Washington State Department of Social & Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION
RESIDENTIAL CARE SERVICES
"Transforming Lives"

CHAPTER 17 – NURSING HOMES

Nursing Homes – Overview

Nursing Homes (NH), also called Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) depending on funding type, are either Federally Certified and/or State Licensed that provide acute and sub-acute care in a facility setting from qualified staff.

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

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

This chapter contains information about the licensing standards and other topics related to nursing homes. The content is relevant to RCS staff in an effort to better support work process.

Nursing homes must comply with the following state and federal regulations:

- LONG TERM CARE SURVEY PROCESS PROCEDURE GUIDE
- CMS STATE OPERATIONS MANUAL (SOM), CHAPTER 4
- CMS STATE OPERATIONS MANUAL (SOM), CHAPTER 5
- CMS STATE OPERATIONS MANUAL (SOM), CHAPTER 7
- CMS STATE OPERATIONS MANUAL (SOM), APPENDIX PP
- CMS STATE OPERATIONS MANUAL (SOM), APPENDIX Q
- CHAPTER 18.51 RCW NURSING HOMES (NH)
- CHAPTER 388-97 WAC NURSING HOMES (NH)

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

Centers for Medicaid and Medicare Services – CMS Region 10

Department of Health – Construction Review Services (CRS)
Department of Health – Food Safety
Washington State Patrol – Office of State Fire Marshal (OSFM)
Federal & State Long-Term Care Ombuds Program (LTCOP)
Washington Health Care Association (WHCA)
LeadingAge of Washington (LA)

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CHAPTER 17 – NURSING HOMES INDEX

This section contains certain Standard Operating Procedures (SOPs) that RCS staff are required to follow for licensing, oversight and inspection of a Nursing Home (NH). Additional sections will include resources and links to forms as listed below. This Chapter remains under development and will be updated as new procedures are completed and vetted with stakeholders.

OVERVIEW

A. NH PRE-OCCUPANCY STANDARD OPERATING PROCEDURES

B. NH INITIAL CERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

C. NH RECERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

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CHAPTER 17A – NH PRE-OCCUPANCY INSPECTION STANDARD OPERATING PROCEDURES

CURRENTLY UNDER CONSTRUCTION.

This section will contain information on the Pre-Occupancy Inspection.

A. NH PRE-OCCUPANCY INSPECTION STANDARD OPERATING PROCEDURES

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CHAPTER 17B – NH INITIAL CERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

CURRENTLY UNDER CONSTRUCTION.

This section will contain information on the NH Initial Certification survey process.

B. NH INITIAL CERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

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CHAPTER 17C – NH RECERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

This section will contain the Standard Operating Procedures (SOPs) that nursing home RCS staff are required to follow during the standard recertification survey.

C. NH RECERTIFICATION SURVEY STANDARD OPERATING PROCEDURES

1. **CURRENTLY UNDER CONSTRUCTION.**
2. **CURRENTLY UNDER CONSTRUCTION.**
3. **CURRENTLY UNDER CONSTRUCTION.**
4. **PASARR INVESTIGATION PROCESS DURING THE NH RECERTIFICATION SURVEY**
5. **CURRENTLY UNDER CONSTRUCTION.**
6. **CURRENTLY UNDER CONSTRUCTION.**
7. **CURRENTLY UNDER CONSTRUCTION.**
8. **STATE TASKS**
9. **Recertification Survey Communication Process**
10. **Recertification Survey Exit Conference**
11. **CURRENTLY UNDER CONSTRUCTION.**
12. **CURRENTLY UNDER CONSTRUCTION.**

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17C4 – Pre Admission Screening and Resident Review (PASARR) Investigation Process

Background

This Standard Operating Procedure provides instructions to nursing home surveyors regarding investigation of the Pre Admission Screening and Resident Review process during the recertification survey.

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

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

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

Federal and state regulations require a PASARR Level I evaluation for every NF resident prior to admission. The Level I is typically completed by the entity referring the resident for NF admission. If a PASARR Level II evaluation is required, prior to admission, the PASARR evaluator must make the determination the resident 1) has a SMI, ID or RC, 2) is appropriate for NF placement, and 3) whether specialized services are required while at the NF.

Procedure

The Surveyor will:

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

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

B. Review the Level I and/or Level II PASARR forms of the five residents sampled for the "Unnecessary Medication, Psychotropic Medications, and Medication Regimen Review Critical Element" pathway in the investigation portion of the LTCSP.

