PRINCIPLES OF DOCUMENTATION

A MANUAL FOR ALL RESIDENTIAL CARE SERVICES PROGRAMS

MARCH 2022

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INTRODUCTION

Regulatory staff use their knowledge, skills, and abilities to gather all information necessary to determine if an entity meets minimum regulatory requirements. The information gathered is written as deficiency citations, which are collectively referred to as a Statement of Deficiency (SOD). For statewide consistency, the Principles of Documentation (POD) are guidelines used for writing the SODs for all Residential Care Services (RCS) programs. Each principle, in representation of all RCS programs, is presented with an example included in the appendices when applicable to the program.

The SOD is an official record and legal document used as the formal method of communicating detailed information about the deficiency(ies) to the entity. The SOD informs the entity what needs to be corrected.

The entity uses the SOD information to develop a plan of correction for the identified deficiency citations. A SOD that is written in a clear, concise, and organized manner will result in effective communication to the entity.

The information in this reference does not replace or supersede the laws or regulations; rather it provides regulatory staff with guidance for using the POD manual when writing SODs.

LEGAL ASPECTS OF SOD

The regulatory visit process is designed to ensure the entity providing residential support services to vulnerable adults is in compliance with its specific statutes and regulations. The regulatory visit, with supporting documentation, becomes an important part of subsequent legal proceedings evolving out of the visit.

The regulatory visit process, along with the documentation records, determines the compliance or noncompliance of providers and suppliers. The regulatory staff provides the facts that justify any resulting enforcement action and the record on which to defend that action in the appeals process. The State Agency's or the Federal Government's certification of compliance or noncompliance with the applicable requirements is an official finding and determines whether or not the provider or supplier may participate in the Medicare or Medicaid program

Regulatory staff's documentation of observations, interviews, and record reviews must be objective, consistent, and accurate. Each data source becomes an important part of any legal proceedings subsequent to the regulatory visit, such as reconsiderations, judicial reviews, reviews by the Board's Appellate Division, or hearings before an administrative Law Judge (ALJ) of the Departmental Appeals Board (DAB).

An entity may request a formal reconsideration when the entity determines it does not agree with a cited deficient practice that can affect its ability to qualify for participation in the Medicare/Medicaid program.

In the event an entity is determined to no longer meet the regulatory requirements resulting in termination or alternate remedies/sanctions, the actual termination, projected termination, or remedy may be appealed through an evidentiary hearing before an ALJ. During a hearing, the government has the responsibility to provide facts and evidence to support the decision that the entity should be terminated or be subject to alternate remedies of enforcement. The evidence must provide the underlying reason, basis, or rationale for the findings of noncompliance with the regulatory requirement(s). Such a hearing is an adversarial proceeding; witnesses are called to testify for the entity and for the State or Federal regulations subject to cross examination.

A formal reconsideration is a thorough, independent review of the initial decision, including the all-inclusive volume of evidence. If the reconsideration determination upholds the initial decision, the entity may request an evidentiary hearing before an ALJ.

The primary evidence is the SOD along with all other documentation used to establish the determination of the regulatory process results, such as working papers, photos, cell phone contents and computer software documentation. The ALJ relies on the testimony of witnesses and the documentation from the regulatory process in making a decision. This process, all documentation used at the hearing becomes part of the public record.

In conclusion, the ALJ issues a written decision as to whether or not the entity should be found in compliance with the regulatory requirements of the program. The ALJ is usually not a health professional; therefore, it is important the regulator present the findings in plain language. For this reason, it is important the SOD does not contain technical jargon or abbreviations a lay person would not readily understand.

If the State Agency or Federal Government or the entity is dissatisfied with an ALJ decision or dismissal, it may file a request for review to the DAB Appellate Division. If the entity is dissatisfied with the outcome of the DAB review, the entity has the right to seek judicial review. The State Agency and Federal Government do not have this right. The Court's review is limited to the record of the proceedings before the ALJ and the DAB's Appellate Division with the regulatory process documentation continuing to be a crucial aspect of the proceedings.

The SOD documentation remains the vital element in the record to support a determination of noncompliance with regulatory requirements, and, if necessary, to defend the determination before the public, during the appeals process, or in court. The documentation of each and every regulatory process should be treated as if it will be subject to scrutiny. The determination of compliance, as well as noncompliance, must be based on objective and factual observations, record review, and interviews, impulsive and vague conclusions as well as assumptions should be avoided.

A judge will usually rely on regulator judgment if the documentation is thorough and all-inclusive.

If a regulator encounters information/evidence involving vulnerable adult outcomes during the course of the regulatory process, the regulator should make every effort to associate the cited deficiencies to the effects they can have on vulnerable adults or the provision of care, services, and treatments to vulnerable adults. The deficiency citations must also relate to the statutory or regulatory requirements.

A clear and comprehensive SOD is necessary to provide the entity with the information needed to analyze the problems, identify appropriate corrective action(s), and come into compliance with the regulatory requirements.

DEFINITIONS

Abbreviated Regulatory Process: Gathering of investigative information for a focal issue or issues conducted for complaints, change in ownership, or other indicators of specific concern.

Adult Family Home (AFH): State licensed residential homes to care for two to eight vulnerable adults who may have mental health, dementia, and/or developmental disability/special needs. The homes are private businesses providing each person with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services.

Assisted Living Facility (ALF): State licensed facilities providing basic services assuming general responsibility for the safety and well-being of vulnerable adults. ALFs allow the vulnerable adults to live an independent lifestyle in a community setting while receiving necessary services from a qualified workforce. ALFs can vary in size and ownership from a family-operated 7-bed facility to a corporation based facility with 150+ beds. ALFs may provide intermittent nursing services or serve vulnerable adults with mental health needs, developmental disabilities, or dementia.

Attestation: A witnessed declaration executing an instrument in his or her presence according to the formalities required by law.

Certified Community Residential Support Services (CCRSS): Also referred to as Supported Living (SL). These are residential services provided to the Developmental Disabilities Administration (DDA) of vulnerable adults living in their own homes in the community. The client or legal representative owns, rents, or leases the home.

Certification Evaluation: A CCRSS regulatory process whereby contracted evaluators assess provider compliance with statutes and regulations. In addition to certification evaluations at least once every 24 months, contracted evaluators may also conduct follow-up visits.

Code of Federal Regulation (CFR): The Departments and Agencies of the Federal Government providing codification of the general and permanent rules published in the Federal Register.

CMS State Operations Manual, Appendix J: Federal Guidance to Surveyors for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

CMS State Operations Manual, Appendix PP: Federal Guidance to Surveyors for Long Term Care Facilities.

CMS State Operations Manual, Appendix Q: Federal Core Guidelines for Determining Immediate Jeopardy.

Collateral Contact: An external source knowledgeable about the particular situation or concern occurring in the vulnerable adult care setting. The collateral contact typically either corroborates or supports the information of those living in the setting. A few examples include health care staff not employed by the entity, family members, family friends, resident/client representative, legal guardian, law enforcement, or hospital staff.

Conditions of Participation (COP) (ICF/IID only): Refers to a "condition for coverage" relevant to suppliers. The COP are requirements with which an entity must comply in order to participate in the programs. The COP are categorized into three requirements:

1. Structure
2. Process
3. Outcome

Consultation in an AFH: Documentation of a first time violation of statute or regulation with minimal or no harm to vulnerable adults residing in the AFH. Documentation of a consultation includes an entry made on the cover letter that includes both:

- A regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and
- A three to four sentence statement summarizing the deficient practice.

Consultation in an ALF: Documentation of a first time violation of statute or regulation with minimal or no harm to the vulnerable adults residing in the ALF. Consultations are never written for care and services or safety areas that will impact the vulnerable adults living in the ALF. A Consultation is a violation that does not require an attestation. Consultation in an ALF may also occur if the entity corrects the violation and/or the deficient practice meeting the following criteria:

- Is corrected to the satisfaction of RCS prior to the exit;
- Is not a violation of a statute or regulation that was cited in one of the two most recent preceding regulatory processes; and
- Did not pose a significant risk of harm or actual harm to a vulnerable adult.

Documentation of a consultation includes an entry made on the cover letter that consists of both:

- *A regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and*
- *A three to four sentence statement summarizing the deficient practice.*

Consultation in an ESF: Documentation of a first time violation of statute or regulation with minimal or no harm to vulnerable adults residing in the ESF. Documentation of a consultation includes an entry made on the cover letter that includes both:

- A regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and
- A three to four sentence statement or a paragraph summarizing the deficient practice.

Cover Letter: A cover letter is the document used in Community Programs to communicate the determination of noncompliance with the regulatory requirements to the entity. The cover letter is an official, legal record that is available to the public on request.

Deficiency Citation: Documentation of a violation of statute or regulation, other than those defined as a consultation. A deficiency citation consists of:

- The alpha prefix and data tag number for federal programs;
- The applicable Code of Federal Regulations (CFR) in federal programs;
- The applicable State of Washington Administrative Code (WAC) and/or the applicable Revised Code of Washington (RCW);
- The language from that reference, which pinpoints the aspects(s) of the requirement with which the entity failed to comply;
- An explicit statement that the requirement was “not met”, and
- The evidence to support the decision of noncompliance.

Deficient Practice: The action(s), error(s), or inaction on the part of the entity that did not meet the regulatory requirement.

Deficient Practice Statement (DPS): A write up before the supported findings, "Findings included…" establishing why the entity was not in compliance with a regulatory requirement. Also, commonly referred to as "the based on."

Entity: A standard term used throughout this document to depict the long term care program homes, facilities, and licensees participating in transforming lives of the vulnerable adults living in residential settings.

Entity Representative: A person designated by the Provider who is responsible for the daily operation of the adult family home. This person meets all of the requirements of chapter 388-112 WAC.

Enhanced Services Facilities (ESF): A community placement option for individuals moving from state hospitals whose personal care and behavioral challenges do not rise to a level requiring a locked security setting.

Evidence: Data sources, to include observation, interview, and/or record review, described in the findings of the deficiency citation. These data sources within the deficiency citation inform the entity of the failure to comply with the regulation. A minimum of two of the three data sources are required to support the citation. Having documentation of all three data sources is optimal for the deficiency citation to be irrefutable.

Extent of Deficient Practice: The number of deficient cases relative to the total number of sampled cases. This is shown in a numerical format with identifying the number of deficient cases within the universe (1 of 3). Please refer to definitions of scope and severity.

Fact: An event known to have happened. A Fact is a truth known through actual experience of observation, interview, and review of records.

Federal Programs: This includes Intermediate Care Facilities for Individuals with Intellectual Disabilities and Nursing Homes.

Finding: A term used to describe each item of information found during the regulatory process about the entity's practices relative to a specific requirement cited as not met.

Forms CMS-2567, CMS 2567B, CMS-2567L Statement of Deficiencies: The official document(s) communicating the determination of compliance or noncompliance with the Federal requirements. In addition, they are the form(s) an entity uses to submit a plan to achieve compliance. Each form is an official, legal record that is available to the public on request.

Gender Neutral Language: Use of terms to increase the confidentially and be inclusive of the vulnerable adult(s) in the specific setting. This includes pronouns, which do not associate a gender with the vulnerable adult in order to protect the identity, such as, they, them, or theirs. Emphasize attempts to avoid using gender specific pronouns such as he, him his or she her hers.

Identifier: The name, title, or letters/numbers referring to entity staff or those living in the residential setting. Do not use the symbol # in front of the identifier number.

Initial Inspection/Pre-Inspection: Regulators follow statue and regulations in conducting a compliance evaluation for a prospective residential setting.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): The Social Security Act created this optional Medicaid benefit to fund "institutions" (four or more beds) for individuals with intellectual disabilities. The Secretary defines this as providing "active treatment."

Nursing Home (NH): A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

NHs provide vulnerable adults medical or skilled nursing care; rehabilitation services for the rehabilitation of injuries, disabled or sick individuals; and long term care for those who require services for health or personal needs and activities of daily living over a period of time.

Outcome: An actual or potential result/consequences of the entity's practices (e.g., development of avoidable pressure injury; reaction due to receipt of blood; lack of monitors for anticoagulant).

Process: The specification of the ongoing manner that the entity must operate. The process requirements do not allow the entity to vary from what is specified. Examples include the reviewing, revising and/or updating the plan of care; policies and procedures such as, infection control procedures for cleaning/maintaining glucometers; or annual assessments for the vulnerable adults in the residential settings.

Recipient: A vulnerable adult who receives services from an entity regardless of whether or not that person is eligible for, or is receiving, Medicare or Medicaid.

Recurring/Repeated:

1. The department previously imposed an enforcement remedy for a violation of the same section of WAC or RCW for substantially the same problem following any type of inspection within the preceding thirty-six months.
2. The department previously cited a violation under the same section of WAC or RCW for substantially the same problem following any type of inspection on two occasions within the preceding thirty-six months.

