Overview

Adult Family Homes (AFHs) are residential homes that are licensed through Residential Care Services (RCS) to provide personal care for up to eight residents. AFHs are unique in that their fundamental characteristic is that they are home-like, and they are always located in a residential home. The population served by AFHs vary widely and may include people who require minimal care who will live in the home for years or the home may offer services to people who require a great deal of care and are near the end of their life. The type of services that an AFH offers depends greatly on the skill level of the provider and the caregivers they employ.

Residential Care Services regulates these homes and conducts licensing visits every 9 to 18 months. Homes are required to meet the minimum licensing standards as stipulated in Chapter 388-76 Washington Administrative Code (WAC) and Chapter 70.128 Revised Code of Washington (RCW). Adult family homes must also comply with the following WAC and RCW chapters:

1. Chapter 70.129 RCW - Resident Rights
2. Chapter 51.51 WAC - State Building Code
3. Title 42 §441.530 Home and Community-Based Setting
4. Chapter 74.34 RCW – Abuse of Vulnerable Adults
5. Chapter 388-113 WAC – Disqualifying Crimes and Negative Actions
6. Chapter 388-112A WAC – Residential Long-Term Care Services

This chapter contains information about the minimum licensing standards and other topics related to adult family homes. The content is relevant to RCS staff, adult family home providers, and anyone seeking to understand how adult family homes are regulated.

These procedures are not covered by DSHS Administrative Policies as they are specific to Residential Care Services. These procedures will be reviewed for accuracy and compliance at least every five years.

Contacts

- RCS Quality Improvement Unit General Contact, ImproveRCS@dshs.wa.gov
- RCS Policy Unit General Contact, RCSPolicy@dshs.wa.gov

Table of Contents

Part I: Adult Family Home Standard Operating Procedures

A. General Guidelines

Purpose

The purpose of conducting AFH licensing visits is to ensure homes are in compliance or continuing to remain in compliance with minimum licensing standards as defined in Chapter 70.128 RCW and Chapter 388-76 WAC. The primary focus should be on resident's rights and their safety and well-being.

This procedure explains some background information about the timing and general purpose of AFH inspections.

Procedure

Inspection Frequency

1. RCS conducts unannounced inspections in AFHs regularly. An inspection must occur by the end of the eighteenth month after the end of the previous inspection. The first inspection for a newly licensed home must occur no later than the end of the eighteenth month after licensure.
2. RCS may inspect a home every 24 months if the AFH has:
   a. No citations for the past three full consecutive inspections; and
   b. Not had any citations resulting from complaint investigations (CI) that occurred during the last three inspection cycles.
3. The Field Manager (FM) must schedule AFH inspections so they are unpredictable with the average inspection interval being 13-15 months. This is achieved by:
   a. If a home has a history of non-compliance, the inspections should be done between 9-12 months.
   b. If a home has a history of compliance, inspections are done between 16-18 months.
   c. Please note the ultimate goal is to be unpredictable. This is only a guideline and inspections may be scheduled at other times.
   d. Avoid scheduling homes the same month as the previous inspection if possible.
   e. Incorporate variance in timing (time of day, time of week, time of month).

General Information – Licensors must:

1. Follow all procedures to ensure consistent application of the inspection process statewide.
2. Not announce the date of inspection to the adult family home or share the inspection date with anyone.
3. Dress in business casual attire.
4. Conduct themselves in a professional manner when working in the field.
5. Interact with the provider, staff, and residents in a courteous and respectful manner.
6. Fill out the working papers completely. **Every field must be marked**. If there is a field that does not apply to a particular home or inspection, the licensor may choose to write "N/A," "does not apply," or an explanation or other method of noting why the field does not apply.

Example: The Environmental Tour form asks if there is a barrier around water hazards. If the home has no water hazard, the licensor may mark the box "yes" indicating the home is in compliance, write in "N/A" and state there is no water hazard, or otherwise mark that this question was considered but does not apply to this home.

7. Conduct observations and interviews to determine if the provider is in compliance with minimum licensing standards.
8. Conduct record reviews to validate concerns and issues identified during observation and interview.
9. Consult and clearly communicate general observations and concerns with the provider and staff throughout the inspection as long as it does not interfere with the ability to determine failed practice.
10. Minimize the disruption of daily routines for the residents during the inspection.
11. Complete the inspection timely and extend after the last date on-site only in those situations where collateral information (collected off-site) is needed to determine and support deficient practice.
12. Consult with the FM if there are extenuating circumstances in which it is reasonable that a provider does not meet a regulatory requirement, such as a resident who is at the end of their life participating in a fire drill. Factors to consider are:
    a. Potential negative resident outcome; and
    b. If it is reasonable in this specific situation the home does not meet the specific regulatory requirement.

Field Manager Responsibility

FMs are to conduct the following activities in relation to this procedure:

1. Train new staff and ensure they can demonstrate they understand this procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
3. Request training or clarification from leadership as needed.

B. Pre-Inspection Preparation

Purpose

Prior to each inspection, the AFH licensor will complete some pre-inspection preparation or "prep" prior to entering the facility. This gives the licensor time to identify potential concerns based on the home's history or to determine if the home requires a specialized team member such as a licensed nurse.

Procedure

The Licensor will:

1. Plan to initiate the inspection when they can observe care and services being provided to residents.
2. Consider adjusting the timing of the inspection to ensure residents are present during a meal.
3. Enter the data collected during the inspection into the AFH Inspection Packet (DSHS 10-575). This can be done by using the forms from a state-issued device while connected, typing the information into Word, or dictating into Word.
4. Note all the information you gather during the pre-inspection on the Pre-Inspection Preparation (DSHS 10-548) sheet of the working papers.
5. Review the compliance history of the home by looking at the Facility Management System (FMS) and the Secure Tracking and Reporting System (STARS) and noting the citations or consultations for the last three full inspections.
6. Review the Provider Summary in STARS to identify the number of licensed beds, specialty status, exemptions, and previous or uncorrected citations since the last inspection.
7. Review any complaint investigation reports since the last inspection and identify any open complaints. Note the residents and staff names involved in the reports as well as repeat issues or patterns.
8. Review the working papers from the last inspection. If the working papers have been sent to Central Files, the licensor (or Administrative Assistant [AA]) will request the relevant files and review them.
9. If needed, contact the previous licensor to discuss any questions or concerns about the home's history.
10. Assemble necessary supplies such as a thermometer, measurement equipment, calculator, pen, etc. Contact your FM or Regional Administrator (RA) if needed equipment is unavailable.
11. Review the notes from the RCS/Ombuds regional quarterly meetings. Review with the FM any concerns brought up about the home in the quarterly Ombuds meeting.
12. Obtain the home's floor plan from the provider file to note resident bedrooms and other areas used by residents.

> Note: Never remove provider files from the office. Make copies of relevant items such as floor plans and driving directions.

C. Entrance Onsite

Purpose

The way RCS initiates contact with a provider, staff and residents will set the tone for the rest of the inspection. Always be respectful and allow the staff/provider time to ask questions. This procedure explains how to initiate the onsite visit and begin the inspection process.

Procedure

1. Upon arrival to the home begin making observations of the outside of the home and note any environmental hazards or concerns.
2. Treat the AFH like a home and knock on the door and wait for someone to answer.
3. If there is no answer, there are no staff available in the home or if you are denied access contact the FM immediately.
4. If there is no answer, wait 15 to 30 minutes and knock again. If still no answer, call the home and or an alternate number if one is listed on Facility Summary Sheet.
5. If a resident answers the door, ask to speak with the provider. If invited in, you may enter. Observe the residents' immediate environment but do not tour the home. Introduce yourself and explain why you are there. Request that the provider is contacted. If you are unable to contact the provider, call your FM.
6. If a staff member/provider answers the door, present your photo ID, and explain who you are and the reason for the visit.
7. Provide that person with your business card.
8. If you are denied entrance, restate the reason for your visit and suggest the person contact the provider and explain the situation.
9. If the person who answered the door is not the provider, allow them the opportunity to contact the provider but also explain the inspection will not be delayed until the provider arrives.
10. Explain the inspection process including interviews and observations, documentation that will be needed.
11. Ask the staff member/provider if the home has any special features, if there are any residents currently not in the home and what the normal daily routine is for the home.
    a. Explain that the first step will be a guided tour of the areas accessible by residents. Remember the inspection schedule needs to remain flexible to allow residents to receive care and maintain their daily activities. Do not tour or inspect areas that are not accessible to residents.
    b. Give the staff member/provider the Inspection Process & Records Request (DSHS 10-549) form that lists the inspection process and what records will be requested during the inspection.
    c. Ask the provider for a place to work that will not interrupt the daily activities of the home but will provide opportunities for ongoing observation of residents.
12. Request access to a power outlet and a place to sit and work. If needed, request a means to secure belongings and/or RCS equipment.

D. Tour

Purpose

The tour of the AFH not only allows the licensor the opportunity to inspect the physical environment but it also provides the opportunity for the licensors to meet residents and observe how care is happening and note any quality of life or safety concerns. Informal interviews during the tour may lead the licensor to concerns that would otherwise not be identified by record review or observations.

Procedure

1. Allow the staff member/provider a reasonable amount of time to complete any task they were involved in prior beginning the tour.
2. Document observations of the physical environment on the Environmental Tour (DSHS 10-553) form and be sure that all categories are completed on the form.
3. Document data collected from informal interviews on Residential Care Services Notes (DSHS 10-563) form.
4. Refer to the Resident List (DSHS 10-551) form for residents' names and a brief summary of their needs and services.
5. Identify any residents who express concerns or appear to have any unmet care or service needs.
6. Briefly record any identified issues or concerns requiring further clarification on the Comprehensive Resident/Representative Interview (DSHS 10-558) form so you remember to ask about the concern.
7. Ask the staff member/provider to identify any residents that are:
   a. Newly admitted to the home in the last 60 days.
   b. Planning to transfer or discharge in the next 30 days.
   c. Recently hospitalized (within the past 30 days) and the reason for hospitalization.
8. Conduct a brief observation of residents (see Observation of Care and Abuse/Neglect Prevention Review sections for more details), noting things such as hygiene, interactions with caregivers, activities they were engaged in, etc.
9. Note the cleanliness of the home and if it was a homelike setting.
10. Note any special equipment, barriers that would hinder evacuation, use of restraints, etc.
11. Walk around the property and note any environmental or safety hazards such as rodents, garbage or areas that would be unsafe for residents.
12. Conclude the tour thank the staff member/provider for their time and move on to the next part of the inspection.

E. Resident Sample

Purpose

AFHs are licensed for up to six residents (eight under some circumstances) and all AFH residents are considered to be a part of the sample. Licensors should attempt to engage each resident in conversation but will select only two to conduct comprehensive record reviews and full observations and interviews. If several residents share a common concern, such as the food is frequently cold, you may expand your sample and ask all residents if they are satisfied with food temperatures.

Procedure

1. When selecting the resident sample for the comprehensive review, select one resident with minimal care needs and one resident that has more care needs.
2. Consider the timing of the visit. At least two residents must be home during the visit. If there are not at least two residents present, arrange to return at a time when at least two residents are present.

F. Resident and Family Interview

Purpose

The purpose of the resident and representative interview is to ask the interviewee about life in the adult family home and give them a chance to discuss any issues they see in the home. This also allows the licensor to clarify concerns identified during the inspection process. The interviews should focus on resident quality of life, safety, freedom of choice, and care & services.

