Overview

This Standard Operating Procedure (SOP) chapter outlines activities and procedures that Residential Care Services (RCS) staff are required to follow when conducting licensing inspections in an Enhanced Services Facility (ESF).

The Washington State Legislature authorized the Department of Social and Health Services (DSHS) to develop ESFs under Chapter 70.97 RCW. This category of licensed residential facilities provides a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting. Individuals are referred to a facility if they are coming out of state and community psychiatric hospitals or have no other placement option due to their complex behavior, medical needs, chemical dependency, and/or mental health needs.

The general eligibility requirements for ESF residents are individuals who are at least 18 years old and require daily care by or under the supervision of a mental health professional (MHP), chemical dependency professional, or nurse; or assistance with three (3) or more activities of daily living. In addition, the individual must have a mental disorder and/or chemical dependency disorder, organic or traumatic brain injury, or cognitive impairment that results in symptoms or behaviors requiring supervision and facility services.

The maximum bed capacity for a facility is 16 beds. In order to serve facility residents, a facility must be a licensed ESF and be contracted with Home and Community Services (HCS). An ESF also falls under a HCS settings waiver and rules. ESFs use high staffing ratios and behavioral and environmental interventions to serve individuals. They also offer behavioral health, personal care, and nursing services.

The ESFs are inspected to ensure they meet the minimum care and safety requirements specified in law and rule. Inspections include resident and staff interviews, resident record reviews, observations, and physical plant evaluations.

These procedures support:

- The RCS mission to promote and protect the rights, security, and wellbeing of individuals living in licensed or certified residential settings.
- The DSHS mission to transform lives.

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

Enhanced Services Facilities must comply with the following RCW and WAC Chapters:

- Chapter 10.77 RCW Criminally Insane Procedures
- Chapter 13.36 RCW Guardianship
- Chapter 70.97 RCW Enhanced Services Facilities
- Chapter 71.05 RCW Behavioral Health Disorders
- Chapter 71.24 RCW Community Behavioral Health Services Act
- Chapter 74.34 RCW Abuse of Vulnerable Adults
- Chapter 388-107 WAC Facility Licensing Rules
- Chapter 388-112 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 ESF regulations and policies:

- Department of Health (DOH) – Construction Review Services (CRS)
- DOH – Food Safety
- Washington State Patrol (WSP) – Office of State Fire Marshal (OSFM)
- State Long-Term Care Ombuds Program (LTCOP)
- Western State Hospital (WSH) and Eastern State Hospital (ESH)
- Home and Community Services (HCS)

Contacts

- RCS Policy Unit General Contact: RCSPolicy@dshs.wa.gov
- RCS Quality Improvement Unit General Contact: ImproveRCS@dshs.wa.gov
- RCS Training Unit General Contact: RCStraininginquiry@dshs.wa.gov

Chapter Index

Part I: ESF Inspection Procedures

A. General Guidelines

Purpose

The purpose of conducting ESF licensing visits is to ensure facilities are meeting or continuing to meet the minimum licensing standards as defined in Chapter 70.97 RCW and Chapter 388-107 WAC. The primary focus should be on resident outcomes, choice, rights, quality of care, and quality of life. This section explains some background information about the timing and general purpose of ESF inspections.

ESFs must meet and always be in compliance with the applicable minimum licensing requirements and deliver quality care to residents.

Procedure

1. Inspection Frequency
   a. RCS conducts unannounced inspections in ESFs at least every 18 months.
   b. The field manager (FM) must schedule facility inspections so that they are unpredictable with the average inspection interval being 15 months. This is achieved by:
      i. Inspecting a facility between 9-12 months if the facility has multiple, severe, or repeated compliance issues.
      ii. Inspecting a facility between 16-18 months if the facility has few or limited compliance issues.
      Note: The FM has authority to require early inspections if problems are identified.
2. Inspection Procedures
   a. Follow the written inspection procedures and forms to ensure inspections are done in a consistent manner and focus primarily on actual or potential resident outcomes. Use observations and interviews to determine the facility's compliance with the licensing laws and rules. Begin making ongoing observations starting with the entrance, during the tour and throughout the entire inspection.
   b. Use record reviews to validate concerns and issues identified by observation and interviews.
   c. Information can be collected off-site after the on-site inspection is completed if further information is necessary to determine and support non-compliance. Off-site information should be collected as soon as possible after the on-site exit.
   d. Do not communicate about an issue too soon unless it is a serious issue that the facility must deal with immediately. Do not communicate issues that may lead to failed practice until you have collected enough information to make that determination.
   e. Collect data from observations, interviews, and record review to support or invalidate an issue. An observation alone does not always confirm or disprove a deficient practice.

