Overview

An assisted living facility (ALF) is a community setting licensed by the Department of Social and Health Services (DSHS) to care for seven or more residents. There are currently over 500 ALFs in Washington State. The majority are privately-owned businesses. ALFs provide housing, basic services, and assume general responsibility for the safety and well-being of the resident.

ALF residents live in a community setting while receiving necessary services from staff. ALFs can vary in size and ownership from a family-operated 7-bed facility to a large facility operated by a national corporation. Some ALFs provide intermittent nursing services and may serve residents with mental health needs, developmental disabilities, or dementia.

ALFs are required, by law, to be inspected at least every 18 months, in addition to complaint investigations. If a home is not in compliance with licensing requirements, DSHS enforcement actions range from civil fines to license revocation.

This chapter contains information about the licensing standards and other topics related to assisted living facilities. The content is relevant to Residential Care Services (RCS) staff, assisted living facility owners and administrators, and anyone seeking to understand how assisted living facilities are regulated.

ALFs must comply with the following Washington Administrative Code (WAC) and Revised Code of Washington (RCW) chapters:
Chapter 18.20 RCW - Licensing Statute
Chapter 70.129 RCW - LTC Resident Rights Statute
Chapter 74.34 RCW - Abuse of Vulnerable Adults
Chapter 388-78A WAC - Licensing Rules
Chapter 388-110 WAC – Contracted Residential Care Services
Chapter 388-112A WAC - Residential Long-Term Care Services
Chapter 388-113 WAC: Disqualifying Crimes and Negative Actions

RCS partners with the following state agencies and associations to develop ALF regulations and policies:
Department of Health – Construction Review Services (CRS)
Department of Health – Food Safety
Department of Health – Infection Control Assessment & Response (ICAR)
LeadingAge of Washington (LAW)
State Long-Term Care Ombuds Program (LTCOP)
Washington Health Care Association (WHCA)
Washington State Local Health Jurisdictions – Washington State Department of Health
Washington State Patrol – Office of State Fire Marshal (OSFM)

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

Contacts

- RCS Policy Unit: RCSPolicy@dshs.wa.gov
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Part I: ALF Standard Operating Procedures

A. ALF Inspection Procedures

1. General Guidelines

Purpose

The purpose of conducting ALF licensing visits is to verify facilities are meeting or continuing to meet the minimum licensing standards as defined in Chapter 18.20 RCW and Chapter 388-78A WAC. The primary focus should be on residents' rights, safety, and well-being.

This procedure provides background information about the general purpose and timing of ALF inspections.

Procedure

Inspection Frequency

a. RCS conducts unannounced inspections in ALFs at least every 18 months. Licensors will not disclose the planned date of the inspection to anyone except the fire marshal.
b. RCS may inspect a facility every 24 months if the ALF has had:
   1) No citations for the past three consecutive inspections; and
   2) No citations during the same period of time from complaint investigations.
c. The field manager (FM) will schedule the inspections to be unpredictable with the average inspection interval being 13-15 months.
   1) If a facility has known problems, the inspections should be done between 9-12 months.
   2) If a facility has a positive history, inspections are done between 16-18 months.
d. The FM has authority to require early inspections if problems are identified.

Inspection Timing

The team should vary the timing of the inspection by scheduling the entrance at various times of the day and days of the week to increase unpredictability and to observe different aspects of resident care. For example, the team may enter after lunch and stay into the evening to observe dinner and care provided by evening staff or the team may enter on a different day of the week from the last inspection.

The Licensors will:

a. Follow the current written standard operating procedures (SOP) and use the current version of the associated forms, following the instructions provided on them, to ensure that inspections are done in a consistent manner and focus primarily on actual or potential resident outcomes.
   1) When completing the forms, use the allocated check boxes or comment sections when applicable.

2) Denote a line-out or "N/A" if that specific section is not applicable.
3) Use the notes section on forms when the checkbox does not apply but information can be provided to show that the specific information was reviewed.
4) If additional space is needed for documentation of any process, use Attachment L: Notes/Worksheet.

b. Attempt to minimize the disruption of the residents' routines during the inspection.
c. Communication with the administrator:
   1) Observations and concerns throughout the inspection, including when they are in compliance with the regulations and when they have not met the requirements.
   2) Do not include issues that would impede the licensors' ability to determine failed practice if communicated.
   3) Licensors may tell administrators if something that they plan to do would appear to help them meet the regulations or not.
   4) Licensors should not provide technical assistance or best practice information on how to implement the regulations or correct the deficiencies.

> Note: throughout this document, the term "administrator" will also refer to the administrator's designee.

d. Share information with other licensors on the team regarding concerns identified during various stages of the inspection.
e. Data collection:
   1) Data collection during inspections consists of observations, interviews, and record reviews.
   2) Data is:
      a) Collected in a factual and objective manner.
      b) Not affected by assumptions and personal opinions.
      c) Collected in a timely and efficient manner.
      d) Collected to determine failed practice which could result in citations and enforcement.
   3) Use observations and interviews to determine the facility's compliance with licensing rules.
   4) Use record reviews to validate concerns identified by observation and interviews.
   5) Observations:
      a) Form the basis of the most defensible citations.
      b) Are an important part of data collection.
      c) Are critical to either substantiate or rule out information obtained through interview and record review.
      d) Generally require the gathering of additional information from more observations, interviews, and record review to clarify or verify.
      e) By themselves, do not always determine failed practice. Failed practice must be backed by at least two sources of data.
   6) Timely data collection is important. Delay in data collection may negatively impact the department's ability to cite or impose enforcement.

f. Resident rights:
   1) Monitor staff and residents throughout the inspection using observations and interviews for resident rights' issues including but not limited to:
      a) Right to refuse
      b) Choice
      c) Dignity
      d) Quality of life
      e) Communication
      f) Behaviors
      g) Timeliness
      h) Identified needs being met.

Contact the FM immediately if:

a. There is danger or harm to residents and immediate enforcement may be needed.
b. If there is any evidence that residents may be alone in the facility.
c. Someone is impeding the inspection.
d. There is a current or potential infection outbreak.

Contact the FM while on-site if:

a. The timeframe of the licensing visit will likely need to be extended.
b. Licensors are unsure of how to proceed.

Field Manager Responsibility

FMs are to conduct the following activities in relation to this procedure:
a. Train new staff and verify they can demonstrate they understand this procedure.
b. Conduct periodic reviews of this procedure with staff.
c. Request training or clarification from headquarters as needed.

2. Abuse Prevention Review

Purpose

The primary focus of this section is to verify the ALF has policies and procedures which are compliant with regulatory and statutory requirements for mandated reporting, investigating allegations of resident abuse, and protecting residents from harm. This includes observations of suspected or actual abuse or neglect made during any part of the licensing visit.

For the purposes of this chapter, the term "abuse" includes neglect, financial exploitation, improper use of restraint, and abandonment.

> Note: For definitions of abuse, refer to Glossary.

Procedure

Licensors will:

a. Remain alert throughout the visit for indicators of possible abuse.

b. Document information related to any suspected or actual abuse. Potential indicators may be found:
   1) During environment observations.
   2) While conducting interviews.

   > Note: See Resources for specific examples of potential abuse, a link to Key Triggers which may indicate abuse, and sample questions to ask during interview.

c. During administrator and staff interviews, verify understanding of abuse and what to do if abuse is suspected or witnessed. This includes staff understanding of:
   1) Financial exploitation, physical, mental, and sexual abuse.
   2) Steps to take in the event of suspected abuse.
   3) Notification and reporting requirements as described in the ALF's policies and procedures.

d. Request the facility's incident investigation report if you become aware of a probable or actual incident, injury, or accident since the last inspection to determine if:
   1) Mandated reports have been submitted as required by state mandated reporting laws; and
   2) The provider has taken appropriate action to protect residents' safety.

e. Verify mandated reporting postings including the department toll-free complaint number contact and long-term care ombuds.

f. If abuse is suspected or identified, the licensor's first responsibility is as a mandated reporter. Licensors will:
   1) Immediately notify the Complaint Resolution Unit (CRU) by email (cru@dshs.wa.gov), with a cc (carbon copy) to the FM.

2) Contact the FM if any of the following situations occur:
   a) If possible resident abuse or neglect is occurring during the visit.
   b) If the investigation will extend the timeframe of the licensing visit.
   c) If unsure how to proceed.
   d) If investigation should be conducted immediately.
   e) If immediate enforcement may be needed.
   f) If a nurse is needed and a nurse is not on the team.
   g) If law enforcement (LE), Adult Protective Services (APS), or both should be notified for purpose of conducting a joint investigation.
3) Immediately notify LE if:
   a) There is reason to suspect sexual assault has occurred.
   b) There is reason to suspect physical assault has occurred.
   c) There is reason to believe that an act has caused fear of imminent harm.
4) LE does not need to be notified for an incident of physical assault between two residents that causes minor bodily injury and does not require more than basic first aid unless:
   a) Requested by the injured resident/legal representative or family member.
   b) The injury appears on the back, face, head, neck, chest, groin, inner thigh, buttock, genitals, or anal area.
   c) There is a fracture.
   d) There is a pattern of physical assault between the same residents.
   e) There is an attempt to strangle a resident.
5) If resident safety issues were identified during the inspection, verify the areas of concern are addressed before conclusion of the on-site visit.
   a) The FM may ask the administrator to submit a plan to address the safety concerns and provide safety and protection to the resident(s) when imminent risk of harm or actual harm has been identified.

3. Pre-Inspection Preparation & Activities

Purpose

To gather and analyze information regarding the ALF off-site prior to entrance.

Procedures

a. Establish roles and responsibilities including a team coordinator, a facilitator for the resident group meeting, and the team member responsible for conducting the food service task.
b. Identify residents for care and service issues that could be included in the resident sample.
c. Assemble current forms for recording data during the inspection.
d. Assemble supplies that may be needed prior to inspection such as: thermometer, dishwasher temperature strips, hair restraints, tape measure, calculator, paper, and pen, RCWs and WACs pertaining to ALFs, and signs announcing the inspection and the resident group meeting.
e. The process for gathering the pre-inspection information includes:
    1) Review of pertinent documentation on the ALF history since the last full inspection:
        a) Print out licensee summary and room list from the tracking system.
        b) Review tracking system for compliance history, number of licensed beds, contracts, current exemptions, and uncorrected citations since the last inspection, follow up visits, or complaint investigations.
        c) Identify any reported changes to the ALF since the last full inspection, such as change of administrator, change of owner (CHOW), Department of Health (DOH) approved new construction, contract changes or other information that would impact resident care and services.

