

Adult Family Home GUIDEBOOK

Partners in Protection | March 2012



prevention • recognition • resident protection • mandated reporting



ADSA Aging & Disability
Services Administration

Dedication

The Department recognizes that abuse of vulnerable adults happens more often than any of us would like to admit. For every case of abuse reported, some statistics point to as many as five cases that go unreported. Abuse, neglect, abandonment and financial exploitation happen to men and women from all social positions, ethnic backgrounds, and cross all economic boundaries.

As responsible citizens, we all must work to prevent or stop vulnerable adults from being harmed by, or being placed at risk for, abandonment, abuse of all types, neglect, and financial exploitation.

Each resident who lives and receives care and services for health and safety in a licensed adult family home (AFH) deserves our full efforts as “Partners in Protection” to protect him or her from abandonment, abuse, neglect (possible criminal mistreatment) and financial exploitation.

The Department dedicates this Guidebook to all former, current and future residents who live and receive care in licensed AFHs. The Department recognizes and thanks residents, residents’ families and other parties who respectively advocate for themselves, their loved ones or their clients in this licensed long-term care residential setting.



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- Office of the King County Prosecuting Attorney's Elder Abuse Project, Criminal Division
- Office of the King County Medical Examiner
- Adult Family Homes United
- Washington State Residential Care Council (WSRCC)

This Guidebook applies to all businesses licensed, or required to be licensed, to operate as an adult family home in Washington State. This state's main business law for AFHs is found in chapter [70.128](#) Revised Code of Washington (RCW). Our state's licensing rules are in chapter [388-76](#) Washington Administrative Code (WAC). These rules set out the minimum requirements that all AFHs must consistently meet.

The Guidebook Applies:

- Whether the licensed AFH does or does not provide any optional specialty care and services to residents with dementia, mental illness, intellectual/developmental disabilities, or, other future specialty care needs as may be approved by the Department;
- To the delivery of care and services to all residents living in a licensed AFH whether the AFH does or does not accept admission of residents who are state pay clients using the Medicaid program; and
- Uniformly to licensed AFH providers and their staff as they are mandated reporters who are required, under state laws and rules, to report alleged, suspected or actual abuse of all types, abandonment, neglect, injuries of unknown source, financial exploitation, and, death of a resident in certain circumstances.

This Guidebook Assists AFH Providers and Their Staff:

- To more consistently prevent, recognize, report, and protect each resident from all types of abuse, neglect, mistreatment, restraints, involuntary seclusion, abandonment, financial exploitation, and, misappropriation of resident property.
- To be in compliance with our state's AFH regulations.
- To effectively implement the state's AFH laws and rules.
- To recognize key risk factors that may place residents at greater risk for abuse, neglect, and financial exploitation.
- To take all prompt and necessary actions to protect residents following allegations of abuse, neglect, and financial exploitation.
- To carry out facility and individual staff responsibilities as mandated reporters.
- To report to the Department's hotline and local law enforcement as required by law.
- In certain circumstances, to carry out the legal obligation to immediately report the death of a resident to the county Coroner/Medical Examiner.

Introduction

How Big Is the Under-Recognized Problem of Adult Abuse, Neglect & Exploitation?

No one knows for certain. One thing is certain: abuse, neglect and financial exploitation can happen to any older or vulnerable adult – your loved one, your neighbor, your resident or client – it can even happen to you. Nationally, there is no uniform reporting system, and, there are no uniformly-accepted definitions for terms like “elder”, “vulnerable adult”, “abuse”, “neglect”, and, “financial exploitation”.

Published research indicates that more than one in ten elders may experience some type of abuse, but only one in five cases or fewer are reported. So while there are research data related to these crimes, the full extent remains uncertain. There is concern that these incidents/crimes are not recognized by, or are not reported by, individuals who are required to make mandated reports.

It can occur anywhere – at home, in the community-at-large and, in licensed long-term care residential care settings. It affects individuals across all socio-economic groups, cultures and races. Based on research data, women, “older” elders (age 85+) and persons with intellectual and developmental disabilities are at even higher risk to be victimized as vulnerable adults.

This Guidebook provides guidance, but it is not law. It is not big enough to include everything. State law has precedence over this Guidebook’s text and examples regarding prevention, recognition, resident protection and mandated reporting of vulnerable adult abuse, neglect and financial exploitation. You (the provider) are responsible for considering other possible issues and situations to protect residents and to report abuse and neglect.

It contains information that is not intended to limit the Department’s jurisdiction and authority over facilities or entities that the Department licenses or certifies under state or federal law.

It also contains information that is not intended to conflict with any federal requirements that are a necessary condition to receipt of federal funds by Washington State.

[Contact your local Residential Care Services \(RCS\) District Administrator or RCS Field Manager](#) if you have any questions about this Guidebook and its content.

In This Guidebook, Certain Terms Are Considered Equivalent:

- “Facility”, “Entity”, and, “Adult Family Home” (AFH);
- “Resident”, “Client” and, “Vulnerable Adult”;
- “Allegation” “Event”, “Incident”, and “Occurrence”;
- “Department of Social and Health Services” (DSHS) and the “Department”; and
- “Caregiver”, “Staff”, “Staff Person”, and “AFH employee or contractor or volunteer”.



You are responsible for everything that happens in your adult family home... including the actions of your staff.

Chapter 1

Recognizing Abuse and Neglect

As an AFH provider/licensee, you are responsible for everything that happens in your home, whether you are present or not, including the actions of your staff as it pertains to the safety of your residents.

This chapter explores the various types of abuse, including some warning signs and examples of abuse.

“Abuse” as defined in [RCW 74.34.020\(2\)](#) means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

“Abuse” per [RCW 74.34.020\(2\)](#) refers to:

- (a) Sexual Abuse,
- (b) Physical Abuse,
- (c) Mental (Verbal) Abuse, and
- (d) Exploitation of a Vulnerable Adult, including Financial Exploitation

No matter what a resident may have done to staff or others, abuse is never justified. Retaliation by staff is **always** abuse. Assault is **always** abuse, but some abusive actions may not amount to an assault. Assault requires intent to cause harm to a vulnerable adult; it must be reported immediately to both the Department and to local law enforcement.

An action can be abusive even if there is no intent to cause harm. In general, you should presume that:

- Abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident who is a vulnerable adult.
- Instances of abuse cause physical harm, pain, or mental anguish to any resident who is a vulnerable adult.

Examples:

- **Physical Abuse / Resident Death:** A 67-year-old male resident was kicked in the groin and stabbed in his chest and abdomen with a large kitchen knife by another male resident while outside together on the patio. This resident-to-resident altercation was directly observed by a third resident and by the licensed provider. An immediate call was made to 9-1-1 to report to law enforcement and to get emergency medical services (EMS) for the injured resident. Once at the AFH, law enforcement (police) took the one resident into custody. Soon after EMS arrived, the injured resident died. The provider called both the Department and their county's Medical Examiner to report this unprovoked incident of physical assault/abuse and the subsequent death of the injured resident.
- **Alleged Sexual Abuse:** An 85-year-old female resident belatedly told of "not right touching" by her son-in-law and grandson during a late evening visit in her room. This resident reluctantly talked about what happened to her some sixteen (16) hours later, after she was asked by a caregiver why she had been crying off and on all morning and also why she had not eaten breakfast or lunch. The caregiver immediately reported these allegations of inappropriate, unwanted "touching" (potential sexual abuse) to both law enforcement and to the Department.
- **Neglect / Involuntary Seclusion:** A 33-year-old female resident with intellectual and developmental disabilities reported that she had a "bad time" with her legal guardian during a weekend visit. The provider asked her what she meant by a "bad time". The resident eventually shared that she was "very hungry", and was "locked in a strange room for a long time" by her legal guardian of record. The provider promptly called the Department to report this resident's allegations of possible neglect and potential involuntary seclusion by the legal guardian.
- **Mental / Verbal and Physical Abuse:** A 55-year-old male resident, with mental illness diagnoses, was observed by the provider to yell at and to shove another female resident several times during the past week. The female resident had family members that reported this same male resident had been observed to shove their family member during breakfast on at least two different occasions. A caregiver reported that during breakfast on Saturday, the female resident was found on the floor. The male resident was in that same dining area at the time, but was quietly sitting and eating his meal. The female resident was admitted to the hospital for surgery to fix a fractured hip that had resulted from the fall at breakfast. The provider called the Department to report possible mental (verbal) and physical abuse, and, the female resident's significant injury (a fracture) of unknown cause.

“Physical Abuse” as defined in [RCW 74.34.020\(2\)\(b\)](#) means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

Physical abuse – acts by others

- Alleged, suspected or witnessed physical abuse, assault, discipline, inappropriate use of physical restraints or chemical restraints, or, unnecessary or incorrect medications may contribute to or potentially cause a range of “negative outcomes” to a resident/client who is a vulnerable adult.
- Physical contact with a resident for the purpose of retaliation constitutes abuse.
- Abusive physical contact against residents may include but is not limited to:
 - Slapping; hitting; kicking; pinching; punching; physically restraining/holding against their will; pulling hair; and, throwing food or objects.
 - Such abuse is never justifiable no matter what a resident may do to a caregiver, another resident or individual.
 - Such contact is physical abuse even if in response to physical contact by, or verbal abuse from a resident/client.

Broken Bones

- Broken bones are breaks or cracks in bones that may push through skin, and are usually caused when the body strikes or is hit by a blunt object, either directly or indirectly.
- Pain and inability to move a limb/body part, or, unrelieved pain and swelling in an area of the body may be signs of broken bones if a resident has been handled roughly, or, is at risk for fractures due to certain diseases.
- There is any history of current/past broken bones in various stages of healing or in various parts of the body (such as, leg, hip, pelvis, arm or wrist; or, skull, nose or face).

It is essential that staff immediately tell you or the AFH Resident Manager if:

- There is any chance that one or more broken bones or other injuries may have resulted from “problems” while giving care, such as, a resident’s “resistance” to care.
- The resident was “dropped” during any type of care, or, a resident was found on the floor (such as, after an un-witnessed possible fall).
- The resident may have experienced any type of rapid or severe forward and backward movement of head/neck with energy sufficient to potentially cause major internal injuries, such as, ruptured blood vessels/ligaments, or, fractured neck bones.
- There is any chance that the suspected or actual broken bones may have followed a resident-to-resident altercation or a staff-to-resident incident in the AFH.

Skin Trauma

- Burns and blistering skin over widespread areas, or, on certain areas of the body (such as, palms of hands, soles of feet, buttocks) may show a pattern of how the resident may have been burned by scalding water, or, by other heated objects like a heating pad, a cigarette or a hot stove burner.
- Immersion burns of hands/wrists or feet/ankles with such likely burn patterns may resemble “gloves” or “stockings” on the upper or lower limbs of a resident.
- Rope or fabric “burns” or “marks” on a resident’s arms/wrists, legs, neck, waist or torso may also be indicators of possible physical abuse from use of various devices, such as the inappropriate use of physical restraints.
- “Abrasions” usually result when the skin contacts a rough object or surface with sufficient force to rub away part of the surface of a resident’s skin, such as, dragging a resident’s skin against bed linen instead of lifting a resident up to properly move them in bed.
- “Cuts” are usually tissue wounds resulting from a sharp object, under pressure, coming into contact with a resident’s skin, such as being jabbed by a letter opener or table knife.
- “Lacerations” are usually defects in soft tissue resulting from blunt forces, such as, tearing, ripping, or crushing injuries to a resident’s skin.
- Abusive skin injuries, such as intentional wounds, cuts, punctures, or, untreated injuries may be found in various stages of healing or infection.
- Scratches, puncture wounds or other injuries may result when a resident is scratched by a caregiver’s fingernails/jewelry, or, by hazards associated with an AFH’s physical environment or resident equipment.

Bruises

- “Bruises” or contusions are injuries that result from leakage of blood from vessels into soft tissues after sufficient force has been applied to distort soft tissue and to tear blood vessels.
- A “hematoma” is a localized mass of usually clotted blood that is mostly confined within an organ, tissue or space in a resident’s body, like the risk for a brain subdural hematoma after a fall with a blow to the head.
- The coloring of any bruise (purple, blue, green, yellow) does not tell you when the bruise happened or how such bruising may have evolved in its coloring over time.
- Bruises may look different in the skin of persons of color.

Bruising Specific to Elders

When compared to “normal”, “accidental”, or “non-intentional” bruises, research findings* suggest that “suspicious”, “inflicted”, or “abusive” bruises more likely may be:

- Significantly larger in size (2 inches in diameter or more);
- Located on the head (especially the face/neck) and the trunk/torso of the body, rather than predominantly on a resident’s arms or legs;
- Found on a resident’s genitals, buttocks, soles of the feet, or, arm (right or left, depending on a resident’s dominant arm, often raised to block an alleged attack); and
- Residents taking medications that interfere with blood coagulation (i.e., warfarin) may be more likely to have multiple bruises, but these bruises usually do not last any longer than bruises of residents not on such medications.

*Wiglesworth, Austin, Corona, Schneider, Liao, Gibbs, & Mosqueda. (2009). Bruising as a marker of physical elder abuse. *Journal of the American Geriatrics Society*, 57, 1191- 1196.

Even for residents with dementia, such suspicious injuries are often remembered over time for what caused them, as it is often an emotionally charged event that stays with them.

“Sexual Abuse” as defined in [RCW 74.34.020\(2\)\(a\)](#) means any form of non-consensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing and sexual harassment. Sexual contact may include interactions that do not involve touching, including but not limited to sending a resident sexually explicit messages, or cuing or encouraging a resident to perform sexual acts. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under [chapter 71A.12 RCW](#), and a vulnerable adult living in that facility or receiving service from a program authorized under [chapter 71A.12 RCW](#) whether or not it is consensual.