1. For all five sampled NF residents the review will determine:
    a. If the Level I evaluation was completed prior to a resident's admission to the NF.
        1. Note: When reviewing a Level I form for timeliness, do not consider a Level I form that was not completed timely as failed practice if it was completed prior to the last recertification survey. Complete the rest of the PASARR review for that resident.
    b. If a Level II evaluation was required, prior to admission, did the evaluator make the determination the resident had 1) an appropriate diagnosis, 2) needed nursing facility care and 3) whether Level II services were needed.
        1. Note: the full Level II evaluation does not need to be received prior to admission. However, the determination made by the evaluator needs to be completed and received by the facility, verbally or in writing. If verbal confirmation is received, the facility is required to follow up and assure the final Level II evaluation is received in writing and placed in the medical record after admission.
    c. If a Level I completed by the hospital or other referring entity was inaccurate, did the NF complete a new Level I and make a Level II referral (if needed) to the appropriate evaluator upon admission.
2. For any resident with a significant change in condition (as defined in WAC 388-97-1910) the review will determine:
    a. If a new Level I form was completed by the NF.
    b. If a Level II assessment was required, that the NF made a referral to the appropriate agency.
3. For any resident the facility later had credible suspicion (as defined on DSHS Form 14-300, Pre-Admission Screening and Resident Review) of a SMI, an ID or a RC, the review will determine:
    a. If a new Level I form was completed by the NF.
    b. If a Level II assessment was required, that the NF made a referral to the appropriate agency.
4. If no issues are found with the PASARR process, affirmatively document the PASARR process was completed correctly in the Unnecessary Medication pathway
5. If concerns are found with the PASARR process, initiate the PASSAR Critical Element pathway for further investigation. Document findings in the Investigation Notes or the Resident Notes in the LTCSP software.
    a. At survey team discretion, expand the sample if failed practice is found related to the PASARR process.

b. Document PASARR related citations on the Statement of Deficiencies.

THE TEAM COORDINATOR WILL:

A. Ensure all PASARR reviews were completed and documented in the LTCSP software. At the conclusion of the recertification survey, if failed practice was found, alert the Field Manager.

THE FIELD MANAGER, OR DESIGNEE, WILL:

A. Review any PASARR citations to assure the citation is complete and follows the Principles of Documentation.

THE RCS PROGRAM MANAGER FOR PUBLIC DISCLOSURE, DISCOVERY, AND CENTRAL FILES UNIT OR DESIGNEE, WILL:

A. Gather information about failed practice related to the PASARR process from the ASPEN software and forward the information to the Health Care Authority for follow up.

QUALITY ASSURANCE REVIEW

This process will be reviewed at least every two years for accuracy and compliance.

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CHAPTER 17C8 – STATE TASKS

BACKGROUND

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

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

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

This procedure:

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

PROCEDURE

A. OFF-SITE PREPARATION (PRIOR TO STARTING THE SURVEY)

The Team Coordinator will:

1. Determine if the facility has any current waivers in place related to state regulations.
2. Determine and document the name of the Administrator and the Director of Nursing by looking in ASPEN Central Office (ACO), the software maintained by Centers for Medicare and Medicaid Services (CMS) for the names of the Administrator and the Director of Nursing.

3. Print a copy of:
   a. The State Entrance Conference Letter (Attachment C) to provide to the facility during the entrance conference.
   b. The State Task Checklist (Attachment D) for the survey team members to document completion of review(s) during the survey.
   c. The Staffing Pattern Form (Attachment E) to provide to the facility.
4. Ensure either printed or electronic copies of the following forms are available to the survey team during the survey:
   a. Liability Insurance Review (Attachment F)
   b. Trust Fund Review (Attachment G)
   c. OBRA NA Training Onsite Inspection for Survey (NATCEP) (DSHS 16-168)
   d. Paid Feeding Assistant Program Review (Attachment J)
   e. Staff Qualification and Background Review (Attachment L)
   f. TB Testing Review for Staff (Attachment M)
   g. TB Testing Review for Residents (Attachment N)
   h. Pet Record Review (Attachment H)
   i. Medication Assistant Endorsement (Attachment O)

B. DURING THE SURVEY:

The Team Coordinator will:

1. Provide a copy of the State Entrance Conference Letter to the facility during the survey entrance conference, and review the required information in the letter with the Administrator or designee.
2. Provide the facility with the Staffing Pattern Form at the entrance conference. Inform the facility a surveyor will request documentation to verify the data on the Staffing Pattern Form.
3. Ensure the facility provides all required information listed in the State Entrance Conference letter.
4. Assign team members to complete State Tasks.
5. Review any state waivers with the survey team.
6. Ensure completion of all State Tasks by the end of the survey.
7. Compare the names of the current Administrator and Director of Nursing to the Administrator and Director of Nursing names documented from ACO.
   a. If there is any discrepancy between the actual Administrator and Director of Nursing with the names documented in ACO, notify your Field Manager.

