Overview

This Standard Operating Procedure (SOP) chapter outlines activities and procedures that Residential Care Services (RCS) staff are required to follow when conducting pre-occupancy, initial certification, recertification, and post surveys at Nursing Homes (NH), also called Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) depending on funding type. For more information about complaint investigations please refer to SOP Chapter 20 - Complaint Investigations. These facilities are either Federally Certified and/or State Licensed and employ qualified staff to provide care.

Some NHs provide specialized care for residents depending on the assessed needs of each resident e.g. dementia.

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

These procedures support:

- The RCS mission to promote and protect the rights, security, and wellbeing of individuals living in licensed or certified residential settings.
- The Department of Social and Health Services (DSHS) mission is to transform lives.

These procedures are not covered by DSHS Administrative Policies as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years.

Nursing Homes must comply with the following:

- Long Term Care Survey Process (LTCSP) Procedure Guide
- CMS State Operations Manual (SOM), Chapter 2
- 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 partners with the following federal and state agencies and associations to develop NH regulations and policies:

- CMS – Region 10
- Department of Health (DOH)
- Washington State Patrol (WSP) – Office of State Fire Marshal (OSFM)
- State Long-Term Care Ombuds Program (LTCOP)
- Washington Health Care Authority (HCA)
- LeadingAge of Washington (LA)
- Washington State Local Health Jurisdictions (LHJ)

Contacts

- RCS Quality Improvement Unit General Contact: ImproveRCS@dshs.wa.gov
- RCS Policy Unit General Contact: RCSPolicy@dshs.wa.gov
- RCS Training Unit General Contact: RCStraininginquiry@dshs.wa.gov

General Guidelines

Overview

This document explains the general guidelines for Nursing Home Regulators and Field Managers (FM).

Procedure

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

> Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

1. The FM will:
   a. Ensure regulatory staff are trained to complete this procedure.
   b. Be available by phone or in person to consult and support the survey team.
   c. Consult with the Compliance Specialist (CS) in any immediate jeopardy situations.
   d. Ensure timely completion of the Statement of Deficiencies (SOD).
   e. Ensure the facility corrects any deficient practice, following state and federal protocols.
2. The Survey Team will:
   a. Attend all team meetings.
   b. Be on time and prepared to discuss identified concerns, findings, and potential noncompliance.
   c. Be prepared to discuss workload and potential adjustments in workload with other team members.
   d. Listen attentively to other team members' observations, concerns, or other identified issues.
   e. Participate in the exit conference as requested by the TC.
   f. Document all findings of deficient practice on the Statement of Deficiencies (CMS 2567) using the Principles of Documentation (POD).
3. The TC will:
   a. Contact the FM to communicate potential issues and concerns.
   b. Inform the licensee/administrator to expect frequent contact with the survey team and that the team will interview nursing home staff as needed throughout the visit.
   c. Provide information on the survey process and establish a tone to encourage and facilitate frequent communication with the licensee/administrator and facility staff.
   d. Compare the names of the current Administrator and Director of Nursing (DON) to the Administrator and DON names documented from ASPEN Central Office (ACO).
      i. If there is any discrepancy between the actual Administrator and/or DON with the names documented in ACO, notify your FM.

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

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Part I: Pre-Occupancy – Under Construction

Part II: Initial Certification Survey - Under Construction

Part III: Recertification Survey

A. PASRR Investigation Process During Recertification Survey

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

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

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

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

Procedure

1. The Surveyor will:

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

   a. Review the list of PASRR Exempt facilities to determine if the facility requires a PASRR review. The Policy Unit will update this list every January.
   b. According to the LTCSP procedure guide: If a resident has an appropriate diagnosis but is not receiving PASRR Level II services review the record to confirm the information.
   c. If concerns are found in the PASRR process, follow the CMS-20090 PASRR Critical Element Pathway (CEP) found in the Survey Resources zip file on CMS website.
      i. In addition to the pathway:
         1) 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, placed in the medical record after admission, and that level II recommendations are incorporated into the care plan.

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

It is recommended to document in **bold** letters at the top of the page!

d. Document findings in the Investigation Notes or the Resident Notes in the LTCSP.
e. At the survey team's discretion, expand the sample if failed practice is found related to the PASRR process.

