WSR 21-08-055
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)
[Filed April 5, 2021, 8:17 a.m.]

Effective Date of Rule: April 6, 2021.

Purpose: The department is extending the amendment of the rules listed below to assure nursing homes are not significantly impeded from admitting and caring for residents during the COVID-19 outbreak. These amendments will continue to align state nursing home rules with federal rules that are suspended or amended to help facilitate care during the COVID-19 pandemic. The federal rules were amended to remove the timelines for completing and transmitting resident assessments, and to delay the requirement by thirty days for a preadmission screening and resident review (PASRR) screening prior to admission to a nursing home. Federal rules also amended care-planning timelines, discharge and transfer notice requirements, and requirements that ensure residents can meet in groups. The rules identified below currently require a PASRR screen prior to admission, have timelines for completion of the comprehensive resident assessment and care plan, and have timelines for the transmission of the resident assessment. These rules also establish the right of residents to participate in resident groups and require specific notice and time requirements before a resident discharge or transfer can occur.

The department filed a CR-101 Preproposal statement of inquiry as WSR 20-17-005 on August 5, 2020, to begin the permanent rule-making process. In addition, under the rule development phase of rule making, the department is in discussions about adding language to the rules to explain the circumstances and time periods under which suspension of rules due to COVID is necessary.

Citation of Rules Affected by this Order: Repealing WAC 388-97-0920; and amending WAC 388-97-0120, 388-97-1000, 388-97-1020, 388-97-1915, and 388-97-1975.

Statutory Authority for Adoption: RCW 74.42.620.

Other Authority: Chapter 74.34 RCW.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The continued threat of COVID-19 to our most vulnerable populations is significant, especially for those receiving long-term care services in their homes and congregate settings, such as long-term care facilities.

PASRR, resident assessment, and care planning: Current nursing home rules require a PASRR screen, typically performed by hospital staff prior to admission to a nursing home, followed by further evaluation from state agency staff or contractors under certain circumstances. Hospital staff are experiencing an extremely high workload during the pandemic due to the increased number of admissions, coupled with a reduced number of available staff. Additionally, face-to-face evaluation of the transferring resident continues to be restricted in many counties. The PASRR, care-planning and comprehensive assessment amendments will align state nursing home rules with federal rules that were

suspended or amended to help facilitate care during the COVID-19 outbreak by shortening the transfer time from hospital to nursing home, and increasing the flexibility for nursing home staff to be able to prioritize immediate or emergency care needs of incoming residents.

Resident groups: Current rules establish resident rights to participate in resident groups and require the facility to assist with the organization of a group. Extending the amendment of these rules will permit facilities to restrict resident groups, and meets the state and federal recommendations for social distancing and limited gatherings. Extending this amendment also aligns state rules with federal rules that were suspended to accomplish social distancing recommendations.

Transfer and discharge notice: Current nursing home rules regarding discharge and transfer from a nursing home have specific criteria around when transfer or discharge can occur, and specific notice and time period requirements that must be met before a discharge or transfer can occur. The COVID-19 pandemic continues to necessitate that transfer and discharge decisions be made and implemented more quickly than the nursing home rules permit. Extending this amendment would decrease the notice requirements for transfer or discharge, and help expedite infection control processes and maximize the availability of nursing home beds. It would also align state nursing home rules with federal rules that were suspended or amended so facilities could more easily cohort residents to meet infection control goals.

These emergency rules continue to be needed to align state nursing home requirements with suspended or amended federal requirements. Ongoing conversations with stakeholders also support continuation of these emergency rules until a clear timeline for reimplementation, consistent with federal reimplementation, is established.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0;

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0;

Date Adopted: March 25, 2021.

Katherine I. Vasquez
Rules Coordinator

SHS-4799.2

AMENDATORY SECTION (Amending WSR 08-20-062, filed 9/24/08, effective 11/1/08)

WAC 388-97-0120 Individual transfer and discharge rights and procedures. (1) The skilled nursing facility and nursing facility must comply with all of the requirements of 42 C.F.R. § 483.10 and § 483.12, and RCW 74.42.450, or successor laws, and the nursing home

must comply with all of the requirements of RCW 74.42.450 (1) through (4) and (7), or successor laws, including the following provisions and must not transfer or discharge any resident unless:

(a) At the resident's request;

(b) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(c) The transfer or discharge is appropriate because the resident's health has improved enough so the resident no longer needs the services provided by the facility;

(d) The safety of individuals in the facility is endangered;

(e) The health of individuals in the facility would otherwise be endangered; or

(f) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility.