The survey team members, as assigned, will complete a review of the following tasks, using the provided guidance. The surveyor(s) will document completion of each task on the State Task Checklist (Attachment D).

Index of Tasks

1. Incident Reporting Log
2. Staffing Patterns for the Thirty Days Prior to Survey
3. Medical Test Site Waiver
4. Liability Insurance
5. Trust Fund
6. NATCEP Program Review
7. Paid Feeding Assistant Program
8. Call Bell Visible and Audible
9. Dementia Unit Egress Signage
10. Fresh Fruits & Vegetables
11. Staff Qualification and Background
12. Tuberculosis Review for Residents and Staff
13. Pet Records
14. NAC Medication Assistant Program

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 guidelines ("Nursing Home Guidelines," aka The Purple Book) have specific requirements for facilities to keep an incident reporting log including what types of incidents should be logged, what information the log should contain and how long the logs should be kept.

b. Review the facility incident-reporting log(s) for the prior six months. Ensure the nursing home is logging incidents, investigating incidents and reporting to the appropriate state agencies when required.

2. Staffing Patterns for the Thirty Days Prior to Survey

a. State rules (WAC 388-97-1080) require more Registered Nurse (RN) hours than the federal regulation (F727). The state may grant limited waivers. Unlike the federal regulation, the state may not waive the requirement for a full time Director of Nursing. Additionally, the state requires:

I. The nursing home must:

- If the facility is a large nonessential community provider, have a RN on duty directly supervising resident care twenty-four hours per day, seven days per week. "Large nonessential community providers" means nonessential community providers that have more than sixty licensed nursing home beds, even if some of those beds are not set up or are not in use.
- If the facility is an essential community provider (a nursing home which is the only nursing home within a commuting distance radius of at least forty minutes duration, traveling by automobile) or a small nonessential community provider (those with sixty or fewer licensed beds, even if some of those beds are not set up or are not in use), they must have a RN on duty who directly supervises resident care a minimum of sixteen hours per day, seven days per week, and a RN or a licensed practical nurse on duty who directly supervises resident care the remaining eight hours per day, seven days per week.

b. Review the completed Staffing Pattern form (Attachment E) to ensure required RN staffing. 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. Review records provided by the facility, such as time cards or payroll documents to validate the staffing documented on the Staffing Pattern form. Verify staffing hours for RNs, Licensed Practical Nurses (LPNs) and Nursing Assistants, Certified or Registered (NA-C/NA-Rs).

IV. Review any state waivers that permit the facility to have reduced RN hours.

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. Federal regulations in Appendix PP of the State Operating Manual have no specific requirement for liability insurance. State rules (WAC 388-97-4166, 388-97-4167 and 388-97-4168) require the nursing home to maintain liability insurance.

b. Use Attachment F, Liability Insurance Review, to document. Verify the facility has liability insurance that covers the items named in the three liability related WACs. Also, verify the amount of the coverage is at least as much as required in the WACs. If there are concerns with the terms of the liability insurance, interview the Administrator or designee.

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, except for the requirements about when the residents' personal funds are required to be in an interest bearing account:

I. Federal (F567). For all residents except Medicaid residents, the facility must deposit any residents' personal funds in excess of one hundred dollars in an interest bearing account. For residents whose care is funded by Medicaid, the facility must deposit the residents' personal funds in excess of fifty dollars in an interest bearing account (or accounts).

II. State (WAC 388-97-0340). The facility must deposit any resident's personal funds in excess of fifty dollars in an interest-bearing account or accounts. For residents whose care is funded by Medicare, funds in excess of one hundred dollars must be deposited into an interest bearing account.

b. Both federal (F569) and state (WAC 388-97-0340) regulations require the facility to convey the funds and a final accounting of the funds to the resident or the appropriate jurisdiction within 30 days of the discharge, transfer or death of the resident. The LTCSP pathway (CMS-20063 Personal Funds) does not review this aspect of the regulation.

c. Complete this task to ensure the facility credits interest to resident accounts appropriately and conveys funds within 30 days of the resident's discharge, transfer or death. Use Attachment G, Trust Fund Review to document your review.