2. The TC will:
   a. Verify ALL PASRR reviews were completed and documented in LTCSP by all surveyors on the survey team. At the conclusion of the recertification survey, alert the FM if failed practice was found.
3. The FM will:
   a. Review any PASRR citations to ensure the citation is complete and follows the Principles of Documentation.

B. Nursing Assistant Training Program Onsite Inspection

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

Procedure

1. The TC will:
   a. Off-Site Preparation
      i. Ensure the survey team has an electronic or printed copy of Omnibus Budget Reconciliation Act (OBRA) Nursing Assistant Training Onsite Inspection Form for Survey - DSHS 16-168 available for use during survey.
      ii. Check the Washington State Board of Nursing website to determine if the facility identified for inspection or survey has an approved NA training program.
   b. During the Survey
      i. Obtain the following information during the entrance conference:
         1) Determine if there is a facility based approved NA training program.
         2) Determine if there are any current students doing clinical rotations from any other (non-facility based) NA training program.
            a) If non-facility based NA training is occurring, check the Sanctioned Facilities list (ALTSA intranet) to determine if the facility has sanctions that prohibit facility-based training. If the facility has sanctions, note that in Section 5 of the NATCEP form.
            b) A facility with sanctions that prevent them from conducting facility-based training may host non-facility-based NA training under certain circumstances. RCS may authorize this on a case-by-case basis. Contact the NATCEP/OBRA Registry Unit General Contact at OBRARegistry@dshs.wa.gov to confirm.
         3) If the facility has an active facility-based program, request the following documents during the entrance conference:
            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. The curriculum is approved by the DOH for a two-year period.
            c) Five NA training records from the facility's current training program or from students who have graduated from the program within the past 12 months.

d) A copy of an issued "Certificate of Completion" (COC) for the training program, which contains the approved number of hours.

4) 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.
   b. 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.
   c. After the survey:
      i. 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.
      ii. Include a copy of the completed form with survey working papers.
3. The FM will:
   a. Verify a NATCEP form is completed and sent to NATCEP for each re-certification survey.

C. State Tasks

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

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

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

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

- Lakeland Village
- Fircrest School
- Yakima Valley School

Hospitals with free standing SNF/NFs or those with a SNF/NF as a distinct part of the facility require a review of "state tasks" in compliance with Chapter 388-97 WAC.

The following facilities **require** state tasks:

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

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

This procedure:

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

Procedure

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

1. Incident Reporting Log

a. Federal guidelines do not have a specific requirement to keep a log of reported incidents. State regulation (WAC 388-97-0640) and department Nursing Home Guidelines (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.
b. Review the facility incident-reporting log(s) for at least the prior six months. Ensure the nursing home is logging incidents, investigating incidents, and reporting to the appropriate state agencies when required. The survey team may expand the lookback up to the date of the last survey if concerns are identified.

2. Staffing Patterns for the 30 Days Prior to Survey

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

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

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

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

3. Medical Test Site Waiver

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

4. Liability Insurance

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

> Note: Federal regulations in Appendix PP of the State Operating Manual have no specific requirement for liability insurance.

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

5. Trust Fund

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

6. NATCEP Program Review

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

7. Paid Feeding Assistant Program

a. In the entrance conference, the TC will determine if the facility uses paid feeding assistants. If so, the TC will request the following records:
   i. 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.
   ii. A copy of the paid feeding assistant training curriculum.
   iii. Use Attachment J to complete the paid feeding assistant program review.

8. Call Bell Visible and Audible

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

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

9. Dementia Unit Egress Signage

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

10. Fresh Fruits and Vegetables

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

11. Staff Qualification and Background

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

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

12. Tuberculosis Review for Residents and Staff

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

> Note: See – CDC Tuberculin Skin Testing Fact Sheet for information related to induration.

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

13. Pet Records

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

14. NAC Medication Assistant Program

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

D. Recertification Survey Communication Process

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

Regular communication between facility staff, team members, the FM, and other office staff is crucial to a thorough and effective survey or complaint investigation process.
RCS has established formal expectations for nursing home survey teams regarding communication with licensee/administrator and facility staff during the recertification survey process.