Watch for Sexual “Grooming” Indicators:

- Potential offenders may groom their victim before sexual assault, often violating a resident’s personal boundaries.
- Potential offenders may also groom those persons close to the intended resident victim by being overly friendly or helpful, in an effort to win their trust.
- Potential grooming may occur over a period of days, weeks or months as a “test” to see how a resident/client will react.
- Be alert to a pattern of potential sexual “grooming” behaviors or activities being directed towards a particular resident/client, such as:
 - Giving unusual special attention or special treatment
 - Giving exclusive gifts or treats
 - Providing non-care-related physical touching or “massages” with or without others around
 - Inviting a certain resident into the private quarters of the house where the provider/ caregiver sleeps

There are certain risk factors and warning signs to be aware of.

Key Warning Signs of Sexual Abuse / Sexual Assault:

- Resident/client reports sexual abuse or sexual assault, unwanted touching, genital itching or pain
- Any sexual activity that occurs when a resident cannot or does not consent (such as, rape, sexual penetration, sexual threats and coercion, forced kissing, sexually explicit photographing by anyone)
- Non-consensual sexual contact between vulnerable residents when foreseeable and predictable by AFH provider or staff
- Inappropriate sexual contact by a cognitively intact resident against other residents with known dementia
- Any sexual contact between a staff person and a vulnerable adult living in a facility, whether or not it is consensual (such as, sexual touching, kissing, intimate hugging, "dating")
- Unwarranted, intrusive, inappropriate intimate touching of a resident while receiving care and services, such as, during bathing, dressing, toileting, incontinence care
- Bite marks, bleeding, bruising, infection, scarring, or irritation in or near a resident's genitals, thighs, anus/rectum, mouth or breasts
- Staff exposes his genitals to a resident
- Torn, stained or bloody briefs or undergarments
- Forced viewing of pornographic material in any form, even if no physical touching of any resident takes place
- Sudden changes in the behaviors, or the emotional or psychological state, of a resident in the presence of a particular caregiver or any individual with unsupervised access to resident in the AFH or on outings, such as: withdrawal, shying away from being touched, depression, difficulty eating/sleeping, sexually inappropriate behavior, or fear
- Resident reacts to possible offender in inappropriate or romantic ways, such as, saying or telling others that a caregiver is "My girlfriend", or, "He loves me".
- Belatedly recognized pregnancy or possible miscarriage of a pregnancy
- Any physical evidence of rape such as bruising in the vaginal or anal/rectal area, potential for or the actual presence of suspected semen
- Person takes non-care related photographs of nude residents in an AFH, regardless of whether such pictures were ever distributed to other parties or not
- AFH providers are required to keep an incident log to document any injury to a resident, any accidents/incidents affecting a resident's welfare, and, all alleged/suspected incidents of abandonment, neglect, abuse or financial exploitation.

"Mental abuse" as defined in [RCW 74.34.020\(2\)\(c\)](#) means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

Mental / emotional abuse may include:

- Humiliation, harassment, threats of punishment or deprivation, purposefully withholding cigarettes or some form of activity, or withholding something that belongs rightfully to a resident.
- Placing unreasonable restrictions on a resident's mobility or on a resident's ability to communicate with other persons by any means usual for that resident.
- Threats of harm or saying things to frighten or intimidate a resident.

Verbal abuse may include:

- Any use of oral, written or gestured language that willfully includes threats or disparaging terms to or about residents/their families within hearing distance of any resident, regardless of age, ability to comprehend, nature of physical and intellectual disabilities or diagnoses.
- Saying cruel, demeaning, degrading, unwanted, inappropriately crude or sexual language, asking sexual questions of, or making sexual comments to, a resident no matter what the circumstances.
- Resident self-reports to a caregiver that she is being "repeatedly yelled at", "meanly scolded", and, made to "feel bad" by both the AFH resident manager and the AFH provider.
- Changes in behavior not usually/typically associated with the resident, such as, helplessness, hesitation to talk openly, fear, withdrawal, depression, agitation, anger, denial, confusion or disorientation.
- Intentional and repeated verbal harassment intended to potentially or actually frighten, intimidate or harass a resident.
- Deliberately keeping a resident socially isolated from family, friends, or activities of choice or preference.
- Placing unreasonable restrictions on a resident's mobility, such as willfully not charging a motorized wheelchair battery so a resident is not able to be independently mobile by chair.
- Giving a resident the "silent treatment" by failing to respond to or communicate with a resident/client in the usual manner.
- Swearing, insulting, or ridiculing a resident by any person who works in or lives at the AFH.
- Language or actions that treat any resident like a "child", such as, an AFH rule that enforces the same 7:30 PM bedtime for all residents when it is not their choice and even after residents object to this "rule".
- Verbal attacks, threats, rejection, isolation, or belittling acts that could cause mental pain and suffering, anguish or distress to a resident.
- Resident is emotionally upset or agitated out of character for that individual.
- Resident is extremely withdrawn and non-communicative for no apparent reason.
- Resident shows unexplained nervousness and fear of certain individuals, or, certain situations.

“Exploitation” as defined in [RCW 74.34.020\(2\)\(d\)](#) means an act of: forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior; or causing the vulnerable adult to perform services for the benefit of another.

Resident Risk Factors for “Undue Influence” by Others

- Physical and cognitive limitations or disabilities
- Adverse life events
- Difficulty speaking English as a primary language
- Isolation or dependence
- Lack of financial expertise
- Loneliness, fatigue, fear
- Trauma – physical or emotional

Examples of Exploitation

- A female resident is “helped” by a couple from her church who have “adopted” her, after learning from her that she has no close local family. She tells you they are her new “best friends”. She gives them “consent” to transfer her bank account into their names so they can help her pay her bills. Without her knowledge, the couple makes countless withdrawals of the resident’s money to buy themselves three new cars.
- A male resident in an AFH is slowly groomed and manipulated over time by a female AFH caregiver into writing her a \$5,000.00 check as a “gift” of money from him to help her pay off her delinquent car loan.
- An out-of-state male relative, named by a female resident to legally pay bills on her behalf from her personal funds, fails to pay the AFH’s bill for three consecutive months of this resident’s care and services.
- Sudden appearance of previously uninvolved relatives claiming their “right” to take over a resident’s affairs and valuable possessions.
- The resident’s guardian, who is the resident’s “representative payee”, purchases furniture and clothing not intended for the resident.
- Providing services that are not necessary, or, denying services that are necessary, per a resident’s current assessment and negotiated care plan.

“Financial exploitation” as defined in [RCW 74.34.020\(6\)\(a\)\(b\)\(c\)](#) means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person’s or entity’s profit or advantage other than for the vulnerable adult’s profit or advantage. Financial exploitation includes, but is not limited to:

- (a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;

- (b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or
- (c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

Financial Exploitation Acts May Include But Are Not Limited To:

- Scams
- Identity Theft ([RCW 9.35.020](#))
- Theft by Taking/Deception/Embezzlement (RCW 9A.56.030-050)
- Forgery ([RCW 9A.60.020-060](#))
- Undue Influence, Coercion and Fraud
- Abuse of Trust: Powers of Attorney or Legal Guardianships

Examples of Persons Who May Attempt Financial Exploitation of Vulnerable Adults For Their Own Personal Gain or Profit:

- Accountants, attorneys, legal guardians
- Battling family members or distant relatives
- Business employees (car dealer/sales staff), door-to-door unlicensed contractors
- Career criminals/strangers who target the resident and become "friends" ("Stranger and "Sweetheart" scams)
- Caregivers, providers, resident managers, staff provided through employment agencies
- Children from a prior marriage
- Faith leaders, church representatives/members
- Family members, close trusted friends, others with an on-going relationship with a resident
- Financial stockbrokers, institutions, banks
- Power of attorney for resident's financial matters
- Real estate broker representing vulnerable adult
- Trustee of a trust set up for vulnerable adult beneficiary
- Volunteers associated with community groups or agencies who get to know the resident in the AFH

Examples of Financial Exploitation

- A male resident reported “financial problems” along with “missing clothes and radio” when visited by a qualified assessor who had been hired by the AFH provider to evaluate his changing care needs.
- Power of attorney given, or recent changes in or creation of a will or financial trust, when a resident is incapable of making such decisions, due to a prior documented medical diagnosis of severe dementia.
- Routine monthly bank account or charge card statements stop coming in the mail to a resident as had been the usual pattern.
- Caregiver’s secretive use of a resident’s ATM bank card to make large or repeated withdrawals to pay the AFH caregiver’s personal community college tuition bills.
- An AFH resident manager observed a resident being videotaped in his room by “friends” to record that the resident “really signed” important papers. The resident was overheard asking his visitors why he needed to sign anything again, as he didn’t remember asking for any “new papers”.
- Resident reports personal property – Social Security card and medical insurance card – are missing from his wallet.
- Phone call to resident from person claiming to be a “grandchild” stranded and in need of large amounts of money to “get out of trouble”.
- The inclusion of additional names on a client’s multiple bank accounts after a newly met “girlfriend/fiancée” abruptly took this client with dementia out for “errands” and failed to return him to his AFH for over 48 hours.
- Suspicious signatures on checks or other documents that do not resemble a resident’s known signature, or, when the resident is no longer able to sign their name due to dementia.
- Disappearance of extra bank checks, charge cards or ATM cards, cash; unexplained change in cash flow; missing wallet/purse; jewelry.
- Transfer of property – home/car; savings account or insurance policy beneficiaries; or, abrupt change in stock brokerage firm – all without a resident’s knowledge or consent.

“Neglect” as defined in [RCW 74.34.020\(12\)](#) means:

- (a) A pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or
- (b) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult’s health, welfare, or safety, including but not limited to conduct prohibited under [RCW 9A.42.100](#).

As referenced in [RCW 74.34.020\(12\)\(b\)](#), [RCW 9A.42.100](#) – Endangerment with a Controlled Substance says that a person is guilty of a class B felony crime of endangerment with a controlled substance if the person knowingly or intentionally permits a dependent child or vulnerable adult to be exposed to, ingest, inhale, or have contact with certain specifically-named chemical substances used in the manufacture of methamphetamine.

Neglect has many faces / features

- In general, neglect is conduct or inaction (whether intentional, careless, due to inadequate experience, training, or skill, or, insufficient staffing) that results in failure to provide the basic necessities of life, and, to deliver care and services when there is an implied or agreed-upon responsibility to a resident/client.
- Neglect may result when an AFH fails to carry out a resident’s negotiated care plan. Neglect creates serious risk/unnecessary danger to a resident’s health, welfare or safety. In certain cases, neglect may be the crime of criminal mistreatment per [RCW 9A.42.020-037](#).

Range of General Neglect Patterns may include but are not limited to:

- Dehydration, undocumented malnutrition/extreme weight loss, multiple/untreated/undocumented pressure ulcers (bed sores), poor personal hygiene;
- Documented but unattended/untreated injuries or medical problems – acute or chronic;
- Unsanitary and unclean living conditions – dirt, fleas, lice on person, maggots in wounds, soiled bedding, fecal/urine smell, inadequate clothing; and
- Hazardous or unsafe living conditions in AFH – no heat; no running water; improper wiring; no smoke alarms; or, other serious environmental or equipment risks to residents’ health and safety.

Examples of Neglect

- All residents were at serious risk for harm for three hours on Sunday mornings, when the only weekend caregiver regularly left residents inappropriately alone at the AFH so she could attend church services by herself.
- Two clients with known histories of challenging behaviors were not supervised by AFH staff per their resident-negotiated behavioral care plans. This resulted in a prolonged shoving incident that led to minor injuries for both clients.
- The AFH provider was able to verify that a caregiver fell asleep for at least 2.5 hours when he should have been awake and on duty, resulting in failure to assist two residents, well below usual body weights, who needed help with eating/feeding at meals.
- Upon arrival four hours into a caregiver's work shift, the AFH resident manager found this staff member, due to possible alcohol or drug use, intoxicated and impaired in her decision-making and care-giving skills, placing the health and safety of all residents at risk.
- In the past month, one resident has been newly and persistently fearful about leaving her room. AFH staff "leave her alone", rather than trying to determine possible reasons behind this resident's fear/panic.
- A resident, without local family or a court-appointed guardian, has bleeding gums and some painful loose teeth indicating that arranging for a visit to the dentist, on behalf of the resident, is long overdue.
- A resident had assessed care needs/orders for the use of intermittent medical oxygen. The resident was also assessed as needing direct supervision of smoking/smoking materials. One day he was not supervised by either of two caregivers at his AFH, resulting in serious second and third degree burns to the resident's face, lap and legs. This led to the resident spending several months in a specialized burn care unit.
- A resident who needs maximum help to turn periodically in bed and to get in/out of bed is known by AFH staff to have had three pressure ulcers over two bony areas that healed in the last three months. During an unannounced visit to the AFH at 7 PM, the resident was observed by her out-of-state family to: be delirious with a very high fever; look obviously thinner since their last visit; and, smell of a foul odor that they traced to uncovered, multiple open pressure ulcers (bed sores) on her buttocks that had leaked fluid and blood through her nightgown, leaving both wet and dried ring marks on bed linens they found underneath her.
- A resident fell resulting in a very swollen, bruised ankle and foot. She has persistently said that she has "lots of pain". The resident's doctor and family were not notified until Monday morning at 11 AM, even though the AFH resident manager personally saw the resident fall at 8 PM on the prior Friday. Hospital X-rays taken Monday afternoon showed a serious ankle fracture with loose bone chips that required the resident be hospitalized for surgery and follow-up care.