Procedure

1. There are three types of interviews:
   a. Comprehensive interview: When conducting a comprehensive interview, you **must ask all questions in Section A** of the Comprehensive Resident/Representative Interview (DSHS 10-558) form, document the interviewee's response, including if interviewee declines to respond, and gather any additional data necessary. Then you must ask at least one question or related question from each of Sections B through K. For these sections, you may use one of the sample questions given on the form or create your own, as long as it is related to the category.
   b. Condensed interview: Use the Condensed Resident/Representative Interview (DSHS 10-558A) to assess the resident's quality of life, safety, freedom of choice, and care and services. The condensed interview should be a minimum of five questions, with follow-up questions added as appropriate. The licensor can use the example questions or create their own questions. Use the notes section of the form to document questions and answers the licensor creates.
   c. Focused interview: A focused interview occurs when a specific concern has come up during the inspection and one or more resident interviews are needed to gain insight.
   d. None of these interviews are intended to be limited and licensors may expand any interviews as needed in order to explore any issues in more depth.
2. You must conduct a comprehensive interview with each of the residents selected for comprehensive review. If either resident is not able to participate, identify their resident representative or a family member and conduct a comprehensive interview with them instead.
   a. If both residents selected for the comprehensive interview are able to complete the interview, you will still need to contact at least one representative or family member and conduct a condensed interview with them.
3. The following may be contacted for the purposes of the representative interview: the Durable Power of Attorney (DPOA), guardian, or other person designated as the surrogate decision-maker in the resident's file; a person identified by the resident as their representative when asked; the resident's spouse or state registered domestic partner, children, parents, or adult siblings. Consider noting contact information for more than one person in case the first person you contact is unavailable for an extended period (for example, if they will be out of the country for multiple weeks).

Interview 1:	Interview 2:	Interview 3:	Additional interviews:
Required (unless the home has no residents) Comprehensive interview with Resident 1; conducted with resident if possible. Conducted with representative if resident is unable to participate.	Required (unless the home only has one resident) Comprehensive interview with Resident 2; conducted with resident if possible. Conducted with representative if resident is unable to participate.	Required only when both residents participate in the comprehensive interview. Condensed interview with a representative of either Resident 1 or Resident 2.	May use condensed or focused interviews with other residents or their representatives if concerns come up where additional information is needed. Not required for every inspection.

4. Request permission to conduct the interview. If the resident or their representative/family member does not speak English, obtain an interpreter through interpreter services or the language line. This may require a return visit.
5. If you are conducting the interview in the home, relocate to an area in which the interview can be performed with a reasonable amount of privacy if necessary and begin.
6. Inform the resident or representative/family member that information given may be included in the final written report.
7. Inform the resident or representative/family member that they have the right to refuse to answer any question. If they choose to refuse, respect their right to do so and document this on the Comprehensive Resident/Representative Interview form. A refusal is not the same as being unable to participate, and you do not need to attempt another interview in place of an interview that was refused.
8. Ask the appropriate questions for the type of interview being conducted.
9. Unless a representative/family member identified to be interviewed is in the home at the time of inspection, attempt to contact them by phone for their interview. You must make up to three attempts to contact them.
    a. Document each attempt in the working papers. After three attempts, you may stop and write “unable to contact” in the working papers.
10. If a specific concern is identified, you may conduct focused interviews with other residents to assess the situation.
11. Attempt to individually engage all residents in conversation regarding the care they receive and if resident rights are being respected.
12. For any type of interview, if the interviewee expresses a specific concern, you should ask increasingly detailed questions and document the concerns on the Comprehensive Resident/Representative Interview (DSHS 10-558) form.

G. Provider and Staff Interview

Purpose

An important part of the inspection process is to speak with the AFH staff and the provider or resident manager. This is an opportunity to see if they are knowledgeable and have a clear understanding of resident safety and quality of life as well as the care and services each resident receives. Information gathered during the pre-inspection prep work or during the inspection may drive the interview questions otherwise use the questions on the staff/provider interview forms.

Procedure

1. Interview the provider or resident manager and one staff member and document the information on the Staff Interview (DSHS 10-561) form.
2. If the staff member or provider refuses to be interviewed, clarify the reason and remind them that a failure to cooperate with the inspection is a violation of WAC 388-76-10915.
3. General conversations regarding resident care and services and the operation of the home should occur throughout the inspection.
4. Ask open ended questions and be careful not to ask leading questions.
5. Allow the staff member/provider time to clarify information during both informal and formal interviews.

H. Observation of Care

Purpose

Observing resident care as it is happening allows the licensor to assess how well the care and services being provided are meeting the residents' physical and emotional needs. Observation of care should focus on ensuring the care provided reflects appropriate training, is consistent with the needs of the residents, and upholds the resident rights for quality of life, dignity, privacy, and choice.

Procedure

The Licensor must:

1. Make observations throughout the inspection. The licensor may include all residents in the home and any interactions between staff and residents.
2. Document observations with:
   a. Resident name or identifier using numbers (e.g., R1, Resident 1).
   b. Caregiver or Provider name or identifier using letters (e.g., CG A).
   c. Date and Time.
   d. Location.
   e. Description of the observation.
3. Document any issues or concerns that require follow up observed in any of the following areas (this list is not exclusive):
   a. Behavior of residents and level of cognition.
   b. Resident's level of comfort, signs of pain.
   c. Appropriate infection control practices.
   d. Inclusion of resident's participation in the care task to the level of their ability.
   e. Personal hygiene including oral hygiene, grooming, body odors, nail care, clean clothing, and hair care.
   f. Visible skin conditions such as dryness, bruising, wounds, or breakdown.
   g. Mobility.
   h. Functional risk factors such as positioning, vision deficit, or restraints.
   i. Appropriate clothing for the season, dignity, and comfort.
   j. Physical care provided using safe practices and appropriate handling.
   k. How the resident responds to the care being provided.
   l. Resident's level of involvement in daily activities.
4. Make observations in the areas required on the Resident Observations (DSHS 10-555) form of the residents selected for comprehensive review and document them appropriately. Observations of activities involving all residents meet this requirement. If the licensor is unable to make all of the required observations for a resident selected for comprehensive review, the licensor must document the reason in the working papers. The licensor may include observations made of additional residents as appropriate.

5. Document any observations made of personal care activities. When possible, obtain permission from the resident to observe staff providing personal care. If it is not possible, document the reason why in the working papers. Examples of personal care include but are not limited to:
   a. Helping a resident walk.
   b. Transferring.
   c. Turning/repositioning.
   d. Oral care.
   e. Fingernail or foot care.
   f. Assistance with dressing.
   g. Assistance with eating.
6. All licensors may assess a resident's skin condition but only a nurse may perform a clinical assessment of the skin in the bikini area (breasts, genitals, rectal area). See AFH Complaint Investigation Pathways for further guidance on skin observation.
7. Notify the FM when a situation arises that requires the clinical assessment of a nurse such as wound care, injury, pressure sore, etc.
8. Observe the general appearance and demeanor of residents during the entrance and tour. If the tour occurs before the sampled residents have been identified, the licensor may document the observations of the residents they see and do not need to include the residents selected for comprehensive review.
9. Observe and document all residents for participation in activities.
10. Note any residents who express problems or concerns or those who appear to have unmet care needs.
11. Note any caregivers who do not appear to know the residents' needs or have the knowledge, skills, or abilities to meet those needs.
12. Collect additional observational data if any part of the inspection reveals additional concerns. The licensor may ask additional questions raised by any observation made, regardless of whether or not the resident is one of the residents selected for comprehensive review.
13. Always ensure that residents' health and dignity are addressed at all times. Respect a resident's right to refuse to allow you to observe care.
14. Observation of care along with other data sources will help the licensor decide if the needs of the residents are being met.

I. Medication Services

Purpose

AFHs are required to have systems in place to ensure not only that residents receive their medications as prescribed by their doctor, but that medications are stored and documented appropriately. Licensors should not only focus on the details of the sampled residents and their medications but on the system the provider has developed to manage medications over time for all residents.

Procedure

1. Interview the provider or caregiver staff to determine if there will be an opportunity to observe medication services during the inspection.
2. Discretely observe medication services/assistance. Obtain the permission of residents if needed. An example of when permission is needed may include if a resident receives insulin injections in their bedroom compared to when residents are given their medications during mealtime.
3. Follow up on any concerns identified regarding medication services during other parts of the inspection.
4. Complete a comprehensive review of the two selected residents' records for correct identification of medication needs on the assessment and negotiated care plan.
5. For the two selected residents, reconcile the prescription, medication bottle label and the Medication Administration Record (MAR). Record any discrepancies on Resident Medication Review (DSHS 10-557) form. If discrepancies exist, you may expand the sample to other residents to see if it is an isolated error or if a problem exists with the overall system.
6. If a resident is assessed as being independent with their medication, observe them to see if they are able to properly management their medications. If they keep medications in their room, make sure their medications are in a locked storage container.
7. Observe the medication storage area and ensure medications (including over the counter medication such as aspirin) are in a locked storage area. Document the observations on the Environment Tour (DSHS 10-553) form.
8. Observe if all medications are stored in the original containers or in organizers that clearly identify; the resident name, name of medication, dose and frequency.
9. Gather data from other sources to support any concerns with medication services. An observation alone does not necessarily confirm deficient practice.
10. When evaluating the overall medication system:
    a. Review the medication administration record (MAR) with staff.
    b. Observe delivery system to ensure residents receive their medication.
    c. Observe to see if the right medication was given to the right resident.
    d. Observe to see if medication was given at the correct time.
    e. Identify if the level of medication assistance/administration is appropriate for the resident's needs.

f. Observe the resident and staff interaction and make sure that staff are communicating appropriately with residents.
g. Observe the resident's ability to take medication(s) safely and appropriately.

11. Identify any residents who require nurse delegation for medication administration and document it on the Resident List (DSHS 10-551) form.
12. Contact the FM or their designee if a discrepancy is found and they will help determine if a nurse is needed to complete the medication review.

J. Food Service

Purpose

The food people eat can have a significant impact on their quality of life and their food preferences are often driven by cultural and ethnic backgrounds. Licensors are not only looking to see if a home is safely preparing healthy food that meets each resident's dietary needs, but they are also looking for things such as a resident's ability to make their own food choices.

Procedures

1. Plan to complete inspections so you will have the opportunity to observe a meal.
2. Observe the meal preparation area for:
   a. Adequate and safe storage.
   b. Cleanliness of food preparation area.
   c. Proper food handling skills and handwashing.
3. Observe staff technique when they are assisting residents to eat and how they interact with the residents.
4. Observe to see if each resident receives the necessary and reasonable accommodations during the meal.
5. Document observations of the meal, food prep and tour of the kitchen on the Environmental Tour (DSHS 10-553) form.
6. Observe general food service and note the availability of nutritious snacks, liquids and alternate mealtimes as needed or requested by residents.
7. Through observations, interview, and record review, identify residents who may need special assistance or have a specialized or mechanically altered diet.
8. Note how well residents can feed themselves and how the caregiver/provider helped those who may have swallowing problems, visual problems, tremors, loss of motor skills, etc.
9. Conduct meal observations at eye level with residents and don't stand over them.
10. Observe the meal and document for:
    a. Nutritious content.
    b. General appearance of the meal.
    c. Liquids provided per resident choice.
    d. Timeliness of service according to mealtimes noted.
    e. If residents express concerns about food temperature, taste, variety, quality, or quantity.
    f. Note the following for each resident:
       i. If dentures were in place, fit well and there are no obvious care issues or pain.
       ii. If eyeglasses were on If staff help them reposition at the table.
       iii. If staff assisted with cutting food, feeding, observing for choking.
       iv. If they were isolated in their room during mealtime.
       v. If the resident's preferences were considered.

11. Other observations should include:
    a. If physician prescribed supplements or special diets.
    b. If a minimum of three meals a day are being served at regular times.
    c. If mealtimes support resident activities and choice.
    d. If food is being handled and stored properly.
    e. If kitchen equipment is clean and in good condition.
12. Interview staff/provider if there are concerns about their food safety knowledge.
13. If residents assist with food prep, ensure they are following proper food handling techniques as well.

K. Abuse and Neglect Prevention Review

Purpose

The primary focus on abuse/neglect prevention review is to ensure the AFH has policies and procedures in place to protect residents from harm. It is the provider's responsibility to ensure that all the staff working in the AFH has received the proper training and are aware of mandatory reporting laws.