f. Tell the administrator when they are in compliance with the regulations and when they have not met the requirements. The licensor may also tell the administrator whether or not something the administrator plans to do would appear to help meet the regulatory requirements.
g. Do not provide technical assistance or best practice information on how to implement the regulations or correct the deficiencies.
h. Use only the most current approved versions of SOPs and forms posted to the RCS intranet.
i. The inspection is unannounced; therefore, licensors will not disclose the planned date of the inspection to anyone (except the state fire marshal [SFM] if asked).
j. Licensors will attempt to minimize the disruption of resident and facility routines during the inspection.

3. Inspection Dress and Behavior:
   a. Dress professionally.
   b. Wear state identification badge.
   c. Communicate with the administrator, staff, Ombuds, resident families, and residents in a courteous and respectful manner.
4. Data Collection:
   a. Data collection during inspections consists of observations, interviews, and record reviews and is:
      i. Collected in a factual and objective manner.
      ii. Not affected by assumptions and personal opinions.
   b. Timeliness of data collection:
      i. Collect data as quickly as possible.
      ii. Collect data to support decision making for findings which could result in citations and enforcement.
      iii. Delay in data collection may negatively impact the department's ability to cite or do enforcement.
5. Resident Rights:
   a. Monitor staff and residents throughout the inspection for resident rights including:
      i. Right to refuse.
      ii. Choice.
      iii. Dignity.
      iv. Quality of life.
      v. Communication.
      vi. Identified needs being met.
6. Inspection Observations:
   a. Are an important part of data collection.
   b. By themselves, do not usually support a failed practice issue or concern and generally require additional observations, interviews, and record reviews to validate.
   c. Are critical to either substantiate or rule out information obtained through record review

and/or interview.

7. Field Manager Consultation:
   a. Contact the FM for guidance if the following situations occur during the inspection:
      i. Something occurs that will likely extend the timeframe of the licensing visit.
      ii. You are not sure of how to proceed.
      iii. Immediate enforcement may be needed.
      iv. A nurse is needed for some aspect of the inspection and there is no nurse on the team.
      v. Someone is impeding the inspection.
      vi. Residents appear to be alone in the facility or no one is in the facility.

Field Manager Responsibility

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

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

B. Pre-Inspection Preparation

Purpose

The purpose of pre-inspection preparation is to gather and analyze information regarding the ESF prior to entrance on site. The pre-inspection preparation occurs off-site, prior to the on-site visit. The inspection is unannounced to ensure the facility is in compliance with the licensing requirements. Anticipated dates of inspections must not be disclosed to any contacts during the preparation.

Procedures

1. Review the information obtained during the pre-inspection preparation.
2. During the pre-inspection preparation activities, identify residents for care and service issues that could be included in the resident sample.
3. Establish roles and responsibilities including a team coordinator.
4. Make copies or transcribe information from the licensing working papers that may be needed for the inspection.
5. Record all pertinent history, current data, and contact information on the pre-inspection preparation form (Attachment A: Pre-Inspection Preparation).
6. Identify any issues related to abandonment, abuse, financial exploitation, or neglect.
7. Assemble the most current approved forms (Attachments) for recording data during the inspection.
8. Assemble supplies that may be needed prior to inspection.
   Example: personal protective equipment, thermometer, dishwasher temperature strips, hair restraints, tape measure, calculator, paper/pen, and access to the RCWs and WACs pertaining to ESFs.
9. Review pertinent documentation on the facility history since the last full inspection:
   a. Review the tracking system (such as the Secure Tracking and Reporting System [STARS]) and print out facility summary.
   b. Review tracking system for compliance history, number of licensed beds, specialty designations, contracts, current exemptions, and uncorrected citations since the last follow up inspection or complaint investigation.
   c. Identify any reported changes to the facility since the last full inspection, such as change of administrator, change in ownership (CHOW), DOH approved new construction, contract changes or other information that would impact resident care and services. For DOH approved new construction project reports, go to: Construction Review Search.
   d. Review license for exemptions related to facility construction.
   e. Review all Statements of Deficiencies (SODs), including complaint SODs, and consultations since the last full inspection.
   f. Identify and document, if applicable, any patterns of repeat and/or isolated deficiencies and resident identification.
   g. Review the quality review complaints since last full inspection.

   h. Obtain licensed room list, if applicable, from tracking system to note approved licensed rooms at last inspection.
10. Identify any open complaints yet to be investigated. Note resident and staff names and other contacts referenced in the reports as well as repeat issues or patterns.
11. Contact the Ombuds Office.
    a. Note any potential areas of concern and resident names or family members for potential sample residents and other contacts.
    b. Discussions with Ombuds will be focused on care, quality of life, and any concerns about the facility.
    c. The licensor must not discuss the upcoming inspection date.
12. Contact other field staff who were involved with the facility since the last inspection if an issue exists regarding compliance history or if there are current issues in the facility.
13. Contact FM if:
    a. Special concerns exist that would require a licensed nurse, and none is available on the team.
    b. Any questions or concerns arise after data collection.