Revised Code of Washington (RCW): The compilation of all permanent laws now in force. It is a collection of Session Laws (enacted by the Legislature, and signed by the Governor, or enacted via the initiative process), arranged by topic, with amendments added and repealed laws removed. It does not include temporary laws such as appropriation acts.

Regulatory Process: Regulatory staff evaluate current entity compliance with statutes and regulations. Types of regulatory processes include pre-occupancy, abbreviated complaint investigations; full inspection/recertification surveys; initial certification surveys; follow-up or post surveys; initial licensing and relicensing, and monitoring visits.

Regulatory Staff/Regulator: RCS staff responsible for enforcing the rights, safety, and health regulations of individuals living in Washington's licensed or certified residential settings.

Requirement: Any structure, process, or outcome that is required by law or regulation.

Scope: The number of vulnerable adults actually or potentially affected by the entity's noncompliance. This is Illustrated in the deficient practice statement and supported in the findings.

Severity: The effect of the noncompliance on the vulnerable adult.

State Agency (SA): A permanent or semi-permanent organization in government that is responsible for the oversight and administration of specific functions.

Statement of Deficiency (SOD): The official, publicly disclosable document describing the entity's noncompliance with regulatory requirements for AFHs, ALFs, CCRSSs, ESFs, ICF/IID, and NHs. Included in the SOD for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date of the cited deficient practice. The SOD is a legal document available to the public on request.

Structure: Requirements specifying the initial conditions, which must be present for an entity to be certified to participate. They are expected to remain as is unless there is a need for major renovation, re-organization, or expansion of services. Examples include: updating to new windows/carpet/paint; changing the number of bedrooms; changing the size of a room.

Uncorrected: Means the department has cited a violation of WAC or RCW following an inspection and the violation remains uncorrected at the time of a subsequent inspection for the specific purpose of verifying whether such violation has been corrected.

Universe: The total number of individuals, records, observations, objects and/or rooms related to the entity's practice placing vulnerable adults at risk because of a deficient practice. This is the denominator when determining the extent of a deficient practice.

Vulnerable Adult: Defined in RCW 74.34.020: (22). "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 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. Refer to the link for more information: https://apps.leg.wa.gov/RCW/default.aspx?cite=74.34.020.

Washington Administrative Code (WAC): Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.

PRINCIPLES OF DOCUMENTATION

1 The Principle Of Entity Compliance and Noncompliance

In Regulatory Programs, when an entity complies with the regulatory requirements related to the inspection/recertification process, the State Agency (SA) sends a letter containing the explicit statement, "There were no deficiencies found." For NH, a federal program, the SA electronically mails the 0000 page of the Form CMS 2567. For ICF/IID, a federal program, a certified letter containing the 0000 page of the Form CMS 2567 is mailed to the entity. The SA mails a certified letter to the State programs.

If the entity does not comply with one or more regulatory requirements, a letter and Statement of Deficiency, including corresponding consultations and/or deficiency citations, are either sent electronically or via certified mail, depending on the regulatory program, to the entity.

The laws and regulations are the legal authority for determining the entity's compliance with regulatory requirements.

Within the SNF/NF program, if the entity's noncompliance is isolated and does not pose a risk of more than minimal harm such as a scope and severity of A, the deficiency is documented on the "A" Form of the Form CMS-2567L recording the SNF/NF is in substantial compliance.

2 The Principle Of Using Plain Language

The regulatory staff need to:

- Correlate each deficiency citation to a regulatory requirement, statute, or law.
- Write each deficiency citation as a stand-alone citation.
- DO NOT copy and paste from one citation to another citation.
- Be consistent with abbreviations, acronyms, initialism, and language throughout the SOD.
- Write each deficiency citation clearly and objectively using past-tense active voice throughout the citation:
  - Use "The nurse reprimanded the caregiver."
  - Avoid "The caregiver was reprimanded by the nurse."
- Write out numbers one through nine and write out double digit numbers 10 and greater in their numerical form. Exceptions include:
  - Document scope and universe, and identifiers in the DPS in a numerical format. For example 1 of 3 residents (Residents 4, 10, and 24), or 1 of 3 residents (Clients 2 and 4); do not include "#."
  - Spell out all numbers when used as the first word of a sentence.
  - Recording measurements of less than a whole number, record the measurement as a decimal. For example, 0.5 inches or centimeters.
- Document (Residents 1, 2 & 3), avoid (Residents 1-3) or (Residents 1 to 3).
- Keep sentences short; use simple sentence structure.
- Avoid irrelevant or extraneous words.
- Avoid using the word "and" when connecting two ideas. For example, the client walked to the nurse to receive medication and she went to the activity room to listen to the current news. Eliminate the word "and." Create two sentences to be clear to the reader.
- Do not use the language "it was determined."
- Avoid using "but" or "however."
- Use "current" or "discharged," not "open" or "closed" when referring to resident/client records.
- Clarify something within a quote by placing it in brackets. For example, Client 2's progress note, dated XX/XX/XXXX, showed, "I punched the aide [Staff C, Caregiver] lots of times."

- Use “Findings included…” Do not bold these words or place them in an upper case format.
- Do not use, “All observations, record review, and interviews were completed on XX/XX/XXXX unless otherwise indicated.”
- Include only diagnoses that are relevant to the failed practice. Use caution when describing conditions that can identify a vulnerable adult living in the residential setting.

- Place the most harmful case first with all relevant facts and findings in a logical order, if possible, place in chronological order.
- Write the citation to be clear to the reader; think about organizing the “Findings included…” into categories of topics, concepts, issues, units/halls/wings, or residents/clients when multiple entries are documented for the same regulation. Underlining or placing the single angle symbol < > at the beginning and end of the category is acceptable:
  - *Under the regulation of Infection Control organizing into topics:*
    - <Hand Hygiene>
    - <Communicable Disease Outbreak>
    - <Catheter Care>
    - <Linens>
- Under a regulation organizing into Units/Wings/Halls/Rooms:
  - Room 403 OR Room 222
  - Rose Corridor OR Lily Corridor
  - Client 3 OR Room 6
- Only include the facts which support the determination of noncompliance.
- Document in a layout and design that includes adequate white space between paragraphs to separate blocks of text, helpful headings, bulleted lists, and other proven formatting techniques.
- Avoid writing one-sentence paragraphs.

- Select “Replace straight quotes with smart quotes” option in Microsoft Word or other software programs. Quotes should look like apostrophes in style—note the lack of curves in straight quotes (“).
- Use the language in the Minimum Data Set (MDS) when referring to the MDS. For example, independent, limited, supervision and so on.
- Use capital letters with proper names/titles/abbreviations. [(Resident 4, Client 9, the Nursing Assistant (NA).]
- Use one space after a period.
- Use asterisks to fill in a word of profanity. For example, s**t, son of a b***h.
- Avoid writing personal opinions, advice, comments, or assumptions.
- Avoid vague terminology (seems, appears, did not always, timely) and words that imply or state conclusions (only, just, unsatisfactory, unnecessary, throughout, on the second day, or inadequate).
- Define the meaning of an abbreviation or acronym followed immediately by the abbreviation or acronym the first time in use, such as “Twice a day (BID)” then use “BID” throughout the rest of the citation. Do not use “BID” and then later use “bid.” Be consistent throughout the SOD.
- Ensure when multiple regulators are adding to the same citation, the first citation contains the explanation/definition/abbreviation.

- Do not use an abbreviation/acronym if the term is only referenced once in the citation.
- Do not place periods within an acronym, with the exception of a.m. or p.m. For example, use “ESRD,” not “E.S.R.D.”
- Only quote information if it is exact, accurate, and strengthens the citation; document the quote in its entirety without breaking up into clauses; keep quotes to a minimum.
- Include the dates, times, and if relevant, the location of observations and interviews to support evidence of deficient practice.
- Use the actual date that the documents or records reviewed only if the date is pertinent to making the citation stronger. Otherwise, always document the date of the information from the record (“progress note dated”). Use double digit numbers to designate dates with the year as four digits (04/29/XXXX).
- Use generic terms for medications, when possible: for example, blood pressure medication or a medication that controls blood sugar levels. If it is necessary to use the specific name of the medication, describe the purpose of the medication in parenthesis.
- Avoid using medical or technical jargon:
    - The entity and other readers may not understand the intent
    - The entity and other readers may think the language is to make them look ignorant.

- Use gender-neutral pronouns, as able. For example, “they, them, or theirs.” This is a particular consideration with a small number of vulnerable adults residing in the setting.
- Not use “not limited to.”
- Read and edit the citations for errors, punctuation, clarity, and intent of the citation; use spell check.
- Not document what the entity did correctly.

Style

Commas

Commas have specific purposes. Most separate words and phrases to avoid confusion or to clarify, and they can indicate a pause where you want the reader to take a breath.

- Use commas to separate elements in a series; do not put a comma in front of the conjunction in a simple series. For example, Parts of a regulator’s responsibilities include off-site prep, on-site investigation and off-site post activities.
- Do put the comma before the last conjunction in a series, though, if a key part of the series needs a conjunction. For example, Client 4 had orange juice, toast, and ham and eggs.

Dash/Hyphen

- Use a hyphen to join modifiers. For example, performing the responsibilities of a regulator has the potential to be a high-stress job.
- Use a dash to separate parenthetical phrases in a sentence. For example, Staff E, Caregiver, stated she began her shift at 9:00 AM – three hours later than scheduled.

Dates

- When spelling out the date, abbreviate the name of the month in a date. For example, the new employee started working at the home on Nov. 21 XXXX (not 21st).
- Spell out the name of the month when it stands alone or with the year. For example, the background check for Staff F, Provider, was due in November XXXX. There is no comma between the month and year.
- Use eight digits for the date. For example, XX/XX/XXXX.
- Use four digits for each year. For example, 2017, 2020, and 2021.

Ensure/Insure

- "Ensure" is to guarantee. For example, it was everyone's job in the facility to ensure each of the staff assisted with resident safety.
- "Insure" is to protect by issuing an insurance policy. For example, insure yourself against liability and damages when driving a car.

Exclamation marks

- Avoid exclamation marks and CAPITAL LETTERS.
- Use capital letters only to begin sentences, for proper names and in acronyms.

Farther/Further

- Use farther to refer to actual distance. For example, Resident 12 walked farther today than yesterday in the therapy pool.
- Use further to refer to a figurative distance or greater degree or extent. For example, the regulator delved further into the client's concerns with more observations and interviews.

Fewer/Less Fewer

- Use fewer when referring to a number and with plural nouns. For example, Staff A, Caregiver, supervised fewer than five clients during the activity.
- Less refers to degree or amount. Use less with singular nouns. For example, Staff D, Licensed Nurse, told Staff B, Caregiver, that the afternoon session would contain less time (a smaller degree) to complete the on-line training.

None

Grammatically speaking, the word "none" takes a singular verb. Think of "none" as "no one" or "not one." For example, Resident 4's incident reports were requested on 02/13/XXXX, none was provided. "None" in this sentence is singular, not plural.

Quotation marks

- Place quotation marks outside, or after, almost all punctuation marks. For example, "…called out."
- The period and the comma always go within the quotation marks. "…called out."
- The dash, semicolon, question mark, and exclamation point go within the quotation marks when they are part of the quoted matter only. They go outside the quotation marks when they apply to the whole sentence.

That/Which

No punctuation is needed when using the word "that." For example, the bingo prize that Client 4 wanted was gone.

When writing the word "which" use a comma. For example, the bingo prize that Client 4 wanted, which would be therapeutic, was gone.

Time and time ranges

- The regular clock time is used with the hour, minutes, followed by the abbreviations a.m. or p.m.; or AM or PM. The abbreviation needs to be consistent throughout the SOD. For example, 9:15 a.m., 10:30 p.m. or 9:15 AM, 10:30 PM.
- Do not use military or 24-hour clock time.
- Use noon or midnight not 12:00 a.m. or 12:00 p.m. It is redundant to write 9:00 a.m. in the morning or 8:15 p.m. in the evening.
- Write time ranges with the dash as a separator. For example, from 9 – 10 a.m. or from 3:00 p.m. – 3:20 p.m.
- To be factual, do not use the language "approximately."

3 The Principle Of Components of a Deficiency Citation

A deficiency citation consists of a regulatory reference, a deficient practice statement (DPS), and relevant findings.

Each DPS follows the specific objective findings gathered through data collection. The objective findings answer the questions who, what, where, when, and/or how for each deficient practice in order to illustrate the entity's noncompliance.