I. Use the list of residents with funds in trust to choose a sample. Through interview with the facility trust fund manager and record review, verify interest is credited appropriately for three sampled residents.

II. Request names of residents with trust funds who have discharged from the facility. Select one resident who has been discharged for over 30 days to review for timely and appropriate disbursement of funds after discharge.

6. Nursing Assistant-Certified (NA-C or NA) Training Program

a. This review collects information about the NA Training program to ensure compliance with state requirements. The Nursing Assistant Training and Competency Evaluation Program (NATCEP) Manager evaluates and, if needed, takes action on the collected information.

b. Definitions:

I. "Active" NA Training program means the program is facility based and has conducted at least one training in the past 12 months.

II. "Inactive" training program means the facility has an approved facility based program, but has not conducted training in the past 12 months.

c. In the entrance conference, the Team Coordinator will determine if the facility has an active NA Training program. If the facility has an active program, the Team Coordinator 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 nursing assistants 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 this training program, which contains the approved number of classroom hours.

d. The assigned surveyor will review the materials and complete DSHS form 16-168, OBRA NA Training Onsite Inspection Form for Survey (NATCEP).

7. Paid Feeding Assistant Program

a. Federal guidelines (F811) state a facility may use a paid feeding assistant if the paid feeding assistant has completed a State-approved training course and the use of the feeding assistant is consistent with state law. Conduct this review to ensure the state approved curriculum is used and to ensure the facility trains and utilizes feeding assistants according to program guidelines.

b. State approved training curricula. RCS management bulletin R13-025, "Paid Feeding Assistant (Dietary Aide) Program (NH), defines two training curricula currently approved for use in Washington State. Facilities are responsible to ensure their programs meet federal curriculum standards:

   I. "Assisting with Nutrition and Hydration in Long-term Care:" at http://www.hartmanonline.com/fab/index.html

   II. "Eating Matters-A Training Manual for Feeding Assistants;" at https://www.eatright.org/Shop/Product.aspx?id=6442466394

c. In the entrance conference, the Team Coordinator will determine if the facility uses paid feeding assistants. If so, the Team Coordinator 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.

d. The assigned surveyor will:

   I. Mark N/A on the State Task checklist if the facility does not use paid feeding assistants.

   II. If paid feeding assistants are used, conduct observations, interviews and record review to ensure facility compliance with the following items. Use Attachment J, Paid Feeding Assistant Program Review, to document the review.

      - Individuals used as paid feeding assistants successfully completed a State-approved training course;
      - Residents receiving assistance from paid feeding assistants had assessments and were determined to be eligible to receive these services;

- Paid feeding assistants are supervised by a Registered Nurse or a Licensed Practical Nurse;
- Paid feeding assistants know how to obtain assistance in emergencies; and,
- The facility maintains records for paid feeding assistants.

8. Call Bell Visible and Audible

a. State rules (WAC 388-97-2280) require a communication system that registers a call by distinctive light at the room door and by distinctive light and audible tone at the staff workstation. The system must be equipped to receive resident calls from bedsides, common areas, toilet rooms and bathing areas. This exceeds the federal requirements (F919) that require calls to be relayed to a staff member or a centralized nursing station, and the transmission may be audible, visual or through an electronic device. Both state and federal rules require the facility try to accommodate special needs of residents so they can use a call device.

b. Conduct observations and interviews throughout the survey to determine if the call system functions consistently. Confirm a visible signal transmits to the room door and, audible and visible signals transmit to the workstation. If a resident requires accommodation to use a call signal, verify the facility attempted to meet the resident's needs.

9. Dementia Unit Egress Signage

a. 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. Interview visitors and maintenance personnel if signage is not available or directions are not clear.

c. If the facility does not have a secured dementia unit, mark N/A on the checklist.

10. Fresh Fruit & Vegetables

a. Federal regulations (F803 through F808) do not require facilities to offer fruits and vegetables to residents on a daily basis. State regulations (WAC 388-97-1120) require that fresh fruits and vegetables, in season, are available to residents on a daily basis.

b. Conduct observations of meals and snacks. Interview residents or resident representatives about availability of fresh produce and review menus. Consult with the surveyor assigned to the kitchen to gather information about the quality and quantity of fresh produce.