General Communication Principles

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

Procedure

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

b. Upon entrance to the facility:
   i. Make introductions and provide appropriate identification (i.e., name tag/badge and business card).
   ii. Request the information needed immediately according to the Entrance Conference Worksheet within the LTCSP tool.
   iii. Request a room or access to a power outlet, a place to sit and work, and a means to secure belongings and/or RCS equipment.
   iv. Contacts the AA to notify the ombudsman of the entrance.
      1) AA staff emails the ombuds that the licensor/surveyor has entered the building.
      2) The Ombuds office may send an aggregate list of complaints going back one year for the licensor or team awareness.
         a) If sent, regulatory staff review the list of Ombuds complaints for themes or concerns to follow up during the inspection.
      3) Follow the instructions in the LTCSP Procedure Guide.
c. During the survey:
   i. Maintain ongoing dialogue throughout the survey, so the administrator is aware of the basic concerns/issues and can provide additional clarification or documentation on identified issues prior to the exit. For example, if the team has completed a task such as medication pass, the administrator should be given a verbal summary of activities completed and general areas of concerns (if any).
      1) Provide the licensee/administrator the opportunity to ask questions and/or communicate any information regarding the facility such as recent changes or events that have occurred.
      2) Discuss the importance of completing DSHS form 10-207 including completion of the X-5 date when submitting with the POC. Failure to do so could delay the back in compliance (BIC) date of the POC.
   ii. 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.
d. Off-site after the exit conference:
   i. Review the findings of the survey team with the FM.
   ii. If any of the preliminary deficient findings communicated to facility staff during the exit conference change, contact the facility administrator. Explain the changes to the administrator prior to issuing the Statement of Deficiencies.

2. The FM will:
   a. Provide oversight and support to surveyors to implement these communication principles.

E. Recertification Survey Exit Conference

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

Procedure

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

F. Off-Hour Surveys

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

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

Off-hour survey standards for nursing homes:

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

Procedure

1. The Surveyor will:
   a. Conduct an evening, early morning, or weekend survey, as assigned by the FM, or based on concerns identified by the survey team in off-site preparation.
      i. 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.
      ii. At least half of the off-hour surveys will be conducted at facilities CMS has identified with weekend staffing concerns. These surveys will begin at any hour on a weekend day and continue for at least six hours during the first day of survey.
      iii. For off-hour surveys done at facilities that may not be on the weekend staffing concern list:
         1) If the survey starts during early morning hours (before 8 AM) on a weekday, at least two hours of the survey must occur prior to 8 AM.
         2) If the survey starts during evening hours (after 6 PM) on a weekday, at least two hours of the survey must occur after 6 PM.
         3) If the survey is started on a weekend/holiday, the surveys will begin at any hour and continue for at least six hours.
   b. 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.
2. The TC will:
   a. 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) of the off-hour data collection. A sample of the first paragraph of the initial comments of an off-hour survey:

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

3. The FM will:
   a. Ensure that at least 10% of all surveys are conducted as off-hour surveys for the region to satisfy requirements.
   b. Ensure at least half of the off-hour surveys are conducted at facilities identified by CMS with weekend staffing concerns (facilities on the SFF list).
      i. 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.

c. 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.
d. Be accessible for consultation when the survey team is surveying a facility in off hours.
e. Maintain a current list showing which nursing homes are scheduled for an off-hour survey and update the list with changes in schedule. Review current and past off-hour survey lists to ensure that off-hour surveys are distributed among all facilities, unless a facility is identified with concerns that warrant more frequent review (i.e., a facility with significant health and safety concerns occurring in off-hour times).
f. Determine and approve the survey team composition for the off-hour survey.
g. 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.
h. 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.

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

Part V: Post Survey – Under Construction

Part VI: Special Focus Facilities

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 Nursing Homes (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

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

A. Candidate List

Purpose

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 standard health survey cycles and the last three years in complaint survey performance. Each facility is given a numerical score based on the Health Inspection Rating Methodology. Those facilities with the lowest numerical scores in the state are included in the list of candidates. 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:

1. Regional Administrators (RAs)
2. Compliance and Enforcement Unit Manager
3. Office Chief of Headquarters Operations.

B. Initial Selection

Purpose

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

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

Procedure

1. 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.
   a. Upon receipt of the list from the RCS AA5, the RA will meet with the Field Managers (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.
2. 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.
   a. If the group is unable to come to a decision, the RCS Director will have the final determination.
3. 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:
   a. anticipated timeline,
   b. compliance history, and
   c. staffing.
4. 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.