        Note: For DOH approved new construction project reports, go to Construction Review Services.

        d) Review all Statements of Deficiencies (SODs) and enforcement actions since last full inspection for compliance history and identify deficiencies cited or consulted.
        e) Identify and document any patterns of recurring or isolated deficiencies and attestation of correction.
        f) Review all complaint investigation reports including the quality review complaints since last full inspection and identify any open complaints yet to be investigated. Note resident and staff names and other contacts referenced in the reports.
    2) Complete the pre-inspection preparation form (Attachment A: Pre-Inspection Preparation).
    3) Review Infection Prevention and Control (IPC) Inspection Tool (DSHS 13-939) and identify and review National and State IPC standards, rules, and definitions applicable to the setting, identify if there is a reported communicable disease outbreak in the facility, and determine if Personal Protective Equipment (PPE) is needed.

f. Identification of any state contract. If a contract exists and if a concern is identified, licensors may contact the case managers (Home and Community Services [HCS]/Developmental Disabilities Administration [DDA]) prior to the inspection.
   1) Note names of identified residents receiving case management, the last time the case manager was in the ALF, and any area(s) of concern.
   2) Focus on care, quality of life, and any concerns.
   3) Do not discuss the upcoming inspection date.
g. Consult with other RCS staff who have been involved with the facility if there are any historical or current issues.
h. Review the Office of the State Fire Marshal (OSFM) reports in the shared folder since the last full inspection for compliance history.
i. Review the notes from the quarterly regional RCS/ombuds meetings in the shared folder and review any concerns brought up about the facility with the FM.
j. Contact the FM if concerns exist that would require a registered nurse (RN) if there is not one on the team.

4. Entrance On-site

Purpose

To initiate the inspection of the ALF, to provide information to facility staff about the inspection, and to collect initial data regarding the residents, staff, and the physical environment. The way RCS initiates contact with the administrator, staff, and residents will set the tone for the rest of the inspection. Always be respectful and allow the staff and administrator time to ask questions.

Procedures

Entering the ALF:

a. For a small ALF in a residential house setting, knock on main entrance door or operate doorbell.
b. For a large ALF setting, enter the main entrance and go to the reception desk or lobby area to locate staff.
c. If the person who is available at the entrance is not the administrator, request that they notify the administrator that a full inspection is occurring, and that the full inspection will not be delayed until the administrator arrives.
d. If there is no answer or no staff appear at the entry, evaluate the situation:
    1) If a resident answers the door or residents are observed from the entry way, make introductions, and inquire about staff in the ALF.
    2) If there is any evidence that residents may be alone in the ALF, immediately contact the FM for further instructions.
    3) If it appears no one is in the facility:
        a) Call the listed phone number for the ALF.
        b) If no response, call any alternate phone numbers.
        c) If no response, wait outside and try entrance again in 15 to 30 minutes.
        d) If still no response, contact the FM.
e. If denied entrance:
    1) Clearly re-state reason for visit.
    2) If speaking to a person other than the administrator, request they contact the administrator.
    3) If still denied entrance, leave, and contact the FM immediately.

Upon entrance:

a. Make introductions to the administrator and provide a business card for the licensors and FM. Have department nametag or state identification card visible throughout inspection.
b. Give the administrator a reasonable amount of time to complete whatever task with which they were involved before beginning the entrance conference.
c. If waiting, use the time to observe the residents and the immediate environment. Make introductions to any residents or staff in the area and explain the reason for the visit.

d. Request a place for the licensing team to work that does not intrude on or interrupt the daily activities but provides an opportunity for ongoing resident observations. This place should include access to a power outlet and a means to secure belongings and/or RCS equipment.
e. Inform the administrator that they can expect frequent contact during the inspection to gain and share information.
f. Contact the Administrative Assistant 3 (AA3) and/or the FM after arriving onsite. The AA3 will notify the ombuds of entrance.
    1) AA3 staff will email the ombuds that the licensing team has entered the building.
    2) Ombuds office may send an aggregate list of complaints going back one year for the team's awareness.
    3) If sent, the licensing team will review the list of ombuds complaints for patterns or concerns to follow up on during the inspection.
g. At all times during the inspection, minimize disruption of resident and facility routines as much as possible. Adjust procedures of the inspection accordingly; however, do not delay the process. If unable to do a certain inspection task, use the time to do another task of the inspection.

Entrance Conference:

a. Explain that the first step will be a guided tour of the facility and any other areas accessed by the residents.
b. Request a contact person for the facility if the administrator will not be present at any time during the inspection.
c. Provide the administrator a written list of documentation needed (Attachment B: Request for Documentation) and emphasize the timelines for requested materials.

> Note: The facility is not required to complete Attachment D: Resident Characteristics Roster (since requirements for a facility to complete a DSHS form must be in WAC). If the facility does not return the completed Attachment D within two hours of entrance, encourage use of the form by:
> 1. Verifying the administrator knows how to access the form (online or by contacting the department).
> 2. Explaining that the form serves as an informational tool for the facility staff by providing valuable information about each resident and their needs.
> 3. Explaining that presenting the form in a timely manner helps expediate the inspection. The facility can choose to provide the same information on their own form.

d. Ask the administrator to describe any special features of the facility pertaining to resident care and services.

> Example: Are there any changes since the last inspection? Anything new you would like us to know about?

e. Discuss the upcoming resident group meeting with the administrator and establish a location and time for that meeting.
   1) Inquire if the ALF has a resident council and identify the president or leader, if applicable.
   2) Ask the administrator to post the Resident Meeting Poster notifying residents of the ongoing inspection and announcement of the resident group meeting.
      a) Notifications should be placed in conspicuous locations throughout the building.
      b) If the group meeting is occurring after a meal, ask the administrator to announce the meeting to residents during the meal.

f. Observation of a meal may require an adjustment in the order of inspection tasks. For example:
   1) If a meal is occurring at time of entrance or tour, licensors will conduct general observations if more opportunities will occur during the inspection to observe dining.
   2) If no other meal observations will occur or many residents will be out of the ALF during other meals, the team coordinator will inform the administrator that the entrance conference or tour will be postponed in order to conduct a meal observation at that time.

g. Proceed with the tour.

5. Approved Sleeping Room List

Purpose

To provide guidance on how up-to-date approved sleeping room information is maintained by RCS and verified during each licensing visit.

Procedure

Licensors will:

a. At Entrance, provide administrator with the room list printed during pre-inspection preparation.
b. Request the administrator match it with their Resident Characteristics Roster and confirm which rooms have an Assisted Living (AL) resident.

> Note: If the facility reports not notifying CRS of the construction, cite the facility on the unmet requirement and instruct the facility to follow up with CRS.

STARS Facility Features definitions:

a. 'Licensed Bed Capacity' as defined in WAC 388-78A-2020 means the resident occupancy level requested by the licensee and approved by the department. All residents receiving domiciliary care, or the items or services listed under general responsibility for the safety and well-being of the resident as defined in this section count towards the licensed resident bed capacity. Adult day service clients do not count towards the licensed resident bed capacity.
b. 'Reported Beds' are the beds in each room that have an AL resident as identified by the administrator. It is reported as '0' if there is no AL resident in the room.
c. 'RCS Approved Beds' are beds that were approved to have met the licensing requirements under Chapter 388-78A WAC but were not licensed at the time of construction. 'Approved' rooms refers to rooms that were licensable at the time of construction by CRS. Since building codes change every three years, and facilities make modifications both unreported and reported to CRS, it cannot be assumed that these rooms automatically meet minimum licensing requirements when the facility requests licensure of a room.

The approved room list will be verified and updated into the Secure Tracking and Reporting System (STARS) 'Facility Features.' It is required to have it updated in STARS prior to approving a SOD and is included when the SOD is sent to the administrator.

6. Infection Prevention and Control

Purpose

The 2020 COVID-19 Public Health Emergency (PHE) highlighted the need for effective Infection Prevention and Control (IPC) in long-term care (LTC) settings. IPC assessments are a part of every inspection. This process provides licensors with tools and guidance to adequately assess LTC setting infection prevention and control systems and practices.

Procedure

a. DSHS Form 13-939
   1) Completed for all licensing inspections in Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities.
   2) The Centers for Disease Control and Prevention (CDC) Standard Precautions and Transmission-Based Precautions are the nationally accepted standards for IPC practices in LTC settings.
   3) The tool is used to assess the LTC setting application of CDC standards during the licensing visit.
   4) The tool includes areas for documentation of IPC observations, interviews, and record reviews.

b. DSHS Form 13-944
   1) Used in *addition* to DSHS Form 13-939 as a supplemental documentation tool when needed.
   2) Completed DSHS Form 13-939 **must always** accompany supplemental documentation tool.

> If unsure how to complete the IPC Assessment Tool, staff may consult with the Field Manager (FM). The IPC Notes form is used if more space is required for additional documentation or notation.

   3) Review the Resource Links listed at the bottom of DSHS Form 13-939 during pre-inspection preparation.
   4) Prepare to carry sufficient PPE for any Transmission-Based Precaution events (airborne, contact, droplet).
   5) Upon entrance, determine if there is a communicable disease outbreak in the setting.
   6) If a communicable disease outbreak is present in the setting, consult the Field Manager prior to initiating full inspection, and don appropriate PPE as directed or indicated.

7. Tour

Purpose

To allow licensors to inspect the physical environment and provide opportunity to meet residents, observe care, and note any quality of life or safety concerns. Informal interviews that occur during the tour may lead licensors to concerns that would otherwise not be identified by record review or observations.

Procedures

Licensors will:

a. Tour the ALF as a team with the administrator. If the ALF is large and there are multiple staff available who are knowledgeable about the building and residents, split the tour tasks (e.g., kitchen, laundry room, storage areas, etc.) among team members. Do not tour the facility without accompanying staff.
b. Conduct observations of residents, interior and exterior environments, intermittent nursing services if applicable, and required posting of information.
c. Document tour information on Attachment I: Environmental Observations.
d. Refer to Attachment N: Contract Requirement and Attachment O: Environmental Observations – Contract Requirements for specific structural requirements for each state contract, if applicable.
e. Refer to the resident list Attachment C: Resident List or facility list for identification of residents and their room location during the tour.
f. Use Attachment M: Exit Preparation Worksheet throughout the inspection as a guide and tool for exit preparation.
g. Use the observations and conversational interviews during the tour to identify residents for the preliminary resident sample selection.

Observations During the Tour:

The tour is the opportune time to observe residents and their physical environment early in the inspection. If environmental issues are identified during the tour, licensors will have more time to conduct in-depth observations throughout the inspection.

a. Resident observations:
    1) Identify any residents who express concerns or appear to have unmet or special care and service needs.
    2) Determine if residents identified in the pre-inspection preparation are residing in the ALF.
    3) Observe the general appearance of residents, including grooming and dress.
    4) Observe staff to resident interaction related to quality of life, dignity, privacy, and responsiveness to resident needs, including verbal communication, eye contact, and touch.
    5) Observe residents' response to staff.
    6) Observe an open resident room if the resident permits.