11. <u>Staff Qualification & Background</u>

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

b. Under both federal and state rules, the facility must not employ any individual who is on a registry based on a final finding of abuse, neglect, or financial exploitation of a vulnerable adult.

c. F606 and F607 requires the facility to have and implement written procedures for screening potential employees for a history of abuse, neglect, exploitation or misappropriation of resident property. The screening requirements include obtaining (or attempting to obtain) information from previous and/or current employers. Review this federal requirement with State Tasks. If there is failed practice, refer to F606 or F607.

d. The staff sample must include a minimum of five staff. Attempt to sample four staff hired since the last recertification survey, and one staff employed by the facility at least two years. Expand the employment timeframe, if needed, to ensure review of at least five staff. Expand the sample as needed if there are identified concerns.

   I. If the facility uses NA-Cs with a medication assistant endorsement to administer medications or perform treatments, include one medication assistant in the sample of five staff, or expand the sample size. Confirm the medication assistant has the appropriate endorsement and qualifications to perform medication assistant tasks.

e. Using the Staff Qualification and Background Review form (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.

   I. Ensure the facility has confirmed each staff has a current license (if applicable) and has reviewed any action taken against the license.

II. Ensure the facility screened each staff for a history of abuse, neglect or exploitation prior to hire by contacting (or attempting to contact) previous and/or current employers.

III. Ensure the facility completed the department required background check for each employee prior to unsupervised contact with any resident. Verify the facility repeated the background check every two years. If a background check revealed findings that required a Character, Competency & Suitability (CCS) review or disqualification from employment, confirm the facility took the required action.

IV. For Nursing Assistant-Certified (NA-C) staff, verify the facility checked the OBRA registry for any findings of abuse, neglect or exploitation.

12. Tuberculosis (TB) Testing for Residents and Staff

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

b. For both staff and residents, the state requirements (WAC 388-97-1360 through 388-97-1600) are specific to the type of TB screening tests, and to the timing and frequency of screening. They also address the required response to a positive test result, and when testing is or is not indicated.

c. **Residents:** The resident sample should include a minimum of five residents admitted within the last six months. If needed, expand the admission timeframe to ensure review of five residents. Expand the sample if indicated.

I. Using the TB Testing Review for Residents (Attachment N) to document, review the testing records for the sampled residents. Review for screening within three days of admission, the type of screening test administered, the timing of reading the result (for the Tuberculin Skin Test (TST), also known as Mantoux), and the result. For the TST, review for a second skin test, reading and result.

d. **Staff:** The staff sample should 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. Using the TB Testing Review for Staff form (Attachment M) to document, review the testing records for the staff sample. Review for screening within three days of employment, the type of screening test administered, the timing of reading the result (for the TST), and the result. For the TST, review for a second skin test, reading and result. Ensure any staff employed for more than a year received re-screening annually.

e. **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 could include:

- Review of facility assessment requirements (F838);
- Review of physical plant requirements;
- Interviews with caregiving staff to determine implementation of infection prevention processes;
- Interview with the Medical Director; and/or
- Interview with personnel from the county or local health district.

13. **Pet Records**

a. Federal regulations in Appendix PP of the State Operating Manual have no specific requirement regarding resident access to pets. The state regulation (WAC 388-97-0980) addresses resident's right to have access to pets and monitoring pet health.

b. Use Attachment H, Pet Record Review, to document the review.

I. Conduct observations of pet and resident interactions;

I. Interview residents to verify regular access to pets, if desired, or no contact with pets if the resident objects to pets;

II. Interview staff to determine the system in place to monitor pet temperament and pet health;

III. Other avenues of investigation could include review of the incident log, the grievance log and/or the resident council minutes to review for concerns with pets.

14. NAC Medication Assistant Program

a. State WACs 246-841-586 through 246-841-610 provides the criteria and mechanism to enable a Nursing Assistant-Certified 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 Team Coordinator 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 Team Coordinator will obtain the names of all staff used in that capacity.

c. The assigned surveyor will include up to three medication assistants in the sample for review. For the sampled staff, use Attachment O, Medication Assistant Endorsement, to document the following:

I. Conduct observations of medication administration (may be done as part of the LTCSP medication administration observations) and/or treatment administration to ensure the medication assistant(s) are:

- Working within the defined scope of practice;
- Working under RN supervision;
- Documenting their work; and,
- When assigned as a medication assistant, performing only medication assistant tasks.

II. Interview the medication assistant(s) and designated RN(s) to confirm observations.

III. Review medication and or treatment records.

IV. Review medication reconciliation documents to ensure appropriate handling of scheduled medications.

V. Collaborate with the surveyor assigned to the state task, “Staff Qualification and Background,” to ensure one of the sampled medication assistants is reviewed for appropriate credentials.

C. AFTER THE SURVEY

The Team Coordinator will

1. Consult with the Field Manager or designee regarding any findings or possible failed practice revealed through the State Task review.

