| CCRSS PROVIDER NAME | | | | CERTIFICATION NUMBER | | | RCS CONTRACTED EVALUATOR / STAFF NAME | | | | CERTIFICATION EVALUATION DATES | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | ATTACHMENT K  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)  **CCRSS Staff Background Check and Record Review** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Staff Identifier | | **WACs** | **STAFF** | | **STAFF** | **STAFF** | | **STAFF** | **STAFF** | **STAFF** | | **STAFF** | **STAFF** |
| Name | | 388-101D |  | |  |  | |  |  |  | |  |  |
| Hire Date | |  | |  |  | |  |  |  | |  |  |
| Date WA State Name and Date of Birth (WNDOB) background check completed | | 0075 |  | |  |  | |  |  |  | |  |  |
| WNDOB Result Type | |  | NR  RR  D  A | | NR  RR  D  A | NR  RR  D  A | | NR  RR  D  A | NR  RR  D  A | NR  RR  D  A | | NR  RR  D  A | NR  RR  D  A |
| Date of Character, Competence and Suitability Review (CCSR) following WNDOB.  N/A if no record | |  |  | |  |  | |  |  |  | |  |  |
| N/A | | N/A | N/A | | N/A | N/A | N/A | | N/A | N/A |
| Lives out of state? | |  | Yes  No | | Yes  No | Yes  No | | Yes  No | Yes  No | Yes  No | | Yes  No | Yes  No |
| Date Final Fingerprint (FP) Check completed | | 0070 |  | |  |  | |  |  |  | |  |  |
| Fingerprint Result Type | | 0070 | NR  RR  D  A  N/A | | NR  RR  D  A  N/A | NR  RR  D  A  N/A | | NR  RR  D  A  N/A | NR  RR  D  A  N/A | NR  RR  D  A  N/A | | NR  RR  D  A  N/A | NR  RR  D  A  N/A |
| FBI Record of Arrests and Prosecutions (RAP), in file? | |  | Yes  NO  N/A | | Yes  NO  N/A | Yes  NO  N/A | | Yes  NO  N/A | Yes  NO  N/A | Yes  NO  N/A | | Yes  NO  N/A | Yes  NO  N/A |
| Date of CCSR following FP check.  N/A if no record | |  |  | |  |  | |  |  |  | |  |  |
| N/A | | N/A | N/A | | N/A | N/A | N/A | | N/A | N/A |
| Each box for a sampled staff should be completed or have further explanation.  Result Type Meanings: NR – No Record; RR – Review Required; D – Disqualify; A – Additional Information needed. | | | | | | | | | | | | | |
| Training before working alone (IISP, emergency procedures, reporting regulation, client confidentiality) | | 0095 |  | |  |  | |  |  |  | |  |  |
| Training within four weeks | | 0055, 0100 |  | |  |  | |  |  |  | |  |  |
| 75 hours basic training within 120 days – indirect supervision or exemption letter required until then | | 0055, 0100 | Letter | | Letter | Letter | | Letter | Letter | Letter | | Letter | Letter |
| Staff Training within six months | | 0105 |  | |  |  | |  |  |  | |  |  |
| Bloodborne Pathogens | | 0090 |  | |  |  | |  |  |  | |  |  |
| First Aid and CPR (within first six months and current) | | 0105, 0110 |  | |  |  | |  |  |  | |  |  |
| Nurse Delegation Training | | 0160 |  | |  |  | |  |  |  | |  |  |
| NAR / NAC Training | | 0150, 0315 |  | |  |  | |  |  |  | |  |  |
| CP Training | | 0480 |  | |  |  | |  |  |  | |  |  |
| Continuing Education (12 hours per calendar year) | | 0100 |  | |  |  | |  |  |  | |  |  |
| Annual review of DSHS 10-403 (Abuse / Neglect) | | 0500 |  | |  |  | |  |  |  | |  |  |
| The following question is setting specific, if N/A is marked, if the certification is not for a GTH, the entire row will be considered N/A. | | | | | | | | | | | | | |
| TB Test (GTH only) | | 0655 |  | |  |  | |  |  |  | |  |  |
| **Notes** | | | | | | | | | | | | | |
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| CCRSS PROVIDER NAME | | | | CERTIFICATION NUMBER | |
| --- | --- | --- | --- | --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | | CERTIFICATION EVALUATION DATE(S) | | | |
|  | | | | | |
| Text  Description automatically generated | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) ATTACHMENT N RESIDENTIAL CARE SERVICES  CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)  **CCRSS** **Certification Evaluation  Administrator Record Review and Interview** | | | | |
| **Record Request (this checklist is a tool as to what records may be requested, boxes are not required to be checked)** | | | | | |
| Staff list and location of staff records  Updated Client Characteristic Roster ([DSHS 10-691](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=10-691&title=) optional resource for provider – they may choose to provide the same information in their format of choice)  Provider insurance  Organizational chart  Client records in sample and location (IISP, MARs, ETR / ETPs, PBSP and FA, if applicable)  Cost report | | | Community Protection Program (CPP) site approvals (if applicable)  Incident reports (previous 24 months) and location  Policies and procedures  Emergency and disaster plan  Infection Prevention and Control procedures  Other (specify): | | |
| **Administrator (or Designee) Interview Questions** | | | | | |
| STAFF NAME | | | DATE | | TIME  AM  PM |
| Are there currently any communicable disease outbreaks?  Are there any safety concerns (neighborhood safety, bed bugs, lice)?  Do any clients work for your agency?  Does the agency loan money to clients?  How do you make sure shared expenses are completed equitably/timely?  Are any agency funds combined with client funds?  How do you handle cash accounts and client credit / debit / gift cards?  Are there any stolen, lost, or damaged records?  How do you maintain property records?  Do persons who are not clients live with clients? If so, do you provide support to non-clients?  How do you notify DDA of accounts over $1700 and when clients pay for health services?  Do you support any non-CPP clients with CP Clients? If yes, is there Non-CPP client approvals?  What is your policy on staff following Mandatory Reporting?  Any irregularities (issues / theft / staff, etc.) that would be helpful for us to know about?  Who is your Resource Manager?  Verify client sample, addresses, and verify when they will be home with staff:  Will any clients be upset by our visit? | | | | | |