7) Notify residents during the tour of the upcoming Resident Group Meeting.

b. Document observations on Attachment I.

c. Reference Attachment N and use Attachment O to document contract specific observations.

d. Facility observations, including but not limited to:
   1) Interior environment (all areas designated for resident use).
   2) Common areas: look for homelike appearance.
   3) Resident furnishings, beddings, walls, and floors: look for cleanliness and maintenance.
   4) If restricted egress: door buzzers, alarms, keypads, etc.
   5) Activity room(s).
   6) Laundry room(s).
   7) Storage areas, including medication storage.
   8) Restrooms.

e. Observe for safety hazards.

f. Note presence of any objectionable odors.

g. Ask the administrator to explain how the 'resident to facility' communication system operates.

h. Observe for adequate lighting necessary for safety and needs of residents.

i. Observe that room temperature is maintained at a comfortable level for resident living areas (minimum of 60° F during sleeping hours and minimum of 68° F during waking hours, per WAC 388-78A-2990). If it appears very cold or hot in the building, observe how residents are dressed and interview residents about the temperature.

j. Observe for general maintenance and housekeeping.

k. Observe and inquire regarding resident or facility pets if applicable.
   1) Verify pets are not permitted in central food preparation areas.

l. Observe for safe storage of housekeeping supplies, including hazardous supplies and equipment (considering the resident population).

m. Observe hand washing areas for staff and residents and observe whether staff are washing hands as required.

n. Conduct initial kitchen tour and observe for general cleanliness and sanitation practices.

o. Observe and inquire regarding any new construction or changes in the use of rooms in the facility to determine if DOH or DSHS review was required and obtained prior to construction or beginning use. Review the CRS approved plan and verify implementation.

Review intermittent nursing services, if applicable.

a. Observe for:
   1) Storage and handling of nursing equipment and supplies.
   2) "Clean" utility area for sterile nursing supplies.
   3) "Soiled" utility area for storage, cleaning and disinfecting soiled nursing care equipment.

Observe exterior environment:

a. Walk outside and around the property of the ALF.
   1) Observe the area utilized for storage of garbage and refuse.
   2) Observe for rodent/pest presence.
   3) Observe exterior exit.
   4) Observe for resident access to outside without staff assistance and note any uneven walking areas or unsafe areas.
   5) Note any areas with restricted egress and determine if restricted exit is consistent with resident care plans and service needs.
   6) For ALFs with memory care, determine that there is an accessible outside area (WAC 388-78A-2381).
   7) In secure units, including enhanced adult residential care-specialized dementia care (EARC-SDC), facilities must provide access to a secure outdoor space that is protected from the elements, have walking surfaces accessible for residents using wheelchairs and walkers, and have appropriate outdoor activities of interest to residents. For facilities with an EARC-SDC contract, the outside area must be surrounded by walls or fences at least 72 inches high (WAC 388-110-220).
   8) Observe for unsafe stairs, ramps, and handrails requiring maintenance.

Observe and inquire regarding the required posting of:

a. CRU/Ombuds phone number sign.
b. Current ALF license including conditions on the license.
c. Copy of the most recent full inspection by the department, cover letter and plan of correction (if applicable).

Communication During Tour:

a. Communicate with the administrator throughout the tour regarding the features of the ALF and clarification of observation and concerns.
b. Communicate to the residents and staff the purpose of the visit and elicit informal interviews.

> Example: (Resident) What is your name? How long have you lived here? What are you planning to do today? or (Staff) How long have you worked here?

c. Introduce yourself or request the administrator introduce the licensors to the residents and staff during the tour.
d. Request an introduction to the resident council president or resident representative during the tour if applicable.
e. Inform residents that licensors are available to talk to during the inspection.

Completion of Tour:

a. Thank the administrator for the tour.
b. Obtain the completed Attachment D and other documentation requested during the entrance conference.
c. Inform the administrator that the team will be meeting.
d. Inform the administrator what the team will be doing next in the inspection process.
e. Inquire if the administrator has any questions at that time.

8. Environmental Observation

Purpose

To observe the physical environment of the ALF that affects resident care, health, quality of life, and safety.

Procedures

The licensors will:

a. Conduct observations regarding the appearance of the ALF beginning with the entrance and tour process and throughout the inspection.
b. Share observations with the licensors responsible for conducting and coordinating the environmental observations.
c. Ensure any electronic monitoring (audio or video) adheres to WAC 388-78A-2680 and 2690.
d. Document findings of environmental observations using Attachment I.
e. Conduct specific environmental observations in ALF with Assisted Living (AL) Services Contract or Enhanced Adult Residential Care (EARC) or EARC-SDC for contract requirements. Document findings on Attachment O.
f. Check water temperature in half of sampled resident rooms and document results. Conduct more water temperature checks if there are concerns.
g. If the ventilation system was not working properly during initial licensing, and this is the first visit after licensing, check by asking facility staff to place a square of toilet tissue on each required vent. If the ventilation system is working properly, the air from the vent will hold the tissue for a few seconds. If it is not working, the vent will not hold the tissue and will not pass inspection until it is working properly.
h. Observe medication storage area during tour and at other times during the inspection. See Medication Services section for more information.
i. Verify the facility has identified a safe area at least 25 feet from the building if smoking is permitted for residents.

> Note: smoking may require supervision depending on individual care plans.

j. Notify other members of the team if nursing care issues are identified during the environmental observations, such as wound care, incontinence care, pressure sore, or injury. If a nurse needs to join the team to investigate a nursing care issue, contact the FM.
k. Consult with the administrator and staff if any clarification of observations is needed.
l. Notify the FM and contact CRU to report to the State Fire Marshal if information gathered during environmental observations identifies a fire safety issue.

9. Resident Sample

Purpose

To provide guidance on selecting a sample of residents in the ALF that best represents the resident population to collect data on care and services.

Procedures

The licensors will:

a. Complete the resident sample selection as soon as possible after the tour. If the resident group meeting is taking place immediately following the tour, postpone the sample selection until immediately following the meeting.
b. Choose residents in the sample who are currently receiving services from the ALF.
c. Choose the resident sample numbers in accordance with the Sample Size Table below.

Sample Size Table		
Number of residents in ALF	**Complete Review (*core sample*)**	**Focused Review (*expanded sample*)**
3-15	4	2
16-30	5	2
31-60	7	3
61-100	9	3
101-125	12	4
126 and above	15	5

A complete review is the minimum required review for the resident sample. A focused review targets specific issues that are identified that require further investigation to help determine failed practice and whether issues are isolated or systemic. A focused review may also occur if a specific characteristic (such as diabetes or smoking) is not included in the core sample.

d. Refer to Attachment D and information gathered during the pre-inspection preparation, entrance, and tour to verify residents selected represent as many as possible of the applicable categories below:
   1) Able to interview and not able to interview.
   2) Receive nursing services provided by the ALF.
   3) State pay.
   4) Receive basic services such as help with activities of daily living.
   5) Have special needs (e.g., dementia, mental illness, or developmental disability).
   6) Have special dietary needs or significant unexpected weight loss or gain.

7) Receive one or more of the services listed under "general responsibility for safety and well-being" (WAC 388-78A-2020).
8) Receive services through a special contract (refer to Attachment N for specific requirements).
9) Self-administer medication.
10) Receive medication administration/nurse delegation.
11) Have AL, EARC or EARC-SDC contracts to receive medication assistance or administration.
12) Most at risk or concerns for needs not being met (e.g., residents with dementia, infrequent visitors, behavioral issues, non-English speaking, hearing, and vision impaired) and/or require high level of care (e.g., residents with chronic conditions such as diabetes).

> Note: if an interpreter is required for a non-English speaking resident, notify the FM early in the process and begin working to obtain an interpreter.

e. Adjust the resident sample as needed in the following situations:
   1) If the team finds it necessary to remove a resident from the sample, then substitute with a resident who best fulfills the reason the first resident was selected. Reasons a resident may be removed from the sample include:
      a) Resident and representative are not able to be interviewed.
      b) Resident is not available during the inspection.
      c) Resident has been discharged prior to the inspection start date.
   2) If a pattern or specific area of concern is identified during the inspection, expand the sample to investigate focused areas. If the scope of the problem is adequately identified within the current sample, expanding the sample will not be necessary.

f. If a resident is substituted, document the reason for the substitution.

> Example: The initial sample included a resident with diabetes who chose to decline an interview. This resident was substituted with another resident with diabetes. Sample working paper documentation: "Resident A declined interview, substituted with Resident Q who has similar care needs."

g. When possible, include residents who have not been in a previous inspection or complaint sample.
h. The administrator and facility staff may provide important information about residents that can aid in selecting the resident sample.

10. Resident Group Meeting

Purpose

To introduce the licensing team to the residents, provide an explanation for the purpose of the visit, and provide the opportunity for residents to share information. The resident group meeting is conducted with an informal group of residents.

Procedures

The licensors will:

a. Determine the best time to conduct the group meeting following the Entrance On-Site procedures.
b. Verify that the ALF has posted the Resident Meeting Poster after the entrance conference to announce the resident group meeting. Posting(s) should be in areas of the building conspicuous to residents. If notification was not posted timely, work with staff to reschedule and verify posting to ensure residents receive proper notification.
c. Document any particular concerns identified during the pre-inspection preparation, entrance, and tour on Attachment E: Resident Group Meeting. Identified concerns can be brought up during the resident group meeting.
d. See Attachment E for guidance on conducting the Resident Group Meeting and sample questions. In general, the interview questions will follow the established guidelines in Attachment E; however, not every question must be asked. If residents are focused on a particular issue, follow their lead.
e. Let the residents direct the conversation and use open-ended questions to gather more information.
f. Identify and follow up individually with residents who express concerns or appear to have unmet or special care and service needs.
g. Thank the residents for attending and let them know how to contact the team during the inspection and how to contact the department with further question or concerns.
h. Accommodate residents needs and rights by:
    1) Conducting the resident group meeting in a private setting that is easily accessible to residents.
    2) Requesting the assistance of facility staff to escort residents to and from the meetings.
    3) Waiting for a few minutes before starting the formal part of the meeting to accommodate late arrivals.
    4) Using questions modified for the population type.
    5) Stopping the meeting if residents become restless or stressed and will not stay in the meeting, or do not understand the questions and become agitated.
    6) Meeting individually with residents who need one-on-one communication due to special needs.
        a) If still unable to interview, contact families or representatives for interview.
        b) Do more frequent observations of residents that cannot be interviewed.

