication and will not bring unnecessary alarm to the Client. The intent is to confirm whether a medication error (significant or non-significant) was or was not about to occur.
4. Reporting Errors - At the exit conference, describe to facility staff examples of the errors detected. Do not analyze the errors and come to any conclusions on how the facility can correct them. Do not attempt to categorize errors into various classifications (e.g., wrong dose, wrong resident). Stress that an error occurred and that future errors must be avoided.

Field Manager will:

1. Ensure surveyors understand the medication administration process and demonstrate the ability to follow the procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B7 – ICF/IID Survey Task 6, Inspect All Areas of The Facility

Overview

By the end of the survey, each area of the facility serving certified Clients must be visited in order to:

- Ensure that all areas of the facility (including those that are not represented by Clients in the sample) are providing services in the manner required by the regulations.
- Assess the physical safety of the environment. Assess that individual rights are proactively asserted and protected.

Procedure

Surveyor will:

1. After individuals in the sample have been assigned to team members, review the facility's map or building layout. The Team Leader will assign members to visit each remaining residential and on-campus day program site prior to completing the survey.
2. Ensure that each area of the facility that is utilized by Clients has been visited. This visit may be done with or without facility staff accompanying you, based on surveyor preference, and subject to staff availability.
3. Each ICF/IID facility type has a specific form to be used for Task 6. Document all areas inspected on the specific form for the specific facility. Comments can also be documented on the form.
   - Physical Environment Checklist for Rainier School PAT E RHC, Attachment N
   - Physical Environment Checklist for Rainier School PAT C RHC, Attachment O
   - Physical Environment Checklist for Rainier School PAT A RHC, Attachment P
   - Physical Environment Checklist for Lakeland Village RHC, Attachment Q
   - Physical Environment Checklist for Fircrest RHC, Attachment R
   - Physical Environment Checklist for Rocky Bay Health Care Facility, Attachment S
4. Converse with Clients, family members/significant others (if present), and staff. Observe staff interactions with other staff members as well as with Clients for insight into matters such as individual rights and staff responsibilities.

Field Manager will:

1. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B8 – ICF/IID Survey Task 7, Record Review

Overview

Review of the Client record during the Focused Fundamental Survey is kept to a minimum on all Clients in the sample. Should the survey become a full survey, records are reviewed in more detail. During Task 1, sample selection, each sampled Client's IPP was requested and reviewed. Each IPP will be utilized during observations to determine if:

- The Client's skills match the IPP
- The IPP is being followed
- Staff understand the IPP
- Staff and Client interactions during the programs reveal no concerns
- There are no health concerns interfering with the IPP

Do not spend an excessive amount of time looking at fine details in the record review of the selected sample. The purpose for record reviews are to:

- Help the surveyor focus observations on the Client's plan
- Verify the applicable information obtained from your **observations** and **interviews**
- Review revisions that have been made to the objectives
- Verify that needed health and safety supports are in place

If there are no identified concerns, then the record review is complete.
Review the written training programs that are developed for each Client's objective to ensure they meet the regulatory requirements and to familiarize yourself with the strategy to help focus your observations. Review those parts of the record most relevant to your purposes as described below.

If there are noted concerns, the record review will focus on obtaining additional information to clarify areas of question or concern identified during the **observation**.

The records for Clients added to the core sample (expanded sample Clients), should only be reviewed for the observed areas of concern. For instance, in the case of a Client observed to be doing work that appears to be for the benefit of the facility, the record should be reviewed to determine whether the work is included in the client's IPP; whether fair compensation is provided; and whether the client's needs are being addressed by the facility. The Client and the staff should be interviewed and the information compared to the program records.

Procedure for Record Review

Surveyor will:

1. Review the IPP: Identify the developmental, behavioral, and health objectives to accomplish during the current IPP period. Identify what, if any, behavioral strategies (e.g., behavior modification programs, use of psychotropics) are being used with Clients in your

sample. Determine if health or other problems might interfere with participation in program services.

2. Review program monitoring and change: Review the most recent IDT notes to identify what revisions were made to the IPP. Determine whether revisions were based on objective measures of the individual's progress, regression, or lack of progress toward their objectives.
3. Review the health and safety supports to verify:
    - That the Client has received follow-up services for any health or dental needs identified in the IPP.
    - Check the Client's current drug regimen.
    - For Clients with whom restrictive or intrusive techniques are used, verify that the necessary consents and approvals have been obtained.
4. For those Clients observed during administration of medications, reconcile observations from the Medication Pass Observation Worksheet, Attachment L with the MAR and Physicians orders. Clients on self-medication programs will require an additional review of their training objective to verify the correct implementation of the program.
5. During full surveys, review of staff qualifications are required. Use Human Resources Background Check and File Review, Attachment K to record information. Fire drill reviews are required as well. Use Annual Fire Drill Review, Attachment M to record all information.
5. For all other records reviewed that are relevant to findings, document on Surveyor Notes, Attachment V.
6. Only make copies of the Client's record that are needed to verify each deficient practice. Once copies are made, return all records to the Client chart. Ensure all original documents (i.e. those with ink signatures on them) remain in the Client file.
7. At this stage of the survey, you should have a good idea of the Client's active treatment program and whether or not deficiencies are found. If not, further observations and interviews may be needed to determine if deficient practices exist as well as further record reviews.
8. Share all areas of concern during team meetings to identify trends and to confirm deficient practices.

Field Manager will:

1. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
2. Periodically review staff working papers to verify findings.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B9 – ICF/IID Survey Consensus

Overview

The definition of consensus is an end result obtained through a group discussion premised on mutual respect for all involved. It is the team consensus that drives the final decision making process for determining what is to be deemed as a deficiency.

Consensus

1. Once all interviews and records reviews are completed, begin consensus. This activity is facilitated by the Team Leader (see Chapter 16A3: Team Leader Role). Refer to Exhibit 355 Probes as needed.
2. The Team Leader or designee will alert the facility of the pending exit date and secure a meeting place and time. The Team Leader or designee reviews the Survey Review Checklist, Attachment X and the Team Leader Summary, Attachment Y to ensure all survey tasks are completed and all required documents are collected. All team members contribute to the findings of their sampled Clients. The team is to discuss each finding and associated tag, coming to an agreement on the deficient practices.
3. It is imperative that structure and guidelines for the consensus process are followed. If the process is not followed, the facility will notice discord among team members and the process will be delayed, causing difficulties in unforeseeable areas. (Refer to Chapter 16A3: Team Leader Role and 16A4: Surveyor Conduct as needed.)

Ground Rules:

- Treat each other with dignity and respect and be sensitive.
- A team member should have the courtesy of being allowed to complete their verbal presentation of issues without interruptions.
- The presentation of an issue needs to be lucid and logical.
- There should be no side conversations between team members. If this occurs, the team member should stop talking until they have the full team's attention.
- No team member should leave the room or be absent from the group discussion.
- Everyone has the responsibility for calling the team to task if a disruption or a violation of a ground rules occurs.
- Everyone has equal weight in the consensus process.
- If during the consensus process a team member has an issue with another person, that team member needs to attempt to resolve that issue with that person.
- There should be no arguing with team members in an attempt to "convince" or "persuade" them.
- There is to be no voting.
- When an impasse occurs, consult with the Field Manager for direction.
- The team establishes a timeframe required for consensus and agrees to stay within that timeframe.
- The Team Leader is responsible for maintaining the team's focus during the consensus process.

- The Team Leader should not make decisions for the team.

3. The Team Leader will compose preliminary findings on CMS Form 3070H ("Intermediate Care Facilities for Individuals with Intellectual Disabilities Deficiencies Report") for those requirements that are determined to be deficient and the findings that support a deficiency practice with "not met." Write the deficiency statement in terms specific enough to allow staff to understand the aspect of the requirement that is not met. Indicate on the CMS Form 3070H the data prefix tag, followed by a summary of the deficient facility practice(s). Briefly identify the supporting findings for each deficiency (i.e., transfer to the CMS Form 3070H the identifier numbers of all Clients to whom the deficient practice applies.) For specific instructions on properly completing the form, see CMS instructions on the back of the form. This form is a publically dis-closable document.
4. It is not necessary to write a full description of the findings on the CMS Form 3070H since they will be described in more detail on the completed Statement of Deficiencies (CMS Form 3070H). It is necessary to complete the CMS Form 3070H for each survey because the CMS Form 3070H is the only document in which the survey team's recommendations for deficiencies are recorded (which may be changed later on the final CMS Form 2567 as a result of supervisory review) and because not all Client examples may be used on the CMS Form 2567 Form CMS-2567. If the Field Manager is not on survey with the team, notify the Field Manager of the findings at the conclusion of the consensus meeting.
5. All team members sign the CMS Form 3070H page 3.
6. Prepare a confidential Client identifier list for the facility to reference during the exit conference.
7. Conclude the consensus meeting by determining how the team will conduct the exit process if there are particular concerns. The Team Leader or designee will notify the facility when consensus is completed.

Field Manager will:

1. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
2. Periodically review staff working papers to verify findings.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16B10 – ICF/IID Survey, Exit Conference

Overview

The purpose of the exit conference is to describe to the facility the requirements that are not in compliance with the regulations. The Team Leader, along with the survey team, meets with the facility at the end of the survey to present the team's preliminary findings. The team's findings are presented by sharing information from the CMS Form 3070H with the facility. Each issue is explained in enough detail, so the facility knows the deficient practices and is able to begin working on a PoC. A copy of the Client identifier list is given to the administrative staff for reference during the conference. The facility determines who will join in the exit conference.