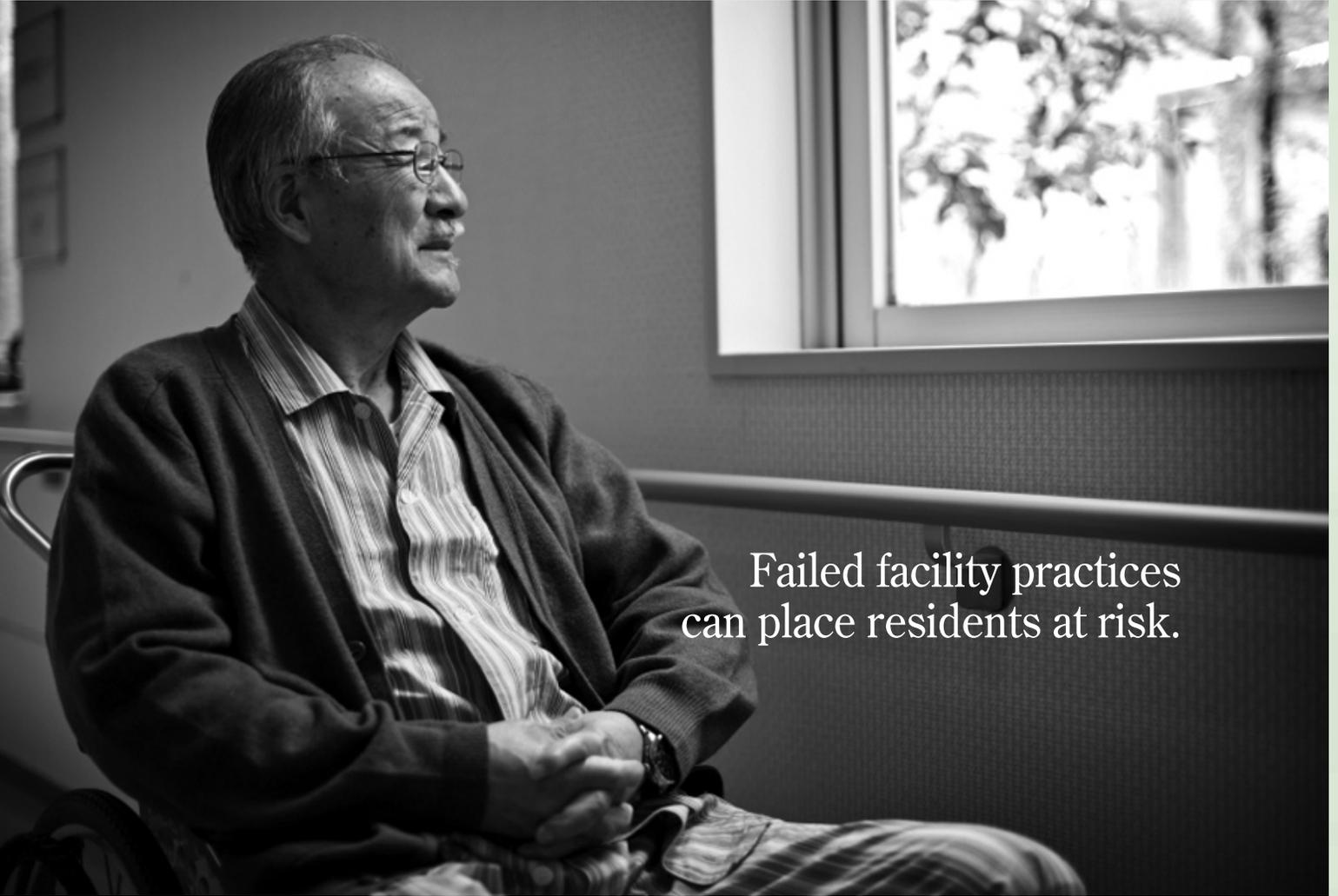
- An 83-year old resident with dementia, and a known prior history of unsafe wandering, was not noticed by AFH staff to be missing until four (4) hours after she was last seen at dinner. This missing resident was found alive but unresponsive by a passing motorist at 2 PM the following day, after she had apparently fallen into a roadside ditch about one half-mile from her AFH.

This resident received emergency medical services (EMS) at the scene where she was found. She was admitted to a local hospital where she died two days later. Both the AFH facility and its two mandated reporter staff working for the AFH failed to immediately notify local police and the Department when resident was discovered missing and could not be quickly found by AFH staff that dark, late evening in January winter weather.

Remember:

AFH Providers are required to keep an incident log to document any injury to a resident, any accidents/incidents affecting a resident's welfare, and, all alleged/suspected incidents of abandonment, neglect, abuse or financial exploitation.





Failed facility practices
can place residents at risk.

Chapter 2

Prevention and Risk Factors

Risk factors for abuse, neglect and financial exploitation can be related to residents in an AFH, to AFH employees, or, to conditions in the AFH itself.

More often it is a combination of these risk factors that will need to be managed by the AFH provider. The more risk factors that are present in your AFH, the greater the risk to each/all resident(s).

Be aware/alert for:

- **Abuse** may be many things, including acts of violence such as physical or sexual assault, or it may be yelling, intimidating or swearing at residents which can be verbal abuse.
- **Neglect** may be failure to provide appropriate care (medication omissions or errors) or proper assistance resulting in potential for or actual harm or injuries. Skin breakdown in a resident that was preventable or that did not get timely and appropriate medical assessment and care can be neglect, particularly if it leads to avoidable pressure ulcers (bed sores) over bony parts of resident's body (i.e., hips, ankles, buttocks, shoulder blades, elbows).
- **Financial Exploitation** may be undue influence or coercion or disappearance of possessions or property. Residents may be abused, neglected or financially exploited by a variety of individuals including: spouse, adult child or other family members, facility staff, volunteers, contracted staff, visitors, or, even other residents.

Potential resident risk factors for abuse, neglect and financial exploitation may include:

- Advanced age with physical or mental impairments
- Calling out or repeated vocalization that is not easily redirected by caregiver or others
- Chronic illness/disability, traumatic brain injury, or unmet chronic pain needs
- Demanding or impatient behaviors when making requests
- Dementia of all types or worsening cognitive impairment
- Documented but untreated injuries or fractures
- History of declining mobility, vision, and unsteady balance
- History of repeated un-witnessed falls, with or without bruises or other injuries
- History of resident-to-resident altercations in care settings
- History of mental illness such as depression or anxiety disorders, or, alcoholism or substance abuse
- History of unsafe wandering, becoming lost, or assessed as being unable to independently return to AFH without assistance

- Inability to clearly or consistently communicate needs and wants
- Inability to self-feed adequate food/fluids for good nutrition and sufficient hydration
- Inability to reposition self while seated or lying down, increasing the risk for avoidable pressure sores over bony areas of the body
- Incontinence of bladder (urine) or bowel (stool)
- Intellectual or developmental disabilities
- Intense feelings of sadness, despair, suspiciousness, hopelessness and worthlessness
- Intrusive behaviors that place resident at-risk for retaliation by others
- Prior history of abuse, neglect, financial exploitation, or, negative “undue influence” by others
- Problems concentrating, remembering or making decisions
- Repeated upsetting thoughts or ritualized behaviors
- Resistive to care given by others
- Sexual acting-out behaviors not predictable for a resident
- Social isolation or low levels of social support, such as few family contacts or local friends outside the AFH
- Striking/hitting-out at caregivers or other residents

Potential risk factors for AFH Employees may include:

- Alcohol abuse or prescription/illegal drug abuse – current or in past
- Apathy or indifference to care needs of residents
- Chronic physical illness negatively impacting work performance on the job
- Consistent pattern of making numerous personal phone calls while on duty
- Disqualifying conviction history – criminal background check or negative action findings
- Evasiveness with provider or co-worker, whether unintended/purposeful or verbal/nonverbal, or both
- Excessive/unexplained work absences or chronic tardiness (arrives repeatedly later than scheduled)
- Family problems or a history of family or domestic violence
- History of mental illness or suicide thoughts/gestures
- Impaired ability to understand, read and implement resident negotiated care plans
- Inappropriate displays of physical affection or giving “favorite” resident special attention or gifts
- Ineffective coping when experiencing stressful events on-the-job or in one’s personal/family life, including anger management issues

- Lack of awareness for when to seek help from AFH supervisor or AFH provider
- Lack of training or poorly trained for assigned duties
- Leaves resident inappropriately alone/unsupervised, or in an isolated or unsafe place
- Not able to understand and speak the English language well enough to respond appropriately to emergency situations
- Numerous disciplinary actions in current/past work history
- Poor self-control or poor self-image
- Resentment of care-giving role and job demands
- Sexual harassment of one or more co-workers, allegedly in the past or currently
- Socially isolated from personal family & friends
- Uses one or more devices as physical restraints (ties resident into a chair/bed), or, uses involuntary seclusion (locks bedroom door to prevent resident from exiting room) done for the sole convenience of the caregiver
- Verbally or emotionally abusive – belittles, curses, ridicules, swears, taunts, threatens or yells at residents
- Work absences with improbable excuses



Failed Facility Practices

When you do not comply with AFH rules and requirements, facility factors and failed practices can place residents at risk for abuse, neglect, or financial exploitation.

Some examples include:

- Person provides personal care, special care and room and board for more than one resident without a Department-issued, valid license to legally operate an AFH. [WAC 388-76-10005]
- Provider lacks understanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of vulnerable adults. [WAC 388-76-10020]
- Provider lacks the ability to consistently meet all personal and AFH business financial obligations. [WAC 388-76-10020]
- Provider admits and retains more residents and exceeds the allowed “resident capacity” listed on the AFH license. [WAC 388-76-10030]
- Provider fails to ensure that they are in full compliance with all multiple AFH management requirements when more than one home is licensed to them. [WAC 388-76-10036]
- Provider admits and retains residents for whom they cannot safely and appropriately meet the assessed needs and preferences for continuing care and services with available staff and through reasonable accommodation. [WAC 388-76-10390]
- Provider fails to ensure that there is always a staff person present in the AFH who can make needed decisions. [WAC 388-76-10040]
- Provider does not give written notice to the Department, residents or applicable resident representatives, sixty (60) calendar days prior to the proposed change of ownership of the AFH. [WAC 388-76-10106]
- Provider starts operation of the AFH at a new location before the Department has granted the license for the new location. [WAC 388-76-10110]
- Provider fails to allow Department staff access to the physical premises and all pertinent records/accounts related to the residents or operation of the AFH during inspections or complaint investigations. [WAC 388-76-10003]
- Provider fails to develop, organize, and carry out a discharge plan that meets the needs of each resident when an AFH chooses to voluntarily close. [WAC 388-76-10210]
- Provider fails to obtain and maintain the type(s) of liability insurance required of every licensed AFH. [WAC 388-76-10191]
- Provider or staff fails to call the Department’s complaint toll-free hotline number to report any actual or potential event requiring any resident to be evacuated; any missing resident; or, conditions that threaten the AFH’s ability to continue to provide care or services to each resident. [WAC 388-76-10225]
- Provider fails to immediately notify all required parties when there is a significant change in a resident’s condition, or a serious injury, trauma, or death of a resident. [WAC 388-76-10225]

- Provider fails to report to the local public health officer and to the Department hotline whenever an outbreak of suspected food poisoning or communicable disease occurs. [\[WAC 388-76-10225\]](#)
- Provider fails to develop and implement policies and procedures which require immediate contact of the local emergency medical services (EMS) when a resident has a medical emergency, unless the emergency relates to the expected death of a resident being monitored by a licensed hospice agency. [\[WAC 388-76-10250\]](#)
- Provider fails to immediately give arriving emergency medical services (EMS) personnel a copy of any order that exists directing medical care for the resident, and, the resident's advance directive for medical care, if available. [\[WAC 388-76-10250\]](#)
- Provider fails to create, maintain, and keep records for residents in the AFH where the residents live so staff has access to the parts of residents' records needed to provide care and services. [\[WAC 388-76-10315\]](#)
- Provider fails to ensure that resident records contain enough information so the needed care and services can be provided to each resident. [\[WAC 388-76-10315\]](#)
- Provider fails to allow representative of the long-term care ombudsman program access, per state and federal law, to a resident record if approved by the resident. [\[WAC 388-76-10315\]](#)
- Provider fails to make resident records available so that authorized Department staff can review the records when requested for inspection or complaint investigation activities. [\[WAC 388-76-10315\]](#)
- Provider fails to have systems in place that meet all laws and rules related to medications if the AFH admits and keeps residents who need medication assistance or medication administration services by a legally authorized person as required in [WAC 388-76-10475](#). [\[WAC 388-76-10430\]](#)
- Provider fails to keep current medication logs for residents as required in [WAC 388-76-10475](#). [\[WAC 388-76-10430\]](#)
- Provider admits and keeps resident(s) with specialty care needs, such as intellectual/developmental disability, mental illness, or dementia, without ensuring that the provider, the entity representative, resident manager and staff at their AFH have completed the specialty training required by chapter [388-112 WAC](#). [\[WAC 388-76-10505\]](#)
- Provider or home and staff willfully prevent, interfere or fail to cooperate with Department staff in the performance of official duties, such as, inspection and complaint investigation activities by the Department. [\[WAC 388-76-10915\]](#)
- Provider or home and staff willfully interfere with a representative of the Washington protection and advocacy system (Disability Rights Washington), or, of the long-term care ombudsman program in the performance of the representative's official duties as provided for in state or federal law. [\[WAC 388-76-10935\]](#)
- Provider unlawfully asks for and makes all residents sign waivers of potential liability in advance for losses of personal property or injury, and, residents' rights set forth in chapters [70.128](#), [70.129](#), [74.34](#) RCW, or in related applicable AFH minimum licensing requirements in chapter [388-76 WAC](#). [\[WAC 388-76-10610\]](#)



If you are unsure...
Report it.

Chapter 3

Reporting Requirements for Mandated Reporters

Adult Family Homes (meaning licensees/providers/staff) are mandated reporters and must comply with all applicable licensing laws and regulations at all times. Each AFH needs to read and understand the different parts and complicated nature of chapter [74.34 RCW](#) to assure that the facility and the individual mandated reporting responsibilities are done as soon as possible.