> Note: An ALF with residents in both an open setting and restricted egress (dementia unit) may require a resident meeting in each setting to ensure all residents have an opportunity to participate and to promote resident rights and safety. Depending on the population type, the licensing team may need to use different methods of communication, such as written questions or repetition of questions.

i. No staff members or resident family members may attend the group meeting except at the request of residents.
j. Non-residents are permitted to attend.

11. Facility Record Review

Purpose

To review facility records and documents, to select a staff sample, and to determine whether the ALF has a systematic and consistent way to verify that staff meet the statutory requirements for training, certification, experience, qualifications, and credentials to provide the care and services required for the residents in the ALF.

The ALF is responsible for new staff orientation and verifying that all staff meet the training requirements specified in Chapter 388-112A WAC and Chapter 388-78A WAC. The ALF is responsible for developing a system that documents administrator and staff's training and other requirements. Records must be obtained and maintained on the ALF premises and easily accessible to department staff.

Procedure

The licensors will:

a. Review the staff list and records the administrator provided at the entrance (Attachment B).
b. Select the ALF staff sample at the team meeting. Staff sample selection criteria:
   1) If there has been a change in administrator since the last inspection, review the administrator's records to verify they meet the appropriate qualification and training requirements.
   2) Review staff list for hire dates and titles:

> Note: Hire date refers to the first date the employee worked in exchange for pay.

      a) Select three staff who have been hired in the period since the last inspection and conduct a full review of training and other requirements and qualifications. If fewer than three were hired, review records for all new staff.
      b) If there have been no new hires since the last inspection, select three staff who were not reviewed during the previous inspection.
      c) In addition, conduct a targeted review of two staff (this could include the administrator) with a work history of over two years at the ALF. The intent of this review is to verify that a system is in place to conduct background re-checks, meet continuing education (CE) requirements, and renew any certifications that expire.

> Note: A minimum of four staff should be reviewed. There is no need to sample more than the minimum unless an issue is identified.

c. Document facility record review Attachment K: Staff Sample/Record Review. Use the instructions on the final page of the form to assist in completion.

d. Criminal history background checks and related sensitive and confidential information should never be included in the working papers. Review these documents while in the facility and notate details in the working papers.
e. The minimum sample size for Respiratory Protection Program (RPP) is three staff.
f. Review all pet records if the facility has three or fewer pets. Identify a random sample of three pets when the pet population exceeds three.
g. Use record review to validate observations and interviews related to staff training and qualifications.
h. Allow the administrator the opportunity to submit complete or up-to-date documentation if omissions or discrepancies have been found.
i. Document IPC record review on the IPC forms.

12. Interview

Purpose

To collect information in the ALF by speaking with residents, resident representatives, resident family members, administrator, facility staff, and other contacts.

Procedures

The licensors will:

a. Conduct informal and formal interviews throughout the inspection.
b. Expand the sample and use focused interviews to obtain additional information if areas of concern are identified.
c. Be available to any residents requesting to speak with licensors throughout the inspection.
d. To conduct a formal interview:
    1) Use pre-visit preparation information, observations, informal interviews conducted during the tour, the resident group meeting, and a review of the negotiated service agreement to supply information and points of discussion for the interview with the resident.
    2) Refer to EARC contract requirements when interviewing sampled residents receiving this service (Attachment N).
    3) Obtain the services of an interpreter if the resident sample includes a non-English speaking resident. This may require a scheduled return visit.
    4) Conduct the interview in a confidential setting.
    5) Introduce yourself and explain the reason for the inspection and the interview.
    6) Discuss the interview process and their right to decline the interview.
    7) Attempt to interview a representative if a sample resident declines to interview. If the representative is not available or declines, adjust the sample as outlined in Resident Sample.
    8) Inform the resident that notes will be taken during the interview and how their comments could be used in the future. Explain that confidentiality cannot be guaranteed and that there may be circumstances when the department must share information, such as an abuse situation.
    9) Obtain permission from each sample resident before sharing information with the administrator.
    10) Let the resident lead the interview by allowing the resident to ask questions or provide any additional information.
    11) Use open-ended questions and active listening skills.
    12) Speak slowly and clearly.
    13) Clarify any statements that are unclear or need further explanation.
    14) Observe the resident and their environment during the interview.
    15) Use Attachment G: Resident Interview to document the interview using instructions on the form. This attachment is to be used for all formal interviews, whether the interviewee is the resident or representative.

16) Make sure any quotes are written verbatim.
17) Complete the interview at a later time if the resident becomes tired during the interview. If they are unable to complete the interview, attempt to interview their representative. If the representative is not available or declines, adjust the sample as outlined in Resident Sample.
18) Inform the resident that you may need to contact them again and inquire as to their availability if a follow up interview is anticipated.
19) Leave a business card with the resident.

e. To conduct an informal interview:

1) For informal interviews of residents, document on Attachment G or Attachment L: Notes/Worksheet (DSHS 10-370).
2) Document administrator and facility staff interviews.
3) Document other contact interviews on Attachment H: Other Contact Interview.
   a) Examples of other contact interviews include resident family members, case managers, health care practitioners, home health agencies, and law enforcement.
   b) Apart from resident family members, other contacts should be interviewed only if issues have been found.

f. Document IPC interviews on the IPC forms.

13. Resident Record Review

Purpose

To collect and review documented data in the ALF to determine if resident care and service needs are being met. The record review is primarily used to obtain information necessary to validate or clarify information already obtained through observations and interviews to determine deficient practice.

Procedure

The licensors will:

a. Conduct a record review for residents in the sample as outlined in Attachment J: Resident Record Review including:
   1) Resident assessment/negotiated service agreement.
   2) Monitoring of resident's well-being.
   3) Medication record.
b. Request additional documents as needed.
c. Communicate with the ALF staff throughout the record review process. Issues that may lead to a failed practice should not be communicated until sufficient evidence is collected unless it represents an immediate danger to a resident.
d. Document using Attachment J.
e. Determine if information obtained from record review will require further interviews and observations.

Expanded Record Review:

a. Expand the sample if a concern has been identified to determine the scope of failed practice (refer to Resident Sample Selection Process).
b. Expand the record review beyond six months *only* when an actual or potential outcome requires further history.

Facility Record Review:

Review a facility record only when an issue is identified that requires further information to determine failed practice.

> Example: review of investigation outcome for a resident with recent falls.

ALF records that may need to be reviewed include:

a. Incident/accident documentation.
b. Policies and procedures.
c. Financial records (only as they are related to resident care or services not being met).

d. Quality Assurance (QA) Committee notes (only for the information necessary to determine the existence of a QA committee and that it is operating in compliance with the regulations, or if the licensee offers the QA committee records as evidence of compliance).

Discharged Resident Record Review:

Review a discharged resident record only when an issue is identified that directly relates to a specific resident no longer in the ALF, if no current residents reside in the ALF, or if there is a concern regarding discharge or transfers.

a. Request a specific discharged resident record if the issue is resident specific or a discharged resident record from the last year if issue is not resident specific.
b. If no specific resident has been identified but a concern regarding discharge or transfer has been determined, review the resident register for recent discharges.
c. Interviews with other residents and staff may also assist in selecting the discharged resident record; therefore, selection of the record may occur later in the inspection process.
d. Note if the discharged resident record was a state contracted resident and review for discharge and bed hold requirements if appropriate according to WAC 388-110-100.
e. Review record for the identified concern and document using Attachment J.
f. Obtain contact information for resident family, resident representative, or healthcare practitioner from the closed record if an interview with them is necessary to determine facility compliance.

Other Records:

Review of records not associated with the ALF will only occur when necessary to determine failed practice.

> Examples: hospital records, police records, agency records, etc.

a. Document contact information regarding outside record on Attachment H.
b. Interview resident or facility staff to verify the contact information is accurate.
c. Initiate the review of outside records (by written request, on-site visits, or phone) as soon as possible.

14. Food Services

Purpose

To inspect ALF food service operation to determine if resident care and service needs are being met. General observations and data collection regarding food services occurs throughout the full inspection. Dining observation is a part of the food service task and will be conducted at one or more meals. Chapter 246-215 WAC Food Code provides the safety standards for food served or sold to the public in Washington State.

Note: In a **Continuing Care Retirement Community (CCRC)**, a full inspection is not required if the Nursing Home surveyor has completed the inspection of the primary kitchen. Contact FM to find out when last survey was conducted. Observe the kitchen areas that serve the ALF residents.

Procedure

The team coordinator or licensors responsible for the food service task as identified at the pre-inspection preparation team meeting will make introductions to food service staff, conduct informal interviews, establish which staff is the contact, and explain the food service task.

The licensors will:

a. Document using Attachment P: Food Service Observations in accordance with WAC 246-215-08430.
b. Use the tour as the first opportunity to observe the food service environment and general food service practices including proper food handling skills and hand washing.
c. Review resident records, interview, and observe residents in the sample with identified diet-related concerns regarding meals and food services, individual nutritional needs, preferences, and reasonable accommodations including, but not limited to, modified or therapeutic diets or feeding tubes for prescribed or non-prescribed nutrient supplements.
d. Interview the administrator, caregiver staff, and food service staff using Attachment P as a guide.
e. Document on Attachment P the food handler cards staff observed during the inspection. If a resident is regularly involved in the preparation of food to be served to other residents, or as part of an employment-training program, request their food handler card.
f. Conduct observation of food services for high risk factors to verify a risk-based inspection is conducted and proper control measures are in place. Risk-based inspection includes staff knowledge of Food Borne Illnesses (FBI); how food is prepared, handled, and stored; how equipment and food contact surfaces and utensils are sanitized; and an overview of dining services and meal planning to meet residents' dietary needs.

g. Wear a hair restraint if applicable throughout the kitchen inspection in accordance with WAC 246-215-02410.
h. Include the consideration of individual resident needs such as:
    1) Preferences.
    2) Alternate choices.
    3) A system for residents to express their comments on food services.
    4) Prescribed diets.
    5) Prescribed nutrient supplements and concentrates.
    6) A variety of daily food choices.
    7) Temperature of food.
    8) Assistance with eating.
i. Observe a meal:
    1) Conduct meal observation while sitting, if possible, to avoid standing over the residents. Documentation should be minimized during the observation to decrease any resident discomfort.
    2) Observe dining area for adequate seating capacity (50% or more residents per meal setting).
    3) Observe for timeliness of meal service.
    4) Observe that sufficient time and staff is provided to meet resident needs.
    5) Observe that meal is attractively served, nourishing, and palatable.
    6) Observe that eating assistance is provided per resident needs.
    7) Identify sample residents that are currently receiving meals in their room, noting the reason and if the meals are assisted per care needs.
j. Check food temperature just before it is served to residents only in response to resident complaint or if prepared food has been sitting for long enough to likely impact the appropriate temperature.
k. Consider requesting a food sample if concerns have been identified.