The exit conference during the onsite survey is both a courtesy to the facility and a way to expedite the facility's planning ahead of the formal receipt of the survey findings in the CMS Form 2567, Statement of Deficiencies (SoD). An exit conference is not guaranteed, as noted in State Operating Manual (SOM), section 2724.

Procedure

Surveyor will:

Exit Conference

1. It is expected that the entire survey team attend the exit conference. Should concerns arise, notify the Field Manager. The Team Leader and the survey team enter the exit conference room at the same time.
2. The Team Leader will ensure at least one team member brings Appendix J to the meeting for reference if needed. Limit the amount of documentation brought into the meeting. It is inappropriate to bring luggage and personal belongings into the conference. Secure such items in the car prior to the meeting.
3. Determine if there will be telephone conferencing to join the meeting and determine the best place to sit that allows all staff to hear.
4. The Team Leader will ensure the survey team is introduced.
5. Distribute the Exit Conference Roster, Attachment U to facility staff for signature and ensure the administrator has a copy of the confidential Client list for reference.
6. Briefly explain the type of survey and why it was conducted.
7. Express appreciation to facility staff for facilitating the survey.
8. Inform the facility that the findings are preliminary and official findings will be communicated via the CMS Form 2567. Explain the timeline for the CMS Form 2567 and the PoC:
    a. The CMS Form 2567 will be provided to the facility within 10 working days.
    b. The facility will have 10 calendar days after the receipt of the CMS Form 2567 to submit a PoC.
9. Explain how the exit conference will be conducted and how the findings will be presented. (Team members may be asked to present portions of the survey findings with examples).

10. Inform the facility that if they believe any survey findings are based on inadequate or inaccurate information, they should provide the survey team with the information they believe would change the decision of the team. Inform the facility that they may also dispute any findings through the RCS Informal Dispute Resolution (IDR) process. See SOP IDR Chapter 22 for details.

Presentation of Findings

1. Provide information about the survey teams preliminary findings in a manner that is understandable to those present, e.g., say the deficiency "relates to the absence of a post discharge plan of care", not to "Tag W205." Provide examples as necessary and allow the facility to provide additional information if it chooses. Avoid using jargon or acronyms.
2. Explain why the findings are a violation of Medicaid requirements, or state requirements. Provide enough detail to assist the provider in expediting correction of the deficiency.
3. If a facility asks for a specific regulatory reference, it should be given with a disclaimer that the code reference is preliminary. If a facility does not specifically ask for the regulatory basis, the survey team will use its own judgment in determining whether this additional information would provide additional insight.
4. If the team is still deliberating about which tag is most pertinent, do not speculate. Describe the general area of non-compliance without specifying a regulatory code.
5. The survey team may describe the general seriousness (e.g., harm) or urgency the deficiency may pose to Clients. With this in mind, if there were IJ finding(s), it is usually discussed first. If the facility asks if the noncompliance is isolated, patterned, or widespread, respond with the facts, such as, "The noncompliance was found to affect "X" number of Clients."
6. Do not make declaratory statements such as "Overall, this facility is very good" or "This condition was not met."
7. Do not discuss survey results in a manner that reveals the identity of an individual Client.
8. During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.

Closure

1. Collect the Exit Conference Roster, Attachment U and the completed CMS Form 3070G (if a recertification survey).
2. Offer additional explanation to the facility administrator or designee about the process of submitting the PoC, pertinent due dates and options for disputes through the RCS IDR department.
3. Ensure the facility administrator or designee has contact information for the survey team and the Field Manager.

Field Manager will:

1. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

Quality Assurance Review

1. Review this procedure at least every two years for accuracy and compliance. Back to Top

Washington State Department of Social & Health Services

Chapter 16C – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Documentation

(SOD, PoCs, Revisits, Timelines, IDR and IJs)

Overview

This section contains the Standard Operating Procedures (SOP) that direct survey staff on documentation procedures, visitation schedules and other timetables involving ICF/IID facilities.

Authority

- RCW Chapter 34.05 Informal Settlement
- RCW 18.51 Enforcement Standards
- Chapter 74.42 Minimum Operating Standards
- RCW 74.34 Vulnerable Adults, Protection from Abuse
- RCW Chapter 70.129 Resident Rights
- SSA 1902 , 1905 (2)(d)Social Security Act
- WA State Plan under Title XIX of the Social Security Act
- 42 CFR 440.150 ICF/IID Services
- 42 CFR 483 Public Health/DSHS
- (SOM) Chapter 2 and SOM Chapter 3 State Operating Manual
- Appendix J Centers for Medicaid Services (CMS) ICF/IID Survey Procedure
- Appendix Q - IJ CMS IJ Procedure
- WAC Chapter 388-97 and WAC 388-111 ICF/IID/RHC Requirements

Back to Top

Change Log

Washington State Department of Social & Health Services

CHAPTER 16C – ICF/IID INDEX

C. Documentation Overview

1. Statement of Deficiencies (SOD)
2. Plan of Correction (PoC)
3. Unacceptable PoC
4. Facility Revisit Surveys
5. Complaints and Investigations
6. Required Timelines
7. Credible Allegation of Compliance
8. Informal Dispute Resolution (IDR), Informal Review, Informal Reconsideration, and Evidentiary Hearing
9. Immediate Jeopardy (IJ)

Back to Top

Change Log

Washington State Department of Social & Health Services

CHAPTER 16C1 – ICF/IID STATEMENT OF DEFICIENCIES (SOD)

Overview

When a facility is out of compliance with any regulations, Conditions of Participation (CoPs), and/or Immediate Jeopardy (IJ), during a survey or complaint investigation, a Statement of Deficiency (SOD) is written on CMS Form 2567 .

Off-site Documentation and SOD Development Procedures

Surveyor/Complaint Investigator will:

1. Complete all data collection such as interviews or further record reviews.
2. Review the pertinent findings and confirm analysis of deficiency citations referring to Appendix J to ensure the reference tags match.
3. Consider any existing or previous enforcement action from a previous inspection. (Is there a previous PoC that the facility should have resolved the problem, etc.?)
4. Confer with the Field Manager (FM) as needed.
5. Follow the Principles of Documentation for ICF/IID when writing the SOD.
6. If there are deficient practices identified, complete the following procedures and divide the duties among individual team members:
    - Finalize the numbered Client Sample Selection, Attachment E;
    - Finalize the lettered staff list (use identifiers);
    - Designate W-tags and/or Code of Federal Regulations (CFRs) that will be cited in the report(s);
    - Document the failed (deficient) practice statements in relation to cited statutes and regulations following the Principles of Documentation;
7. Complete page one on the SOD using guidelines and examples from ASPEN 0000 page entering Initial comments in ASPEN.
8. Reference findings from one key deficiency citation to other cascading findings when there is a direct cause and effect relationship to the deficient practices described.
9. Document any corresponding Washington State statutes and regulations at the end of each W-tag citation if needed.
10. When more than one team member participates in the survey, meet with the team to review, edit, and finalize the SOD.
11. Coordinate completion of the review and approval of SOD report with the FM. Submit the completed SOD, Client and staff list to the FM for approval prior to the 10 working days deadline of the survey exit date.
12. If there are significant changes to the potential problem areas identified at the exit meeting, inform the facility administrator of the changes prior to sending out the completed SOD.
13. Submit the approved SOD to the Administrative Assistant 3 (AA3). The facility is to receive the SOD within 10 working days of the exit from the facility (within two working days for an IJ).
14. If it is determined that the facility is noncompliant with the Federal Regulations, enter the information in ASPEN on CMS Form 2567. See ASPEN Central Office (ACO) Procedure

Guide and/or ASPEN System (ACTS) Procedure Guide: ASPEN CO-ASPEN ACTS; Enter Complaints in the TIVA System.

15. For IJ Findings, see SOM Appendix Q - IJ for further details.

Field Manager will:

1. Review the SOD to determine if a sufficient basis exists to support the recommended deficiencies, enforcement action, or both.
2. Use "Components to be Documented in a Deficiency Citation" SOD Review Checklist in Principles of Documentation routinely for quality assurance purposes and Complaint Checklist for complaints.
3. Confer with Office Chief to consider alternate remedies.

Administrative Assistant 3 will:

1. Draft the appropriate notice in ASPEN.
2. Send the approved SOD report, sample Client list, and cover letter to the facility within ten (10) working days of the exit date (within two working days for an IJ).
3. Send the completed SOD and notice letter to the state Long Term Care Ombuds office.
4. Notify applicable parties (i.e. HCS, DDA, MH, Ombuds, AAG, etc.) of alternate sanction action initiated, via email distribution of the applicable enforcement letter.
5. Document activities on the Tracking Tool Surveys and Citations.
6. Collect completed survey packets and send to RCS Central Office Unit for storage.

Amendment of Statement of Deficiencies

Surveyor/Complaint Investigator will:

1. Upon direction by the FM, incorporate changes into the SOD report in ASPEN.
2. Submit to the FM for final approval.
3. Once approved by the FM, print a copy for the AA3.