C. Notification to Facility of Initial Selection

Purpose

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

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

Procedure

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

D. Meeting to Discuss Significance of SFF Selection

Purpose

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

1. CMS and RCS will develop a communication plan and talking points for the meeting with the NH (see 'Initial Selection' for more information).
2. The RCS AA5 will schedule a meeting with the NH's accountable parties, CMS Branch Manager, the RCS Director, Compliance and Enforcement Unit Manager, Compliance Specialist (CS), Office Chief for Headquarters Operations, and the RA/FM who have oversight of the SFF. Topics to be covered must include:
   a. The seriousness of the designation as a SFF;
   b. 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;
   c. Resources available to SFFs to support quality improvement; and
   d. CMS expectations for good faith effort by the NH for systemic change to improve quality.

   Examples include but are not limited to:
   - Regular engagement with CMS Quality Improvement Organization (QIO);
   - Hiring an external consultant to support performance improvement;
   - Implementation of evidence-based interventions to improve quality; and
   - Measurable and sustained operational changes (e.g., leadership or key staffing changes, increased staffing levels, etc.).

E. Progressive Enforcement

Purpose

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

Procedure

1. 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.
2. 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.
3. Enforcement remedies must be imposed immediately, without an opportunity to correct, when:
   a. The SFF has a standard health survey or a complaint survey with deficiencies cited at Scope and Severity (S/S) level of "F" or higher; or
   b. Life Safety Code (LSC)/Emergency Preparedness (EP) survey with deficiencies cited at S/S level "G" or higher.
4. Subsequent surveys that also result in citations at these levels must have enforcement remedies of increasing severity imposed. This can include:
   a. Imposing a higher Civil Monetary Penalty than was previously imposed;
   b. Increasing from one remedy to more than one remedy being imposed;
   c. Denial of Payment for New Admissions (DPNA);
   d. State imposed remedies of conditions or stop placement of new admissions.
5. CMS considers the good faith efforts of the facility when considering applicable enforcement remedies.

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

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

Purpose

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

Factors considered for graduation or termination include:

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

1. Graduation from the SFF Program

A SFF cannot graduate with pending complaint surveys triaged at 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 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.

2. Termination

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

1. SFFs with deficiencies cited at S/S of IJ on any two surveys (standard health, complaint, LSC or EP) while in the SFF program will be considered for discretionary termination.
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 D for questions CMS will pose to RCS when assessing options.

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

G. Post-Graduation

Purpose

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

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

Procedure

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

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

Part VII: Master Survey Schedule

Note: Throughout this document, the terms Administrator, Licensee, FM, and Team Coordinator (TC) can also refer to their designee.

Purpose

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

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

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

Procedure

Annual Master Schedule Preparation

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

Annual Final Master Schedule

1. The FM will:
   a. Finalize the NH 15-Month Master Schedule for distribution by September 10th each year.
   b. Ensure the NH 15-Month Master Schedule is available to all NH surveyors, NH complaint investigators, the NH Unit Administrative Assistant (AA), and the Regional Administrator (RA).
   c. Ensure an electronic copy of the Final NH 15-Month Master Schedule is maintained.

d. Ensure an updated copy of the schedule for each month is emailed to RCSComplianceUnit@dshs.wa.gov by the 10th day of the preceding month.

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

i. 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
   6) Number of licensed beds.
   7) City of facility location.
   8) TC name.
   9) Number of survey team members.

> Note: Surveyors in training do not count in this number.

ii. Ensure the monthly emails with the electronic copy are saved per unit process.

2. The NH Compliance Administrative Assistant (AA) will:
   a. Rename each final NH monthly document with correct Region and Unit.
   b. Email all updated NH monthly schedules to the following:
      i. Centers for Medicare and Medicaid Services (CMS),
      ii. Office of the State Fire Marshall (OSFM),
      iii. NH Compliance Specialist (CS),
      iv. RCS Federal Training Unit,
      v. NH Case Mix Manager, and
      vi. Regional Administrator (RA).
   c. Save the monthly emails with the forwarded monthly schedules in a shared electronic file.

