

SURVEY REQUIREMENTS FOR STATE VETERANS HOMES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy for surveying State Veterans Homes (SVH) that provide any of three levels of care: nursing home care, domiciliary care and/or adult day health care.

2. SUMMARY OF MAJOR CHANGES: This VHA directive:

a. Updates national requirements for surveying SVH due to new Federal regulations, that include domiciliary care as well as the elimination of formal recommendations to obtain a “Met” survey rating. Formal recommendations now must be written as a citation, all deficiencies found on survey must be marked as “Not Met” (see paragraph 5.k.(6)).

b. Adds provisions to enhance oversight (see paragraph 5).

c. Provides that newly designated SVH Veterans Integrated Services Network (VISN) Liaisons and SVH Department of Veterans Affairs (VA) medical facility Representatives must receive training on the use of SVH survey software, including the State Home Online Survey Tool (SHOST) (see paragraph 12).

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Geriatrics and Extended Care (GEC) (12GEC) within the Office of Patient Care Services is responsible for the contents of this directive. Questions may be referred to 202-461-6750.

5. RESCISSIONS: VHA Directive 1145.01, Survey Procedures for State Veterans Homes (SVH) Providing Nursing Home Care and/or Adult Day Health Care, dated November 2, 2016, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA, RN
Assistant Under Secretary for Health
for Patient Care Services

February 18, 2021

VHA DIRECTIVE 1145.01

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NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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SURVEY REQUIREMENTS FOR STATE VETERANS HOMES

1. PURPOSE

This Veterans Health Administration (VHA) directive provides requirements to the field for administration, oversight and processing Recognition, Annual, and For-Cause Surveys of State Veterans Homes (SVH) providing nursing home care, domiciliary care, or adult day health care. **AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 1710, 1720, 1741-1745, 8131-8138; Title 38 Code of Federal Regulations (C.F.R.) Part 51.

2. BACKGROUND

a. SVH across the United States provide nursing home care, domiciliary care and/or adult day health care. The State receives a per diem payment from the Department of Veterans Affairs (VA) for providing care to eligible Veterans when VA recognizes the home as a SVH. In addition, VA's survey and certification process is required for the SVH that provides nursing home care, domiciliary care and/or adult day health care to continue to receive per diem payments. The State owns, operates and manages all SVH. VA is required to survey SVH to ensure the homes meet VA standards to be eligible for continued per diem payments.

b. VA identified the need to standardize the national survey process in 2007, which resulted in VA contracting with a private vendor to review clinical and life safety standards. VA staff employees are responsible for conducting the administrative and fiscal audit portions of the survey assigned to them by VA Central Office (VACO). In addition, VA has a maintenance and support contract with a vendor to assist in all aspects of the electronic software program utilized to complete all SVH surveys.

c. The goals of this SVH survey policy are to ensure SVH are performing according to VA regulations and to ensure eligible Veterans are receiving the best quality of care and safety. This directive provides policy and a standardized approach for the following:

- (1) VHA policies and procedures for Recognition, Annual and For-Cause Surveys;
- (2) The communication and relationships between VACO, Veteran Integrated Services Networks (VISNs), VA medical facilities of jurisdiction, SVH and the VA Survey Team;
- (3) Full utilization of defined VA standards for long-term care support and services;
- (4) Expectations of VHA leadership, VISN and field staff employees in assessment of proper care and safety for Veterans in a SVH; and
- (5) Full operation of the SVH survey electronic system.

3. DEFINITIONS

a. **Abatement Plan.** An abatement plan is a corrective action plan (CAP) presented and approved by the VA Survey Team at the SVH before departure of the VA Survey Team from the SVH to show that any deficiency cited as Immediate Jeopardy (IJ) has been corrected.

b. **Adverse Event.** For purposes of this directive, adverse events are events that occur in SVH, not determined to be a sentinel events, but reportable to public health agencies pursuant to State regulations.

c. **Anniversary Month.** The anniversary month is the month of determination for the recognition and certification of a SVH by VA. This month can change with another recognition survey or a written agreement between officials of the SVH and the Director, VA medical facility of jurisdiction, and approval by the Office of Geriatrics and Extended Care (GEC).

d. **Certification.** The Director of the VA medical facility of jurisdiction will certify a SVH based on a survey conducted at least once every 270-450 calendar days at VA's discretion, and will notify the State official authorized to oversee operations of the SVH of the decision regarding certification. A SVH must be certified no later than 450 calendar days after the home is recognized. Certifications expire 600 calendar days after the date of their issuance.

e. **Corrective Action Plan.** A CAP clearly addresses a cited deficiency. It states specific interventions to correct the non-compliance(s) with target dates for remediation; identifies trends and patterns; considers core causes; and includes a plan to monitor effectiveness over time. A CAP is required for any standard rated as "Not Met."

f. **Immediate Jeopardy.** An IJ is a situation in which the SVH's non-compliance with one or more Federal regulations has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. This includes any condition that poses an immediate threat to public or patient safety.

g. **Per Diem.** Per diem is the daily rate of reimbursement for care that SVH provide to eligible Veterans, established by VA for each SVH program of care.

h. **Scope and Severity Matrix.** The scope and severity matrix is a tool developed by the Centers for Medicaid and Medicare Services (CMS) which VA has adapted to assess the scope of a deficiency (e.g., whether the deficiency was isolated to one person or was widespread), and the severity of the deficiency (e.g., whether an individual suffered injury, harm, impairment or death). **NOTE:** *The CMS Program Scoring Algorithm can be found at: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-05.pdf>.*

i. **Sentinel Event.** For the purposes of this directive, a sentinel event is an adverse event that results in the loss of life, limb or permanent loss of function as outlined in 38 C.F.R. Part 51.

j. **State Home Online Survey Tool.** The State Home Online Survey Tool (SHOST) is a VA web-based tool used to create, score, store, complete and analyze all survey data that will improve the efficiency and utilization of VA medical facility staff, SVH VISN liaisons and GEC staff involved in the oversight of the nationwide SVH program. This software automates the survey process and makes information available in a more timely and efficient manner.

