| Attachment D |
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|  | AGING AND LONG-TERM SUPPORTADMINISTRATION (ALTSA)**State Task Checklist**For use during Recertification Surveys of Nursing Homes | FACILITY NAME |
| ENTRY DATE |
| **Instructions:** Enter surveyor initials and date in the first column when each state task is completed. Mark a check box to indicate if failed practice was found in the second column. Document on the corresponding forms or on Surveyor Notes Worksheets (CMS-807) if needed. Print your name in the Surveyor Signature Legend area to identify your initials. Turn in all forms and related documents to the Team Coordinator. |
| SURVEYOR INITIALS / DATE | FAILED PRACTICE | TASK |
| YES | NO |
|   |  | State Task Entrance Letter provided to Administrator at the Entrance Conference (Attachment C – State Entrance Conference Letter). Upon entrance, request a copy of any State Waivers. |
|   | Document any current state waivers granted to the facility: [ ]  None.[ ]  The facility has the following waivers:  |
|   | Document the name of the current Administrator and Director of Nursing.Administrator Name: Director of Nursing Name:  |
|   | [ ]  | [ ]  | Incident Reporting log(s) review. (WAC 388-97-0640 and “The Purple Book.”) |
|   | [ ]  | [ ]  | Prior 30-day staffing information reviewed and verified (Attachment E – Staffing Pattern). (WAC 388-97-1080) |
|   | [ ]  | [ ]  | Medical Test Site Waiver(s) review. (RCW 740.42.030)Expiration date:   |
|   | [ ]  | [ ]  | Certificate of Liability Insurance review (Attachment F – Liability Insurance Review). (WAC 388-97-4166 through 388-97-4168) |
|   | [ ]  | [ ]  | Trust Fund review. (Attachment G – Trust Fund). (WAC 388-97-0340) |
|   | [ ]  | [ ]  | Nursing Assistant Training Program review. Mark N/A if there has not been an active training program in the past 12 months or if the facility does not have an approved program. Fill out DSHS Form 16-168 OBRA NA Training Onsite Inspection Form for Survey (NATCEP). (WAC 246-842) |
|  [ ]  N/A |
|   | [ ]  | [ ]  | Paid Feeding Assistant Training Program review (Attachment J – Paid Feed Assistant Program Review). Mark N/A if there is not a Paid Feeding Assistant program. (F811; RCS MB R13-035) |
|  [ ]  N/A |
|   | [ ]  | [ ]  | Call Bell Visible AND Audible. (WAC 388-97-2280) |
|   | [ ]  | [ ]  | Dementia Care Unit Egress Signage. Mark N/A if there is not a Dementia Care Unit. (WAC 388-97-2920) |
|  [ ]  N/A |
|   | [ ]  | [ ]  | Fresh fruit / vegetables available daily. (WAC 388-97-1120) |
| SURVEYOR INITIALS / DATE | FAILED PRACTICE | TASK |
| YES | NO |
|   | [ ]  | [ ]  | Staff Qualification and Background Review (Attachment L – Staff Qualification and Background Review). (WAC 388-97-1790 through 388-97-1820)  |
|   | [ ]  | [ ]  | TB Testing Review for Staff (Attachment M – TB Testing Review for Staff). (WAC 388-97-1360 through 388-97-1600) |
|   | [ ]  | [ ]  | TB Testing Review for Residents (Attachment N – TB Testing Review for Residents). (WAC 388-97-1360 through 388-97-1600) |
|   | [ ]  | [ ]  | Pet Record review (Attachment H – Pet Record Review). (WAC 388-97-0980) |
|   | [ ]  | [ ]  | Medication Assistant Endorsement (Attachment O – Medication Assistant Endorsement). Mark N/A if there are no NA-Cs in the facility with a Medication Assistant Endorsement utilized as a medication assistant. (WAC 246-841-586 through 246-841-595) |
|  [ ]  N/A |
| **Surveyor Signature Legend (for those surveyors completing state tasks)** |
| INITIALS | NAME (PLEASE PRINT) |
|  |  |
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|  |  |
|  |  |
| TEAM COORDINATOR’S NAME COMPLETION DATE |