Overview

Nursing Homes (NH), also called Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) depending on funding type, are either Federally Certified and/or State Licensed. These settings employ qualified staff to provide acute and sub-acute care.

There are currently over 210 NHs in the state of Washington that can range in size from 8-bed to 200+ beds operated independently or by a corporation. Some NHs provide specialized care for residents depending on the assessed needs of each resident.

NHs are required by law to be surveyed every 9 to 15 months with a 12-month average. Additionally, complaint investigations are not factored into this timeline and can happen at any time on the survey timeline. If a NH is found to not be in compliance with certification or licensing requirements there may be enforcement actions against the facility ranging from civil fines to conditions on a license or even possible license revocation in the case of DSHS, and civil money penalties (CMPs) or de-certification by Centers for Medicaid and Medicare Services (CMS).

This chapter contains information about the licensing standards and other topics related to NHs. The content is relevant to RCS staff in an effort to better support work process. These procedures are not covered by DSHS Administrative Policies as they are specific to Residential Care Services. These procedures will be reviewed for accuracy and compliance at least every five years.

Authority

- Long Term Care Survey Process Procedure Guide
- CMS State Operations Manual (SOM), Chapter 4
- CMS State Operations Manual (SOM), Chapter 5
- CMS State Operations Manual (SOM), Chapter 7
- CMS State Operations Manual (SOM), Appendix PP
- CMS State Operations Manual (SOM), Appendix Q
- Chapter 18.51 RCW – Nursing Homes (NH)
- Chapter 388-97 WAC – Nursing Homes (NH)

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

- Centers for Medicaid and Medicare Services (CMS) – Region 10
- Department of Health (DOH) – Construction Review Services (CRS)
- Department of Health (DOH) – Food Safety
- Washington State Patrol (WSP) – Office of State Fire Marshal (OSFM)
- Federal & State Long-Term Care Ombuds Program (LTCOP)
- Washington Health Care Association (WHCA)
- LeadingAge of Washington (LA)

Contacts

- Nursing Home Policy Program Manager: Molly McClintock
- Nursing Home Training Program Manager: Christine Kubiak
- Nursing Assistant Training Competency and Evaluation Program (NATCEP) Manager, Anne Richter
- RCS Policy Unit General Contact: RCSPolicy@dshs.wa.gov
- RCS Quality Improvement Unit General Contact: ImproveRCS@dshs.wa.gov

Chapter Index

Part I: NH Pre-Occupancy Standard Operating Procedures – Under Construction

Part II: NH Initial Certification Survey Standard Operating Procedures – Under Construction

Part III: NH Recertification Survey Standard Operating Procedures

1. PASSAR Investigation Process During the NH Recertification Survey
2. Nursing Assistant Training Program Onsite Inspection
3. State Tasks
   A. Incident Reporting Log
   B. Staffing Patterns for the Thirty Days Prior to Survey
   C. Medical Test Site Waiver
   D. Liability Insurance
   E. Trust Fund
   F. NATCEP Program Review
   G. Paid Feeding Assistant Program
   H. Call Bell Visible and Audible
   I. Dementia Unit Egress Signage
   J. Fresh Fruits & Vegetables
   K. Staff Qualification and Background
   L. Tuberculosis Review for Residents and Staff
   M. Pet Records
   N. NAC Medication Assistant Program
4. Recertification Survey Communication Process
5. Recertification Survey Exit Conference
6. Off-Hour Surveys

Part IV: NH Recertification Survey for State Only Licensed Facilities Standard Operating Procedures – Under Construction
Part V: NH Post Survey Standard Operating Procedures – Under Construction
Part VI: Special Focus Facilities
1. Candidate List
2. Initial Selection
3. Notification to Facility of Initial Selection
4. Meeting to Discuss Significance of SFF Selection
5. Progressive Enforcement
6. Factors Considered for Graduation or Termination Graduation from the SFF Program
   A. Graduation from the SFF Program
   B. Termination
7. Post-Graduation

Part VII: NH Master Survey Schedule
Part VIII: Appendices
1. Glossary of Terms
2. Acronym List
3. Resources and Forms
   A. Resources
   B. Forms
4. Model Letter to Provider Selected as a Special Focus Facility
5. CMS Questions to State Agency (SA) on SFF Status
6. SFF Process Tracking Tool (CMS Job Aide)
7. Change Log

Part I: NH Pre-Occupancy Standard Operating Procedures – Under Construction

Back to top Change Log

Part II: NH Initial Certification Survey Standard Operating Procedures – Under Construction

Part III: NH Recertification Survey Standard Operating Procedures

1. PASSAR Investigation Process During the NH Recertification Survey

Background

This Standard Operating Procedure (SOP) provides instructions to NH surveyors regarding investigation of the Pre-Admission Screening and Resident Review (PASSAR) process during the recertification survey.

During the recertification survey, the Long-Term Care Survey Process (LTCSP) directs the facility to identify and document on a matrix any resident(s) who have a serious mental illness (SMI), intellectual disability (ID) or a related condition (RC) but do not have a PASARR Level II evaluation and determination.

PASARR (also known as PASRR) is a federal requirement (42 CFR§483.100-138) for Medicaid certified nursing facilities (NF) ensuring that individuals with a SMI, ID, or RC are appropriately placed in nursing facilities for long term care. The key PASARR requirements are:

- Each NF applicant is evaluated for SMI, ID and RC prior to NF admission;
- Individuals with SMI, ID or RC are offered the most appropriate setting for their needs; and
- Individuals with SMI, ID or RC receive the services they need in those settings.

Federal and state regulations require a PASARR Level I evaluation for every NF resident prior to admission. The Level I is typically completed by the entity referring the resident for NF admission. If a PASARR Level II evaluation is required, prior to admission, the PASARR evaluator must make the determination the resident:

- has a SMI, ID or RC;
- is appropriate for NF placement; and
- whether specialized services are required while at the NF.

Procedure

A. The Surveyor will:
   1. Following the Long-Term Care Survey Process (LTCSP) Procedure Guide instructions, include in the investigation sample any resident(s) identified:
      a. During the initial pool process, any resident identified as having an appropriate diagnosis (a SMI, ID, or RC) but are not receiving PASARR Level II services, if a brief record review confirms the need for further investigation.
      b. In off-site preparation with a PASARR related concern.
      c. On the matrix who have a SMI, ID, or RC and do not receive PASARR Level II services.

d. During the survey process with a PASARR related concern.

2. Review the Level I and/or Level II PASARR forms of the five residents sampled for the "Unnecessary Medication, Psychotropic Medications, and Medication Regimen Review Critical Element" (CE) pathway in the investigation portion of the LTCSP. For all five sampled NF residents the review will determine:
   a. If the Level I evaluation was completed prior to a resident's admission to the NF.
      Note: When reviewing a Level I form for timeliness, do not consider a Level I form that was not completed timely as failed practice if it was completed prior to the last recertification survey. Complete the rest of the PASARR review for that resident.
   b. If a Level II evaluation was required, prior to admission, did the evaluator make the determination the resident had:
      i. an appropriate diagnosis;
      ii. needed NF care; and
      iii. whether Level II services were needed?
      Note: the full Level II evaluation does not need to be received prior to admission. However, the determination made by the evaluator needs to be completed and received by the facility, verbally or in writing. If verbal confirmation is received, the facility is required to follow up and assure the final Level II evaluation is received in writing and placed in the medical record after admission.
   c. If a Level I completed by the hospital or other referring entity was inaccurate, did the NF complete a new Level I and make a Level II referral (if needed) to the appropriate evaluator upon admission?
3. For any resident with a significant change in condition (as defined in WAC 388-97-1910) the review will determine:
   a. If a new Level I form was completed by the NF.
   b. If a Level II assessment was required, that the NF made a referral to the appropriate agency.
4. For any resident the facility later had credible suspicion (as defined on Level One Pre-Admission Screening and Resident Review (PASRR) (DSHS 14-300)) of a SMI, an ID, or a RC, the review will determine:
   a. If a new Level I form was completed by the NF.
   b. If a Level II assessment was required, that the NF made a referral to the appropriate agency.
5. If no issues are found with the PASARR process, affirmatively document the PASARR process was completed correctly in the Unnecessary Medication pathway.
6. If concerns are found with the PASARR process, initiate the PASSAR Critical Element (CE) pathway for further investigation. Document findings in the Investigation Notes or the Resident Notes in the LTCSP software.
   a. At the survey team's discretion, expand the sample if failed practice is found related to the PASARR process.
   b. Document PASARR related citations on the Statement of Deficiency (SOD).

B. The Team Coordinator (TC) will:
    1. Ensure all PASARR reviews were completed and documented in the LTCSP software. At the conclusion of the recertification survey, if failed practice was found, alert the Field Manager (FM).
C. The FM/designee, will:
    1. Review any PASARR citations to assure the citation is complete and follows the Principles of Documentation (POD).
D. The RCS Program Manager (PM) for Public Disclosure, Discovery, and Central Files Unit/designee will:
    1. Gather information about failed practice related to the PASARR process from the ASPEN software and forward the information to the Health Care Authority (HCA) for follow up.

