388-97-0100 UTILIZATION REVIEW.

(1) To assure appropriate use of medicaid services, the nursing facility must determine whether each medicaid resident's health has improved sufficiently so the resident no longer needs nursing facility care.

(a) The nursing facility must base its determination on:

(i) An accurate, comprehensive assessment process; and

(ii) Documentation by the resident’s physician.

(b) The nursing facility is not responsible to assess under WAC 388-97-1960, PASSR level II screening assessment.

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 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) 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) Place copies of the completed state approved RAI in each resident’s clinical record, unless all charting is computerized;

(c) Maintain all copies of resident assessments completed within the resident’s active clinical record for fifteen months;

(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 approved by the department;

(ii) Within ten days of completion of any RAI required under this subsection; and

(iii) Within ten days of discharging or readmitting a resident.
388-97-1020 COMPREHENSIVE PLAN OF CARE.

(1) The nursing home must develop a comprehensive plan of care for each resident that

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

(f) 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

(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. 08-20-062, § 388-97-1020, filed 9/24/08, effective 11/1/08.]

388-97-1920 PREADMISSION SCREENING — LEVEL I.

(1) Preadmission screening (PAS) is a process by which individuals are evaluated:

(a) For the presence of a serious mental illness or a developmental disability, before admission to the nursing facility;

(b) For nursing facility level of care; and

(c) If the individual does have either a serious mental illness or a developmental disability, to determine whether there is a need for specialized services, or services of a lesser intensity.

(2) The referring hospital, physician, or other referral source must:

(a) Perform the identification screen using a standardized department-specified Level I screening form for all individuals seeking admission to a nursing facility unless they:

(i) Are being readmitted to the nursing facility from the hospital; or

(ii) Are being transferred from one nursing facility to another, with or without an intervening hospital stay.

(b) Identify whether the individual may have a serious mental illness or a developmental disability as defined under 42 C.F.R. § 483.102, or successor laws; and

(c) Refer all individuals identified as likely to have a serious mental illness or a developmental disability to the department for a nursing facility level of care assessment and a Level II screening.
388-97-1940 ADVANCED CATEGORICAL DETERMINATIONS, NOT SUBJECT TO PREADMISSION SCREENING — Level II.

Individuals identified as having symptoms of mental illness or a developmental disability and meeting any of the advanced categorical determinations do not need to be referred for a Level II screening. The determinations include that the individual:

(1) Is admitted to the nursing facility for respite care as defined under WAC 388-97-1880, or convalescent care, following treatment in an acute care hospital, not to exceed thirty days;

(2) Cannot accurately be diagnosed because of delirium. NOTE: The individual would be subject to a Level II screening when the delirium cleared;

(3) Has been certified by a physician to be terminally ill as defined under section 1861(dd)(3)(A) of the Social Security Act;

(4) Has been diagnosed with a severe physical illness such as coma, ventilator dependence, and is functioning at a brain stem level;

(5) Has a severe level of impairment from diagnoses such as:
   (a) Chronic obstructive pulmonary disease;
   (b) Parkinson's disease;
   (c) Huntington's chorea;
   (d) Amyotrophic lateral sclerosis;
   € Congestive heart failure; or

(6) Has a primary diagnosis of dementia, including Alzheimer's disease or a related disorder. NOTE: There must be evidence to support this determination.

388-97-1960 PREADMISSION SCREENING — LEVEL II.

For individuals likely to have a serious mental illness or developmental disability, the department must determine their need for nursing facility level of care. If they meet the nursing facility level of care, the department refers them to the department's designee, either the mental health PASRR contractor or the division of developmental disabilities, for a Level II screening.

In the Level II screening, the department's designee will verify the diagnosis and determine whether the referred individuals need specialized services, or services of a lesser intensity:
"Specialized services" for an individual with mental retardation or related conditions is defined under 42 C.F.R. § 483.120 (a)(2), and 42 C.F.R. § 483.440 (a)(1), or successor laws. These specialized services do not include services to maintain a generally independent individual able to function with little supervision or in the absence of a treatment program; and

"Specialized services" for an individual with a serious mental illness is defined under 42 C.F.R. § 483.120 (a)(1), or successor laws. These services are generally considered acute psychiatric inpatient care, emergency respite care, or stabilization and crisis services.

The need for specialized services, for a nursing facility applicant, will be determined as follows:

If the individual is identified as likely to have a serious mental illness, a qualified mental health professional will verify whether the individual has a serious mental illness and, if so, will recommend whether the individual needs specialized services; and

If the individual is identified as likely to have a developmental disability, a licensed psychologist will verify whether the individual has a developmental disability and, if so, staff of the division of developmental disabilities will assess and determine whether the individual requires specialized services.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97]

388-97-1980 RESIDENT REVIEW.