NOTE: At times, this law may be updated and changed. Be certain you are always working with the most current version of this law. You can access this online at <http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34>

This Guidebook reviews some, but not all, sections of this law.

Priority of AFH Actions for Resident Protection:

Each AFH must always use good judgment in deciding the best course of action to be taken to protect their residents following discovery or report of an incident or allegation of abuse, neglect, exploitation, abandonment, or, resident death. This is a reminder of what an AFH must do and the order in which these actions should be done.

FIRST PRIORITY:

Protect the victim/resident and other residents from harm or further harm.

SECOND PRIORITY:

Report as soon as possible, after the victim/resident is safe/protected, to the Department, law enforcement and to other entities as required by state law. You may need to gather more information about the alleged or actual incident and make additional calls.

Protection of residents, gathering of sufficient information about what may have/did happen, and reporting abuse and neglect allegations or incidents per state law usually can be done at the same time.

Chapter [74.34 RCW](#) requires both DSHS licensed facilities and staff of those licensed facilities to make separate mandated reports of abuse, neglect and financial exploitation.

This state law covers many topics including but not limited to:

- When and what type of information to report and to whom;
- Confidentiality and immunity for a mandated reporter;
- Failure to make a report to all proper parties;
- False or bad faith reporting; and
- Possible legal sanctions for failure to report or making a false report.

For a general pamphlet on your mandated responsibilities, visit: <http://www.aasa.dshs.wa.gov/Professional/RCS/documents/Mandator%20Reporting%20Pamphlet.pdf>

Where to Report:

1. The Department's Complaint Resolution Unit (CRU) Hotline:

- The Hotline number, 1-800-562-6078, is available 24 hours a day, seven days a week; the time and date of phone messages are recorded.

2. Local Law Enforcement:

- Dial 9-1-1 first for any life-threatening emergency. Then call the hotline number after the emergency has been handled and residents have been protected. For non-emergency situations, use the local number specified by your law enforcement authorities. The AFH must have this number readily available for staff.
- You can also locate police, sheriff and other law enforcement agencies for the state, cities and counties in Washington at: <http://www.the911site.com/911pd/washington.shtml> or use your local phone directory.

3. Coroner/Medical Examiner:

- You can locate your county's Coroner or Medical Examiner contact information at: <http://www.dahp.wa.gov/sites/default/files/WA%20Stat%20Medical%20Examiners-Coroners.pdf>
- Call the number specified by your county's coroner or medical examiner to report accurately and as soon as possible any resident death in which there may have been abuse or neglect (the crime of criminal mistreatment), even if the death otherwise appears to be due to natural causes.
- When an AFH provider or staff person knows that, or is unsure if, a resident's death should be reported to their county's coroner or medical examiner – REPORT IT!
- Such reporting does not apply if the death was to be expected and the resident was receiving "hospice services" from, and was being monitored by, a licensed hospice agency immediately prior to death.

4. State Department of Health (DOH):

- In certain circumstances, the AFH is required to report an employee who holds a professional license or certificate, usually a nurse or a certified or registered nursing assistant, to the appropriate disciplining authority at the DOH, Health Professions Quality Assurance Division.
- These reports must be submitted to the disciplining authority as soon as possible. Contact DOH Customer Service at 360-236-4700 or access online at hsqa.csc@doh.wa.gov.

Method of Reporting:

- By telephone.

When to Report:

- **Immediately (as soon as the victims/residents are safe)** telephone reporting is required for allegations of abuse, neglect, exploitation and misappropriation.

Who Should Make an AFH Facility Report:

- The AFH provider; or
- A person designated by the AFH provider to do the facility mandated reporting.

What to Report...**...to the Department:**

- All alleged incidents/events involving abandonment, abuse, exploitation, financial exploitation, and neglect or mistreatment, including injuries of unknown source.
- "Substantial injuries of unknown source" (not related to suspected abuse or neglect).
- When there is reasonable cause to believe a crime, other than those previously listed, has occurred.
- Medication errors that are probable abuse, neglect, or negligent treatment.
- Refer to Appendix "B" for CRU Hotline questions associated with mandated reporting by a facility – select Option 2 when calling in an AFH facility report.

What to Report...**...to Law Enforcement:**

- When there is a reason to suspect an incident is sexual assault.
- When there is reason to suspect an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.
- An incident of physical assault between vulnerable adults that causes more than minor bodily injury and requires more than basic first aid; the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.
- An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.
- When there is reasonable cause to believe a crime, other than assault, has occurred.

What to Report...

...to the Coroner or Medical Examiner:

- When the resident death is sudden and unexpected, such as, a resident that appeared in good health 1-2 days before their death; [Such reporting does not apply if the death was to be expected and the resident was receiving hospice services and was being monitored by a licensed hospice agency immediately prior to death.]
- When the circumstances indicate the death was caused by unnatural or unlawful means; [Such as, a fall resulting in recent head injuries (brain bleeding/hematoma); major bruises; significant pressure ulcers (bed sores); death following episode of choking on food/liquids; suspicions of abuse or neglect (the crime of criminal mistreatment)]
- The death occurs under suspicious circumstances;
- The death is caused by any violence whatsoever;
- An autopsy, post mortem or inquest is to be held;
- The death results from unknown or obscure causes;
- The death is caused by alleged rape or other sexual crimes;
- The death is due to a contagious or suspected contagious disease that may represent a public hazard; [Such as, a sudden illness with a high fever or rash right before death]
- The death apparently resulted from drowning, hanging, burns, exposure, strangulation, starvation, alcoholism, suffocation or smothering; or
- The death occurred within a year after a resident suffered burns, or was in an accident resulting in physical injury.

Once a Resident's Death is Reported:

- **If Jurisdiction Is Taken**, your county's coroner or medical examiner is responsible for investigating the "cause of death" and "manner of death" to decide the most appropriate "death certification" for that resident; or
- **If jurisdiction Is Not Taken**, then the coroner or medical examiner will issue a "no jurisdiction assigned" ("NJA") number associated with this death report. This "NJA" number should be documented in the resident's record by the person designated by the provider to make this report for the AFH.

What to Report...

...to the Department of Health's (DOH) Disciplining Authority for License or Certificate Holders:

- The AFH must report to the DOH, any employee/ staff person who is a licensed nurse or other professional, or a certified or registered nursing assistant who is under the disciplinary authority of the DOH, and, for whom there are allegations of abandonment, abuse, neglect, or financial exploitation of a vulnerable adult
- These and other certain employees/staff are under the DOH's monitoring and disciplinary authority, regardless of where these individuals are employed, as the DOH issues professional licenses or certificates so these individuals are able to work in our state.

The same basic reporting requirements apply for incidents between residents.

Individual Mandated Reporters (Including AFH staff)

- The identity of the person making a mandated report is kept confidential unless that person consents or there is a judicial proceeding as provided in [RCW 74.34.035\(9\)](#).
- A person making a mandated report in good faith or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding is immune from liability resulting from the report or testimony. [\[RCW 74.34.050\(1\)\]](#)
- The identity of the person making a mandated report will not be kept confidential when the Department determines that the report or complaint was not made in good faith. [\[RCW 74.34.180\(1\)\]](#) An individual mandated reporter who is required to make a report under [RCW 74.34.053\(1\)](#) and who knowingly fails to make the report is guilty of a gross misdemeanor.
- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- Licensing action may be taken by the appropriate professional disciplining authority (DOH) based upon failure to report, by those professionals, of incidents of suspected abuse or neglect.
- A person who intentionally, maliciously, or in bad faith makes a false report of alleged abandonment, abuse, financial exploitation or neglect of a vulnerable adult is guilty of a misdemeanor. [\[RCW 74.34.053\(2\)\]](#)
- The identity of the person making a mandated report will not be kept confidential when the Department determines that the report or complaint was not made in good faith. [\[RCW 74.34.180\(1\)\]](#)

Reporting to the AFH Provider or Resident Manager (Supervisor):

Remember that for the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual abuse and physical abuse, the person mandated to report to the Department is any AFH staff person who:

- Observes the incident or hears the victim state it happened and/or
- Hears about an incident from a permissive reporter who has direct knowledge of the incident.

Your reporting obligation under the law is NOT met if you ONLY report to your supervisor. The law states that each facility employee is a mandated reporter. Therefore, you must make the reporting call when you have “reasonable cause to believe” or “reason to suspect” the incident/event is reportable.

A staff person is permitted to consult with their AFH supervisor, before making a mandated report, to get help in making the determination if there is a reasonable cause to believe or a reason to suspect the incident/event is reportable.

Protection for the Individual Mandated Reporter

- A mandated reporter cannot be terminated, suspended or disciplined by the employer as long as the mandated report is made in good faith. [\[RCW 74.34.180\(3\)\]](#)
- However, a mandated reporter may be terminated, suspended, or disciplined by the employer for other lawful purposes. This could include, but is not limited to, when a facility exercises its authority to terminate, suspend, or discipline any employee who engages in workplace reprisal or retaliatory action against a whistleblower. [\[RCW 74.34.180\(4\)\]](#)

Additional Reporting

Refer to Appendix "A" for a summary of abuse/neglect reporting guidelines for Adult Family Homes, as well as reporting requirements for other AFH issues or events, such as fire; a missing resident; any actual/potential event requiring any resident to be evacuated; outbreak of suspected food poisoning or communicable disease.



Chapter 4

Provider Role and Responsibilities

At all times, it is the responsibility of each AFH provider to understand and be in compliance with all state laws and rules that apply to the legal and safe operation of their AFH business.

You must:

- Keep an incident log to document any injury to a resident, any accidents or incidents affecting a resident's welfare, and all alleged/suspected incidents of abandonment, neglect, abuse or financial exploitation.

You are also expected to:

- Protect all residents in the home while you try to figure out what may have happened, especially to a resident who may have been abused.
- Work to understand how a resident may have been the victim of non-accidental physical harm or injury through the use of excessive and inappropriate physical force, since such injuries may be warning signs of physical abuse.
- Understand physically abusive actions like biting, choking, kicking, pinching, pushing, slapping, striking, or unauthorized use of physical or chemical restraints to one or more residents can result in a variety of harmful, negative outcomes including but not limited to: abrasions, broken bones, bruises, burns, cuts/lacerations, welts, untreated injuries/ sores, or risk of death.
- Realize that injuries to a resident may not be immediately obvious and may not show up for several days, such as deep bruises or a slow delayed gathering of blood ("hematoma") on the brain, resulting from a fall with a hard hit (trauma) to a resident's head.

Washington State's Long-Term Care Resident Rights

The legislature has determined that the public interest is best served by providing the same basic resident rights to residents in all licensed long-term care settings. For example, all residents have the same rights regardless of whether they live in a nursing home, a boarding home or an adult family home.

The rights set forth in chapter [70.129 RCW](#) – Long-term Care Resident Rights are the minimal rights guaranteed to all residents of long-term care facilities.

The rights in this law in no way diminish from rights set forth in other state or federal laws that may contain additional rights.

It is the intent of the legislature that long-term care residents have the opportunity to exercise reasonable control over life decisions. The legislature intends that each resident should live in a safe, clean, comfortable, and homelike environment that allows the resident to use his or her personal belongings to the extent possible.

Laws Designed to Help Protect Residents

- Chapter [9A.04 RCW](#) – Washington Criminal Code
- Chapter [11.88 RCW](#) – Guardianship: Appointment
- Chapter [11.92 RCW](#) – Guardianship: Powers/ Duties
- Chapter [18.130 RCW](#) – Regulation of Health Professions
- Chapter [43.43 RCW](#) – Criminal Background Checks
- Chapter [70.129 RCW](#) – Long Term Care Resident Rights

Selected Examples of Long-Term Care Resident Rights Include But Are Not Limited To:

- Notice of rights and services – admission of residents
- Protection of resident funds and financial affairs rights
- Privacy and confidentiality of personal and medical records
- Ability to voice grievances and prompt facility efforts to resolve
- Posted notice about and readily available state inspection and complaint investigation reports and plans of correction in effect
- Privacy rights related to mail, telephone, electronic monitoring
- Contact with groups (such as, State or Regional Long Term Care Ombudsman or program volunteers, Disability Rights Washington) for advocacy access and visitation rights
- Safe, clean, comfortable and homelike living environment
- Use of personal property and lockable storage space
- Limitations on waivers of provider liability and resident rights
- Disclosure, transfer and discharge requirements, including reasonable accommodation of needs
- Freedom from use of physical restraints or chemical restraints
- Protection from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion
- Quality of life including dignity of and respect for residents
- Disclosure of fees and notice requirements
- Refund rules related to fees or other charges

Each AFH Provider must comply with Facility required Duties & Actions Related to Prevention, Recognition, Resident Protection, and Mandated Reporting of Abuse, Neglect, and Financial Exploitation.