2. Gather all documentation for state tasks and include in survey working papers according to office procedure.

The Survey Team will

1. Document any deficient practice findings on CMS-2567, Statement of Deficiencies.

The Field Manager will

1. Ensure timely completion of the Statement of Deficiencies.
2. Ensure the facility corrects any deficient practice, following state and federal protocols.

Field Manager Responsibility

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

FORMS AND ATTACHMENTS FOR USE WITH THE STATE TASK REVIEW:

INSTRUCTIONS: Attachment C link follows below. To access all other attachments, search for the DSHS form number in **DSHS Intranet Forms**

1. Attachment C – State Entrance Conference Letter
2. Attachment D – State Task Checklist (DSHS 10-625)
3. Attachment E – Staffing Pattern (DSHS 10-626)
4. Attachment F – Liability Insurance Review (DSHS 10-627)
5. Attachment G – Trust Fund Review (DSHS 10-628)
6. Attachment H – Pet Record Review (DSHS 10-629)
7. Attachment J – Paid Feeding Assistant Program Review (DSHS 10-630)
8. OBRA NA Training Onsite Inspection Form for Survey (NATCEP) (DSHS 16-168)
9. Attachment L – Staff Qualification & 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 Assistant Endorsement (DSHS 10-634)

REFERENCES:

1. Management Bulletin R17-006 Reviewing State Licensing Requirements in Nursing Homes
2. Management Bulletin R16-035 NH Swing Beds and Non-Licensed Facility List
3. Management Bulletin R13-035 Paid Feeding Assistant (Dietary Aide) Program (NH)

4. WAC 388-97 Nursing Homes
5. WAC 246-841 Nursing Assistants (includes Medication Endorsement)
6. CMS State Operations Manual and Appendix PP
7. LTCSP Procedure Guide
8. The Purple Book
9. RCW 70.42.030 Medical Test Sites
10. WAC 388-113 Disqualifying Crimes and Negative Actions

QUALITY ASSURANCE REVIEW

This process will be reviewed at least every two years for accuracy and compliance.

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17C9 – RECERTIFICATION SURVEY PROCESS
COMMUNICATION

BACKGROUND

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

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

This procedure is guided by:

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

PROCEDURE

General Communication Principles

A. The survey team will follow communication prompts/guidelines within the LTCSP Procedure Guide.

B. 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.

C. The survey team will communicate clearly, objectively, and in a manner easily understood when explaining or documenting deficient practice to ensure the licensee/administrator understands all identified issues and preliminary findings of deficient practice prior to the receipt of the Statement of Deficiencies.

1. The communication will not include advice, personal opinions, comments or directions aimed at the nursing home.

D. Communication is crucial to a thorough investigation. Ongoing communication will occur throughout the nursing home survey between the survey team and the facility staff.

E. The survey team will keep the administrator informed daily of the progress of the survey and complaint investigations.

F. All surveyor conversations and presentations will respect resident confidentiality and protected health information will be handled according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

G. 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.

The Survey Team Coordinator will:

A. During off-site preparation:
1. Contact the Office of the State Fire Marshall to confirm entrance date and time.
2. Share data with survey team members according to the LTCSP Procedures Guide (Step 10).

B. Upon entrance to the facility:
1. Make introductions and provide appropriate identification, i.e. name tag/badge and business card.
2. Request the information needed immediately according to the Entrance Conference Worksheet (Step 12 in the LTCSP).
3. Request a room with a power outlet and place to sit.
4. Contact the RCS field office to initiate the process of notifying the regional Ombudsman about the start of the survey.
5. Conduct a brief entrance conference with the administrator or designee.
    a. Follow the instructions in the LTCSP Procedure Guide (Step 12) and utilize the Entrance Conference Worksheet found in the LTCSP software.
    b. Give a copy of the Entrance Conference Letter to the Administrator or designee. This letter contains information needed to review state regulations. Review and clarify the information requested in the letter.
    c. If the beginning of the survey occurs outside regular business hours or when the administrator is not present, complete Step 12 of the LTCSP Procedure Guide with the designated person in charge, and provide them with the state Entrance Conference Letter. Conduct a follow-up Entrance Conference with the administrator, as needed, after his/her arrival at the facility.
6. Inform the licensee/administrator or designated representative to expect frequent contact with survey team and that the team will interview nursing home staff as questions or specific issues arise.
7. Provide information on the survey process and establish a tone to encourage and facilitate frequent communication with the licensee/administration or designated representative and facility staff.