15. Observation of Care

Purpose

To observe care provided to residents throughout the inspection and gather information related to resident care needs, including intermittent nursing care, provision of care, staff to resident interaction, staff training, and possible complications regarding special care needs of a resident.

Procedure

The licensors will:

a. Conduct observations of residents at all times during the inspection.
b. If possible, observe the caregiver providing assistance with personal care to a resident identified as having care issues.
c. Do not touch or examine a resident or provide hands-on care. Request facility staff to provide the direct care if the resident agrees.
d. Document observations including description of observation, resident name, caregiver name, date, time, and location of observation when location is relevant. Documentation may be completed on any of the appropriate forms:
   1) Attachment G: Resident Interview
   2) Attachment I: Environmental Observations
   3) Attachment O: Environmental Observations – Contract Requirements
   4) Attachment L: Notes/Worksheet

   Note: Attachment L: Notes/Worksheet may be used to record any information not captured on other forms, or when additional space is needed.
e. Collect additional data through interview and record review that may be required to validate, clarify, or invalidate the observations.
f. Document IPC observations on the IPC forms.
g. RCS RN staff will conduct all observations that require looking at a resident's breasts, genitalia, and buttocks.

Data Gathering:

Residents may be identified for potential observation of care through any part of the inspection including the pre-inspection preparation, resident group meeting, and interviews with residents, staff, and other contacts.

a. Review Attachment D and documentation of interviews with residents, facility staff and other contacts to identify care issues requiring observations.
b. Make observations of residents throughout various times and locations of the inspection to provide a more complete perspective of the residents' engagement in services and activities at the facility.

> Example: Note where the residents are, what the residents are doing, appearance, needs being met, assistive devices available or in use, etc. Consider hourly rounds, to determine a compliance condition that needs a longer observation period for documenting an apparent issue that may impact the resident consistently throughout the day. For example, residents that have fall histories but have no mobility assist devices to reduce their propensity for fall injuries.

c. Respect each resident's health, dignity, choice, quality of life and right to privacy at all times. Respect each resident's right to refuse. If a sample resident refuses to be observed for a specific issue, explain again and, if the resident continues to refuse, substitute with another resident with similar care needs who is willing to be observed.

Types of Observations:

Some observations of the resident's general appearance and circumstances can occur at any time during the inspection. These include but are not limited to:

a. Personal hygiene including oral hygiene, grooming, body odors, nail and hair care, clean and intact clothing.
b. Visible skin condition.
c. Behavior issues and level of cognition.
d. Mobility.
e. Functional risk factors such as positioning, vision and/or hearing deficit, side rail use, or restraints.
f. Appropriate clothing for season, dignity, and comfort.
g. Shoes or other footwear appropriate for safety, comfort, or therapeutics.
h. Mobility devices in good repair, clean, and functional.

Some observations are specific to a resident care issue and require more structure and a planned setting for the observation. Observe for the following:

a. The resident response to the care provided, such as their:
   1) Behavior.
   2) Level of comfort.
b. The staff performing the care, such as their:
   1) Technique and knowledge.
   2) Staff to resident interaction.
   3) Demonstration of appropriate infection control practices.

      > Example: when using "Point-of-Care" devices such as finger-stick devices (e.g., pen-like device) and blood glucose meters.

   4) Assistance provided as identified in the negotiated care plan and for level of care needed by the resident.
   5) Physical care provided using safe practices, appropriate handling, and inclusion of resident's participation in the care task to the maximum of their ability as identified in the negotiated care plan.

16. Medication Services

Purpose

To provide licensors with an overview of the ALF medication service system. The medication service task incorporates observations, interviews, and record review to verify the ALF has developed and implemented a medication system that promotes the safe delivery of medications for all residents. Observations and data collection regarding medications are resident outcome oriented, focusing on medication storage, medication delivery system, and respect for resident rights.

Procedure

The licensors will:

a. Review medication services including:
   1) Medication storage: safety, labeling, organizers, and general organization.
   2) Medication delivery system: documentation, assistance/administration (nurse delegation), alterations, appropriate for resident needs.
   3) Medication prescriptions received timely.
   4) Respect of resident rights: right to refuse, individual choice, and preference.
   5) Disposal of medications.

b. Document observations of medication services throughout the inspection.

c. Observe medication storage area during tour and at other times during the inspection for the following:
   1) Medications are secure for residents not capable of self-storage.
   2) Medication is properly labeled.
   3) Medications for a specific resident are stored together and are kept separate from other resident medications, food, or toxic chemicals.
   4) Storage area is locked and accessible only to designated staff.
   5) Medications are stored according to medication label recommendations.

d. Conduct observations of medication service systems during medication assistance/administration throughout the inspection for:
   1) Staff knowledge and technique.
   2) Staff to resident interaction.
   3) Appropriate level of assistance.

e. Identify residents for medication services task by:
   1) Reviewing Attachment D, identifying residents self-administering medication or receiving medication administration, and noting if nurse delegation is provided.
   2) Reviewing Attachment D and identifying any sample residents with AL, EARC, or EARC-SDC contracts receiving medication assistance or administration. ALF must provide medication administration for contracted residents who need that service.
   3) Identifying residents who receive family assistance or administration with medications if ALF allows this.

f. Review medication records for sample residents with medication assistance or administration, noting:
   1) Any documentation of refusal, if the physician was notified of the refusal, and if appropriate action was taken if there was a pattern of refusal.
   2) Lack of availability of medications.
g. Conduct resident record review noting if the negotiated service agreement addresses medication plan for residents receiving assistance or administration and any significant changes that impact the medication services for the resident.
h. Interview staff regarding nurse delegation practices if applicable.
i. If a concern comes up during medication observation, conduct observations of a medication pass. During medication pass observations:
   1) Compare observations with the prescriber's orders.
   2) Review the medication records for accuracy and completeness.
   3) Review if the ALF reconciles and secures controlled medications.
   4) Observe whether staff confirmed the resident's identity prior to giving medications.
   5) Record procedures staff use to handle and administer medications.
   6) Identify medications not being given in a timely manner.
   7) Consult with an RCS RN if clinical questions arise.
j. Verify facility has obtained a written plan from family members assisting with medications, treatments, or obtaining supplies as specified in WAC 388-78A-2290 if applicable.
k. Review how emergency medication issues are handled by:
   1) Reviewing facility policy.
   2) Observations and interviews with residents.
   3) Reviewing resident MARs.
l. Conduct interviews with staff to address medication storage with residents, including:
   1) System for controlling and securing medications for residents assessed to be capable of self-administration or self-administration with assistance.
   2) Use of medication organizers.
m. Observe resident rooms during interviews for medication issues such as medications on floor or inappropriately stored.
n. Reconcile medications with the logs for documentation of residents receiving medications and supplements as ordered.

Focused Review

If issues are identified with medication services with potential or actual negative outcomes, conduct a focused review.

The licensors will:

a. Expand the sample. Use the Resident Sample chart to determine the number to sample for the focused review.

b. Make observations and interviews as needed relating to the specific issue(s) identified.
   1) Observations of residents may include determining level of ability and appropriateness of services.
   2) Interviews of staff and residents may include targeted questions regarding medication services.
   3) Additional observations of medication systems may be needed.
   4) Interview outside contacts if further data is needed to determine non-compliance.

> Examples of outside contacts: family members, resident representatives, case managers, health care practitioners, law enforcement.

17. Exit Preparation

Purpose

To prepare for the exit conference after the completion of the inspection by reviewing and analyzing all information gathered during the inspection to identify deficiencies, based on the regulations and statutes (WAC, RCW), and determine whether further action is required.

Procedure

The licensors will:

a. Notify the administrator when the on-site inspection has been completed and the team is meeting for the exit preparation.
b. Schedule the exit conference with the administrator and invite the ombuds and interested residents to attend. Best Practice: give ombuds as much notice as possible prior to exit conference.
c. Conduct the exit preparation in a setting that is on-site and confidential.
d. Facilitate the exit preparation and organize the information to be presented in a manner that can be clearly understood.
e. Review information and deficiencies and identify actual or potential negative resident outcomes using specific residents when possible.

> Note: If residents are present or have requested that their issues be kept confidential, confidentiality must be maintained to the extent possible.

f. Conduct a team meeting to:
   1) Review the inspection.
   2) Identify concerns based on observations, interviews, and record reviews.
   3) Identify deficient practice.
g. Use Attachment M: Exit Preparation Worksheet to document and prioritize the information with the most serious issues presented first and consults last.
h. If a deficiency is identified, follow the SOP Chapter 7: Enforcement to establish the scope and severity and what specific action is required.
i. If a deficient practice is identified that requires an immediate plan of correction, notify the FM, and obtain FM approval to request a written immediate plan of correction prior to leaving the facility.

> Note: Exit preparation may not be the final determination of compliance. Further analysis and data collection may continue after the on-site visit including collateral contact interviews, collateral record review, and review of documentation. Decide if further information will be required after the exit and establish the licensors responsible for that data collection.

18. Exit Conference

Purpose

To provide the ALF with the results of the inspection and to provide the administrator an opportunity to present additional information. The exit conference occurs at the end of the on-site inspection and is conducted with the RCS licensing team and the administrator. Other participants may include ALF staff, the ombuds, residents, and resident's representatives.

The exit conference is held in a private setting in the facility, observing confidentiality and encouraging dialogue.

Procedure

a. The team coordinator will facilitate the exit conference.
b. The licensors will:
   1) Utilize Attachment M to facilitate the conference and address all issues.
   2) Identify deficient practices with the appropriate regulation or statute (WAC/RCW).
   3) Provide examples when appropriate, identifying specific resident issues, if possible, without violating a resident's request for confidentiality.

      Note: If residents are present or have requested that their issues be kept confidential, confidentiality must be maintained to the extent possible.

   4) Provide the information in an organized, clear manner using language and examples that are easily understood by those attending the exit, with the most serious issues presented first and consults last.
   5) Provide the administrator an opportunity to discuss, ask questions, and present additional information.
   6) Inform the administrator that:
      a) Further data collection may be required off-site.
      b) If any changes or additions are made to the information presented during the exit, after consultation with the FM, the administrator will be notified of these changes prior to receipt of the SOD.
      c) A SOD report will be sent to the ALF within 10 working days of the last date of data collection.
      d) An attestation statement must be completed for each cited deficiency in the SOD and returned to the department within 10 calendar days of receiving the SOD.