Field Manager will:

1. Review, and approve the amended SOD.

Administrative Assistant 3 will:

1. Draft the approved cover letter in ASPEN.
2. Notify applicable parties (i.e. HCS, DDA, MH, Ombuds, AAG, etc.) of action initiated, via email distribution if applicable.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.
4. Document activities on the Tracking Tool Surveys and Citations.
5. Collect complete survey packets and send to RCS Central Office Unit for storage.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C2 – ICF/IID Plan of Correction (PoC)

Overview

Following the survey process and upon receipt of the SOD, the facility must develop a Plan of Correction (PoC) to address all stated deficiencies outlined in the SOD within 10 calendar days of receipt of the SOD. Regulations allow certification of ICF/IID facilities with deficiencies at the standard level "only if the facility has submitted an acceptable PoC for achieving compliance within a reasonable period of time acceptable to the Secretary." Failure to submit a PoC could result in termination of the facility agreement.

Decisions on acceptance of the PoC by the survey team must occur within 5 working days of receipt by RCS.

In the event of noncompliance with the CoP, a "credible allegation of compliance letter" is required in addition to a PoC and an unannounced revisit occurs. See Chapter 16C7: Credible Allegation of Compliance for details. For all remaining deficiencies, determine compliance by the information located in the PoC.

The facility has no longer, than 60 calendar days to implement the PoC and correct the deficiency. The correction date for a specific deficiency may be less depending on the circumstances of the deficiency.

Procedure

Surveyor/Complaint Investigator will:

1. Review the PoC within 5 working days of receipt of the PoC.
2. An acceptable PoC must contain the following elements:
    - The plan for correcting the specific deficiency cited. The plan should address the internal facility processes that lead to the deficiency being cited;
    - The procedures for implementing the PoC for the specific deficiency cited;
    - The monitoring procedure to ensure that the PoC is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements;
    - The title of the person responsible for implementing the PoC.
3. PoCs must be specific and realistic, stating exactly how the correction to the deficiency occurred. The administrator, or other authorized official, must sign and date the PoC. Additional documentation attached to CMS Form 2567 is acceptable. All deficiencies corrected since the survey, must have the corrected date on the form.
4. Do not routinely accept dates for correction at 60 calendar days. If a corrected deficiency is possible well before 60 calendar days, then the correction date should reflect that.
5. Discuss the decision with the Field Manager. Determine possible revisits as needed.
6. If the PoC is acceptable (depending on a paper review and/or onsite revisit if needed), complete the CMS Form 2567B in ASPEN.
7. If the PoC is not acceptable, see Chapter 16C3: Unacceptable PoC for procedures.

8. Report the decision to the Administrative Assistant 3 (AA3) for documentation.

Field Manager will:

1. Review and determine if the PoC is acceptable.
2. Determine if a revisit for standard level citations are needed.
3. Inform the team of a final decision.
4 If the facility requests additional time to develop the plan, inform the facility that they are obligated to complete the PoC as precisely as present information permits, and that a more specific plan follows, as early as possible. Advise the administrator to return the PoC to the survey unit promptly.
5. Inform the facility administrator that within 90 calendar days of the last day of the survey, the law requires that CMS Form 2567 is available for disclosure to the public. (Note- this information may be included in the SOD cover letter)

Administrative Assistant 3 will:

1. For PoCs that arrive after the 10th calendar day (or the next working day if that day falls on a weekend or holiday), call the facility administrator (or designee) on the 10th calendar day (or next working day) and ask them to submit the documentation to the department within 24 hours.
2. Complete documentation of the date of the PoC and the team's decision to accept the PoC in the Tracking Tool Surveys and Citations.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.
4. The facility may submit evidence of correction or a modified PoC to the survey team at any time. Retain a copy of the material in the certification file and forward the original to the central office as appropriate.
5. Mail letters/documents as determined from ASPEN.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C3– Unacceptable Plan of Correction (PoC)

Overview

If the PoC is not acceptable, the facility must submit a revised PoC within five calendar days of notice.

Generally, the facility makes changes to the PoC. The survey team does not amend a PoC without the facility's concurrence. The facility must sign changes to a PoC. However, if the adjustments required to the PoC are minor in nature (e.g., the facility failed to include a date for one of several deficiencies), the survey team may contact the facility by telephone, make the necessary adjustments on CMS Form 2567 and then submit the change to the facility.

Procedure

Surveyor/Complaint Investigator will:

1. Review the PoC within 5 working days of receipt. Determine why the PoC is not acceptable and discuss the concerns with the Field Manager (FM).

Field Manager will:

1. Ensure staff understand the PoC process as outlined in this SOP.
2. Notify the facility administrator or designee by phone regarding the unacceptable PoC and review the concerns with them. Inform the facility they must revise the PoC to ensure it has all of the required elements and return it to the survey unit.
3. Conduct periodic reviews of this procedure to ensure staff are following the SOP correctly.

Administrative Assistant 3 will:

1. Produce a "not acceptable" PoC letter for the FM signature.
2. Send via certified mail the "not acceptable" PoC letter to the facility.
3. Document the sent date of the letter in the Tracking Tool Surveys and Citations.
4. Once the corrected PoC arrives, document the date in the Tracking Tool Surveys and Citations and forward the PoC to the survey team for review.
5. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C4 – ICF/IID Facility Revisit Survey

Overview

When a facility has been found to be out of compliance and submits an acceptable PoC, a revisit determines if the facility has regained compliance. The revisit survey will focus on the regulations cited as non-compliant.

The facility's PoC is a guide to begin the revisit process at the facility, but the revisit survey purpose is to determine compliance with the cited regulations.

Appropriate PoCs received for all standard level citations may not require a revisit survey. The Field Manager will make the determination.

Failure of a facility to comply with one or more Conditions of Participation (CoP) requires a revisit. Any facility that does not comply with all of the CoPs is considered limited in its capacity to furnish services at an adequate level or quality. Compliance with all CoPs is required for certification.

When the facility has a revisit survey and they have failed to implement the PoC or credible letter of compliance, adverse actions continue, based on findings of the first survey and the findings of the revisit. If at the time of the revisit the facility complies with the requirements forming the basis for the original termination, but has new deficiencies that are also grounds for termination, a new termination process commences with the revisit. See Chapter 16D: Alternate Sanctions for details.

Procedure

The Surveyor/Complaint Investigator will:

1. Review the PoC with the FM and determine the need for a revisit survey or if compliance can be determined without a revisit.
2. If the PoC is acceptable for standard level citations and no revisit is necessary per Field Manager, complete the post-certification revisit report, CMS Form 2567B in ASPEN.
3. If a revisit survey is needed, the Team Leader from the original survey (or the complaint investigator) will write a revisit Survey Action Plan, Attachment A or Complaint Survey Action Plan, Attachment Z and select a team (if necessary) to include members from the original survey, and brief the team on the action plan.
4. Conduct the revisit survey (see Chapter 16B for related tasks) and determine if the facility complies with the cited regulations and the PoC.
5. If conducting a revisit survey or follow-up to an investigation (and the FM has approved of an on-site revisit) use the PoC to determine if the facility is back in compliance. Explore each step of the facilities PoC by observing practices and/or collecting the needed documentation. Since the deficient practice relates directly to the PoC, by determining if

the PoC is implemented and working correctly, the citation can be considered corrected and the citation can be closed.

6. Upon completion of the survey, the Team Leader determines if the facility complies with federal regulations or not, and conducts an exit conference.
7. If regulations are not in compliance, develop a new SOD with a CMS Form 2567. If regulations are back in compliance, a post-certification revisit report, CMS Form 2567B is completed.

The Field Manager will:

1. Review the facilities PoC and determine if a revisit is necessary.
2. Consult with the Team Leader regarding the revisit survey action plan and team formation.

Administrative Assistant 3 will:

1. Complete documentation in the Tracking Tool Surveys and Citations.
2. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.
3. Mail letters/documents as determined from ASPEN.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Revisit/Date of Compliance Grid

Revisit #	Noncompliance with a PoC for standard/key level citations	Noncompliance at Condition of Participation level (CoP)	Continued noncompliance at CoP or IJ	Noncompliance continues	Any noncompliance
1st Revisit	1. Compliance is certified as of the latest correction date on the approved PoC. No revisits necessary, unless determined by the Field Manager that a revisit is needed to verify compliance. 2. When a PoC is accepted with no 2nd onsite revisit, compliance is certified as of the date confirmed by the PoC. (SOM Chapter 2 section 2732 A, B)	1. A 2nd onsite revisit is required with an acceptable credible allegation of compliance letter (before the 45th day) to determine/verify if acceptable evidence is provided. (SOM Chapter 3 section 3016A, 3038B)	1. A 2nd onsite revisit is required. 2. Acceptable credible allegation of compliance letter (before the 45th day) and evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date. (SOM 3012) 3. IJ — continues on termination track (SOM Chapter 3 section 3010B & Appendix Q - IJ)	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered as the compliance date. (SOM 3026C) 3. IJ – continues on termination track (SOM Chapter 3 section 3010B & Appendix Q - IJ)	
2nd revisit		**CMS must approve 2nd onsite revisit**: Compliance is certified as of the date of the 2nd onsite revisit (between the 46th - 90th day) or the date confirmed by the acceptable evidence, whichever is sooner. (SOM Chapter 3 section 3020A2)	**CMS must approve 2nd onsite revisit**: Compliance is certified as of the date of the 2nd onsite revisit or the date confirmed by the acceptable evidence, whichever is sooner.	As of the 55th day of noncompliance, forward documentation to CMS. As of the 60th day, Denial of payment letter is sent and opportunity for informal hearing.	1. A remedy must be imposed if not already imposed. 2. Either conduct a 3rd onsite revisit (per CMS approval) and/or proceed to termination.
A 3rd REVISIT IS NOT ASSURED AND MUST BE APPROVED BY THE HCA and/or CMS					
3rd revisit	Compliance is certified as of the date of the 3rd onsite revisit.				Proceed to termination (SOM Chapter 3 section 3018)

Examples of acceptable evidence may include, but are not limited to:

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-services training.
- Interviews with more than 1 training participant about training.
- Contact with resident representative, e.g., when dignity issues are involved.