Due to the fact that all relevant information demonstrating noncompliance is provided in the deficient practice statement, a conclusion and/or summary remarks at the end of the deficiency citation are not necessary and MUST NOT be written.

Regulatory Reference Includes:

- The applicable federal survey data tag number, WAC, RCW, and/or other relevant subsections
- For federal programs, the Code of Federal Regulation (CFR)
- The language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant and
- An explicit statement that the "condition," "standard," or "requirement" is "not met."

Deficient Practice Statement Includes (5 Components):

1. The informational data source(s) related to obtaining the evidence: observation, interview, and/or record review.
2. The specific action(s), error(s), and lack of action (deficient practice) relative to the regulation: "the entity was not in compliance with..."
3. A description of the extent of the deficient practice or the number of deficient cases (scope) relative to the total number of actual and potential cases (universe). For example, 1 of 3 clients/residents with incontinence.

4. The identifier of the individuals referenced in the extent of the deficient practice:
    a. Singular: Client 1; Resident 8; Staff C, Certified Nursing Assistant
    b. Multiple: Residents 45, 2, & 18, or Clients 1, 2, and 3
    c. It is not necessary to use the # symbol in front of the identifier number.
5. The outcome(s) or potential outcome(s), also referred to as the risk statement or "so what" statement relative to the deficient practice. For example:
    a. Actual Outcome/Risk: This failure resulted in the resident being bed bound for three months.
    b. Potential Outcome/Risk: This failure placed residents at risk for being bed bound for an extended period.

The DPS defines what the entity did or did not do without repeating the regulation. The specific action or lack of action in the DPS must be described in concise, clear terms so that the entity can determine why and which part of the regulation was "not met." The DPS should be organized and flow in a logical manner relating to each part of the regulation of which the entity failed to comply.

To maintain confidentiality of those living in the residential setting and others referred to in the SOD, identifiers are used. The identifiers can be letters or numbers. The identifiers in the DPS ***must*** *match those identifiers in the findings.*

Each DPS identifies the data sources: observation, interview, and/or record review. There must be at least two of the three data sources. The data sources identified in the DPS must be represented in the findings.

Whenever possible, if a follow-up/revisit regulatory process finds noncompliance for the same individual as in the original inspection, reassign the same identifier. If it is not possible to use the same identifier, use a different set of letter/numbers for revisits so that in the event of a hearing, the same identifier is not used for two different individuals correlating to the original regulatory visit. Unused letter/number identifiers can be documented as "intentionally left blank" on the vulnerable adult and staff lists.

The extent of the deficient practice (scope/universe) relates to the prevalence or frequency of deficient cases within the universe expressed in a numerical format: 1 of 3. The scope is the number of vulnerable adults actually affected by the entity's noncompliance. The universe is the number of vulnerable adults potentially affected. For example, 1 of 3 sampled clients/residents.

If the citation includes ALL of the vulnerable adults, with the failed practice affecting each individual, then each vulnerable adult's identifier needs to be documented in the DPS.

When the failed practice does not affect all the vulnerable adults, the regulatory staff must determine the relevant universe or total number of vulnerable adults, specific environment, or failed practice issues that could potentially be affected, such as: wheelchairs, shower rooms, courtyards, or pharmacy medications.

A separate statement is documented showing this is a system wide issue. For example, if the failed practice relates to diabetic management, then the universe would only include individuals with diabetes. Another example is if the entity does not have a qualified person to administer insulin injections, only the vulnerable adults needing the administration of an insulin injection would be affected. Dependent upon the scope and severity, the deficient practice could be related to a single vulnerable adult or environmental item.

The DPS identifies relevant outcomes and risks answering the question "So what?" which is pertinent to the deficient practice. The outcome, risk, or "so what" statement reflects actual or potential negative outcomes including failure to improve or maintain, deterioration, and actual or potential harm. The SOD describes the specific results and consequences of the entity's noncompliance with a regulatory requirement.

Relevant Facts/Findings

The objective findings describe the facts with enough detail regarding what happened to support the failed practice. Only include relevant information pertaining to the deficient practice addressing the regulation. All identifiers and data sources included in the deficient practice statement must be included in the findings. The identifiers in the relevant findings must match those that are documented in the DPS. When an entity's staff member is referred to in the SOD, document the staff's identifier followed by their specialty/knowledge base/experience. For example, Staff C, Administrator or Staff E, Department of Nursing Service. Use the identifiers Staff C and Staff E throughout the rest of the citation when referring to these staff members.

Facts are the actual occurrence: something known to exist or to have happened through observation, interview, and possibly record review. Without the presence of facts, the evidence can be construed to mean that an assumption was made rather than a known conclusion about the entity's practice.

The objective findings need to be ordered in a logical sequence of events. Place the order of events chronologically when possible. The findings must include the date, time, and when pertinent, the location of the data collection. The organization of the findings must clearly convey to the reader the logical events that resulted in a deficiency citation.

Data Sources

Observation: the process of gathering information based on input obtained from the five senses. It is what the regulator sees, hears, touches, smells, and/or tastes during the regulatory process.

Documenting Observations:

- Document the date, time and, when pertinent, the location of the observation.
- Use the verbs "showed," "exhibited," or "indicated." For example, an observation on XX/XX/XXXX at 2:30 p.m. showed Client 2…"

Interview: the process of asking someone questions to gather information. Interviews with the vulnerable adult(s), family members, guardian, representative, visitors, staff members, physicians, and ombudsman (gender-neutral term, originated in Sweden) can provide new information or validate data collected from a different source.

Use identifiers to provide confidentiality. Every effort should be made to protect an interviewee's privacy. If the interviewee does not wish the entity to know the source of the provided information, that information may be documented in the SOD without an identifier using a statement such as, "During a confidential interview…" The interviewee must be told that there is no guarantee this information will remain confidential as a court may require that the confidential information be disclosed. If the interviewee's identity is not disclosed to the entity, the SOD must contain sufficient information for the entity to correct the deficient practice.

Documenting Interviews:

- Use the verb "stated," "said," "indicated," "replied," "reported," or "answered."
- Use the verb "stated" for direct quotes with quotation marks.
- Use "stated that" for paraphrasing general intent.
- Document the date, time, and if applicable, the location of the interview.
- Document the staff's identifier followed by their specialty/knowledge, base/experience, and when applicable, ending with an abbreviated title.

Example:

On XX/XX/XXXX at 10:13 a.m., Staff A, Director of Nursing Service, stated, "We don't have a policy on background checks for volunteers." Staff A said, "This is something for the facility to work on."

Record Review: the process of reading and/or analyzing documents to gather information. Record review is used to clarify and validate data collected through observation and interview. Identify the record that contained the information in addition to the date of the document. Do not write the actual reviewing date of the document, unless the date is truly relevant to the citation, making it stronger.

Referencing a Facility Policy:

- Place the facility policy at the beginning of the citation.
- Use only the part of the policy that supports the citation.
- Do not include the words "in part."
- Do not identify the section of the policy from which you are quoting material.
- Only put the policy title in quotes, not the policy directives being included.
- Key punctuations place a comma after the word titled, name the policy in quotes, and follow that with another comma.

Refer to the following examples when documenting a policy

Example of a dated policy using one piece of information from the policy:

Record review of the facility's policy titled, "Caring for Individuals with Dementia," dated XX/XX/XXXX, showed that if the resident refuses, staff are required to re-approach the client three times.

Example of an undated policy using three or more pieces of information from the policy:

Record review of the facility's undated policy titled, "Caring for Individuals with Dementia," showed that the requirement for facility staff is to re-approach the resident three times when the resident refuses, is resistive to care, communicates with inappropriate verbal comments, and/or becomes aggressive.

Example of a revised policy using one piece of information from the policy:

Record review of the facility's policy titled, "Caring for Individuals with Dementia," revised on XX/XX/XXXX, showed that staff are required to re- approach the client three times if the resident refuses.

Example of either no existing policy or policy not provided as requested:

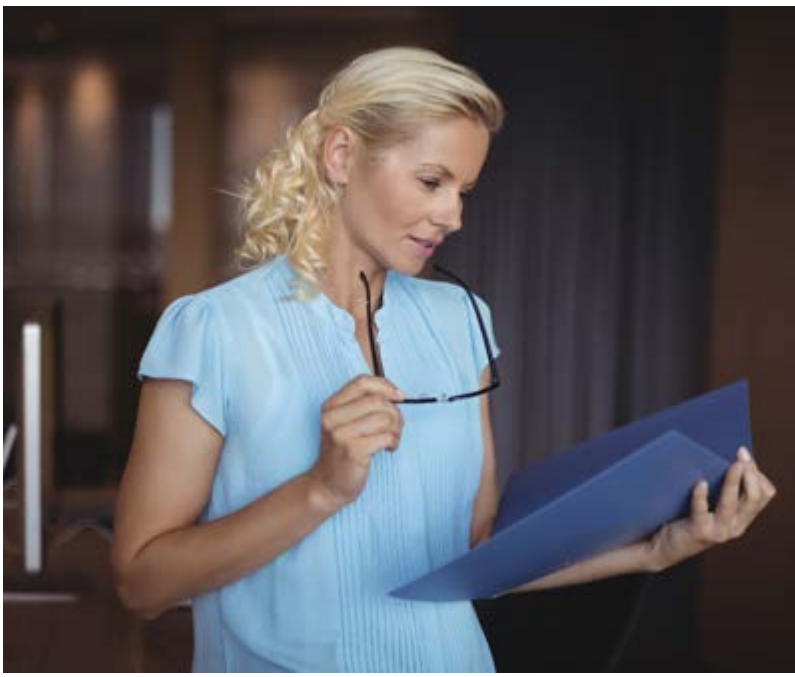
Record review of the electronic medical record policy showed that the facility had no process for identifying the staff members' electronic signatures.

Record review of background checks showed that the facility did not provide policies as requested for staff background checks who are volunteers.

4 The Principle Of Relevance of Onsite Correction of Findings

For the AFH program, if the home corrects the deficient practice to the Department's satisfaction while staff is on-site, first determine if the violation meets the criteria for a consultation. Please refer to the Definitions section. If the violation meets the criteria in the definition, write the deficiency as a consultation, including the statement "This deficiency was corrected on-site at the time of visit" following the summary statement. Otherwise, write the deficient practice as a citation, including the statement "This deficiency was corrected on-site at the time of visit" following the findings.

For the ESF program, if the facility corrects the deficient practice to the Department's satisfaction while staff is on-site, first determine if the violation meets the criteria for a consultation. Please refer to the Definitions section. If the violation meets the criteria in the definition, write the deficiency as a consultation. Otherwise, write the deficient practice as a citation.



For the ALF program, in the event that the entity corrects the deficient practice while the regulatory staff is on-site for a full inspection, document in the working papers that a deficiency that was corrected.

If an entity demonstrates practices that result in the residential setting being out of compliance, there may be a system failure. The findings used as part of the evidence must illustrate the result of that failure; the findings are not the cause of it. A correction of the finding prior to the exit conference would not necessarily ensure the entity addressed the cause of the finding. Through the data sources of observation, interview, and record review, regulators eventually determine the cause of the deficient practice. However, it is the ultimate responsibility of the entity to ascertain the cause of the system failure and correct the deficient practice.

Notify the field manager to discuss any deficient practice requiring an immediate plan of correction to protect the health, safety, or welfare of those living in the licensed or certified residential setting. For State programs, the entity must develop a written plan to correct, then sign and date the plan prior to the regulatory staff leaving the setting.

For Federal programs NH and ICF/IID, the entity develops a removal plan that must include a date by which the entity asserts the likelihood for serious harm to any recipient no longer exists.

5 The Principle Of Interpretive Guideline (NH & ICF/IID Only)

In Federal regulations, the deficiency citation describes how the entity failed to comply with the regulatory requirements. The deficiency citation does not write to the failure of complying with the guidelines for the interpretation of those regulatory requirements.

6 The Principle Of Citation of State or Local Code Violations (NH & ICF/IID Only)

The entity's failure to comply with State or local laws or regulations is not documented in the Form CMS-2567 except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has made an adverse action that has been sustained through the hearing process (such as removal of the license to operate), the Form CMS-2567 should note that the entity no longer has a license.

7 The Principle Of Cross References

The cross-referencing of requirements is an acceptable form of documentation in the SOD only when it is applicable and directly pertains to the linked deficiency citation. Descriptive evidence (Findings included…) from one deficiency citation may be linked to the evidence for a deficiency citation of another regulatory requirement. The evidence being cross-referenced must support the determination of noncompliance with that regulatory requirement. Each deficiency citation must contain all components described in this document independent of the additional information being linked into that deficiency citation.

Cross-referencing is most effective when the linked deficiency citation has a direct cause and effect relationship to the deficient practice described in both deficiency citations. In all instances, each deficiency citation must contain relevant facts to demonstrate noncompliance for the referenced regulation independent of any other deficiency citation referenced. Each citation must be able to stand on its own.