Ongoing 15-Month Master Schedule Maintenance and Updating

1. The FM 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 or more reasons, including:
      i. Facility with significant compliance issues may need to be surveyed sooner.
      ii. Staff emergencies requiring adjusting 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 months, or facility graduates from the SFF and may return to standard survey schedule.

   c. When a change(s) is made:
      i. Ensure all parties have adequate notice of the change(s) to maintain the unpredictability of the survey schedule.
2. The RA will:
   a. Conduct a quality assurance (QA) review on a quarterly basis using the 365-day report of completed standard NH surveys to monitor progress toward meeting federal and state averages on the NH 15-Month Master Schedule.
   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.

Part VIII: Appendices

A. Resources

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

B. Forms

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

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

IMPORTANT NOTICE – PLEASE READ CAREFULLY

(Date)

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

Dear (Nursing Home Administrator Name)

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

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

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

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)

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

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

E. SFF Process Tracking Tool (CMS Job Aide)

Special Focus Facility Process Tracking Sheet
Facility Name:
Facility CCN:
Date of Selection Letter:
Date of Meeting with Facility and Accountable Parties:
Date of Recertification Survey # 1:
---Total # Tags Survey #1
≥ 13 at S/S E = red
s/s ≥ 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**

F. Glossary of Terms

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

Agency – State agency.

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).

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

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.

CMS State Operations Manual, Appendix J – Federal Guidance to Surveyors for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

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

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

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

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

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

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

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

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

Deficient practice – The action(s), error(s), or inaction on the part of the entity relative to a regulatory requirement and to the extent possible, the resulting outcome.
Deficient practice statement (DPS) – A statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulatory requirement. Also commonly referred to as the "based on" statement.
Department – This term refers to the Washington state Department of Social and Health Services (DSHS).
Electronic medical record (EMR) or Electronic health record (EHR) – a digital version of a chart with resident medical/health information stored in a computer.
Entity – A standard term used throughout this document to depict the long-term care program homes, facilities, and licensees participating in transforming lives of the vulnerable adults living in residential settings.
Evidence – Data sources, to include observation, interview and/or record review, described in the findings of the deficiency citation. These data sources within the deficiency citation inform the entity of the failure to comply with regulations. A minimum of two of the three data sources are required to support the citation. Having documentation of all three data sources is optimal for the deficiency citation to be irrefutable.
Facility – as defined in RCW 74.34.020.
Fact – An event known to have actually happened. A truth that is known by actual experience of observation, interview, and review of records.
Failed 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."
Federal programs – This includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Homes (NH).
Finding – A term used to describe each item of information found during the regulatory process about entity's practices relative to a specific requirement cited as being not met.
Fingerprint check – means a fingerprint check is considered a positive identification check. The fingerprints of an applicant are reviewed to match fingerprints taken at the time of an arrest or conviction of a crime.
Formal interviews – structured interviews with sample residents, the service provider, staff, family members or representatives, or other collateral contacts.
Forms CMS-2567, CMS 2567B, CMS-2567L Statement of Deficiencies – The official document(s) communicating the determination of compliance or noncompliance with the Federal requirements. In addition, they are the form(s) an entity uses to submit a plan to achieve compliance. Each form is an official, legal record that is available to the public on request.
Gender neutral language – Use of terms to increase the confidentially and be inclusive of the vulnerable adult(s) in the specific setting. This includes pronouns, which do not associate a gender with the vulnerable adult in order to protect the identity, such as, they, them, or theirs. Emphasize attempts to avoid using gender specific pronouns such as he, him, his or she, her, hers.

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

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

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

Imminent danger or **Immediate threat** – means serious physical harm to or death of a resident has occurred, or there is a serious threat to the resident's life, health, or safety.

Incident – An official notification communicated to RCS's CRU from a self-reporting provider/provider representative that RCS licenses or regulates. Owners, operators, and managers of facilities must self-report incidents and/or allegations of vulnerable adult abuse, abandonment, financial exploitation, sexual abuse, physical abuse, mistreatment, neglect, and/or misappropriation of a vulnerable adult's property. Nursing homes must also report vulnerable adult injuries of unknown origin and any other requirements outlined in WAC 388-97 (Nursing Homes).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Noncompliance – means failure to meet one or more federal health, safety, and/or quality regulations.

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 nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

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

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

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

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

Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the entity (e.g., development of avoidable pressure injury; reaction due to receipt of blood; lack of monitors for anticoagulant). Harm to vulnerable adults unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.

