Overview

Adult family homes, also known as AFHs, are residential homes that are licensed through Residential Care Services (RCS) to provide personal care for up to eight residents. Adult family homes 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:

A. Chapter 70.129 RCW - Resident Rights
B. Chapter 51.51 WAC - State Building Code
C. Title 42 §441.530 Home and Community-Based Setting
D. Chapter 74.34 RCW – Abuse of Vulnerable Adults
E. Chapter 388-113 WAC – Disqualifying Crimes and Negative Actions
F. 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 specific to Residential Care Services and are not covered by DSHS Administrative Policies.

Contacts

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Chapter Index

Part I: Adult Family Home Standard Operating Procedures

Back to top

Part I: Adult Family Home Standard Operating Procedures

1. Pre-Occupancy

The Standard Operating Procedures (SOPs) that RCS staff are required to follow when conducting pre-occupancy inspections, as part of the application process for opening an adult family home are found in Chapter 11, Residential Inspection and Quality Assurance Program.

Back to top Change Log

2. AFH Inspections Standard Operating Procedures

A. General Guidelines

Background

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

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

B. Pre-Inspection Preparation

Background

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 Facility Management System (FMS) and 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 will request the relevant files and review them.
   Note: Request and return of working papers to Central Files may be completed by the AA3.
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.

Field Manager Responsibility

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Quality Improvement Review

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Back to top Change Log

C. Entrance Onsite

Background

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.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:

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2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
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Quality Improvement Review

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Back to top Change Log

D. Tour

Background

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.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:

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Quality Improvement Review

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Back to top Change Log

E. Resident Sample

Background

Adult family homes 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.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:

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3. Request training or clarification from headquarters as needed.

Quality Improvement Review

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Back to top Change Log

F. Resident and Family Interview

Background

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. 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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

G. Provider and Staff Interview

Background

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.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:
1. Train new staff and ensure they can demonstrate they understand this procedure.
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3. Request training or clarification from headquarters as needed.

Quality Improvement Review

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Back to top Change Log

H. Observation of Care

Background

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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

I. Medication Services

Background

Adult family homes 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.

Field Manager Responsibility

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Quality Improvement Review

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Back to top Change Log

J. Food Service

Background

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.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:

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Quality Improvement Review

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Back to top Change Log

K. Abuse and Neglect Prevention Review

Background

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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

L. Resident Record Review

Background

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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

M. Staff Record Review

Background

The provider or entity representative is responsible for ensuring that all staff are competent and qualified for their positions. Qualifications range from tuberculosis 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 the field office.
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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

N. Exit Preparation

Background

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 the Chapter 7, Enforcement to establish the scope and severity 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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

O. Exit

Background

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.
9. Ensure there are no surprises for the provider and that all information about deficient practice was discussed prior to the provider receiving their Statement of Deficiency (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.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

P. Follow-up Visits

Background

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

FIELD MANAGER RESPONSIBILITY

Field managers 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, tuberculosis 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.

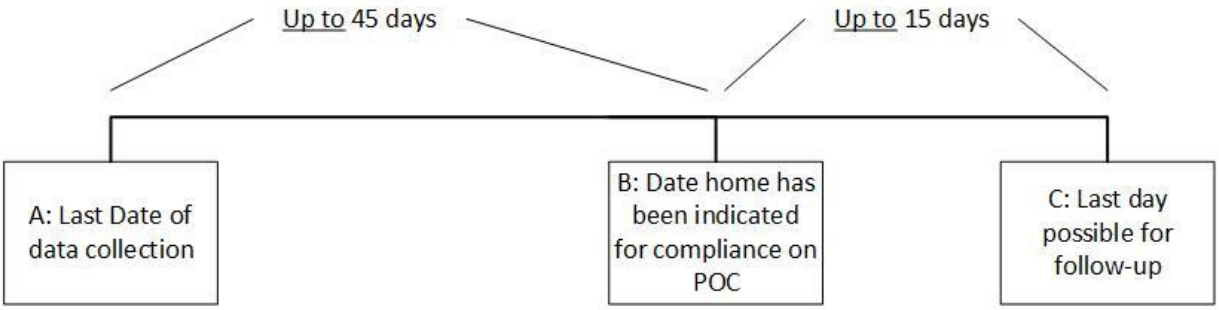
ON-SITE VERIFICATION

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 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 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 statements of deficiency (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 Compliance Specialist as needed and may require more than one follow-up visit.