Back to top Change Log

2. Nursing Assistant Training Program Onsite Inspection

Background

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

Procedure

A. Off-Site Preparation (prior to starting the survey)
   1. The TC will:
      a. Ensure the survey team has an electronic or printed copy of the Omnibus Budget Reconciliation Act (OBRA) Nursing Assistant (NA) Training Onsite Inspection Form for Survey (NATCEP) (DSHS 16-168) available for use during survey.
      b. Check the Department of Health (DOH) Nursing Assistant (NA) Training Program website to determine if the facility identified for inspection or survey has an approved NA training program.
         Note: The list is sorted by county, but a search feature is available to search by county, city, facility name, program type or training type.

B. During the Survey
   1. The TC will:
      a. Obtain the following information during the entrance conference:
         a. Determine if there is a facility based approved NA training program.
            1) If there is no facility-based program, check the "No program" box in Section One of the NATCEP form.
            2) If there is a facility-based NA training program but no training has occurred in the last 12 months, check the "Inactive" box of Section One of the NATCEP form.
            3) If there is a facility-based training program and NA training has occurred in the last 12 months, check the "Active" box of Section One of the NATCEP form.
         b. Determine if there are any current students doing clinical rotations from any other (non-facility based) NA training program. If other NA training is occurring, check "Yes" in Section One of the NATCEP form under Non-Facility Based Program and note the name of the entity providing the training on the form.
            1) If non-facility based NA training is occurring, check the Sanctioned Facilities list to determine if the facility has sanctions that prohibit facility-based training. If the facility has sanctions, note that in Section 5 of the NATCEP form.

2) A facility with sanctions that prevent them from conducting facility-based training may host non-facility-based NA training under certain circumstances. RCS may authorize this on a case-by-case basis.

c. If the facility has an active facility-based program, request the following documents during the entrance conference:
   1) Applications for current NA Training Program Director and primary instructors teaching in the NA Training Program.
   2) A copy of the most recently approved NA training curriculum. The curriculum is approved by the DOH for a two-year period.
   3) Five nursing assistant training records from the facility's current training program or from students who have graduated from the program within the past 12 months.
   4) A copy of an issued "Certificate of Completion" (COC) for the training program, which contains the approved number of hours.

d. If the facility has no program, an inactive program, or only non-facility-based training, complete Section One of the NATCEP form, and note any concerns in Section Five of the NATCEP form. Sections Two, Three and Four do not need to be completed if the facility has no program, an inactive program, or only non-facility-based training.

e. At the conclusion of survey, email the NATCEP form to: obraregistry@dshs.wa.gov.

b. If the facility has an active program, assign the task to a survey team member. Provide the surveyor with the partially filled out NATCEP form, and the information and documents gathered during the entrance conference.

2. The assigned surveyor will:
   a. Review the NA training program materials, documenting the review on the NATCEP form.
      i. Section Two, Names of Facility Staff: List the names of the program director and instructor(s) as reported by facility.
      ii. Section Three, Program Hours, and Curriculum:
         1) When the sampled COC hours of classroom and clinical training meet or exceed 85 hours, check the appropriate box on the NATCEP form to indicate fulfillment of the requirement. Total hours required are 85, with a minimum of 35 classroom hours and a minimum of 50 clinical hours (10 of which can be lab hours). Write in the number of classroom and clinical hours taught in the spaces provided.
         2) From the facility provided materials, locate the curriculum. If it is the approved DOH curriculum, check the appropriate box. The facility must have an approval letter from the Nursing Commission/DOH that identifies them as an approved training program.
      iii. Section Four, Students: When reviewing student files, locate the completed "skills checklist." If the checklist is complete, place a check on the applicable box on the form for evidence in the checklist that students:
         1) Only perform skills for which they have been trained and demonstrated proficiency.
         2) Receive 16 hours supervised practical training in lab or other clinical setting.

3) Perform skills under supervision of Licensed Practical Nurse (LPN) or Registered Nurse (RN).
4) Are not charged for training or testing.

iv. Conduct interview(s) with the program director, the instructor and/or students to resolve any concerns not addressed through record review of the student files.
v. Section Five, Areas of Concern: Document information about any areas of concern or any items reviewed that did not fulfill requirements.

C. After the survey:
1. The TC/designee will:
a. Email the completed NATCEP form to the NATCEP manager at obraregistry@dshs.wa.gov for filing or further action. Send the form after every survey, whether there is an active program, an inactive program, or no program.
b. Include a copy of the completed form with survey working papers.

Field Manager Responsibility

A. Ensure survey staff are trained to complete this procedure.
B. Ensure a NATCEP form is completed and sent to NATCEP for each re-certification survey, whether the surveyed facility has an approved NA training program (active or inactive) or does not have a program.

Back to top Change Log

3. State Tasks

Background

RCS conducts a periodic survey of each NH to ensure compliance with both state and federal regulations. RCS uses the federal Long Term Care Survey Process (LTCSP) to ensure compliance with the minimum standards of federal requirements.

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

All NH facilities require a review of all state requirements, including State Tasks, except in certain limited circumstances (see RCS Management Bulletins (MBs) R17-006 and R16-035).

This procedure:

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

Procedure

A. Off-Site Preparation (Prior to Starting the Survey)
   1. The TC will:
      a. Determine if the facility has any current waivers in place related to state regulations.
      b. Determine and document the name of the Administrator and the Director of Nursing (DON) by looking in ASPEN Central Office (ACO), the software maintained by CMS for the names of the Administrator and the DON.
      c. Print a copy of:
         i. Attachment C: State Entrance Conference Letter to provide to the facility during the entrance conference.
         ii. Attachment D: State Task Checklist (DSHS 10-625) for the survey team members to document completion of review(s) during the survey.
         iii. Attachment E: Staffing Pattern (DSHS 10-626) to provide to the facility.
      d. Ensure either printed or electronic copies of the following forms are available to the survey team during the survey:
         i. Attachment F: Liability Insurance Review (DSHS 10-627)
         ii. Attachment G: Trust Fund Review (DSHS 10-628)

iii. Attachment H: Pet Record Review (DSHS 10-629)
iv. Attachment J: Paid Feeding Assistant Program Review (DSHS 10-630)
v. Attachment L: Staff Qualification and Background Review (DSHS 10-631)
vi. Attachment M: TB Testing Review for Staff (DSHS 10-632)
vii. Attachment N: TB Testing Review for Residents (DSHS 10-633)
viii. Attachment O: Medication Assistant Endorsement (DSHS 10-634)
ix. OBRA NA Training Onsite Inspection for Survey (NATCEP) (DSHS 16-168)

B. During the Survey:
   1. The TC will:
      a. Provide a copy of the State Entrance Conference Letter to the facility during the survey entrance conference and review the required information in the letter with the Administrator or designee.
      b. Provide the facility with the Staffing Pattern Form at the entrance conference. Inform the facility a surveyor will request documentation to verify the data on the Staffing Pattern Form.
      c. Ensure the facility provides all required information listed in the State Entrance Conference Letter.
      d. Assign team members to complete State Tasks.
      e. Review any state waivers with the survey team.
      f. Ensure completion of all State Tasks by the end of the survey.
      g. Compare the names of the current Administrator and DON to the Administrator and DON names documented from ACO.
         i. If there is any discrepancy between the actual Administrator and/or DON with the names documented in ACO, notify your FM.

C. After the Survey:
   1. The TC will:
      a. Consult with the FM or designee regarding any findings or possible failed practice revealed through the State Task review.
      b. Gather all documentation for state tasks and include in survey working papers according to office procedure.
   2. The Survey Team will:
      a. Document any deficient practice findings on CMS-2567, Statement of Deficiencies.
   3. The FM will:
      a. Ensure timely completion of the SOD.
      b. Ensure the facility corrects any deficient practice, following state and federal protocols.

Field Manager Responsibility

A. Ensure survey staff are knowledgeable about the State Task procedure.
B. Ensure surveyors review all State Tasks appropriately during the recertification survey.

State Tasks:

A. Incident Reporting Log

1. Federal guidelines do not have a specific requirement to keep a log of reported incidents. State regulation (WAC 388-97-0640) and department Nursing Home Guidelines (a.k.a., The Purple Book) have specific requirements for facilities to keep an incident reporting log including what types of incidents should be logged, what information the log should contain and how long the logs should be kept.
2. Review the facility incident-reporting log(s) for the prior six (6) months. Ensure the NH is logging incidents, investigating incidents, and reporting to the appropriate state agencies when required.

B. Staffing Patterns for the Thirty Days Prior to Survey

1. State rules (WAC 388-97-1080) require more Registered Nurse (RN) hours than the federal regulation (F727). The state may grant limited waivers. Unlike the federal regulation, the state may not waive the requirement for a full time DON. Additionally, the state requires:
   a. The NH must:
      i. If the facility is a large nonessential community provider, have a RN on duty directly supervising resident care 24 hours per day, seven (7) days per week. "Large nonessential community providers" means nonessential community providers that have more than 60 licensed NH beds, even if some of those beds are not set up or are not in use.
      ii. If the facility is an essential community provider (a NH which is the only NH within a commuting distance radius of at least 40 minutes duration, traveling by automobile) or a small nonessential community provider (those with 60 or fewer licensed beds, even if some of those beds are not set up or are not in use), they must have a RN on duty who directly supervises resident care a minimum of 16 hours per day, seven (7) days per week, and a RN or a licensed practical nurse (LPN) on duty who directly supervises resident care the remaining eight (8) hours per day, seven (7) days per week.
2. Review the completed Attachment E: Staffing Pattern (DSHS 10-626) to ensure required RN staffing. Surveyors may use information provided on the form as part of the Sufficient Staffing pathway review in the LTCSP.
   a. Confirm the documented information through observations, and interviews with residents, nursing staff and/or administrative staff.
   b. Correlate information on the form with actual nursing schedules.
   c. Review records provided by the facility, such as timecards or payroll documents to validate the staffing documented on the Staffing Pattern form. Verify staffing hours for RNs, LPNs, and Nursing Assistants, Certified or Registered (NA-C/NA-Rs).
   d. Review any state waivers that permit the facility to have reduced RN hours.