k. **State Official.** State official refers to the personnel of the State agency responsible for the SVH.

l. **Standard Survey.** A standard survey is a periodic, resident-centered inspection that gathers information about the quality of service furnished in a SVH to determine compliance with the requirements for participation. In the SHOST, this is called a State survey, as the survey is performed by the State to ascertain if a SVH meets the requirements for participation in the CMS program. The State survey evaluates performance and the provision of safe, quality care and quality of life.

m. **State Veterans Home.** SVH means a home, approved by VA, which a State has established primarily for the care of Veterans disabled by age, disease or otherwise, who by reason of such disability are incapable of earning a living. A SVH may provide nursing home care, domiciliary care and/or adult day health care. A SVH is owned and operated by the State.

n. **VA-Administered Survey Types.**

(1) **Recognition Survey.** A Recognition Survey is an announced survey of a SVH that is used to determine its compliance with VA standards, including compliance with all applicable Federal, State and local laws, and the relevant professional standards for VA purposes to recognize the home as a SVH.

(2) **Annual Survey.** An Annual Survey is an unannounced survey performed yearly to determine a SVH's compliance with VA standards to achieve certification in order for the SVH to receive continued per diem payments.

(3) **For-Cause Survey.** A For-Cause Survey is an unannounced survey authorized by GEC to review a major, significant concern; a trend or a series of incidents; or complaints, deficiencies or events that may jeopardize the health or safety of residents.

4. POLICY

It is VHA policy that all SVH are surveyed in accordance with Federal regulations and timelines. The purpose of the surveys is to establish standardized external review procedures in alignment with industry standards, applicable to the survey process for State homes that provide nursing home care, domiciliary care or adult day health care to eligible Veterans. The survey process represents VHA's oversight responsibility to ensure the health and well-being of Veterans in each SVH.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Ensuring overall VHA compliance with this directive.

(2) Making a written determination to recognize a home as a SVH based on a current survey that the home and its management meet all the standards of 38 C.F.R. Part 51 (see paragraph 6.I.)

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for supporting GEC with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the VISNs.

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

d. **Executive Director, Geriatrics and Extended Care.** The Executive Director of GEC is responsible for:

(1) Providing oversight for VISN and VA medical facility compliance with this directive and ensuring corrective action is taken if non-compliance has been identified.

(2) Developing and recertifying national VHA policy for SVH.

(3) Responding to a State's request letter requesting recognition notifying them of survey and the necessary required documents in seeking the Under Secretary for Health's recognition.

(4) Once a SVH has been recognized by VA, ensuring the SVH is properly surveyed at least annually in accordance with the requirements, timelines and certification given by the VA medical facility Director, as appropriate.

(5) Receipt and recording of State written notice per 38 C.F.R. Part 51, Subpart D 51.210(b) of individuals responsible for oversight of a SVH home including: the SVH Administrator; the Director of nursing services (or other individual in charge of nursing services); and the State employee responsible for oversight of a SVH if a contractor operates the SVH.

e. **National Director, Facility Based Care Programs.** The National Director of Facility Based Care (FBC) in GEC is responsible for:

- (1) Managing the SVH survey process for VA.
- (2) Promoting SVH program development in the field through operational guidance, support, email groups, conference calls and educational programs.
- (3) Providing survey oversight for the SVH program.
- (4) Coordinating and scheduling Recognition Surveys.
- (5) Communicating with State officials and SVH Administrators regarding VA's requirements for participation in the SVH program and the survey process.
- (6) Communicating with the Director, VA medical facility of jurisdiction, regarding their responsibilities for the SVH survey process as specified in this directive.
- (7) Providing recognition checklists of necessary items to the SVH VA medical facility representative in advance with orientation and education on the processes (see paragraphs 6.g., 6.o.)
- (8) Providing the SVH VA designated representatives a copy of the recognition letter signed by the Under Secretary for Health via email.
- (9) Reviewing and providing comments, as necessary to the VA Survey Team, for all survey reports.
- (10) Authorizing Recognition and For-Cause Surveys, reviewing deficiencies and providing guidance on an appropriate action to the VA medical facility.
- (11) Ensuring oversight of all the contractors who conduct SVH surveys, including the quarterly observational surveys of a contractor's performance and the accuracy of the contractor's findings at each SVH. This includes providing quarterly oversight, including on-site survey observation of contractor surveyor performance with documentation and necessary action or feedback to the vendor.
- (12) Providing national analyses and summaries semi-annually of the survey deficiencies for State officials.
- (13) Appointing the Contact Officer Representative (COR) for the national clinical and life safety survey contract.
- (14) Overseeing program management of maintenance, technical support and provisions of the SHOST, and providing guidance, as necessary, along with monthly training to the SVH VISN liaisons and SVH VA medical facility representatives on utilization of the SHOST software.

(15) Providing guidance, training on the survey process and clarification to the field regarding the SVH program via daily emails and monthly national calls.

(16) Notifying the designated SVH VISN liaison and the designated SVH VA medical facility representative of the scheduled date(s) for all surveys and providing contact information for the contracted vendor that will assist in conducting the survey a month in advance; emailing the SVH VISN liaison, SVH VA medical facility representative and SVH VA fiscal representatives that the scheduled survey dates have been placed on the SVH SharePoint site.

(17) Conducting two-way communication with SVH VISN liaisons and designated SVH VA medical facility representatives.

(18) Receiving and processing SVH disputes, which can come from any SVH Administrator, and implementing the Informal Dispute Resolution process as outlined in the standard operating procedure on the GEC SharePoint site.

(19) Receiving, reviewing, documenting and analyzing all SVH reported adverse events and sentinel events reported to the VA medical facility Director of jurisdiction, whereby the VA medical facility Director creates an Issue Briefs (IBs) to GEC. GEC requests clarification or action from the VA medical facility Director on any reported event.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and that appropriate corrective action is taken if non-compliance has been identified.

(2) Administering the SVH program within the VISN in accordance with established VHA national policies, procedures and timelines.

(3) Appointing a SVH VISN liaison to perform the duties listed under the SVH VISN liaison (see paragraph 5.g.). When appointing this position, the VISN Director must ensure that the SVH VISN liaison has the knowledge, skills and abilities in external review procedures and performance improvement.