You Must:

- Ensure each caregiver has a current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter [388-112 WAC](#). [[WAC 388-76-10135](#)]
- Meet all resident rights requirements related to protection, liquidation or transfer of funds that any resident may have deposited with the AFH. [[WAC 388-76-10215](#)]
- Send the final accounting and funds payable to the Department's financial recovery office if a deceased resident had some of his or her AFH care paid for by the Department with Medicaid funds. [[WAC 388-76-10215](#)]
- Keep an incident log of alleged/suspected instances of abandonment, neglect, abuse or financial exploitation; accidents/incidents affecting a resident's welfare; and, any injury to a resident. [[WAC 388-76-10220](#)]
- Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion. [[WAC 388-76-10670](#)]
- Ensure each resident's right to be free from physical or chemical restraints used for discipline or convenience. [[WAC 388-76-10655](#) & [WAC 388-76-10660](#)]
- Ensure that unsupervised access to any resident is not allowed until background check results verify that any person required to have such a check per [WAC 388-76-10161](#) is known to not have any disqualifying criminal convictions or negative action findings as described in [WAC 388-76-10180](#). [[WAC 388-76-10164](#)]
- Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion and must protect all other residents. [[WAC 388-76-10670](#)]
- Ensure that all entity representatives, resident managers, owners, caregivers, staff, and students that provide care and services to residents know that they are mandated reporters and must make reports in accordance with chapter [74.34 RCW](#). [[WAC 388-76-10673](#)]
- Develop and implement written rules and policies that do not allow abandonment, abuse, neglect of any resident, exploitation or financial exploitation of any resident. [[WAC 388-76-10675](#)]
- Develop and implement written rules and policies that require staff to report possible abuse, and other related incidents, as required in chapter [74.34 RCW](#). [[WAC 388-76-10675](#)]
- Develop and implement written rules and policies that do not interfere with the requirement that employees and other mandated reporters file reports directly with the Department and with law enforcement if they suspect sexual or physical assault to have occurred. [[WAC 388-76-10675](#)]
- Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring. [[WAC 388-76-10670](#)]

Wrongful Discharge of a Resident

- As long as the Department has “substantiated” a complaint, neither the resident making the complaint, nor the resident who is the subject of the complaint, may be discharged from the facility (AFH).
- An action, by the AFH facility, to discharge a resident who makes a complaint or who was the subject of a complaint, substantiated by the Department within one year from the date a complaint was made, is presumed to be a retaliatory discharge and prohibited by law.
- The presumption that the discharge was motivated by the complaint may be disproved, and a discharge may therefore be permitted, by showing that the increased needs of the resident cannot be met by the reasonable accommodation of the facility or that the discharge action was begun prior to the complaint having been filed. [[RCW 74.34.180\(2\)](#)]
- In addition to the mandated reporter requirements related to resident transfer or discharge, AFH facilities must continue to meet state law related to resident discharge and not discharge a resident unless those requirements are met.
- Refer also to [RCW 70.129.110](#) – Disclosure, Transfer and Discharge Requirements and [WAC 388-76-10615](#) – Resident Rights – Transfer and Discharge, for specific rights that apply to all residents, and, for related specific requirements that apply to all adult family homes.



Chapter 5

Rules and Regulations

Review of State Laws Related to Vulnerable Adult Abuse, Neglect, Financial Exploitation, Resident Death

There are state laws related to resident rights, abuse/neglect of vulnerable adults and mandated reporting requirements that apply to all AFH providers and their staff. Chapter [74.34 RCW](#) – Abuse of Vulnerable Adults and Chapter [68.50 RCW](#) – Human Remains are two of these laws included for your information and review.

Vulnerable Adult Abuse Law Applies to ALL Residents in ANY Licensed AFH

Chapter [74.34 RCW](#) is the state law that addresses Abuse of Vulnerable Adults. The legislature declares that some adults are vulnerable and may be subjected to abuse, neglect, financial exploitation, or abandonment by a family member, care provider, or other person who has a relationship with the vulnerable adult.

DEPARTMENT ROLE AND REGULATIONS

Licensure of Facilities

Residential Care Services (RCS) is a Division of the DSHS' Aging and Disability Services Administration (ADSA). Under state law, RCS is responsible for licensing and regulating health and safety issues at adult family homes (AFH), boarding homes (BH), nursing homes (NH), and, RCS also certifies intermediate care facilities for persons with intellectual disabilities (ICF/ID) and community residential services and support (CCRSS) settings. The majority of these licensed settings are privately owned businesses.

As of 2011, RCS licensed and/or certified over 3,700 long-term care facilities or programs that had bed capacity across the state for more than 69,000 residents/clients.

Protection of Residents/Clients

Residential Care Services (RCS) is critical to the safety and care of vulnerable people in long-term care settings, whether they are Medicaid clients or private-pay residents. Not only are RCS' inspections, surveys and complaint investigations key to resident health and safety and their basic and long-term care rights, these "unannounced" regulatory activities are a critical component in the assurance of quality for federally approved waivers.

These waivers allow DSHS to place Medicaid clients in various licensed community settings. As of 2011, there were approximately 2,900 licensed Adult Family Homes in our state.

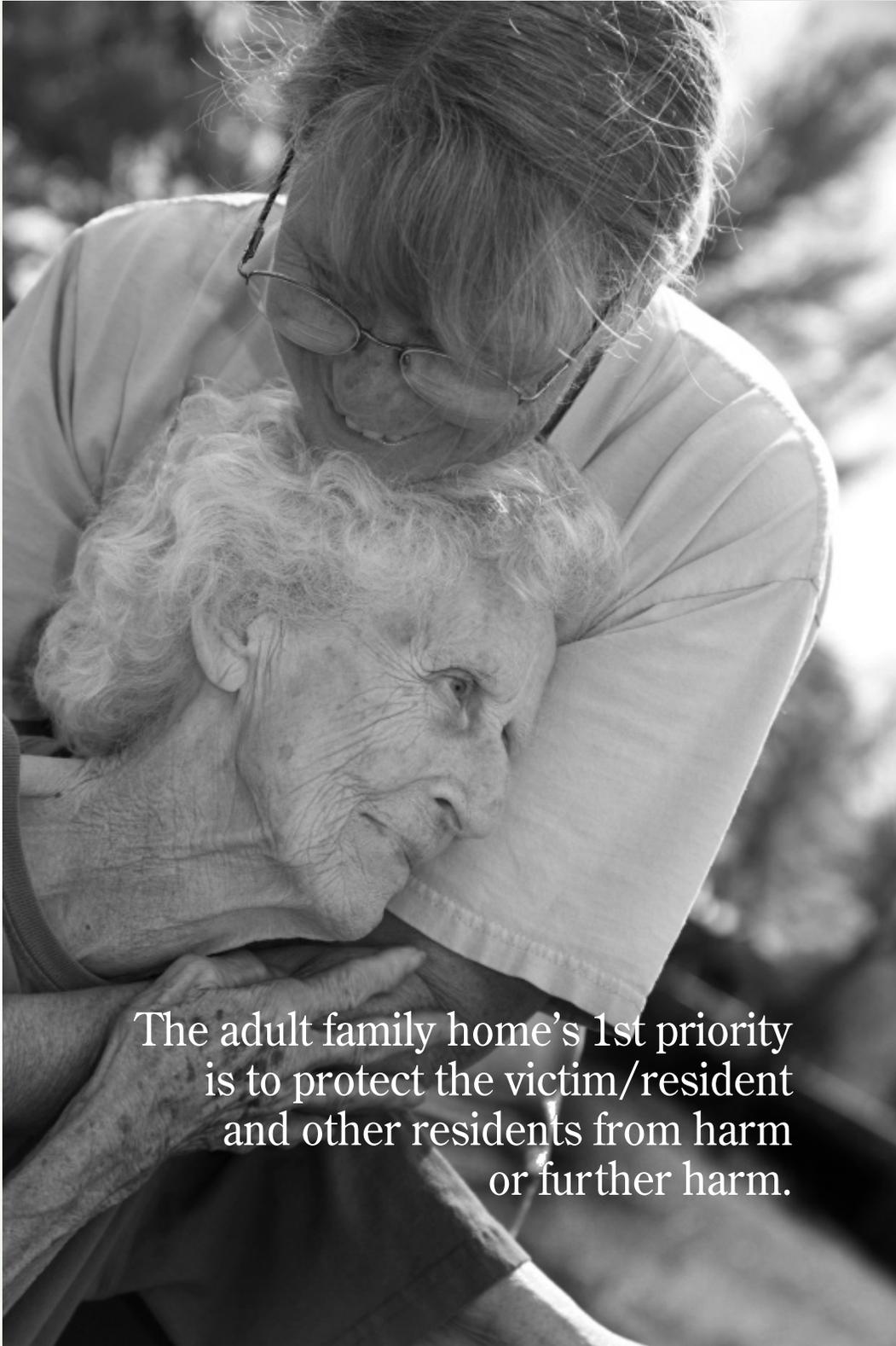
Each AFH Facility is Required to:

- Prevent abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect (criminal mistreatment) and involuntary seclusion of all residents; [WAC 388-76-10670]
- Protect all residents who, by law, are considered “vulnerable adults”; [WAC 388-76-10670]
- Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect (criminal mistreatment) and involuntary seclusion from occurring to residents; [WAC 388-76-10670]
- Gather facts upon discovery of, or report of, abuse, abandonment, neglect, or exploitation so that the AFH has enough information to provide the needed care and services to each resident; [WAC 388-76-10315]
- Report information to the Department, law enforcement, the county coroner or medical examiner, and, to the Department of Health’s appropriate disciplining authority, depending on the circumstances; [WAC 388-76-10225]
- Develop and implement written rules and policies related to abuse. [WAC 388-76-10675]



State Regulatory Oversight

- Reviewing and processing applicants for facility licensure or certification and considering a variety of factors, such as: criminal background check results; assessments for financial stability and responsibility; status of professional licenses; and, review of completion of Department-approved orientation, education or training requirements;
- Conducting initial inspections before licensure to review the physical structure of the facility or home, and, to review written rules, policies and procedures in place to meet the residents' physical, medical and emotional needs;
- Doing unannounced full inspections that include observations of care delivery to residents, and, doing interviews with residents, families and staff on a variety of topics to assess residents' quality of care, quality of life and preservation of their basic civil and long-term care resident rights;
- Conducting unannounced re-inspections as needed when problems are identified that require Department staff to return on-site to validate that the provider has corrected previously cited facility deficient practices or violations;
- Conducting unannounced on-site work following official notification of an allegation of abuse, neglect or financial exploitation communicated to the Department's Hotline from a self-reporting provider that RCS licenses or regulates;
- Conducting unannounced complaint investigations into alleged provider practice regulatory violations that may have potentially or actually negatively impacted or harmed residents/clients;
- Conducting unannounced complaint investigations into alleged, suspected or actual abuse of all types, abandonment, neglect or mistreatment, financial exploitation or misappropriation of resident/client property;
- Conducting unannounced Resident and Client Protection Program ("RCPP") investigations of individuals who are alleged to have abandoned, abused, neglected, mistreated, exploited, or financially exploited a resident or client in any facility or program licensed or certified by RCS;
- Taking "enforcement actions" for "substantiated" facility deficient practices by a licensed provider as required or permitted under state law; and
- Making administrative findings when applicable so that certain individuals investigated by RCPP are placed on a Department list prohibiting future employment in nursing homes or limiting hiring in other licensed and/or certified programs providing care and services to vulnerable adults.



The adult family home's 1st priority
is to protect the victim/resident
and other residents from harm
or further harm.

PROTECTING SENIORS / TAXPAYERS FROM FRAUD



Washington State Office of the Attorney General

Medicaid Fraud Control Unit
P.O. Box 40114 - Olympia, WA 98504
Phone: (360) 586-8888
Fax: (360) 586-8877
MFCUreferrals@atg.wa.gov

WHAT IS MEDICAID?

Medicaid is health insurance for qualifying low-income and needy people. Medicaid eligible recipients can include children, the elderly and persons with a disability. Each state designs and administers its own Medicaid program. The federal government jointly funds the program with the state as long as the program complies with the requirements mandated by the Centers for Medicaid and Medicare Services (CMS).

WHAT IS MEDICAID FRAUD?

Medicaid Fraud is generally defined as the billing of the Medicaid program for services, drugs, or supplies that are: unnecessary; not performed; more costly than those actually performed; and purportedly covered items which were not actually covered.

MEDICAID COVERED SERVICES

Medicaid covered services include in-home care, respite care, hospital care, skilled nursing home care, residential adult family care services, and professional services provided by physicians, laboratories and other health care professionals.

MEDICAID FRAUD CONTROL UNIT

Established in 1978, the Washington State Medicaid Fraud Control Unit (MFCU) investigates and prosecutes fraud committed by Medicaid providers. This Unit also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and boarding homes. The MFCU provides assistance to law enforcement in investigating and prosecuting facility-based crimes committed against vulnerable adults. The MFCU also independently investigates and prosecutes provider fraud committed against the Medicaid program, regardless of the location of the offense. The fraud can occur in home, in a facility, in a provider's office, or any other location in Washington. This Unit is part of the Criminal Justice Division of the Attorney General's Office.

Appendix A: REPORTING CHART

REPORTING KEY:

DSHS Hotline 1-800-562-6078	Police/9-1-1	WA State Dept. of Health	Local Fire Authority	Coroner / Medical Examiner	Local Health Department	Adult Protective Services
 Washington State Department of Social & Health Services						

TYPE	REPORT TO		
Staff –to-Resident <ul style="list-style-type: none"> Abuse – Sexual, Physical, Assault with bodily harm Neglect / Mistreatment / Negligent treatment Financial Exploitation / Misappropriation of Resident Property <p><i>*DOH when allegation involves licensed, certified or registered health care workers</i></p>			
Non-Staff to Resident <ul style="list-style-type: none"> Abuse/Assault, Neglect Misappropriation / Exploitation <p><i>*The call to the DSHS hotline will meet the requirement for reporting to APS, but you may still want to contact your local APS office.</i></p>			
Injuries of Unknown Source Substantial injury (not stemming from an incident of abuse or neglect; origin unknown)			
Resident-to-Resident <ul style="list-style-type: none"> Physical abuse <u>with</u> bodily harm or psychological harm Mental abuse <u>with</u> psychological harm Sexual abuse/assault Misappropriation/Financial Exploitation <p><i>Repeated physical abuse without bodily or psychological harm may become abuse or neglect if measures are not taken to more effectively address the resident's need for care & services.</i></p>			
Unexpected Resident Death <ul style="list-style-type: none"> Possibly related to abuse or neglect Suicide Not related to abuse or neglect but suspicious <p>See RCW 68 50.010 for certain suspicious circumstances that may need to be reported to police.</p>			
Other Miscellaneous <ul style="list-style-type: none"> Evacuation (Actual/Potential Event) Risk of Discontinuance of Services (such as no food, water or care supplies) 			
<ul style="list-style-type: none"> Fire/Explosion 	9-1-1		
<ul style="list-style-type: none"> Communicable Disease Outbreak Suspected Food borne Illness 			
<ul style="list-style-type: none"> Missing Resident 			

Appendix B: STATE HOTLINE QUESTIONS

1-800-562-6078

To make an official facility report, listen to the main message and then press “2”. If you wish to bypass the next menu, press the number that represents the type of incident you will be reporting.