C. Medical Test Site Waiver

1. According to federal regulations (F770), if a facility provides its own laboratory services or performs any laboratory tests directly (e.g., blood glucose monitoring, etc.) the provisions of 42

CFR Part §493 apply and the facility must have a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility. State law (RCW 70.42.030) provides for a Medical Test Site waiver from the CLIA requirement for facilities that perform only certain low risk testing.

2. Review the Medical Test Site waiver (or the CLIA certificate, if applicable) and ensure the facility has a valid waiver/certificate that is current.

D. Liability Insurance

1. Federal regulations in Appendix PP of the SOM have no specific requirement for liability insurance. State rules (WAC 388-97-4166, 388-97-4167, and 388-97-4168) require the NH to maintain liability insurance.
2. Use Attachment F: Liability Insurance Review (DSHS 10-627) to document. Verify the facility has liability insurance that covers the items named in the three liability related WACs. Also, verify the amount of the coverage is at least as much as required in the WACs. If there are concerns with the terms of the liability insurance, interview the Administrator or designee.

E. Trust Fund

1. Federal regulations (F567, F568, F569 and F570) and state regulations (WAC 388-97-0340) have the same requirements for trust funds, except for the requirements about when the residents' personal funds are required to be in an interest-bearing account:
   a. Federal (F567) - For all residents except Medicaid residents, the facility must deposit any residents' personal funds in excess of $100.00 in an interest-bearing account. For residents whose care is funded by Medicaid, the facility must deposit the residents' personal funds in excess of $50.00 in an interest-bearing account (or accounts).
   b. State (WAC 388-97-0340) - The facility must deposit any resident's personal funds in excess of $50.00 in an interest-bearing account or accounts. For residents whose care is funded by Medicare, funds in excess of $100.00 must be deposited into an interest-bearing account.
2. Both federal (F569) and state (WAC 388-97-0340) regulations require the facility to convey the funds and a final accounting of the funds to the resident or the appropriate jurisdiction within 30 days of the discharge, transfer, or death of the resident. The LTCSP pathway (CMS-20063 Personal Funds Review) does not review this aspect of the regulation.
3. Complete this task to ensure the facility credits interest to resident accounts appropriately and conveys funds within 30 days of the resident's discharge, transfer, or death. Use Attachment G: Trust Fund Review (DSHS 10-628) to document your review.
   a. Use the list of residents with funds in trust to choose a sample. Through interview with the facility trust fund manager and record review, verify interest is credited appropriately for three (3) sampled residents.
   b. Request names of residents with trust funds who have discharged from the facility. Select one (1) resident who has been discharged for over 30 days to review for timely and appropriate disbursement of funds after discharge.

F. NATCEP Program Review

1. This review collects information about the NA Training program to ensure compliance with state requirements. The NATCEP Manager evaluates and, if needed, acts on the collected information.
2. In the entrance conference, the TC will determine if the facility has an active NA Training program. If the facility has an active program, the TC will request the following records:
   a. Applications for current NA Training Program Director, and primary instructors teaching in the NA training program.
   b. A copy of the most recently approved NA training curriculum in use by the training program, including the letter approving the program.
   c. Training records of five (5) nursing assistants from the facility training program, either past or current students (not necessarily currently employed with the facility).
   d. A copy of an issued "Certificate of Completion" for this training program, which contains the approved number of classroom hours.
3. The assigned surveyor will review the materials and complete the OBRA NA Training Onsite Inspection Form for Survey (NATCEP) (DSHS form 16-168).

G. Paid Feeding Assistant Program

1. Federal guidelines (F811) state a facility may use a paid feeding assistant if the paid feeding assistant has completed a State-approved training course and the use of the feeding assistant is consistent with state law. Conduct this review to ensure the state approved curriculum is used and to ensure the facility trains and utilizes feeding assistants according to program guidelines.
2. State approved training curricula. RCS MB R13-035, "Paid Feeding Assistant (Dietary Aide) Program (NH), defines two t(2) raining curricula currently approved for use in Washington State. Facilities are responsible to ensure their programs meet federal curriculum standards:
   a. Assisting with Nutrition and Hydration in Long-term Care
   b. "Eating Matters-A Training Manual for Feeding Assistants;" at https://www.eatright.org/Shop/Product.aspx?id=6442466394
3. In the entrance conference, the TC will determine if the facility uses paid feeding assistants. If so, the TC will request the following records:
   a. A list of names of staff, including agency staff, who have successfully completed training for paid feeding assistants and who are currently assisting selected residents with eating meals and/or snacks.
   b. A copy of the paid feeding assistant training curriculum.
4. The assigned surveyor will:
   a. Mark N/A on the State Task checklist if the facility does not use paid feeding assistants.
   b. If paid feeding assistants are used, use Attachment J to conduct observations, interviews, and record reviews to ensure facility compliance with the following items:
      i. Individuals used as paid feeding assistants successfully completed a State-approved training course;

ii. Residents receiving assistance from paid feeding assistants had assessments and were determined to be eligible to receive these services;
iii. Paid feeding assistants are supervised by a RN or a LPN;
iv. Paid feeding assistants know how to obtain assistance in emergencies; and,
v. The facility maintains records for paid feeding assistants.

H. Call Bell Visible and Audible

1. State rules (WAC 388-97-2280) require a communication system that registers a call by distinctive light at the room door and by distinctive light and audible tone at the staff workstation. The system must be equipped to receive resident calls from bedsides, common areas, toilet rooms and bathing areas. This exceeds the federal requirements (F919) that require calls to be relayed to a staff member or a centralized nursing station, and the transmission may be audible, visual or through an electronic device. Both state and federal rules require the facility try to accommodate special needs of residents so they can use a call device.
2. Conduct observations and interviews throughout the survey to determine if the call system functions consistently. Confirm a visible signal transmits to the room door and, audible and visible signals transmit to the workstation. If a resident requires accommodation to use a call signal, verify the facility attempted to meet the resident's needs.

I. Dementia Unit Egress Signage

1. WAC 388-97-2920 requires the facility to have directions for releasing the egress control device at each egress-controlled door and gate.
2. If the facility has a secured dementia unit, observe for the presence of instructions at each entrance and exit of the unit, and for visitors' ability to enter and exit the unit. Interview visitors and maintenance personnel if signage is not available or directions are not clear.
3. If the facility does not have a secured dementia unit, mark N/A on the checklist.

J. Fresh Fruits & Vegetables

1. Federal regulations (F803 through F808) do not require facilities to offer fruits and vegetables to residents on a daily basis. State regulations (WAC 388-97-1120) require that fresh fruits and vegetables, in season, are available to residents on a daily basis.
2. Conduct observations of meals and snacks. Interview residents or resident representatives about availability of fresh produce and review menus. Consult with the surveyor assigned to the kitchen to gather information about the quality and quantity of fresh produce.

K. Staff Qualification and Background

1. State rules (WAC 388-97-1800) require the NH to have a valid criminal history background check for any employed individual who may have unsupervised access to any resident. Facilities must repeat the check every two (2) years. Further, WAC 388-97-1820 prohibits the NH from employing any individual who has a criminal conviction or pending charge, which is disqualifying under Chapter 388-113 WAC. These requirements exceed the federal requirements (F606).

2. Under both federal and state rules, the facility must not employ any individual who is on a registry based on a final finding of abuse, neglect, or financial exploitation of a vulnerable adult.
3. F606 and F607 requires the facility to have and implement written procedures for screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property. The screening requirements include obtaining (or attempting to obtain) information from previous and/or current employers. Review this federal requirement with State Tasks. If there is failed practice, refer to F606 or F607.
4. The staff sample must include a minimum of five (5) staff. Attempt to sample four (4) staff hired since the last recertification survey, and one (1) staff employed by the facility at least two (2) years. Expand the employment timeframe, if needed, to ensure review of at least five (5) staff. Expand the sample as needed if there are identified concerns.
    a. If the facility uses NA-Cs with a medication assistant endorsement to administer medications or perform treatments, include one (1) medication assistant in the sample of five (5) staff, or expand the sample size. Confirm the medication assistant has the appropriate endorsement and qualifications to perform medication assistant tasks.
5. Using Attachment L: Staff Qualification and Background Review form (DSHS 10-631), review the personnel information for each of the sampled staff. Increase the scope of the investigation based on failed practice or concerns observed during the survey.
    a. Ensure the facility has confirmed each staff has a current license (if applicable) and has reviewed any action taken against the license.
    b. Ensure the facility screened each staff for a history of abuse, neglect, or exploitation prior to hire by contacting (or attempting to contact) previous and/or current employers.
    c. Ensure the facility completed the department required background check for each employee prior to unsupervised contact with any resident. Verify the facility repeated the background check every two (2) years. If a background check revealed findings that required a Character, Competency & Suitability (CCS) review or disqualification from employment, confirm the facility took the required action.
    d. For Nursing Assistant-Certified (NA-C) staff, verify the facility checked the OBRA Registry for any findings of abuse, neglect, or exploitation.