(2) The following notice requirements apply if a nursing home/facility initiates the transfer or discharge of a resident. The notice must:

(a) Include all information required by 42 C.F.R. § 483.12 when given in a nursing facility;

(b) Be in writing, in language the resident understands;

(c) Be given to the resident, the resident's surrogate decision maker, if any, the resident's family and to the department;

(d) Be provided thirty days in advance of a transfer or discharge initiated by the nursing facility, except that the notice may be given as soon as practicable when the facility cannot meet the resident's urgent medical needs, or under the conditions described in (1)(c), (d), and (e) of this section; and

(e) Be provided fifteen days in advance of a transfer or discharge initiated by the nursing home, unless the transfer is an emergency.

(3) The nursing home must:

(a) Provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the nursing home;

(b) Attempt to avoid the transfer or discharge of a resident from the nursing home through the use of reasonable accommodations unless agreed to by the resident and the requirements of WAC 388-97-0080 are met; and

(c) Develop and implement a bed-hold policy. This policy must be consistent with any bed-hold policy that the department develops.

(4) The nursing home ((~~must provide the~~)) bed-hold policy((~~, in written format, to the resident, and a family member, before the resident is transferred or goes on therapeutic leave. At a minimum the policy~~)) must state, at a minimum:

(a) The number of days, if any, the nursing home will hold a resident's bed pending return from hospitalization or social/therapeutic leave;

(b) That a medicaid eligible resident, whose hospitalization or social/therapeutic leave exceeds the maximum number of bed-hold days will be readmitted to the first available semi-private bed, provided the resident needs nursing facility services. Social/therapeutic leave is defined under WAC 388-97-0001. The number of days of social/therapeutic leave allowed for medicaid residents and the authorization process is found under WAC 388-97-0160; and

(c) That a medicaid eligible resident may be charged if he or she requests that a specific bed be held, but may not be charged a bed-

hold fee for the right to return to the first available bed in a semi-private room.

(5) The nursing facility must send a copy of the federally required transfer or discharge notice to:

(a) The department's home and community services when the nursing home has determined under WAC 388-97-0100, that the medicaid resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; and

(b) The department's designated local office when the transfer or discharge is for any of the following reasons:

(i) The resident's needs cannot be met in the facility;

(ii) The health or safety of individuals in the facility is endangered; or

(iii) The resident has failed to pay for, or to have paid under medicare or medicaid, a stay at the facility.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-0120, filed 9/24/08, effective 11/1/08.]

AMENDATORY SECTION (Amending WSR 18-11-001, filed 5/2/18, effective 6/2/18)

WAC 388-97-1000 Resident assessment. (1) The nursing home must:

(a) Provide resident care based on a systematic, comprehensive, interdisciplinary assessment, and care planning process in which the resident participates, to the fullest extent possible;

(b) Conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity;

(c) ((~~At the time~~)) As soon as practicable after each resident is admitted:

(i) Have physician's orders for the resident's immediate care; and

(ii) Ensure that the resident's immediate care needs are identified in an admission assessment.

(d) Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The comprehensive assessment must include at least the following information:

(a) Identification and demographic information;
(b) Customary routine;
(c) Cognitive patterns;
(d) Communication;
(e) Vision;
(f) Mood and behavior patterns;
(g) Psychosocial well-being;
(h) Physical functioning and structural problems;
(i) Continence;
(j) Disease diagnosis and health conditions;
(k) Dental and nutritional status;
(l) Skin conditions;
(m) Activity pursuit;
(n) Medications;

(o) Special treatments and procedures;

(p) Discharge potential;

(q) Documentation of summary information regarding the assessment performed; and

(r) Documentation of participation in assessment.

(3) ((~~The nursing home must conduct comprehensive assessments:~~

~~(a) No later than fourteen days after the date of admission;~~

~~(b) Promptly after a significant change in the resident's physical or mental condition; and~~

~~(c) In no case less often than once every twelve months.~~

~~(4)~~)) The nursing home must ensure that:

(a) ((~~Each resident is assessed no less than once every three months, and~~)) As appropriate, the resident's assessment is revised to assure the continued accuracy of the assessment; and

(b) The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care under WAC 388-97-1020.