Givens:

- An approved PoC is required whenever there is noncompliance;
- Remedies can be imposed anytime for any level of noncompliance;
- Onsite revisits can be conducted anytime for any level of noncompliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C5 – ICF/IID Complaints and Investigations

Overview

All DSHS staff are designated mandated reporters and are legally required to report any suspicion of abuse, abandonment, neglect, or financial exploitation of a vulnerable adult. Calls to the Complaint Resolution Unit toll-free hotline at **1-800-562-6078,** or email to **CRU@dshs.wa.gov** to generate reports that require investigations. People who are not mandatory reporters are also strongly encouraged to report abuse. For types of physical assault, see RCW 74.34.035(4).

The ICF/IID program is unique in that all surveyors conduct both complaint investigations and facility surveys.

Because of potential abuse, surveyors investigate individual complaints for all Clients living in ICF/IID facilities. Surveyors look at the facility's investigative system, how thorough their investigations are, how facilities support the victim, their plans to prevent further abuse, and whether the facility complies with all of the required federal regulations.

Procedure

Surveyor/Complaint Investigator will:

1. Follow all procedures as outlined in RCS Standard Operating Procedure (SOP) Chapter 20 (Complaint Investigations) and:
2. Use the ICF/IID Complaint Survey Action Plan, Attachment Z, Complaint Allegation, Attachment AA or Surveyor Notes, Attachment V to prepare for the visit.
3. Upon entrance to the facility, do not disclose the nature of the complaint. After identifying yourself, the surveyor may request a computer printout of incident reports within the last 30-90 days.
4. With a requested printout, look for patterns and/or trends. Request additional complaints as appropriate for the current investigation.
5. Highlight the investigative files you will be reviewing. Ask the facility administrator will retrieve the requested files for you and request an area to review the files.
6. From the investigative file(s), only make copies of pertinent information to assist you in the investigation.
7. Replace all original documents in the correct file and in the correct order as was found.
8. Return all files back to the facility for storage.
9. Begin your investigation. Document actions and activities on Surveyor Notes, Attachment V and provide a copy of Vulnerable Adult Statement of Rights (VASOR) DSHS 16-234A for ICF/IID that are RHCs (Rainier School, Lakeland Village and Fircrest) or DSHS 16-234 for non-RHC ICF/IIDs when interviewing Clients for abuse, neglect or mistreatment, documenting if the VASOR was given or not and the reasons in the working papers. Refer to Chapter 20 for specific instructions.
10. Conduct an exit conference with at least one administrative staff from the facility.

11. Once back at the office, document actions and dates of the investigation on your personal complaint-tracking sheet and in the TIVA, ACTS and ACO tracking systems.
12. Write SOD if needed and route according to timelines.

Field Manager will:

1. Review and assign complaints to surveyors/complaint investigators for investigation. Determine if the priority is correct for the incident or whether to change the complaint priority to a Quality Review (QR). Refer to the ICF/IID Reporting Grid for assistance.
2. Monitor staff activities to ensure initiation of investigations are timely.
3. Review SODs as needed.

Administrative Assistant 3 will:

1. Complete documentation of the facility activity in the Tracking Tool Surveys and Citations.
2. Mail letters/documents (SOD, VASOR) as determined from ASPEN and SOPs.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C6 – Required Timelines for Condition of Participation (CoP) and Immediate Jeopardy (IJ)

Overview

ICF/IID certification/recertification/complaint deficiencies have several levels:

- Standard level citations
- Condition of Participation (CoP) level citations
- Immediate Jeopardy (IJ) level of citations

There are federal requirements and timelines for each level and specific revisit schedules. Standard level citations may not require a revisit with an acceptable PoC (unless directed by the Field Manager (FM)).

Exit conferences are a curtesy and not always promised. The day the team exits the facility is considered the date of the survey. The following day begins day one of the 10 business day tracking, as required by CMS. Below are described timelines and procedures.

Surveys with Conditions of Participation that are out of compliance

CoP Unmet Chart - Visual Flow Chart

If there is not an immediate jeopardy to Client health or safety, the survey team uses the following schedule:

1. **Date of Survey** - Regardless of when the exit conference is held, the date of the survey is the date on which the survey team left the facility.

2. **Tenth Working Day** – On the tenth working day, (day one begins following the day the team exits from the facility); the survey team sends the Statement of Deficiencies (SOD) CMS Form 2567 containing the deficiencies to the facility and HCA and/or CMS. The survey team informs the facility in writing that there is a determination of noncompliance and that it is recommending termination to be effective within 90 calendar days from the date of the survey. The recommended termination date is included in the letter.

   The survey team informs the facility that the termination process provides an opportunity to make corrections and achieve compliance. This opportunity allows the facility ten calendar days to complete and return a PoC on the CMS Form 2567. The Field Manager gives notice in the letter with the SOD that they will make a revisit within 45 calendar days of the survey if they receive a credible allegation of compliance (see Chapter 16C7 for details).

3. **Forty-Fifth Calendar Day** - If the facility has made a credible allegation of compliance for CoPs, (see Chapter 16C7) the survey team conducts a revisit to determine whether compliance or acceptable progress has been achieved. **Only two revisits are permitted; one within the first 45 calendar days and one between the 46th and 90th**

calendar days. (Note – The facility can request a revisit at any time until the 90th day.) If the facility fails to make a credible allegation, no revisit is necessary. The 90-day termination track continues.

4. **Fifty-Fifth Calendar Day** - If the facility is not able to gain compliance as noted in the PoC, the Field Manager notifies the facility that termination is recommended and alerts the State Medicaid Agency (HCA and/or CMS).

5. **Sixtieth Calendar Day** – Send a Denial of Payment for new admissions letter to the facility. The survey team has the opportunity to impose other alternate remedies in conjunction with the DPNA. See Chapter 16D for details.
   The facility has the opportunity for informal hearing. A delay of the termination track is permissible; however, it can go no longer than 120 days.

6. **Sixty-Fifth Calendar Day** - Within 65 calendar days following the date of survey, HCA and/or CMS determines whether survey findings continue to support a determination of noncompliance for CoPs.

7. **Seventieth Calendar Day** – HCA and/or CMS sends an official termination notice to the facility and the public. Notices must appear at least 15 calendar days before the effective date of termination.

8. **Ninetieth Calendar Day** – Noncompliance of CoPs at 90 days proceeds to termination. It can take effect in fewer than 90 calendar days if required procedures are completed.

NOTE: All timeframes are maximum. HCA and/or CMS may terminate more quickly as long as the regulatory requirements for notification of the public and facility are satisfied.

Washington State Department of Social & Health Services

Abbreviated Condition of Participation (CoP) Timeline Grid:

a.	Date of Survey - The date of the survey is the date on which the entire survey is completed, regardless of when the exit conference is held. (SOM Chapter 3 section 3010B)
b.	IJ – 2nd Working Day – IJ SOD delivery no later than 2 working days following the survey date. (Appendix Q - IJ & SOM Chapter 3 section 3010B)
c.	10th Working - Day send SOD with COP cover letter.
d.	IJ – 23rd Calendar Day – Termination takes effect unless IJ removed prior to 23rd day. (Appendix Q - IJ & SOM Chapter 3 section 3010B)
e.	45TH Calendar Day – If Credible Allegation received, conduct 1st revisit survey
f.	46th to 90th – 2nd opportunity for revisit survey
g.	55th Calendar Day - If compliance has not been achieved, forward documentation to HCS and/or CMS. Notify facility that termination is recommended
h.	60th Calendar Day Denial of Payment Letter and opportunity for informal hearing. (SOM Chapter 3 section 3006C)

Surveys with IJ Findings: 23-Day Termination Procedure

IJ Chart 1 and IJ Chart 2 – Visual Flow Chart

1. **Date of Survey** - The date of the survey is the date on which the entire survey is completed, regardless of when the exit conference is held. The survey team will provide the facility a copy of the completed IJ template.

2. **Second Working Day** – The survey team will compose the SOD and submit it to the facility no later than 2 working days following the survey date.
   Field Manager (or designee) will:
   a. Telephone HCA and/or CMS informing them that the state agency is certifying noncompliance and that an immediate jeopardy exists; and
   b. Notify the facility in person if possible (or by overnight express mail, FAX or e-mail) of its deficiencies and inform the facility you are recommending termination to HCA and/or CMS, which will issue a formal notice. The notice advises the facility of its right to due process, the expected schedule for termination action, and that the survey team must verify the corrected deficiency to halt the termination.

3. **Third Working Day** – The Field Manager or designee will forward all supporting documentation to HCA and/or CMS (e.g., statement of deficiencies, correspondence, contact reports). Forward the information by overnight mail to assure that HCA and/or CMS receives it in time to meet the 5-working-day deadline. Upon receipt of the information, HCA and/or CMS reviews the documents and makes its determination of noncompliance.

