VIRGINIA DEPARTMENT OF HEALTH

# NURSING HOME OVERSIGHT PLAN

PHASED FRAMEWORK · 2026-2027

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The residents of Virginia's 291 nursing homes and their families entrust the Commonwealth with their care, their safety, and their dignity. These residents are some of Virginia's most vulnerable people, often with chronic conditions, advanced age, and significant care needs. The Virginia Department of Health (VDH) seeks to ensure that all nursing home residents receive quality care that they expect and deserve, no matter where they live.

To do this, the Commonwealth requires a system of nursing home oversight that strikes an appropriate balance of state agency responsibilities and those of nursing home providers. We need a system that reflects an appropriate degree of collaboration and enforcement, trust and verification. It's also essential that our system is appropriately resourced so it can operate with excellence.

The Nursing Home Oversight Plan for 2026-2027 is VDH's commitment to rebuild that system. This plan establishes a strategic framework to strengthen nursing home oversight in Virginia. The operational objective of the plan is to move VHD's Office of Licensure and Certification (OLC) from a reactive posture to a disciplined, data-informed oversight model to ensure that nursing home residents across the Commonwealth receive safe, appropriate, and high-quality care.

The plan directs OLC to stabilize long-term care survey operations, reduce the nursing facility recertification backlog, protect complaint response capacity, standardize enforcement decision-making, and build the internal infrastructure needed to sustain performance gains.

The plan is organized around three phases to operate in parallel, with clear performance measures, leadership visibility, and escalation points:

- Phase 1 focuses on immediate stabilization and measurable recertification workload reduction.
- Phase 2 establishes a more consistent enforcement and engagement framework.

- Phase 3 strengthens training, onboarding, quality assurance, workforce sustainability, and data systems.

None of this work would be possible without genuine partnership. I would like to thank VDH's partners in the nursing home industry and other state agencies, along with nursing home residents' family members and advocate groups for their collaboration, guidance, and support as we implement this vitally important plan.

Sincerely,

Dr. Cameron Webb
State Health Commissioner

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# Executive Summary

This plan establishes a strategic action framework to strengthen nursing home oversight in Virginia. It directs the Office of Licensure and Certification (OLC) to stabilize long-term care survey operations, reduce the nursing facility recertification backlog, protect complaint response capacity, standardize enforcement decision-making, and build the internal infrastructure needed to sustain performance gains.

The plan is organized around three coordinated phases. Phase 1 focuses on immediate stabilization and measurable recertification workload reduction. Phase 2 establishes a more consistent enforcement and engagement framework. Phase 3 strengthens training, onboarding, quality assurance, workforce sustainability, and data systems. These phases are designed to operate in parallel, with clear performance measures, leadership visibility, and escalation points.

The operational objective is to move OLC from a reactive posture to a disciplined, data-informed oversight model. Success will be measured by improved survey timeliness, protected response to high-priority complaints, consistent enforcement actions, stronger staff readiness, and increased leadership visibility into risk, workload, and production. The ultimate purpose remains resident protection: ensuring that nursing home residents across the Commonwealth receive safe, appropriate, and high-quality care.

# Purpose and Operating Context

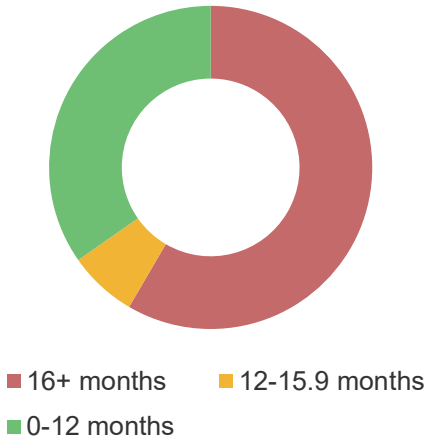
The Nursing Home Oversight Plan directs immediate and long-term action to stabilize current operations, reduce the long-term care recertification workload, strengthen regulatory consistency, improve stakeholder engagement, and build the systems needed to sustain high-quality oversight over time. While the immediate focus is nursing home oversight, the operating model established in this plan is intended to strengthen OLC's broader role as the State Agency responsible for oversight across multiple service lines.

OLC's long-term care oversight functions have experienced sustained operational pressure as survey, complaint, enforcement, and certification responsibilities have grown. Staffing levels, certified surveyor capacity, data infrastructure, and internal operational supports have not kept pace with the volume and complexity of the work. As a result, OLC must manage recertification workload reduction, complaint response, enforcement consistency, workforce development, and data modernization as connected elements of one oversight strategy.

The plan addresses these pressures through an action-oriented structure: define the baseline, establish measurable targets, align internal and contractor capacity, protect high-priority resident safety work, strengthen enforcement consistency, and build the workforce and data systems required for sustained performance.

# Current State and Progress to Date

## Current Recertification Picture



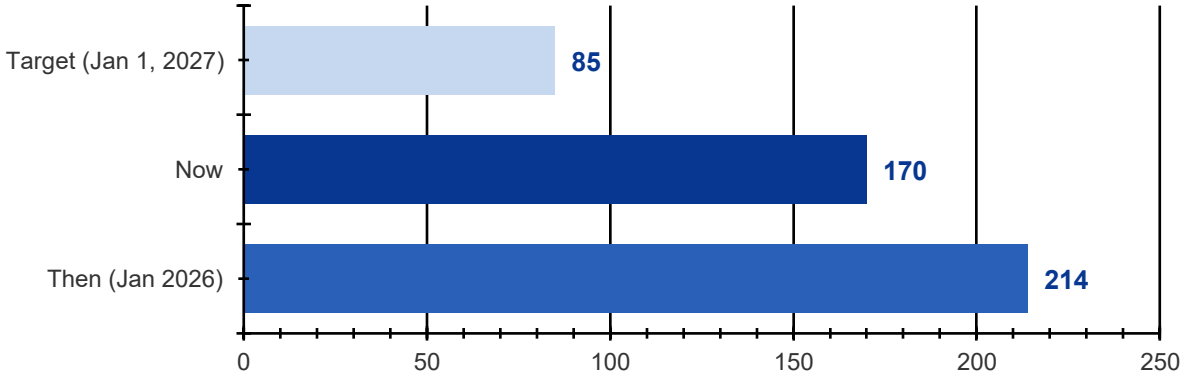

| 291 | 170 | 121 |
|---|---|---|
| **Planning Universe** | **16+ Months** 58.8% outside window | **Within 15.9 Mo.** 41.2% of facilities |

The current iQIES extract shows 291 nursing facility records. The immediate task is to reduce the 16+ month group while preventing the near-due group from growing into a new backlog.