After a resident’s admission the nursing facility must:

Review the Level I screening form for accuracy and make changes as needed if the resident develops a qualifying diagnosis or if the resident’s symptoms were undetected or misdiagnosed;

Refer residents who have qualifying diagnoses and who require further PASRR assessment to the mental health PASRR contractor or division of development disabilities;

Record the identification screen information or subsequent changes on the resident assessment instrument according to the schedule required under 42 C.F.R. § 483.20;

Maintain the identification screen form and PASRR assessment information, including recommendations, in the resident’s active clinical record; and

Promptly notify the mental health PASRR contractor or division of developmental disabilities after a significant change in the physical or mental condition of any resident that is mentally ill or mentally retarded.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-971980, filed 9/24/08, effective 11/1/08.]
388-97-2000 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) DETERMINATION AND APPEAL RIGHTS.

(1) The resident has the right to choose to remain in the nursing facility and receive specialized services if:

   (a) He or she has continuously resided in a nursing facility since October 1, 1987; and

   (b) The department determined, in 1990, that the resident required specialized services for a serious mental illness or developmental disability but did not require nursing facility services.

(2) In the event that residents chose to remain in the nursing facility as outlined in subsection (1) above, the department, or designee, will clarify the effect on eligibility for medicaid services under the state plan if the resident chooses to leave the facility, including its effect on readmission to the facility.

(3) An individual applying for admission to a nursing facility or a nursing facility resident who has been adversely impacted by a PASRR determination may appeal the department’s determination that the individual is:

   (a) Not in need of nursing facility care as defined under WAC 388-106-0350 through 388-106-0360;

Not in need of specialized services as defined under WAC 388-97-1960; or

Need for specialized services as defined under WAC 388-97-1960.

(4) The nursing facility must assist the individual applying for admission or resident, as needed, in requesting a hearing to appeal the department’s PASRR determination.

(5) If the department’s PASRR determination requires that a resident be transferred or discharged, the department will:

   (a) Provide the required notice of transfer or discharge to the resident, the resident’s surrogate decision maker, and if appropriate, a family member or the resident’s representative thirty days or more before the date of transfer or discharge;

   (b) Attach a hearing request form to the transfer or discharge notice;

   (c) Inform the resident, in writing in a language and manner the resident can understand, that:

      (i) An appeal request may be made any time up to ninety days from the date the resident receives the notice of transfer or discharge;

      (ii) Transfer or discharge will be suspended when an appeal request is received by the office of administrative hearings on or before the date of transfer or discharge set forth in the written transfer or discharge notice; and

      (iii) The resident will be ineligible for medicaid nursing facility payment:
(A) Thirty days after the receipt of written notice of transfer or discharge; or

(B) If the resident appeals under subsection (1)(a) of this section, thirty days after the final order is entered upholding the department's decision to transfer or discharge a resident.

(6) The department's home and community services may pay for the resident's nursing facility services after the time specified in subsection (5)(c)(iii) of this section, if the department

(7) The department will:

(a) Send a copy of the transfer/discharge notice to the resident's attending physician, the nursing facility and, where appropriate, a family member or the resident's representative;

(b) Suspend transfer or discharge:

(i) If the office of administrative hearings receives an appeal on or before the date set for transfer or discharge or before the resident is actually transferred or discharged; and

(ii) Until the office of appeals makes a determination; and

(c) Provide assistance to the resident for relocation necessitated by the department's PASRR determination.

(8) Resident appeals of PASRR determinations will be in accordance with 42 C.F.R. § 431 Subpart E, chapter 388-02 WAC, and the procedures defined in this section. In the event of a conflict between a provision in this chapter and a provision in chapter 388-02 WAC, the provision in this chapter will prevail.

[Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-2000, filed 9/24/08, effective 11/1/08.]

74.42.140 PRESCRIBED PLAN OF CARE — TREATMENT, MEDICATION, DIET SERVICES.
The facility shall care for residents by providing residents with authorized medical services which shall include treatment, medication, and diet services, and any other services contained in the comprehensive plan of care or otherwise prescribed by the attending physician.

[1979 ex.s. c 211 § 14.]

74.42.150 PLAN OF CARE — GOALS — PROGRAM — RESPONSIBILITIES — REVIEW.

(1) Under the attending physician's instructions, qualified facility staff will establish and maintain a comprehensive plan of care for each resident which shall be kept on file by the facility and be evaluated through review and assessment by the department. The comprehensive plan
contains:

(a) Goals for each resident to accomplish;

(b) An integrated program of treatment, therapies and activities to help each resident achieve those goals; and

(c) The persons responsible for carrying out the programs in the plan.

(2) Qualified facility staff shall review the comprehensive plan of care at least quarterly.

[1980 c 184 § 7; 1979 ex.s. c 211 § 15.]