4. **Fifth Working Day** – HCA and /or CMS notify the facility and the public of the proposed termination action by the most expeditious means available. A press release to the radio and television stations serving the area in which the facility or institution is located is acceptable if a newspaper notice is unable to arrange so in the allotted time. At least two calendar days prior to the effective date of termination, send notice. (See 42 CFR 488.456(c))

5. **Tenth Working Day** – For any non-IJ deficiencies found during the same survey or investigation, (standard/key level), compose 2567 with those deficiencies and forward copies to the facility, HCA and/or CMS within ten working days. Include information on the ASPEN 000 page.

6. **Twenty-Third Calendar Day** - The termination takes effect unless the facility removes the threat. If the threat has been removed, but deficiencies still exist at the Condition level, give the facility up to 67 more calendar days, or 90-calendar day's total (23 plus 67) to fix the issues. These dates are maximum times.

Considerations:

If HCA and/or CMS disagrees with the survey findings, based upon its review of the documentation, HCA and/or CMS discusses the results of the review with the survey team and solicits further evidence to support the survey team's recommendation. HCA and/or CMS confers with the survey team as to the appropriate action to take.

Should HCA and/or CMS and the survey team fail to agree that an immediate jeopardy exists, HCA and/or CMS conducts a revisit with the survey team and together they ascertain if immediate jeopardy to the Client's health and safety exists or removed. If the HCA and/or CMS and the survey team agree that an immediate jeopardy exists, no revisit is necessary by HCA and/or CMS. Federal surveyors base the determination of IJ on an onsite determination. Under no circumstances should HCA and/or CMS reverse a survey team recommendation that an immediate jeopardy has been removed or not removed.

If the facility fails to submit an IJ removal plan, HCA and/or CMS terminates the ICF/IID facility with an immediate jeopardy situation within the above time limits.

If either CoP or IJ (or both) are identified, the Surveyor/Complaint Investigator will:

1. Conduct recertification and revisit surveys as determined by the FM.
2. Confer with the FM on findings and enforcement recommendations.
3. If IJ is determined, complete the IJ template and give a copy to the facility at the exit. Refer to the above timelines as needed for specific situations and see Chapter 16C9 for details on IJs.
4. Document findings on CMS Form 2567 (and/or CMS Form CMS Form 2567B) and complete ASPEN entries.

Field Manager will:

1. If there is an IJ, work with the team to determine if, the facility can immediately remove the IJ or if it warrants a 23-day termination action. Consult with the Office Chief, HCA and/or CMS to ensure they support the IJ and 23-day termination action or alternative sanctions. During this call, discuss plans and timeframes to ensure you are all in agreement. Consultation for CoPs not met is not required however, when in question; make sure the consultation occurs, particularly if you are recommending alternative sanctions.
2. If there are IJ's or CoPs not met during the revisit survey, notify HCA and/or CMS as the state may extend the compliance deadline for up to 90 days. At this point, working with the Office Chief, compose a letter to the facility Director of the termination process and requirements.
3. In lieu of the termination agreement, the state can impose one or more sanctions (only in the absence of an IJ). See Medicaid State Plan Amendment 2016 and 08/01/2018 Amendment under XIX of the Social Security Act. Discussions with HCA and/or CMS are ongoing as needed. Initiate recommendations for remedies. Refer to Chapter 16D: Alternate Sanctions for details.
4. Determine the possibility of a revisit for key/standard deficiencies to ensure compliance. Consider the nature of the citation, facility history of compliance and other extenuating circumstances.
5. Ensure completion of the CMS Form CMS Form 2567B.

Surveyor/Complaint Investigator will:

1. Conduct revisits as determined by the FM.
2. If an enforcement action is initiated and the surveyor/complaint investigator discovers new information not related to existing examples in the existing SOD, a new SOD is developed.

Administrative Assistant 3 will:

1. Complete documentation in the Tracking Tool Surveys and Citations.
2. Mail letters/documents as determined from ASPEN.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C7 – Credible Allegation of Compliance

Overview

Following the survey process and if the facility is out of compliance with a CoP, IJ or is in Denial of Payment status (onetime denial of payment for new admissions for a period of up to 11 months after the month it was imposed), the facility can submit a Credible Allegation of Compliance letter, if they have corrected the deficiencies. The survey team will revisit the facility to determine if the facility is in compliance.

Credible Allegation of Compliance

A credible allegation is a statement, letter or documentation that:

- Is realistic in terms of the possibility of the corrective action being accomplished between the exit conference and the date of the allegation; and
- Indicates resolution of the problem(s).

Only compliance can stop a termination action with the exception of alternate sanctions. This action applies only for citations of CoP, IJ or if the facility is in Denial of Payment status.

Procedure

Surveyor/Complaint Investigator will:

1. Conduct revisits according to the directive of the Field Manager.
2. Complete documentation in ASPEN as indicated, according to the findings.

Field Manager will:

1. Review Credible Allegation of Compliance letter for required elements.
2. Maintain contact with RCS Director, Office Chief and HCA and/or CMS regarding the determination of the second re-visit. See Chapter 16C4: Facility Revisit Surveys for details.
3. If the survey team conducts a CMS approved second revisit, forward all supporting documentation of compliance/noncompliance to HCA and/or CMS immediately following the revisit.
4. If the facility makes an additional credible allegation that, they corrected deficiency in an earlier revisit or between the 46th and 90th calendar day prior to the effective date of termination, notify HCA and/or CMS by telephone. Submit all evidence or documentation regarding the facility's allegation and its recommendation regarding the facilities alleged compliance. HCA and/or CMS makes a determination whether a second revisit is appropriate.
5. Initiate recommendation for further enforcement action when the facility is unable to comply with the PoC stated in the Credible Allegation of Compliance Letter.
6. For standard/key level citations, consider revisits to determine compliance as stated on the PoC.

Administrative Assistant 3 will:

1. Complete documentation of the facility activity in the Tracking Tool Surveys and Citations.
2. Mail letters/documents as determined from ASPEN. See #4 above.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C8 – ICF/IID Informal Dispute Resolution (IDR), Informal Review, Informal Reconsideration, and Evidentiary Hearing

Overview

If a facility disputes a finding in a Statement of Deficiency (SOD), the facility can request an IDR through the RCS IDR Unit within 10 calendar days of receiving the SOD. The IDR Unit will review requests, schedule an IDR meeting (which could be in person) to determine a result to the disputed finding.

CMS SOM Chapter 3 has options outlined for informal hearings, informal reconsiderations and formal hearings. These options are not part of the RCS IDR Unit processes.

Procedure

A. Initial disputes

1. If the facility disputes a finding and requests an IDR, follow the RCS IDR process outlined in Chapter 22, Informal Dispute Resolution (IDR).
2. The facility may or may not use the RCS IDR process. The RCS IDR process does not include the following options noted below.

B. Informal/Formal Hearings and other Appeal Options

1. This is determined at the RCS Director, or appointee level.
2. Given the complexity of facility enforcement processes, the following grid outlines the opportunity for informal hearings according to the State Operating Manual (SOM Chapter 3).
3. Informal hearing opportunities are highlighted in **BOLD** for deficiencies at CoP and IJ levels pending termination.
4. Further appeal options - Informal Reconsideration and Evidentiary Hearings are **BOLDED** as well.

Appeal Fast Track Termination (IJ not removed)	**Appeal** Termination or Non-Renewal (No IJ or IJ Removed)	**Appeal** Denial of Payments for New Admissions (No IJ or IJ Removed)
DSHS must begin termination of provider agreement if there is an IJ.(42 CFR 442.117) DSHS gives provider up to 23 days to remove I.J. SOM Chapter 3 section 3010. Provider must be given an **informal reconsideration** prior to termination. (42 CFR 431.153(e)) 1. If the provider is unable to remove I.J. by given date , then a) the contract will be terminated on the date set; b) FFP will be continued for 30 days if residents are being relocated (42 CFR 441.11); and c) an **evidentiary hearing** must be held no later than 120 days after the termination date. (42 CFR 431.153)* * (A hearing before the state Office of Administrative Hearings.) 2. If, prior to the termination date, the provider removes the serious and immediate threat, but a condition of participation is still not met, then a) the termination date can be extended for up to 67 days (SOM Chapter 3 section 3010) ; or b) the denial of payments process can be initiated (42 CFR 442.118).	DSHS must begin termination or nonrenewal if provider does not meet conditions of participation. (42 CFR 442.117) If I.J. does not exist, or the I.J. has been removed, provider is given up to 90 days to correct condition level deficiencies (SOM Chapter 3 section 010) The provider may **appeal** the termination and is entitled to an **evidentiary hearing**, which must be completed within 120 days of the termination. (42 CFR 431.153) If agreement will be terminated prior to the hearing, an **informal reconsideration** must be provided before the termination. (42 CFR 431.153) FFP is available after termination, pending the **appeal**, provided that an I.J. does not exist. FFP will end 1) on the date **ALJ upholds decision** or 2) 120 days after termination, whichever occurs earlier. (42 CFR 442.40) In both cases, 30 days of additional FFP are available under (42 CFR 441.11).	The provider is given up to 60 days from survey date to correct. If not corrected by the specified date, DSHS must give the provider notice of intent of deny payment for new admissions, and of right to **an informal hearing** before a "State Medicaid Official." (42 CFR 442.118; SOM Chapter 3 section 3060C.) If the provider does not request an **informal hearing**, the denial of payment takes effect immediately. If the denial of payment is upheld following the **informal hearing**, the facility and the public must be given 15 days' notice of intent to impose the remedy. (42 CFR 442.118; SOM Chapter 3 section 3006C.) A denial of payment can be imposed for up to 11 months. (Can be lifted if provider is in compliance or is making a good faith effort) (42 CFR 442.118) If the facility is not in substantial compliance at the end of the 11 months, then the facility must be terminated and is entitled to an **evidentiary hearing**. (42 CFR 442.119)

Field Manager will:

1. Notify staff involved with the survey citation in question, that the facility has filed an IDR or hearing request.
2. Retrieve documents relevant to survey citation in question for review.
3. Provide survey team representation during the IDR, informal reconsideration, informal hearing, and evidentiary hearing, outlining the reason for the cited deficiency.
4. Notify staff of the findings.
5. Request training or clarification from headquarters as needed.
6. At the request of formal hearings, consult with the Office Chief and RCS Director.
7. Consult the AG as needed.
8. Monitor status of findings and provide expert witness as appropriate.