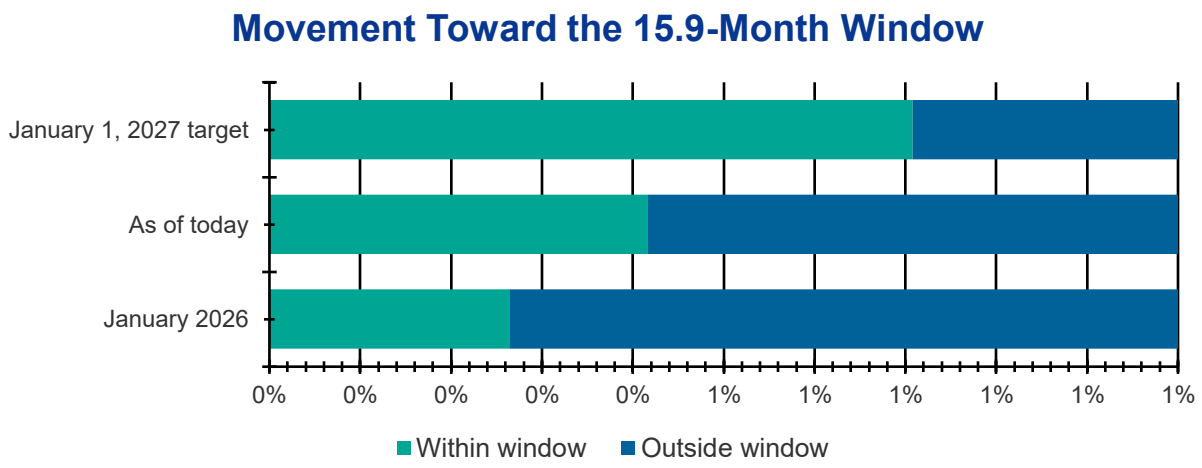
**The goal is not simply to catch up — it is to build a sustainable recertification cycle.**

Progress has already been made. Since January 2026, the number of facilities in the 16-plus month category has decreased from approximately 214 to 170 facilities, a reduction of 44 facilities, or approximately 20.6%. The share of facilities within the 15.9-month window increased from approximately 26.5% in January 2026 to 41.6% in the current baseline (see image below).

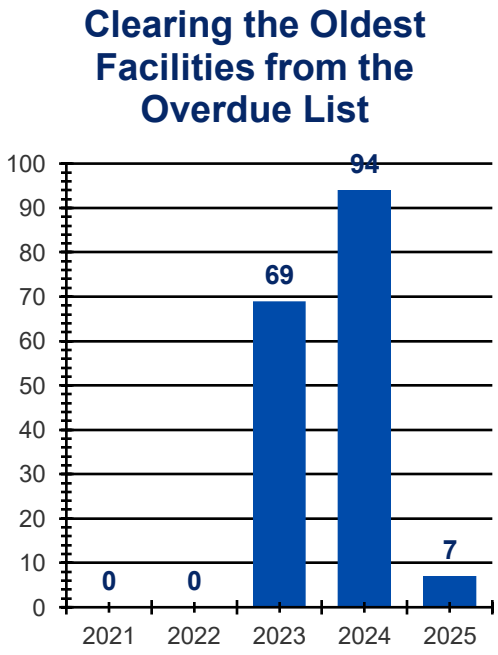
## Progress to Date: Overdue Recertifications




**44 fewer overdue facilities since January 2026 | 20.6% DECREASE**




OLC has now cleared all facilities with last health surveys in 2021 and 2022 from the overdue list. The remaining overdue inventory is concentrated in more recent survey years (see image below).




**Oldest Backlog Progress**

**2021 Facilities Remaining on Overdue List**

**0** ✓ **Fully cleared**

All 2021 facilities cleared off the list.

**2022 Facilities Remaining on Overdue List**

**0** ✓ **Fully cleared**

All 2022 facilities cleared off the list.

**The remaining overdue inventory is now concentrated in more recent survey years.**

# Guiding Principles

- Resident health, safety, and quality of care remain the central priority for all operational, staffing, survey, complaint, enforcement, and data decisions.

- Oversight must be timely, consistent, transparent, and defensible, with clear documentation and legally sound regulatory action.
- Operational improvements must be realistic, measurable, and sustainable, grounded in actual workforce capacity, certification timelines, complaint volume, and contractor availability.
- Stakeholder engagement must inform system improvement while preserving OLC's regulatory responsibility and accountability.
- Internal infrastructure must support long-term workforce capacity, staff readiness, quality assurance, and consistent statewide implementation.
- Data must guide decisions, monitor progress, identify risk, and support timely leadership action.

01 PHASE 1 · 2026

# Phase 1: LTC Immediate Stabilization and Path to 90% Standard-Due Performance

**TIMEFRAME: JULY 2026 - JANUARY 2027**

OBJECTIVE

*Phase 1 directs immediate action to stabilize long-term care survey operations, reduce the nursing facility recertification and complaint investigation workload, and establish a measurable path to 90% standard-due performance. The strategy aligns internal survey production, HMS/contractual survey support, strengthened complaint triage, risk-based scheduling, workforce stabilization, and active performance monitoring.*

## BOTTOM LINE UP FRONT

**Phase 1 is not simply a backlog-reduction effort.**
**It is an operational reset.**

| 1. Internal Production | 2. Contractual Capacity | 3. Dedicated Complaint Resources | 4. Workforce Development | 5. Risk-Based Scheduling |
|---|---|---|---|---|
| Sustain recertification throughput and active backlog reduction. | Use HMS/contractual support to expand survey capacity and improve completion pace. | Bring complaint analysts and investigators onboard to protect recertification capacity and strengthen triage. | Advance SMQT certification, support onboarding, and stabilize long-term staffing capacity. | Prioritize the oldest and highest-risk facilities using data-informed scheduling decisions. |

**OLC is building a more disciplined, data-informed, and sustainable oversight model to reduce the backlog while maintaining focus on resident health, safety, and quality of care.**

## Objective

Phase 1 directs immediate action to stabilize long-term care survey operations, reduce the nursing facility recertification and complaint investigation workload, and establish a measurable path to 90% standard-due performance. The strategy aligns internal survey production, HMS/contractual survey support, strengthened complaint triage, risk-based scheduling, workforce stabilization, and active performance monitoring.