C. During the survey:

1. Conduct an end of the day team meeting with all survey team members. In the LTCSP procedure guide, see Step 15 for end of the Day One team meeting instructions and Step 21 for other end of the day meeting instructions.
    a. Prior to the meeting, the team coordinator will electronically receive all team members' data.
    b. The team meeting will be conducted using the prompts in the LTSCP team meeting screen.
    c. Following the meeting, the team coordinator should share all team members' data electronically with each team member. See Steps 14 and 15 in the LTCSP Procedure Guide.
2. Conduct daily progress meetings with the administrator or designee to inform him or her of the progress of the survey. For example, if the team has completed a task such as medication pass, the administrator should be given a verbal summary of activities completed and general areas of concerns (if any).
    a. Provide the licensee/administrator or designated representative the opportunity to ask questions and/or communicate any information regarding the facility such as recent changes or events that have occurred.
3. Maintain ongoing dialogue throughout the survey, so the administrator or designated representative is aware of the basic concerns/issues and can provide additional information prior to the exit to assist in clarification of issues and data collection.
4. If a potential immediate jeopardy situation is identified:
    a. Consult with the Field Manager and Compliance Specialist (or others as needed) regarding any serious and/or immediate risk of harm to residents.
    b. Guided by the communication with the Field Manager and Compliance Specialist, and following the guidance in Appendix Q of the SOM,
        1. Inform the Administrator or designee of the immediate jeopardy situation.
        2. Request a plan from the administrator or designee for removal of the immediate jeopardy.
5. Consult with the Field Manager 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.
6. At the conclusion of the survey, conduct an exit conference following guidelines in Chapter 17 of the Standard Operating Procedure, subsection 17C10.

D. After the survey:

1. Review the findings of the survey team with the Field Manager.

2. If any of the preliminary deficient findings communicated to facility staff during the survey change, contact the facility administrator. Explain the changes to the administrator or designee prior to issuing the Statement of Deficiencies.

The Survey Team will:

A. Attend all team meetings.
   1. Be on time and prepared to discuss identified concerns, findings, and potential noncompliance.
   2. Be prepared to discuss workload and potential adjustments in workload with other team members.
   3. Listen attentively to other team members' observations, concerns or other identified issues.
   4. Provide the team coordinator with information to share with the licensee/administrator at the daily progress meetings and exit meeting.

B. When a surveyor identifies potential deficiencies, the surveyor should explain the deficiency to the provider in terms specific enough to allow a reasonably knowledgeable person to understand why the requirement is not met.

C. Participate in the exit conference as requested by the team coordinator.

D. Document all findings of deficient practice on the Statement of Deficiencies using the Principles of Documentation.

THE FIELD MANAGER, OR DESIGNEE, WILL:

B. Be available by phone or in person to consult and support the survey team.

C. Provide oversight and support to surveyors to implement these communication principles.

QUALITY ASSURANCE REVIEW

This process will be reviewed at least every two years for accuracy and compliance.

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17C10 – RECERTIFICATION SURVEY PROCESS
EXIT CONFERENCE

BACKGROUND

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.

The purpose of the exit conference is to informally communicate preliminary survey team findings and provide an opportunity for the exchange of information with the administrator, designee or other invited staff. The exit conference during the onsite survey is both a courtesy to the facility and a way to expedite the facility's planning ahead of the formal receipt of the survey findings in the Form CMS-2567, Statement of Deficiencies. An exit conference is not guaranteed, as noted in section 2724 of the State Operating Manual.

This procedure is guided by:

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

PROCEDURE

THE TEAM COORDINATOR OR DESIGNEE WILL:

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

5. Explain the timeline for the CMS-2567 and the Plan of Correction.
    a. The CMS-2567 will be provided to the facility within 10 working days.
    b. The facility will have 10 calendar days after the receipt of the CMS-2567 to submit a Plan of Correction.

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

c. Presentation of findings
    1. Provide information about survey team preliminary findings in a manner that is understandable to those present, e.g., say the deficiency “relates to development of pressure ulcers”, not to “Tag F686.”
        a. Avoid using jargon or acronyms.
        b. Include preliminary findings for federal regulations, and state regulations that do not have an equivalent federal regulation.
    2. Explain why the findings are a violation of Medicare or Medicaid requirements, or state requirements. Provide enough detail to assist the provider in expediting correction of the deficiency.
    3. If a facility asks for a specific regulatory reference, it should be given with a disclaimer that the code reference is preliminary. If a facility does not specifically ask for the regulatory basis, the survey team will use its own judgment in determining whether this additional information would provide additional insight.
    4. If a team is still deliberating about which tag is most pertinent, do not speculate. Describe the general area of non-compliance without specifying a regulatory code.
    5. Do not provide the Scope and Severity for a given deficiency, unless it is an immediate jeopardy.
        a. The survey team may describe the general seriousness (e.g., harm) or urgency the deficiency may pose to residents.
        b. If a facility asks if the noncompliance is isolated, patterned, or widespread, respond with the facts,

such as, “The noncompliance was found to affect “X” number of residents.”