Administrative Assistant 3 will:

1. Document findings and actions on the Tracking Tool Surveys and Citations.
2. Send letters to the facility as required. See ASPEN for templates.
3. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16C9 – ICF/IID Immediate Jeopardy (IJ) Determination and Process

Overview

CMS interprets IJ to mean a situation in which immediate corrective action is necessary because the facilities noncompliance with one or more Conditions of Participation (PoC) has caused, or is likely to cause, serious injury, harm, impairment, or death to a Client receiving care in a facility. See Appendix Q - IJ.

The facility must accurately identify the situation, thoroughly investigate, and resolve it as quickly as possible. In addition, noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for facilities. An IJ situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for correction to avoid further or future serious harm.

There are identified triggers that can assist in considering IJ. Triggers describe situations that may cause the surveyor to consider if further investigation will determine the presence of IJ. The listed Appendix Q Triggers do not automatically equal IJ. The team must investigate and use professional judgment to determine if the situation has caused or is likely to cause serious harm, injury, impairment or death.

3 Core Components of IJ

1. Noncompliance:

An entity has failed to meet one or more federal health, safety, and/or quality regulations; the survey team should also identify, to the best of their ability, when the IJ began. This means determining at what point the entity's noncompliance made serious injury, serious harm, serious impairment, or death occur or likely to occur. Duration of IJ is dependent on the nature and extent of noncompliance and the recipients at risk. Often, a serious adverse outcome is identified in an event or incident. However, the survey team's investigation should seek to determine how long the IJ has existed, which may be prior to the event or incident.

The duration of the IJ does not automatically end, even if the Client is no longer in danger by the noncompliance (e.g., Client is no longer in the facility or has expired). The survey team must determine if the noncompliance continues to create a likelihood for serious injury, serious harm, serious impairment, or death for any other recipients.

2. Serious Adverse Outcome or Likely Serious Adverse Outcome:

As a **result** of the identified noncompliance, serious injury, serious harm, serious impairment or death has occurred, is occurring, or is likely to occur to one or more identified Clients at risk; this serious adverse outcome may be physical, mental, and/or psychosocial in nature. The surveyor will use evidence gathered during observations,

interviews and/or record reviews to support the assertion that the Client has suffered a serious adverse outcome as a result of the identified noncompliance. Only one Client needs to have suffered or be likely to suffer a serious adverse outcome for IJ to exist. Consider a serious adverse outcome when the noncompliance has caused death, loss of a limb, or permanent disfigurement. To determine if there is a likelihood of a serious adverse outcome, the surveyor/survey team uses their professional judgment, taking into account the nature and scope of the identified noncompliance, the particular vulnerabilities of the Clients at risk, and any other relevant factors to determine whether serious harm will likely occur if no corrective action or inadequate action is taken.

Serious adverse outcomes may not always effect physical functioning, but may have an effect on mental or psychosocial functioning (e.g., noncompliance that causes a Client to suffer psychosocial harm, such as from sexual abuse).

Consider IJ when noncompliance causes a Client to experience avoidable pain that is excruciating, and more than transient in nature. Consider pain avoidable when there is a failure to assess, reassess, and/or take steps to manage the recipient's pain. IJ exists not only when a facility's noncompliance has **caused** or is **likely** to cause serious injury, harm, impairment or death. Determine if there is no immediate action taken, could one reasonably expect a serious adverse outcome**.**

Psychosocial/Mental Harm and using the Reasonable Person Concept:
Noncompliance rising to the level of IJ may also affect the Client's mental or psychosocial well-being. Some situations in which the psychosocial outcome to the Client may be difficult to determine. Consider if a reasonable person in a similar situation could expect to experience a serious adverse outcome because of the same noncompliance.

3. Need for Immediate Action:

The noncompliance creates a need for immediate corrective action by the facility to prevent serious injury, serious harm, serious impairment or death from occurring or recurring. When noncompliance causes a serious adverse outcome or creates the likelihood that a serious adverse outcome will occur, the facility must take immediate corrective action to prevent the serious injury, serious harm, serious impairment or death from occurring or recurring. Even if the Client has been removed from the situation, e.g., transferred to acute care, discharged, or has died, immediate action must be taken to remove the systemic problems, which contributed to, caused, or were a factor in causing the serious adverse outcome, or making such an outcome likely.

IJ exists when the facility's noncompliance has caused (or created the likelihood of) either serious injury, serious harm, serious impairment, or death, and creates the **need for immediate action** so that the serious adverse outcome will not occur, or recur.

Procedure - Systematic approach to determining if an IJ exists

Surveyor/Complaint Investigator will:

1. Document activities on Surveyor Notes, Attachment V and provide a copy of Vulnerable Adult Statement of Rights (VASOR) DSHS 16-234A for ICF/IIDs that are RHCs (Rainier School, Lakeland Village and Fircrest) or DSHS 16-234 for non-RHC ICF/IIDs when interviewing Clients for abuse, neglect or mistreatment (documenting if the VASOR was given or not and the reasons in the working papers). The documentation should include the full name of the person interviewed. Include the time and date of the interview. Indicate any witnesses present.
2. When unable to discern the Client's response to a facility's noncompliance, attempt to interview the Client's family, or other individuals involved in the Client's life to determine how the Client reacted or would have reacted to the noncompliance. If unable to conduct interviews with the family or representative, apply a reasonable person approach.
3. Meet as a team.
4. Refer to Appendix Q - IJ guidelines as needed.
5. Share collected data.
6. If the case involves a potential criminal action, the surveyor should be aware to preserve any physical evidence for law enforcement agencies.
7. Contact the Field Manager (FM) to inform the status of the finding.
8. Proceed to validate the gathered information with facility staff. Consider the facilities response to any harm or potential harm that meets the definition of IJ.
9. Identify and clarify any inconsistencies or contradictions between interviews, observations and record reviews.
10. Determine the specific Federal regulation for the situation.
11. Use the IJ Template to document evidence of each component of the IJ. The IJ Template conveys information to the facility. Any information presented on this template is subject to change and does not reflect an official finding against a Medicare provider or supplier. CMS Form 2567 is the only form that contains official survey findings of the IJ.
12. In order for IJ to exist, the survey team must answer "Yes" to all three components and provide a preliminary fact analysis in the right hand column to support their determination

.

   a. **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.
   b. **Noncompliance** means failure to meet one or more federal health, safety, and/or quality regulations.
   c. **Recipient at Risk** is a Client who, because of noncompliance, and in consideration of the Clients physical, mental, psychosocial or health needs, and/or vulnerabilities, is likely to experience a serious adverse outcome. Serious injury, serious harm, serious impairment or death are adverse outcomes which result in, or are likely to result in:
      - Death; or
      - A significant decline in physical, mental, or psychosocial functioning, or
      - Loss of limb, or disfigurement; or
      - Avoidable pain that is excruciating, and more than transient; or

• Other serious harm that creates life-threatening conditions.

13. Identification of IJ will be made while onsite. With confirmation of the IJ by the Field Manager, complete the IJ Template. Use one IJ Template for each tag considered at IJ level. Use evidence gathered from observations, interviews, and record reviews to carefully consider each component of the IJ outlined in the left-hand column of this IJ Template.
14. Notify the facility administration of the IJ with a clear and concise finding written on the IJ Template. Note the date and time that the facility received the form at the top of page two. In most cases, this will be before the exit conference or deliver the notice describing the IJ to the facility no later than 2 days of the end of the survey. After the survey ends, review and discuss the findings and document on the CMS Form 2567.
15. If official notification of all deficiencies, i.e., CMS Form 2567, was not given on the second day, send a completed CMS Form 2567 to the facility by the tenth working day. If an IJ was identified after the survey team has exited the premises (which is rare), the survey team must return to the facility to validate the finding using the IJ Template.
16. Report any criminal act to the local law enforcement agency. The facility should be encouraged to make the report. The facility should begin immediate removal of the risk to Clients, and immediately implement corrective measures to prevent repeat Jeopardy situations.
17. Findings are always preliminary (until recorded on CMS form 2567), whether the IJ is removed or not. Refer to SOM Chapter 2, Section 2724.
18. **Approval of the Removal Plan** Determine if implemented appropriately, would the removal plan remove the likelihood that serious harm will occur, or recur. Approving the written removal plan does not mean the IJ is removed.