Phase 1 treats January 1, 2027 as an interim performance checkpoint, not the endpoint. OLC will use weekly and monthly performance data to manage production, identify barriers, escalate risks, and adjust scheduling based on actual field capacity and resident safety priorities.

## Current Recertification Workload and Capacity Assessment

| Months Since Last Health Survey | Number of Facilities | Percent of Adjusted Baseline | Planning Significance |
|---|---|---|---|
| 16+ months | 170 | 58.4% | Current overdue workload; prioritize based on age of last survey, risk factors, complaints, enforcement history, and capacity. |

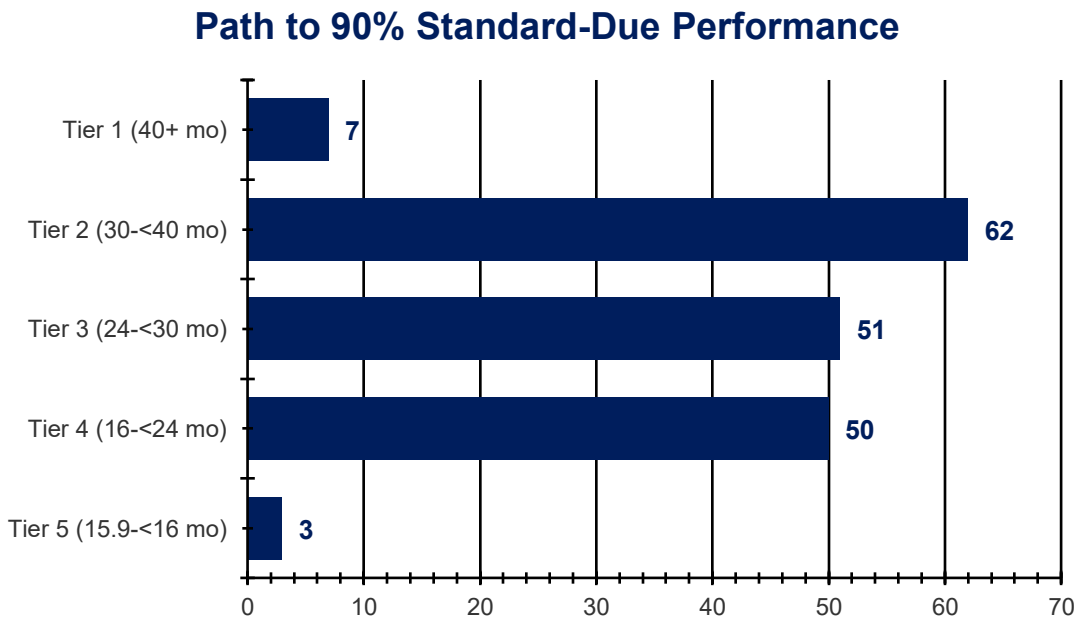
| Months Since Last Health Survey | Number of Facilities | Percent of Adjusted Baseline | Planning Significance |
|---|---|---|---|
| 12 to 15.9 months | 20 | 6.9% | Near-term due group; incorporate into scheduling to prevent additional workload growth. |
| 0 to 12 months | 101 | 34.7% | Current or more recently surveyed facilities; three have due dates by December 31, 2026 and must be reflected in workload planning. |
| **Total** | **291** | **100.0%** | **Full July 2026 planning universe.** |

CURRENT POSITION
**173**
facilities remain outside standard due

GOAL
**90%**
of facilities at standard due

TARGET DATE
**Dec. 31, 2027**
measurable path to full performance

The workload assessment establishes the operational baseline. The following graphic translates the baseline into a performance pathway by organizing facilities by survey age, priority, and movement toward the standard-due window.



### Path to 90% Standard-Due Performance: Tier Detail

| Tier | Time Since Last Survey | Status | Volume | What This Represents |
|---|---|---|---|---|
| Tier 1 | 40+ months | Highest-priority remaining facilities | 7 (4.0%) | Smallest and oldest remaining group; last health surveys January-February 2023 |
| Tier 2 | 30-<40 months | Largest acceleration opportunity | 62 (35.8%) | Largest remaining cohort and biggest opportunity to improve the age profile; last health surveys February-December 2023 |
| Tier 3 | 24-<30 months | Momentum building | 51 (29.5%) | Mid-range cohort showing continued progress toward standard due; last health surveys January-June 2024 |
| Tier 4 | 16-<24 months | Closest to standard due | 50 (28.9%) | Most recent overdue facilities and those closest to returning to standard due; last health surveys July 2024-February 2025 |
| Tier 5 | 15.9-<16 months | Entering the standard-due window | 3 (1.7%) | Facilities at the standard-due threshold; last health surveys March 2025 |