The AFH has up to 45 calendar days (at the discretion of the department) from the last day of data collection to complete their corrective action. Completing a follow-up visit within 60 calendar days will allow the licensor 15 calendar days beyond the 45-day mark to make the follow-up visit. Best practice is for the licensor to conduct the follow-up visit between 1 and 15 days from the last date indicated for compliance on the POC/Attestation rather than take the entire 60 day period when possible.

2. Providers are not required to submit an attestation statement for citations they are disputing in Informal Dispute Resolution (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 Statement of Deficiencies 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 Statement of Deficiency writing processes for any follow-up visit resulting in uncorrected deficiencies.
8. Follow the FMS processes necessary to schedule and complete the follow-up visit.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

Q. Inspection After Revocation or Suspension

Background

RCW 70.128.070 states that the department shall conduct inspections at least every eighteen months on licensed adult family homes. 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 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 day after the enforcement action, if the AFH does not appeal the enforcement action.
   b. On the 29th 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 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 may conduct monitoring visits according to FM discretion. The FM must work with the Compliance Specialist, 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 may work with the Compliance Specialist 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 Chapter 20-Complaint Investigations.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

R. Change of Ownership (CHOW)

Background

A change of ownership of an adult family home 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 change of ownership (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 plan of correction (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 Analysis and Applications Unit (BAAU) 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 field staff will:
   a. Report any concerns relevant to the applicant and/or application to the BAAU as requested, prior to licensure.
   b. Determine the need to schedule an inspection after licensure.
   c. Follow the inspection processes for any inspection done.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

3. Additional AFH Standard Operating Procedures

A. AFH Licensing Fees

Background

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 Manager (or designee) will:
   a. Generate a list of AFHs with overdue accounts from the Facility Management System (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 Complaint Resolution Unit.
   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 Compliance Specialist for further follow up.
2. The Complaint Resolution Unit 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 Field Manager 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 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 Statement of Deficiencies (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 have not been received, recommend the FM refer the home for enforcement action based on uncorrected citations.

If payment has not been received:

FIELD MANAGER RESPONSIBILITY

1. Review the SOD and refer to the Compliance Specialist for imposition of condition requiring the provider to pay the full annual licensing fee within 15 days.
2. Work with the Investigator, Compliance Specialist, and Business Operations Manager to monitor the home for payment. Keep complaint open until confirming payment with the Business Operations Manager.

THE COMPLIANCE SPECIALIST WILL:

1. Review the SOD and enforcement recommendations.
2. Facilitate the enforcement process according to the following progression:
   a. 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.
   b. 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.
   c. If the licensing fees are not paid in full within 30 days of the stop placement order, a civil fine will be imposed of $100 per day until the fees are paid.
   d. 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.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

B. Facilities Relinquishing Medicaid (Under Construction)

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

C. Facility Volunteer Closure (Under Construction)

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

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

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

E. Nursing Duties (Under Construction)

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

F. AFH Information Changes

Background

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 Business Analysis and Application Unit (BAAU) 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 AFH central files.
2. Additional Bedroom Inspection Procedures:
   a. 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 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 BAAU.
   b. Once the FM receives an email from BAAU indicating the new number of licensed beds and the effective date, they will forward it to appropriate licensor.
4. Adult Family Home 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 field administrative support staff will send the AFH Facility Closure Checklist and supporting documentation to the Business Operations Unit Representative at headquarters.
   d. Business Operations Unit Representative will:
      i. Complete the "Headquarters" section of the AFH Facility Closure Checklist;
      ii. Consult with the compliance specialist to ensure there are no pending actions against the home;
      iii. Close the home in FMS; and either:
         - Forward the AFH Facility Closure Checklist and all supporting documents to Contracts if the home has a Medicaid Contract; or
         - File the AFH Facility Closure Checklist and all supporting documents in AFH central files if the home does not have a Medicaid Contract.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