L. Tuberculosis Review for Residents and Staff

1. Federal regulation (F880) requires facilities to have "a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment…" For residents, the guidance under F880 specifies, "appropriate resident tuberculosis screening should be performed based on state requirements." For staff, the guidance states the facility must have written health policies that address assessing risks for tuberculosis (TB) and screening staff to the extent permitted under applicable federal guidelines and state law.
2. For both staff and residents, the state requirements (WAC 388-97-1360 through 388-97-1600) are specific to the type of TB screening tests, and to the timing and frequency of screening.

They also address the required response to a positive test result, and when testing is or is not indicated.

3. Residents: The resident sample should include a minimum of five (5) residents admitted within the last six (6) months. If needed, expand the admission timeframe to ensure review of five (5) residents. Expand the sample if indicated.
   a. Using Attachment N: TB Testing Review for Residents (DSHS 10-633) to document, review the testing records for the sampled residents. Review for screening within three (3) days of admission, the type of screening test administered, the timing of reading the result (for the Tuberculin Skin Test (TST), also known as Mantoux), and the result. For the TST, review for a second skin test, reading and result.
4. Staff: The staff sample should include a minimum of four (4) staff hired since the last survey and one (1) staff person employed for two (2) years or more by the facility.
   a. Using Attachment M: TB Testing Review for Staff (DSHS 10-632) to document, review the testing records for the staff sample. Review for screening within three (3) days of employment, the type of screening test administered, the timing of reading the result (for the TST), and the result. For the TST, review for a second skin test, reading and result. Ensure any staff employed for more than a year received re-screening annually.
5. For both residents and staff: Interview Infection Control (IC) staff to verify a system for adequate TB screening is in place, and to ensure appropriate monitoring and follow up is completed when results indicate.
   a. If there are concerns with the TB surveillance program, possible follow up investigation could include:
      i. Review of facility assessment requirements (F838);
      ii. Review of physical plant requirements;
      iii. Interviews with caregiving staff to determine implementation of infection prevention processes;
      iv. Interview with the Medical Director; and/or
      v. Interview with personnel from the county or local health district.

M. Pet Records

1. Federal regulations in Appendix PP of the State Operating Manual have no specific requirement regarding resident access to pets. The state regulation (WAC 388-97-0980) addresses resident's right to have access to pets and monitoring pet health.
2. Use Attachment H: Pet Record Review (DSHS 10-629) to document the review.
   a. Conduct observations of pet and resident interactions;
      i. Interview residents to verify regular access to pets, if desired, or no contact with pets if the resident objects to pets;
      ii. Interview staff to determine the system in place to monitor pet temperament and pet health;
      iii. Other avenues of investigation could include review of the incident log, the grievance log and/or the resident council minutes to review for concerns with pets.

N. NAC Medication Assistant Program

1. State WACs 246-841-586 through 246-841-595 provides the criteria and mechanism to enable a NA-C to obtain a medication assistant endorsement. This endorsement permits the NA-C to administer certain medications and perform certain treatments under the supervision of a RN. Federal regulation (F755) allows unlicensed personnel to administer medication if state law permits, but only under the supervision of a RN.
2. The TC will determine at the entrance conference if the facility uses NA-Cs with a medication assistant endorsement to administer medications or perform treatments. If the facility uses medication assistants, the TC will obtain the names of all staff used in that capacity.
3. The assigned surveyor will include up to three (3) medication assistants in the sample for review. For the sampled staff, use Attachment O: Medication Assistant Endorsement (DSHS 10-634), to document the following:
   a. Conduct observations of medication administration (may be done as part of the LTCSP medication administration observations) and/or treatment administration to ensure the medication assistant(s) are:
      i. Working within the defined scope of practice;
      ii. Working under RN supervision;
      iii. Documenting their work; and,
      iv. When assigned as a medication assistant, performing only medication assistant tasks.
   b. Interview the medication assistant(s) and designated RN(s) to confirm observations.
   c. Review medication and or treatment records.
   d. Review medication reconciliation documents to ensure appropriate handling of scheduled medications.
   e. Collaborate with the surveyor assigned to the state task, "Staff Qualification and Background," to ensure one (1) of the sampled medication assistants is reviewed for appropriate credentials.

Back to top Change Log

4. Recertification Survey Communication Process

Background

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

The survey and certification process attempts to ascertain whether providers meet program participation requirements. To survey effectively, surveyors must understand how/when to gather and convey information. There are numerous times throughout the survey process when communication occurs between surveyors and facility staff. Additionally, strong communication between team members, the FM and other field office staff helps to assure an effective and professional survey process occurs.

This procedure is guided by:

- The Long-Term Care Survey Process (LTCSP);
- The Centers for Medicare and Medicaid Services (CMS),
  - Administrative Memo 08-33
  - Policy Memo 16-11-ALL;
- The State Operations Manual (SOM)

Procedure

A. General Communication Principles:
   1. The survey team will follow communication prompts/guidelines within the LTCSP Procedure Guide.
   2. The survey team will not release information related to potential noncompliance until the information gathering is complete and the survey team has determined that a deficiency may be issued. This does not preclude interviewing facility staff for an investigation.
   3. The survey team will communicate clearly, objectively, and in a manner easily understood when explaining or documenting deficient practice to ensure the licensee/administrator understands all identified issues and preliminary findings of deficient practice prior to the receipt of the SOD.
      a. The communication will not include advice, personal opinions, comments, or directions aimed at the NH.
   4. Communication is crucial to a thorough investigation. Ongoing communication will occur throughout the NH survey between the survey team and the facility staff.
   5. The survey team will keep the administrator informed daily of the progress of the survey and complaint investigations.
   6. All surveyor conversations and presentations will respect resident confidentiality and protected health information will be handled according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7. Prior to beginning a survey, RCS staff will assure that surveys are unannounced by keeping confidential the date, time, and location of surveys, and limiting their communication about survey schedules to those who are required to know.

B. The Survey TC will:
   1. During off-site preparation:
      a. Contact the Office of the State Fire Marshall (OSFM) to confirm entrance date and time.
      b. Share data with survey team members according to the LTCSP Procedures Guide (Step 10).
   2. Upon entrance to the facility:
      a. Make introductions and provide appropriate identification (i.e., name tag/badge and business card).
      b. Request the information needed immediately according to the Entrance Conference Worksheet (Step 12 in the LTCSP).
      c. Request a room with a power outlet and place to sit.
      d. Contact the RCS field office to initiate the process of notifying the regional Ombudsman about the start of the survey.
      e. Conduct a brief entrance conference with the administrator or designee.
         i. Follow the instructions in the LTCSP Procedure Guide (Step 12) and utilize the Entrance Conference Worksheet found in the LTCSP software.
         ii. Give a copy of the Entrance Conference Letter to the Administrator or designee. This letter contains information needed to review state regulations. Review and clarify the information requested in the letter.
         iii. If the beginning of the survey occurs outside regular business hours or when the administrator is not present, complete Step 12 of the LTCSP Procedure Guide with the designated person in charge and provide them with the state Entrance Conference Letter. Conduct a follow-up Entrance Conference with the administrator, as needed, after their arrival at the facility.
      f. Inform the licensee/administrator or designated representative to expect frequent contact with the survey team and that the team will interview NH staff as questions or specific issues arise.
      g. Provide information on the survey process and establish a tone to encourage and facilitate frequent communication with the licensee/administration or designated representative and facility staff.
   3. During the survey:
      a. Conduct an end of the day team meeting with all survey team members. In the LTCSP procedure guide, see Step 15 for end of the Day One team meeting instructions and Step 21 for other end of the day meeting instructions.
         i. Prior to the meeting, the TC will electronically receive all team members' data.
         ii. The team meeting will be conducted using the prompts in the LTSCP team meeting screen.

iii. Following the meeting, the TC should share all team members' data electronically with each team member. See Steps 14 and 15 in the LTCSP Procedure Guide.

b. Conduct daily progress meetings with the administrator or designee to inform him or her of the progress of the survey. For example, if the team has completed a task such as medication pass, the administrator should be given a verbal summary of activities completed and general areas of concerns (if any).
   i. Provide the licensee/administrator or designated representative the opportunity to ask questions and/or communicate any information regarding the facility such as recent changes or events that have occurred.

c. Maintain ongoing dialogue throughout the survey, so the administrator or designated representative is aware of the basic concerns/issues and can provide additional information prior to the exit to assist in clarification of issues and data collection.

d. If a potential immediate jeopardy (IJ) situation is identified:
   i. Consult with the FM and Compliance Specialist (CS) (or others as needed) regarding any serious and/or immediate risk of harm to residents.
   ii. Guided by the communication with the FM and CS, and following the guidance in Appendix Q of the SOM,
      1) Inform the Administrator or designee of the IJ situation.
      2) Request a plan from the administrator or designee for removal of the IJ.

e. Consult with the FM regarding any serious issues encountered during the survey process, such as any situation that threatens the health or safety of team members, any situation that significantly affects the expected course of the survey process, or any particularly challenging or stressful communication that occurs.

f. At the conclusion of the survey, conduct an exit conference following guidelines in the section labelled 'Exit Conference.'

4. After the survey:
   a. Review the findings of the survey team with the FM.
   b. If any of the preliminary deficient findings communicated to facility staff during the survey change, contact the facility administrator. Explain the changes to the administrator or designee prior to issuing the SOD.