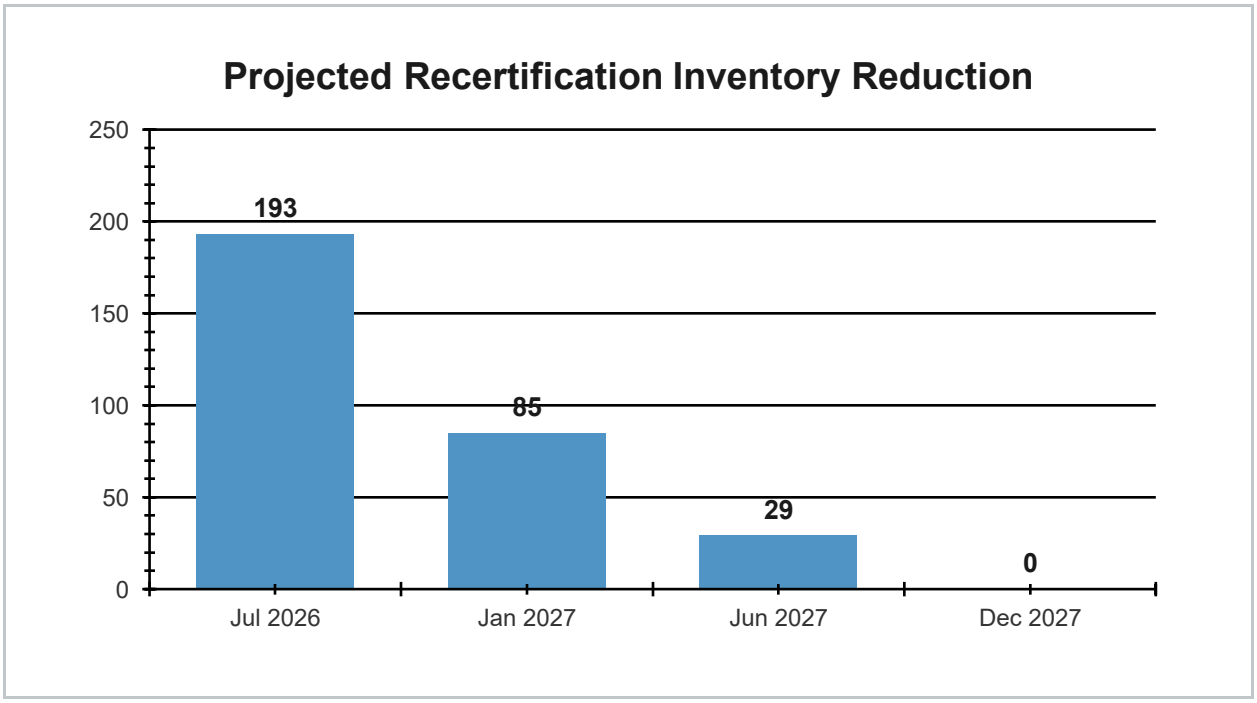
This tiered view will guide Phase 1 scheduling, HMS deployment, and weekly performance monitoring. The goal is to reduce the oldest survey ages first while steadily increasing the percentage of facilities within the standard-due window.

## Production Capacity and Projected Gap

| Category | Planning Value | Planning Implication |
|---|---|---|
| Current overdue workload from adjusted July 2026 baseline | 170 recertifications | Starting point for 2026 reduction planning. |
| Additional facilities projected to become due/overdue by January 1, 2027 | 23 recertifications | New workload that must be built into the schedule. |
| Near-term workload to address by January 2027 | 193 recertifications | Combined workload requiring internal and supplemental capacity. |
| Current internal production pace | ~3/week; ~13/month | Baseline state production capacity. |

| Category | Planning Value | Planning Implication |
|---|---|---|
| Projected internal production, July-December 2026 | ~78 recertifications | Estimated state-completed surveys at current pace. |
| Projected remaining gap without HMS or supplemental support | ~115 recertifications | Workload exceeding current internal capacity. |
| Minimum planned HMS contribution | ~5-6/month; ~30-36 by December 2026 | Supplemental capacity tracked separately from internal production. |
| Projected carry-forward after internal + HMS production | ~79 to 85 recertifications | Estimated remaining workload into 2027 under the minimum HMS scenario. |

The revised trajectory establishes a realistic production path. With internal production at approximately 78 recertifications and HMS completing approximately five to six recertification surveys per month, the projected carry-forward into 2027 is reduced to approximately 79 to 85 facilities. This allows OLC to demonstrate measurable reduction while continuing to prioritize the oldest and highest-risk facilities.



## Operational Factors Affecting the Trajectory

- Workforce readiness: new staff must complete onboarding, field training, and SMQT certification before they can independently contribute to production.
- Survey complexity: older recertifications require longer lookback periods, more extensive documentation review, and more post-survey work.
- Complaint workload: 3-day and 15-day complaints, Immediate Jeopardy activity, revisits, and 45-day complaints incorporated into recertifications reduce available recertification capacity.
- Workforce sustainability: the same experienced SMQT-certified staff support recertifications, complaints, revisits, enforcement follow-up, and training of new hires. Dedicated complaint investigators will be phased in to reduce competing demands.
- Supplemental support: contractual survey capacity remains necessary while recruitment, training, retention, and fee-supported staffing increases build the future-state model.

## Phase 1 Priorities and Required Actions

### 1. Implement a measurable path to 90% standard-due performance

OLC will replace the prior assumption of full backlog elimination by January 1, 2027 with a measurable trajectory that can be tracked weekly and monthly. Based on the current adjusted baseline, the target is to reduce the January 1, 2027 due/past-due inventory to no more than approximately 85 facilities, reducing the total recertification universe to approximately 29 facilities by June 30, 2027, and clear the current certification universe by December 31, 2027.

- Set monthly and weekly expectations based on combined internal and HMS production.
- Track performance against revised monthly targets: approximately 18 to 19 recertifications per month from July through December 2026, 17 per month from January through June 2027, 14 per month from July through November 2027, and 11 in December 2027.
- Prioritize facilities based on survey age, proximity to the 15.9-month window, complaint patterns, enforcement history, Immediate Jeopardy findings, repeat deficiencies, and other risk indicators.
- Use weekly leadership review to assess scheduled surveys, completed surveys, remaining inventory, staffing barriers, HMS production, complaint-related diversions, and schedule adjustments.

### 2. Track HMS and internal production separately

OLC will track HMS completions separately from internal state completions so leadership can determine whether supplemental contractor support is increasing total production, reducing the carry-forward inventory, and preserving internal capacity for complaints, revisits, Immediate Jeopardy work, enforcement follow-up, and training.