(4) Meeting with the SVH VISN liaisons to ensure awareness of any issues at the SVH.

(5) Submitting IBs to the 10N tracker using the current IB format (see paragraph 10).

(6) Ensuring the suffix code request to VHA Finance is completed when a new SVH is recognized by a signed letter from the Under Secretary for Health.

g. **State Veteran Home Veterans Integrated Services Network Liaison.** The SVH VISN Liaison is responsible for:

- (1) Managing the SVH program within the VISN.
- (2) Serving as the main intermediary between the SVH VA medical facility representative, SVH VA fiscal representative and GEC.
- (3) Communicating sentinel events at a SVH according to Federal regulations and contacting the SVH, as needed, for additional or clarifying information regarding a sentinel event.
- (4) Reviewing IBs for completeness and requesting additional information from the VA medical facility Director, if necessary.
- (5) Serving as the point of contact for the survey process, survey deficiencies, managing all survey-related problems, training, follow-up and all activities pertaining to the SVH program in the VISN.
- (6) Informing and ensuring that both the SVH VA medical facility representative and the SVH VA fiscal representative participate and are physically present the first day of the survey and remain present during the survey until their assessment is complete with a report to the SVH leadership before exiting.
- (7) Reviewing the Annual Survey reports and CAPs submitted for any survey conducted by the VA Survey Team in the SHOST no later than 14 days after it is entered.
- (8) Attending monthly national SVH conference calls, the semi-annual VISN and VA Central Office (VACO) calls to review the SVH survey scorecard, barriers, CAPs and educational needs.
- (9) Ensuring the national mail groups and listings are kept current with SVH VA medical facility points of contact and notifying GEC when there are any changes or updates.
- (10) Collaborating with the VISN Business Office for per diem-related issues as appropriate.
- (11) Providing a mechanism for sharing information between the SVH VA medical facility representatives and SVH VA fiscal representatives within the VISN (e.g., mail groups, conference calls and face-to-face meetings).
- (12) Ensuring SVH VA medical facility representatives are tracking the submission of documents at completion of surveys until certification is granted by the Director, VA medical facility of jurisdiction (see paragraph 5.h.(14)).
- (13) Monitoring trends in survey results by individual SVH as well as aggregate results for the SVH in the VISN annually to the Executive Leadership Council.

(14) Promoting positive relationships between the SVH administration, contracted survey staff, maintenance and support contracted vendors and SVH VA medical facility representatives.

(15) Communicating with GEC for guidance regarding survey results, trends or concerns.

(16) Serving as an educational resource for VA medical facility staff employees in the VISN regarding the SVH program.

(17) Completing the annual TMS training for the SVH VA medical facility representative and the SVH VA fiscal representative. TMS modules must be completed before the first survey of the calendar year (see paragraph 12).

(18) Maintaining annual TMS competency training records completed by the SVH VA medical facility representatives and SVH VA fiscal representatives and ensuring dates of completion are recorded in the SHOST.

(19) Providing guidance to the SVH VA medical facility representative(s) and SVH VA fiscal representative(s); and effectively communicating with State officials and GEC staff employees.

h. **VA Medical Facility Director.** The Director, VA medical facility of jurisdiction, provides oversight for the VA medical facility SVH program and is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive and that appropriate corrective action is taken if non-compliance has been identified.

(2) Appointing a VA employee to serve as the SVH VA medical facility representative to perform the duties listed under SVH VA medical facility representative (see paragraph 5.i.).

(3) Appointing a VA employee to serve as the SVH VA fiscal representative to conduct the SVH survey related to assigned fiscal standards and accounting principles and ensuring the appointed VA employee physically attends the survey with the VA Survey Team on day one of the survey; remains on site during the survey and performs all associated steps to complete the process (see paragraph 5.j.).

(4) Notifying GEC and the SVH liaison in writing when there is a change in either the SVH VA medical facility representative or the SVH VA fiscal representative.

(5) Ensuring annual TMS competency training is completed by the SVH VA medical facility representative and SVH VA fiscal representative before the first survey of the calendar year and validating completion with course certificate (see paragraph 12).

(6) Meeting with the SVH VA medical facility representative and SVH VA fiscal representative, as necessary, to ensure awareness of any issues at the SVH.

(7) Ensuring that at least one person has awareness of all contracts, sharing agreements, Memoranda of Understanding and Telehealth Service Agreements between the SVH and the VA medical facility.

(8) Communicating with the SVH VISN liaison on matters concerning the SVH.

(9) Approving and submitting IBs to the VISN Director per the current IB format (see paragraph 10).

(10) Reporting SVH sentinel events and adverse events to the VISN Director by creating an IB. Sentinel events must be reported within 24 hours of identification per Federal regulation. The VISN Director enters SVH IB into the 10N Tracker (see paragraph 5.f.(5)).

(11) Reviewing all survey reports and CAPs to confirm compliance with VA standards prior to granting and signing any letter of certification to the SVH.

(12) Signing an appointment/entrance letter to be presented to the SVH Administrator on the first day the VA Survey Team enters the building for all survey processes (see paragraphs 6.d., 7.d. and 8.c.).

(13) Sending a letter with a copy of the completed survey report from the SHOST to SVH management in 20 business days from the last day of the on-site survey for all survey processes (see paragraphs 6.k., 7.l. and 8.k.).

(14) Annually providing written certification to a SVH for a full certification if the survey had no deficiencies or a provisional certification when the CAP is accepted. This is followed by a full certification when the SVH has completed the submitted CAP with evidence to demonstrate that they are fully compliant with applicable Federal regulations.

(15) Preparing the suffix code request to VHA Finance through the VISN Director when a new SVH is recognized by a signed letter from the Under Secretary for Health.

i. **SVH VA Medical Facility Representative.** The SVH VA medical facility representative is designated by the Director, VA medical facility of jurisdiction, and is responsible for:

(1) Managing the SVH program at the VA medical facility level.

(2) Completing the annual TMS competency training for the SVH VA medical facility representative before the first survey of the calendar year and submitting a copy of the certificate of completion to the SVH VISN liaison (see paragraph 12).