    The facility's removal plan must:
    - Identify those Clients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
    - Specify the action the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Notify the FM of all of the elements of the removal plan.

19. **IJ Removal** Confirmation of IJ removal is verified onsite after approval of the facility's removal plan and implementation. Closely verify through observation, interview, and record review, that all actions the facility took were effective in removing the likelihood that serious injury, serious harm, serious impairment or death would occur or recur. Removal of IJ means that the facility took immediate action to prevent a serious adverse outcome from occurring or recurring.

    Even if the facility implements the removal plan prior to the exit conference of the original survey in which IJ was cited, the IJ continues until an onsite revisit verifies the date that IJ was removed. During onsite revisit surveys, verify that that the facility implements all elements of the removal plan.

With the implementation of the removal plan, and all elements of the removal plan eliminated, is on the date determined that actions taken were completed in a manner that eliminates the likelihood of serious injury, serious harm, serious impairment, or death.

Removing the IJ does not ensure that substantial compliance has been achieved. With confirmation of the removal of the IJ, issue a completed CMS Form 2567 and request a PoC that achieves substantial compliance.

20**. IJ Removed, Deficient Practice Corrected** When IJ has been identified and removed during the current survey or the revisit, ensure the core components of IJ and the actions taken by the entity to remove the IJ are documented on the CMS Form 2567. See ASPEN 0000 page guidelines. The documentation must identify and describe the following information:

- The date the IJ began (the date facility's noncompliance caused a serious adverse outcome, **or** made a serious adverse outcome likely), if known;
- The date the facility was notified;
- The specific requirement violated, including a description of the noncompliance and the serious adverse outcome that occurred, or was likely to occur;
- Identification of Client(s) affected or identified at risk of serious injury, harm, impairment, or death within the deficient practice statement;
- Date when the IJ was removed, as confirmed by an onsite verification.
- A statement of the seriousness of the remaining noncompliance, if any (i.e. Condition/Standard level).

21**. IJ's that are not removed** begin the 23-Day termination procedure (See Chapter 16C6: Required Timelines)

Field Manager:

1. Notify the Office Chief and HCA and/or CMS immediately when there is any situation involving the likelihood of life threatening risk to a Client (imminent risk, imminent harm) and/or when the survey team recommends a denial order prohibiting admissions.
2. Ensure staff understand the IJ procedures and correct documentation on the IJ Template and CMS Form 2567 procedures.
3. Evaluate and approve the facilities removal plan.
4. Initiate recommendation for enforcement action when the facility is unable to comply with the PoC requirements for the CoP.

Administrative Assistant 3:

1. Document on the Tracking Tool Surveys and Citations the survey activities.
2. By the **Second Working Day** – Deliver the written notice describing the IJ to the facility no later than 2 days of the end of the survey. If the official notification of all deficiencies (CMS 2567) was not given on the second day, send a completed SOD on the CMS form 2567 to the facility on the tenth working day.
3. By the **Third Working Day** – Upon request, forward all supporting documentation to the HCA and/or CMS. Forward the information by overnight mail to assure that the HCA and/or

CMS receives it. Upon receipt of the survey information, the HCA and/or CMS reviews the documents and makes its determination of noncompliance.

4. On the **Tenth Working Day** - If notification of the IJ deficiencies was only sent on the second working day to the facility and HCA/CMS, and there are other, non IJ deficiencies found during the same survey or investigation, (standard/key level), send the composed CMS Form 2567 with those deficiencies to the facility and forward copies to HCA and/or CMS within ten working days.
5. Complete Survey and Complaint Investigation Tracking Cover sheet, Attachment CC. Retain a copy for records.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Chapter 16D – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Alternate Sanctions

Overview

Whenever possible, the Health Care Authority (HCA) and/or the Centers for Medicaid will conduct the termination notification and decision-making process in the 90-day timeframe used for Medicare terminations (see Chapter 16C6: Required Timelines for details).

However, there are circumstances that require CMS to give a facility extra time. For example, with state-owned facilities, it sometimes takes longer to get a PoC because of the need for action by other parts of State government, thus requiring additional processing time. Keep these situations to an absolute minimum.

The Washington State Plan was amended October 1, 2016 and August 1, 2018 to include additional remedies in lieu of facility termination.

Alternative Sanctions, used as remedies for deficiencies that do not constitute Immediate Jeopardy (IJ) to Client health and safety, is an option for the survey team. This applies to all ICF/IID certified facilities. The survey team may impose one or more alternate sanctions against a facility instead of provider agreement to termination for Condition of Compliance (CoP) level noncompliance.

Authority

42 CFR 442.118 ,SOM 3006A Denial of Payment
42 CFR 442.119 SOM 3005E Termination
42 CFR 438.702 Temporary Manager
42 CFR 438.66, SOM 3006.4 State Monitoring
RCW 18.51.490 Receivership
SOM 3006.2 Directed Plan of Correction/Directed in-service
SOM 3040 Termination with Look behind

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D – ICF/IID Index

D. Alternate Sanctions Overview

1. Alternate Sanction Considerations
2. Sanction Options **TBD**
3. Denial of Payments and Admissions **TBD**
4. Directed In-Service Training **TBD**
5. Directed Plan Of Correction **TBD**
6. Monitoring **TBD**
7. Temporary Management (Receivership) **TBD**
8. Facility Notifications **TBD**

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D1 – ICF/IID Alternate Sanction Considerations

Overview

In lieu of termination, alternative sanctions, used as remedies for deficiencies that do not constitute Immediate Jeopardy (IJ) to Client health and safety, remain an option for the ICF/IID survey team to use to assist a facility with compliance measures. More than one alternate sanction may be imposed against a facility for CoP level non-compliance.

Alternative sanctions will be considered when:

- There is no actual or potential harm to the Client;
- Deficiencies with CoPs;
- When deficiencies fall under:
    - Client behavior and facility practices (W266)
    - Health care services (W318)
    - Active Treatment (W195)

The State Plan allows the implementation of the following alternative sanctions for non-compliant facilities having non-immediate jeopardy deficiencies:

- Denial of new Admissions/Payments
- Directed In-Service Training
- Directed Plan of Correction (DPOC)
- Monitoring
- Temporary Management (Receivership)

With the exception of denial of payment for new admissions, the timing and notice of the alternative sanctions begin on the date the facility receives the written notice and Statement of Deficiencies, as documented by the Certified Mail Return Receipt. The facility has 60 days from the date they receive formal verbal notice of the state's findings (known as the "exit date") for the correction to be accomplished.

Procedure

Surveyor will:

1. Discuss all recommendations from survey revisits with the Field Manager.

Field Manager will:

1. When determining sanction options, consult with the Office Chief to consider the facility history, relationship between and among deficiencies and, what is most likely to help the facility achieve compliance.

   A determination of the appropriateness of the alternative sanction(s) is on a case-by-case basis and involves consideration of the following factors:

    - Seriousness of the violations(s);

- Number and Nature of the current violation(s);
- Potential for immediate and serious threats to ICF/IID Clients;
- Potential for serious harm to ICF/IID Clients;
- The presence of repeat deficiencies;
- A facilities willingness to become compliant with program rules and regulations;
- Mitigating circumstances; and
- Other relevant factors

2. Consult with the RCS Director to determine alternate sanction options within 10 calendar days of the survey date. This information is documented in the SOD cover letter, emailed, and sent to the facility by certificated mail within 10 days of the survey exit date. Inform HCA and/or CMS of the decision.

3. Provide detailed information to the facility regarding the sanction(s) within 10 calendar days of the facilities receipt of the SOD (as documented by the Certified Mail Return Receipt). Central office will send the second letter, by certified mail.

4. If in question, consult with the Attorney General's Office to determine if a sufficient basis exists to approve the enforcement action recommendations.

5. If there is a determination to establish alternative sanctions in addition to the already existing alternative sanction of denial of payment for new admissions (for non-immediate jeopardy situations), the plan (in addition to the cover letter) should describe:
   - Timing and notice requirements;
   - When the remedy will be applied;
   - How the alternative remedy is effective in deterring noncompliance; and
   - Factors considered in selecting the remedy.

6. The ICF/IID Field Manager reserves the right to determine visits and/or revisits to ensure compliance as needed with any sanction.

Administrative Assistant 3 will:

1. Document on the ICF/IID Tracking Spreadsheet the facilities activities and state the directed remedy.

2. Collect facility packets. Include documented copies of communications and written reports of oral communications with the facility including the date of contact, the person involved, the purpose, and the content of the communication.

3. Mail letters/documents as determined from ASPEN. All information will be documented in the SOD cover letter (along with the outlined remedy plan), email, and send to the facility by certificated mail within 10 days of the survey exit date.

Quality Assurance Review

1. Review this procedure for accuracy and compliance at least every two years.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D2 – ICF/IID Sanction Options

This section is under construction.

Back to Top

Change Log

Chapter 16D3 – ICF/IID Denial of New Admissions/Payments

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D4 – ICF/IID Directed In-Service Training

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D5 – ICF/IID Directed Plan of Correction

This section is under construction.