- Report internal recertification completions, HMS completions, and combined completions as separate weekly metrics.
- Compare internal, HMS, and combined production against the monthly target to determine whether the trajectory is on pace, improved, or delayed.
- Assign HMS capacity strategically to the oldest recertification tiers and other priority work as appropriate.
- Escalate funding, scheduling, contractor capacity, or contractor performance barriers early.

## 3. Expand workforce capacity and sustain the existing workforce

OLC will use a combined recruitment, onboarding, certification, and retention strategy to expand survey capacity while protecting the current workforce. Filled positions will not be counted as full production capacity until staff are trained, certified, and ready for independent field deployment.

- Track vacancies and recruitment activity by position, region, and stage of the hiring process, including posting dates, applicant volume, interview status, offers, time to fill, declined offers, and barriers affecting recruitment. Use the data to adjust outreach, incentives, job postings, and other recruitment strategies.
- Prioritize recruitment of candidates with long-term care, nursing facility, regulatory, clinical operations, quality assurance, infection prevention, life safety, and resident care experience.
- Use recruitment incentives, including sign-on bonuses where appropriate, to improve competitiveness for hard-to-fill positions.
- Sustain new hires through a revised training model that combines virtual modules, early field exposure, structured precepting, supervisor feedback, and targeted SMQT preparation.
- Track each cohort from hire date through SMQT testing, including time in training, exam date, pass rate, and readiness for independent deployment.
- Monitor vacancies, turnover, extended leave, training burden, preceptor availability, supervisory span of control, and the number of experienced SMQT-certified surveyors available for independent survey work.
- Use retention supports including staff bonuses, overtime, compensatory time where appropriate, certification support, and career development opportunities.

*Note: (Medical Field Investigator [MFI])*

## SMQT Certification Plan to Full Capacity

| SMQT Wave | Cohort/Staff Group | Staff Included | Hire Dates | Exam Date | Outcome | Planning Significance |
|---|---|---|---|---|---|---|
| Wave 1 | Cohorts 1 and 2 | 7 MFIs | Oct. 2025 | April 10, 2026 | 7 of 7 passed; 100% pass rate | Confirms that structured training and SMQT preparation can produce successful certification outcomes. |
| Wave 2 | Cohort 3 | 3 MFIs; 1 MFI Supervisor | Jan. 2026 | July 8, 2026 | To be tracked following exam | Expands the certified surveyor pool and strengthens supervisory and field capacity. |
| Wave 3 | Cohort 4 | 3 MFIs | Feb. 2026 | Aug. 13, 2026 | To be tracked following exam | Supports increased survey capacity heading into late 2026. |
| Post-Wave Recruitment | Additional hiring after Wave 3 | TBD based on vacancies, attrition, and regional needs | TBD | TBD | To be tracked by cohort | Offsets attrition and maintains staffing needed for recertification, complaint, and revisit workload. |

## 4. Improve operational efficiency through risk-based scheduling, regional realignment, and process controls

OLC will align survey resources with recertification status, resident safety risk, regional coverage needs, and staff deployment realities. These actions are intended to reduce unnecessary travel, improve scheduling discipline, increase visibility into production, and strengthen operational controls.

- Use each facility's last inspection date and proximity to the 15.9-month recertification window as the primary scheduling anchor.

- Layer in risk factors such as compliance history, complaint trends, Immediate Jeopardy or harm-level findings, repeat deficiencies, CMS provider rating scale information, and other quality indicators.
- Maintain the May 2026 regional boundary changes that established a dedicated Northern Virginia regional survey team.
- Implement the August 1, 2026 MFI realignment to place staff in the regions where their home-based offices are located, to the extent operationally feasible.
- Coordinate recertification and complaint work where feasible to reduce duplicative onsite activity.
- Monitor Form CMS-2567 completion, revisit timeliness, survey documentation quality, schedule adherence, and operational barriers.

## 5. Reduce complaint investigation workload and strengthen regional complaint capacity

Complaint workload reduction is necessary to protect recertification capacity because both workstreams rely on the same limited pool of experienced, SMQT-certified survey staff. OLC will strengthen triage, hire complaint analysts, phase in dedicated complaint investigators, and use complaint trend data to support prevention and accountability.

- Strengthen complaint triage with CMS-aligned training and technical assistance so complaints are categorized based on allegation type, immediacy of risk, available evidence, and required response timeframe.
- Establish six complaint analyst positions aligned regionally to identify facility patterns, recurring allegation types, and emerging risk areas.
- Phase in seven dedicated complaint investigators, with one in each region and two in East Central based on workload and operational need.
- Track new complaints received, triage category, pending complaints, completed investigations, complaints incorporated into recertification surveys, and surveys delayed or diverted due to Immediate Jeopardy, high-priority complaints, or revisits.
- Prioritize high-risk allegations while batching lower-priority complaints by facility where appropriate.
- Share aggregate, non-confidential complaint trends with provider associations and partners to support targeted training and quality improvement.
- Improve complainant communication and status visibility while preserving confidentiality, investigative integrity, and compliance with federal and state requirements.

## Phase 1 Deliverables

- Revised recertification performance trajectory implemented through December 2027, with January 1, 2027 treated as an interim checkpoint.
- Weekly reporting that separates internal production, HMS production, and combined completion rate.
- Increased monthly recertification throughput compared with the current internal production pace.
- Reduction in the oldest survey-age tiers, with priority on 40+ month and 30- to 40-month facilities.
- Improved regional alignment and field efficiency.
- Expanded SMQT-certified survey capacity through tracked certification waves.
- Complaint investigation workload tracking structure and CMS-aligned complaint triage consistency review.
- Aggregate complaint trend communication to support prevention-focused improvement.
- Weekly leadership performance review structure tied to production, barriers, staffing, HMS performance, and complaint impact.
- Contractor support strategy aligned to recertification, complaint, revisit, enforcement, and training needs.