Procedure

1. If a licensor identifies possible abuse or neglect during an inspection, they must call the Complaint Resolution Unit (CRU) to file a report and notify their FM.
2. Observe residents and the environment for possible issues regarding abuse, neglect, and involuntary seclusion.
3. Observe resident-to-resident interaction for possible unsafe behavior of one resident toward another.
4. Interview residents for any concerns regarding possible abuse, neglect, involuntary seclusion, and misappropriation of property. Questions are to be open-ended and not leading. Document answers in the AFH working papers.
5. Observe for signs of abuse such as:
   a. Presence of locks on doors preventing residents from exiting.
   b. The use of physical or chemical restraints.
   c. Residents who appear fearful.
   d. Uncommon or numerous skin tears.
   e. Bruising or injuries with unknown cause.
6. Note staff to resident interactions and look for staff's demeanor toward residents, noting any intimidation, ignoring resident's needs, yelling, physical aggression, or verbal abuse.
7. Observe resident's responses to staff and note any sign of fear, flinching, pulling back when approached, etc.
8. Review the facility's incident log if you become aware of an incident, injury, or accident since the last inspection to determine if the facility followed the process for reporting and documenting the information.
9. What to do if you identify possible abuse or neglect:
   a. Call a formal complaint into the CRU.
   b. Contact the FM for further instruction.
   c. Complete a complaint investigation along with the inspection if you are told to do so by the FM.

L. Resident Record Review

Purpose

The resident record review is to ensure that the information contained in the resident's record is consistent with the resident's care and service needs. All concerns that arise from a record review should be followed-up on with interviews and observations to determine failed practice.

Procedure

1. The Licensor will conduct a complete review of the records for the two residents chosen for a comprehensive review.
2. The focus of the complete resident record review will be on determining if the information is accurate and current, and how the information supports the quality of life, safety and provision of care and services for the resident.
3. Additional resident record review will consist of only those sections/areas needed to verify and clarify the information necessary to make compliance decisions.
4. The inspection process should rarely include a review of records from outside agencies and/or closed records.
5. The record review will focus on documentation since the last inspection.
6. Conduct a complete review of the two residents that were selected for a comprehensive review.
7. Document the findings on the Resident Record (DSHS 10-556) form.
8. Evaluation of records should include:
   a. Resident assessment.
   b. Preliminary Service Plan or Negotiated Care Plan.
   c. Staff notes included in the resident record.
9. The record review should be resident centered and reflect their current status and care needs.
10. During the record review process, be alert at all times to the residents' environment and activities around you.
11. If there are no current residents in the home, review one closed resident record.
12. Review a collateral record only if there is an actual or potential negative resident outcomes and the collateral record review is necessary to clarify or validate identified issues.
13. During the inspection, it may become evident that more information is needed to complete accurate data collection such as:
    a. Healthcare practitioner records.
    b. Hospital records.
    c. Home health records.
    d. Police or law enforcement records.
14. Document a contact name and phone numbers, fax numbers and/or addresses regarding a contact for the collateral record information only if required to complete the data collection.
15. Do not delay necessary collateral record review (written request, onsite visits, fax, or phone call) because time is important, and the inspection process is not considered complete until the last date of data collection.

M. Staff Record Review

Purpose

The provider or entity representative is responsible for ensuring that all staff are competent and qualified for their positions. Qualifications range from tuberculosis (TB) testing to background checks and training, and more. It is up to the provider to develop a system to keep track of all the necessary qualifications for their staff.

Procedure

1. Request to review one current caregiver staff record and the record of one of the following: a provider, the entity representative, or the resident manager.
2. Request to review copies of the background check results for all employees employed since the last inspection, even if the employee no longer works in the home. This includes:
   a. The provider (including each co-provider) or the entity representative if the provider is an entity;
   b. A resident manager who is not also the provider/entity representative;
   c. All staff who may have unsupervised access to residents;
   d. All volunteers and students; and
   e. Household members who are 11 years old or older.
3. Review only the provider record if there are no staff employed at the AFH other than the provider.
4. Review the records listed on the Administrative Records Review (DSHS 10-559) form. Record the dates of training and expiration dates on that form.
5. When reviewing continuing education credits, record the number of hours the person received in the time period between their last two birthdays. For example, a review conducted on December 1, 2018 of a person born on Jan 1 would need to have all hours between Jan 1, 2017 and Jan 1 2018 reviewed. Registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this requirement, unless voluntarily certified as a home care aide.
   a. The licensor may use the number of credits found at the last inspection only if less than a year has passed since the last inspection, the staff member was reviewed during that inspection, and the staff member has not had a birthday since the last inspection,
   b. Only DSHS-approved courses may be used to meet the continuing education requirements. Licensors must verify that continuing education courses were DSHS-approved. Verification may be done by logging into the Instructor & Curriculum Tracking System (ICTS). If the licensor does not have access to ICTS at the inspection site, they may contact their FM with the course number and the FM will verify the courses for them. If the FM is unavailable or unable to verify the data prior to the end of the inspection or if there are concerns about the certificate, the licensor may also make a copy of the certificate and verify the courses when they return to their workstation.
6. If records appear incomplete or dates are not current from certifications or trainings, communicate the findings to the provider or caregiver to ensure there are not more recent documents available.
7. Expand the staff record review sample if observations, interviews, or record reviews reveal concerns regarding staff records.

N. Exit Preparation

Purpose

Once the inspection is completed, the licensor will review all the data collected through observations, interviews and record review and will use all the data to make decisions regarding AFH compliance.

Procedure

1. Review the forms and documentation to identify concerns and specific issues relating to any requirements the AFH potentially failed to meet.
2. Document your conclusions in the AFH working papers.
3. Note examples to assist the provider with understanding the non-compliance issues.
4. Note any potential deficiency which requires further information or data collection.
5. Review the information to determine if the failure to meet a requirement has resulted in a negative resident outcome or has the potential for a negative outcome.
6. Follow SOP Chapter 7: Enforcement to establish the scope and severity (s/s)and what action is required if a deficiency is identified.
7. Well organized data will help facilitate the communication between the licensor and the provider during the exit as well as provide the licensor with a useful tool while writing the Statement of Deficiencies (SOD).
8. The information given at the exit is not necessarily the final determination of the home's compliance. Further analysis and data collection may need to continue after the on-site visit including family and resident representative contacts and review of documentation.

O. Exit

Purpose

The purpose of the exit conference is for the licensor to clearly explain the findings during the inspection and to explain the preliminary decision/s regarding non-compliance with licensing requirements. Licensors should explain what information or evidence they are using to support their decision. The licensors should also allow the provider or caregiver to provide additional information they feel is relevant to the discussion.

Procedure

1. Briefly discuss each resident included in the sample and summarize:
   a. Observations of the resident.
   b. Observations of the environment.
   c. Any expressed concerns or unmet needs. Be sure to ask the resident for permission to share any information they disclosed to you.
2. Based on regulations, describe the preliminary deficiency finding(s) and other issues and or concerns (if any) you have that will require further information after leaving the home.
3. Provide the provider/representative the opportunity to discuss and supply additional information that they believe is pertinent to the findings.
4. If unsure of all deficiencies at the time of exit, provide a status update to the provider/representative and inform them that the deficiencies discussed may be amended upon completion of the data collection or consultation with the FM.
5. Inform the provider prior to leaving the home that a written report will be sent within 10 working days of completion of data collection.
6. Discuss the concept of immediately beginning the correction of deficient practice with the provider.
7. After the exit, telephone the provider to conduct an Outcome Conference to confirm the citations or discuss anything in the report that was not clearly identified during the exit status update. The call should be made prior to sending out the report.
8. A written plan of correction or safety plan may be required prior to leaving the home if:
   a. Issues found are serious and impact the resident's immediate health, safety, and welfare; and
   b. With approval of the FM and Compliance Specialist (CS).
9. Ensure there are no surprises for the provider and that all information about deficient practice was discussed prior to the provider receiving their SOD.
10. Ensure all citations are based on facts supported by evidence and current WACs or RCWs.
11. Do not provide feedback that reflects personal preference, opinions, or views.

> Note: Do not argue with a provider about identified failed facility practice. Explain their appeal rights and that an Informal Dispute Resolution (IDR) or administrative hearing can be requested.

P. Follow-up Visits

Purpose

A follow-up visit is conducted to determine if the home is back in compliance with the state licensing laws and rules cited in any previous inspection or complaint investigation. The follow-up visit is focused on the areas of deficient practice previously cited. Citing additional issues not cited in the original visit should be a rarity and take place only following consultation with the FM.

Procedure

The FM will determine the type of follow up visit based on the following criteria. They may delegate to or consult with the licensor as needed.

> Note: Two sources of evidence (e.g., observations, interviews, record reviews) are needed to support any findings.

Telephone verification

1. Correction of the deficiencies may be verified by telephone when:
   a. The deficiencies do not have a direct, adverse impact on resident care, (i.e., citations are not associated with a negative or potentially negative resident outcome);
   b. The deficient practice issue is such that there are clear, objective criteria for determining compliance; and
   c. The provider has a good history of compliance with the provision of care and services to residents.
2. Procedure:
   a. Contact the provider to discuss what systems were put in place to correct the deficient practice.
   b. Place a note recording the pertinent details of the telephone conversation in the facility file. Include a statement on the Follow-Up Inspection form (DSHS 10-568) verifying whether or not the home was found to be back in compliance and the provider was notified.

Documentation/letter verification

1. Correction of deficiencies may be verified by letter or documentation submitted by the provider when:
   a. The deficiencies do not have a direct, adverse impact on resident care, (i.e., citations are not associated with a negative or potentially negative resident outcome);
   b. The home sends a letter that fully addresses the necessary actions taken by the home to implement the correction, whether their plan(s) worked and how and when correction was achieved; and
   c. The home sends copies of documents as verification (i.e., cardiopulmonary resuscitation/first aid cards, TB test results, orientation checklists, criminal background check results).

2. Procedure:
   a. Review all documents to ensure that all areas of deficient practice are addressed.
   b. Place documentation in the facility file. Include a statement on the Follow-Up Inspection (DSHS 10-568) form verifying whether or not the home was found to be back in compliance and the provider was notified.

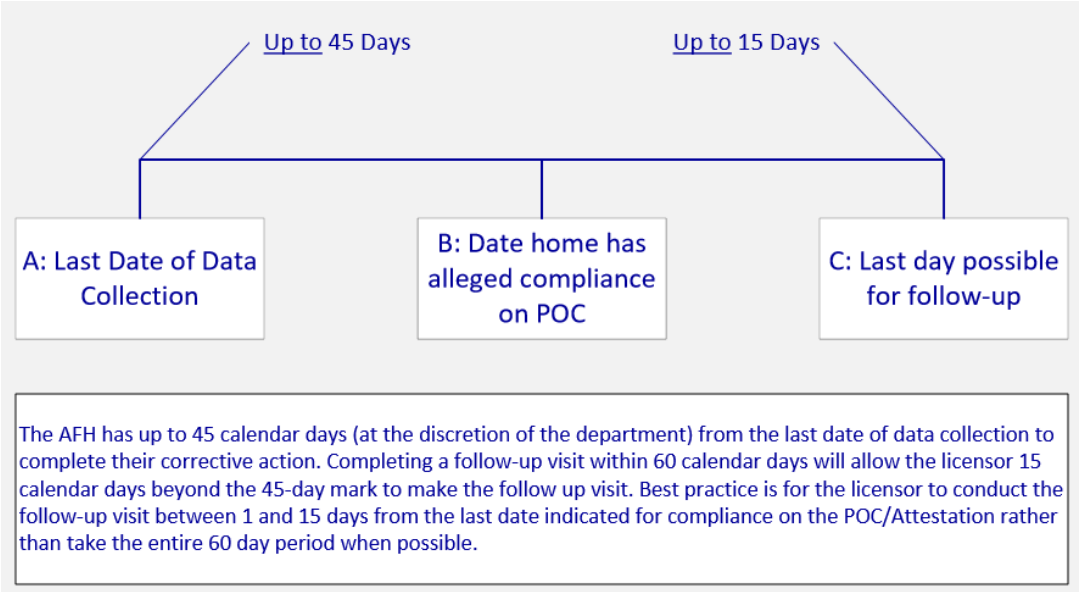
On-site verification

1. Corrections of deficiencies must be verified by an on-site visit when:
   a. Deficiencies exist with a negative or potentially negative resident outcome;
   b. The documentation submitted by the provider does not adequately support the conclusion that correction has been achieved; or
   c. At the FM's discretion.
2. Procedure
   a. Work with the licensor to schedule the follow-up visit.
   b. Ensure the licensor has completed the Follow-Up Inspection (DSHS 10-568) form, including a statement verifying whether or not the home was found to be back in compliance.
3. Schedule and track any additional visits/citations once the home is initially out of compliance. Remember that attestation timeframes are at the Department's discretion. While a home may have up to 45 calendar days to implement corrective actions, the FM can require a shortened timeframe for correction based on other compliance issues or the health and welfare of the residents in the home.
4. Include the person who did the original inspection or complaint investigation in the follow-up visit, whenever possible.
5. Generally, limit the practice of investigating new complaints during follow-up visits. If possible, the follow-up visit should be completed before any new complaint investigations so that the provider is back in compliance before writing new citations.
6. Notify the Compliance and Enforcement Unit Manager (UM) to strategize further enforcement action steps if the provider has failed the second follow-up visit.
7. Only schedule a third follow-up visit after consultation with the Compliance and Enforcement UM.