(3) Coordinating communication between SVH management, contracted vendors, Director, VA medical facility of jurisdiction, SVH VA fiscal representative, SVH VISN liaison and GEC.

(4) Acting as the VA Co-Team Lead during each survey and overseeing the process for Recognition, Annual and For-Cause Surveys by performing the following duties:

(a) Preparing and obtaining a signed appointment/entrance letter from the Director, VA medical facility of jurisdiction's signature to be presented to the SVH Administrator on the first day of the survey when entering the building (see paragraphs 6.d., 7.d. and 8.c.).

(b) Co-leading the entrance, daily and exit conferences during the survey.

(c) Remaining at the SVH for the duration of all surveys to include any IJ situations until fully abated.

(d) Conducting the administrative standards review, which includes obtaining all required and signed VA forms, including the completed VA Form 10-3567, State Home Inspection – Staffing Profile.

(e) Reporting survey updates to the SVH VA fiscal representative, Director, VA medical facility of jurisdiction, and the SVH VISN liaison.

(f) Creating, scoring, storing and processing the survey report with required attachments using the SHOST.

(g) Entering all CAP information required into SHOST located on the web.

(h) Entering the staffing profile data in the SHOST.

(i) Completing the recognition checklist received by the National Director of Facility Based Programs in its entirety. The recognition checklist and package must be submitted through the SVH VISN liaison to GEC within 20 business days from the last day of the survey (see paragraphs 6.g., 6.o.).

(j) Responding to inquiries from SVH management and referring SVH management to the appropriate VA office for assistance.

(k) Assisting the SVH, SVH VISN liaison and GEC, as requested.

(l) Immediately notifying the Director, VA medical facility of jurisdiction, and SVH VISN liaison that a sentinel event, negative publicity or any situation resulting in immediate jeopardy (IJ) to residents' health or safety has occurred. This includes preparing and submitting the IB to the appropriate level, clarifying any questions and continuing to update the SVH VISN liaison until resolution.

(m) Serving as an educational resource for VA medical facility staff employees and SVH staff employees regarding the SVH program.

j. **SVH VA Fiscal Representative.** The SVH VA fiscal representative is designated by the Director, VA medical facility of jurisdiction, and is responsible for:

(1) Possessing the knowledge, skills and ability to perform external reviews; interpret regulations and laws; assess CAPs; and to communicate with SVH leadership, contractors and the entire VA Survey Team.

(2) Completing the annual TMS competency training for the SVH VA fiscal representative before the first survey of the calendar year and submitting a copy of the certificate of completion to the SVH VISN liaison (see paragraph 12).

(3) Communicating, collaborating and participating with the SVH VA medical facility representative in all surveys to include physically attending the survey with the VA Survey Team on day one of the survey and remaining at the survey site until completion of all assigned fiscal standards.

(4) Conducting a review of the assigned fiscal standards to include any fiscal audit and reconciliation of records.

(5) Reporting a verbal summary to the SVH management at the daily exit conference if the Fiscal Representative completes all their assigned standards prior to the end of a survey.

(6) Providing a verbal summary of all their fiscal findings based on the standards to the SVH management team at the close of the survey during the exit conference.

(7) Completing the fiscal survey summary template located on the SVH SharePoint site of any deficiencies to the SVH VA medical facility representative within 5 business days from the last date of the survey.

(8) Remaining at the SVH if an IJ situation is identified until fully abated.

k. **VA Survey Team.** The SVH VA medical facility representative acts as the Co-Team Lead of the VA Survey Team (see paragraph 5.i.). The second Co-Team Lead is one of the contracted surveyors. The VA Survey Team is responsible for:

(1) Being on site within 15 business days after official notification is made by GEC to the VA medical facility of jurisdiction for a For-Cause Survey (see paragraph 8).

(2) Being on site within 10 business days of the receipt of request, or a specific date requested by a SVH for a Recognition Survey (see paragraph 6 and 7).

(3) Being on site for an Annual Survey according to the monthly survey schedule posted to the SVH SharePoint site by GEC.

(4) Conducting an entrance conference at the time of arrival at the SVH, as well as daily and exit conferences with SVH management and staff employees, as appropriate. (see paragraphs 6, 7 and 8).

(5) Conducting Annual, For-Cause and Recognition Surveys according to the requirements of this directive (see paragraphs 6, 7 and 8).

(6) Ensuring that all failures to meet the quality standards identified by the VA Survey Team will be cited as deficiencies during the SVH surveys. Formal recommendations now must be written as a citation, all deficiencies found on survey must be marked a “Not Met.”

6. RECOGNITION SURVEY PROCESS

a. A Recognition Survey is required when a SVH seeks to become eligible for VA per diem payments. The Recognition Survey is conducted to review policies, procedures, processes, staffing patterns, life safety and all other requirements of the appropriate level of care standards. This survey type is a pass/fail survey with an option to appeal the decision.

b. To begin the recognition process, the State sends a written request for recognition, bed numbers and level of care signed by the authorizing State official to GEC. GEC then notifies the Director, VA medical facility of jurisdiction, of the recognition application and requests the appointment of a SVH VA medical facility representative and a SVH VA fiscal representative, if one has not yet been assigned.

c. After receipt of a letter requesting recognition, VA will survey the home in accordance with 38 C.F.R. 51.31 to determine whether the home and program of care meet the applicable requirements of 38 C.F.R. Part 51, Subpart C, and the applicable standards in Subparts D, E or F of this part. For purposes of the recognition process, including the survey, references to SVH in the standards apply to homes that are being considered by VA for recognition as SVH. The Recognition Survey is an announced survey of a SVH. GEC sends written notification to the State of which documents must be available and presented at time of the survey along with the electronic link to the Federal regulations.

d. The SVH VA medical facility representative prepares and presents a signed appointment/entrance letter by the Director, VA medical facility of jurisdiction, to the SVH Administrator on the first day of the survey. The SVH VA medical facility representative provides the team the previous VA survey report if the SVH failed the previous survey. The contracted vendor is responsible for obtaining the State report and State quality indicator report, if applicable, before starting the survey.