6. Do not make declaratory statements such as “Overall, this facility is very good” or “This condition was not met.”
7. Do not discuss survey results in a manner that reveals the identity of an individual resident.
8. During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.

d. Closure
   1. Close the exit conference.
   2. Offer additional explanation to the facility administrator or designee about the process of submitting the Plan of Correction, and pertinent due dates.
   3. Ensure the facility administrator or designee has contact information for the survey team and the Field Manager.

e. Team Coordinators may use, but are not required to, Attachment A, “Exit Conference Template” to organize the meeting presentation.

THE SURVEY TEAM WILL:

A. At the request of the Team Coordinator,
   1. Assist with organizing the exit conference presentation,
   2. Attend the exit conference, and/or
   3. Present portions of the exit conference.

THE FIELD MANAGER, OR DESIGNEE, WILL:

A. Ensure the survey teams follow this procedure.

QUALITY ASSURANCE REVIEW

This process will be reviewed at least every two years for accuracy and compliance.

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CHAPTER 17D – NH RECERTIFICATION SURVEY FOR STATE ONLY LICENSED FACILITIES STANDARD OPERATING PROCEDURES

CURRENTLY UNDER CONSTRUCTION.

This section will contain information on survey procedures for State Only Licensed NH facilities.

D. NH RECERTIFICATION SURVEY FOR STATE ONLY LICENSED FACILITIES STANDARD OPERATING PROCEDURES

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CHAPTER 17E – NH POST SURVEY STANDARD OPERATING PROCEDURES

CURRENTLY UNDER CONSTRUCTION.

This section will contain information on NH post survey procedures.

E. NH POST SURVEY STANDARD OPERATING PROCEDURES

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CHAPTER 17F – OTHER NH STANDARD OPERATING PROCEDURES

CURRENTLY UNDER CONSTRUCTION.

This section will contain information on additional processes for nursing homes.

F. OTHER NH STANDARD OPERATING PROCEDURES

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APPENDIX A – NH RESOURCES AND FORMS

CURRENTLY UNDER REVISION.

This section will contain additional resources and links to information, regulations, processes, etc.

APPENDIX A: NURSING HOME RESOURCES AND FORMS

RESOURCES (*Docs and Links*)

1. Professional Page for Providers
2. LTCSP Resources & Guides
3. Title 42 Code of Federal Regulations 483

FORMS AND ATTACHMENTS

13. Attachment A – Exit Conference Template

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APPENDIX B - CHAPTER 17 CHANGE LOG

EFFECTIVE DATE	CHAPTER SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION &TRAINING PLAN
06/07/19	17C8	Established subchapter 17C8, State Tasks		**MB issued R19-041**
05/03/19	17C10	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**
05/03/19	17C9	Updated to reflect new LTCSP and other changes	Guidance from CMS	**MB issued R19-037**
03/08/19	17C10	Rescinded "Final Status Meeting" as 17C10 and renumbered index to reflect removal.	Guidance from CMS	**MB issued R19-025**
9/27/2018	Overview and Resource sections	Changed references from the QIS survey process to the LTCSP.	New survey process	**MB issued R18-060** R18-060 - Updated SOP on PASARR Inves
9/27/2018	Index	Updated and expanded the index, including re-numbering existing SOPs.	Changed the index in preparation for additional SOPs.	**MB issued R18-060** R18-060 - Updated SOP on PASARR Inves
9/27/2018	**17C4** – PASARR Invest. Process	Established subchapter 17C4.		**MB issued R18-060** R18-060 - Updated SOP on PASARR Inves
4/14/2017	Communication	SOP conversion and updated language to include new Federal Regulatory Groupings.	**New** Federal Regulatory Groupings replace care areas.	
4/14/2017	Status Meeting	SOP conversion and updated language to include new Federal Regulatory Groupings.		

EFFECTIVE DATE	CHAPTER SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION &TRAINING PLAN
4/14/2017	Exit with Resident and Ombuds	SOP conversion and updated language to include new Federal Regulatory Groupings.		

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