C. The Survey Team will:
   1. Attend all team meetings.
      a. Be on time and prepared to discuss identified concerns, findings, and potential noncompliance.
      b. Be prepared to discuss workload and potential adjustments in workload with other team members.
      c. Listen attentively to other team members' observations, concerns, or other identified issues.
      d. Provide the TC with information to share with the licensee/administrator at the daily progress meetings and exit meeting.

2. When a surveyor identifies potential deficiencies, the surveyor should explain the deficiency to the provider in terms specific enough to allow a reasonably knowledgeable person to understand why the requirement is not met.
3. Participate in the exit conference as requested by the TC.
4. Document all findings of deficient practice on the Statement of Deficiencies using the Principles of Documentation.

D. The FM/designee, will:
1. Be available by phone or in person to consult and support the survey team.
2. Provide oversight and support to surveyors to implement these communication principles.

Back to top Change Log

5. Recertification Survey Exit Conference

Background

The purpose of this procedure is to establish formal expectations for the NH survey team regarding the exit conference with facility leadership, residents, and ombudsman during the survey process.

The purpose of the exit conference is to informally communicate preliminary survey team findings and provide an opportunity for the exchange of information with the administrator, designee, or other invited staff. 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 Form CMS-2567, Statement of Deficiencies. An exit conference is not guaranteed, as noted in section 2724 of the SOM.

This procedure is guided by:

- The Long-Term Care Survey Process (LTCSP);
- The Centers for Medicare and Medicaid Services (CMS) Policy Memo 16-11-ALL;
- The State Operations Manual (SOM), Chapter 2 (sections 2724 and 2727)

Procedure

A. The TC/designee will:
   1. Conduct an exit conference using Step 24 in the LTCSP Procedure Guide and section 2724 of the SOM as guidance.
      a. Invite facility staff, the ombudsman, an officer of the organized resident's group, if one exists, and one to two residents to the exit conference.
         i. Following field office procedures, notify the regional ombudsman 24 hours in advance of the start of the exit conference, if possible.
      b. Follow the directions prescribed for conducting exit conferences in the SOM, section 2724, including:
         i. Introductory remarks:
            1) Introduction of the survey team.
            2) Explain why the survey was conducted.
            3) Express appreciation to facility staff for facilitating the survey.
            4) Reinforce findings are preliminary and official findings will be communicated via the CMS-2567.
            5) Explain the timeline for the CMS-2567 and the Plan of Correction (POC).
               a) The CMS-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-2567 to submit a POC.
         ii. Ground rules of the conference

1) Explain how the exit conference will be conducted and how the findings will be presented.
2) Inform the facility that where there are disagreements between the team and the facility, the facility will have the opportunity to submit additional evidence to the State, and there is a process for the facility to refute or appeal survey findings.

iii. Presentation of findings

1) Provide information about survey team preliminary findings in a manner that is understandable to those present (e.g., say the deficiency "relates to development of pressure ulcers", not to "Tag F686").
   a) Avoid using jargon or acronyms.
   b) Include preliminary findings for federal regulations, and state regulations that do not have an equivalent federal regulation.
2) Explain why the findings are a violation of Medicare or 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 a 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) Do not provide the Scope and Severity (s/s) for a given deficiency unless it is an immediate jeopardy.
   a) The survey team may describe the general seriousness (e.g., harm) or the level of urgency the deficiency may pose to residents.
   b) If a 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 residents."
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 resident.
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.

iv. Closure

1) Close the exit conference.
2) Offer additional explanation to the facility administrator or designee about the process of submitting the POC, and pertinent due dates.
3) Ensure the facility administrator or designee has contact information for the survey team and the FM.

v. TCs may use, but are not required to, Attachment A: Exit Conference Template to organize the meeting presentation.

B. The Survey Team will:
   1. At the request of the TC:
      a. Assist with organizing the exit conference presentation;
      b. Attend the exit conference; and/or
      c. Present portions of the exit conference.

C. The FM, or designee, will:
   1. Ensure the survey teams follow this procedure.

6. Off-Hour Surveys

Background

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

Previous to June 11, 2020, state NH rules (RCW 18.51.230) and federal rules (42 CFR§488.307) differed on what constituted an off-hour survey. Surveys for NHs were conducted in accordance with state rules, federal rules, or both, depending on if the home was licensed by the state, certified with CMS, or both licensed and certified.

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

Off-hour survey standards for NHs:

A. State law, RCW 18.51.230: "The department shall, in addition to any inspections conducted pursuant to complaints filed pursuant to RCW 18.51.190, conduct a periodic general inspection of each nursing home in the state without providing advance notice of such inspection. Such inspections must conform to the federal standards for surveys under 42 C.F.R. Part 488, Subpart E."
B. Federal regulations (42 CFR§488.307), and the SOM, Chapter 7, Section 7207, requires that at least ten percent (10%) of all recertification surveys must be conducted as off-hour surveys and the off-hour surveys must occur on consecutive days.
    1. CMS released additional guidance for federal off-hour surveys in Quality, Safety & Oversight (QSO) memo 19-02-NH. Due to staffing concerns in NFs on weekends, CMS specified that half (50%) of the required federal off-hour surveys will be conducted at facilities CMS has identified as having weekend staffing concerns. The off-hour surveys conducted at facilities with weekend staffing concerns will begin on a weekend day.
        a. CMS will periodically provide RCS notice of which facilities have weekend staffing concerns.
C. Off-Hour Survey Requirements:
    1. The survey must begin on the weekend, a holiday, or the evening/early morning hours before 8:00 AM or after 6:00 PM.
        a. A holiday is defined as those days the state recognizes as a state or federal holiday.
        b. An off-hour survey initiated on a holiday, or a weekday may not be counted as a required survey for facilities with weekend staffing concerns.
    2. Once started, the survey must be conducted on consecutive calendar days, including Saturdays, Sundays, and holidays.
    3. Abbreviated surveys (complaint investigations) conducted during off-hour times are not included in calculating off-hour requirements.

Procedure

A. The Surveyor will:
   1. Conduct an evening, early morning, or weekend survey, as assigned by the FM, or based on concerns identified by the survey team in offsite preparation.
      a. Surveyors will begin the survey in an off-hour timeframe. Evening surveys must commence after 6 PM; early morning surveys must begin before 8 AM; weekend or holiday surveys must start any time during weekends/holidays. Once started, the survey team will continue the survey on consecutive days until the survey is completed.
      b. At least half (50%) of the off-hour surveys will be conducted at facilities CMS has identified with weekend staffing concerns. These surveys will begin at any hour on a weekend day and continue for at least six (6) hours during the first day of survey.
      c. For off-hour surveys done at facilities that may not be on the weekend staffing concern list:
         i. If the survey starts during early morning hours (before 8 AM) on a weekday, at least two (2) hours of the survey must occur prior to 8 AM.
         ii. If the survey starts during evening hours (after 6 PM) on a weekday, at least two (2) hours of the survey must occur after 6 PM.
         iii. If the survey is started on a weekend/holiday, the surveys will begin at any hour and continue for at least six (6) hours.
   2. The entire survey team assigned a resident sample must be present during the entire first day of the off-hours portion of the survey. The FM may approve a reduction in team size. To count as an off-hour survey, a health survey team of typical size and composition must enter the facility together.

B. The TC will:
   1. Contact the FM to communicate issues and concerns.
   2. When preparing the CMS-2567 Statement of Deficiencies and/or the State of Washington 2567 licensing form, ensure the initial comments reflect an off-hour survey was conducted. Document the dates(s) and time(s) of the off-hour data collection. A sample of the first paragraph of the initial comments of an off-hour survey:
      a. "This report is the result of an unannounced Off-Hour Long Term Care Survey [and Complaint Investigation (if appropriate)] conducted at [Facility Name] on [dates of survey]. The off-hour survey included data collection on [date and time, such as "06/30/2020 from 4:00 AM to 8:00 AM"]. A sample of [#] residents was selected from a census of [#]. The sample included [#] current residents and the records of [#] discharged residents."

C. The FM/designee will:
   1. Ensure that at least 10% of all surveys are conducted as off-hour surveys for the region to satisfy requirements.
   2. Ensure at least half (50%) of the off-hour surveys are conducted at facilities identified by CMS with weekend staffing concerns. Off-hour surveys for those facilities must begin on weekends (Saturday or Sunday).

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

Back to top Change Log

Part IV: NH Recertification Survey for State Only Licensed Facilities Standard Operating Procedures – Under Construction

Part V: NH Post Survey Standard Operating Procedures – Under Construction

Part VI: Special Focus Facilities (SFF)

Overview

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

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

Authority

QSO-23-01-NH
White House Fact Sheet

1. Candidate List

Background

On a monthly basis, CMS issues a list of NHs identified as SFF candidates to the RCS Director. Candidates are selected for inclusion on the list based on their last three (3) standard health survey cycles and the last three (3) years in complaint survey performance. Each facility is given a numerical score based on the Health Inspection Rating Methodology. Those facilities with the lowest numerical scores in the state are included in the list of candidates. CMS informs the SFF candidates of their inclusion in the monthly preview of the Five-Star Quality Rating update.