When cross referencing, note the references after the relevant fact and findings. For example: Refer to WAC 388-78A-2210(1)(b)..

8 The Principle Of
Conditions of Participation (COP) Deficiencies (ICF/IID Only)

The COP citation includes a statement(s) of the entity's deficient practice(s) with findings included to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements, which must be corrected to find the COP in compliance, or by a narrative description of the individual findings. The COP citation includes ONLY those requirements that must be corrected to achieve compliance with the COP.

If a COP is determined to be deficient, the deficiency report identifies the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these secondary requirements may be referenced under the COP citation.

9 The Principle Of
Citations with More Than One Regulatory Reference

If the deficient practice can be applied to more than one regulatory requirement, then the deficient practice must be evaluated for the regulation that most represents the deficient practice. The regulatory requirement should contain the language that best demonstrates what the entity failed to comply with. Each deficiency citation must reference only the most applicable WAC and/or RCW and must not contain multiple regulatory requirements under the same citation.

If the deficient practice can be associated with more than one regulation and each regulation can be independently supported with sufficient facts of noncompliance, each citation must be written separately. Cross-referencing may be applied between the citations if there is a direct cause and effect relationship between the two citations.

There may be rare instances in which the deficiency citation will reference multiple regulatory requirements. However, this is limited to situations in which the specific regulatory requirements are outlined in a WAC other than WAC 388-76, WAC 388-78A, 388-101, 388-101D or 388-107. The authority to cite that specific requirement is covered in 388-76, 388-78A, 388-101, 388-101D or 388-107. In these specific situations, multiple WACs must be listed to be clear what the entity must do in order to meet the requirements.

To properly cite this in the deficiency citation, the specific section of WAC 388-76, 388- 78A, 388-101, 388-101D or 388-107, which references the outside WAC must be included in the deficiency citation. Then the outside WAC showing how the entity did not meet the requirement must also be present in the deficiency citation.

For example: WAC 388-78A-2474 requires administrators or designees and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC. The CPR training requirements are listed in WAC 388-112A.

The deficiency citation must also include WAC 388-112A-0720, which specifically covers the CPR requirement.

If the failed practice is that Staff A did not have a CPR card, then the deficiency citation would include WAC 388-78A-2474 which indicates: 1) staff hired on or after this date must meet training and home care aide certification requirements, and 2) staff must also meet training requirements of 388-112A.

10 The Principle Of Components of Consultation (AFHs, ALFs, ESFs Only)

A consultation consists of a regulatory reference, and a deficient practice summary of the failed practice.

Regulatory reference includes:

- The applicable WAC and, if applicable, RCW and/or other WAC number and any relevant subsections; and
- The language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant.

Deficient practice summary for a consultation is brief (three to four sentences) indicating what the failed practice was. The actual or potential outcome may also be documented.

Remember, each consultation must include a regulatory reference, followed by the summary of the failed practice.

11 The Principle Of Recurring/Repeated, Uncorrected and/or Previously Cited Deficiencies (ALFs, AFHs, ESFs Only)

This principle is for ALF, AFH and ESF guidance only. Refer to the definitions section in this manual for a better understanding of recurring, repeated and uncorrected terminology. Discuss these patterns of failed practice/ deficiencies with your Field Manager and Compliance/ Enforcement. The findings with the deficiency citations must be of substantially the same problem for the exact same WAC/RCW section(s) within the prior 36 months.

The following is guidance on specific language to document for recurring, repeated and uncorrected or previously cited deficiencies for statement of deficiencies and consultation(s). When noting recurring/repeated/uncorrected dates, order dates from most current to oldest. Add this documentation at the end of the citation. See Principle #11 examples in each programs Appendices. Do not include current citation dates in the new SOD.

ALF will use the language recurring and uncorrected.

AFH will use the language repeated and uncorrected.

ESF will use the language recurring and uncorrected.

How to write in the SOD
Repeated/Recurring Deficiencies:
Use of the word repeated or recurring when citing a previous deficiency and MUST be used only when within the prior 36 months:

1. The department imposed an enforcement related to the cited WAC, Or
2. This is the same second or third deficiency citation

When cited two or more times write: This is a repeated deficiency previously cited on [add previous cited date(s).]

Repeated/Recurring and Uncorrected Deficiencies within the prior 36 months:
Write: This is a repeated deficiency on [previous date cited] and an uncorrected deficiency previously cited on [most recent previously cited date and other date(s) previously cited when multiple dates].

Uncorrected Deficiencies within the prior 36 months:
Write: This is an uncorrected deficiency previously cited on [most recent previously cited date].

Previous Consultation with a current citation within the prior 36 months:
Write: This is a previous consultation on [most recent previous consultation date].

AFH failed Follow-up:
First and subsequent failed Follow-up for only part(s) of the previously cited WAC(s) have uncorrected deficiencies:
Write: This is an uncorrected deficiency previously cited on [most recent previously cited date and other date(s) previously cited when multiple dates] for subsection(s) [specify only the sections that are not corrected].

ALF/ESF failed Revisit:
First and subsequent failed Revisit for only part(s) of the previously cited WAC(s) have uncorrected deficiencies:
Write: This is an uncorrected deficiency previously cited on [most recent previously cited date and other date(s) previously cited when multiple dates] for subsection(s) [specify only the sections that are not corrected].
only the sections that are not corrected].

>>>The following appendices include RCS' programs with examples for each principle as applicable.<<<

APPENDIX A: Adult Family Home

PRINCIPLE #1: Entity Compliance and Noncompliance

The cover page for either Compliance or Noncompliance is printed on DSHS letterhead. All words shown in red are specific to each office.

Compliance:

DEPARTMENT LETTERHEAD
Department's Address
Date: XX/XX/XXXX

Home's Name
Home's Address
Home's City, WA, Zip Code

RE: Home's Name, License #

Dear Provider:

The Department completed a full inspection of your Adult Family Home, on Date: XX/XX/XXXX and found no deficiencies.

The Department staff who did the inspection:
Name of Regulatory Staff

If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

Noncompliance:

DEPARTMENT LETTERHEAD
Department's Address

Date: XX/XX/XXXX
CERTIFIED MAIL
XXXX XXXX XXXX XXXX XXXX XX

Home's Name
Home's Address
Home's City, WA, Zip Code

RE: Home's Name, License #

Dear Provider:

The Department completed a full inspection of your Adult Family Home on XX/XX/XXXX and found that your home does not meet the adult family home licensing requirements.

The Department:
- Wrote the enclosed report; and
- May take enforcement action based on any deficiency listed on the enclosed report.

You Must:
- Within 10 calendar days after you receive this letter, provide a written plan on the enclosed report, according to the attached "Plan":
- Indicating the date you have or will correct each deficiency; and
- Signing and dating after each citation to certify that you have or will take corrective measures to correct each cited deficiency, and
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction within 45 days, or sooner if directed by the Department; and
- Sign and date the first page of the enclosed report; and
- Return the report to the Department; and
- Have your plan approved by the Department.

The Department:
- Expects all deficiencies to be corrected within the time frame accepted by the Department; and
- May inspect the home to determine if you have corrected all deficiencies.

You May:
- Receive a letter of enforcement action based on any deficiency listed in the enclosed report.

- Ask questions and provide written information to help clarify or dispute the deficiencies.
- Ask for an informal dispute resolution meeting, according to the attached “Informal Dispute Resolution” instructions; and

If You Have Any Questions:

- If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

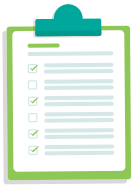
Sincerely,

Field Manager’s Name, Field Manager
Region X, Unit X
Residential Care Services

Enclosure

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.



PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(b) The resident's representative, if one exists;

(c) The resident's health care provider;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on observation, interview and record review, the provider failed to report a serious injury (bruise to the face) to the representative and health care provider for 1 of 2 residents, (Resident 1). This failure placed Resident 1 at risk for not receiving informed decisions by their representative and health care provider.

Relevant Facts/Findings

Findings included…

On 01/01/XXXX at 10:00 AM, a Home Health Nurse (CC3) stated they saw Resident 1 on 12/20/XXXX with a bruise on the right front of their face. During the resident visit, CC3 said Staff C, Caregiver, reported they did not know how the bruise happened.

An observation on 01/01/XXXX at 1:00 PM, showed a round, red, yellow, and purple bruise on the right side of Resident 1's face measuring 0.6 centimeters (cm) by 0.4 cm.

On 01/01/XXXX at 2:00 PM, Staff C, stated they told the Provider, but they were not able to get a hold of the resident's representative for two or three days.

On 01/01/XXXX at 2:30 PM, the Provider stated it was unknown how the bruise happened, but they believed it happened around 12/18/XXXX. The Provider stated Staff C called resident's representative to tell them about the bruise; they notified the Home Health Nurse within a couple of days; and left a voicemail with R1's health care provider.

Resident 1's records as of 01/01/XXXX, showed no documentation the Provider or staff reported the injury to the representative or health care provider.

On 02/01/XXXX at 9:09 AM, Resident 1's health care provider (CC2), indicated they reviewed Resident 1's medical record and stated there was no record of the home calling to report the bruise.

On 02/01/XXXX at 10:00 AM, the resident representative stated the home did not notify them. They said the first time they became aware of the bruise was the weekend before Christmas and they immediately called the Provider. The Provider stated they did not know how it happened.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Regulatory Reference

WAC 388-76-10475 Medication Log.

The adult family home must:

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the home failed to initial the medication log for medications administered to 1 of 2 sampled residents (Resident 4). This failure placed the resident at risk for medication errors.

Relevant Facts/Findings

Findings included…

Admission records showed Resident 4 was admitted on 01/21/XXXX with diagnoses including chronic pain and muscle spasms.

Practitioner orders on 01/21/XXXX showed Resident 4 received a pain medication, twice daily and a muscle relaxant, three times daily for muscle spasms.

According to Resident 4's medication administration record, she received both the pain medication and muscle relaxant on 07/01/XXXX, 07/02/XXXX, and 07/08/XXXX. There were no initials on the medication log as to who administered these medications to the resident on these dates.

During an interview on 07/11/XXXX at 4:00 p.m., Staff A, Provider, stated the caregivers were trained and expected to initial the medication log once they administered a medication.

This deficiency was corrected on-site at the time of visit.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)
PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

Not applicable.

PRINCIPLE #7: Cross-References

Regulatory Reference

388-76-10146 Qualifications—Training and home care aide certification.

Training and home care aide certification.

(6) The adult family home must ensure that all staff receives the orientation and training necessary to perform their job duties.

The requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the entity failed to provide orientation and transfer training for 1 of 3 staff members (Staff B). This failure placed residents at risk for receiving care from untrained staff.

Relevant Facts/Findings

Findings included…

Record review on 11/15/XXXX of Staff B's personnel file, showed the skill and orientation competency checklists were blank.

On 11/15/XXXX at 9:42 a.m., Staff B stated since their hire date of 09/01/XXXX, they did not receive orientation or specific training for their job tasks and duties.

On 11/15/XXXX at 10:25 a.m., Staff A, the Provider, stated orientation and skills training had not been completed for Staff B.

Refer to 388-76-10400 Care and Services

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)

Not applicable.

PRINCIPLE #9: Citations with More Than One Regulatory Reference

No example at this time.

PRINCIPLE #10: Components of a Consultation (AFH, ALF, ESF Only)

Provider's Name
Home's Name
Home's Address
Home's City, WA, Zip Code

RE: Home's Name, License #

Dear Provider:

The Department completed a complaint investigation of your Adult Family Home on Date: XX/XX/XXXX and found that your home does not meet the adult family home licensing requirements below.

The Department staff who did the investigation and provided consultation:
Name/Title of Regulatory Staff

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit

Two Consultation Examples:

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit.

1. **WAC 388-76-10165 Background checks—Washington state name and date of birth background check—Valid for two years—National fingerprint background check—Valid indefinitely.**
   (1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:
   (a) A new DSHS background authorization form is submitted to the Department's background check central unit every two years for each individual listed in WAC 388- 76-10161;
   (b) There is a valid Washington state background check for all individuals listed in WAC 388-76-10161.

The Provider and Co-Provider's background checks expired XX/XXXX, six months past the expiration date. During the investigation, the Provider submitted a new online background authorization form to the BCCU for

the both of them producing a receipt. Each background check shows the character, competence, and suitability to work with the vulnerable adults.