Back to Top

Change Log

Chapter 16D6 – ICF/IID Monitoring

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D7 – ICF/IID Temporary Management (Receivership)

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16D8 – ICF/IID Facility Notifications

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16E – ICF/IID Employee Development

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16E – ICF/IID Index

E. Employee Development Overview TBD

1. Training and Refresher **TBD**
2. Skill Building Tools **TBD**

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16E1 – ICF/IID Training and Refresher

This section is under construction.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16E2 – ICF/IID Skill Building Tools

This section is under construction

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16F – Additional ICF/IID Standard Operating Procedures - Index

Overview

This chapter of the ICF/IID SOP is utilized for new and additional policy procedures and guidance for ICF/IID surveyors and Headquarters staff.

Index

Back to Top

Change Log

Washington State Department of Social & Health Services

CHAPTER 16 F1 - Privately Owned ICF/IID Facility Certification and State Nursing Home/Assisted Living Facility Licensing Requirements

Overview

Under the Department's rules, all privately owned ICF/IID facilities with a certified capacity of at least sixteen beds must be licensed as nursing homes, and all privately owned ICF/IID facilities with less than sixteen beds must be licensed as assisted living facilities. WAC 388-835-0040(3)-(4).

See 42 U.S.C. § 1396d(d); 42 CFR 435.1010(a). An ICF is an institution that "is primarily for the diagnosis, treatment, or rehabilitation of Individuals with Intellectual Disabilities" or related conditions.

Federal law does not exempt privately owned ICF/IIDs from state regulation as nursing homes or assisted living facilities.

Authority

WAC 388-835-0040(3)-(4)

Procedure for privately owned ICF/IIDs

All dual certified/licensed ICF/IID facilities require a federal certification survey and a licensed nursing home/assisted living facility survey.

ICF/IID Surveyors will

1. Only regulate to the ICF/IID federal regulations.
2. Conduct unannounced certification, re-certification surveys at different times than the state NH or ALF relicensing schedule.
3. Conduct all ICF/IID surveys and revisit surveys according to CMS Appendix J regulations as recorded in statute 42 CFR 483.420-460.
4. Complete and review all required documents related to ICF/IID surveys, including and not limited to: 2567, 2567B, ICF survey forms, plans of correction, etc.
5. Enter all documents in ASPEN as required.
6. Refer all questions related to nursing homes and assisted living facilities to the ICF/IID Field Manager (FM).

Back to Top

Change Log

ICF/IID Surveyors (Complaint Investigators) will

1. Initiate **all** investigations related to reports of misconduct within the noted time frame according to the CRU referral and record the initiation date in TIVA as required.
2. Direct complaint referrals back to CRU for complaints related to nursing home practices (after initiating them in TIVA). Nursing home investigators will complete all nursing home related investigations and will document findings in TIVA.
3. Follow procedures for Complaint Investigations as required in SOP Chapter 20.
4. Refer to CRU SOP Chapter 4 for further details.

Life Safety Code Surveys

1. Private, federally certified ICF/IID facilities will be surveyed under Life Safety Code surveys by the State Fire Marshal and results will be recorded in ASPEN.
2. Dual state licensed and federally certified ICF/IID facilities will also require a state nursing home or assisted living facility Life Safety Code survey **however**, this action will be handled by other departments.

ICF/IID Field Manager will

1. Ensure staff understand this procedure.
2. Review CRU referrals for appropriate department investigations.
3. Refer to RCS SOP Chapter 17 and RCS SOP Chapter 13 for licensing expectations of nursing homes or assisted living facilities if needed and consult with Nursing Home and Assisted Living FM's as needed.

ICF/IID Administrative Assistant will

1. Notify the state fire marshal of survey activities regarding ICF/IID facilities only. Ensure the ICF/IID surveys are scheduled within the CMS timeframe but at different times than the state NH or ALF relicensing schedule to avoid confusion and ensure consistent practices.
2. Document survey information in ASPEN and on the Survey and Citation ICFIID Tracking Tool.

Quality Assurance

1. Review this procedure at least every two years for accuracy and compliance.

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16 Appendix – A/B Index

Appendix A: Resources and Forms

1. Common Abbreviations
2. POD and Resources
3. ICFIID Forms

Appendix B: Change Log

Back to Top

Change Log

Washington State Department of Social & Health Services

Appendix A1- Common Abbreviations

- AC (1, 2, 3) – Attendant Counselor
- ACM – Attendant Counselor Manager
- ATP – Adult Training Program
- ATS – Adult Training Specialist
- BRF – Behavior Reporting Form
- BRT – Behavior Response Team
- CFA – Comprehensive Functional Assessment
- Clt – Client
- DCS – Direct Care Staff
- DDA (1, 2) – Developmental Disabilities Administrator
- DON – Director of Nursing
- GER – General Event Report (incident report for the small facilities)
- HPA – Habilitation Program Administrator
- HRC – Human Rights Committee
- HSS – Health Services Supervisor
- ICP – Ice Cream Parlor
- IDT – Interdisciplinary Team
- IHP – Individual Habilitation Plan
- IPP – Individual Program Plan
- IR – Incident Report
- ISC – Individual Support Counselor
- LN – Licensed Nurse
- LV – Lakeland Village
- OT – Occupational Therapist
- PA – Psychology Associate
- PAT – Program Area Team
- PBSP – Positive Behavior Support Plan
- POC – Plan of Correction
- Psych – Psychologist
- PT – Physical Therapist
- QA – Quality Assurance
- QIDP – Qualified Individual Disabilities Professional
- RN – Registered Nurse
- RSC – Residential Services Coordinator
- SOD – Statement of Deficiencies
- 1:1 - one staff to one Client ratio for supervision of the Client

Back to Top Change Log

Washington State Department of Social & Health Services

Appendix A2 – Principles of Documentation and Resources

- Principles of Documentation POD writing requirements.
- Vulnerable Adult Statement of Rights Form. (VASOR)
  DSHS 16-234A for CCRSS (Supported Living) and ICF/IID that are RHCs (Rainier School, Lakeland Village and Fircrest).
  DSHS 16-234 for all other settings (NH, AFH, ALF, ESF, non-RHC ICF/IIDs).
- CMS Statement of Deficiencies and Plan of Correction CMS form 2567
- Corrected Citations CMS form 2567B
- ICF/IID Survey Report CMS form 3070G
- ICF/IID Deficiencies Report CMS form 3070H
- Survey Work Hours 670 Hours MB
- Appendix J
- Appendix Q
- IJ Triggers
- Reporting Grid
- ICF/IID Locator
- Adult Protective Services
  - Phone: 1-877-734-6277
  - TTY: 1-800-672-7091
  - Fax: 1-360-664-9103
- See map: Google Maps, Yahoo! Maps, MapQuest
- Long Term Care Ombuds
  - Email address: ombudspt@localaccess.com
  - Phone: 360-943-6018
  - Fax: 360-736-1997
  - DDA Ombuds
- ALTSA Headquarters Staff Phone Numbers

Back to Top

Change Log

Washington State Department of Social & Health Services

Appendix A3 – Forms

ICF/IID Forms

- Recertification survey action plan, Attachment A
- Complaint Allegation, Attachment AA
- Survey hour tracking, Attachment B
- Entrance conference attendance record, Attachment C
- Survey/Complaint Investigation Tracking Cover sheet, Attachment CC
- Required provider survey documents, Attachment D
- Dignity and respect, Attachment DD
- Sample selection, Attachment E
- First hour observation report, Attachment F
- Task 2 phase one, Attachment G
- Task 2 phase two, Attachment H
- Client sample interview/observation, Attachment I
- Meal observation, Attachment J
- Human resources BG check, Attachment K
- Medication pass observation, Attachment L
- Annual fire drill, Attachment M
- Physical Environment Rainier E, Attachment N
- Physical Environment Rainier C, Attachment O
- Physical Environment Rainier A, Attachment P
- Physical Environment Lakeland, Attachment Q
- Physical Environment Fircrest, Attachment R
- Physical Environment Rocky Bay, Attachment S
- Team Leader notes, Attachment T
- Exit conference roster, Attachment U
- ICF/IID Notes, Attachment V
- Team Leader Focused Fundamental checklist, Attachment W
- Team Leader Full survey checklist, Attachment X
- Team Leader summary, Attachment Y
- Complaint survey action plan, Attachment Z
- Individual Workload
- Complaint Checklist (for ISR)
- SOD Review Checklist
- Survey Certification Workload Report
- IJ Triggers

- ICF/IID Reporting Grid
- Initial Comments - Standard Format Guidelines
- Initial Comments - Example
- SOD Mailing Instructions
- Immediate Jeopardy Template
- Cop Timeline Unmet Chart 1
- Immediate Jeopardy Chart 2
- Immediate Jeopardy Chart 3
- Tracking Tool Survey and Citations

Back to Top

Change Log

Washington State Department of Social & Health Services

Chapter 16 – APPENDIX B

CHANGE LOG

EFFECTIVE DATE	CHPT SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION &TRAINING PLAN
6/12/2020	16F	Development of Chapter 16F	Establish new section in the SOP for additional procedures	MB/SOP R20-071
9/20/2019	16B	Development of subchapter 16B and 16D	Subsection B and D added to ICF/IID SOP Chapter	MB/SOP R19-070
7/12/2019	16C	Development of subchapter 16C	Subsection C added to ICF/IID SOP Chapter	MB/SOP R19-049
4/19/2019	16A	Development of Chapter 16A	Establish new ICF/IID SOP Chapter	MB/SOP R19-034

Back to Top