Procedure

Upon receipt of the Candidate List, the Administrative Assistant 5 (AA5) for the RCS Director will send the information to the:

A. RAs
B. Compliance and Enforcement Unit Manager
C. Office Chief of Headquarters Operations.

Back to top Change Log

2. Initial Selection

Background

SFFs are selected from the Candidates List provided monthly by CMS (see 'Candidate List' for more information). When a SFF slot becomes available, RCS must select a new facility from the candidate list **within 21 calendar days** from when the slot opens. A slot opens once the current SFF either graduates from the program or is terminated. When the former SFF is notified of termination/graduation, RCS must be prepared with a recommendation to CMS for which facility should be moved into the slot.

Given the importance of staffing and its relationship to quality of care, CMS requires staffing levels to be considered when selecting a SFF. For example, if RCS is considering two (2) facilities with similar compliance history for the SFF slot, CMS recommends selecting the facility with lower staffing.

Procedure

A. Due to the short timeline of choosing the next SFF, RCS must begin the process of determining which NH will be recommended to be the next SFF as soon as RCS becomes aware that the current SFF will be recommended for graduation or termination.
   1. Upon receipt of the list from the RCS AA5, the RA will meet with the FMs who have oversight for any NH included in the candidate list, seeking their input on which facility should be chosen as the next SFF.

B. The RCS AA5 will schedule a meeting with the RCS Director, RAs, Compliance and Enforcement Unit Manager, and the Office Chief of Headquarters Operations to discuss the recommendations and come to a decision which facility to recommend.
   1. If the group is unable to come to a decision, the RCS Director will have the final determination.

C. The RCS AA5 will schedule a meeting with the CMS Local Office Branch Manager and team, the RCS Director, RAs, Compliance and Enforcement Unit Manager, and the Office Chief of Headquarters Operations to present their recommendation to CMS. The following information will be included in the recommendation:
   1. anticipated timeline,
   2. compliance history, and
   3. staffing.

D. Once CMS approves the selected facility, the meeting attendees will develop a communication plan so all are in agreement about presenting the information to the chosen SFF.
   Note: The FM with oversight of the proposed SFF will have a list of accountable parties to be provided to the RCS AA5 once CMS approves the recommendation.

Back to top Change Log

3. Notification to Facility of Initial Selection

Background

Upon CMS approval of the new SFF selection, RCS must provide notice in writing, **within 5 working days,** to the NH and all accountable parties, including but not limited to:

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

Procedure

A. The RCS AA5 will send notification to the NH via certified letter. A model letter is included in Appendix D. The AA5 will also:
   1. Send copies to CMS and all accountable parties.
   2. Store a copy of the letter in the Q: drive.

4. Meeting to Discuss Significance of SFF Selection

Background

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

Procedure

A. CMS and RCS will develop a communication plan and talking points for the meeting with the NH (see 'Initial Selection' for more information).
B. The RCS AA5 will schedule a meeting with the NH's accountable parties, CMS Branch Manager, the RCS Director, Compliance and Enforcement Unit Manager, CS, Office Chief for Headquarters Operations, and the RA/FM who have oversight of the SFF. Topics to be covered must include:
    1. The seriousness of the designation as a SFF;
    2. The importance of organizational culture (i.e., leadership behavior, staff approach, and system processes) to drive sustained compliance and protect the health and safety of residents;
    3. Resources available to SFFs to support quality improvement; and
    4. CMS expectations for good faith effort by the NH for systemic change to improve quality. Examples include but are not limited to:
        a. Regular engagement with CMS Quality Improvement Organization (QIO);
        b. Hiring an external consultant to support performance improvement;
        c. Implementation of evidence-based interventions to improve quality; and
        d. Measurable and sustained operational changes (e.g., leadership or key staffing changes, increased staffing levels, etc.).

Back to top Change Log

5. Progressive Enforcement

Background

While a NH is in the SFF program, RCS will conduct a standard health survey at least once every six (6) months (as unpredictable as possible), as required by §1819(f)(8) and §1919(f)(10) of the Act. Progressively stronger enforcement actions will be recommended in the event of continued failure to meet the requirements for participation in Medicare and/or Medicaid. Refer to the SOM Chapter 7 for more information on the Survey and Enforcement Process for NH.

Procedure

A. All survey outcomes for the SFF must be reported to CMS Local Office. The FM with oversight of the SFF will notify CMS when the CMS-2567 is ready for review for any recertification survey, complaint abbreviated survey, and all revisits.
B. The RA who has oversight of the SFF must provide monthly updates to the CMS Local office by the last week of each month. The report will include a history memo that demonstrates all survey activity and deficiencies, as well as enforcement actions to date.
C. Enforcement remedies must be imposed immediately, without an opportunity to correct, when:
    1. The SFF has a standard health survey or a complaint survey with deficiencies cited at S/S level of "F" or higher; or
    2. Life Safety Code (LSC)/Emergency Preparedness (EP) survey with deficiencies cited at S/S level "G" or higher.
D. Subsequent surveys that also result in citations at these levels must have enforcement remedies of increasing severity imposed. This can include:
    1. Imposing a higher CMP than was previously imposed;
    2. Increasing from one (1) remedy to more than one (1) remedy being imposed;
    3. Denial of Payment for New Admissions (DPNA);
    4. State imposed remedies of conditions or stop placement of new admissions.
E. CMS considers the good faith efforts of the facility when considering applicable enforcement remedies.
    Note: The SFF program does not supersede the three-month mandatory DPNA or the six-month mandatory termination required under §1819(h)(2) and §1919(h)(2)(3) of the Act.

Back to top Change Log

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

Background

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

Factors considered for graduation or termination include:

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

A. Graduation from the SFF Program

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

The NH will graduate from the SFF program once it has completed two (2) consecutive standard health surveys with 12 or fewer deficiencies cited at an S/S of "E" or less on each survey since being selected as the SFF.

The SFF will ***not*** graduate if the following occurs:

1. Any standard health survey results in deficiencies cited at an S/S level of "F" or higher; or
2. Any LSC or EP survey results in deficiencies cited at an S/S level of "G" or higher; or
3. 13 or more total deficiencies cited on any survey (standard health, LSC, EP, or complaint)
4. Intervening complaint surveys with 13 or more total deficiencies, or any deficiencies cited at an S/S level of "F" or higher.

B. Termination

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

1. SFFs with deficiencies cited at S/S of IJ on any two (2) surveys (standard health, complaint, LSC or EP) while in the SFF program will be considered for discretionary termination.

2. SFFs that have not yet met program graduation criteria after three (3) standard surveys require a CMS review of their status in the program.
   a. The RCS AA5 must schedule a conference call with CMS Branch Manager and team to discuss:
      i. the efforts the NH has made towards improvement;
      ii. the reasons for continued non-compliance; and
      iii. the likelihood of the NH achieving sustained compliance.
   b. The meeting will include the following attendees: CMS Branch Manager, the RCS Director, Compliance and Enforcement Unit Manager, CS, Office Chief for Headquarters Operations, and the RA/FM who have oversight of the SFF.

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

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

Back to top Change Log

7. Post-Graduation

Background

CMS closely monitors graduates from the SFF program for a period of three (3) years to ensure improvements are sustained. For the SFFs that graduate and demonstrate poor compliance as identified on any survey (e.g., actual harm, substandard quality of care [SQC], or IJ deficiencies), CMS may impose enhanced enforcement options, up to, and including discretionary termination from the Medicare/Medicaid programs.

RCS will also closely monitor SFF graduates for a period of three (3) years, with the focus of early identification of concerns related to quality of care.

Procedure

After every survey, if a SOD is warranted due to identified noncompliance, the FM responsible for oversight of the NH will:

A. Review the SOD (CMS-2567) for approval following the process outlined in this SOP and Chapter 20 – Complaint Investigations.
B. If concerns about ongoing compliance are apparent, the FM will consult with the RA to determine if the RCS Director needs to be notified.
C. If the RCS Director is notified, they will determine next steps (e.g., continued monitoring, consult with Enforcement and Compliant unit manager and CS, CMS, etc.).

Back to top Change Log

Part VII: NH Master Survey Schedule

Background

The survey and certification provisions under §1819(g)(2)(A)(iii) and §1919(g)(2)(A)(iii) of the Social Security Act, under 42 CFR§488.308, and under RCW 18.51.095 require that each SNF and NF be subject to a standard survey no later than 15 months after the last day of the previous standard survey; and that the statewide average interval between standard surveys of SNFs and NFs not exceed 12 months.

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

The schedule is subject to change due to multiple factors, but with the possible changes still must meet all the federal and statewide average components to maintain compliance. NH standard surveys can occur at a minimum of 9 months and a maximum of 15 months. RCS will make every effort to schedule upcoming standard surveys as unpredictable as feasible.

Procedure

A. Annual Master Schedule Preparation
   1. The FM will:
      a. Schedule a meeting date(s) and time(s) on or before September 10 each year with all survey members/complaint investigators (CIs) and:
         i. Ensure an in-person meeting room and virtual meeting invitations are provided to all meeting attendees.
         ii. Provide a list of all NHs licensed in the Region to surveyors/complaint investigators.
         iii. Make the previous year calendar available for review.
   2. The Surveyors/CIs will:
      a. Be prepared to discuss work schedule in the upcoming meeting(s).
      b. Be prepared to discuss annual, sick, and other leave plans in the upcoming meeting(s) for coverage and scheduling purposes.

B. Annual Master Scheduling Meeting
   1. The FM will:
      a. Have the Unit AA3 prepare a meeting room for both in-person and virtual meeting attendance and:
         i. Provide electronic copies of the current 15-Month Master Schedule, a list of all NHs in the Region, and access to an office white board or an electronic white board.

ii. Provide access to blank copies of all calendar months from October to September of the following year (electronic calendar or an office white board) for mapping out next 15-month Master Schedule.

b. Provide all necessary office supplies for in-person meeting(s).