Licensor Responsibility:

1. Follow-up visits must be completed no more than 60 calendar days after the last day of data collection. Licensors should plan to visit the home between 1 and 15 days after the date on the Plan of Correction (POC)/Attestation unless circumstances inhibit the licensor's ability to visit in that timeline. When planning the date for the follow-up visit, the licensor should consider how much time they need to allow for the provider to be able to demonstrate compliance. For example, if the home needs to improve training on how to complete the medication log, the licensor may want to allow the home several days after indicating they will be back in compliance to show they have adequately corrected the issue.

If a home has multiple SOD reports from multiple visits (i.e., complaint investigations), whenever possible, these should be combined for one follow-up visit within the 60-day period following the first visit that placed the provider out of compliance. Those cases where circumstances prevent the provider from coming into compliance and/or RCS from conducting a follow-up within the 60-day period (i.e., a SOD is written at day 59) should be staffed with the FM and CS as needed and may require more than one follow-up visit.



2. Providers are not required to submit an attestation statement for citations they are disputing in IDR until after the IDR is complete. Do not delay the follow-up visit waiting for the IDR results or an attestation of correction. The AFH is still expected to correct the deficiency within the 45-day timeframe, even when the IDR occurs after the 45 days. The licensor does not need to conduct an additional follow up visit after IDR, unless the AFH has not corrected the issue.
3. Document on the Follow-Up Inspection (DSHS 10-568) form the issues from prior visit and WAC/RCW reference(s).
4. Base the sample size on the deficient practice cited and the number of residents necessary to review in order to determine compliance (more than one resident will likely need to be included in the sample in order to have enough information to determine compliance).
5. Conduct the on-site follow-up visit:
   a. Consider the following prior to the follow-up visit:
      i. Current deficient practice issues, including the nature, **scope** (number of residents impacted or potentially impacted) and **severity** (seriousness or extent of the impact or potential seriousness or extent of the impact on residents) of each cited deficiency; and
      ii. The enforcement remedies imposed as a result of the inspection.
   b. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.

   c. Focus the sample selection on residents who are most likely to be at risk of problems/conditions/needs resulting from the deficient practice cited in the original report.
   d. Only review evidence obtained between the provider's last date on the POC/Attestation and the date of the revisit to make compliance decisions.
   e. Record corrected and new or uncorrected deficiencies on the Follow-Up Inspection (DSHS 10-568) form.
6. Complete a second follow-up visit before 90 calendar days from the last date of data collection when the first follow-up visit resulted in any deficiency.
7. Upon completion of all follow-up visits:
   a. Record corrected and new or uncorrected deficiencies in STARS.
   b. Write a new SOD for any new or uncorrected deficiencies.
   c. Process telephone, letter, or document review follow-up visits in the same manner as an on-site follow-up visit.
   d. After the telephone call, letter, or document review, if there is a question regarding whether there is enough information to correct deficiencies, discuss with the FM to determine whether an on-site follow-up is needed.
   e. Follow the appropriate tasks of the inspection process necessary to determine home compliance.
   f. Follow the decision making and SOD writing processes for any follow-up visit resulting in uncorrected deficiencies.
8. Follow the STARS processes necessary to schedule and complete the follow-up visit.

Part II: Additional Guidance

A. Inspection After Revocation or Suspension

Purpose

RCW 70.128.070 states that the department shall conduct inspections at least every 18 months on licensed AFHs. When a home's license is under summary suspension or revocation, but they are appealing that enforcement action, the decision when to conduct an inspection within this timeline should be made on a case-by-case basis. Some of the determining factors are what type of enforcement action it is, if there are residents left in the home, and if health and safety risks persist. Homes are expected to be in compliance with Chapter 388-76 WAC until the appeals process is complete and the decision to revoke the license is final. This section gives guidance on how to determine an inspection schedule in this situation. Further information about enforcement actions can be found in SOP Chapter 7: Enforcement.

Procedure

1. If an AFH license has a summary suspension:
   a. Summary suspension orders are effective immediately, which also suspends the requirement to continue inspections.
   b. In general, if a home appeals the enforcement action and a resident remains in the home, the department may continue inspections until the appeal process has been completed in order to ensure the safety of the resident. The FM may decide to discontinue inspections if there are no residents living in the home.
2. If an AFH license is revoked without summary suspension:
   a. Revocation orders are not effective until the enforcement action is final, which includes the timeline for filing an appeal. The department must continue inspections, starting within six months of the date of the written notice of enforcement.
3. The enforcement action is considered complete according to the following timeline:
   a. On the 29th calendar day after the enforcement action, if the AFH does not appeal the enforcement action.
   b. On the 29th calendar day after the initial order by the Office of Administrative Hearings (OAH), if the AFH appeals the enforcement action but does not request review of the initial order; or
   c. On the 10th calendar day after the final order by the Board of Appeals, if the AFH requests a review of the initial order.

> Note: More information about calculating timelines can be found in WAC 388-02-0035.

Field Manager Responsibility

1. While an AFH is appealing revocation with or without a summary suspension, the department must conduct monitoring visits according to the FM's discretion. The FM must work with the CS, the RA, and the Compliance and Enforcement UM to make these determinations.
   a. A monitoring visit entails reviewing any aspects of the home that are relevant to the cause for the suspension, or revocation, or both; and may include resident or staff interviews, making observations, record review, and any other relevant actions needed to determine if the rights and safety of residents are maintained.
   b. Factors to consider when determining a schedule of monitoring visits include:
      i. Whether there are remaining residents in the home;
      ii. Ensuring necessary resident transfers have been completed;
      iii. If health and safety risks persist because the home has not made any corrections related to the reason for suspension or revocation; or
      iv. Potential changes to the physical plant
   c. Providers are required to be in compliance with Chapter 388-76 WAC at all times, which applies until the license revocation is final. If providers ask about the purpose of the visit, staff may inform the provider that the purpose is to determine resident safety and compliance with license requirements during the appeal process.
2. Full inspections must be conducted starting within six months of the date of the written notice of enforcement, or sooner at the discretion of the FM. The FM will work with the CS to make these determinations.
3. If the department receives a complaint about a home that is under summary suspension, or revocation, or both; staff must follow normal complaint investigation procedures found in SOP Chapter 20: Complaint Investigations.

B. Monitoring Visits

Purpose

Monitoring visits are used to determine if an AFH is in compliance with statute, laws, and regulations in accordance with RCW 70.128.160 and WAC 388-76-10910. These visits are conducted at the discretion of the Field Manager in consultation with the Compliance Specialist. The purpose of the visits is to gather information related to the safety and welfare of residents in the home and to determine if the home is able to provide necessary care and services to residents. Monitoring visits typically occur after the completion of the investigation and after issuing the Statement of Deficiency (SOD) with enforcement. There are three avenues for monitoring visits to occur:

1. Monitoring visit(s) **must** be conducted when the home is under the following enforcement actions, until the action is completed:
   a. Summary Suspension and Revocation of a License, including a Stop Placement Order Prohibiting Admissions; and/or
   b. Revocation of a License and Stop Placement Order Prohibiting Admissions.
2. Monitoring visit(s) **may** be conducted when there is a:
   a. Stop Placement Order; or
   b. Condition(s) on License Order.
3. Monitoring visits MAY be conducted after issuing a SOD with citations when there is no enforcement for findings and residents are at high risk while correction is pending. For example:
   a. Finding made due to a serious lack of judgment on the part of the provider, but no resident harm resulted.
   b. RCS requested a safety plan due to risks present in the home.
4. The decision to conduct a monitoring visit for a citation without enforcement will be made in consultation with the Regional Administrator and the Field Manager.

Operational Requirements

1. Monitoring visits will be:
   a. Unannounced;
   b. Brief in duration;
   c. Focused on the residents' safety and welfare.
2. During the monitoring visit, the Licensor will:
   a. Note how many residents are in the home and conduct both focused observations and informal interviews of residents and staff. Conduct interviews with others not associated with the home only if necessary.
   b. Review resident records only if there is a need to seek additional information related to potential or actual resident welfare and safety issues.
   c. Consult with the Field Manager if there are new or unresolved safety or welfare concerns.
   d. Communicate with the licensee/designee as needed about regulatory matters.
   e. Complete the Monitoring Visit form (DSHS 10-384). The only report to be completed is the monitoring visit form.

3. The Licensor will record the dates of monitoring visits in STARS.
4. The Licensor will retain monitoring visit forms according to retention rules and use as needed to verify that visits were made.

Procedure

The Field Manager will:

1. Consult with the CS (FSA when not related to enforcement) to determine:
   a. If monitoring visits are needed;
   b. If needed, the frequency the visits should occur;
   c. The duration or number of monitoring visits to be made (most monitoring visits will be for a limited time period); and
2. Create a task in STARS and assign staff to conduct the monitoring visit(s). The FM may delegate this task to the AA3. Include in the task:
   a. The name of resident(s) allowed by the FM to return to the home under a Stop Placement Order, if any.
   b. Information regarding special issues, such as residents or family members who should or should not be reviewed.
3. Assign new complaint intakes to appropriate investigator conducting monitoring visit. Complaints may be addressed during the monitoring visit.

The Licensor will:

1. Review and understand the:
   a. Purpose of the monitoring visit(s);
   b. Recent history of enforcement actions in effect and any previous monitoring visit(s);
   c. Resident lists from current or previous monitoring visits;
   d. Most appropriate time of visit related to the issues, such as evenings or weekends; and
   e. Status of on-going complaints, if any.
2. Conduct the Monitoring Visit following the guidance in this procedure.

Follow Up Activities:

1. The Licensor will:
   a. Consult with the FM about any new concerns found during the monitoring visit.
   b. Report to the CRU any new concerns or new information related to the open investigation.
2. The FM will:
   a. Assign any new intakes to the Licensor doing the monitoring visit. The FM may assign to a different Licensor at their discretion.
   b. Notify the CS (or FSA if visit is not related to enforcement) of the new investigation or new concerns or both.
3. The CS, when involved, will:
   a. Inform the Compliance and Enforcement UM about additional findings related to the home's noncompliance and risks related to safety and welfare.

C. Change of Ownership (CHOW)

Purpose

A change of ownership (CHOW) of an AFH can occur for many reasons; the provider may be selling their home, changing their business structure, or adding or removing someone from their license. The following section provides direction on how to handle a CHOW as it relates to the inspection process in the field.

Procedure

1. No inspections are done prior to licensure for any CHOW.
2. If the CHOW consists of changes to the administrative structure of the home, the previous inspections schedule should be maintained.
3. A full inspection must be completed within 30 days if the home is under a POC for outstanding violations at the time of the CHOW.
4. If the home is under a POC for outstanding violations:
   a. A Full inspection must be completed within 30 days if the person or entity is not licensed for another home at the time of the CHOW.
   b. A full inspection must be completed within six months if the person or entity is licensed for another home at the time of the CHOW.
5. The FM may call for an inspection at any time if the problems are identified in the home.
6. All inspections will be unannounced and done according to the inspection procedure.