e. The VA Survey Team will conduct an entrance conference at the time of arrival at the SVH, as well as daily, and will conduct exit conferences with SVH management and staff employees, as appropriate.

f. The entrance conference provides the opportunity for the VA Survey Team and SVH to discuss the scope and schedule for the survey. Entrance conferences must be scheduled at a mutually agreeable time. At the meeting, the VA Survey Team must outline survey objectives, survey time schedules and the process of reporting. The SVH must designate a member of their staff as the primary contact person for the VA Survey Team questions and assistance. Any areas of concern for the SVH must be brought up

at this stage. Daily exit conferences must discuss any developing deficiencies or areas of concern. Final exit conferences inform the SVH if they have passed or failed.

g. Throughout the remainder of the Recognition Survey process, the SVH Administrator will present the documentation required for recognition to the Director, VA medical facility of jurisdiction. A Recognition Survey checklist of necessary items is provided to the SVH VA medical facility representative in advance with orientation and education on the processes by the National Director of Facility Based Programs.

h. A Recognition Survey generally occurs after the original construction or renovations to a SVH are complete. VA will not conduct a Recognition Survey unless the required minimum requirements are met. For nursing homes and domiciliaries, the State home must have at least 20 residents or a number of residents consisting of at least 50% of the resident capacity. For adult day health care programs, the program must have at least ten participants or a number of participants consisting of at least 50% of the participant capacity of the program.

i. The Recognition Survey is performed within 10 business days of authorization by GEC, or at a specific requested time by the SVH.

j. Any surveyor on the VA Survey Team may identify a deficiency against a standard. This requires the surveyor who identified the deficiency to provide a written description of the deficiency to include the condition that exists and a scope and severity rating. An initial rating of the deficiency must be provided on the "Survey Findings" Microsoft Word document or survey report and be given to the SVH VA medical facility representative to electronically score and add into the final survey report.

k. The Director, VA medical facility of jurisdiction, sends a letter with a copy of the completed survey report from the SHOST to SVH management in 20 business days from the last day of the on-site survey.

l. If the survey report indicates that the SVH does meet the standards, the Director, VA medical facility of jurisdiction, sends a letter addressed to the Under Secretary for Health through the VISN Director and GEC, recommending whether, based on the survey, the SVH and SVH management meet the standards in 38 C.F.R. Part 51.

m. If the survey report indicates that the SVH does not meet the standard(s), the Director, VA medical facility of jurisdiction, notifies GEC through the SVH VISN liaison. If the Director, VA medical facility of jurisdiction, recommends that the SVH or SVH management does not meet a standard(s) of 38 C.F.R. Part 51, the SVH is notified in writing of the standard(s) "Not Met." The Director, VA medical facility of jurisdiction, sends a copy of this notification with the survey report from the SHOST to the State official authorized to oversee operations of the SVH, the VISN Director and GEC. This letter must include the reasons for the recommendation and indicate that the State has the right to submit a response to the Under Secretary for Health, including any additional evidence, no later than 30 calendar days after the date of notification to the State. After receipt of a recommendation from the Director and allowing 30 calendar

days for the State to respond to a negative recommendation and to submit evidence, the Under Secretary for Health will award or deny certification based on all available evidence. The SVH leadership will be notified of the decision in writing. Adverse decisions may be appealed to the Board of Veterans' Appeals.

n. A request for a CAP is not required for a failed Recognition Survey because the survey is pass or fail only. The SVH can take the amount of time needed to reach full compliance and make another request for recognition when those "Not Met" standards have been corrected. All information for a failed Recognition Survey must be entered into the SHOST by the SVH VA medical facility representative and then closed by GEC.

o. A Recognition Survey checklist is provided by the National Director of Facility Based Programs to the VA medical facility representative and SVH VISN liaison that outlines required forms, information, data and letters that are to be mailed with the original copies to GEC. The recognition checklist must be completed in its entirety by the VA medical facility representative and package must be submitted through the SVH VISN liaison to GEC within 20 business days from the last day of the survey.

p. The recognition will remain in effect unless the State requests that the recognition be withdrawn, or the Under Secretary for Health decides that the SVH does not meet VA standards. After a SVH is recognized, any new annex, new branch or other expansion in the size or capacity of a SVH, or any relocation of the SVH to a new facility must be separately recognized.

q. When a SVH that received a failed Recognition Survey corrects the deficiencies identified in the failed Recognition Survey, they must notify the VA medical facility Director of jurisdiction, or the National Director of Facility Based Programs that they are ready for another full Recognition Survey to be scheduled. GEC will schedule the next Recognition Survey.

r. The State must report any decreases in the capacity for a particular program of care to GEC no later than 30 calendar days after such decrease and must provide an explanation for the decrease.

7. ANNUAL SURVEY PROCESS

a. An annual unannounced survey must be completed on one of the following three timelines: every 12 months during the recognition anniversary month; during a month agreed upon by the Director, VA medical facility of jurisdiction and the SVH Administrator; or at least once every 270-450 calendar days at VA discretion, as specified in 38 C.F.R. Part 51. The Director, VA medical facility of jurisdiction, certifies whether a SVH providing nursing home care, domiciliary care and/or adult day health care meets VA standards for continued per diem payments.

b. During all SVH surveys, the VA Survey Team uses a recognized industry standard survey process for long-term care support services. The length of the Annual Survey is based on the individual number of recognized beds and the level of care in each SVH. The VA Survey Team must possess and review the previous VA survey,

State report, if applicable, and the State quality indicator report before starting the survey.

c. The SVH VA medical facility representative prepares and presents a signed appointment/entrance letter by the Director, VA medical facility of jurisdiction, to the SVH Administrator on day one of the survey.

d. The VA Survey Team will conduct an entrance conference at the time of arrival at the SVH, as well as daily and exit conferences with SVH management and staff employees, as appropriate.