2. The Surveyor/CI will:
   a. Join the scheduled meeting(s) either in-person or virtually.
   b. Bring yearly leave requests for planning purposes.
   c. Provide expertise and feedback related to scheduling the NH 15-Month Master Schedule to support RCS in scheduling upcoming standard surveys so they are as unpredictable as feasible (e.g., rotate facility survey dates from the previous calendar).

C. Annual Final Master Schedule
1. The FM will:
   a. Finalize the NH 15-Month Master Schedule for distribution.
   b. Ensure the NH 15-Month Master Schedule is available to all NH surveyors, CIs, the Unit AA3, and the RA.
   c. Maintain an electronic copy of the Final NH 15-Month Master Schedule.
   d. Direct the Unit AA3 to:
      i. Set an automatic calendar reminder to send monthly copies of the NH 15-Month Master Schedule by the 5th of each month.
      ii. Use a standard form that includes:
         1) Region and Unit numbers;
         2) FM name and contact phone number;
         3) Date each survey starts and ends;
         4) Facility name;
         5) Current Census Number (CCN);
         6) Number of licensed beds;
         7) City of facility location;
         8) Number of survey team members;
         9) TC name;
      iii. Send the monthly copy of the NH 15-Month Master Schedule via email to the Compliance AA3 with a cc to the FM by the 10th of each month.
      iv. Save the monthly emails with the electronic copy of the Final NH 15-Month Master Schedule maintained by the FM.
2. The Compliance AA3 will:
   a. Rename each final NH 15-Month Master Schedule monthly document with correct Region and Unit.
   b. Email all NH 15-Month Master Schedules on a monthly basis to the following:
      i. CMS,
      ii. OSFM,
      iii. CS,

iv. RCS Training Unit, and
v. NH Case Mix Manager.

c. Save the monthly emails with the forwarded monthly NH 15-Month Master Schedules in a shared electronic file.

D. Ongoing 15-month Master Schedule Maintenance and Updating

1. The FM/designee will:
   a. Ensure accessible copies of the 15-Month Master Schedules are available for changes.
   b. If a schedule change(s) needs to be made to the NH 15-Month Master Schedule, ensure the change(s) do not compromise the integrity of the 15-month average requirements. Schedule change(s) can be for one (1) or more reasons, including:
      i. Facility with significant compliance issues may need to be surveyed sooner.
      ii. Staff emergencies requiring adjustment to the NH 15-Month Master Schedule.
      iii. Facility has an emergent situation (i.e., infectious disease spread) and unsafe for survey staff to enter the facility due to risk of exposure.
      iv. Facility has been identified as a Special Focus Facility (SFF) and needs survey every six (6) months, or facility graduates from the SFF and may return to standard survey schedule.
   c. When a change(s) is made, communicate the change(s) to all involved parties (i.e., survey team members, OSFM Deputy) and the RCS Training Unit ensuring all parties have adequate notice of the change(s) to maintain the unpredictability of the survey schedule.
   d. Ensure all involved parties receive an updated electronic copy of the NH 15-Month Master Schedule.
   e. Maintain an electronic copy of the changes to the NH 15-Month Master Schedule.
2. The Unit AA3 will:
   a. Send changes to the monthly NH 15-Month Master Schedule via email to the Compliance AA3.
   b. Save the email with the electronic copy of the changes to the NH 15-Month Master Schedule maintained by the FM.
3. The Compliance AA3 will:
   a. Rename each monthly NH 15-Month Master Schedule document with correct Region and Unit upon receipt.
   b. If significant changes are made, request an updated monthly form to track the change.
   c. Forward via email all monthly NH 15-Month Master Schedules to a distribution list currently including:
      i. CMS
      ii. OSFM
      iii. CS
      iv. RCS Training Unit, and
      v. NH Case Mix Manager.
   d. Save the emails with the electronic copy of the Final NH 15-Month Master Schedule in a shared electronic file.

4. The RA will:
    a. Conduct a quality assurance (QA) review on a quarterly basis using the 365 report of completed standard NH surveys to monitor progress toward meeting federal and state averages on the NH 15-Month Master Schedule.
    b. Document when quarterly QA reviews are completed.
    c. Review and provide oversite of all processes each federal fiscal year to ensure federal and state averages on the NH 15-Month Master Schedule are maintained.

Back to top Change Log

Part VIII: Appendices

1. Glossary of Terms

Active status (OBRA) – means the individual has successfully completed a training and competency program meeting federal requirements. They must have worked in a nursing or nursing related capacity for compensation within the past 24 months and must not have actions or findings that render them ineligible.
Administrator or designee – Includes the various titles of the responsible person(s) for the provider. This list includes but is not limited to superintendent, director, provider, program manager, individual or entity representative, resident manager, administrator, or executive director.
Agency – State agency
Aspen (Automated Survey Process Environment) – a suite of software applications designed to help State Agencies collect and manage healthcare provider data.
Aspen Central Office (ACO) - refers to Centers for Medicaid and Medicare Services (CMS).
Certification – The process used by the department to determine if an applicant or service provider complies with federal health, safety, and program standards and is eligible to provide certified community residential services and support to clients.
Character, competence, and suitability (CCS) – the screening and assessment of the potential personal and professional capability of an employee or applicant to work with or serve minor or vulnerable adults based on a review of crimes and negative actions.
Deficiency citation - Documentation of a violation of statute or regulation, other than those defined as a consultation. Documentation of a deficiency citation includes an entry made on the Statement of Deficiencies that consists of: 1) The applicable Washington Administrative Code (WAC) and/or the applicable Revised Code of Washington (RCW), 2) the language from that reference which pinpoints the aspects(s) of the requirement with which the home failed to comply, 3) an explicit statement that the requirement was "not met" and 4) the evidence to support the decision of noncompliance.
Complaint – A report communicated to Residential Care Services' (RCS) Complaint Resolution Unit (CRU) by anyone NOT acting as an administrator or designee for a provider licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of property for one or more vulnerable adult. The complainant could be a vulnerable adult, a family member, a health care provider, a concerned citizen, other public agencies, or a mandated or permissive reporter. Report sources may be verbal or written.
Complaint investigation/investigator (CI) – An onsite visit that resulted from a complaint rather than a routine inspection. An RCS staff assigned to investigate a complaint received by the department.
Confidential information – A type of information that is protected by state or federal laws, including information about vulnerable adults, DSHS clients, employees, vendors or contractors, and agency systems that is unavailable to the public without legal authority.

Deficient practice – The action(s), error(s), or lack of action on the part of the provider/licensee relative to a requirement and to the extent possible, the resulting outcome.
Deficient practice statement – A statement at the beginning of the evidence that sets out why the provider/licensee was not in compliance with a regulation.
Department – This term refers to the Washington state Department of Social and Health Services (DSHS).
Expired status (OBRA Registry) – means the individual has not performed nursing or nursing-related services for a period of 24 consecutive months for monetary compensation. If no work history in the past 24 months is established, the individual with expired status is not eligible to work in the NH setting, unless or until, they successfully re-train and re-test, or re-test. If they successfully re-test, the expired status returns to active status.
Extent of deficient practice – The prevalence or frequency of a deficient practice.
Failed facility practice – Describes the action(s), error(s), or inaction(s) on the part of the licensee relative to statute(s) or regulation(s) and, to the extent possible, the resulting negative outcome(s) to vulnerable adult(s). Term includes deficient practice, which is defined as "lacking an essential quality or element, and inadequate in amount or degree."
Finding – A term used to describe each item of information found during the regulatory process about provider practices relative to a specific requirement cited as being not met.
Health care – The care, services or supplies related to the health of a vulnerable adult, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling for a physical or mental condition, a prescribed drug, device, or equipment.
Health Insurance Prospective Payment System (HIPPS) - rate codes represent specific sets of patient characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems. HIPPS codes are alpha-numeric codes of five digits. Which positions of the code carry the case mix group information may also vary by payment systems. The first position of the code represents both the Physical and Occupational Therapy case-mix group. The second position represents the Speech-Language Pathology case-mix group. The third position represents the nursing case-mix group. The fourth position represents the Non-Therapy Ancillary case-mix group. This leaves the fifth position to represent the AI (Assessment Indicator) code.
Immediate Jeopardy – means a situation in which immediate corrective action is necessary because the non-compliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a vulnerable adult receiving care in a facility.
Ineligible status (OBRA Registry) – means there is a state disciplinary action or findings of abuse, neglect, or misappropriation of property in WA state or any other state. Individuals with ineligible status are not eligible to work in the NH setting unless reassigned by a state NH survey and certification agency as eligible based on the finding or action being overturned.