((~~(5)~~)) (4) The skilled nursing facility and nursing facility must:

(a) For the required assessment, complete the state approved resident assessment instrument (RAI) for each resident in accordance with federal requirements;

(b) Maintain electronic or paper copies of completed resident assessments in the resident's active medical record for fifteen months; this information must be maintained in a centralized location and be easily and readily accessible;

(c) Place the hard copies of the signature pages in the clinical record of each resident if a facility maintains their RAI data electronically and does not use electronic signatures;

(d) ((~~Assess each resident not less than every three months, using the state approved assessment instrument; and~~

~~(e)~~)) Transmit all state and federally required RAI information for each resident to the department((~~:~~

~~(i)~~)) in a manner and time period approved by the department((~~;~~

~~(ii) Within fourteen days of completion of any RAI assessment required under this subsection; and~~

~~(iii) Within fourteen days of discharging or admitting a resident for a tracking record~~)).

[Statutory Authority: Chapter 74.42 RCW and 42 C.F.R. 483.20. WSR 18-11-001, § 388-97-1000, filed 5/2/18, effective 6/2/18. Statutory Authority: Chapters 18.51 and 74.42 RCW. WSR 13-04-093, § 388-97-1000, filed 2/6/13, effective 3/9/13. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-1000, filed 9/24/08, effective 11/1/08.]

AMENDATORY SECTION (Amending WSR 08-20-062, filed 9/24/08, effective 11/1/08)

WAC 388-97-1020 Comprehensive plan of care. (1) The nursing home must develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.

(2) The comprehensive plan of care must:

(a) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under WAC 388-97-1060;

(b) Describe any services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment (refer to WAC 388-97-0300 and 388-97-0260;

(c) ((~~Be developed within seven days after completion of the comprehensive assessment;~~

~~(d)~~)) Be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents needs;

((~~(e)~~)) (d) Consist of an ongoing process which includes a meeting if desired by the resident or the resident's representative; and

((~~(f)~~)) (e) Include the ongoing participation of the resident to the fullest extent possible, the resident's family or the resident's surrogate decision maker.

(3) The nursing home must implement a plan of care to meet the immediate needs of newly admitted residents, prior to the completion of the comprehensive assessment and plan of care.

(4) The nursing home must:

(a) Follow the informed consent process with the resident as specified in WAC 388-97-0260, regarding the interdisciplinary team's plan of care recommendations;

(b) Respect the resident's right to decide plan of care goals and treatment choices, including acceptance or refusal of plan of care recommendations;

(c) Include in the interdisciplinary plan of care process:

(i) Staff members requested by the resident; and

(ii) Direct care staff who work most closely with the resident.

(d) Respect the resident's wishes regarding which individuals, if any, the resident wants to take part in resident plan of care functions;

(e) Provide reasonable advance notice to and reasonably accommodate the resident family members or other individuals the resident wishes to have attend, when scheduling plan of care meeting times; and

(f) Where for practical reasons any individuals significant to the plan of care process, including the resident, are unable to attend plan of care meetings, provide a method for such individuals to give timely input and recommendations.

(5) The nursing home must ensure that each comprehensive plan of care:

(a) Designates the discipline of the individuals responsible for carrying out the program; and

(b) Is reviewed at least quarterly by qualified staff, as part of the ongoing process of monitoring the resident's needs and preferences.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-1020, filed 9/24/08, effective 11/1/08.]

AMENDATORY SECTION (Amending WSR 15-18-026, filed 8/25/15, effective 9/25/15)

WAC 388-97-1915 PASRR requirements ((~~prior to admission of~~)) for new residents. ((~~Prior to every~~)) Within thirty days of admission ((~~of a new resident~~)), the nursing facility must:

(1) Complete a PASRR level I screening, or verify that a PASRR level I screening has been completed((~~, and deny admission until that screening has been completed~~)).

(2) Require a PASRR level II evaluation, or verify that a PASRR level II evaluation has been ((~~completed~~)) requested when the individual's PASRR level I screening indicates that the individual may have serious mental illness and/or intellectual disability or related condition((~~, and deny admission until that evaluation has been completed, unless all three of the following criteria apply and are documented in the PASRR level I screening:~~

~~(a) The individual is admitted directly from a hospital after receiving acute inpatient care;~~

~~(b) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and~~

~~(c) The individual's attending physician has certified that the individual is likely to require fewer than thirty days of nursing facility services~~)).