AUTHORITY

- RCW 70.128.005
- RCW 70.128.007
- RCW 70.128.070
- RCW 70.128.090

Back to top Change Log

G. Capacity Increase

Background

A home 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 Business Analysis and Application Unit (BAAU), 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 (6) Beds or Fewer

Before coming to the field:

If the requested capacity is six (6) or fewer, the BAAU ensures the form is filled out completely and there are no errors. Once both of these requirements are verified, the BAAU forwards the form to the appropriate field office for inspection.

The Field Manager or their designee:

1. Receives the form and assigns the inspection to a licensor. If the request is made before the file has been transferred to the field team from Residential Inspection and Quality Assurance Program (RIQAP) after initial licensing, send the request to the RIQAP Unit Manager.
2. 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.

The Licensor must:

1. Review the floor plan on file for the home, the capacity increase form, and any other documents received from BAAU.
2. Check the file for any previous documentation from the Washington Association of Building Officials (WABO) or previous changes to the floor plan.
3. Review the home's facility summary and visit log in FMS.
4. 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.
    a. If the home had previously had the bedrooms that will be used by the additional residents inspected and approved by both WABO 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.
    b. If RCS records do not show evidence that the bedrooms had previously been inspected and approved by WABO, 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.

5. 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.
6. 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.
7. Once all the documentation is gathered, schedule a time for the inspection with the provider if an onsite visit is required.
   a. If the licensor has all of the necessary information, they may schedule the inspection during their first contact with the provider.
   b. 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.
8. Prepare for the onsite visit if required by completing any pre-inspection work and compiling the following documents:
   a. Two copies of the proposed floor plan.
   b. 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.
9. Assemble necessary supplies, such as measurement equipment, thermometer, etc.
10. 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.
11. Observe the bedrooms that will be used by the additional residents. Document any of the following:
    a. Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
    b. Any toxic or other unsafe substances or items that need to be removed or fixed.
    c. 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.).
    d. Any concerns about the lighting or available storage space.
12. 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.
13. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.

14. Review the data collected throughout the inspection process to determine if the applicant meets the Adult Family Home (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.
15. Before leaving the home, let the provider know one of the following:
    a. A recommendation will be made to approve the capacity increase and someone from BAAU will contact them about paying their additional bed fee;
    b. 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.
16. 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.
    a. 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.
17. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation from a Compliance Specialist, RA, Office Chief, or Division Director.

<u>If the capacity increase request will be approved:</u>

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

<u>If the capacity increase request will not be approved:</u>

1. If the capacity will not be increased, the FM or their designee will notify the BAAU 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 Compliance Specialist, RA, Office Chief, or Division 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. 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 sixty (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 sixty days have passed, if the home has not made the necessary corrections, send the file back to BAAU with the notification that the application is not approved.

4. The BAAU will create the notice to the applicant that the application is not approved.

Procedure-Capacity Increase to Seven (7) or Eight (8) Beds

Before coming to the field:

The BAAU processes the application fee, ensures the form is filled out correctly and there are no errors and verifies all of the required documentation is included. The entire application packet is then sent to a Compliance Specialist, who reviews the application to ensure the applicant meets the following qualifications required by the statute:

1. Home has no outstanding bed fees.
2. Home has been licensed for twenty-four months or more.
3. Home has been licensed for a capacity of six for twelve months or more.
4. Home has received two full inspections or more.
5. Home has not had any enforcement actions taken on the license for the period of the last two full inspections.
6. Home has given residents a 60-day notice.

If the Compliance Specialist finds that the home does not meet these criteria, they will send a notification to the BAAU that the application is void and cannot be accepted. If the Compliance Specialist can verify that the applicant meets all of these criteria, they will send a notification to the BAAU that the application can move forward. The BAAU will then send the application packet to the appropriate field office for inspection.