#	TYPE OF INCIDENT
1	Follow-up Call
2	Resident-to-Resident Incident
3	Staff-to-Resident Incident
4	Injury of Unknown Source
5	Resident Fall
6	Exploitation/Misappropriation of Resident Property
7	Other Types of Resident Incidents
8	Medication Error

The following standard information is required by facilities making reports to the state hotline:

ALL TYPES OF INCIDENTS:

1. Caller's first and last name;
2. Name of the facility followed by phone number;
3. The name of the resident(s) who is/are involved in the incident;
4. Identify if the doctor and responsible parties were notified of the incident
5. The resident's diagnosis
6. The resident's mental status
7. The resident's ambulatory and transfer status, or if wheelchair bound, identify if the resident self-propels and if he/she was using an assistance device
8. The date and time of the allegation, incident, or injury, or the date and time when the allegation, incident or injury was first discovered.
9. Identify if the care plan has changed.

In addition to the above questions, be prepared to provide the following information when calling to report:

FOLLOW-UP CALL – Select 1:

1. Identify the date of the initial report;
2. Identify the conclusion of the investigation;
3. Identify measures put in place to prevent a reoccurrence.

A RESIDENT-TO-RESIDENT INCIDENT – Select 2:

1. Describe the incident and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.
5. Identify if the incident is isolated or a pattern;
6. Describe the plan to prevent further incidents.

ALLEGATION OF STAFF TO RESIDENT ABUSE OR NEGLECT – Select 3:

1. Describe the alleged incident, and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.
5. Identify the correct spelling and name of the employee(s) including their middle initial;
6. Identify the employee's title and if a nursing assistant, if he or she is certified;
7. Identify the employee's date of hire and date of birth;
8. Identify the employee's social security number;
9. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
10. Identify if the employee has had previous warnings or incidents at your facility;
11. Describe the measures taken to protect the resident during the investigation;
12. Describe measures taken to prevent reoccurrences of the incident.

AN INJURY OF UNKNOWN SOURCE – Select 4:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.

RESIDENT FALL – Select 5:

1. Describe other falls within the last 12 months;
2. Identify witnesses;
3. If staff involved, state their name and explain the circumstances.
4. Identify if the care plan was followed at the time of the fall;
5. Identify the action taken to prevent reoccurrences.

EXPLOITATION OR MISAPPROPRIATION OF RESIDENT PROPERTY – Select 6:

1. Describe the details of the exploitation or misappropriation of property including the dollar amount;
2. Identify if local law enforcement has been notified, if so, identify the case number;
3. Identify the alleged perpetrator and identify the person's title or relationship to the resident;
4. If an employee is involved, identify their name including the middle initial, title, date of hire, date of birth and social security number;
5. Identify the action taken to prevent reoccurrences.

OTHER TYPES OF RESIDENT INCIDENTS – Select 7:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.
4. Identify witnesses.
5. Identify the action taken to prevent reoccurrences.

MEDICATION ERROR – Select 8:

1. Identify the correct spelling and name of employee(s) involved including their middle initial;
2. Identify the employee's title and if a nursing assistant, if he or she is certified;
3. Identify the employee's date of hire and date of birth;
4. Identify the employee's social security number;
5. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
6. Identify if the employee has had previous medication error incidents at your facility;
7. Describe the medication error. Include the time and date of the medication error, the name and dosages of the medication and when it was discovered.

NOTE: If you believe there is further information relevant to the event/incident that is not addressed in the questions outlined, please feel free to leave that information at the end of your call.

Appendix C: DSHS SECRETARY'S LIST OF CRIMES/NEGATIVE ACTIONS

Crimes:

A person who has a crime listed below is denied unsupervised access to vulnerable adults, juveniles, and children.

If "(5 or more years)" or "(3 or more years)" appears after a crime, the person cannot be in a position to be left alone with a vulnerable adult unless 5 or more years or unless 3 or more years has passed since the date of the conviction.

After 5 or 3 years has passed, an overall assessment of the person's character, competence, and suitability to have unsupervised access will determine denial.

Abandonment of a child
 Abandonment of a dependent person
 Abuse or neglect of a child
 Arson 1
 Assault 1
 Assault 2
 Assault 3
 Assault 4/simple assault (3 or more years)
 Assault of a child
 Burglary 1
 Child buying or selling
 Child molestation
 Commercial Sexual Abuse of a Minor/Patronizing a juvenile prostitute
 Communication with a minor for immoral purposes
 Criminal mistreatment
 Custodial assault
 Custodial interference
 Custodial sexual misconduct
 Dealing in depictions of minor engaged in sexual explicit conduct
 Endangerment with a controlled substance
 Extortion
 Forgery (5 or more years)
 Incest
 Indecent exposure/Public indecency (Felony)
 Indecent liberties
 Kidnapping
 Malicious harassment
 Manslaughter
 Murder/Aggravated murder
 Promoting pornography
 Promoting prostitution 1

Prostitution (3 or more years)
 Rape
 Rape of child
 Registered Sex Offender
 Robbery
 Selling or distributing erotic material to a minor
 Sending or bringing into the state depictions of a minor
 Sexual exploitation of minors
 Sexual misconduct with a minor
 Theft 1
 Theft 2 (5 or more years)
 Theft 3 (3 or more years)
 Unlawful imprisonment
 Vehicular homicide (negligent homicide)
 Violation of child abuse restraining order
 Violation of the Imitation Controlled Substance Act (manufacture/deliver/intent)
 Violation of Uniform Controlled Substance Act (manufacture/deliver/intent)
 Violation of the Uniform Legend Drug Act (manufacture/deliver/intent)
 Violation of the Uniform Precursor Drug Act (manufacture/deliver/intent)
 Voyeurism

Negative Actions:

Negative Actions are considered under individual program law and rule and may lead to denial of unsupervised access to vulnerable adults.

A **negative action** is an administrative or civil action taken against an individual and may include:

- A finding that an individual abused, neglected, exploited, or abandoned a vulnerable adult, juvenile or child issued by an agency, an Administrative Law Judge, or a court of law. A finding by an agency is not a negative action if the individual was not given the opportunity to request an administrative hearing to contest the finding
- Termination, revocation, suspension, or denial of a license, certification, and/or State or Federal contract
- Relinquishment of a license, certification, or contract in lieu of an agency negative action
- Revocation, suspension, denial or restriction placed on a professional license
- Department of Health disciplining authority finding
- A protection order issued under chapter 74.34 RCW. (A conviction for violation of a protection order issued under chapter 74.34 RCW is evidence that a protection order was issued).

The preceding Appendix C is the Department's List of Crimes and Negative Actions dated 12/1/2011 and may be amended or updated at any time. Check the Department's Web site frequently to be sure your facility is always working with the most current criminal history disclosure information. This can be accessed online at <http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml> under Residential Care Services/Adult Family Homes. Also, keep current with any provider letters on related topics.

Appendix D: GLOSSARY OF TERMS

Unless the context clearly requires otherwise, definitions apply throughout the Department's AFH Guidebook on Abuse, Neglect, Financial Exploitation.

For terms not in this glossary, see a basic dictionary.

A

“Abandonment” means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

“Abuse” means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult: (1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain or mental anguish; and (2) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **“Sexual abuse”** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual contact may include interactions that do not involve touching including but not limited to sending a resident sexually explicit messages, or cuing or encouraging a resident to perform sexual acts. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual. Refer to chapter 9A.44 RCW – Sex Offenses.

(b) **“Physical abuse”** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) **“Mental abuse”** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **“Exploitation”** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

“Accident” means an unexpected, unintended event that can cause a resident bodily injury. Foreseeable incidents/events are not unavoidable accidents.

“ADSA” stands for the Aging and Disability Services Administration in the Department of Social and Health Services, State of Washington.

“Adult family home” (AFH) means: 1) A home licensed under chapter 70.128 RCW; 2) A residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services; and 3) The person or entity that is licensed to operate an adult family home.

“Adults” means persons who have attained the age of eighteen years.

“Advance Directive” means any instructions, written or given orally, to a health care provider in anticipation of the potential need for medical treatment. Federal law passed in 1990 (Patient Self-Determination Act - PSDA) requires health care providers to give residents information about Advance Directives and making health care decisions at end stage of life.

“Agency action” means licensing, the implementation or enforcement of a statute, the adoption or application of an agency rule or order, the imposition of sanctions, or the granting or withholding of benefits (see “Enforcement Action” and “Licensing”). Refer to RCW 34.05.010 – Administrative Procedure Act.

“Allegation” means a statement or gesture made by someone (regardless of capacity or decision-making ability) that indicates abandonment, abuse, neglect, financial exploitation, or misappropriation of resident property may have occurred.

“Applicant” means an individual, partnership, corporation, or other entity seeking a license to operate an adult family home. **“Affiliated with an applicant”** means any person listed on the application as a partner, officer, director, resident manager, or majority owner of the applying entity, or is the spouse or domestic partner of the applicant.

“APS” stands for Adult Protective Services. APS is part of the Home and Community Services Division within ADOSA that receives and investigates abuse (physical, mental, sexual, and exploitation of person), abandonment, neglect, self-neglect and financial exploitation of vulnerable adults living primarily in their own homes and in facilities where there is an allegation of mistreatment by someone outside of the facility. APS may offer protective services to vulnerable adult alleged victims if they give written consent. APS is not able to remove the alleged victim from his/her home without his/her permission, or detain the vulnerable adult due to mental capacity issues (see **“Mental Capacity”** and **“Protective Services”**).

“Assault” means any intentional touching or striking of another person that causes physical harm or fear of physical harm to that person (see **“Abuse – Physical”**). Refer to chapter 9A.36 RCW – Assault – Physical Harm.

B

“Basic necessities of life” means food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen and medication.

“Bed sores” – See **“Pressure ulcers”**.

“Bodily injury” means the physical pain or injury, illness or an impairment of physical condition of a vulnerable adult (see **“Great bodily harm”** and **“Substantial bodily harm”**). Refer to chapter 9A.42 RCW – Criminal Mistreatment.

“Bruises” mean skin injuries that result from leakage of blood from vessels into soft tissues after sufficient force has been applied to distort soft tissue and to tear blood vessels (see **“Hematoma”**).

C

“Capacity” (resident occupancy allowed in AFH) means the maximum number of persons in need of personal or special care who are permitted to reside in an adult family home at a given time. **“Capacity”** includes: (1) The number of related children or adults in the home who receive personal or special care and services; plus (2) The number of residents the adult family home may admit and retain - the resident capacity. The capacity number listed on the license is the **“resident capacity.”**

“Caregiver” means any person eighteen years of age or older responsible for providing direct personal or special care to a resident and who is not the provider, entity representative, a student or volunteer.

“Cause of death” means the disease or injury (including intoxications or poisonings) that caused or contributed to death (see **“Manner of death”**). Refer to chapter 68.50 RCW – Human Remains.

“Chemical restraint” means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident’s medical symptoms (see **“Abuse – Physical”** and **“Psychopharmacology”**).

“Client” – See **“Resident”**.

“Coercion” refers to efforts by another person to try to dominate or force a vulnerable resident to act or to think in a certain way as a result of pressure, threats or intimidation.

“Complainant” means the person who reports or files a complaint to the department by calling or writing the CRU with information about a situation, concern or problem in question. Any complainant (hotline reporter) is considered by the department as a partner in its efforts to help protect residents in residential long-term care residential settings.

“Complaint” means a situation, problem, or concern that may pose a health or safety threat or has the potential to cause harm to a vulnerable adult. The complaint can be general or specific and can involve staff, residents/clients, volunteers, physical environment of the facility (AFH), the AFH’s administration, or, other issues. While regulations address many important areas, not all issues reported to the CRU that impact a resident are potential regulatory violations.

“Consent” means express agreement and written permission given (“consent”) after the vulnerable adult or his or her legal representative has been fully informed of the nature of the services to be offered and that the receipt of such care and services is voluntary.

“Coroner” means an appointed or elected public official, in a particular geographic jurisdiction, whose official duty is to make an inquiry into a death, assign a cause and manner of death, and, list this information on the certificate of death. Coroners or coroner-prosecutors are rarely physicians and the typical coroner usually needs to contract with one or more pathologists to conduct autopsies.

“Criminal mistreatment” means a person entrusted with the physical custody of a dependent person or a person employed to provide the basic necessities of life to a dependent person, with criminal negligence creates an imminent and substantial risk of, or actually causes injury or extreme emotional distress, up to and including substantial or great bodily harm (see “Great bodily harm” and “Substantial bodily harm”). Refer to chapter 9A.42 RCW – Criminal Mistreatment.

“Criminal negligence” means a person is criminally negligent or acts with criminal negligence when he or she fails to be aware of a substantial risk that a wrongful act may occur and his or her failure to be aware of such substantial risk constitutes a gross deviation from the standard of care that a reasonable person would exercise in the same situation. Refer to RCW 9A.08.010 – Principles of Liability.