e. The entrance conference provides the opportunity for the VA Survey Team and SVH to discuss the scope and schedule for the survey. Entrance conferences must be scheduled at a mutually agreeable time. At the meeting, the VA Survey Team must outline survey objectives, survey time schedules and the process of reporting. The SVH must designate a member of their staff as the primary contact person for the VA Survey Team questions and assistance. Any areas of concern of the SVH must be brought up at this stage. Daily exit conferences must discuss any developing deficiencies or areas of concern. Exit conferences must keep the SVH informed about how the survey is going. No final ratings are to be given at the exit conference.

f. The SVH VISN liaison provides clarification to standards, as needed during the survey, and GEC is available for consultation.

g. Any surveyor on the VA Survey Team may identify a deficiency against a standard. This requires the surveyor who identified the deficiency to provide a written description to include the condition that exists and a scope and severity rating. An initial rating of the deficiency must be provided on the "Survey Findings" document and/or survey report and given to the SVH VA medical facility representative to electronically score into the final survey report.

h. When the survey activities have been completed, the contracted vendor Co-Team Lead submits the clinical and life safety survey report ratings and deficiencies, along with the life safety checklist(s), to the SVH VA medical facility representative no later than 10 business days after the last day of the survey.

i. The SVH VA fiscal representative provides the survey report and ratings to include deficiencies to the SVH VA medical facility representative no later than 5 business days following the last day of the survey.

j. All ratings for each standard and level of care must be entered into the SHOST no later than 20 business days following the last day of the survey.

k. The life safety checklist and VA Form 10-3567 – Staffing Profile for each designated level of care are included as an attachment in the software.

l. The SVH VA medical facility representative is to notify the Director, VA medical facility of jurisdiction, and the SVH VISN liaison of all survey deficiencies. The survey

report can be electronically reviewed on the SHOST. The Director, VA medical facility of jurisdiction, sends a signed written letter of the survey results with the official survey report from the SHOST to the SVH management no later than 20 business days from the last day of the survey.

m. The letter includes the following information:

(1) Identifies all standards rated “Not Met.”

(2) States reasons for the decision on any standard rated “Not Met.”

(3) Requests submission of a written CAP from SVH management to remedy each deficiency in a specific amount of time for each standard(s) rated “Not Met” no later than 20 business days upon receipt of the letter.

n. The Director, VA medical facility of jurisdiction, requests submission of the CAP within 20 business days of when the SVH received the survey report and letter. The Director, VA medical facility of jurisdiction, also will request the SVH to submit evidence of corrective actions with the CAP(s) for the deficiencies listed.

o. If SVH facility management has a concern regarding their legal survey report, GEC has established a standardized approach which is the IDR Standard Operating Procedure. This procedure is defined on the SVH SharePoint site. Through the IDR, all concerns will be resolved prior to the State’s submission of the CAP.

p. The SVH VA medical facility representative sends the received CAP from the SVH to the VA Survey Team member(s) who identified a deficient standard. The VA Survey Team member(s) will review and recommend to the VA medical facility Director an approval or denial. If denying, they must include the reason(s) for denying and suggestions for enhancing the CAP within 5 business days. The CAP is entered into the SHOST on the “CAP” screen in 10 business days from when the CAP has final recommended approval by the VA Survey Team with concurrence by the Director.

q. The Director, VA medical facility of jurisdiction, reviews the submitted CAP and recommendations made by the VA Survey Team. The Director has the discretion to accept or not accept the CAP and can request additional information or additional evidence directly from the SVH.

r. If the Director, VA medical facility of jurisdiction, does not accept the CAP, the Director must request the SVH to submit a revised CAP or additional information in writing for the CAP to be returned no later than 10 business days after receipt of the letter. This is recorded in the SHOST by documenting the date the CAP was not accepted, the date a request was made to the SVH for a revised CAP or additional information and the date the revised CAP was submitted and accepted into the SHOST. This information must be entered in the evidence text box in the CAP screen in the SHOST.

s. If the Director, VA medical facility of jurisdiction, accepts the CAP, the Director must send a provisional certification letter to the SVH management. The name of the Director, VA medical facility of jurisdiction, and the date of the signed letter must be entered into the SHOST.

t. A provisional certification will be issued by the Director, VA medical facility of jurisdiction, only upon a determination that:

(1) The SVH or home management does not meet one or more of the standards;

(2) The deficiencies do not jeopardize the health or safety of the residents; and

(3) The plan is reasonable and the Director, VA medical facility of jurisdiction, agreed to the CAP to remedy the deficiencies in a specified amount of time.

u. The Director, VA medical facility of jurisdiction, must notify the official in charge of the SVH of the provisional certification in writing. A full certification will be issued by the Director, VA medical facility of jurisdiction, only upon a determination that the SVH or facility management meet all standards at the time of the Annual Survey, or when the agreed-upon plan of correction to remedy each deficiency has been implemented with written verification from SVH management. The SVH VA medical facility representative must document comments and evidence received from the SVH that the proposed corrective action was implemented and the SVH is back to full compliance with the regulation on the "CAP" screen in the SHOST, as received from the SVH.

v. When a full certification is granted, the Director, VA medical facility of jurisdiction, must notify the official in charge of the SVH in writing.

w. When evidence shows the SVH is fully compliant for each deficiency, a final rating of a deficient standard will be designated as "Met" in the SHOST on the "CAP" screen. The name of the Director, VA medical facility of jurisdiction, and the date of the full certification letter must be entered into the SHOST. The SVH VISN liaison must ensure that the VA medical facility representative complete all of these steps in the SHOST.