The Field Manager or their designee:

1. Receives the form and assigns the inspection to a licensor. If the request is made before the file has been transferred to the field team from Residential Inspection and Quality Assurance Program (RIQAP) after initial licensing, send the request to the RIQAP Unit Manager.
2. 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.

The Licensor must:

1. Review the floor plan on file for the home, the capacity increase form, and any other documents received from BAAU.
2. Check the file for any previous documentation from the Washington Association of Building Officials (WABO) or previous changes to the floor plan.
3. Review the home's facility compliance summary and visit log in FMS. Check for complaints or citations indicating a lack of financial solvency or insufficient staffing.

4. 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.
   a. If the home had previously had the bedrooms that will be used by the additional residents inspected and approved by both WABO and RCS, verify that RCS files reflect that the requested rooms have been approved.
   b. If RCS records do not show evidence that the bedrooms had previously been inspected and approved by WABO, 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.
5. 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.
6. 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.
7. Once all of the documentation is gathered, schedule a time for the inspection with the provider.
   a. Inform the provider that the local planning office needs to be contacted by RCS, following the process in the next section.
      i. Once the local planning office has been contacted, contact the provider again to schedule the inspection.
      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.
8. Prepare for the onsite visit by completing any pre-inspection work and compiling the following documents:
   a. Two copies of the proposed floor plan.
   b. 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.
9. Assemble necessary supplies, such as measurement equipment, thermometer, etc.
10. Conduct the onsite visit. Fill out the working papers completely.
11. Observe the bedrooms that will be used by the additional residents. Document any of the following:
    a. Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
    b. Any toxic or other unsafe substances or items that need to be removed or fixed.

c. 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.).
d. Any concerns about the lighting or available storage space.

12. 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.
13. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.
14. Review the data collected throughout the inspection process to determine if the applicant meets the Adult Family Home (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.
15. Before leaving the home, let the provider know one of the following:
    a. A recommendation will be made to approve the capacity increase and someone from BAAU will contact them about paying their additional bed fee;
    b. 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.
16. 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.
    a. 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.
17. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation from a Compliance Specialist, RA, Office Chief, or Division Director.

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

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 adult family home 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 WABO inspection form to determine what jurisdiction is appropriate.
d. If the local jurisdiction has not responded after five business days inclusive of the day the email was sent, send a follow-up email on the sixth business day. If they have not responded by the tenth business day, contact the provider on the eleventh business day to schedule the inspection. Document your attempts to contact the local jurisdiction on the working papers.
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.
f. Document any of the above variations on contacting the planning office on the working papers.

2. Review the additional documents received from BAAU:
   a. The licensor will verify the power, water, sewer, and sanitation bills have all been paid for the last six months as a measure of financial solvency. Note any questions you may have about these for the provider interview.
      i. The Compliance Specialist will verify the reason why any bill is missing before the file is sent to the field, such as if the home is on a septic system or does their own trash disposal. Licensors will document the information received on missing bills in the working papers.
   b. Review the attestation statement.
   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.
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 BAAU 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 BAAU 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 Compliance Specialist, RA, Office Chief, or Division Director.

Field Manager Responsibility

Field Managers 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 headquarters as needed.

Quality Improvement Review

The review for the accuracy and compliance of this procedure will happen at least every five years.

Back to top Change Log

Part II: Appendices

1. Glossary of Terms

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 that is licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of vulnerable adult property for one or more vulnerable adult(s)/vulnerable adult(s). 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 (CI) – An onsite visit that resulted from a complaint rather than a routine inspection.
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 in the home.
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 (1 – 2 sentences) statement summarizing the deficient practice.
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: 1) The applicable Washington Administrative Code (WAC) and/or the applicable Revised Code of Washington (RCW), 2) the language from that reference which pinpoints the aspects(s) of the requirement with which the home failed to comply, 3) an explicit statement that the requirement was "not met" and 4) the evidence to support the decision of noncompliance.
Deficient Practice – The action(s), error(s), or lack of action on the part of the provider/licensee relative to a requirement and to the extent possible, the resulting outcome.
Deficient Practice Statement – A statement at the beginning of the evidence that sets out why the provider/licensee was not in compliance with a regulation.
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.
Extent of Deficient Practice – The prevalence or frequency of a deficient practice.
Fact – An event known to have actually happened. A truth that is known by actual experience or observation.
Finding – A term used to describe each item of information found during the regulatory process about provider practices relative to a specific requirement cited as being not met.