2. WAC 388-76-10320 Resident Records-Content.

The adult family home must ensure that each resident record contains, at a minimum, the following information:
(10) A current inventory of the resident's personal belongings dated and signed by:
(a) The resident; and
(b) The adult family home

The home did not maintain a current inventory list when Resident 2's family brought him new clothing items. The family stated they were happy no clothing items were missing. The family explained that they were on a budget without the ability to purchase more clothing at this time.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the home to determine if you have corrected all deficiencies.

You May:

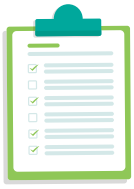
- Ask for an informal dispute resolution meeting, according to the attached "Informal Dispute Resolution" instructions; and
- Ask questions and provide written information to help clarify or dispute the deficiencies.

If You Have Any Questions:

- If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services



PRINCIPLE #11: Recurring/Repeated, Uncorrected and/or Previously Cited Deficiencies (AFH, ALFs, ESFs Only)

Regulatory Reference

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(b) The resident's representative, if one exists;

(c) The resident's health care provider;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on observation, interview and record review, the provider failed to report a serious injury (bruise to the face) to the representative and health care provider for 1 of 2 residents, (Resident 1). This failure placed Resident 1 at risk for not receiving informed decisions by their representative and health care provider.

Relevant Facts/Findings

Findings included…

On 01/01/XXXX at 10:00 AM, a Home Health Nurse (CC3) stated they saw Resident 1 on 12/20/XXXX with a bruise on the right front of their face. During the resident visit, CC3 said Staff C, Caregiver, reported they did not know how the bruise happened.

An observation on 01/01/XXXX at 1:00 PM, showed a round, red, yellow, and purple bruise on the right side of Resident 1's face measuring 0.6 centimeters (cm) by 0.4 cm.

On 01/01/XXXX at 2:00 PM, Staff C, stated they told the Provider, but they were not able to get a hold of the resident's representative for two or three days.

On 01/01/XXXX at 2:30 PM, the Provider stated it was unknown how the bruise happened, but they believed it happened around 12/18/XXXX. The Provider stated Staff C called resident's representative to tell them about the bruise; they notified the Home Health Nurse within a couple of days; and left a voicemail with R1's health care provider.

Resident 1's records as of 01/01/XXXX, showed no documentation the Provider or staff reported the injury to the representative or health care provider.

On 02/01/XXXX at 9:09 AM, Resident 1's health care provider (CC2), indicated they reviewed Resident 1's medical record and stated there was no record of the home calling to report the bruise.

On 02/01/XXXX at 10:00 AM, the resident representative stated the home did not notify them. They said the first time they became aware of the bruise was the weekend before Christmas and they immediately called the Provider. The Provider stated they did not know how it happened.

This is a repeated deficiency on 03/12/XXXX and an uncorrected deficiency previously cited on 08/23/XXXX.

APPENDIX B: Assisted Living Facility

PRINCIPLE #1: Entity Compliance and Noncompliance

The cover page for either Compliance or Noncompliance is printed on DSHS letterhead. All words shown in red are specific to each office.

Compliance:

DEPARTMENT LETTERHEAD
Department's Address

Corporation's Name
Facility's Name
Facility's Address
Facility's City, WA, Zip Code

RE: Facility's Name, License #

Dear Administrator:

The Department completed a full inspection of your assisted living facility on Date: XX/XX/XXXX and found no deficiencies.

The Department staff who did the inspection:
Name of Regulatory Staff

If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

Noncompliance:

DEPARTMENT LETTERHEAD
Department's Address

Statement of Deficiencies	License #: XXXX	Completion Date
Plan of Correction	FACILITY'S NAME	XXXX XX, XXXX
Page X of XX	License: NAME	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

The Department has completed data collection for the unannounced on-site full inspection and/ or complaint investigation on: Date: XX/XX/XXXX

Facility's Name
Facility's Address
Facility's City, WA, Zip Code

The following sample was selected for review during the unannounced on-site visit: X of X current residents and X former residents.

The Department staff that inspected / investigated the assisted living facility:
Name of Regulatory Staff

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region X, Unit X
Department's Address
City, WA Zip Code
(Area Code) Phone Number

As a result of the on-site visit(s) the Department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) _____ Date _____

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.

PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:
(b) Verify staff persons' work references prior to hiring;
(3) The assisted living must:
(d) maintain the following documentation of the assisted living premises, during employment, and at least two years following termination of employment:
(A) Training required by chapter 388-112A WAC;
(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on record review and interview, the facility failed to verify and maintain reference check documentation for 4 of 8 sampled staff members (Staff B, D, E, & G) in each of their personnel files. This failure placed residents at risk of receiving care from unqualified staff members.

Relevant Facts/Findings

Findings included…

According to the facility's hiring policy, "Steps to Hiring Quality Staff," dated 06/XXXX, showed staff reference checks were to be completed prior to hire. A copy of the reference checks was to be maintained in each of the staff member's file.

Staff B and D
Staff B, Caregiver, and Staff D, Caregiver were hired on 08/15/XXXX.
On 03/25/XXXX, Staff B and D's personnel files each contained three blank reference check forms.

Staff E and G
Staff E, Licensed Nurse, and Staff G, Caregiver, personnel file showed they were hired on 07/06/XXXX.

On 03/25/XXXX at 3:23 p.m., Staff G's personnel file contained one blank reference check form with Staff G's name documented on it. The facility was unable to locate Staff E's personnel file.

On 03/25/XXXX at 4:00 p.m., Staff A, the Administrator, stated the reference checks were completed for Staff B and D, neither being documented. Staff A reported there had been several unsuccessful attempts to contact Staff E and G's references.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Not applicable.

If the entity corrects the deficient practice while the regulatory staff is onsite for a full inspection, document in the working papers that the entity corrected the deficiency.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)

PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

Not applicable.

PRINCIPLE #7: Cross-Reference

Refer to Community Program Examples.

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)

Not applicable.

PRINCIPLE #9: Citations with More Than One Regulatory Reference

Regulatory Reference

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to: (e) Continuing education.

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below. (d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of twelve hours of continuing education within forty-five calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the facility failed to track 12 hours of continuing education (CE) for 1 of 4 caregivers (Staff B). This resulted in residents receiving care from an unqualified caregiver.

Findings included…

Relevant Facts/Findings

A review of Staff B's personnel file showed a birth date of June 10, a hire date of 09/07/XXXX, and two hours of CE hours completed between 06/10/XXXX-06/10/XXXX.

During an interview on 11/20/XXXX, at 5:00 p.m., Staff E, Administrator, stated the facility had computer system problems preventing Staff B to complete electronically the required 12 CE hours. The Administrator stated Staff B printed the answer sheets to complete with a pencil. Staff E stated Staff B's answers were not placed in the computer resulting in no certificates to maintain in his personnel file. Staff E was unable to locate Staff B's answer sheets.

This was a recurring citation from the previous three inspections dated 09/13/XXXX, 06/11/XXXX and 05/11/XXXX.

PRINCIPLE #10: Components of a Consultation (AFH, ALF, ESF Only)

Facility's Name
Facility's Address
Facility's City, WA, Zip Code

RE: Facility's Name, License #

Dear Administrator:
The Department completed a complaint investigation of your Assisted Living Facility on Date: XX/XX/XXXX and found that your facility does not meet the Assisted Living Facility licensing requirements below.

The Department staff who did the investigation and provided consultation:
Name/Title of Regulatory Staff

Consultation:

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report

WAC 388-78A-2620 Pets.

If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington State;

The community cat's (Garfield) rabies vaccine expired on 04/13/XXXX, three months earlier. The ALF scheduled a veterinarian appointment the following week for Garfield to receive the rabies vaccine.

You Are Not:

- Required to submit a plan-of-correction for the consultation deficiency or deficiencies not listed on the enclosed report.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.
- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an Informal Dispute Resolution (IDR) review within 10 working days after you receive this letter. Your IDR request must include:
- What specific deficiency or deficiencies you disagree with;
- Why you disagree with each deficiency; and
- Whether you want an IDR to occur in-person, by telephone or as a paper review, send request to:
- IDR Program Manager

Department of Social and Health Services Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

PRINCIPLE #11: Recurring/Repeated, Uncorrected and/or Previously Cited Deficiencies (AFH, ALFs, ESFs Only)

Regulatory Reference

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:
(b) Verify staff persons' work references prior to hiring;
(3) The assisted living must:
(d) maintain the following documentation of the assisted living premises, during employment, and at least two years following termination of employment:
(A) Training required by chapter 388-112A WAC;
(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on record review and interview, the facility failed to verify and maintain reference check documentation for 4 of 8 sampled staff members (Staff B, D, E, & G) in each of their personnel files. This failure placed residents at risk of receiving care from unqualified staff members.

Relevant Facts/Findings

Findings included…

According to the facility's hiring policy, "Steps to Hiring Quality Staff," dated 06/XXXX, showed staff reference checks were to be completed prior to hire. A copy of the reference checks was to be maintained in each of the staff member's file.

Staff B and D
Staff B, Caregiver, and Staff D, Caregiver were hired on 08/15/XXXX.
On 03/25/XXXX, Staff B and D's personnel files each contained three blank reference check forms.

Staff E and G
Staff E, Licensed Nurse, and Staff G, Caregiver, personnel file showed they were hired on 07/06/XXXX.

On 03/25/XXXX at 3:23 p.m., Staff G's personnel file contained one blank reference check form with Staff G's name documented on it. The facility was unable to locate Staff E's personnel file.

On 03/25/XXXX at 4:00 p.m., Staff A, the Administrator, stated the reference checks were completed for Staff B and D, neither being documented. Staff A reported there had been several unsuccessful attempts to contact Staff E and G's references.

This is an uncorrected deficiency previously cited on 02/15/XXXX.

APPENDIX C: Certified Community Residential Support Services

PRINCIPLE #1: Entity Compliance and Noncompliance

The cover page for either Compliance or Noncompliance is printed on DSHS letterhead. All words shown in red are specific to each office.

Compliance:

DEPARTMENT LETTERHEAD
Department's Address

Home's Name
Home's Address
Home's City, WA, Zip Code

RE: Home's Name, License #

Dear Provider:

The Department completed a full inspection of your Certified Community Residential Support Services, on Date: XX/XX/XXXX and found no deficiencies.

The Department staff who did the inspection:
Name of Regulatory Staff

If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

Noncompliance:

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your Certified Community Residential Support Services Certification.

The Department has completed data collection for the unannounced on-site full inspection and/ or complaint investigation: Date: XX/XX/XXXX

Home's Name
Home's Address
Home's City, WA, Zip Code

This document references the following complaint number:
Complaint #
Date: XX/XX/XXXX

The Department staff that inspected / investigated the Certified Community Residential Support Services:
Name/Title of Regulatory Staff

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region X, Unit X
Department's Address
City, WA Zip Code
(Area Code) Phone Number

As a result of the on-site visit(s) the Department found you are not in compliance with the certification laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand, to maintain a Certified Community Residential Support Services Certification, license I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) _____ Date _____

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.

PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

WAC 388-101D-0125 Client rights.

(3) The right to privacy, including the right to receive and send private mail and telephone calls;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on observation, interview, and record review, the provider failed to allow privacy during incoming and outgoing phone calls for 1 of 3 clients (Client 1). This failure resulted in intruding on a client's right to privacy.

Relevant Facts/Findings

Findings included…

On 06/21/XXXX, at 10:05 a.m., Client 1 was observed at his home on the phone. Client 1 told staff to whom they were speaking with.

Record review of Client 1's, record dated 01/02/2021, showed a "Phone Log" with columns labeled as "Date," "Who Called," "Number," "Did They Talk," and "Staff" with a selection box for incoming and outgoing phone calls.

On 06/21/XXXX at 2:28 p.m., Staff H, Nurse Aide Registered, who was in the home of Client 1, stated staff were to log each client's phone calls on each of their personal phone logs.

On 06/22/XXXX at 10:15 a.m., Staff B, Administrator, said all clients have a phone log with staff expectation to document incoming and outgoing phone calls. Staff B stated the clients were not asked if staff could document their phone calls on a log.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Not applicable.

If the entity corrects the deficient practice while the regulatory staff is onsite for a full inspection, document in the working papers that the entity corrected the deficiency.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)

PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

Not applicable.

PRINCIPLE #7: Cross-References

Regulatory Reference

WAC 388-101D-0125 Client rights.

Clients have the same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution, federal and state law unless limited through legal processes. Service providers must promote and protect all of the following client rights, including but not limited to:
(5) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment, and financial exploitation;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the Provider failed to ensure 1 of 4 sampled clients (Client 1) received staff supervision while in the kitchen. This failure resulted in Client 1 developing hand blisters from the hot water. This caused harm to Client 1.