8. FOR-CAUSE SURVEY PROCESS

a. A For-Cause Survey may be authorized by GEC to review a major or significant specific concern, or a series of incidents, complaints, deficiencies or events that may jeopardize the health or safety of residents. This is still a full survey, but focuses on the specific events or acts that prompted the survey. The VA Survey Team must be on site within 15 business days after official notification from GEC to the VA medical facility of jurisdiction.

b. The decision to initiate a For-Cause Survey is determined by GEC based on all available information, trends, reports and recommendations made by the SVH VISN liaison and Director, VA medical facility of jurisdiction. This is an unannounced survey to the SVH.

c. The SVH VA medical facility representative must prepare and present a signed appointment/entrance letter by the Director, VA medical facility of jurisdiction, to the SVH Administrator on day one of the survey. The VA Survey Team must possess and review the previous VA survey, State report, if applicable, and the State quality indicator report before starting the survey.

d. Any surveyor on the VA Survey Team may identify a deficiency against a standard. This requires the surveyor who identified the deficiency to provide a written description that includes the condition that exists and a scope and severity rating. An initial rating of the deficiency must be provided on the "Survey Findings" document or survey report and given to the SVH VA medical facility representative to electronically score into the final survey report.

e. All ratings for each standard for each level of care are entered by the SVH VA medical facility representative into the SHOST no later than 20 business days following the last day of the survey.

f. The VA Survey Team will conduct an entrance conference at the time of arrival at the SVH, as well as daily conferences and a conference at the time of exit with SVH management and staff employees. The time frames will be established after consultation with the SVH management.

g. The entrance conference provides an opportunity for the VA Survey Team and SVH to discuss the scope and schedule for the survey. Entrance conferences must be scheduled at a mutually agreeable time. At the meeting, the VA Survey Team must outline survey objectives, survey time schedules and the process of reporting. The SVH may designate a member of their staff as the primary contact person for VA Survey Team questions and assistance. Any areas of concern of the SVH must be brought up at this stage. Daily exit conferences must discuss any developing deficiencies or areas of concern. Exit conferences must keep the SVH informed about how the survey is going. No final ratings are to be given at the exit conference.

h. When the survey activities have been completed, the contracted vendor Co-Team Lead submits the clinical and life safety survey report ratings, deficiencies and the life safety checklist(s) to the SVH VA medical facility representative no later than 10 business days from the last day of the survey.

i. The life safety checklist and VA Form 10-3567 – Staffing Profile for each designated level of care must be included as an attachment in the SHOST.

j. The SVH VA medical facility representative must notify the Director, VA medical facility of jurisdiction, and the SVH VISN liaison of all survey deficiencies. The survey report can be electronically reviewed on the SHOST.

k. The Director, VA medical facility of jurisdiction, must send a signed, written letter of survey results with the official survey report from the SHOST to the SVH management no later than 20 business days from the last day of the survey.

l. The letter must include the following information:

(1) Identify all standards rated “Not Met;”

(2) State reasons for the decision on any standard rated “Not Met;”

(3) Request submission of a written corrective action plan (CAP) from SVH management to remedy each deficiency in a specified amount of time for each standard(s) rated “Not Met” no later than 20 business days upon receipt of the letter.

m. The Director, VA medical facility of jurisdiction, must request submission of the CAP within 20 business days from when the SVH received the survey report and letter. The Director, VA medical facility of jurisdiction, must request the SVH to submit evidence of the corrective actions with the CAP for any and all deficiencies listed.

n. If SVH facility management has a concern regarding their legal survey report, GEC has established a standardized approach which is the IDR Standard Operating Procedure. This procedure is defined on the SVH SharePoint site. Through the IDR, all concerns will be resolved prior to the State’s submission of the CAP.

o. The SVH VA medical facility representative sends the received CAP from the SVH to the VA Survey Team member(s) who identified a deficient standard. The VA Survey Team member(s) will review and recommend to the VA medical facility Director an approval or denial. If denying, they must include the reason(s) for denying and suggestions for enhancing the CAP within 5 business days. The CAP is entered into the SHOST on the “CAP” screen in 10 business days from when the CAP has final recommended approval by the VA Survey Team with concurrence by the Director.

p. The Director, VA medical facility of jurisdiction, reviews the submitted CAP and recommendations made by the VA Survey Team. The Director has the discretion to accept or not accept the CAP and can request additional information or additional evidence directly from the SVH.

q. If the Director, VA medical facility of jurisdiction, does not accept the CAP, the Director must request that the SVH submit a revised CAP or additional information in writing to be returned no later than 10 business days from receipt of the new letter. This is recorded in the SHOST by documenting the date the CAP was not accepted, the date a request was made to the SVH for a revised CAP or additional information and the date the revised CAP was submitted and accepted in the SHOST. The information must be entered in the evidence text box in the “CAP” screen in the SHOST.

r. A provisional certification will be issued by the Director, VA medical facility of jurisdiction, only upon a determination that:

(1) The SVH or home management does not meet one or more of the standards;

(2) The deficiencies do not jeopardize the health or safety of the residents; and

(3) The plan is reasonable and the Director, VA medical facility of jurisdiction, agreed to the plan of correction to remedy the deficiencies in a specified amount of time.

s. The Director, VA medical facility of jurisdiction, must notify the official in charge of the SVH, in writing, of the provisional certification. A full certification will be issued by the Director, VA medical facility of jurisdiction, only upon a determination that the SVH or facility management meets all standards at the time of the For-Cause Survey or when the agreed plan of correction to remedy each deficiency has been implemented with written verification. The SVH VA medical facility representative must document in the "CAP" screen in the SHOST, under the evidence box, proof the SVH implemented all corrective actions and are back to full compliance with the regulations.

t. When a full certification is granted, the Director, VA medical facility of jurisdiction, must notify the official in charge of the SVH in writing.

u. When there is evidence that a SVH is back to full compliance for each deficiency, the final rating of a deficient standard is designated "Met" in the SHOST on the "CAP" screen. The name of the Director, VA medical facility of jurisdiction, and date of the full certification letter is entered in the SHOST.