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.
Initial Inspection – A generic term use to describe a process conducted by RCS staff in evaluating a prospective licensee for compliance with the statutes and regulations required for an Adult Family Home license or Boarding Home license.
Inspection – A generic term used to describe the process by which RCS staff evaluates a licensee's compliance with statutes and regulations. Types of inspections include licensing inspections, follow-up visits, complaint investigations, and monitoring visits.
Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the licensee or designee. Harm to vulnerable adults that is unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.
Requirement – Any structure, process, or outcome that is required by law or regulation.
Scope and Severity – The effect of the noncompliance on the resident (severity) and the number of residents actually or potentially affected (scope) by the provider's/licensee's noncompliance. Illustrated in the deficient practice statement and supported in the findings.
Statement of Deficiencies (SOD) – The official 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.
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.

Back to top Change Log

2. Acronym List

AA3	Administrative Assistant 3
AFH	Adult Family Homes
ALTSA	Aging and Long-Term Support Administration
BAAU	Business Analysis and Applications Unit
CCS	Character, Competency and Suitability
CFR	Code of Federal Regulations
CHOW	Change in Ownership
CG	Caregiver
CI	Complaint Investigations
CRS	Construction Review Services
CRU	Complaint Resolution Unit
DOH	Department of Health
DPOA	Durable Power of Attorney
DPS	Deficiency Practice Statement
DSHS	Department of Social and Health Services
e-CFR	Electronic Code of Federal Regulation
FM	Field Manager
FMS	Facility Management System
HQ	Headquarters
ICTS	Instructor and Curriculum Tracking System
ID	Identification
IDR	Informal Dispute Resolution
LPN	Licensed Practical Nurse
MAR	Medication Administration Records
N/A	Not Applicable
POC	Plan of Correction
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
STARS	Secure Tracking and Reporting System
UM	Unit Manager
WABO	Washington Association of Building Officials
WAC	Washington Administrative Code

3. Resources and Forms

A. Resources

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

B. Forms

1. AFH Application (DSHS 10-410)
2. Request for Adult Family Home Application Fee Waiver (DSHS 15-436)
3. Disclosure of Services Form (DSHS 10-508)
4. Disclosure of Charges Form (DSHS 15-449)
5. AFH Information Change Form
6. Change in Licensed Bed Capacity Increase (DSHS 06-168)
7. Change in Licensed Bed Capacity Decrease (DSHS 06-169)
8. AFH Inspection Forms (DSHS 10-575)
9. Adult Family Home Relinquishment Letter (DSHS 10-412)
10. Adult Family Home Notice of Transfer or Discharge (DSHS 15-456)

Back to top

Change Log

4. Frequently Asked Questions

AFH Working Paper FAQ

(Based on results from 2018 QA Process review)