Licensee or designee – A generic term to describe individuals/entities/providers licensed or certified to provide adult family home, assisted living facility and/or nursing home care in the state of Washington.
Mandated reporter – As defined in RCW 74.34.020(8), this is an employee of the Department; law enforcement; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to Chapter 18.130 RCW.
MDS inaccuracy – means that the during the on-site CMAR visit, the CMAR process found a MDS item that was coded incorrectly. The facility's coding is indicated as the Facility Value (FV) on the RUG Item Category Report. The MDS item is inaccurate and the documentation by the facility in the MDS cannot be substantiated. The FV can impact the assigned RUG or classification category and may decrease or increase the corresponding classification category.
Minimum Data Set (MDS) – a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.
Nurse's Aide, Nursing Assistant-Certified – refers to the individuals on the OBRA Registry or applying to be on the registry. The terms are interchangeable.
Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a NF are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare SNF services.
Omnibus Budget Reconciliation Act (OBRA) of 1987 – Provisions set forth in law regarding the use of nurse's aides. In addition to nurse aide training requirements, the act specifies that each state must have a registry for nurse aides.
Omnibus Budget Reconciliation Act (OBRA) Registry – A registry containing information related to all individuals who have successfully completed a nurse aide training and competency evaluation program and found by the State to be competent to function as a nurse aide or who may function as a nurse aide because of meeting criteria in 42 CFR §483.150.
Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the licensee or designee. Harm to vulnerable adults unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.
Requirement – Any structure, process, or outcome that is required by law or regulation.

Scope and severity – The effect of non-compliance on a resident (severity) and the number of residents actually or potentially affected (scope) by the provider's non-compliance. Illustrated in the deficient practice statement and supported in the findings.

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

Statement of deficiencies (SOD) – The official written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS.

Vulnerable adult – Comprehensively defined in RCW 74.34.020, includes a person:

a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
b) Subject to a guardianship under RCW 11.130.265 or adult subject to conservatorship under RCW 11.130.360; or
c) Who has a developmental disability as defined under RCW 71A.10.020; or
d) Admitted to any facility; or
e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under Chapter 70.127 RCW; or
f) Receiving services from an individual provider; or
g) Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.

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

Back to top Change Log

2. Acronym List

AA/AA3/AA5	Administrative Assistant/Administrative Assistant 3/ Administrative Assistant 5
ACO	Aspen Central Office
ACTS	ASPEN Complaints/Incidents Tracking System
AKA	Also known as
ALTSA	Aging and Long-Term Support Administration
ASPEN	Automated Survey Processing Environment System
BIC	Back In Compliance
CAA	Care Area Assessment
CC	Carbon Copy (in emails)
CCN	Current Census number
CCS	Character, Competency and Suitability
CE	Critical Elements
CEP	Critical Element Pathways
CFR	Code of Federal Regulations
CI	Complaint Investigator
CLIA	Clinical Laboratory Improvement Amendment
CMP	Civil Monetary Penalty
CMS	Center for Medicare and Medicaid Services
COC	Certificate of Completion
COVID	Coronavirus Disease
CR	Construction Review
CRS	Construction Review Services
CS	Compliance Specialist
DOH	Department of Health
DON	Director of Nursing
DPNA	Denial of Payment for New Admissions
DSHS	Department of Social and Health Services
e-CFR	Electronic Code of Federal Regulation
EP	Emergency Preparedness
FM	Field Manager
HCA	Health Care Authority
HIPAA	Health Insurance Portability and Accountability Act
IC	Infection Control
ID	Intellectual Disability
IJ	Immediate Jeopardy
LA	LeadingAge of Washington
LE	Law Enforcement

LPN	Licensed Practical Nurse
LSC	Life Safety Code
LTC	Long-Term Care
LTCO	Long-Term Care Ombuds
LTCOP	Long-Term Care Ombuds Program
LTCSP	Long-Term Care Survey Process
MB	Management Bulletin
MDS	Minimum Data Set
MFCD	Medicaid Fraud Control Division
NA	Nurse's Assistant
NAC	Nursing Assistant Certified
NAR	Nursing Assistant Registered
NATCEP	Nursing Aide Training and Competency Evaluation Program
NF	Nursing Facility
NH	Nursing Homes
OBRA	Omnibus Budget Reconciliation Act
OSFM	Office of State Fire Marshal
PASSAR/PASRR	Pre-Admission Screening and Resident Review
PM	Program Manager
POC	Plan of Correction
POD	Principles of Documentation
QA	Quality Assurance
QIO	Quality Improvement Organization
QSO	Quality, Safety and Oversight
RA	Regional Administrator
RC	Related Condition
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
SA	State Agency
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SFF	Special Focus Facility
SFM	State Fire Marshal
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOD	Statement of Deficiency
SOM	State Operations Manual
SOP	Standard Operating Procedures
SQC	Substandard Quality of Care

S/S	Scope and Severity
TB	Tuberculin/Tuberculosis
TC	Team Coordinator
TST	Tuberculin Skin Test
WAC	Washington Administrative Code
WD	Working Day
WHCA	Washington Health Care Authority
WSP	Washington State Patrol

Back to top Change Log

3. Resources and Forms

A. Resources

1. Department of Health Nursing Assistant Training Programs
2. Professional Page for Providers
3. LTCSP Resources and Guides

B. Forms

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

Back to top Change Log

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

IMPORTANT NOTICE – PLEASE READ CAREFULLY

(Date)

(Nursing Home Administrator Name)
(Facility Name)
(Address)
(City), WA (Zip)

Dear (Nursing Home Administrator Name)

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

What Does This Mean?
You will be subject to at least one standard health survey every six months as required under Section 1819(f)(8)(B) and 1919(f)(10)()(B) of the Social Security Act (42 U.S.C. §1395-i3(f)(8)(B) and §1396(f)(10)(B), respectively). The Centers for Medicare & Medicaid Services (CMS) will be closely monitoring your facility with the objective that your facility can attain and maintain substantial compliance with Medicare and/or Medicaid participation requirements.
• You must provide the names, telephone numbers, email addresses, and physical addresses of the accountable parties (e.g., the administrator, chairperson(s) of the Governing Body, holder of the facility's provider agreement, any party who owns more than a five percent interest in the facility, the management company (if applicable), facility landlord(s), the mortgage holder, and corporate owner(s) for chain-operated nursing homes) **within 5 business days** of receipt of the SFF selection notice to the SA;

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

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

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

The CMS location retains discretion on decisions regarding graduation from the SFF program and discretionary termination based on factors unique to each facility and CMS' authority to terminate a provider's participation with the Medicare and/or Medicaid programs. These factors include:
• A facility's good faith efforts to improve performance;
• The circumstances or details of any noncompliance that occurred (e.g., a facility that technically meets the criteria to graduate, but due to some of the details related to noncompliance, CMS remains concerned about the facility's quality and does not grant graduation);
• Situations when discretionary termination may potentially cause issues related to access to care.

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

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

Good Faith Efforts

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

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

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

The SFF list can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf. The SFF list is updated and posted on cms.gov monthly.

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

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

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

Sincerely,
(Name and Title)

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

Back to top Change Log

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

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

11. What are issues preventing the facility from graduating?
12. Who is the Administrator and who is the DON and how long employed?

Administrator: _____ Length of employment: _____	DON: _____ Length of employment: _____

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

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

Back to top Change Log

6. SFF Process Tracking Tool (CMS Job Aide)

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

Graduation Criteria		
☐ **Met**	☐ **Not Met**	Two consecutive standard health surveys with 12 or fewer deficiencies cited at scope and severity level (S/S) of "E" or less on each survey.
☐ **Met**	☐ **Not Met**	Facility back in compliance
☐ **Met**	☐ **Not Met**	No pending complaints at IJ or non IJ high
☐ **Met**	☐ **Not Met**	CMS concurrence with state recommendation

Recommendations		
☐ **Graduate**	☐ **Terminate**	☐ **Continue in SFF Program**

Back to top Change Log

7. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/08/2023	Part VI added. Special Focus Facilities	Established subchapter Part VI	Added to provide guidance for SFF process	MB R23-046
01/04/2023	17G NH Master Survey Schedule	Established subchapter 17G	Adopted in response to SAO Audit finding and related CAP	MB issued R23-002
08/03/2020	17C11 Recertification Off-Hour Surveys	Established subchapter 17C11		MB issued R20-090
11/27/2019	17C7 Recertification NA Training Program Oversight	Established subchapter 17C7		MB issued R19-089
06/07/2019	17C8 Recertification State Tasks	Established subchapter 17C8		MB issued R19-041
05/03/2019	17C10 Recertification Exit Conference	Updated to reflect new LTCSP and other changes (was 17C11 until it was renumbered on 3/8/19)	Guidance from CMS	MB issued R19-037
05/03/2019	17C9 Recertification Communication	Updated to reflect new LTCSP and other changes	Guidance from CMS	MB issued R19-037
03/08/2019	17C10 Recertification Exit Conference	Rescinded "Final Status Meeting" as 17C10 and renumbered index to reflect removal.	Guidance from CMS	MB issued R19-025
09/27/2018	Overview and Resource sections	Changed references from the QIS survey process to the LTCSP.	New survey process	MB issued R18-060
09/27/2018	Index	Updated and expanded the index, including re-	Changed the index in preparation for additional SOPs.	MB issued R18-060

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
		numbering existing SOPs.		
09/27/2018	17C4 PASARR Investigation Process	Established subchapter 17C4.		MB issued R18-060
04/14/2017	Communication	SOP conversion and updated language to include new Federal Regulatory Groupings.	New Federal Regulatory Groupings replace care areas.	
04/14/2017	Status Meeting	SOP conversion and updated language to include new Federal Regulatory Groupings.	New Federal Regulatory Groupings replace care areas.	
04/14/2017	Exit with Resident and Ombuds	SOP conversion and updated language to include new Federal Regulatory Groupings.	New Federal Regulatory Groupings replace care areas.	

Back to top