Application Process

1. The Business Operations and Analysis Unit (BOAU) will:
   a. Receive and process the application.
   b. Notify the field about the application and ask for relevant feedback on the applicant.
   c. Route the completed application through the FMS system to the designated approver.
   d. Issue the approved license and notify the field.
2. The Licensor will:
   a. Report any concerns relevant to the applicant and/or application to the BOAU as requested, prior to licensure.
   b. Determine the need to schedule an inspection after licensure.
   c. Follow the inspection processes for any inspection done.

D. AFH Licensing Fees

Purpose

A billing statement is sent to AFH providers for licensing fees, indicating that the fees are due on the 15th of the month that the home had been initially licensed. The cost per bed is determined by the legislature and is meant to cover the cost of regulating the home. RCS is unable to make payment arrangements for licensing fees, and complaints are reported when the fees are not paid on time. Refer providers to Information Sheet: Annual Fees for more information.

Procedure

1. The Business Operations and Analysis Unit (BOAU) Manager (or designee) will:
   a. Generate a list of AFHs with overdue accounts from FMS on the 20th of each month.
   b. From the list of overdue accounts, look up each listed AFH in FMS to determine:
      i. If there is a summary suspension or closure; if so, remove them from the list.
      ii. If there has been an increase/decrease in the capacity in the month payment is due; if so, determine if this resolves the pay discrepancy and, if it does, remove them from the list. If not, the home should remain on the list.
   c. Forward the final list to the CRU.
   d. Review and monitor the current unpaid licensing fees report monthly. If a home remains on the report for more than one month, notify the appropriate FM and CS for further follow up.
2. The CRU will:
   a. Generate a complaint intake based on unpaid licensing fees.
   b. Assign a 20-day working priority for each complaint intake.
   c. Follow CRU regular procedure and assign to field for investigation.
3. The FM will:
   a. Assign complaint investigation to a complaint investigator.
   b. Track the outcome of the complaint investigation using FMS to determine if the home has paid the outstanding fees.
   c. Inform the investigator if they are notified that the home has paid their licensing fees in full.
4. The Complaint Investigator (CI) will:
   a. Once assigned, review FMS to see if payment has been received.
   b. If full payment has been received:
      i. Close the complaint.
      ii. Complete the required investigation tasks per established investigative procedures.
   c. If full payment has not been received, in order to ensure that financial issues are not impacting resident care and safety:
      i. Conduct a field visit to ensure residents are safe and follow all established investigative procedures.

ii. Discuss the late licensing fees with the provider, resident manager, or entity representative and the expectation that the annual licensing fee is to be paid in full in the anniversary month the AFH was licensed.
iii. Explain to the provider that RCS is unable to accept partial payments or payment plans.
iv. Prepare a SOD if non-payment of annual licensing fee is verified.
v. Conduct a follow-up visit 30 days after the SOD is issued. The follow-up may be but is not required to be on-site. If the annual licensing fee has been paid in full and the payment is verified through FMS or any other means, the follow-up visit can be conducted in the office and the complaint can be closed.
vi. If the full amount of the licensing fees has not been received, recommend the FM refer the home for enforcement action based on uncorrected citations.

If payment has not been received:

1. The FM will:
   a. Review the SOD and refer to the CS imposition of condition requiring the provider to pay the full annual licensing fee within 15 days.
   b. Work with the CI, CS, and BOAU Manager to monitor the home for payment. Keep the complaint open until confirming payment with the BOAU Manager.
2. The CS will:
   a. Review the SOD and enforcement recommendations.
   b. Facilitate the enforcement process according to the following progression:
      i. A condition is imposed stating the home must pay the licensing fees in full within 15 calendar days of the effective date of the condition.
      ii. If the licensing fees are not paid within 30 days of the effective date of the condition, the home will be issued a stop placement order.
      iii. If the licensing fees are not paid in full within 30 days of the stop placement order, a civil fine will be imposed of $10 per day until the fees are paid.
      iv. If the licensing fees are still not paid in full after 30 days of the issuance of the civil fine, the home will be issued a summary suspension and revocation. See SOP Chapter 7: Enforcement for information on summary suspension and revocation.

> Note: The time between the due date of the condition and the next enforcement step allows time for payments to be processed.

E. Facilities Relinquishing Medicaid – Under Construction

F. Facility Voluntary Closure – Under Construction

G. Character Competence and Suitability (CCS) Review for Providers – Under Construction

H. Nursing Duties – Under Construction

I. AFH Information Changes

Purpose

The purpose of this chapter is to ensure there is a clear and consistent process for Department staff to follow when information pertaining to an AFH changes. For the following changes, the provider will complete, sign, and date the AFH Information Change form located on the AFH professional provider page and submit to the BOAU for processing:

1. AFH phone, fax (except confidential fax), mailing address, and/or email address;
2. Adding/removing specialty designation(s);
3. Change the home's resident manager; and
4. Change the home's entity representative.

Procedure

1. Licensing Additional Bedrooms:
   a. If the home has added a new bedroom to the home, then the provider must provide a Building Inspection Checklist that shows the area passed inspection by the local building official.
   b. If the additional bedroom results in a resident increase, then the capacity increase process will also be followed.
   c. Once the provider has notified the field and submitted a new floor plan, and if appropriate, the Building Inspection Checklist, the FM will assign a licensor to inspect the new bedroom following the Additional Bedroom Inspection procedures.
   d. Once the new bedroom meets minimum licensing requirements, the licensor will:
      i. Update the floor plan and Floor Plan Key and provide a copy to the provider (provider must always sign an updated Floor Plan Key);
      ii. Inform the FM the bedroom has passed the additional bedroom inspection.
      iii. Keep a copy of the floor plan and Floor Plan Key for the field office files and send all documents to RCS Central Files.
2. Additional Bedroom Inspection Procedures:
   a. The Licensor will:
      i. Ensure the provider has submitted all required documents to the Department.
      ii. Either schedule a date/time to inspect the bedroom or conduct the inspection during the next full inspection if the full inspection will be conducted within a month of licensor receiving the inspection assignment.
      iii. Print out and take with you for the onsite inspection the "Resident Bedroom/Bathroom Worksheet", "Floor Plan Key" (two copies), and the "Exit Summary Worksheet" from the Residential Inspection and Quality Assurance Program (RIQAP) Unit's working papers. Also have with you two copies of the updated floor plan.
      iv. Inspect the bedroom in accordance with the "Resident Bedroom/Bathroom Worksheet".

v. Determine if the number of toilets in the home will accommodate the proposed capacity increase.
vi. If the bedroom(s)/bathroom(s) do not meet minimum licensing requirements document the areas which do not meet requirements on the "Exit Summary Worksheet." Keep a copy of this form in the licensing file and give one copy to the provider. Complete the follow-up inspection once the provider has corrected the deficiencies.
vii. Inform the FM the bedroom has passed the additional bedroom inspection.

3. Decreasing Licensed Bed Capacity:
   a. The provider will complete and submit the Request Decrease form to BOAU.
   b. BOAU will request approval from the FM.
   c. Once approved, BOAU will email the FM indicating the new number of licensed beds and the effective date. The FM will forward it to appropriate licensor.
4. AFH Closures:
   a. The FM will:
      i. Complete their portion of the AFH Facility Closure Checklist; and
      ii. Complete the "Basis for Closure" field with one of the following FMS "descriptors:"
         - Closed/foreclosure.
         - End of provisional license.
         - License revoked.
         - Nonpayment closure.
         - Provider deceased.
         - Voluntary closed relocation.
         - Voluntary surrender in lieu of revocation.
         - Voluntary closed.
   b. Gather supporting documentation for closure.
   c. The Unit AA3 will send the AFH Facility Closure Checklist and supporting documentation to the BOAU Representative at HQ.
   d. The BOAU Representative will:
      i. Complete the "Headquarters" section of the AFH Facility Closure Checklist;
      ii. Consult with the CS if there is pending enforcement actions noted within STARS or if there is a revocation in process;
      iii. Close the home in FMS; and either:
         - Forward the AFH Facility Closure Checklist and all supporting documents to Contracts if closure is the result of a revocation; or
         - File the AFH Facility Closure Checklist and all supporting documents in RCS Central Files.

J. Capacity Increase

Purpose

An AFH may request an increase in their bed capacity at any time by submitting a completed Change in Licensed Bed Capacity – Increase form (DSHS 06-168). This form is submitted to the BOAU, and it will be passed to the field from this unit. There are specific requirements when a home is requesting a bed capacity increase to seven or eight beds that are addressed below. This procedure outlines the process for conducting an inspection after any bed capacity increase request, as well as specific instructions for conducting an inspection after a bed capacity increase to seven or eight beds.

Procedure-Capacity Increase to Six Beds or Fewer

1. The BOAU will:
   a. If the requested capacity is six or fewer, the BOAU ensures the form is filled out completely and there are no errors. Once both of these requirements are verified, the BOAU forwards the form and supporting documentation to the appropriate field office for inspection.
2. The FM/designee will:
   a. Receives the form and assigns the inspection to a licensor. If the request is made before the file has been transferred to the field from RIQAP after initial licensing, send the request to the RIQAP UM.
   b. Does not alter a home's planned inspection schedule to accommodate an expected request to increase capacity. An inspection to increase capacity is scheduled and should not be conducted at the same time as an unannounced full inspection.
3. The Licensor will:
   a. Review the floor plan on file for the home, the capacity increase form, and any other documents received from BOAU.
   b. Check the file for any previous documentation from the local building official or previous changes to the floor plan.
   c. Review the home's facility summary and visit log in FMS.
   d. Contact the home to determine if the additional residents will be living in a bedroom that has previously been inspected or one that has been added or modified. Request an updated floor plan if a previously unlicensed bedroom will be added.
      i. If the home had previously had the bedrooms that will be used by the additional residents inspected and approved by both the local building official and RCS, verify that RCS files reflect that the requested rooms have been approved. If the requested capacity is six or fewer, an onsite visit may not be required. Work with the FM to determine if this will be necessary.

ii. If RCS records do not show evidence that the bedrooms had previously been inspected and approved by the local building official, request that the provider submit an AFH Building Inspection Checklist for the additional bedrooms. The checklist must be marked "passed" and signed by the building official in order to be accepted. An onsite visit is required, even if the bedrooms had been previously inspected and approved by RCS, to review any changes that may have been made.

e. Review the proposed floor plan with the provider to determine if the home has sufficient toilets to meet the one toilet to five people living in the home ratio required per WAC 388-76-10780.

f. If the home is on a septic system, review documentation from the local health jurisdiction to verify the septic system is approved for the total number of people who will be living in the home (e.g., if a provider intends to live in the home with their spouse and six residents, the septic system should be approved for eight or more).