9. IMMEDIATE JEOPARDY

Immediate Jeopardy (IJ) is a situation in which the SVH's non-compliance with one or more Federal regulations has caused, or is likely to cause, serious injury, harm, impairment or death to a resident, participant or the public. The process for handling these situations during a survey is as follows:

a. The contracted vendor has the responsibility for surveying the clinical and life safety standards. Any member of the VA Survey Team may propose an IJ situation on a survey to the entire VA Survey Team.

b. When a contracted surveyor or a SVH VA medical facility representative encounters a situation, which they believe warrants an IJ discussion or review, they must share that information with the entire VA Survey Team.

c. Upon discussion and review of the findings and evidence discovered on site at the SVH and how the IJ was identified by the onsite VA Survey Team, the Project Director for the contracted vendor will email a summary of the findings and evidence to the VA Contracting Officer Representative (COR) as well as a telephone call to the VA COR. If the Project Director contacts the VA COR with identification and findings after VHA business hours, the VA COR will communicate with one member of GEC to collaborate.

d. The VA COR will communicate the summary information to GEC. The timeline for these communications must not exceed 1 hour once GEC receives the information as feasibly possible, so that the onsite surveyors can be informed of the results or questions of the communications in a timely fashion. The VA Survey Team and GEC will be available for a pre-determination conference call while onsite.

e. At the conclusion of the VA communications, the VA COR will communicate with the Project Director whether the evidence supports an IJ or not.

f. The contracted surveyors will work with the VA Co-Team Lead, after an IJ has been determined, to inform the SVH facility senior staff.

g. However, if GEC does not agree that an IJ is determined, then the survey will move forward as usual.

h. VA Co-Team Lead contacts the SVH VISN liaison and the VA medical facility Director of the facility of jurisdiction to notify them of the IJ situation when it has been confirmed by the VA COR.

i. After the VA has determined the IJ, at no time will the entire VA Survey Team leave the home until the SVH submits an acceptable CAP to abate it.

j. The CAP must be sent by email to the VA COR once received by the Project Director.

k. The SVH VISN liaison, in collaboration with the VA Survey Team and GEC, will schedule a conference call while the VA Survey Team is still on site, if possible. VA medical facility leadership, VISN leadership, VACO and the VA Survey Team are requested to be on the call. GEC will forward the meeting invite to appropriate staff in VACO and the Project Director. The SVH leadership is not a part of this call.

l. If the IJ occurs after VHA business hours, a conference call with the VA Survey Team will not take place until the next business day. If the IJ occurs after VHA business hours on the last day of the scheduled survey the VA COR and GEC will determine if a call is necessary. If the call is determined to be necessary, VA COR will work with Project Director for scheduling. If not, GEC will provide a summary report to VA leadership in the SVH program.

m. Suggested IJ Issue Brief (IB) language can be found at the following SVH SharePoint site link: <https://dvagov.sharepoint.com/sites/VHAstate-veterans-homes>. **NOTE:** *This is an internal VA website that is not available to the public.* The IB will be submitted after the survey is complete.

10. ISSUE BRIEFS

a. The SVH management must report sentinel events to the Director of the VA medical facility of jurisdiction within 24 hours of identification. Pursuant to 38 C.F.R. Part 51, the Director, VA medical facility of jurisdiction must report all sentinel events by generation of an IB to the VA VISN Director (10N 1-23). The VISN Director is to enter SVH IB into the 10N Tracker. Sentinel events must be reported within 24 hours of identification per Federal regulation. This Issue Brief Tracker is a central repository for all IBs submitted to VA Central Office. The tracker is used as an administrative tool and enables the Office of Network Support to review, analyze and trend issues reported by

VISN and VA medical facilities. The Office of Network Support uses the information to submit a Critical Incident Report to VHA Senior Leadership on a weekly basis.

b. The SVH management must establish a mechanism to review and analyze a sentinel event that results in a written report no later than 10 business days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors or personnel; and to manage injuries that do occur; and to minimize any negative consequences to the injured individuals and SVH. The VISN Director must update all sentinel event IBs and enter all IBs into the 10N Tracker if the SVH management submitted a written report to the Director, VA medical facility of jurisdiction.

c. The VISN must assure the formal name of the SVH is listed in the IB. If follow-up action will be taken, a reasonable target date must be included in the IB for completion of that action.

d. In addition to SVH management being required to report sentinel events, VA also requests that SVH report adverse events to the Director, medical facility of jurisdiction, which they normally would report these sentinel events to in their respective States in accordance with State law. As State law varies, the events requested by VA include, but are not limited to, the following:

(1) Allegations of mistreatment, neglect, abuse or misappropriation of resident property;

(2) Elopements, pursuant to State regulations;

(3) Infectious disease outbreaks;

(4) Resident-to-resident or resident-to-staff altercations resulting in any injury other than a minor injury;

(5) Information regarding a SVH that appears in local or national media; and

(6) Falls with significant injury that require the resident to be sent out of the SVH for medical intervention.

11. COMMUNICATIONS

It is strongly recommended that:

a. Each VISN or each VA medical facility with a designated SVH develop and implement at minimum, a quarterly meeting with leaders of the SVH management to establish communication and partnership for the care and treatment of Veterans according to the Federal regulations that govern the SVH program. Members of the group may consist of VISN or VA medical facility leadership staff employees, appointed and designated SVH liaisons and representatives, other affiliates in the Office of

Community Care, GEC or quality management and others with an interest or responsibility in the oversight of the SVH program; and

b. Each SVH VISN liaison, designated SVH VA medical facility representative and SVH VA fiscal representative must attend the monthly SVH National Conference Calls and regularly access the SVH SharePoint designation for review of updated program information.

12. TRAINING

a. The following training modules are required annually for all SVH VISN liaisons, SVH VA medical facility representatives and SVH VA fiscal representatives before the first SVH survey of the calendar year:

(1) State Veterans Home Medical Center Representative Course (VA 4409911) located at:
https://www.tms.va.gov/learning/user/deeplink_redirect.jsp?linkId=ITEM_DETAILS&componentID=4409911&componentTypeID=VA&revisionDate=1515525420000. **NOTE:** *This is an internal VA website that is not available to the public.*

(2) State Veterans Home Fiscal Service Representative Web-based Module (VA 3861243).

b. SHOST training is required for the following:

(1) **SVH VISN Liaisons.** 1 month after being designated by the VISN Director.

(2) **SVH Medical Facility Representatives.** 1 month after their first on-site survey after being designated by the VA medical facility Director.

13. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created in this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

14. REFERENCES

a. 38 U.S.C. § 1710.

b. 38 U.S.C. § 1720.

c. 38 U.S.C. §§ 1741-1745.

d. 38 U.S.C. §§ 8131-8135.

e. 38 C.F.R. Part 51.

f. VA Form 10-3567, State Home Inspection – Staffing Profile.