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C. Infection Prevention and Control

Purpose

The COVID-19 pandemic highlighted the need for effective Infection Prevention and Control (IPC) in long-term care settings. As a result, IPC assessments will be part of every inspection. This process provides field staff with tools and guidance to adequately assess community infection prevention and control practices and protocols.

Procedure

1. Determine the appropriate form(s) to utilize. The IPC Pathway **OR** the IPC Tool must be utilized for all inspections.
   a. IPC Pathway: DSHS 00-411
      i. The Pathway provides expanded instructions based on the COVID Response Plan for Long Term Care Recommendations and Requirements, which includes Centers for Disease Control and Prevention, Department of Health, and Local Health Jurisdiction guidance.
      ii. The Pathway offers more detailed instructions for the IPC Assessment.
   b. IPC Tool: 00-412
      i. The Tool has a checklist on the front of the page with condensed instructions and a notes section on the back page for documentation.
      ii. The Tool offers less detailed instructions for the IPC Assessment.
   c. IPC Notes: DSHS 00-412A
      i. The Notes form is not meant to replace the Tool or the Pathway. It is designed as a supplement when additional documentation is needed.
      ii. The Tool and the Pathway are organized by sections with corresponding letters for easy documentation reference on the Notes form.

      Note: The Pathway and the Tool are forms designed to guide regulatory staff to assess elements through observations, interviews, and record reviews required to complete the IPC assessment. The specific form to use depends on the knowledge, experience, and understanding of the process of each regulatory staff. If unsure of which form to use, staff may consult with the FM. The IPC Notes form is used if more space is required for additional documentation or notation. These forms will be updated as the LTC COVID Response Plan is updated.
   d. Review the references listed on form DSHS 00-411 and DSHS 00-412 during pre-inspection preparation. Document the review on the selected form.
   e. Determine if there is a communicable disease outbreak in the facility and document on the form.
   f. Indicate the Personal Protective Equipment (PPE) plan on the form.
   g. Discuss the PPE plan during the team meeting.

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D. Entrance Onsite

Purpose

The way RCS initiates contact with an administrator, staff, and residents will set the tone for the rest of the inspection. Always be respectful and allow the administrator and staff time to ask questions.

The goal of the on-site entrance procedure is to:

1. Initiate the unannounced full inspection of the ESF.
2. Provide information regarding the inspection.
3. Collect initial data regarding residents, staff, and physical environment.

Procedures

1. The team must vary the timing of the entrance (different days of the week, different times of the day) to increase unpredictability and to observe and capture different aspects of resident care. 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 different days of the week.
2. Entering the facility:
    a. Announce yourself at the main entrance.
    b. If the person who appears at the entry is not the administrator, suggest they notify them that a full inspection is occurring. Inform them the full inspection will not be delayed until the administrator arrives.
    c. If no staff appear at the entry, evaluate the situation.
        i. If a resident answers the door or residents are observed from the entry way, make introductions, and inquire about staff in the facility.
        ii. Do not complete the tour of the facility without staff or administrator present. After the initial tour, field staff do not need to be accompanied by facility staff.
        iii. If there is any evidence that residents may be alone in the facility, immediately contact the FM for further instructions.
    d. If it appears no one (facility staff or residents) is in the facility:
        i. Check licensing information in pre-inspection preparation papers and call the listed phone number for the facility. If no answer, call any alternate phone numbers.
        ii. Wait outside and try entrance again in 15 to 30 minutes.
        iii. Contact FM is still unable to enter facility.
    e. If denied entrance:
        i. Attempt to clearly re-state reason for visit.
        ii. Suggest staff or resident contact the administrator if speaking to someone other than the administrator.
        iii. Leave and immediately contact FM if still denied entrance.