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

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

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

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

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

Regulatory process – Regulatory staff evaluate current entity compliance with statutes and regulations. Types of regulatory processes include pre-occupancy, abbreviated complaint investigations; full inspection/recertification surveys; initial certification surveys; follow-up or post surveys; initial licensing and relicensing, and monitoring visits.

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

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

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

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

Resident representative – means either the resident's legal representative or the individual filing a complaint involving, or on behalf of, a resident.

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

Scope and severity (S/S) – The effect of non-compliance on a resident (severity) and the number of residents actually or potentially affected (scope) by the entity's non-compliance. Illustrated in the deficient practice statement and supported in the findings.
Secure fax location – (as defined by the Washington State Patrol [WSP]) a location accessible only to designated employees responsible to handle and process authorization forms and information related to background checks.
Serious adverse outcome or **Likely serious adverse outcome** – means serious injury, harm, impairment, or death has occurred, is occurring, or is likely to occur to one of more vulnerable adult receiving care in a facility due to the facility's noncompliance with health, safety, or quality regulations.
Skilled nursing facility (SNF) – a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under section 1819(a) of the federal Social Security Act.
State agency (SA) – A permanent or semi-permanent organization in government that is responsible for the oversight and administration of specific functions.
State Tasks - are the (14) state requirements reviewed in all facilities that have a Medicaid contract, in addition to the LTCSP.
Statement of deficiencies (SOD) – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date for the cited deficient practice. The SOD is a legal document available to the public on request.
Uncorrected – Means the department has cited a violation of WAC or RCW following an inspection and the violation remains uncorrected at the time of a subsequent inspection for the specific purpose of verifying whether such violation has been corrected.
Universe – The total number of individuals, records, observations, objects, related to the provider's/licensee's practice at risk as a result of a deficient practice. Used as the denominator when determining the extent of deficient practice.
Vulnerable adult – as defined in RCW 74.34.020.
Washington Administrative Code (WAC) – Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

G. Acronym List

AA	Administrative Assistant
ACO	Aspen Central Office
ALTSA	Aging and Long-Term Support Administration
ASPEN	Automated Survey Processing Environment System
BIC	Back In Compliance
CE	Critical Elements
CEP	Critical Element Pathways
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendment
CMS	Center for Medicare and Medicaid Services
COC	Certificate of Completion
CS	Complaint Specialist
DOH	Department of Health
DON	Director of Nursing
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
EHR	Electronic Health Record
EMR	Electronic Medical Record
ePOC	Electronic Plan of Correction
FM	Field Manager
HCA	Health Care Authority
HIPAA	Health Insurance Portability and Accountability Act
ID	Intellectual Disability
IJ	Immediate Jeopardy
LA	Leading Age of Washington
LHJ	Local Health Jurisdiction
LPN	Licensed Practical Nurse
LTC	Long-Term Care
LTCOP	Long-Term Care Ombuds Program
LTCSP	Long-Term Care Survey Process
MD	Mental Disorder
MDS	Minimum Data Set
NA	Nursing Assistant
NA-C	Nursing Assistant-Certified
NA-R	Nursing Assistant-Registered
NATCEP	Nursing Aide Training and Competency Evaluation Program
NF	Nursing Facility
NH	Nursing Home
OBRA	Omnibus Budget Reconciliation Act
OSFM	Office of State Fire Marshal

PASRR	Pre-Admission Screening and Resident Review
POC	Plan of Correction
POD	Principles of Documentation
QA	Quality Assurance
QSO	Quality, Safety & Oversight
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
RO	Regional Office
SA	State Agency
SFF	Special Focus Facility
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
TC	Team Coordinator
WAC	Washington Administrative Code
WD	Working Day
WSP	Washington State Patrol

H. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
06/14/2024	Full Chapter	Sunset Review update to capture current systems	Provide current guidance to staff	MB R24-053
06/14/2024	Full Chapter	Updated to new formatting	Provide for easier document navigation	MB R24-053
05/08/2023	Part VI added. Special Focus Facilities	Established subchapter Part VI	Added to provide guidance for SFF process	MB issued 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

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
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-numbering existing SOPs.	Changed the index in preparation for additional SOPs.	MB issued R18-060
09/27/2018	17C4 PASARR Investigation Process	Established subchapter 17C4.		MB issued R18-060