         Note: Attestations are not required for consultations.

      e) Discuss the Informal Dispute Resolution (IDR) process with the administrator.
   7) Thank the administrator for their cooperation with the inspection.

19. Off-site Activities

Purpose

To provide guidance on final inspection tasks conducted off-site after the exit conference and prior to the SOD writing.

Procedure

Licensors will:

a. Determine if additional interviews or record reviews outside the ALF are needed to determine failed practice.

> Note: Not all inspections require additional data gathering. These should be kept to a minimum and stay within scope to determine the failed practice.

   1) All contact attempts should be completed within seven working days from exit, unless FM approval to extend this time frame is received and documented.
   2) Make a minimum of three attempts to reach outside contacts and document the date and time of attempts on Attachment H.

> Note: Interviews with resident representatives or family members completed when a resident is not interviewable should be documented on Attachment G.

b. Save electronic documents to the office shared files using the standardized naming guidelines outlined in the Electronic Document Naming Key.
c. Review and analyze all data collected after exit to make final determination of failed practice.
   1) If failed practice is identified, the findings will be documented in detail within the SOD based on identified rules and regulations.
d. Coordinate any enforcement recommendations with the FM (SOP Chapter 7 – Enforcement).
e. Create the Identifier List using standardized template.
f. Complete data entry in Secure Tracking and Reporting System (STARS).
g. Write SOD using standards outlined in the Principles of Documentation.
h. Notify the administrator if:
   1) Information in the SOD is different from what was communicated during the exit conference (including additions, deletions, or changes).
   2) There are delays in completion of the SOD.

The FM will:

a. Discuss with licensors if any enforcement actions will occur and follow process for enforcement (SOP Chapter 7 – Enforcement).

20. Follow Up Visits

Purpose

To determine if the ALF is back in compliance with the state licensing laws and rules cited in any previous inspection or complaint investigation. Follow up inspections will be brief, focused, and purposeful reviews of previously cited deficiencies.

Procedure

The FM will:

a. Consult with the licensors to determine if the follow up will be done off-site or on-site.
   1) Off-site
      a) Correction of the deficiencies may be verified off-site only if all three criteria below are met:
         1. The deficiencies do not have a direct, adverse impact on resident care (e.g., citations are not associated with a negative or potentially negative resident outcome).
         2. The deficiencies have objective criteria not requiring observation to determine compliance.
         3. The ALF sends evidence of compliance, fully addressing necessary actions taken by the facility to correct each deficiency, including: the actions the provider has taken to implement the correction, whether the plan worked, when the correction was achieved and how correction will be maintained.
   2) On-site
      a) Corrections of deficiencies must be verified by an on-site visit if any of the follow are true or at the FM's discretion:
         1. Deficiencies involve a negative or potentially negative resident outcome.
         2. Documentation was not submitted or does not adequately validate that correction has been achieved.
         3. The deficiencies require observation to determine compliance.
         4. Violations are serious, recurring, or uncorrected from a previous citation, and create actual or threatened harm to one or more residents' well-being.
         5. A stop placement has been imposed and the facility has returned their request for lifting the stop placement. In this case, the on-site follow up must be completed within 15 working days from the receipt of the request for follow up.
b. Schedule and track any additional visits and citations once the facility is initially out of compliance. Remember that attestation timeframes are at the Department's discretion. While a facility may have up to 45 calendar days to implement corrective actions, the FM can require a shortened timeframe for correction based on other compliance issues or the health and welfare of the residents in the facility.
c. Include at least one licensor who participated in the original visit in the follow up whenever possible.

d. Investigating new complaints during follow ups should not occur unless directed by the FM. When possible, the follow up is completed before writing new citations.
e. If the ALF continues to be out of compliance after the second follow up, notify the Compliance Specialist (CS) to strategize further enforcement action steps (SOP Chapter 7: Enforcement).
f. Only schedule a third follow up after consultation with the CS.

Timelines:

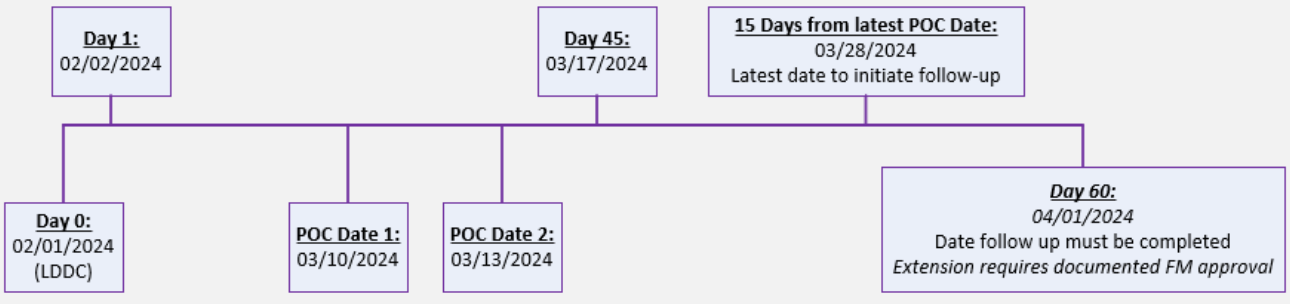
a. Date of alleged compliance (45 day): Date of alleged compliance must not exceed 45 calendar days from the last date of data collection, unless approved by the FM.
b. Follow up due date – requirement 1 (15 day): Follow up must be initiated within 15 calendar days from the latest date the ALF has listed on the Attestation unless the FM approves an extension.
c. Follow up due date – requirement 2 (60 day): Follow up visits must be completed no more than 60 calendar days following the last date of data collection, unless an extension is approved by the FM.
d. Second follow up due date (if first follow up determined provider not back in compliance): If first follow up results in a deficiency, second follow up must occur within 45 calendar days from the last date of data collection from the first follow up, unless an extension is approved by the FM.

> Note: If the first follow up results in a deficiency, the CS must be consulted.

e. When planning the date for the follow up visit, the licensors should consider how much time they need to allow for the provider to be able to demonstrate compliance.

Example

- If Last Date of Data Collection (LDDC) is 02/01/2024, this is considered day 0. Day 1 of the timeline would be 02/02/2024.
- The date of alleged compliance is the latest date the ALF has attested the deficient practice will be corrected (POC Date). In the example scenario, our ALF provider has two deficiencies with different correction dates. The timeline below demonstrates how this would be mapped out:



The licensors will:

a. Consider the following prior to the follow up:
   1) 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.
   2) 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. Base the sample size on the number of residents necessary to determine compliance, focusing on residents who are most likely to be at risk of issues resulting from the deficient practice cited in the original SOD. Usually more than one resident in the sample is needed to have enough information to determine compliance. Best practice is to include at least one resident from the original sample and at least one previously unsampled resident.
d. Only review evidence obtained between the ALF's last date on the attestation and the date of the follow up to make compliance decisions.
e. Write a statement in STARS indicating if the facility was found back in compliance.
f. For off-site:
   1) Review documentation and call the administrator to discuss the issues to determine if sufficient documentation is present to justify reporting the deficiency as corrected or to recommend to the FM that an on-site revisit inspection be conducted.
   2) Document pertinent details of the call.
   3) Store the documents sent by the ALF to demonstrate compliance in the Shared Drive.

Upon completion of all follow ups:

a. Record corrected and any new or uncorrected deficiencies in STARS.
b. Follow SOD writing processes for any new or uncorrected deficiencies.
c. Follow the STARS and Electronic Working Paper (EWP) processes to document the follow up.

General:

a. Consult with an FM when additional issues are discovered during a follow up that may require an intake.
b. If a citation is being disputed in IDR, the facility is not required to submit attestation for that citation. However, licensors may ask the administrator to demonstrate how they are ensuring resident safety, well-being, and quality of life by addressing the issues identified during the informal dispute. If an attestation arrives without a signature or date on an attestation line, the facility should only be contacted for a signature and date if an IDR has not been requested for that specific citation. After the dispute is completed, and if the citation remains, the facility must submit the attestation signature and date for the citation(s) disputed within 10 calendar days from receipt of the IDR results letter. The date of the results letter is the same date that the facility receives their results letter electronically; this date can be found in STARS.

Note: Per RCW 18.20.195, request for an IDR does not delay the effective date of any enforcement remedy except payment of civil monetary fines.

c. Document on Attachment R: Follow Up Visit or in the follow up visit section of EWP.

21. Fire Safety Code Deficiencies

Purpose

RCS collaborates with the Office of the State Fire Marshal (OSFM) for the purpose of conducting State Fire Safety Code Annual inspections and fire safety related complaint investigations in ALFs as required in Chapter 212.12 WAC. The OSFM does not have statutory authority to impose remedies when licensed ALFs have disapproved inspections and deficiencies or do not correct fire safety code deficiencies in the specified time frame. RCS as a regulatory agency has the authority to impose citations and enforcement remedies to promote the safety of the residents residing in the facilities and ensure facilities return to substantial compliance.

RCS may request that OSFM not conduct an inspection at any time.

Procedure

OSFM Annual Inspections

The OSFM will:

a. Conduct annual fire safety code inspections through an automated OSFM system and conduct complaint investigations when referred by the Complaint Resolution Unit (CRU).
b. Provide the facility with the OSFM detailed report including deficiency(ies), which gives the facility a timeline (generally 30 days) to correct deficiency(ies).
c. Send completed OSFM report(s) to the RCS Field Managers (FMs) and Public Disclosure Unit (PDU) on a weekly basis.

> Note: This comes in an email from OSFM titled “heads up.”

The FM will:

a. Review the OSFM reports within five working days of receipt.
b. Ensure the licensors/complaint investigators have access to review OSFM reports to establish history of uncorrected fire safety code deficiency(ies) in preparing for full licensing inspections or complaint investigations.
c. Assign a complaint investigator to complete the RCS portion of an OSFM complaint referral, if needed.
d. Save the OSFM reports electronically in the shared drive following defined naming conventions.

The Licensor/Complaint Investigator will:

a. Conduct the inspection or investigation and review any concerns identified during the Pre-Inspection Preparation & Activities.
b. Consult with the OSFM as needed.

c. Draft SOD report using WAC 388-78A-2040(2) including details the OSFM identified as meeting serious fire safety code deficiency(ies) when applicable and any observations validating deficiencies.
d. Consult with FM if additional concerns are identified.

The ALF Compliance Specialist (CS) will:
a. Review the OSFM reports.

OSFM Annual inspections, re-inspections, or complaints with serious fire safety code issues

The OSFM is responsible for identifying when concerns meet a serious fire safety code deficiency threshold. Below is the procedure to follow if a potentially serious fire safety code deficiency(ies) is(are) identified during an annual licensing re-inspection.