“CRU” stands for the Complaint Resolution Unit. The CRU is a centralized intake unit associated with the toll-free statewide telephone Hotline [1-800-562-6078] provided by the department for reporting abuse, neglect and financial exploitation. The CRU hotline accepts calls about nursing homes, boarding homes, adult family homes, institutions for persons with intellectual disabilities, and certified supported living settings. The CRU has the capability of referring calls about other settings to the appropriate agencies. Depending on the nature and severity of the reported issues, calls may also be referred to local law enforcement, licensing boards, Medicaid Fraud, county prosecutors and sheriffs, and the RCS Resident Client Protection Program. The CRU assigns a control number to each complaint received to help both the hotline and the RCS investigator track calls and concerns from a complainant or a self-reporting facility that RCS licenses, certifies or regulates.

D

“Death certification” refers to the legal obligation of a coroner and medical examiner to “certify” (determine and document) both the “cause of death” and “manner of death” of a person in certain circumstances. Refer to chapter 68.50 RCW – Human Remains.

“Dementia” is defined as a condition documented through the assessment process required by WAC 388-76-10335 – Resident Assessment Topics.

“Department” means the department of state government responsible for licensing or certifying the provider in question (see “DOH” and “DSHS”).

“Department case manager” means the department authorized staff person or designee assigned to negotiate, monitor, and facilitate a care and services plan for residents receiving services paid for by the department.

“Developmental disability” means:

- (1) A person who meets the eligibility criteria defined by the division of developmental disabilities under WAC 388-823-0040; or
- (2) A person with a severe, chronic disability which is attributable to cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (i.e., autism); and
 - (a) The condition was manifested before the person reached age eighteen;
 - (b) The condition is likely to continue indefinitely; and
 - (c) The condition results in substantial functional limitations in three or more of the following areas of major life activities: (i) Self-care; (ii) Understanding and use of language; (iii) Learning; (iv) Mobility; (v) Self-direction; and (vi) Capacity for independent living.

“Direct supervision” means oversight by a person who has demonstrated competency in the basic training and specialty training if required, or who has been exempted from the basic training requirements and is: (1) On the premises; and (2) Quickly and easily available to the caregiver.

“DOH” stands for the Department of Health of the State of Washington (see “Department”).

“Domestic partners” means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership (see “Applicant”).

“DRW” stands for Disability Rights Washington. DRW is a private non-profit organization that protects the rights of people with disabilities statewide. DRW is not part of state government. DRW’s mission is to advance the dignity, equality, and self-determination of people with disabilities. DRW works to pursue justice on matters related to human and legal rights. DRW provides free advocacy services to people with disabilities. DRW focuses its legal resources

on major cases which will improve service systems for persons with disabilities. Contact DRW for: Disability rights information and referrals; Problem-solving strategies for disability issues; Community education and training; and Legal services for disability discrimination or violation of rights. Voice: (206) 324-1521 or (800) 562-2702 & TTY (206) 957-0728 or (800) 905-0209. Email: info@dr-wa.org. Website: www.DisabilityRightsWA.org.

“DSHS” stands for the Department of Social and Health Services of the State of Washington (see “Department”).

E

“Electronic monitoring” refers to the use of audio and video monitoring equipment. Refer to WAC 388-76-10720 and WAC 388-76-10725 for requirements related to limited use of such electronic monitoring equipment in an AFH.

“Emotional Abuse” – See **“Abuse – Mental”**.

“Enforcement action” refers to the implementation or enforcement of a “statute”, the adoption or application of an agency rule (see “WAC”) or order, the imposition of sanctions, or the granting or withholding of benefits. Such actions may include prescribed remedies, such as a temporary hold on new admissions to the facility and/or a civil fine penalty required or permitted by state law. Refer to RCW 34.05.010 – Administrative Procedure Act.

“Entity” – See **“Facility”**.

“Entity representative” means the individual designated by a provider who is or will be responsible for the daily operation of the adult family home and who meets the requirements of chapter 388-76 WAC and chapter 388-112 WAC.

“Event” – See **“Incident”**.

“Exploitation” – See **“Abuse – Exploitation”**.

F

“Facility” means a long-term care setting licensed or required to be licensed under chapter 18.20 RCW, boarding homes; chapter 18.51 RCW, nursing homes; chapter 70.128 RCW, adult family homes; chapter 72.36 RCW, soldiers’ homes; or chapter 71A.20 RCW, residential habilitation centers; or any other facility licensed or certified by the department.

“Fiduciary” refers to a person who assumes a formal or informal position of trust or a “fiduciary duty” on behalf of the welfare of another person. The fiduciary may enter into a formal relationship with the vulnerable adult via guardianship, a trust, or a durable power of attorney (POA) for finances and/or health care. Or, the fiduciary may have an informal/confidential relationship with the vulnerable adult, such as an adult child taking care of his/her elderly parent (see “Undue Influence”).

“Financial exploitation” mean the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person’s or entity’s profit or advantage other than for the vulnerable adult’s profit or advantage. “Financial exploitation” includes, but is not limited to: (a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or (b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or (c) Obtaining or using a vulnerable adult’s property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds (see “Undue Influence”).

“Financial institution” has the same meaning as in RCW 30.22.040 and 30.22.041. For the purposes of chapter 74.34 RCW, “financial institution” also means a “broker-dealer” or “investment adviser” as defined in RCW 21.20.005.

G

“Great bodily harm” means bodily injury which creates a probability of death, or which causes significant serious permanent disfigurement, or which causes a significant permanent loss or impairment of the function of any bodily part or organ. Refer to RCW 9A.04.110 – Washington Criminal Code.

“Grooming” refers to a process of manipulation often used by offenders, intended to reduce a victim’s or potential victim’s resistance to sexual abuse. Typical sexual “grooming” activities/behaviors include gaining the vulnerable adult’s trust or gradually escalating boundary violations of the vulnerable adult’s body in order to desensitize the victim or potential victim to further abuse.

“Guardian” means a person who has been appointed by the court to make health care or financial decisions on behalf of an incapacitated person (see “Fiduciary”). A guardianship deprives an incapacitated person of the ability to make his or her own health care and/or financial decisions. The court provides on-going oversight of guardianships. Refer to chapter 11.88 RCW – Guardianship. No one who owns or works in an AFH in this state may be the guardian of an AFH resident. [WAC 388-76-10235 – Guardianship]

H

“Hematoma” means an abnormal, localized collection of usually clotted blood that is mostly confined within an organ, tissue or space somewhere in a person’s body (see “Bruises”).

“Home” – See **“Adult Family Home”**.

“Home and community services” means adult family homes, in-home services, and other services administered or provided by contract with the department directly or through contract with area agencies on aging or similar services provided by facilities or agencies licensed by the department. Refer to RCW 74.39A – Long-Term Care Service Options – Expansion.

“Hospice services” mean health care services designed to give the terminally ill resident comfort and support at the end stages of living. Hospice care can be provided by a licensed hospice agency in a variety of settings, including an AFH. A physician must certify that the resident may have less than six months to live if the disease process advances in its normal pattern and progression.

“Hotline” – See **“CRU”**.

“Hydration” means to provide a resident with sufficient fluids by one means or another.

I

“Identity theft” refers to an individual’s means of identification or financial information that was knowingly obtained, possessed, used, or transferred without the authorization, consent or permission of the victim, living or dead, with an intent to commit, or to help commit, any crime. Generally, the crime of “identity theft” is stealing someone’s personal, identifying information for the purpose of using that information fraudulently. Personal, identifying information includes but is not limited to: one’s name, date of birth, Social Security number, credit card and banking account numbers, usernames, passwords, and resident records. There are numerous types of information protected from misuse by identity theft. Refer to RCW 9.35.020 – Identity Theft.

“Imminent danger” means serious physical harm to or death of a resident has occurred, or there is a serious threat to resident life, health, or safety. Refer to RCW 70.128.010 – Adult Family Homes.

“Incapacitated person” means a person who is at a significant risk of personal or financial harm. Refer to RCW 11.88.010 – Guardianship: Appointment, Qualification, Removal of Guardians.

“Incident” means: 1) An occurrence or event involving a resident in which mistreatment, neglect, abuse, exploitation or misappropriation of resident property is alleged or suspected; or, a substantial injury of unknown source, or cause, or circumstance; and, 2) An official notification communicated to RCS’ Complaint Resolution Unit (CRU) Hotline from a self-reporting provider that RCS licenses, certifies or regulates.

“Incident log” refers to information required to be documented and maintained by every AFH about any resident related to: (1) Alleged or suspected instances of abandonment, neglect, abuse or financial exploitation; (2) Accidents or incidents affecting a resident’s welfare; and (3) Any injury to a resident. [WAC 388-76-10220]

“Indirect supervision” means oversight by a person who: (1) Has demonstrated competency in the basic training and specialty training if required; or (2) Has been exempted from the basic training requirements; and (3) Is quickly and easily available to the care giver, but not necessarily on-site.

“Individual provider” means a person under contract with the department to provide services in the home under chapter 74.09 RCW – Medical Care or chapter 74.39A RCW – Long-term Care Service Options – Expansion.

“Inspection” means a review by department personnel to determine the adult family home’s compliance with chapter 388-76 WAC and chapters 70.128, 70.129, 74.34 RCW, and other applicable rules and regulations. The department’s review may include unannounced on-site visits for investigation of allegations of abandonment, abuse of all types, neglect, exploitation, and financial exploitation called into the department’s Hotline.

“Intellectual disabilities” means conditions as defined in RCW 71A.10.020 (see “Developmental Disabilities”).

“Involuntary seclusion” means inappropriately isolating a vulnerable adult from family, friends or regular activity in violation of a resident’s right to be free from isolation against his or her will (see “Abuse – Mental”).

J

“Jurisdiction” means that a county coroner or medical examiner has made a decision to take custody of, and transport, a person’s body following death in certain circumstances to conduct an investigation into this person’s official “cause of death” and “manner of death”. Refer to chapter 68.50 RCW – Human Remains.

K – [Intentionally left blank]

L

“Law Enforcement” means an agency such as the police department, the prosecuting attorney, the State Patrol, the Director of Public Safety, or the Office of the Sheriff. “Law enforcement officer” generally refers to an employee of a public law enforcement agency under the authority of the state or a county, city or town.

“Licensing” includes the agency process respecting the issuance, denial, revocation, suspension, or modification of a license (see “Agency action”). Refer to RCW 34.05.010 – Administrative Procedure Act.

“Long-term care facility” means a facility that is licensed or required to be licensed under chapter 18.20, 72.36, or 70.128 RCW.

“Long-term Care Ombudsman Program” (LTCOP) refers to a program mandated by the federal Older Americans Act intended to improve the quality of life for people who live in long-term care settings, including but not limited to licensed adult family homes. Residents in long-term care settings are guaranteed certain rights by various state laws and regulations. Under the leadership of the Washington State Long Term Care Ombudsman, other state and regionally professionally trained, certified staff and community volunteers work to protect and promote these rights and assist in empowering residents in long-term care settings to become self-advocates. Voice: (800)-562-6028 and Website: ltop@multi-servicecenter.com.

“Long-term Care Resident Rights” means the minimum rights guaranteed set forth in chapter 70.129 RCW for all residents of long-term care facilities licensed or certified by the department.

M

“Management agreement” means a written, executed agreement between the adult family home and another individual or entity regarding the provision of certain services on behalf of the adult family home.

“Mandated reporter” means an employee of the department, law enforcement, officer, social worker, professional school personnel, individual provider, an employee of a facility, an employee of a social service, welfare, mental health, adult day health, adult day care, or hospice agency, county coroner or medical examiner, Christian Science practitioner, or health care provider subject to chapter 18.130 RCW. For the purpose of the definition of a mandated reporter, “Facility” means a residence licensed or required to be licensed under chapter 18.20 RCW (boarding homes), chapter 18.51 RCW (nursing homes), chapter 70.128 RCW (adult family homes), chapter 72.36 RCW (soldiers’ homes), chapter 71A.20 RCW (residential habilitation centers), or any other facility licensed or certified by the department.

“Manner of death” depends on circumstances of the death, if known, and indicates partial or complete responsibility for death. Circumstances are only part of the considerations that determine death (see “Cause of death”). **“Manner of death”** is certified as:

- **Natural** – means that natural causes, without external causes or neglect, are completely responsible for the death;
- **Suicide** – means that the person was responsible for an action that caused or contributed to their own death.
- **Accident** – means that an external condition, in which there was no evidence of intent to cause harm, was responsible for the death.
- **Homicide** – means that another person was responsible for an action that caused or contributed to the death.
- **Undetermined** – means that there is insufficient evidence to place the manner of death in any of the other four categories above.

“Medical Examiner” means a physician, when acting in an official capacity, within a particular jurisdiction, who is charged with the investigation and examinations of persons dying of sudden, unexpected or violent death. The medical examiner is expected to bring medical expertise to the evaluation of the medical history and physical examination of the deceased. Medical examiners are required to be board-certified forensic pathologists.

“Mental abuse” – See **“Abuse – Mental”**.

“Medical device” means any piece of medical equipment used to treat a resident’s assessed need. (1) A medical device is not always a restraint and should not be used as a restraint; (2) Some medical devices have considerable safety risks associated with use; and (3) Examples of medical devices with known safety risks when used are transfer poles, Posey or lap belts, and side rails (see – **“Physical restraints”**).

“Medication administration” means giving resident medications by a person legally authorized to do so, such as a physician, pharmacist or nurse.

“Medication organizer” is a container with separate compartments for storing oral medications organized in daily doses.

“Mental Capacity” means a resident’s ability to understand the nature and risk of a decision affecting their person or estate, or the attributes of a resident that enables him or her to perform certain acts.

“Mental illness” is defined as an Axis I or II diagnosed mental illness as outlined in the most current volume of the Diagnostic and Statistical Manual of Mental Disorders.