## Phase 1 Measures of Success

- Monthly recertification production trends upward from the current internal pace and is reported against the through-2027 performance target.
- Internal state production, HMS production, and combined production are visible to leadership weekly.
- The January 1, 2027 due/past-due inventory is reduced to no more than approximately 85 facilities, with continued reduction toward approximately 29 by June 30, 2027.
- The current certification universe is cleared by December 31, 2027, assuming sustained internal production and continued supplemental support.
- The percentage of nursing facilities within the 15.9-month window improves over time toward 90% standard-due performance.
- Pending complaint investigations decrease or stabilize while high-priority complaint response timeframes are protected.
- Survey capacity becomes more stable and less dependent on reactive reassignments and overtime.

02 PHASE 2 · 2026-2027

# Phase 2: Enforcement Strategy, Engagement, and System Alignment

## TIMEFRAME: MAY 2026 - JANUARY 2027

**OBJECTIVE**

*Phase 2 establishes a standardized, legally grounded enforcement framework while engaging stakeholders and partner agencies to improve transparency, strengthen accountability, and support sustained compliance across nursing facilities. The phase proceeds through two coordinated workstreams: Enforcement Decision Points and Regulatory Consistency, and Engagement and System Alignment.*

**Bottom Line Up Front**

- **Standardized enforcement framework**
- **Clear escalation and sanctions guidance**
- **Stakeholder and cross-agency engagement**
- **System alignment to inform Phase 3 improvements**

### Workstream 1: Enforcement Framework

**KEY ACTIONS**

- Standardize enforcement decision points
- Use a tiered escalation structure and enforcement tools
- Create a centralized adjudication function
- Train staff and publish provider-facing guidance

**PRIMARY OUTPUTS**

Guidance document, sanctions regulations, adjudication structure, training materials.

### Workstream 2: Engagement and System Alignment

**KEY ACTIONS**

- Launch the Nursing Home Oversight Advisory Panel
- Conduct provider, resident/family, and partner engagement
- Strengthen cross-agency coordination
- Use findings to inform enforcement, training, and Phase 3 improvements

**PRIMARY OUTPUTS**

Engagement sessions, cross-agency input, recommendations, system improvement priorities.

## Objective

Phase 2 establishes a standardized, legally grounded enforcement framework while engaging stakeholders and partner agencies to improve transparency, strengthen accountability, and support sustained compliance across nursing facilities. The phase proceeds through two coordinated workstreams: Enforcement Decision Points and Regulatory Consistency, and Engagement and System Alignment.

## Workstream 1: Enforcement Decision Points and Regulatory Consistency

OLC will implement a more objective and defensible enforcement approach that can be applied consistently across all regions. This work includes development and issuance of a guidance document and finalization of regulatory action pertaining to sanctions. The framework will provide clearer criteria for escalation, corrective or monitoring tools, administrative sanctions currently authorized by statute and regulation, and documentation of enforcement rationale.

- Define standardized enforcement decision points based on severity, scope, pattern of noncompliance, and failure to correct.
- Establish a tiered enforcement structure that links repeated or severe deficiencies to progressively stronger action.
- Standardize use of enforcement tools, including civil monetary penalties, consent agreements, admissions restrictions, and licensure actions.
- Clarify when consent agreements are appropriate and when stronger enforcement responses are warranted.
- Develop a centralized adjudication function to support consistent review and handling of disputes.
- Align implementation with 2026 legislative changes related to change of ownership and operator requirements, quality oversight expectations, and liability insurance compliance.
- Train MFIs, supervisors, and leadership on enforcement decision pathways, documentation standards, and defensibility.
- Publish provider-facing guidance on enforcement pathways, corrective action expectations, and escalation thresholds.

### Workstream 1 Deliverables and Measures

- Guidance document containing a standardized enforcement framework and decision matrix.
- Final amendments to nursing home licensure regulations pertaining to sanctions.

- Centralized adjudication structure and clearer internal review processes.
- Provider-facing guidance and training materials.
- More consistent statewide use of enforcement tools and clearer provider understanding of expectations and consequences.

### Workstream 1 Implementation Timeline

| Period | Focus | Required Activities |
|---|---|---|
| January-July 2026 | Framework development and staffing | Define enforcement decision points; draft escalation structure and decision matrix; initiate hiring recruitment for LTC Hearing Officer and Policy and Planning Specialist; design centralized Informal Fact-Finding Conference (IFFC) process. These are conferences which are designed to ensure the factual basis for agency decisions and resolve disputes informally through discussion and negotiation versus opting into a formal hearing. |
| June-August 2026 | Legislative integration and system build | Implement legislation enacted by 2026 General Assembly; align framework with CMS requirements; finalize IFFC workflows. |
| June 2026-ongoing | Sanctions regulation development | Support executive branch review, public comment, and final regulation development. |
| July-September 2026 | Training and initial rollout | Develop training materials; train MFIs, supervisors, and leadership; begin application and monitor gaps. |
| August-October 2026 | Provider communication | Publish provider guidance and conduct webinars or stakeholder briefings. |
| September 2026-January 2027 | Initial implementation and stabilization | Apply framework statewide; track consistency, IFFC outcomes, and provider compliance trends; refine based on operational and legal feedback. |

## Workstream 2: Engagement and System Alignment

OLC will engage providers, residents, families, advocates, sister agencies, and other partners to identify system barriers, clarify communication gaps, and inform enforcement, training, and system improvement priorities. Engagement will support transparency and system alignment without diminishing OLC's responsibility to enforce applicable requirements and respond to resident safety concerns.

- Establish the Nursing Home Oversight Advisory Panel.

- Hold recurring engagement meetings with industry associations and provider leadership groups.
- Maintain cross-agency leadership engagement with partners including Department of Medical Assistance Services, Department for Aging and Rehabilitative Services, Department of Social Services, the Long-Term Care Ombudsman Program, Department of Behavioral Health and Developmental Services, and hospital partners where applicable.
- Analyze complaint trends, deficiency patterns, and oversight data to inform engagement and regulatory priorities.
- Conduct regional engagement sessions to capture frontline, provider, resident, family, and partner perspectives.
- Synthesize findings into recommendations that inform enforcement framework development, training priorities, and Phase 3 system improvements.