The FM will:
a. Notify the CS when the OSFM has determined a potential deficiency(ies) may be serious or if consultation with the OSFM is needed to determine the potential seriousness of identified fire safety code deficiency(ies).
b. Provide the draft SOD to the CS with the details of the issue(s) identified, including any necessary facility history (i.e., facility census, past OSFM enforcement, etc.).

> Note: While the FM may consult directly with the OSFM, it is important to ensure the CS is aware of any potentially serious concerns related to any entity regulated by RCS.

The CS will:
a. Contact the OSFM when requested by the FM to request a determination of the seriousness of an identified potential fire safety code deficiency.
    1) If fire safety code ***does*** meet the criteria of needing immediate action by OSFM or RCS, the CS will determine, in collaboration with the OSFM and FM, the best enforcement remedy(ies) for the situation.
        a) If the remedy imposed will include a fire watch protocol, the OSFM will provide the specific language to the CS and FM (including how frequent, who is responsible, how long, and reporting requirements).
    2) If potential fire safety code deficiency ***does not*** meet criteria for a need for immediate action by OSFM or RCS, then the CS will notify the FM of the OSFM's determination.
b. Send email request for enforcement notice to the Compliance Administrative Assistant 3 (AA3), when remedy(ies) will be imposed.
c. Follow the STARS enforcement referral process if needed.

When enforcement remedies will be imposed, the FM will:

a. Provide any enforcement remedy information to the licensor to verbally impose while on-site if ALF licensors ***are*** in the process of completing a full licensing inspection at the time.
b. Send a referral to the CRU to generate a 2-Day complaint for RCS investigation if ALF licensors ***are not*** completing a full inspection at the time.
    1) Assign a licensor or complaint investigator to go on-site to validate the identified fire safety code deficiency(ies).
    2) Provide enforcement remedy information to the licensor or complaint investigator to verbally impose while on-site.
c. Follow STARS enforcement referral process.

The Compliance AA3 will:

a. Review the email request for enforcement notice.
b. Follow the STARS enforcement referral process.
c. E-Fax or email the completed enforcement notice to the facility either as a pending notification or as a final notice with the RCS Statement of Deficiency (SOD).

Facility Compliance

The FM will:

a. Notify the OSFM when, to the best of their knowledge, the facility is likely back in compliance.

The OSFM will:

a. Conduct fire safety code follow-up visit per their agency process, including any needed notifications.

OSFM Follow-up Visits (2nd and 3rd visits) with uncorrected deficiency(ies)

The OSFM will:

a. Conduct fire safety code follow-up visits per OSFM process.
b. Provide the facility with the OSFM detailed report to include any uncorrected deficiency(ies) which gives the facility a timeline (generally 30 days) to correct deficiency(ies).
c. Send completed OSFM report(s) to the RCS FMs and Public Disclosure Unit on a weekly basis.

The FM will:

a. Review the OSFM failed re-visit report within 5 working days.
b. Initiate a 10-day intake with CRU unless prioritized differently by the OSFM.
c. Ensure the licensors/compliant investigators have access to review OSFM reports to establish history of fire safety code deficiency(ies) in preparing for a complaint investigation.
d. Assign a complaint investigator to validate the uncorrected fire safety code deficiency(ies).
e. Provide the draft SOD citing WAC 388-78A-2040 (1) to the CS for review with the OSFM, including correction timelines.

The CS will:
a. Provide the draft SOD for the failed follow-up to the OSFM and work in collaboration with the OSFM and the FM to determine the best enforcement remedy(ies) for the situation.
b. Send an email request for enforcement notice to Compliance AA3.
c. Follow the STARS enforcement referral process.

Continued Facility Non-Compliance

The OSFM will:
a. If two follow-up visits have been completed by the OSFM and the facility remains non-compliant, provide an email titled "NONCOMPLIANCE" to the Public Disclosure Unit, FM, and CS with the details of the continued deficient practice.

The FM will:
a. Review the OSFM "NONCOMPLIANCE" report within five working days.
b. Ensure the licensors/complaint investigators have access to review OSFM reports to establish history of uncorrected fire safety code deficiency(ies) in preparing for a follow-up visit.
c. Assign a licensor/complaint investigator to complete the follow-up visit to validate the OSFM uncorrected deficiency(ies).
d. Provide the draft SOD citing WAC 388-78A-2040 (1) to the CS for review with the OSFM, including correction timelines.
e. Follow the STARS enforcement referral process.
f. Coordinate subsequent visits with the OSFM, if necessary.

The CS will:
a. Review the OSFM "NONCOMPLIANCE" report.
b. Determine, in collaboration with the OSFM and FM, the best enforcement remedy(ies) for the situation and the severity of the deficiency.
c. Send email request for enforcement notice to the Compliance AA3, when remedy(ies) will be imposed.
d. Follow the STARS enforcement referral process.

The Compliance AA3 will:
a. Review the email request for enforcement notice.
b. Follow the STARS enforcement referral process.
c. E-Fax or email the completed enforcement notice to the facility either as a pending notification or as a final notice with the RCS SOD.

Part II: Appendices

A. Resources

1. Professional Page for Providers
2. Interpreter Resources
   a. Interpreter Slide deck and Q&A (May 2023 Support Call)
   b. Language Access SharePoint
   c. Four Corners Translation LLC is our current vendor for in-person interpreters and pre-scheduled phone and video interpreter services. To access the contract and schedule an interpreter, send licensors name, email address, and role (User or Requestor Administrator) to Linda Garcia (ADA/LEP/Voter Registration Program Manager from the Office of Equity, Diversity, Access and Inclusion/Language Equity team).
   d. For unscheduled/on-demand phone interpreter services, use one of the following DSHS On-Demand OPI contracts:
      1) 911 Interpreters
      2) Linguistica International - Interpretation Services
      3) Language Link
3. Additional Guidance: Abuse Prevention Review
   a. Observations for indicators of possible abuse:
      1) Client-to-client interaction for possible unsafe behavior of one client toward another.
      2) Staff-to-client interactions should support client rights and dignity. Look for staff's demeanor toward clients noting any intimidation, fear, ignoring client's needs, yelling, physical aggression, or verbal abuse.
      3) Potential abuse issues including the presence and use of physical or chemical restraints. This may include beds pushed up against the wall, recliners, merry walkers, locks preventing exit. If restraints are present, double check that any restraints used are included in the care plan and follow WAC 388-78A-2660.
      4) Uncommon or numerous skin tears.
      5) Bruising with injuries with unknown cause.
   b. Key Triggers
   c. Sample Interview Questions (see Appendix E of SOP Chapter 20)

B. Forms

1. Approved Sleeping Room List – DSHS 10-389 / Instructions
2. Attachment A: Pre-Inspection Preparation (DSHS 10-359)
3. Attachment B: Request for Documentation (DSHS 10-360)
4. Attachment C: Resident List (DSHS 10-361)
5. Attachment D: Resident Characteristics Roster (DSHS 10-362)
6. Attachment E: Resident Group Meeting (DSHS 10-363)
7. Attachment G: Resident Interview (DSHS 10-365)
8. Attachment H: Other Contact Interview (DSHS 10-366)
9. Attachment I: Environmental Observations (DSHS 10-367)
10. Attachment J: Resident Record Review (DSHS 10-368)
11. Attachment K: Staff Sample/Record Review (DSHS 10-369)
12. Attachment L: Notes/Worksheet (DSHS 10-370)
13. Attachment M: Exit Preparation Worksheet (DSHS 10-371)
14. Attachment N: Contract Requirement (DSHS 10-372)
15. Attachment O: Environmental Observations – Contract Requirements (DSHS 10-373)
16. Attachment P: Food Service Observations (DSHS 10-486)
17. Attachment Q: Medication Pass Worksheet (DSHS 10-487)
18. Attachment R: Follow Up Visit (DSHS 10-577)
19. Infection Prevention and Control Forms
20. ALF Confidential Identifier List (DSHS 27-236)

C. Glossary of Terms

Abandonment – as defined in RCW 74.34.020.

Abuse – as defined in RCW 74.34.020.

Activities of daily living (ADL) – Those activities needed on a regular basis for self-care, such as: bathing, dressing, mobility, toileting, eating, transferring, or other related activities. This includes the "late-loss" ADLs (eating, toileting, bed mobility, and transferring), which are used to classify a resident into a RUG-IV group and/or other case-mix models.

Administrator – Includes the various titles of the responsible person(s) for the entity. This list includes but is not limited to superintendent, director, provider, program manager, individual or entity representative, resident manager, administrator, or executive director. Please refer to the WAC relevant to the setting type for more information.

Agency – State agency.

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

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

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

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

Chemical restraint – as defined in RCW 74.34.020.

Collateral contact – An external source knowledgeable about the particular situation or concern occurring in the vulnerable adult care setting. The collateral contact typically either corroborates or supports the information of those living in the setting.

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

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

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

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

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

Confidential information – A type of information that is protected by state or federal laws, including information about vulnerable adults, DSHS clients, employees, vendors or contractors, and agency systems unavailable to the public without legal authority.

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

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

Deficiency citation – Documentation of a violation of statute or regulation, other than those defined as a consultation. Documentation of a deficiency citation includes an entry made on the Statement of Deficiencies that consists of:

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

Deficient practice – The action(s), error(s), or inaction on the part of the entity relative to a regulatory requirement and to the extent possible, the resulting outcome.

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

Department on-site monitoring – means an optional remedy of on-site visits to an entity by department staff according to department guidelines for the purpose of monitoring resident care or services or both.