1. **Why is it important to check all the relevant boxes?**
   Checking all the relevant boxes demonstrates that you have completed all parts of the inspection. If boxes are left empty, a reviewer does not know if that is because the corresponding item met requirements or if you failed to check that item. Funding for our program and our work depends on our ability to show we have completed our inspections according to our policies and procedures. If an item is not checked as completed, we have no way to prove that the inspection was completed properly, which could have negative consequences for our program.
2. **In some places, the only choices are "yes" and "no," which can be confusing if the answer is neither. For example, on the Environmental Tour form, under "Barrier around water hazard," if there is no water hazard, do I put "no" because I see neither barrier nor water hazard, or "yes" because there is no issue with a barrier around a water hazard?**
   The questions are intended to mean "yes, the home is in compliance," or "no, the home is not in compliance." A no means there is a problem regarding a water hazard or its barrier. If there is no finding, you may check "yes." If the home has no water hazard, write "N/A" and put "no water hazard" in the notes.
3. **Where do we need to note the time in the working papers?**
   Note the time of entrance on the Entrance Information and Observation form, time of temperature checks on the Environmental Tour form, and in each box next to your observations on the Resident Observation form.
4. **What should I put on the Residential Observation form if I don't have any observations for a particular section (for example, I did not see any interactions or activities while I was there)?**
   Write N/A.
5. **What questions from the Provider Interview form need to be asked with answers documented during the Provider interview?**
   All questions on the Provider Interview form are required and must be asked with answers documented.
6. **What should I do about the Staff Interview form if there are no staff present while I am on site?**
   If no staff are available during the inspection, obtain contact information and worktime availability for at least one staff member and call them for an interview. This interview may be conducted while they are on duty at the home or in their off time if they request to be interviewed when they are not on duty. Only one staff member must be interviewed. Document each attempt at contact. If you are unable to contact a staff member after three attempts, you may mark this on the Staff Interview form and stop attempting to contact.
   There is no expectation that either AFH staff or licensing staff be required to work outside their normal working hours. For this reason, if the only option for contacting a staff member at work would require a licensor to work when they are not normally scheduled or to contact an AFH staff

member when they are not working (unless they have specifically requested it), note this in the working papers and skip the staff interview.

7. **What about if there are no staff, and the provider is the only staff person?**
   If the home has no staff other than the provider, the staff interview is not required. Write "home has no staff other than provider" on the Staff Interview form.
8. **What questions are required to be asked during a comprehensive interview of the sampled resident/representative?**
   All of the questions in Part A of the Comprehensive Resident/Representative Interview form are required. In addition, you must ask a question that addresses each of the categories in Parts B-K. You may use a sample question or create your own.
9. **Do I need to do representative interview?**
   You must conduct at least one representative interview. You must conduct two representative interviews only if both residents are not interviewable. If you were able to conduct a comprehensive interview with both sampled residents, you still need to attempt to contact at least one representative and conduct an interview. However, you may conduct a condensed interview of only a few general questions.
10. **How do I document that I wasn't able to reach a representative by phone?**
    Document each attempt to contact the representative. If you are unable to contact them within three attempts, write "unable to reach a representative" in the comments box.

Back to top Change Log

5. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
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 issued 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 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	To improve standardized practice across the state and to ensure essential observations are completed	• MB issued R20-086

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		Reorganize information for clarity		
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 issued R20-051
7/2019	• 12B6 Resident and Family Interview	Clarified that there are different types of interviews, when to use them, and with whom to conduct them	Clarify the procedure for better staff understanding and consistency	• MB issued R19-053
7/2019	• 12C7 AFH Information Changes	Changes SOP was created but never added to the Chapter	To advise staff on forms and resources for changes in an AFH	• MB previously issued R17-053
7/2019	• 12C1 AFH Licensing Fees	Update procedure for communication between Business Operations and the field; update names of reports used	This chapter had not been updated in several years and the practices were out of date	• MB issued R19-050
3/2019	• 12B1 General Guidelines	Timeline for inspections changed from every 18 months to by the end of the 18th month	The previous version did not specify whether inspections can happen in the 18th month	• MB issued R19-031
3/2019	• 12B16 Follow-Up Visits	Clarified the requirements around timelines for follow-up inspections	The previous timeline did not allow enough flexibility for licensors to make follow-up visits	• MB issued R19-023
2/2019	• 12D3 Frequently Asked Questions	Created an FAQ section to clarify issues that staff commonly have		• MB issued: R19-013