| **Notes** | | | | | |
|  | | | | | |
| **Provider Insurance** | | | | | |
| Total Number of vehicle(s) owned by provider:  Are agency vehicles insured?  Yes  No (notify FM if no insurance)  Name of insurance agency:  Expiration: | | | | | |
| Agency Insurance – two million coverage or 3 million coverage for CPP providers?  Yes  No (notify FM if no insurance)  Name of insurance agency:  Expiration: | | | | | |
| **Infection Prevention and Control (IPC) Provider Information; explain in Notes any answer marked “No.”** | | | | | |
| **Are there written Infection Control Policies and Procedures** to prevent the spread of infection:  YES NO   * Standard precautions * Transmission based precautions * Reference to national, state, and/or local standards * Outbreak management   **Respiratory Protection Program** (only required for GH or GTH, or if in Provider Policy)  N/A   * Written program * Medical evaluation to wear an N95 respirator * Training (annual and on hire) * Fit testing (initial, annual, after physical change) * Record keeping (medical clearance, training, fit test results)   **Sick Leave Policies** – non-punitive, flexible, requires ill staff to stay home  **Contingency Staffing Plans** – how homes are staffed during a crisis  **Staff and Client Education** to prevent the spread of infection  **IPC Supplies** – provider ensures:   * Personal Protective Equipment (PPE) supplies in each home for clients, staff, and visitors (gowns, masks, gloves) * Alcohol Based Hand Rub (ABHR) and hand hygiene products available for clients, staff, and visitors * Environmental Protection Agency (EPA) registered products and cleaning of high touch areas | | | | | |
| **Notes** | | | | | |
|  | | | | | |
| **IPC Resource Links** | | | | | |
| * [Standard Precautions](https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html) * [Centers for Disease Control (CDC) Return to Work Guidance for Healthcare Workers](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) * [Outbreak definition](https://preparedness.cste.org/wp-content/uploads/2020/11/HC-Outbreak-Definition.pdf) * [Respiratory Protection Program](https://app.leg.wa.gov/WAC/default.aspx?cite=296-842) * [Washington State Local Health Departments and Districts](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FAboutUs%2FPublicHealthSystem%2FLocalHealthJurisdictions&data=05%7C01%7Cmillie.brombacher%40dshs.wa.gov%7Cc1bf499e0bb1419144d908daf36d8208%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638089949418399924%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=AJ0lvJ8a0e4quRtA09NeDflQ5RQIL4kVGTxeU%2F6q5M0%3D&reserved=0) * [ALTSA Provider / Administrator Letters](https://www.dshs.wa.gov/altsa/residential-care-services/altsa-provider-letters?type=CRS&field_date_value%5Bvalue%5D%5Byear%5D=&subject=) | | | | | |

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| --- | --- | --- | --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | | CERTIFICATION EVALUATION DATE(S) | | |
|  | | | | |
| Text  Description automatically generated | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) ATTACHMENT Q RESIDENTIAL CARE SERVICES  CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)  **CCRSS** **Certification Evaluation  Exit Preparation / Exit Conference** | | | |
| Date: Time:   AM  PM | | | Location:  Teams  In provider office | |
| Administrator / Designee present (Designee’s name: ) | | | | |
| **Introductions** | | | | |
| Thank the provider and staff for everyone’s cooperation during the evaluation.  The purpose of the exit conference is to provide information about any preliminary deficiencies. We may still need to gather further information following the on-site visit. If additional information is discovered after this meeting that impacts what is discussed today, we will call you prior to receiving the written report. Any issues that arise during the exit that cannot be answered by the evaluators during the exit conference will be forwarded to the RCS FM for follow up. | | | | |
| Notes: | | | | |
| **Sampled Clients** | | | | |
| During the evaluation, we take a representative sample of clients with varying levels of needs and supports. This helps us to obtain an accurate picture of your overall performance and compliance. Identify the sampled clients | | | | |
| Notes: | | | | |
| **Preliminary Deficiencies (include client / staff names or identifier, summary of the issue and WAC / RCW)** | | | | |
|  | | | | |
| **Next Steps** | | | | |
| * Please send any requested information to evaluator(s) (provide time frame – ideal within 24 hours, no later than seven calendar days after exit) * Explain:   + Process and timeframes for RCS management review / approval of SOD     - A SOD report will be sent within 10 working days of the last date of data collection (not the exit date)   + Submission process and timelines to submit plan of correction (POC)     - A POC is not required for consultations.   + Provider responsibility to initiate POC, even if planning to request IDR.   + IDR process, which will also be included on the final report. * A follow-up **may** occur. | | | | |
| **Notes** | | | | |
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