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

Evidence – Data sources, to include observation, interview and/or record review, described in the findings of the deficiency citation. These data sources within the deficiency citation inform the entity of the failure to comply with regulations. A minimum of two of the three data sources are required

to support the citation. Having documentation of all three data sources is optimal for the deficiency citation to be irrefutable.
Facility – as defined in RCW 74.34.020.
Fact – An event known to have actually happened. A truth that is known by actual experience of observation, interview, and review of records.
Failed facility practice – Describes the action(s), error(s), or inaction(s) on the part of the licensee relative to statute(s) or regulation(s) and, to the extent possible, the resulting negative outcome(s) to vulnerable adult(s). Term includes deficient practice, which is defined as "lacking an essential quality or element, and inadequate in amount or degree."
Financial exploitation – as defined in RCW 74.34.020.
Finding – A term used to describe each item of information found during the regulatory process about entity's practices relative to a specific requirement cited as being not met.
Fingerprint check – means a fingerprint check is considered a positive identification check. The fingerprints of an applicant are reviewed to match fingerprints taken at the time of an arrest or conviction of a crime.
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.
Food service worker – means according to chapter 246-217 WAC, an individual who works (or intends to work) with or without pay in a food service establishment and handles unwrapped or unpackaged food or who may contribute to the transmission of infectious diseases through the nature of the individual's contact with food products or equipment and facilities. This does not include persons who simply assist residents with meals.
Formal interviews – structured interviews with sample residents, the service provider, staff, family members or representatives, or other collateral contacts.
Gender neutral language – Use of terms to increase the confidentially and be inclusive of the vulnerable adult(s) in the specific setting. This includes pronouns, which do not associate a gender with the vulnerable adult in order to protect the identity, such as, they, them, or theirs. Emphasize attempts to avoid using gender specific pronouns such as he, him, his or she, her, hers.
Homelike – means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to decorate one's living area and arrange furnishings to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.
Identifier – The name, title, or letters/numbers referring to entity staff or those living in the residential setting within a Statement of Deficiency, following guidance contained within SOP Chapter 18 – Across All Settings and Principles of Documentation (POD).
Immediate or **immediately** – means within twenty-four hours for purposes of reporting abandonment, abuse, neglect, or financial exploitation of a vulnerable adult.
Improper use of restraint – as defined in RCW 74.34.020.
Incident – An official notification communicated to RCS's CRU from a self-reporting provider/provider representative that RCS licenses or regulates. Owners, operators, and managers of facilities must self-report incidents and/or allegations of vulnerable adult abuse, abandonment,

financial exploitation, sexual abuse, physical abuse, mistreatment, neglect, and/or misappropriation of a vulnerable adult's property. Nursing homes must also report vulnerable adult injuries of unknown origin and any other requirements outlined in WAC 388-97 (Nursing Homes).
Informal interviews – general conversations or information gathering which may occur during any part of the inspection process.
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, an Assisted Living Facility license, or an Enhanced Services Facility license.
Inspection – A generic term used to describe the process by which RCS staff evaluates a licensee's compliance with statutes and regulations. Complaint/incident investigations are only one type of on-site inspection/survey done to determine the health and safety of vulnerable adults in licensed or certified long-term care residential settings.
Last Date of Data Collection (LDDC) – The final date data was collected for the Compliance Determination (CD).
Legal representative—A generic term which includes the resident representatives who act on behalf of the resident concerning care and services provided by the facility, home, or entity. This would include power of attorney, surrogate decision-maker, guardian, or any other person authorized by law to act for another person.
Licensed bed capacity – means the resident occupancy level requested by the licensee and approved by the department. All residents receiving domiciliary care, or the items or services listed under general responsibility for the safety and well-being of the resident as defined in this section count towards the licensed resident bed capacity. Adult day service clients do not count towards the licensed resident bed capacity. WAC 388-78A-2020.
Licensee – A generic term to describe individuals or entities licensed or certified to provide services as an adult family home, assisted living facility, enhanced services facility, and/or nursing home care in the state of Washington.
Likely/likelihood – means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.
Long-term care facility – As defined in RCW 70.129.010(3).
Mandated reporter –this is an employee of the Department or the Department of Children, Youth and Families (DCYF); law enforcement officer; social worker; professional school personnel; individual provider; an operator of a facility or a certified residential services and supports agency under Chapter 71A.12 RCW; an employee of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, hospice or certified residential services and supports agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to Chapter 18.130 RCW.
Mechanical restraint – as defined in RCW 74.34.020.
Medication pass – The process through which medication is administered to patients.
Mental abuse – as defined in RCW 74.34.020.
Minimal harm – means violations that result in little to no negative outcome or little or no potential harm for a resident.

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

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

Neglect – as defined in RCW 74.34.020.

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

Nonresidential individual (ALF) – means an individual who resides in independent senior housing, independent living units in continuing care retirement communities, other similar living environment, or an unlicensed room located within an ALF. A nonresident individual must not receive from the ALF:

- Domiciliary care directly or indirectly; or
- Items or services listed in the definition of "general responsibility for the safety and well-being of the resident," except as allowed under WAC 388-78A-2032 or when the person is receiving adult day services.

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

Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the entity (e.g., development of avoidable pressure injury; reaction due to receipt of blood; lack of monitors for anticoagulant). Harm to vulnerable adults unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.

Personal exploitation – as defined in RCW 74.34.020.

Physical abuse – as defined in RCW 74.34.020.

Physical restraint – as defined in RCW 74.34.020.

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

Process – The specification of the ongoing manner that the entity must operate. The process requirements do not allow the entity to vary from what is specified.

> Examples include the reviewing, revising and/or updating the plan of care; policies and procedures such as, infection control procedures for cleaning/maintaining glucometers; or annual assessments for the vulnerable adults in the residential settings.

Provider – a) any individual or entity that provides services to DSHS clients, OR b) a person, group, or facility that provides services to DSHS clients. RCS providers include Adult Family Homes, Assisted Living Facilities, Certified Community Residential Services and Supports, Enhanced Services Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities and Nursing Homes.

RCS approved beds (ALF) – beds that were approved to have met the licensing requirements under Chapter 388-78A but were not licensed at the time of construction. 'Approved' rooms refers to

rooms that were licensable at the time of construction by CRS. Since building codes change every three years, and facilities make modifications both unreported and reported to CRS, it cannot be assumed that these rooms automatically meet minimum licensing requirements when the facility requests licensure of a room.

Recurring/Repeated –

- The department previously imposed an enforcement remedy for a violation of the same section of WAC or RCW for substantially the same problem following any type of inspection within the preceding 36 months for AFH, ALF, or ESF (24 months for CCRSS).
- The department previously cited a violation under the same section of WAC or RCW for substantially the same problem following any type of inspection on two occasions within the preceding 36 months for AFH, ALF, or ESF (24 months for CCRSS).

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

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

Reported beds (ALF) – the beds in each room that have an Assisted Living resident as identified by the administrator. It is reported as '0' if there is no Assisted Living resident in the room.

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

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

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

Resident (ALF) – means an individual who:

1) Chooses to reside in an ALF, including an individual receiving respite care;
2) Is not related by blood or marriage to the operator of the ALF;
3) Receives basic services; and
4) Receives one or more of the services listed in the definition of "general responsibility for the safety and well-being of the resident," and may receive domiciliary care or respite care provided directly, or indirectly, by the assisted living facility. Whereas a nonresident individual may receive services that are permitted under WAC 388-78A-2032.

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

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

Scope and severity (S/S) – The effect of non-compliance on a resident (severity) and the number of residents actually or potentially affected (scope) by the entity's non-compliance. Illustrated in the deficient practice statement and supported in the findings.

Serious adverse outcome or **Likely serious adverse outcome** – means serious injury, harm, impairment, or death has occurred, is occurring, or is likely to occur to one of more vulnerable adult receiving care in a facility due to the facility's noncompliance with health, safety, or quality regulations.

Sexual abuse – as defined in RCW 74.34.020.

Statement of deficiencies (SOD) – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date for the cited deficient practice. The SOD is a legal document available to the public on request.

Structure – Requirements specifying the initial conditions, which must be present for an entity to be certified to participate. They are expected to remain as is unless there is a need for major renovation, re-organization, or expansion of services.

> Examples include updating to new windows/carpet/paint; changing the number of bedrooms; changing the size of a room.

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

Universe – The total number of individuals, records, observations, objects, related to the provider's/licensee's practice at risk as a result of a deficient practice. Used as the denominator when determining the extent of deficient practice.

Unsupervised access – means not in the presence of:

- Another employee or volunteer from the same business or organization; or
- Any relative or guardian of any of the children or individuals with a developmental disability or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization (RCW 43.43.830).

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

Whistle blower – means a resident, employee of an entity, or any person licensed under Title 18 RCW, who in good faith reports alleged abandonment, abuse, financial exploitation, or neglect to the department, the department of health or to a law enforcement agency.

Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

D. Acronym List

AA	Administrative Assistant
AL	Assisted Living
ALF	Assisted Living Facilities
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
ARC	Adult Residential Care
CC	Carbon Copy (in emails)
CCRC	Continuing Care Retirement Community
CCS	Character, Competency and Suitability
CD	Compliance Determination
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CHOM	Change in Management
CHOW	Change in Ownership
COVID	Coronavirus Disease
CR	Construction Review
CRS	Construction Review Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DDA	Developmental Disabilities Administration
DOH	Department of Health
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care
EARC-SDCS	Enhanced Adult Residential Care-Specialized Dementia Care
EWP	Electronic Working Papers
FBI	Foodborne Illness
FM	Field Manager
FSA	Field Services Administrator
HCBS	Home and Community-Based Services
HCS	Home and Community Services
ICAR	Infection Control Assessment & Response
IDR	Informal Dispute Resolution
IDT	Interdisciplinary Team
IPC	Infection Prevention and Control
LA	LeadingAge of Washington
LDDC	Last Date of Data Collection
LE	Law Enforcement
LHJ	Local Health Jurisdiction
LTC	Long-Term Care
LTCOP	Long-Term Care Ombuds Program

MAR	Medication Administration Records
N/A	Not Applicable
OSFM	Office of State Fire Marshal
POC	Plan of Correction
POD	Principles of Documentation
PPE	Personal Protective Equipment
QA	Quality Assurance
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
RPP	Respiratory Protection Program
SFM	State Fire Marshal
SOD	Statement of Deficiency
SOP	Standard Operating Procedures
STARS	Secure Tracking and Reporting System
WAC	Washington Administrative Code
WD	Working Day
WHCA	Washington Health Care Authority

E. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/2024	I.A.21 Fire Safety Code Deficiencies	A new section was added to outline to process for coordinating with the Office of the State Fire Marshall	Provide staff guidance	MB R24-047
05/2024	I.A.6 Infection Prevention and Control	Guidance updated to reflect changes that have occurred since the end of the Public Health Emergency	Provide guidance to staff, including use of updated forms	MB R24-047
02/2024	Entire Chapter	Updated formatting and clarified guidance	Provide for easier document navigation and to capture current processes and systems	MB R24-010 • Staff training during the 02.06.2024 support call
02/2024	I.A.6. Infection Prevention and Control	A new section was added to outline the process for infection prevention and control	Provide staff guidance	MB R24-010 • Staff training during the 02.06.2024 support call
02/2024	I.A.20 Follow Up Visits	A new section added to outline the process for follow up visits	Provide staff guidance	MB R24-010 • Staff training during the 02.06.2024 support call
09/2021	13B11 Section added for Room List	The Room List section of CH5 Construction Service is being moved into CH13. Updated Pre-Inspection Preparation as well.	CH5 was a holding place for the section developed with DOH/CRS; associated MB instructions often missed.	1. Training scheduled for Sept 16, 2021-Part I Overview & October 14, 2021, Part II-Measuring Rooms. MB issued R21-085

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