“MFCU” stands for the Medicaid Fraud Control Unit, a part of the Criminal Justice Division of the Washington State Attorney General’s Office. This Unit investigates and prosecutes fraud committed by Medicaid providers and monitors complaints of resident abuse and neglect in Medicaid funded nursing homes, adult family homes and boarding homes. This Unit provides assistance to law enforcement in investigating and prosecuting facility-based crimes committed against vulnerable adults. It also independently investigates and prosecutes provider fraud committed against the Medicaid program, regardless of the location of the fraud offense.

“Misappropriation of resident property” means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings, money or other property (see **“Identity theft”** and **“Property”**).

“Multiple facility provider” means a provider who is licensed to operate more than one adult family home. Such a provider must successfully demonstrate to the department financial solvency and management experience for the homes under ownership. Such a provider must have the ability to meet other relevant safety, health, and operating standards pertinent to the operation of multiple homes. [RCW 70.128.065] In certain circumstances of serious risk to residents, the department may impose remedies on more than one of multiple homes licensed to such a provider (WAC 388-76-10985).

N

“Neglect” means (a) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult’s health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. However, neglect does not include failure to provide treatment or service that a resident has refused, with knowledge and understanding of the results of the refusal.

“Nurse delegation” means a registered nurse transfers the performance of selected nursing tasks to competent nursing assistants in selected situations. The registered nurse delegating the selected task retains the responsibility and accountability for the nursing care of the resident.

“NJA” stands for **“no jurisdiction assumed”**. This is a term used when a county Coroner or Medical Examiner decides not to conduct an investigation into a death and then issues a **“NJA”** number that should be recorded in a resident’s record maintained in the AFH.

O

“Occurrence” – See **“Incident”**.

“Ombudsman” – See **“Long term Care Ombudsman Program”**.

“Omission” means a failure to act.

“Over-the-counter medication” is any medication that can be purchased without a prescriptive order, including but not limited to vitamin, mineral, or herbal preparations.

P

“Permissive reporter” means any person, including, but not limited to, an employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults, such as the Long Term Ombudsman Program or Disability Rights Washington (see **“DRW”**).

“Personal care services” means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident’s needs and does not include assistance with tasks performed by a licensed health professional.

“Physical abuse” – See **“Abuse – Physical”**.

“Physical restraint” means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and not required to treat the resident’s medical symptoms (see **“Abuse – Physical”** and **“Medical device”**).

“Power of Attorney” means a legal document that authorizes another person to act on the resident’s behalf with regard to their financial and/or health care matters. A power of attorney does not deprive a resident of the ability to make his or her own financial or health care decisions provided the resident has mental capacity. Unlike guardianships, powers of attorney are entered into without court involvement and are not reviewed by the court (see **“Fiduciary”**).

“Practitioner” includes a physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant licensed in the state of Washington.

“Prescribed medication” refers to any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

“Pressure ulcers” refers generally to areas of unrelieved pressure over one or more defined areas of skin, usually over bony areas (i.e., hips/ankles/elbows/heels), that results in lack of oxygen to the skin, leading to cell and tissue death. Pressure ulcers can result in various stages of damage to underlying layers of skin, fat, muscle or bone. Pressure ulcers (bed sores) are often preventable, are painful, and, can worsen over time if they are not quickly recognized by caregivers or family, and, if they are not treated in a timely manner by the resident’s practitioner. In lightly pigmented skin, the ulcer may appear initially as a defined area of persistent redness. In darker skin, the ulcer may initially appear with persistent red, blue, or purple hues (see **“Practitioner”**).

“Probable” means that based on information or evidence readily obtained from various sources, it is likely the incident occurred. Sources of information may include: personal observation of the incident; the resident who is subject of incident; resident records; other persons who may have relevant information; resident behavior; other relevant information.

“Property” means anything of value, whether tangible or intangible, real or personal (see **“Abuse – Exploitation”**, **“Financial Exploitation”**, and, **“Identity Theft”**).

“Protective services” means any services provided by the department to a vulnerable adult with the consent of the vulnerable adult, or the legal representative of the vulnerable adult, who has been abandoned, abused, financially exploited, neglected, or in a state of self-neglect. These services may include, but are not limited to case management, social casework, home care, placement, arranging for medical evaluations, psychological evaluations, day care, or referral for legal assistance (see **“APS”**).

“Provider” means any person who is licensed under chapter 70.128 RCW to operate an adult family home. For the purposes of this definition, “person” means any individual, partnership, corporation, association, or limited liability company that is licensed to operate an adult family home and meets the requirements of this same chapter.

“Psychopharmacology” refers to the use of prescribed medications to alter behavior, affect, and/or the cognitive process of a person (see “Chemical Restraints”).

Q – [Intentionally left blank]

R

“RCPP” stands for the Resident and Client Protection Program. The RCPP in RCS conducts investigations of individuals alleged to have abandoned, abused, neglected, exploited and financially exploited a resident or client in the following programs: Nursing Homes, Boarding Homes, Adult Family Homes, Intermediate Care Facilities for Persons with Intellectual Disabilities, and, Certified Community Residential Services and Supports. RCPP is able to make an administrative finding where criminal convictions or licensing and/or certification actions cannot be taken or are not appropriate. The names of those individuals are placed on a department list. Persons on this list may not be employed in any Nursing Home and may not work in the other listed settings if they might have unsupervised access to vulnerable adults.

“RCS” stands for the Division of Residential Care Services in Aging and Disability Services Administration, Department of Social and Health Services in the state of Washington.

“RCW” means Revised Code of Washington which are the laws and statutes for this state.

“Reasonable accommodation” by a facility to the needs of a prospective or current resident has the meaning given to this term under the federal Americans with Disabilities Act of 1990, 42 U.S.C. Sec. 12101 et seq. and other applicable federal or state antidiscrimination laws and regulations.

“Reasonable cause to believe” means a mandated reporter thinks it is “probable” that an incident of abuse, abandonment, neglect, or financial exploitation happened; or, “a belief that the incident probably happened” based upon personal observation of the resident/victim, records, other people and various other sources of relevant information. (RCW 74.34.035)

“Reason to suspect” means to have reason to believe without conclusive proof that someone may have abused, neglected, exploited a resident, or misappropriated a resident’s property; or, “a belief that the incident could have happened” based upon observations and other sources of information. (RCW 74.34.035)

“Recklessness” means a person is reckless or acts recklessly when he or she knows of and disregards a substantial risk that a wrongful act may occur and his or her disregard of such substantial risk is a gross deviation from conduct that a reasonable person would exercise in the same situation. Refer to RCW 9A.08.010 – Principles of Liability.

“Representative” means a person authorized to provide informed consent for health care on behalf of a resident who has been determined not to be competent to consent (see “Consent”). Refer to RCW 7.70.065 – Informed Consent.

“Representative Payee” (RP) is a person or agency assigned by whoever administers the benefit (Social Security, Office of Personal Management, Veteran’s Administration, pensions, etc.) to receive, disburse and report on the fund activity as the benefit for someone else.

“Resident” means any adult unrelated to the provider who lives in an AFH, needs care and receives services in a long-term care facility. For decision-making purposes, the term “resident” means the resident’s attorney-in-fact, guardian, or other legal representative acting within the scope of their authority under state law.

“Resident manager” means a person employed or designated by the provider to manage the adult family home.

S

“Secretary” means the secretary of the Department of Social and Health Services (DSHS).

“Self-neglect” means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult’s physical or mental health, and the absence of which impairs or threatens the vulnerable adult’s well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

“Serious disregard of consequences” means that the facility or individual actually had knowledge, or should have known (based on training or educational background), that the act committed or omitted was a clear and present danger to the resident’s health, welfare, or safety; or that the act was committed or omitted with reckless disregard of its clearly dangerous consequences.

“Sexual abuse” – See **“Abuse – Sexual”**.

“Sexual assault” means forced or manipulated unwanted sexual contact between two or more persons (see **“Abuse – Sexual”**).

“Significant change” means: (1) A lasting change, decline or improvement in the resident’s baseline physical, mental or psychosocial status; (2) The change is significant enough so the current assessment and/or negotiated care plan do not reflect the resident’s current status; and (3) A new assessment may be needed when the resident’s condition does not return to baseline within a two week period of time.

“Special care” means care beyond personal care services, such as, services for residents with dementia, mental illness, and, developmental/intellectual disabilities.

“Staff” means any person who: (1) Is employed or used by an adult family home, directly or by contract, to provide care and services to any resident. (2) Staff must meet all of requirements of chapter 388-76 WAC – AFH Minimum Licensing Requirements, and, chapter 388-112 WAC – Residential Long-term Care Services.

“Statute” means the Constitution or an act of the legislature or initiative or referendum of Washington state.

“Stolen” means obtained by theft, robbery, or extortion. Refer to chapter 9A.56 RCW – Theft and Robbery.

“Strangulation” means to compress a person’s neck, thereby obstructing the person’s blood flow or ability to breath, or doing so with the intent to obstruct the person’s blood flow or ability to breathe.

“Substantial bodily harm” means bodily injury which involves a temporary but substantial disfigurement, or which causes a temporary but substantial loss or impairment of the function of any bodily part or organ, or which causes a fracture of any bodily part. Refer to RCW 9A.04.110 – Washington Criminal Code.

“Substantial injuries of unknown source” refer to injuries that are more than superficial. Substantial injuries require more than first aid and may require close assessment and monitoring by nursing or medical staff. All injuries (regardless of the extent) occurring in non-vulnerable areas of the body are considered substantial injuries.

“Substantiated” refers to the process of complaint or incident investigation in which the department verified that one or more allegations made actually did occur or are likely to have occurred at some time.

“Suffocation” means to block or impair a person’s intake of air at the nose and mouth, whether by smothering or other means, with the intent to obstruct the person’s ability to breathe.

“Superficial injuries of unknown source” refer to injuries limited to: the surface layers of the skin, easily treated with first aid, not requiring a licensed practitioner’s orders for treatment (such as sutures or diagnostic x-rays), and, are located in areas generally vulnerable to trauma.

Superficial injuries of unknown source may or may not be incidents of suspected or alleged abuse or neglect.

T – [Intentionally left blank]

U

“Unannounced” means the lawful policy and uniform practice by RCS of not giving any advance notice about when RCS’ department staff will arrive to do routine inspection, complaint or incident investigation activities. RCS staff and management are prohibited from giving advance notice, in any way, to anyone including but not limited to: a resident; a resident representative or family; any complainant; any resident advocacy groups; providers, facilities or programs that RCS licenses, certified or regulates.

“Undue influence” occurs when people use their relationship, power and control to deceive, betray the trust and exploit the dependencies of others, especially vulnerable adults. Undue influence is not specifically defined in state law. A claim of “undue influence” is often associated with a claim that the potentially affected vulnerable adult lacks sufficient “mental capacity” to execute a contract, will, trust, or gift. Undue influence may occur in situations involving large gifts of money or property by a vulnerable adult to a fiduciary when there is not a natural/ reasonable explanation for such gifting actions or significant changes in a resident’s will (see “Fiduciary” and “Mental capacity”).

“Unsubstantiated” refers to a process of complaint or incident investigation in which the department found that none of the allegations made were able to be verified.

“Unsupervised” means not in the presence of: (1) another employee or volunteer from the same business or organization; or (2) any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization.

V

“Verbal abuse” – See **“Abuse – Mental”**.

“Vulnerable adult” includes a person:

- (a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
- (b) Found incapacitated under chapter 11.88 RCW; or
- (c) Who has a developmental disability as defined under RCW 71A.10.020; or
- (d) Admitted to any facility; or
- (e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed or required to be licensed under chapter 70.127 RCW; or
- (f) Receiving services from an individual provider; or
- (g) Who self-directs his or her own care and receives services from a personal aide under chapter 74.39 RCW.

W

“WAC” refers to Washington Administrative Code. Regulations are issued by authority of legislation and the Constitution and are the source of our main laws in Washington State (see “statutes”). These regulations are then converted (codified) into codes (WACs) and arranged by subject or by agency, i.e., chapter 388-76 WAC – AFH Minimum Licensing Requirements.

“Willful” means the deliberate or non-accidental action or inaction by an individual that he/she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish.

X, Y, Z – [Intentionally left blank]

NOTICE

Concerned about abuse, neglect or violation of the rights of a resident in a nursing home, adult family home, or boarding home?

Contact:

**Aging & Disability Services
Administration
1-800-562-6078**

TTY Users 1-800-737-7931

If you need help in resolving any problems or questions about adult family homes, nursing homes, and boarding homes, contact: STATE OMBUDSMAN

1-800-562-6028



Selected Resources

For access to your city, county police, sheriff or other law enforcement agencies, use your local phone directory or visit:

<http://www.the911site.com/911pd/washington.shtml>

Emergency situations: DIAL 9-1-1 or your county's emergency services number.

Non-emergency situations: use local numbers for Police/Sheriff/State Patrol

For access to contact information and the phone number of your county's coroner or medical examiner, visit: http://198.239.150.197/pages/Documents/documents/WAStateMedicalExaminers-Coroners_000.pdf

For access to a complete archive of the Department's letters and other basic information and links to other resources for AFH professionals, residents and families, advocates, interested parties, and the general public, visit: <http://www.adsa.dshs.wa.gov/professional/afh.htm>

For access to the most current criminal history disclosure information from the Department of Social and Health Services Secretary's List of Crimes and Negative Actions that may be amended or updated at any time, visit: <http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml> and select Adult Family Homes (the last bullet under Item #1)

For access to the Department's brochure Partners in Protection (DSHS 22-810X) written and available in English and seven other languages to help protect residents from abandonment, abuse, neglect and financial exploitation, visit: http://www.adsa.dshs.wa.gov/Library/publications/brochurestext.htm#abuse_mandated

DSHS Mandated Reporter Resource online:

<http://www.adsa.dshs.wa.gov/APS/training/training.htm>