### Workstream 2 Implementation Timeline

| Period | Focus | Required Activities |
|---|---|---|
| Mid-June 2026 | Launch and initial engagement | Initiate industry engagement; build cross-agency structure; establish cadence for regional and statewide engagement. |
| July-December 2026 | Active engagement and insight development | Continue listening tour; maintain provider, frontline, resident/family, and partner engagement as appropriate; identify systemic barriers, workforce challenges, operational trends, and emerging best practices. |
| December 2026 | Synthesis and integration | Complete thematic analysis; develop recommendations for enforcement, training, and system improvements. |

## Phase 2 Measures of Success

- Enforcement actions are more consistent across regions.
- Staff have clear guidance on escalation and documentation.
- Providers have improved clarity on expectations and consequences.
- Engagement sessions are completed with strong participation and actionable findings.
- Cross-agency input is incorporated into oversight planning while preserving regulatory independence.

# Phase 3: Internal System Improvements

## TIMEFRAME: JUNE 2026 - FEBRUARY 2027

### OBJECTIVE

*Phase 3 strengthens the internal infrastructure required to sustain improvements achieved in Phases 1 and 2. The phase focuses on training, onboarding, quality assurance, workforce sustainability, and data capabilities so that backlog reduction and enforcement improvements are supported by durable systems rather than temporary workarounds.*

**Bottom Line Up Front**

Build the internal systems, training, and data infrastructure needed to sustain Phase 1 and 2 improvements.

## STRATEGIC OUTCOMES

- **Faster time to competency**
- **Standardized onboarding**
- **Modern role-specific training**
- **Stronger QA/QI for survey work**
- **Better data and decision support**

## PHASE 3 PRIORITIES

| 1. Compressed Training Model | 2. Standardized Onboarding | 3. Training Modernization | 4. Quality Assurance / Improvement | 5. Data and Technology Infrastructure | 6. Workforce Support and Sustainability |
|---|---|---|---|---|---|
| Accelerate readiness through phased learning, field practice, and competency-based progression. | Use consistent expectations, milestones, and 30-, 60-, and 90-day benchmarks. | Build a modular training program for health surveys, Life Safety Code, complaints, and documentation. | Review documentation, citation practices, timeliness, and findings with feedback loops. | Improve backlog tracking, complaint trends, dashboards, enforcement monitoring, and data validation. | Monitor workload, travel burden, span of control, and sustainability of productivity expectations. |

## Objective

Phase 3 strengthens the internal infrastructure required to sustain improvements achieved in Phases 1 and 2. The phase focuses on training, onboarding, quality assurance, workforce sustainability, and data capabilities so that backlog reduction and enforcement improvements are supported by durable systems rather than temporary workarounds.

## Strategic Outcomes

- Reduce time to competency for new MFIs.
- Establish a standardized onboarding model.
- Implement a modern, role-specific training program.
- Develop a quality assurance and quality improvement framework for survey work.
- Define and begin implementing a data and technology roadmap to improve transparency and internal decision-making.

## Phase 3 Priorities

### 1. Compressed training model

Refine a phased training model that prioritizes critical survey competencies and accelerates readiness while maintaining quality and compliance. Sequence staff from foundational learning to supervised field practice to independent work using observable competencies and supervisor feedback.

### 2. Standardized onboarding

Implement a structured onboarding model with consistent expectations, role clarity, field exposure, and feedback during the earliest stages of employment. Use defined milestones and 30-, 60-, and 90-day benchmarks.

### 3. Training modernization

Develop a sustainable training program aligned with operational needs, including modular curriculum for health surveys, Life Safety Code, complaints, documentation, and related functions.

### 4. Quality assurance and quality improvement

Implement QA/QI processes that review survey documentation, deficiency citation practices, timeliness, and written findings, with feedback loops between supervisors, surveyors, training staff, and leadership.

## 5. Data and technology infrastructure

Partner with the VDH Office of Information Management (OIM) to define a roadmap for stronger data visibility and internal decision-support tools, including backlog tracking, complaint trend analysis, productivity dashboards, enforcement monitoring, and data validation.

## 6. Workforce support and sustainability

Monitor workload expectations, travel burden, staff experience level, supervisory span of control, and the impact of complaint work on planned survey activity. Align productivity expectations with workforce sustainability.

## Phase 3 Implementation Timeline

| Period | Focus | Required Activities | Expected Outcome |
|---|---|---|---|
| Completed through May 2026 | Active implementation and data initiation | Continue compressed training; use onboarding checklist and mentor model; initiate OIM collaboration; begin data needs assessment and QA/QI design. | Compressed training operational; onboarding framework and data needs assessment underway. |
| June-August 2026 | Development, refinement, and early pilots | Refine training model; develop curriculum; define QA tools and dashboard scope; evaluate vendor/state-supported options. | Modular training, QA/QI tools, and initial data roadmap developed. |
| September-December 2026 | Pilot implementation and system integration | Launch updated training materials; implement onboarding; pilot QA/QI and dashboards; begin supervisor and leadership use. | Pilot dashboards and QA/QI processes operating; training updates implemented. |
| January-March 2027 | Full implementation and strategic alignment | Embed QA/QI into supervisory processes; finalize data strategy; continue OIM partnership for multi-year technology needs. | Standardized training and QA/QI framework implemented; data strategy ready for broader planning. |

## Phase 3 Deliverables and Measures of Success

- Compressed training model refined and operational.
- Standardized onboarding framework implemented.
- Modernized training materials developed and deployed.
- QA/QI structure implemented with defined review processes and performance measures.
- Data needs assessment and roadmap completed, with initial internal dashboard and reporting improvements piloted.
- Recruitment activity and staff vacancy rates tracked by position and region, with a goal of maintaining the overall vacancy rate at or below 10%.
- Time to fill positions improves, qualified applicant pools increase, and recruitment barriers are identified and addressed.
- Time to competency improves; survey productivity and consistency improve; leadership has better operational visibility.

# Management Approach

The three phases will operate in parallel where appropriate. Phase 1 addresses immediate operational stabilization and recertification workload reduction. Phase 2 builds the enforcement and engagement framework needed for consistent statewide oversight. Phase 3 strengthens the internal infrastructure required to sustain performance gains.