> Note: If the documentation from the local health jurisdictions lists the number of bedrooms rather than the number of people, ask the applicant to contact the local health jurisdiction to get the approval changed to the number of people the system can support.

g. Once all the documentation is gathered, schedule a time for the inspection with the provider if an onsite visit is required.
   i. If the licensor has all of the necessary information, they may schedule the inspection during their first contact with the provider.
   ii. When scheduling the inspection, inform the provider that a staff member who is not the provider or entity representative will need to be available for interview. They can be available over the phone, but they need to be able to complete the interview.

h. Prepare for the onsite visit if required by completing any pre-inspection work and compiling the following documents:
   i. Two copies of the proposed floor plan.
   ii. One copy of the working papers, which include two copies of the floor plan key. Make extra copies of the bedroom inspection pages as necessary.

i. Assemble necessary supplies, such as measurement equipment, thermometer, etc.

j. Conduct the onsite visit. Fill out the working papers completely. If the requested capacity will be for six or fewer residents, the licensor must indicate this in the sections required only for homes requesting to increase to seven or eight beds by marking the appropriate check boxes.

k. Observe the bedrooms that will be used by the additional residents. Document any of the following:
   i. Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
   ii. Any toxic or other unsafe substances or items that need to be removed or fixed.
   iii. Any aspect of the physical space that does not meet the WAC requirements (e.g., door or window size or ability of resident to use them to exit in any emergency, nonfunctioning smoke detector, non-approved heat source, etc.).

iv. Any concerns about the lighting or available storage space.

l. Measure the room to determine the resident capacity. Do not include the space used by a door swing, closet, armoire or wardrobe, or bathroom in the calculated useable floor space.
m. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.
n. Review the data collected throughout the inspection process to determine if the applicant meets the AFH minimum licensing requirements. Further analysis and data collection may be needed. Discuss any issues or concerns related to the requested capacity increase with the FM.
o. Before leaving the home, let the provider know one of the following:
    i. A recommendation will be made to approve the capacity increase and someone from BOAU will contact them about paying their additional bed fee;
    ii. A recommendation cannot be made to approve the capacity increase, the reason why, and how the provider can follow up with the licensor to schedule a follow up visit if they are able to correct the reason the recommendation cannot be made.
p. If all or part the requested capacity increase is approved, fill out both copies of the new floor plan and new floor plan key. Sign and date and ask the provider to sign and date. Leave one copy with the provider and keep one copy for the home's file.
    i. If only part of the requested capacity increase is approved, discuss with the provider if they are able to and wish to make changes that will allow the full capacity increase to be recommended. If so, let the provider know how to follow up with the licensor to schedule a follow up visit.
q. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation with the CS, RA, Office Chief, or RCS Director.

If the capacity increase request will be approved:

1. If the capacity increase will be approved, the FM or their designee will notify the BOAU that the new rooms have been approved and the capacity of the home can be updated in FMS.

If the capacity increase request will not be approved:

1. If the capacity will not be increased, the FM or their designee will notify the BOAU of the decision and the reason why and all supporting documentation.
2. The FM will work with the licensor to determine if the application needs further consultation from a CS, RA, Office Chief, or RCS Director.
    a. Applications that are not approved that do not need further consultation are clear and indisputable violations of the WAC. Examples are a bedroom that does not meet the size requirements or does not have an outside window.
    b. Applications that are not approved that may need further consultation are those that are not clear and indisputable violations of the WAC. Examples are residents who do not believe the home has the capacity to care for two additional residents or doubts about financial solvency.

Section Overview | Glossary of Terms | Acronym List | Table of Contents

> Note: These are examples only. It is up to the licensor and the FM to determine if they believe a recommendation from a resident or indications of lack of financial solvency are sufficient to not approve the application. The licensor and FM may make this decision without consultation, but consultation can be used if another opinion or further guidance is needed.

3. Allow the provider 60 calendar days from the date of the inspection to contact the licensor regarding any corrections to the deficiencies that may allow the home to increase their capacity.
   a. Once 60 days have passed, if the home has not made the necessary corrections, send the file back to BOAU with the notification that the application is not approved.
4. The BOAU will create the notice to the applicant that the application is not approved.

Procedure-Capacity Increase to Seven or Eight Beds

1. The Business Operations and Analysis Unit (BOAU) will:
   a. Process the application fee;
   b. Ensure the form is filled out correctly.
   c. Verify all required documentation is included.
   d. Conduct a credit check on the applicant, and spouse if applicable, to determine financial solvency.
2. The BOAU reviews the entire application packet to ensure the applicant meets the following qualifications required by the statute:
   a. Home has no unpaid licensing fees .
   b. Home has been licensed for 24 months or more.
   c. Home has been licensed for a capacity of six for 12 months or more.
   d. Home has received two full inspections or more.

   > **Between June 6, 2024 and January 1, 2026**, homes meeting all criteria except two full inspections may submit a capacity increase application and have their inspections completed upon receipt of the application.

   e. Home has not had any enforcement actions taken on the license for the period of the last two full inspections.
   f. Home has given residents a 60-day notice.
3. If the BOAU finds that the home does not meet these criteria, they will send a notification to the applicant that the application is void and cannot be accepted.
4. If the BOAU can verify that the applicant meets all of these criteria, they will send the application packet to the appropriate field office for inspection.

5. The Field Manager (FM) will:
   a. Receive the form and assign the inspection to a licensor.
   b. When a home needs one or two full inspections, assign full inspection onsite within 90 days of receiving application packet from BOAU.
   c. Assign a second inspection at least six months after the first inspection when two inspections are needed. When a home is out of compliance as a result of the first inspection the second inspection will be completed at least six months after the home is back in compliance.
   d. Determine whether the seven or eight bed capacity inspection will be completed during the same visit as the second full inspection.
6. The Licensor will:
   a. Review the floor plan on file for the home, the capacity increase form, and any other documents received from BOAU.
   b. Check the file for any previous documentation from the local building official or previous changes to the floor plan.
   c. Review the home's Provider Summary in STARS. Check for complaints or citations indicating a lack of financial solvency or insufficient staffing.
   d. When one or two full inspections are needed
      i. complete the full (unannounced) inspection before completing the remaining steps in this procedure, unless the FM determines the capacity increase visit will occur during the full inspection.
      ii. when approved by the FM, complete the capacity increase visit during the full inspection. Complete the remaining steps in this procedure prior to the full inspection *with the exception of contacting the provider or the local building jurisdiction*. This is to ensure the full inspection is unannounced, in compliance with WAC 388-76-10910.
   e. Contact the home to determine if the additional residents will be living in a bedroom that has previously been inspected or one that has been added or modified. Request an updated floor plan if a previously unlicensed bedroom will be added.
      i. If the bedrooms that will be used by the additional residents were previously inspected and approved by both the local building official and RCS, verify that RCS files reflect that the requested rooms have been approved.
      ii. If RCS records do not show evidence that the bedrooms had previously been inspected and approved by the local building official, request that the provider submit an AFH Building Inspection Checklist for the additional bedrooms. The checklist must be marked "passed" and signed by the building official in order to be accepted. An onsite visit is required, even if the bedrooms had been previously inspected and approved by RCS, to review any changes that may have been made.
   f. Review the proposed floor plan with the provider to determine if the home has sufficient toilets to meet the one toilet to five people living in the home ratio required per WAC 388-76-10780.

g. If the home is on a septic system, review documentation from the local health jurisdiction to verify the septic system is approved for the total number of people who will be living in the home (e.g., if a provider intends to live in the home with their spouse and six residents, the septic system should be approved for eight or more).

> Note: If the documentation from the local health jurisdictions lists the number of bedrooms rather than the number of people, ask the applicant to contact the local health jurisdiction

h. Once all of the documentation is gathered, schedule a time for the inspection with the provider.
   i. Inform the provider that the local planning office needs to be contacted by RCS, following the process in the next section.
   ii. Once the local planning office has been contacted, contact the provider again to schedule the inspection.
   iii. When scheduling the inspection, inform the provider that a staff member who is not the provider or entity representative will need to be available for interview. They can be available over the phone, but they need to be able to complete the interview.

i. Prepare for the onsite visit by completing any pre-inspection work and compiling the following documents:
   i. Two copies of the proposed floor plan.
   ii. One copy of the working papers, which include two copies of the floor plan key. Make extra copies of the bedroom inspection pages as necessary.

j. Assemble necessary supplies, such as measurement equipment, thermometer, etc.

k. Conduct the onsite visit.

l. Observe the bedrooms that will be used by the additional residents. Document any of the following:
   i. Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
   ii. Any toxic or other unsafe substances or items that need to be removed or fixed.
   iii. Any aspect of the physical space that does not meet the WAC requirements (e.g., door or window size or ability of resident to use them to exit in any emergency, nonfunctioning smoke detector, non-approved heat source, etc.).
   iv. Any concerns about the lighting or available storage space.

n. Measure the room to determine the resident capacity. Do not include the space used by a door swing, closet, armoire or wardrobe, or bathroom in the calculated useable floor space.

o. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.

p. Review the data collected throughout the inspection process to determine if the applicant meets the AFH minimum licensing requirements. Further analysis and data collection may be needed. Discuss any issues or concerns related to the requested capacity increase with the FM.

q. Before leaving the home, let the provider know one of the following:
   i. A recommendation will be made to approve the capacity increase and someone from BOAU will contact them about paying their additional bed fee;
   ii. A recommendation cannot be made to approve the capacity increase, the reason why, and how the provider can follow up with the licensor to schedule a follow up visit if they are able to correct the reason the recommendation cannot be made.

r. If all or part the requested capacity increase is approved, fill out both copies of the new floor plan and new floor plan key. Sign and date and ask the provider to sign and date. Leave one copy with the provider and keep one copy for the home's file.
   i. If only part of the requested capacity increase is approved, discuss with the provider if they are able to and wish to make changes that will allow the full capacity increase to be recommended. If so, let the provider know how to follow up with the licensor to schedule a follow up visit.

s. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation with the CS, RA, Office Chief, or RCS Director.

Additional steps for homes requesting a capacity increase to seven or eight beds, the licensor must:

1. Contact the local jurisdiction where the home is located. The passed legislation requires the department to notify the local jurisdiction of the home's request to increase their capacity to seven or eight and allow the jurisdiction to provide a recommendation to the department. In order to fulfill this requirement, contact the local jurisdiction via email using the template linked here prior to scheduling the inspection to notify them of the request to increase bed capacity and to allow them to provide recommendations on whether to approve the request. For the purpose of fulfilling this requirement, the planning office of the city in which the AFH is located will be the local jurisdiction you must contact.
   a. If the city or town does not have a planning office, contact the operator, and ask for direction on who to contact.
   b. If the home is located outside of city limits, contact the county in which the home is located.
   c. Use the information on the local building official's inspection form to determine what jurisdiction is appropriate.
   d. If the local jurisdiction has not responded after five working days (WD) inclusive of the day the email was sent, send a follow-up email on the sixth WD. If they have not responded by the 10th WD, contact the provider on the 11th WD to schedule the inspection.
   e. If you receive a recommendation from a different office within the local jurisdiction other than the planning office, this should still be considered when determining whether to recommend approval or denial of the request. Document who contacted you and what their response was on the working papers. If you do not also receive a response from the planning office, you do not need to follow up, but can consider this recommendation in place of a recommendation from the planning office.

2. Review the additional documents received from BOAU:
   a. Review the notification given to residents/representatives of the capacity increase.
      i. If new residents have moved in since the capacity increase application was submitted, the licensor will request from the provider a copy of the 60-day notice to the new resident(s).
   b. Review the traffic mitigation plan.
   c. Review the documentation of the sprinkler system. The home must either provide a signed permit from the local fire authority or an inspection document from a licensed sprinkler provider showing that the inspection was passed (look for words like 'passed', 'compliant', etc. within the report).
      i. The inspection must have been conducted on the entire sprinkler system. There are separate requirements for testing the backflow, but this is not sufficient. We need documentation that the entire system was inspected.
      ii. A signature is not required. Licensors are not required to contact the company to verify the report if it is not signed. However, if a licensor feels a report may be fraudulent for any reason, they may work with their FM to determine if they need to contact the company to verify the report.
      iii. Some homes may not have a sprinkler because their license is limited to serving only residents who are independent with evacuation. The home will check the box noting this on the capacity increase request form. The home must have a limit placed on their license noting that the home may only admit and care for residents who are independent with evacuation. This may already be in place or can be added when you approve the increase.
3. Choose at least one resident to interview and complete the resident interview section. If no resident can be interviewed, choose a resident's representative to interview. Document the reason for interviewing a resident representative.
4. Choose at least one staff member who is not the provider or entity representative to interview and complete the caregiver interview section. If the home does not have a caregiver who is not the provider or entity representative, document this in the working papers. Also state how this affects your decision to recommend approval or denial of the request to increase capacity.

If the capacity increase request will be approved:

1. If the capacity increase will be approved, the FM or their designee will notify the BOAU that the new rooms have been approved and the capacity of the home can be updated in STARS.
2. For homes that do not have a sprinkler system because they only care for residents independent with evacuation, notify BOAU that a limit needs to be placed on the license.