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		issues with or questions about		
2/2019	• 12B13 Staff Record Review	Outlined requirements for verifying CE credits for AFH staff	Required by CMS for Medicaid waiver	• MB issued: R19-003 • PowerPoint created by HCS
2/2019	• Overview	Updated contact information for the policy program manager	The AFH PPM changed	• None required
2/2019	• 12A Pre-Occupancy	Noted that this section is in a different chapter	The RIQAP has its own chapter	• None required
9/2016	• 12B16 Follow Up Visit	Nothing	Converted SOP to Chapter Format	• MB Review
6/2016	• Full Chapter Update	Clarifications Formatting Edits Addition to/of Sections	• Minor changes in formatting; Addition of Sections	• Repost on SOP Manual site
6/2016	• 12B1 General Guidelines	Added **#4** (reasonableness) to outline section **B**. **Licensors will:**	Staff Requested clarification when it may be reasonable a requirement is not met.	• **MB issued:** R16-042Posted online for staff review •
6/2016	• 12B2 Prep – Off site			•
3/2016	• Full Chapter Update	All SOPs, forms & resources are captured in a formal RCS Chapter format	To ensure all staff are familiar with all processes; To comply with Director mandate.	• **MB issued:** R15-069 • Mandatory on-line AFH Procedure training • Posted for employee review
2/2016	• 12B6 Resident/Fam Interview	Added the requirement to ask specific questions listed on the Resident Interview Form	Mandatory questions per HCBS/CMS regulation	Posted online for staff review • **MB issued:** R16-021
11/12/2015	• 12B13	Updated form names (working	The AFH "working papers" required to	Posted for on-line review

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	Staff Record Review	papers) and added the DSHS #s. Rephrased the paragraph explaining background check sample. Included language to compare the new employee list to the old employee list with a note explaining why it is important.	have DSHS form numbers. Audit findings require we check all background checks. Request from the field to provide clarity and add info to compare the old list to the current was requested.	• **MB Issued** R15-072 On-line background check training • **MB issued** R15-076 Mandatory on-line AFH Procedure training. • **MB issued** R15-079
11/13/2015	• 12B2 Prep – Off site	Updated all the form titles and added their new DSHS numbers Added a step that involves printing the resident and staff list from the previous inspection Added information on checking for the Disclosure of Services Form Updated Director's name on OPP	Form was updated and published Prevents residents from being selected in sample 2 yrs in a row. SB5630 requires AFHs complete 2 disclosure forms RCS has a new director	Info posted for on-line review. • **MB issued R15-072**
1/27/2014	• 12B8 Observation of Care	Clarification that only a licensor who is a licensed nurse can observe care where resident privacy must be protected.	Staff requested clarification	• **MB issued:** R14-003

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1/27/2014	• 12B6 Resident/Fam Interview	Clarification about: who to interview interpreter services during family interviews	Staff expressed confusion in these areas	• **MB issued** R14-003
5/2011	• 12B13 Staff Record Review	Last update prior to chapter conversion		•
5/2011	• 12B17 Change of Ownership (CHOW)	Last update prior to chapter conversion		•
5/2011	• 12B7 Provider/Staff Interview	Last update prior to chapter conversion		•
5/2011	• 12B5 Resident Sample	Last update prior to chapter conversion		•
5/2011	• 12B3 Entrance On-Site	Last update prior to chapter conversion		•
5/2011	• 12B2 Prep – Off site	Last update prior to chapter conversion		•
5/2011	• 12B1 General Guidelines	Last update prior to chapter conversion		•
6/2010	• 12B4 Tour	Last update prior to chapter conversion		•
6/2010	• 12B8 Observation of Care	Last update prior to chapter conversion		•
6/2010	• 12B12 Resident Record Review	Last update prior to chapter conversion		•
6/2010	• 12B11 Abuse & Neglect Prevention	Last update prior to chapter conversion		•
6/2010	• 12B10 Food Service	Last update prior to chapter conversion		•

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6/2010	• 12B9 Medication Services	Last update prior to chapter conversion		•
6/2010	• 12B16 Follow-up Visits	Last update prior to chapter conversion		•
6/2010	• 12B15 Exit	Last update prior to chapter conversion		•
6/2010	• 12B14 Exit Prep	Last update prior to chapter conversion		•

Back to top