Relevant Facts/Findings

Findings included…

Review of Client 1's Person Centered Support Plan (PCSP), dated 06/07/XXXX, showed the client was diagnosed with intellectual disabilities and mental health disorders. Client 1 required activities of daily living assistance to avoid health and safety hazards. The staff were required to supervise the client at all times, especially in areas having access to water such as the bathroom and kitchen.

Record review of the Incident Report (IR), dated 01/10/XXXX, documented Staff A, Program Manager, found Client 1 in the kitchen with his left hand under the hot water of the sink's faucet. Staff A documented the left hand was observed to be red in color with white areas. The IR indicated Client 1 was taken to an emergency room and treated for second degree burns (damage to the first and second layers of the skin with blisters) to the left hand. The IR showed there was only one staff in the home who was assisting another client.

On 01/15/XXXX at 10:00 a.m., Staff A stated Client 1's home should have been staffed with two caregivers. Staff A stated Staff C, Caregiver, left the home to do a personal errand.

Refer to WAC 388-101D-0170 Physical and safety requirements.

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)

Not applicable.

PRINCIPLE #9: Citations with More Than One Regulatory Reference

Regulatory Reference

WAC 388-101-3020 Compliance.

The service provider must be in compliance with:

(5) Other relevant federal, state and local laws, requirements, and ordinances. AC 388-101-3020 Compliance

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the home failed to provide staff assistance to 3 of 4 clients (Clients 2, 3 and 4), in three separate households receiving Department-issued food benefits. This failure placed clients at risk of losing their food benefits.

Relevant Facts/Findings

Findings included…

Per WAC 388-408-0034, WAC 388-408-0035 and RCW 74.04.510, if clients sharing a residence bought food together and prepared meals together their eligibility for Basic Food benefits must be assessed together as one "Assistance Unit." Supported living clients who purchase, prepare, and consume their own food were considered one individual "Assistance Unit" to qualify for Basic Food benefits. Sharing of food expenses and food was not appropriate under the food benefit rules for individual Assistance Units.

Review of Client 2's Individual Support Plans (ISP), dated 03/01/XXXX, Client 3's ISP, dated 04/01/XXXX, and Client 4's ISP, dated 05/01/XXXX, showed the Provider was each of the client's Representative Payee with receiving Basic Food benefits as an individual.

On 05/15/XXXX at 10:12 a.m., Staff A, Financial Services Specialist, stated Clients 2, 3 and 4, each received Basic Food benefits as Individual Assistance Units.

On 05/15/XXXX at 1:15 p.m., review of Clients 2, 3 and 4's financial records showed canceled checks made out to other clients in their household. These three client records contained statements showing deposits of money received from other clients in their households.

On 05/15/XXXX at 3:20 p.m., Staff A stated each client in a household used a combination of Basic Food benefits deposited on a Quest card (state electronic fund transfer to a card used to purchase food items) and money from their checking accounts to buy food on a weekly basis. If one client in a household spent more than the Quest card allotment of $50.00, the other clients would reimburse the difference via check. Staff A explained the system was used to ensure all clients in one household spent equitable

PRINCIPLE #10: Components of Consultation (AFH, ALF, ESF Only)

Not applicable.

APPENDIX D: Enhanced Services Facilities

PRINCIPLE #1: Entity Compliance and Noncompliance

The cover page for either Compliance or Noncompliance is printed on DSHS letterhead. All words shown in red are specific to each office.

Compliance:

DEPARTMENT LETTERHEAD
Department's Address

Facility's Name
Facility's Address
Facility's City, WA, Zip Code

RE: Facility's Name, License #

Dear Administrator:

The Department completed a full inspection of your Enhanced Services Facility on Date: XX/XX/XXXX and found no deficiencies.

The Department staff who did the inspection:
Name of Regulatory Staff

If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

Noncompliance:

Facility's Name
Facility's Address
Facility's City, WA, Zip Code

RE: Facility's Name, License #

Dear Administrator:

The Department completed a complaint investigation of your Enhanced Services Facility on Date: XX/XX/XXXX and found that your facility does not meet the Enhanced Services Facility minimum licensing requirements.

The Department:

- Found one or more deficiencies which impacts the health or safety of a resident or with probable impact to the health or safety of a resident;
- Wrote the enclosed Statement of Deficiencies (SOD) report;
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- Will inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, provide a written Plan of Correction (POC) which must include for each citation:
    - How the facility will correct the deficiency as it relates to the resident;
    - How the facility will act to protect residents in similar situations;
    - Measures the facility will take, or the systems it will alter, to ensure that the problem does not recur;
    - How the facility plans to monitor its performance to make sure that solutions are sustained;
    - Dates when the corrective action will be completed which cannot be more than 45 days from the date of the SOD. Should a citation require more than 45 days to complete, you must obtain permission from the Field Manager;
    - The title of the person or persons responsible to ensure correction for each deficiency;
    - Administrator Signature and date signed;
- Sign the SOD;
- Mail the SOD and POC with original signature to:
    Field Manager's Name, Field Manager
    Residential Care Services
    Region X, Unit X
    Department's Address
    City, WA Zip Code
- Complete correction(s) within 45 days, or sooner if directed by the Department after review of your proposed correction dates.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.
- Contact me for clarification of the deficiency or deficiencies found.

Informal Dispute Resolution:
RCW 70.97 does not provide an option for the Enhanced Living Facility to participate in an Informal Dispute Resolution (IDR) process.

If You Have Any Questions:

- If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.

PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

388-107-0370 Treatment services.

The enhanced services facility must:
(1) Provide for diagnostic and therapeutic services prescribed by the attending clinical staff that meet all of the resident needs identified in the person-centered service plan, to include mental health and chemical dependency treatment

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the facility failed to provide mental health services in accordance with person-centered service plans for 2 of 6 sampled residents (Residents 3 & 5). This failure placed residents at risk of not having their mental health needs met.

Relevant Facts/Findings

Findings included…

Resident 3

- Resident 3's admission paperwork showed they admitted on 08/11/XXXX with multiple mental health diagnoses and mood disorders. The person-centered service plan, dated 08/11/XXXX, documented Resident 3 was to receive mental health services from a qualified provider three times a week.
- On 10/19/XXXX at 11:26 a.m., Resident 3 stated he had not seen a mental health provider (MHP) since admission to the facility.
- Resident 3's care notes, reviewed on 10/19/XXXX, showed no documentation of a MHP visit.

Resident 5

- Resident 5's admission paperwork showed they admitted on 08/15/XXXX, with multiple mental health diagnoses. The person-centered service plan, dated 08/15/XXXX, documented Resident 5 was to receive mental health services from an MHP.
- The resident's care notes, reviewed on 10/19/XXXX, indicated Resident 5 had a scheduled appointment with the MHP on 10/16/XXXX.
- On 10/19/XXXX at 1:56 p.m., Resident 5 stated they had an appointment to meet an MHP on 10/16/ XXXX, at the facility and the MHP did not show up. Resident 5 said they were unaware of a new appointment date.

On 10/19/XXXX at 3:00 p.m., Staff C, Administrator, stated they neither Resident 3 or Resident 5 have been seen by an MHP.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Regulatory Reference

WAC 388-107-0980 Mechanical Heating systems.

The facility must ensure:

(3) Electric resistant wall heat units and portable space heaters are prohibited.

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on observation and interview, the facility failed to prohibit space heaters in the rooms for 4 of 6 residents' (Resident 1, 2, 3, & 7). This failure placed residents at risk for safety hazards and injury.

Relevant Facts/Findings

Findings included…

On 11/06/XXXX at 1:40 p.m., Resident 1's room contained a space heater. The resident stated they turned on the heater when their room was cold.

On 11/06/XXXX at 2:40 p.m., Staff M, Director of Maintenance, reported space heaters were in most of the resident rooms. Staff M explained the building was old, along with the heating system, making it difficult to keep the residents' rooms warm.

On 11/06/XXXX at 3:00 p.m., during a walk through the facility with Staff G, Caregiver, showed Residents 2, 3 and 7 had space heaters in their rooms.

On 11/06/XXXX at 3:10 p.m., Staff H, Administrator, stated the facility provided space heaters to each resident enabling them to better control the temperature in their room.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)
PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

Not applicable.

PRINCIPLE #7: Cross-References

Regulatory Reference

WAC 388-107-0740 Required review of building plans.

(2) The facility must notify construction review services of all planned new construction regarding the facility prior to beginning work on any of the following:

(b) An addition of, or modification or alteration to an existing facility, including, but not limited to, the facility's:

(ii) Electrical fixtures or systems;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on observation and interview, the facility failed to submit plans to Construction Review Services (CRS) for a ceiling fan placement in the living room used by 5 of 7 sampled residents (Residents 1, 2, 3, 4, and 5). This failure had the potential for an unsafe installation and location of the ceiling fan.

Relevant Facts/Findings

Findings included…

On 02/13/XXXX at 8:00 a.m., Residents 1, 2, 3, 4, and 5 were sitting in the living room watching TV.

At 08:10 a.m., an observation showed a fan on the living room ceiling.

On 02/13/XXXX at 09:40 a.m., Staff C, Caregiver, explained the facility installed the ceiling fan two weeks prior. On 02/13/XXXX at 10:07 a.m., Staff Z, Administrator, stated he was not aware the ceiling fan was installed. As Staff Z observed the ceiling fan, he said there were no plans to send to construction review.

On 03/14/XXXX at 11:12 a.m., CRS stated there were no construction review documents submitted from this facility requesting to install a ceiling fan.

Refer to WAC 388-107-0730(6) Application codes-New construction.

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)

Not applicable.

PRINCIPLE #9: Citations with More Than One Regulatory Reference

No example at this time.

PRINCIPLE #10: Components of a Consultation (AFH, ALF, ESF Only)

Facility's Name
Facility's Address
Facility's City, WA, Zip Code

RE: Facility's Name, License #

Dear Administrator:

The Department completed a complaint investigation of your Enhanced Services Facility on Date: XX/XX/XXXX and found that your facility does not meet the Enhanced Services Facility licensing requirements below.

The Department staff who did the investigation and provided consultation:
Name/Title of Regulatory Staff

Consultation:

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report

WAC 388-107-0100 Person-centered service planning team.

The enhanced services facility must develop and maintain a person-centered service planning team for each resident. The ESF must:

(1) Ensure the person-centered service planning team includes the resident, the resident's representative when applicable, individuals chosen by the resident, a mental health professional, nursing staff, the Medicaid client's Department case manager, and other persons as needed;

(2) Provide the necessary information and support to ensure that the resident has an opportunity to identify team members, make informed choices and decisions regarding care and treatment, and direct the person-centered service planning process as much as possible;

(3) Ensure the person-centered service planning team has a coordinated approach to the development, implementation, and evaluation of the comprehensive person centered service plan for the resident; and

(4) Ensure the person-centered service planning team meets at least monthly and more often as needed, at times and locations convenient to the resident, to review and modify the comprehensive person-centered service plan as needed.

The ESF had not developed, implemented, or evaluated an organized person-centered service planning team process to meet the needs of each of the residents. This failure has the potential to result in unmet care and service needs for each resident.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.
- Contact me for clarification of the deficiency or deficiencies found.

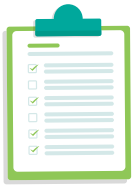
Informal Dispute Resolution:
RCW 70.97 does not provide an option for the Enhanced Living Facility to participate in an Informal Dispute Resolution (IDR) process.

If You Have Any Questions:

- If you have any questions please, contact me at office telephone number (XXX) XXX- XXXX.

Sincerely,

Field Manager's Name, Field Manager
Region X, Unit X
Residential Care Services



PRINCIPLE #11: Recurring/Repeated, Uncorrected and/or Previously Cited Deficiencies (AFH, ALFs, ESFs Only)

Regulatory Reference

388-107-0370 Treatment services.

The enhanced services facility must:

(1) Provide for diagnostic and therapeutic services prescribed by the attending clinical staff that meet all of the resident needs identified in the person-centered service plan, to include mental health and chemical dependency treatment

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the facility failed to provide mental health services in accordance with person-centered service plans for 2 of 6 sampled residents (Residents 3 & 5). This failure placed residents at risk of not having their mental health needs met.

Relevant Facts/Findings

Findings included…

Resident 3

- Resident 3's admission paperwork showed they admitted on 08/11/XXXX with multiple mental health diagnoses and mood disorders. The person-centered service plan, dated 08/11/XXXX, documented Resident 3 was to receive mental health services from a qualified provider three times a week.
- On 10/19/XXXX at 11:26 a.m., Resident 3 stated he had not seen a mental health provider (MHP) since admission to the facility.
- Resident 3's care notes, reviewed on 10/19/XXXX, showed no documentation of a MHP visit.