(3) ((~~Decline to admit any individual whose PASRR level II evaluation determines that he or she does not require nursing facility services or that a nursing facility placement is otherwise inappropriate.~~

~~(4)~~)) Coordinate with PASRR evaluators to the maximum extent practicable in order to avoid duplicative assessments and effort, and to ensure continuity of care for nursing facility residents with a serious mental illness and/or an intellectual disability or related condition.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. § 483.100-138. WSR 15-18-026, § 388-97-1915, filed 8/25/15, effective 9/25/15.]

AMENDATORY SECTION (Amending WSR 15-18-026, filed 8/25/15, effective 9/25/15)

WAC 388-97-1975 PASRR requirements after admission of a resident. ((~~Following~~)) After the thirtieth day of a resident's admission, the nursing facility must:

(1) Review all level I screening forms for accuracy. If at any time the facility finds that the previous level I screening was incomplete, erroneous or is no longer accurate, the facility must immediately complete a new screening using the department's standardized level I form, following the directions provided by the department's PASRR program. If the corrected level I screening identifies a possible serious mental illness or intellectual disability or related condition, the facility must notify DDA and/or the mental health PASRR evaluator so a level II evaluation can be conducted.

(2) Record the evidence of the level I screening and level II determinations (and any subsequent changes) in the resident assessment in accordance with the schedule required under WAC 388-97-1000.

(3) Maintain the level I form and the level II evaluation report in the resident's active clinical record.

(4) Immediately complete a level I screening using the department's standardized form if the facility discovers that a resident does not have a level I screening in his or her clinical record, following directions provided by the department's PASRR program. If the level I screening identifies a possible serious mental illness or intellectual disability or related condition, notify the DDA and/or mental health PASRR evaluator so a level II evaluation can be conducted.

(5) ((~~Notify the DDA and/or mental health PASRR evaluator when a resident who was admitted on an exempted hospital discharge appears likely to need nursing facility services for more than thirty days, so a level II evaluation can be performed. This notification must occur as soon as the nursing facility anticipates that the resident may require more than 30 days of nursing facility services, and no later than the twenty-fifth day after admission unless good cause is documented for later notification.~~

~~(6)~~)) Notify the DDA and/or mental health PASRR evaluator when a resident who was admitted with an advance categorical determination appears likely to need nursing facility services for longer than the period specified by DDA and/or the mental health PASRR evaluator, so that a full assessment of the individual's need for specialized services can be performed. This notification must occur as soon as the nursing facility anticipates that the resident will require more than the number of days of nursing facility services authorized for the specific advance categorical determination and no later than five days before expiration of the period (three days for protective services) unless good cause is documented for later notification.

((~~(7)~~)) (6) Immediately notify the DDA and/or mental health PASRR evaluator for a possible resident review when there has been a significant change in the physical or mental condition, as defined in WAC 388-97-1910, of any resident who has been determined to have a serious mental illness or intellectual disability or related condition. Complete a new level I screening for the significant change.

((~~(8)~~)) (7) Provide or arrange for the provision of any services recommended by a PASRR level II evaluator that are within the scope of nursing facility services. If the facility believes that the recommended service either cannot or should not be provided, the facility must document the reason(s) for not providing the service and communicate the reason(s) to the level II evaluator.

((~~(9)~~)) (8) Immediately complete a new level I screening using the department's standardized form if the facility finds that a resident, not previously determined to have a serious mental illness, develops symptoms of a serious mental illness, and refer the resident to the mental health PASRR evaluator for further evaluation.

((~~(10)~~)) (9) Provide services and interventions that complement, reinforce and are consistent with any specialized services recommended by the level II evaluator. The resident's plan of care must specify how the facility will integrate relevant activities to achieve this consistency and the enhancement of the PASRR goals.

((~~(11)~~)) (10) Discharge, in accordance with WAC 388-97-0120, any resident with a serious mental illness or intellectual disability or related condition who does not meet nursing facility level of care, unless the resident has continuously resided in the facility for at

least thirty months and requires specialized services. The nursing facility must cooperate with DDA and/or mental health PASRR evaluator as it prepares the resident for a safe and orderly discharge.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. § 483.100-138. WSR 15-18-026, § 388-97-1975, filed 8/25/15, effective 9/25/15.]

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-97-0920	Participation in resident and family groups.