Implementation will use clear ownership, routine leadership review, defined performance measures, and escalation pathways when milestones are at risk. Leadership review will focus on throughput, staffing, certification progress, HMS production, complaint workload, enforcement consistency, engagement findings, and implementation of internal system improvements.

Each workstream will distinguish between actions that are on track, actions requiring adjustment, and actions dependent on external decisions such as funding, hiring, technology support, regulatory review, or legal guidance.

# Conclusion and Path Forward

This strategic action framework gives OLC a structured path to strengthen nursing home oversight in Virginia. It addresses immediate operational demands while building the regulatory consistency, stakeholder alignment, workforce capacity, and internal infrastructure needed for long-term success.

The plan moves OLC toward a stable, transparent, and accountable oversight model that better protects residents, informs providers, and equips staff to carry out the work effectively across the Commonwealth. Successful implementation will require sustained leadership attention, continued partnership with internal and external stakeholders, and disciplined follow-through on the operational, enforcement, workforce, and technology improvements described in this plan.

# Appendix A: Engagement Contacts

FACILITIES, ASSOCIATIONS, AND PARTNERS ENGAGED IN SUPPORT OF THIS PLAN.

## Facilities Identified for Engagement and Support

| Name | Address | Owner Group | Administrator Contact | Email |
|---|---|---|---|---|
| Amelia Rehab & Healthcare | 8830 Virginia St, Amelia Court House, VA 23002 | YAD Healthcare | Christopher Calloway | ccalloway@ameliarehab.com |
| Thalia Gardens Rehabilitation and Nursing | 4142 Bonney Rd, Virginia Beach, VA 23452 | Eastern | Charlie Phillips | chaphillips@ehg.care |
| Canterbury Health & Rehab | 1776 Cambridge Dr., Richmond, VA 23238 | Marquis | Veronica Haskins | vhaskins@cantebruryrehab.com |

## Facilities Identified as Demonstrating Potential Best Practices

| Name | Address | Owner Group | Administrator Contact | Email |
|---|---|---|---|---|
| Abingdon Health & Rehab Center | 15051 Harmony Hills Lane, Abingdon, VA 24211 | CCR | Colbey Smith | vdhadmin@abingdon-rehab.com |
| Monroe Health & Rehab | 1150 Northwest Dr, Charlottesville, VA 22901 | Saber | Mark Morris | mark.morriss@saberhealth.com |
| Heritage Hall-Laurel Meadows | 16600 Danville Pike, Laurel Fork, VA 24352 | American Health Care | Mark Nester | mnester@ahc.cc |

## Association Contacts

| Association | Contact | Phone | Email |
|---|---|---|---|
| Virginia Health Care Association | Keith Hare | 804-212-1693 | Keith.Hare@vhca.org |
| LeadingAge Virginia | Dana Parsons | 804-925-2565 | Dana@leadingagevirginia.org |
| Virginians Advocating for Seniors | Matt Benka | 804-240-7984 | matt@mdbstrategies.com |

# Appendix B:
# HMS Contractor Support and Production Targets

**HOW CONTRACTOR CAPACITY SUPPORTS THE JANUARY 1, 2027 CHECKPOINT AND THE THROUGH-2027 TRAJECTORY.**

This appendix establishes the recertification performance target and describes the role of HMS contractor support in achieving the January 1, 2027, checkpoint and the broader through-2027 performance trajectory. HMS contractor support is a critical component of OLC's near-term backlog reduction strategy. While OLC staff remain responsible for the core survey and certification workload, internal production alone is not sufficient to reach the January 1, 2027 checkpoint. HMS provides supplemental survey capacity that allows OLC to maintain forward progress while state staff continue to balance recertifications, complaints, revisits, immediate jeopardy work, onboarding, training, and other operational demands.

Based on current planning assumptions and early production trends, HMS is on track to average approximately five to six recertification surveys per month through the end of December 2026. This level of contractor production, combined with OLC's internal average of approximately three recertifications per week, creates a more realistic path to reducing the number of facilities carried into calendar year 2027.

## Key Facts

- The July 2026 planning universe includes 291 nursing facility records and is adjusted to reflect completion of the final 2022 recertification survey during the week of July 20, 2026.
- The adjusted baseline includes 170 facilities in the 16-plus month grouping and 23 additional facilities projected to become due or overdue by January 1, 2027, creating a near-term workload of 193 recertifications.
- OLC's current internal production average is approximately three recertifications per week, or about 13 per month.
- At the current internal pace, state staff are projected to complete approximately 78 recertifications between July and December 2026.
- HMS is projected to provide supplemental capacity of approximately five to six recertifications per month through December 2026.
- Together, OLC and HMS are expected to average approximately 18 to 19 recertifications per month between July and December 2026.
- Internal capacity alone is not sufficient to meet the January 1, 2027 checkpoint; HMS and other supplemental capacity are necessary to close the gap and reduce the number of facilities carried into 2027.
- Continued contractor support remains necessary because OLC's internal workforce is simultaneously responsible for recertifications, complaint investigations, revisits, immediate jeopardy follow-up, enforcement activity, training, and onboarding of new staff.

## Through-2027 Performance Trajectory

| JULY–DEC. 2026 | JAN.–JUNE 2027 | JULY–NOV. 2027 | DEC. 2027 |
|---|---|---|---|
| **≤85 by Jan. 1, 2027** | **≤29 by June 30, 2027** | **~11 by Nov. 30, 2027** | **0 by Dec. 31, 2027** |
| Target ~18-19/month · Est. completions ~108-114 | Target ~17/month · Est. completions ~102 | Target ~14/month · Est. completions ~70 | Target 11 total · Est. completions 11 |

The July–December 2026 target assumes continued internal production of approximately 13 recertifications per month and HMS contractor production of approximately five to six recertifications per month. This combined production target is intended to reduce the carry-forward inventory to no more than approximately 85 facilities by January 1, 2027.

These targets should be treated as management benchmarks and adjusted as actual production, complaint volume, staffing, survey complexity, HMS availability, revisit demands, immediate jeopardy activity, and other operational conditions change.