Resident 5

- Resident 5's admission paperwork showed they admitted on 08/15/XXXX, with multiple mental health diagnoses. The person-centered service plan, dated 08/15/XXXX, documented Resident 5 was to receive mental health services from an MHP.
- The resident's care notes, reviewed on 10/19/XXXX, indicated Resident 5 had a scheduled appointment with the MHP on 10/16/XXXX.
- On 10/19/XXXX at 1:56 p.m., Resident 5 stated they had an appointment to meet an MHP on 10/16/ XXXX, at the facility and the MHP did not show up. Resident 5 said they were unaware of a new appointment date.

On 10/19/XXXX at 3:00 p.m., Staff C, Administrator, stated they neither Resident 3 or Resident 5 have been seen by an MHP.

This is a recurring deficiency previously cited on 12/01/XXXX and 02/20/XXXX.

APPENDIX E: Intermediate Care Facilities for Individuals with Intellectual Disabilities

PRINCIPLE #1: Entity Compliance and Noncompliance

When an entity complies with the regulatory requirements applicable to the specific completed survey, the Form CMS-2567 consists of an explicit statement that the entity is in compliance for that particular survey. If an entity does not comply with one or more regulatory requirement(s), the Form CMS-2567 includes corresponding citations of noncompliance. The statutes and regulations are the legal authority for determining an entity's compliance with Federal and State requirements for participation or coverage in Medicare, and Medicaid.

Compliance

This report is the result of an unannounced Type of Survey and/or Complaint Investigation(s) conducted at Facility Name on Dates of Survey. A sample of # residents was selected from a census of #. The sample included # current residents and the records of # discharged residents.

The following were complaints investigated as part of this survey:
Complaint #'s

No deficiencies found.

Noncompliance

1. This report is the result of an unannounced Type of Survey and/or Complaint Investigation(s) conducted at Facility Name on Dates of Survey. A sample of # residents was selected from a census of #. The sample included # current residents and the records of # discharged residents.

The following were complaints investigated as part of this survey:
Complaint #'s

2. This report is the result of an unannounced Type of Survey and Extended Survey conducted at Facility Name on Dates of Survey. A sample of # residents was selected from a census of #. The sample included # current residents and the records of # discharged residents.

An Immediate Jeopardy was identified on insert date. The facility was notified of the noncompliance on insert date regarding insert the specific noncompliance that was violated, including a description the serious adverse outcome that occurred, or was likely to occur.

The Immediate Jeopardy was removed insert date and validated onsite on insert date. A statement of the seriousness of the remaining noncompliance.

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.

PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

Tag	Summary Statement of Deficiencies
W227	(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.440(c)(4) that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, This STANDARD is not met as evidenced by:

Deficient Practice Statement

Tag	Summary Statement of Deficiencies
W227	Based on observation, interview and record review, the facility failed to document objectives for a compulsive behavior on a Positive Behavior Support Plan (PBSP) for 1 of 6 sampled clients (Client 3). This failure placed the client at risk for unidentified behavior objectives.

Relevant Facts/Findings

Tag	Summary Statement of Deficiencies
W227	Findings included… Record review of Client 3's Comprehensive Functional Assessment, dated 07/10/XXXX, showed Client 3 had a behavior of walking around picking things up from off the floor and holding onto them. Record review of Client 3's PBSP, dated 07/11/XXXX, listed one of Client 3's behaviors as "Compulsive scanning of the environment for objects out of place and needing to be picked up off of the floor." There was no individual program addressing this identified behavior. Observations on the following dates and times showed Client 3 picking things from off the floor and holding onto them: • 01/07/XXXX, at 1:42 p.m., at Building 2044, Room 204 picked up a gum wrapper • 01/08/XXXX, at 7:34 a.m., at Seaside House picked up a shoe • 01/09/XXXX, at 1:20 p.m., at Building 2033, Room 201 picked up a leaf

	On 01/09/XXXX at 6:30 p.m., an interview with Staff L, Psychology Associate, stated the PBSP did not contain objectives addressing Client 3's behavior of picking things from off the floor and holding onto them.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Notify the field manager to discuss any deficient practice requiring an immediate plan of correction to protect the health, safety, or welfare of those living in the licensed or certified residential setting.

For Federal programs NH and ICF/IID, the entity develops a removal plan that must include a date by which the entity asserts the likelihood for serious harm to any recipient no longer exists.

Regulatory Reference

Tag	Summary Statement of Deficiencies
W426	Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by:

Deficient Practice Statement

Tag	Summary Statement of Deficiencies
W426	Based on observation and interview, the facility failed to ensure hot water temperatures did not exceed 110 degrees Fahrenheit (F) in 2 of 3 bathrooms (Side A and Side B) in House Lavender. This failure resulted in elevated hot water temperatures placing clients at risk of injury.

Relevant Facts/Findings

Tag	Summary Statement of Deficiencies
W426	Findings included… On 04/05/XXXX at 10:15 a.m., Side A's bathroom of House Lavender, the water temperature observed on the facility's thermometer was 114.7 degrees F. At 10:32 a.m., Side B's bathroom of House Lavender, the water temperature on the facility's thermometer was 118.3 degrees F. At 10:40 a.m., Staff A, House Manager, reported the water felt hotter today than usual. Staff A stated they did not check the water temperature in either Side A or B's bathrooms of the Lavender House to

	determine if the water temperatures were within a safe range. Staff A spoke on the phone to Staff D, Maintenance Worker, to inform him of the water temperatures feeling hotter than usual. At 3:40 p.m., Staff D, stated he checked the water system verifying the water heater mixing valve was malfunctioning. The Maintenance Worker said the valve needed to be replaced.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)

For the federal regulations, the deficiency citation shows how the entity fails to comply with the regulatory requirements. The deficiency citation does not demonstrate how the entity fails to comply with the guidelines for the interpretation of those requirements. Various appendices to the Federal SOM contain "Interpretive Guidelines" or "Guidance to Surveyors." These Guidelines were designed to assist regulators in developing a better understanding of the regulatory requirements, how to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although regulators must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation. Therefore, the Guidelines may not be used as the basis for a citation. However, the Guidelines do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist regulators in making determinations about an entity's compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the regulator must document such on the Form CMS-2567.

Regulators should carefully consider how the practices of the entity relate to the designs within the Interpretive Guidelines. Then, compare the entity's practice to the specific language and requirement of the regulation before determining that a deficiency exists.

Tag	Summary Statement of Deficiencies
W214	**§483.440(c)(3)(iii) Identify the client's specific developmental and behavioral management needs;** **Guidance §483.440(c)(3)(iii)** The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture. "Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or self-injurious behavior). A functional behavioral assessment is a problem-solving process for evaluating client inappropriate behavior. It relies on a variety of techniques and strategies to identify the purpose of the specific behavior(s) and to help the Interdisciplinary Team (IDT) select interventions to directly address the behavior(s). A functional behavior assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant client-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non- occurrence) of specific behaviors. The CFA must identify the specific accommodations that address the client's needs to ensure better opportunity for the client's success. The identified accommodations may be assistive technology which can help a person learn, play, complete tasks, get around, communicate, hear or see better, control their own environment and take care of their personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.). This Standard is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to assess behavioral management needs for 1 of 8 sampled clients (Client 7). This failure resulted in Client 7 not having a training plan for completing tasks and following instructions. Findings included... On 09/10/XXXX at 2:15 p.m., an observation in the Sound and Light Sensory room showed Client 7 did not provide eye contact or recognition when Staff A, Adult Training Specialist (ATS), cued him. On 09/11/XXXX at 9:20 a.m., an observation in the 307 House, showed Client 7 sitting on the floor

looking through a pile of magazines. Different staff made several attempts requesting Client 7 to stand up from off the floor. Client 7 did not provide eye contact or recognition to any of the staff.

On 09/12/XXXX at 1:00 p.m., an observation at the Sound and Light Sensory room, showed Client 7 sitting in a chair in the corner. When the ATS staff provided verbal cues, Client 7 did not provide eye contact or follow the cues.

On 09/12/XXXX, a review of Clients 7's Individual Habilitation Plan (IHP) and Comprehensive Functional Assessment (CFA), dated 12/07/XXXX, showed no documented guidance or instructions on how to successfully engage Client 7 in a group activity or follow cues.

On 09/13/XXXX at 10:00 a.m., Staff P, Qualified Intellectual Disability Professional, stated it was difficult to encourage Client 7 to engage in group activities. Staff P reviewed the CFA and the IHP showing Client 7's behaviors of not listening to staff or engaging in group activities were not documented.

PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

PRINCIPLE #7: Cross-References

Regulatory Reference

Tag	Summary Statement of Deficiencies
W186	DIRECT CARE STAFF 483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. This STANDARD is not met as evidenced by:

Deficient Practice Statement

Tag	Summary Statement of Deficiencies
W186	Based on observation, interview and record review, the facility failed to ensure there were sufficient direct care staff to provide active treatment for 1 of 6 sampled clients (Client 3). This failure resulted in Client 3 sitting idle or participating in activities not on the client's Individual Habilitation Plan (IHP).

Relevant Facts/Findings

Tag	Summary Statement of Deficiencies
W186	Findings included… Record review of Client 3's IHP, undated, showed long range goals included, to increase self-management at mealtime, in dressing skills, leisure skills and improving self-medication skills. An observation on 06/11/XXXX, at 7:46 a.m., in the Evergreen Cottage, showed Staff A, Attendant Counselor, led Client 3 into the bathroom. Staff A washed Client 3's face, brushed their teeth and hair. On 6/11/XXXX at 8:19 a.m., Staff C, Direct Care Staff, assisted Client 3 with breakfast to include buttering the toast, cutting up the pancakes, opening the hot chocolate packet and pouring the contents into the cup of hot water, and pouring the milk over the cold cereal. At 8:21 a.m., Staff C assisted Client 3 with eating, which included, scooping the cereal, raising the spoon to the client's mouth and then obtaining another spoonful. Staff C switched to a fork obtaining a forkful of pancakes, raising to the client's mouth and then obtaining another forkful of pancakes. At 8:56 a.m., Staff C stated Client 3 needed one to one training to learn the skills for dressing, grooming and eating.

	On 6/11/XXXX, observations from 8:58 a.m. to 9:32 a.m., showed Client 3 in the living room sitting in a rocking chair with stuffed animals on their lap. Client 3 was not engaged in any activity. During this time, Staff B and Staff A took turns taking their morning breaks. At 11:55 a.m., Staff C fed Client 3 their lunch. At 12:39 p.m., Staff C cued Client 3 to take their dishes to the sink. Staff C rinsed Client 3's dishes without client's assistance. Client 3 walked to the front room and sat in her rocker. At 12:53 p.m., Client 3 continued to sit idle in the front room.

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)

Tag	Summary Statement of Deficiencies
W102	§483.410 Condition of participation: Governing body and management Based on observation, interview and record review facility failed to implement the Condition of Participation for Active Treatment for 6 of 6 sampled clients (Clients 1, 2, 3, 4, 5, & 6) and the Condition of Health Care Services for 2 of 6 sampled clients (Clients 2 & 6). These failures resulted in a lack of training clients to improve their independence. Findings included… Clients 1, 2, 3, 4, 5, and 6 did not receive active treatment services. Clients 2 and 6 did not receive health care services to meet or improve their health needs. This resulted in not meeting the Condition of Participation for Health Care Services. Refer to W318.

PRINCIPLE #9: Citations with More Than One Regulatory Reference

None at this time.

PRINCIPLE #10: Components of a Consultation (AFH, ALF, ESH Only)

Not applicable.

APPENDIX F: Skilled Nursing Facility

PRINCIPLE #1: Entity Compliance and Noncompliance

When an entity complies with the regulatory requirements applicable to the specific completed survey, the Form CMS-2567 consists of an explicit statement that the entity is in compliance for that particular survey. If an entity does not comply with one or more regulatory requirement(s), the Form CMS-2567 includes corresponding citations of noncompliance. The statutes and regulations are the legal authority for determining an entity's compliance with Federal and State requirements for participation or coverage in Medicare and Medicaid.

The Initial Comments, F0000 page, for either Compliance or Noncompliance is generated in ePOC with electronic submission to the entity. All words shown in red are specific to each office.

Compliance:

This report is the result of an unannounced Long-Term Care Survey and/or Complaint Investigation(s) conducted at Facility Name on Dates. A sample of # residents was selected from a census of #. The sample included # current residents and the records of # discharged residents.

The following were complaints investigated as part of this survey:
Complaint #'s

No deficiencies found.

NONCOMPLIANCE

This report is the result of an unannounced Type of Survey and Extended Survey conducted at Facility Name on Dates of Survey. A sample of # residents was selected from a census of #. The sample included # current residents and the records of # discharged residents.

An Immediate Jeopardy was identified on insert date. The facility was notified of the noncompliance on insert date regarding insert the specific noncompliance that was violated, including a description the serious adverse outcome that occurred, or was likely to occur.