If the capacity increase request will not be approved:

1. If the capacity will not be increased, the FM or their designee will notify the BOAU of the decision and the reason why and all supporting documentation.
2. The FM will work with the licensor to determine if the application needs further consultation with the CS, RA, Office Chief, or RCS Director.

K. Licensing Additional Bedrooms or Bathrooms

Procedure

When a provider requests that an additional bedroom and/or bathroom be licensed, the licensor will:

1. Ask the provider to send in a copy of the Building Inspection Report showing that the bedrooms in question have been inspected and approved by the local building inspector.
2. If this room has been added to the home or modified, request copies of all applicable building inspections.
3. Determine if the home's capacity will increase once the rooms have been inspected and approved. If so, the provider should have already sent in a capacity increase request to ALTSA Business Operations and Analysis Unit (BOAU). If the provider has not yet sent in this request, they must submit a request for capacity increase and the associated fee prior to proceeding with the onsite inspection. Once the BOAU receives the increase form, they will contact the assigned Field Manager to let them know that the home is ready for onsite inspection.
4. Determine the number of toilets available to staff, household members, and residents. The AFH must have at least one toilet per five people in the home. For example, if the home only has one toilet, the home will be limited to four residents and one caregiver. Homes licensed after August 1, 2023, that have a licensed capacity of more than five residents must have at least two indoor flush toilets available and accessible for resident use without requiring any resident to go through another person's room.
5. Obtain a current, accurate floor plan of the home. Have an electronic copy of the floor plan and floor plan key ready for use at the onsite inspection. Also bring two copies of the floor plan key to update at the end of the visit.
6. Discuss whether these additional rooms will affect the provider's current Medicaid Policy. The Medicaid Policy may need to be updated if the home plans to take more or less Medicaid residents, plans to designate new Medicaid bedrooms, or plans to charge supplemental fees for the newly licensed rooms. If so, plan to review the policy during your onsite visit.
7. Discuss with provider the condition the rooms should be in for licensing. The room must be clean, and all doors, windows, blinds, etc. must be in good working order.
8. Have an electronic copy of the initial licensing working papers, "Resident Bedroom/ Bathroom Worksheet", and/or, "Resident Bathroom Worksheet," as necessary, as well as "Notes and Drawings," "Exit Summary Worksheet," and, "Adult Family Home Floor Plan Key". These are the documents that you will use during the onsite inspection.

Onsite Inspection-Bedrooms

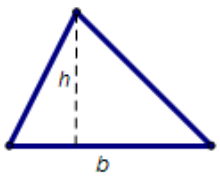
The licensor will:

1. Observe the room for any significant damage that may affect a resident's health or cause the room to not be homelike. For instance: chipped paint/exposed drywall, marred doors or doorways, damaged paneling, holes in walls, etc.
2. Observe the room for cleanliness. For instance: stains in carpets, dirty walls, fingerprints on doors, cobwebs, dust, etc.
3. Check all drawers and closets for unsafe items, and toxins which should be removed.
4. Windows:
   a. Measure the rooms windowsill height to ensure it does not exceed 44 inches from the floor.
   b. Measure the bedrooms window to ensure it has a minimum of 5.7 square feet opening unless it is a ground level floor window opening, which may have a minimum clear window opening of 5.0 square feet.
   c. In addition to the above minimum square footage, the egress window must have a minimum window opening height of 24 inches, and a minimum opening width of 20 inches.
   d. Check inside and outside of windows for any obstructions located above the windowsill like headboards or footboards, tall dressers, plants, or trees, etc. If there is more than one window in the room, at least one must be available for emergency egress.
   e. Check window coverings to ensure they open and close easily and allow for residents' privacy.
   f. Check window to ensure that it opens and closes easily and requires no key or tool to open. The window should be in good working order and should open without difficulty or getting stuck.
   g. Inspect screen to ensure it is securely installed and prevents the entry of insects.
   h. Check the window, track, and sill for cleanliness.
5. Lighting:
   a. Check to ensure lighting is adequate for the space.
   b. Check to ensure the fixture and bulbs are in good working order.
   c. All light sockets should have a light bulb.
6. Doors:
   a. Open and close doors to ensure they open and close easily and latch properly when shut.
   b. For existing door locks, ensure that the provider has an unlocking device nearby and is able to gain rapid access to the room when locked. Make sure the bedroom door handle does not have a lock on the outside where one could be locked in the bedroom.
   c. If the door does not have a lock, discuss with the provider the plan to ensure privacy.
7. Closets/Armoire:
   a. Inspect inside of closet for safety hazards.
   b. Make sure you are able to open the closet door(s) from the inside. For sliding closet doors this may mean having handles on the inside, or a stopper to prevent the doors from closing all the way.
   c. For sliding closet doors, ensure there are floor guides installed securely.
   d. Bi-folding doors do not require an inside door handle as you can just push the door open from the inside.

8. Smoke detector:
   a. Inspect the detector for damage and ensure that it is securely installed.
   b. Have the provider set off the smoke alarm to ensure it works properly and can be heard from the farthest point in the home. Smoke detectors must be interconnected.
9. Heat Source:
   a. Identify that the room has a heater in good working order.
   b. If there is an electric wall heater and/or cadet heater, check for a manufacturer's label which should identify how much distance must be left between the heater and flammable items such as the bed, nightstand, curtains, clothes, etc. Typically, the recommendation is a 3-foot allowance away from the heater. If the heating element is hot to the touch, a fire-resistant barrier must be installed to prevent access to the hot heating surface.
10. Utility Access in Bedrooms
    a. If there is an electrical panel, water shut off valve, access to a crawl space or attic through the bedroom in question, the provider must provide written notice to residents that these utilities are located in the bedroom and may need to be accessed.
    b. If there is utility access in the bedroom, the provider must ensure the resident(s) living in the room are unable to gain access to the utility to ensure their safety.
11. Measuring the room:
    a. First, measure the length and the width of the room, from baseboard to baseboard, excluding built in closets. Calculate the subtotal square footage of the room and record this information on the working papers.
    b. Second, determine if there is an armoire (used in lieu of a closet), door swing, vestibule or other unusable area in the room that must be subtracted. Measure this area, calculate the square footage and record on the working papers.
    c. Subtract the unusable square footage (calculated in B) from the room subtotal (calculated in A) to determine the usable square footage of this room.

> Note: Length in inches × Width in inches ÷ 144 = Square footage

Calculations: For 'Door Swings'			
Door Width in Inches = Sq Ft for ¼ of Circle Swing			
Dr Width"	Sq Ft ¼ Swing	Dr Width "	Sq Ft ¼ Swing
25"	3.41 Sq Ft	33"	5.94 Sq Ft
26"	3.69 Sq Ft	34"	6.30 Sq Ft
27"	3.98 Sq Ft	35"	6.68 Sq Ft
28"	4.28 Sq Ft	36"	7.07 Sq Ft
29"	4.59 Sq Ft	37"	7.47 Sq Ft
30"	4.91 Sq Ft	38"	7.88 Sq Ft
31"	5.24 Sq Ft	39"	8.30 Sq Ft
32"	5.59 Sq Ft	40"	8.73 Sq Ft

Triangular Area (calculate sq ft)
 A=1/2(**bh**)
Measure the base **(b)** of the triangle
Measure the height **(h)** of the triangle
Multiply the base by the height **(b x h)**
Divide this amount by two

12. Room Capacity, Configuration and Limitations:
    a. If the usable square footage of the room is 80 - 120 sq. ft. the room may be licensed for one resident as long as the configuration of the room allows for the placement of one bed.
    b. If the usable square footage of the room is 120 and above, the room may be licensed for two residents as long as the configuration of the room allows for the placement of two beds.

    > Note: The furniture must be able to be placed in safe locations in the room (i.e., beds may not be near electric heaters, dressers may not obstruct window openings, there must be adequate space to access the closet.)

    c. Some residents who utilize mobility aids for ambulation are unable to safely navigate through narrow doorways and walkways. If you identify a bedroom with a narrow doorway (less than 27" wide) or that can only be accessed through a narrow hallway (less than 27" wide) this bedroom will need to be limited to independent residents only.

Onsite Inspection-Bathrooms

The licensor will:

1. Inspect the configuration and size of the bathroom to determine the accessibility for those using mobility aids or needing standby assistance. If the bathroom is small and does not allow for unrestricted use by those residents using mobility aids or needing standby assistance, contact your Field Manager/Upper Management to determine if the bathroom will be licensed for Independent residents only. The initial licensing program reviews such scenarios with the Program Manager.
2. Inspect the bathroom for cleanliness and safety hazards, like toxins, area rugs, etc.
3. Doors:
    a. Open and close doors to ensure they open and close easily and latch properly when shut.
    b. For existing door locks, ensure that the provider has an unlocking device nearby and is able to gain rapid access to the room when locked.
    c. Check to ensure that nothing obstructs the provider's ability to open the door from the outside, such as vanity drawers that pull out in front of the door.
4. Water:
    a. Ensure that water measures between 105- and 120-degrees Fahrenheit.
    b. Ensure that the water runs clear/clean and is not rusty or dirty.
    c. Ensure that the aerator is in good working condition and does not spray water out of the sink.
    d. Make sure the sink drains properly.
5. Shower/Tub:
    a. Ensure that at least one grab bar is available in the bath, shower, or toilet.
    b. Check the floor of the shower/tub for a non-slip surface. A shower mat on the floor that rolls or moves easily underfoot is not safe and should not be accepted.
    c. If shower doesn't have a shower curtain have a conversation regarding how they will prevent water from getting on the floor and causing a slip/fall hazard.

6. Toilets:
   a. Check to see that there is a toilet paper holder within arm's reach of the toilet.

Procedure-After the Onsite Inspection

1. If the bedrooms or bathrooms meet licensing requirements, the licensor will:
   a. Update the floor plan and floor plan key to reflect the rooms previously and newly licensed. Include the room designation (A, B, C, etc.), the number of residents that can be in each room, and the assigned evacuation level of each room (Independent or Independent/Needing Assistance). Always be sure the floor plan and the key match.
   b. Review and have the applicant sign the Floor Plan Key contained in the AFH Electronic Working Papers. Email a copy of the Floor Plan Key to the applicant and keep a copy in the electronic licensing file folder.
   c. If the home's capacity has changed, note the home's new capacity on the floor plan and the key.
   d. If the newly licensed bedrooms will affect the provider's Medicaid Policy you should have reviewed the policy to ensure that no residents' rights are infringed upon, and the policy is in compliance with licensing requirements. If the policy did not meet requirements at the onsite visit, have the provider send in an acceptable policy before recommending that the additional rooms be licensed.
   e. If the home's capacity will change, either the licensor or the FM, based on your unit's protocol, will contact the BOAU to let them know that the new rooms have been licensed and the capacity of the home can be updated in FMS.
   f. If the AFH's capacity cannot be increased, the FM will notify the BOAU. The BOAU will send the AFH provider a denial letter and the ALTSA Finance and Accounting Unit will send a refund in 4-6 weeks.
   g. The provider cannot exceed their current licensed capacity until the BOAU has formally changed the home's licensed capacity. The BOAU will send the home a new license reflecting the change in capacity.
2. If the bedrooms/bathrooms do not meet minimum licensing requirements, document the items that do not meet requirements on the "Exit Summary Worksheet." Keep a copy of this form in the licensing file and give a copy to the provider. The provider will need to contact the licensor for another onsite inspection once the identified issues have been addressed.