The Immediate Jeopardy was removed insert date and validated onsite on insert date. A statement of the seriousness of the remaining noncompliance.

PRINCIPLE #2: Using Plain Language

Refer to page 14 for a list of specific details to follow.

PRINCIPLE #3: Components of Deficiency Citation

Regulatory Reference

Tag	Summary Statement of Deficiencies
F697	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:

Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F697	Based on interview, observation and record review, the facility failed to initiate non-medication related interventions prior to the administration of pain medication for 1 of 4 sampled residents (Resident 38). This failure placed the resident at risk for a lack of non-medication interventions to relieve ongoing pain.

Relevant Facts/Findings

Tag	Summary Statement of Deficiencies
F697	Findings included… Resident 38 was admitted to the facility on 02/15/XXXX with diagnoses to include history of falling, difficulty in walking, and muscle weakness. On 04/11/XXXX at 11:22 a.m., Resident 38 stated, "I have pain in my back from a fall several years ago. I take pain medication, which takes the edge off. Truly, I am in constant pain." On 04/13/XXXX at 12:55 p.m., Resident 38 was asked if staff offered non-medication related interventions for the pain. The resident stated, "Nope. They offer warm blankets if I'm cold but not for pain in my back."

	Resident 38's pain assessment, dated 02/19/XXXX, showed the following non-pharmacological interventions: offer a warm blanket, provide one to one care, offer assistance with repositioning and offer activities. Review of Resident 38's Medication Administration Record (MAR), from 02/19/XXXX through 04/13/XXXX, showed no documentation of attempted non-pharmacological interventions for pain management. On 04/17/XXXX, at 2:32 p.m., when asked what non-pharmacological pain interventions where in place to manage Resident 38's pain, Staff V said other than pain medication, she wasn't aware of any additional interventions. On 04/18/XXXX at 9:20 a.m., Staff H, Director of Nursing Services, stated non-pharmacological pain interventions were documented on the MAR. Staff H reviewed Resident 38's MAR for the months of March and April XXXX, and said there were no non-pharmacological pain interventions documented on the MAR.

PRINCIPLE #4: Relevance of Onsite Correction Findings

Notify the field manager to discuss any deficient practice requiring an immediate plan of correction to protect the health, safety, or welfare of those living in the licensed or certified residential setting.

For Federal programs NH and ICF/IID, the entity develops a removal plan that must include a date by which the entity asserts the likelihood for serious harm to any recipient no longer exists.

Regulatory Reference

Tag	Summary Statement of Deficiencies
F558	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:

Deficient Practice Statement

Tag	Summary Statement of Deficiencies
F558	Based on interview, observation and record review, the facility failed to ensure the height of a closet rod accommodated the need for 1 of 10 residents (Resident 11) reviewed for accommodation of needs. This failure placed the resident at risk for the loss of independence.

Relevant Facts/Findings

Tag	Summary Statement of Deficiencies
F558	Findings included… Resident 11 was admitted to the facility on 03/17/XXXX. Review of the Minimum Data Set assessment, dated 10/13/XXXX, showed the resident was cognitively intact. Review of Resident 11's care plan, dated 04/01/XXXX, showed the resident wanted to be independent and on occasion, required staff to obtain clothing from her closet. The care plan showed the resident had limited physical mobility and general muscle weakness. On 01/04/XXXX at 9:41 a.m., Resident 11 stated she had arthritis preventing her from reaching high enough to get clothes in or out of her closet. The resident was observed attempting to reach for a sweater in her closet and was unable to extend either of her arms to the height of the clothing rod.

On 01/09/XXXX at 10:10 a.m., Resident 11 said it was very important to her to be as independent as possible and disliked having to call for help each time she wanted something in her closet. Resident 11 stated staff were aware she was unable to reach items in her closet. The resident said she would be "so happy" if the rod in the closet was low enough for her to independently access her clothes.

On 01/11/XXXX at 12:41 p.m., Staff U, Nursing Assistant, said Resident 11 had voiced concerns she was unable to reach items in her closet. Staff U stated she had told the nurse several times regarding Resident 11's concern. Staff U said she was unaware what, if anything, was done.

On 01/12/XXXX at 8:49 a.m., Staff R, Registered Nurse, said she was told about the difficulty Resident 11 had reaching the clothes in her closet. Staff R stated, "The bar is too high for her." Staff R said she informed the Resident Care Manager and the maintenance staff several times.

At 9:43 a.m., Staff W, Director of Maintenance, said staff usually wrote work requests in the maintenance log located at each nurses' station. Staff W reviewed the maintenance logs from August XXXX to January XXXX, which showed no documentation of a request to readjust Resident 11's closet rod. Staff W said he was unaware of a resident needing their closet rod readjusted.

PRINCIPLE #5: Interpretive Guidelines (NH & ICF/IID Only)

For the federal regulations, the deficiency citation shows how the entity fails to comply with the regulatory requirements. The deficiency citation does not demonstrate how the entity fails to comply with the guidelines for the interpretation of those requirements.

Various appendices to the Federal SOM contain "Interpretive Guidelines" or "Guidance to Surveyors." These Guidelines were designed to assist regulators in developing a better understanding of the regulatory requirements, how to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although regulators must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation. Therefore, the Guidelines may not be used as the basis for a citation. However, the Guidelines do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist

regulators in making determinations about an entity's compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the regulator must document such on the Form CMS-2567.

Regulators should carefully consider how the practices of the entity relate to the designs within the Interpretive Guidelines. Then, compare the entity's practice to the specific language and requirement of the regulation before determining that a deficiency exists.

PRINCIPLE #6: Citation of State or Local Code Violations (NH & ICF/IID Only)

The entity's failure to comply with State or local laws or regulations is only documented in the Form CMS-2567 when the Federal regulation requires compliance with State or local laws.

PRINCIPLE #7: Cross-References

Tag	Summary Statement of Deficiencies
F657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be— i. Developed within 7 days after completion of the comprehensive assessment. ii. Prepared by an interdisciplinary team, that includes but is not limited to-- A. The attending physician. B. A registered nurse with responsibility for the resident C. A nurse aide with responsibility for the resident. D. A member of food and nutrition services staff. E. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. F. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. iii. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

	This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to initiate a pain management care plan for 1 of 3 residents (Resident 38) reviewed for pain management. This failure placed the resident at risk for unmet pain control needs. Findings included… Resident 38 was admitted to the facility on 02/15/XXXX, with a history of back pain due to several falls. On 04/11/XXXX at 11:22 a.m., Resident 38 stated, "I have pain in my back from a fall several years ago. I take pain medication which takes the edge off. Truly, I am in constant pain." Resident 38's pain assessment, dated 02/19/XXXX, showed the following non-medication interventions: offer a warm blanket, provide one to one care, offer assistance with repositioning and offer activities. Review of Resident 38's medical record on 04/17/XXXX, showed there was no care plan for pain management. On 04/17/XXXX, at 2:14 p.m., Staff L, Certified Nursing Assistant, was asked how she knew how to care for Resident 38. Staff L stated she would review the resident's care plan. On 04/18/XXXX at 9:20 a.m., when asked how staff knew what care and services the resident required, Staff H, Director of Nursing Services, said there were care plans for the resident's medical concerns. Staff H reviewed Resident 38's medical record and said the resident did not have a care plan for pain management.
	Refer to F697 Pain Management.

Tag	Summary Statement of Deficiencies
F865	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) program plan with Good Faith attempts to identify known problematic events, implement policies or practices and implement action plans to correct identified deficiencies for 1 of 6 residents (Resident 23) for abuse at Immediate Jeopardy; 4 of 4 shower rooms (Halls 200, 300, 400 and 500) for unsanitary shower rooms. These failures placed residents at risk for a non-functioning QAPI program that placed residents at repeated risk for unmet needs impacting their safety and environment.

Findings included...

In an interview with Staff Z, Administrator, on 12/13/XXXX at 3:18 p.m., they stated the facility held Quality Assessment and Assurance (QA&A) committee meetings at least quarterly with all department heads, the medical director and the pharmacist. Staff Z said facility staff were supposed to communicate quality care issues through various avenues.

At 3:20 p.m., Staff N, Director of Nursing, explained when trends were identified a performance improvement plan was developed, implemented, and a root cause analysis conducted.

Throughout the recertification survey process, the identified deficiencies included:

Abuse at Immediate Jeopardy

On 12/13/XXXX at 4:00 p.m., Staff A, Certified Nursing Aide stated Resident 23 created mental anguish and a fearful environment for other residents. The facility did not implement written policies or corrective actions to prevent abuse of residents.

At 4:30 p.m., The Administrator stated he was frustrated this occurred. The facility's QAPI plan was for ongoing, constant, and diligent training with reporting and identifying triggers.

Refer to F600, F609 and F610.

Sanitary Environment

On 12/13/XXXX at 4:40 p.m., Staff Z, said he was unaware of a black substance on the walls and grout in the facility's shower rooms (200, 300, 400, 500). He stated he needed to review the housekeepers' checklist to discuss this environmental issue at the next QA&A meeting.

Refer to F584.

PRINCIPLE #8: COP Deficiencies (ICF/IID Only)
PRINCIPLE #9: Citations with More Than One Regulatory Reference
Not applicable.
PRINCIPLE #10: Components of a Consultation (AFH, ALF, ESF Only)

APPENDIX G: Deficiency Citation Analysis Tool (DCAT)

The use of the Quality Assurance Analysis Tool (Appendix G) assists in writing each deficiency citation for each program. The DCAT addresses the regulatory reference, the deficient practice statement, and the findings. Regulatory staffs' and Field Managers' utilization of the DCAT will provide a quality assurance assessment of the documentation in the citation to ensure all of the components of a deficiency citation are included. The DCAT tool is located on the next page.

The original writer of the citation(s) or the team will read and edit each citation for errors, clarity, and precision of meaning. Accomplish this by using the Deficiency Citation Analysis Tool (DCAT), reading aloud, spell check, and adhering to plain language. Then, the Statement of Deficiency is complete and ready to submit to the field manager.

Deficiency Citation Analysis Tool

Tag # or WAC	Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC		Tag # or WAC	
Document The Tag or WAC For Each Citation																		
+ is yes, - is no	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
Evidence: Each Deficient Practice Statement (DPS) Has Corresponding Findings																		
Based On Statement (Data Sources)																		
Failed To Statement																		
Extent of Deficient Practice: Scope Universe																		
Identifiers (Confidential)																		
So What Statement/Potential/Actual Outcome																		
Plain Language Describing Regulatory Violation																		
Clearly Understood What The Facility Is To Fix																		
The Regulation IS NOT Repeated																		
The DPS Is NOT A Cut And Paste From Another Tag in the SOD																		
State/Local Code Reference, If Applicable																		
Findings/Facts																		
Documented Statement: Findings Included…																		
Who																		
What																		
When																		
Where																		
How																		
Potential or Actual Outcome/Risk Statement																		
Observations/Interviews include Date, Time																		
Document Reviews Include Date(s) Of Data Entry																		
Logical Organization Of Facts/Chronological Order																		
Applicable To The Selected Regulation																		
Written In Plain Language With Active Voice																		
Free Of: Irrelevant Words/Medical Jargon																		
Remarks/Advice																		
Vague/Abstract Terms																		
Irrelevant Diagnoses/Run-on sentences																		
Assumptions/Conclusions																		
Spelling/Grammar Errors																		
Findings Included Match the DPS																		

Reviewer: _____ _____ Date Reviewed: _____

Residential Setting's Name and Date of Final SOD: _____

REFERENCES

- SOP Chapter 27 Principles of Documentation: https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/SOP/Chapter%2027%20-%20POD.pdf
- Administrative Policy No. 2.11, Plain Talk: Clear Written Communications; Revised: November 24, 2015
- Center for Medicare and Medicaid, State of Operations Manual Exhibit 7A Principles of Documentation, undated
- Office of Communications Branding Standards and Style Guide, January 2019, http://one.dshs.wa.lcl/Communications/Communications%20Resources/DSHS-Style- Guide.pdf
- Statement of Deficiency Writing Guidelines, CMS Preceptor Manual, 2017
- Use of Gender Pronouns in Employee Signature Blocks, email message dated 04.07.2017
- Washington Governor, https://www.governor.wa.gov/issues/issues/efficient- government/plain-talk
- Washington State Employees LGBTQ + Business Resource Group, https://ofm.wa.gov/sites/default/files/public/PronounsCompilation.pdf

APPENDIX H: Change Log

Effective Date	CHPT Sect #	What Changed? Brief Description	Reason for Change?	Communication & Training Plan

Washington State
Department of Social
& Health Services

Transforming lives