Part III: Appendices

A. Resources

1. Professional Page for Providers
2. Definitions
3. Frequently Asked Questions

B. Forms

1. Inspection Forms

a. AFH Inspection Forms (DSHS 10-575)
b. Pre-Inspection Packet (DSHS 10-548)
c. Inspection Process & Records Request (DSHS 10-549)
d. Entrance Information & Observation (DSHS 10-550)
e. Staff List (DSHS 10-552)
f. Environmental Tour (DSHS 10-553)
g. Environmental Tour – Bedrooms (DSHS 10-554)
h. Resident Observations (DSHS 10-555)
i. Resident Record (DSHS 10-556)
j. Resident List (DSHS 10-551)
k. Resident Medication Review (DSHS 10-557)
l. Comprehensive Resident/Representative Interview (DSHS 10-558)
m. Condensed Resident/Representative Interview (DSHS 10-558A)
n. Administrative Records Review (DSHS 10-559)
o. Administrative Records Review Continuation (DSHS 10-559A)
p. Administrative Records Review-Former Staff (DSHS 10-559B)
q. Provider/Resident Manager Interview (DSHS 10-560)
r. Staff Interview (DSHS 10-561)
s. Exit Preparation Worksheet (DSHS 10-562)
t. Notes (DSHS 10-563)
u. Follow-Up Visits (DSHS 10-568)
v. Monitoring Visit (DSHS 10-684)
w. AFH Confidential Identifier List (DSHS 27-235)

2. Community Engagement Partner Forms

a. AFH Application (DSHS 10-410)
b. Request for Adult Family Home Application Fee Waiver (DSHS 15-436)
c. Disclosure of Services Form (DSHS 10-508)
d. Disclosure of Charges Form (DSHS 15-449)
e. AFH Information Change Form
f. Change in Licensed Bed Capacity Increase (DSHS 06-168)
g. Change in Licensed Bed Capacity Decrease (DSHS 06-169)
h. Adult Family Home Relinquishment Letter (DSHS 10-412)
i. Adult Family Home Notice of Transfer or Discharge (DSHS 15-456)

C. Glossary of Terms

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.

Agency – State agency.

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

Background check – means a name and date of birth check or a fingerprint-based background check, or both. WAC 388-113-0010.

Background Check Central Unit (BCCU) – means a division within the department that processes background checks for department authorized service providers and department programs who serve vulnerable individuals across Washington State. WAC 388-113-0010.

Character, competence, and suitability (CCS) – the screening and assessment of the potential personal and professional capability of an employee or applicant to work with or serve minor or vulnerable adults based on a review of crimes and negative actions. CCS requirements must meet those in WAC 388-113-0060.

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.

> Examples include health care staff not employed by the entity, family members, family friends, resident/client representative, legal guardian, law enforcement, or hospital staff.

Community programs – includes Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), and Enhanced Services Facilities (ESF).

Complaint – A report communicated to Residential Care Services' (RCS) Complaint Resolution Unit (CRU) by anyone NOT acting as an administrator or designee for a provider licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of property for one or more vulnerable adult. The complainant could be a vulnerable adult, a family member, a health care provider, a concerned citizen, other public agencies, or a mandated or permissive reporter. Report sources may be verbal or written.

Complaint investigation/investigator (CI) – An onsite visit that resulted from a complaint rather than a routine inspection. An RCS staff assigned to investigate a complaint received by the department.

Comprehensive interview, record review or observation – Involves pre-determined subject areas that licensors are required to look at during every inspection for selected individuals. It is in contrast to a focused interview, record review or observation that is in response to an identified issue or concern. Focused reviews are different for every inspection depending on the issues identified.

Consultation in AFH – Documentation of a first-time violation of statute or regulation with minimal or no harm to residents identified in an adult family home. Documentation of a consultation includes an entry made on the cover letter that consists of:

- a regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and
- a brief (2 – 4 sentences) statement 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. Documentation of a deficiency citation includes an entry made on the Statement of Deficiencies that consists of:

- The alpha prefix and data tag number for federal programs;
- The applicable Code of Federal Regulations (CFR) in federal programs;
- The applicable 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 relative to a regulatory requirement and to the extent possible, the resulting outcome.

Deficient practice statement (DPS) – A statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulatory requirement. Also commonly referred to as the "based on" statement.

Department – This term refers to the Washington state Department of Social and Health Services (DSHS).

eFax – is the use of the internet and email to send a fax (facsimile), rather than using a standard telephone connection and a fax machine.

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 388-112A WAC and WAC 388-76-10130.

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 regulations. 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 (e.g., 1 of 3). Please refer to definitions of scope and severity.

Fact – An event known to have actually happened. A truth that is known by actual experience of observation, interview, and review of records.

Focused interview, record review or observation – A focused review or interview involves a specific issue rather than a comprehensive review. You may look at it like the focused review is in response to an identified issue or potential issue. A comprehensive interview or record review covers many areas that are pre-determined.

Home – A generic term used to describe an adult family home in the State of Washington.

Household member – means a person who uses the address of the adult family home as their primary address and who is not a resident.

Identifier – The name, title, or letters/numbers referring to entity staff or those living in the residential setting within a Statement of Deficiency, following guidance contained within SOP Chapter 18 – Across All Settings and Principles of Documentation (POD).

Inspection – A generic term used to describe the process by which RCS staff evaluates a licensee's compliance with statutes and regulations. Complaint/incident investigations are only one type of on-site inspection/survey done to determine the health and safety of vulnerable adults in licensed or certified long-term care residential settings.

Last Date of Data Collection (LDDC) – The final date data was collected for the Compliance Determination (CD).

Licensee – A generic term to describe individuals or entities licensed or certified to provide services as an adult family home, assisted living facility, enhanced services facility, and/or nursing home care in the state of Washington.

Likely/likelihood – means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.

Minimal harm – means violations that result in little to no negative outcome or little or no potential harm for a resident.

Moderate harm – means violations that result in negative outcome and actual or potential harm for a resident.

Monitoring visits – A visit occurring after the last day of data collection to verify resident health and safety or compliance. Most monitoring visits are implemented due to an enforcement remedy but may be implemented at the Department's discretion. New information gathered during a monitoring visit, whether it is related to the cited failed practice, or a new deficiency will be reported to the CRU.

Noncompliance – means failure to meet one or more federal health, safety, and/or quality regulations.

Plan of correction – means an entity's written response to cited deficiencies that explains how it will correct the deficiencies and how it will prevent their reoccurrence.

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.

Proof of service – means notification sent to a provider by way of a declaration of personal service; an affidavit or certificate of mailing; a signed receipt from the person who accepted the certified mail or package delivery; or proof of fax transmission. Any of these methods confirms that notice was sent to a provider when the State is going to take action related to that provider. WAC requires notice be served for the following communications: Written Consultation, Statements of Deficiency, and Enforcement Letters.

Psychopharmacologic medications – the class of prescription medications, which includes but it not limited to antipsychotics, antianxiety medications, and antidepressants, capable of affecting the mind, emotions, and behavior.

Recurring/Repeated –

- 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 36 months for AFH, ALF, or ESF (24 months for CCRSS).
- 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 36 months for AFH, ALF, or ESF (24 months for CCRSS).

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.

Reporter (Complainant) – means the individual making the report of alleged abuse, neglect, financial exploitation, or other non-compliance with regulatory requirements to the CRU. Reporter types are *Public, Facility, State Employees, Law Enforcement or Anonymous*.

- **Public** – are generally residents or clients, family of residents or clients, Long Term Care Ombudsman staff, facility staff when it is clear they are not making an official facility report or are reporting as whistle blowers, hospital staff, and teachers.
- **Facility** – are generally facility or agency Administrators or other management staff making a report as the official "facility" or provider report, staff who leave the facility/agency phone number and give permission to call them back, staff who state they reported their call to the hotline to their management.
- **State Employees** – are generally DSHS staff who are making a report in the natural course of their job duties.

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

Resident representative – means either the resident's legal representative or the individual filing a complaint involving, or on behalf of, a resident.

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.

Scope and severity (S/S) – The effect of non-compliance on a resident (severity) and the number of residents actually or potentially affected (scope) by the entity's non-compliance. Illustrated in the deficient practice statement and supported in the findings.
Serious adverse outcome or **Likely serious adverse outcome** – means serious injury, harm, impairment, or death has occurred, is occurring, or is likely to occur to one of more vulnerable adult receiving care in a facility due to the facility's noncompliance with health, safety, or quality regulations.
Statement of deficiencies (SOD) – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date for the cited deficient practice. The SOD is a legal document available to the public on request.
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.
Unit leadership – means the individuals responsible for the activities of a designated unit. This can include Unit Managers, Program Managers, Field Managers, Field Services Administrators, and Regional Administrators.
Universe – The total number of individuals, records, observations, objects, related to the provider's/licensee's practice at risk as a result of a deficient practice. Used as the denominator when determining the extent of deficient practice.
Unsupervised access – means not in the presence of: • Another employee or volunteer from the same business or organization; or • Any relative or guardian of any of the children or individuals with a developmental disability or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization (RCW 43.43.830).
Volunteer – an individual who interacts with residents without reimbursement.
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.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

D. Acronym List

AA	Administrative Assistant
AFH	Adult Family Homes
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
BAAU	Business Applications and Analysis Unit
BCCU	Background Check Central Unit
BOAU	Business Operations and Analysis Unit
CC	Collateral Contact
CCS	Character, Competency and Suitability
CE	Continuing Education
CHOW	Change in Ownership
CI	Complaint Investigator/Investigations
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DOH	Department of Health
DPOA	Durable Power of Attorney
DPS	Deficient Practice Statement
DSHS	Department of Social and Health Services
EWP	Electronic Working Papers
FM	Field Manager
FSA	Field Services Administrator
HCBS	Home and Community-Based Services
HCS	Home and Community Services
HH	Household Members
HQ	Headquarters
I	Independent
I/A	Independent or Needs Assistance
ICTS	Instructor and Curriculum Tracking System
ID	Identification
IDR	Informal Dispute Resolution
IPC	Infection Prevention and Control
LDDC	Last Date of Data Collection
LN	Licensed Nurse (includes both RNs and LPNs)
LPN	Licensed Practical Nurse
MAR	Medication Administration Records
N/A	Not Applicable
POC	Plan of Correction
POD	Principles of Documentation
PPE	Personal Protective Equipment
RA	Regional Administrator

RCS	Residential Care Services
RCW	Revised Code of Washington
RIQAP	Residential Inspection and Quality Assurance Program
RN	Registered Nurse
SOD	Statement of Deficiency
SOP	Standard Operating Procedures
S/S	Scope and Severity
STARS	Secure Tracking and Reporting System
WAC	Washington Administrative Code
WD	Working Day

E. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/2024	• II.J. Capacity Increase 7 or 8 beds	Added expedited timeframes for capacity increases	To provide guidance to staff on the expedited process criteria	• MB R24-045
05/2024	• I.A. Pre-Occupancy	Section removed (moved to Chapter 11 in 02/2019)	Removed placeholder in chapter	• MB R24-045
05/2024	• FAQs	Section removed	To avoid confusion among staff by including potentially outdated guidance	• MB R24-045
09/2023	• Monitoring Visits	Section added	To provide staff guidance for this process	• MB R23-070
08/2023	• Licensing Additional Bedrooms/Bathrooms	Section added	To provide staff guidance for this process	• MB R23-061
03/2023	• Full Chapter	Chapter reformatted. Clarification for POCs when IDR is being requested. Requirement for sprinkler systems to be inspected annually removed.	Provide a more user-friendly document. Provide current and accurate guidance.	• MB R23-026
11/2020	• 12C8 Capacity increase • 12C7 Information changes	A new section was added to outline the process for a capacity increase. The previous procedure for capacity increase was removed from 12C7.	Passed legislation allows some adult family homes to increase their capacity to 8. These homes have additional requirements and must be inspected. This new section	• MB R20-136 • A staff training was conducted as part of the Statewide Community Call on 6/22/2020. • Staff were asked to use a draft for practice and provide feedback

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
				prior to final implementation.
10/2020	• 12B1 General guidelines	Added a requirement to fill out the working papers completely.	To ensure staff are reviewing every aspect required by the working papers, the working papers must be completely filled out.	• MB issued
7/2020	• 12B8 Observation of Care	Document which observations are required and which can be done as needed Document which residents must be observed and which can be observed as needed Reorganize information for clarity	To improve standardized practice across the state and to ensure essential observations are completed	• MB R20-086
4/2020	• 12B17 Inspection After Revocation or Suspension	Includes information about timelines for inspections when a home is appealing an order for suspension or revocation	To advise staff how to meet statutorily required timelines when under revocation or suspension order	• MB R20-051