3. Upon entrance:
   a. Make introductions to the administrator or staff and provide a business card. Have department nametag visible or show state identification (ID) card.
   b. Give the administrator or staff a reasonable amount of time to complete what they were doing before beginning the entrance conference.
   c. Use any waiting time to observe the residents and the immediate environment, make introductions to any residents or staff in the area, and briefly 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 for 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 or facility staff that they can expect frequent contact from licensing team during the inspection to gain and share information.
   f. Remain aware of minimizing disruption of resident and facility routines as much as possible throughout the inspection. Adjust procedures of the inspection accordingly. However, do not delay the process. If unable to do a certain inspection task, use this time to do another task of the inspection before returning to the prior task.
4. Entrance Conference:
   a. Review the inspection process and expectations with administrator and staff.
   b. Explain that the first step will be a guided tour of the facility as well as other areas accessed by the residents.
   c. Request a facility contact person if the administrator will not be present at any time during the inspection.
   d. Provide the administrator or staff a written list of documentation needed (Attachment B: Request for Documentation) and emphasize the timelines for requested materials:
      i. By the beginning of the tour
         1) Completed List of Residents (Attachment C: Resident List), facility created list or Attachment D: Resident Characteristic Roster and Sample Selection.
      ii. By the end of the tour
         1) Completed Resident Characteristic Roster and Sample Selection (Attachment D: Resident Characteristic Roster and Sample Selection).
         2) Completed facility generated list of staff with names, position title, birthdate, shift, and date of hire.
         3) A copy of evidence of liability insurance coverage.
         4) A copy of the facility Admissions Agreement to identify the scope of care and services.
   e. The facility is not required to complete a DSHS form. If the facility does not return the completed Attachment D: Resident Characteristic Roster and Sample Selection by the end of the tour, encourage use of the form by the following:
      i. Verify the administrator knows how to access the form (online or by contacting the department).

ii. Explain that the form serves as an informational tool for the facility staff by providing valuable information about each resident and their needs.
iii. Explain that presenting the form in a timely manner helps speed along the inspection.

f. Ask the administrator or staff 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?

5. Proceed with the tour.

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E. Tour

Purpose

The tour of the facility allows the licensor the opportunity to:

1. Inspect the physical environment.
2. Meet residents.
3. Observe how care is provided.
4. Note any quality of life or safety concerns.

The tour provides the licensing team with an initial introduction to and observation of the residents, facility staff, and the physical environment with a focus on the resident for the following issues: quality of life, care and services, environment, and safety issues. Data collection during the tour consists of observations and informal interviews with residents, their representatives or families, and staff members.

- **Formal interviews** are with residents and their representatives or families selected in the sample.
- **Informal interviews** are with residents not selected in the sample and the interviews are not structured or planned. Informal interviews conducted during the tour may lead the licensor to concerns that would otherwise not be identified by record review or observations.

Procedures

1. Tour the facility as a team with the administrator. The licensors may split the tour tasks (e.g., kitchen, laundry room, storage areas, etc.) among team members if facility staff other than the administrator are available who are knowledgeable about the building and residents. If the administrator or knowledgeable staff are not available, ask available staff to accompany and conduct tour.
2. Communicate with the administrator throughout the tour regarding the features of the facility and request clarification related to observations or concerns as needed.
3. Conduct observations of residents, interior and exterior environments, nursing services, and required posting of information.
4. Document tour information on Attachment G: Environmental Observations and Attachment K: Notes/Worksheets.
5. During the tour, refer to the completed resident list (Attachment C: Resident List) or facility provided list for identification of residents and their room location.
6. Use the observations and informal interviews during the tour to identify residents for the preliminary resident sample selection.
7. Document observations as needed.
8. Observations During the Tour:

The tour is the 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. The following will be completed by the end of the tour:

a. Identify residents who express concerns or appear to have unmet or special care and service needs.
b. Determine if residents identified in the pre-inspection preparation are in the facility.
c. Observe the general appearance of residents.
d. Observe staff to resident interaction related to quality of life, dignity, privacy, and responsiveness to resident needs including verbal communication, eye contact, and touch.
e. Observe residents' response to staff.
f. Observe interior environment.
g. Identify and conduct general observations of all areas designated for resident use including:
    i. Common areas for homelike appearance.
    ii. Resident furnishings, beddings, walls, and floors for maintenance and cleanliness.
    iii. Activity room(s).
    iv. Laundry room(s).
    v. Storage areas, including medication storage.
    vi. Restrooms.
h. Observe for any safety hazards.
i. Note presence of any objectionable odors.
j. Ask the administrator to explain how the 'resident-to-facility' communication system operates.
k. Observe for adequate lighting necessary for safety and needs of residents.
l. Observe for room temperature to determine if it is maintained at a comfortable temperature for resident living. If it appears very cold or hot in the building, continue collecting data including observing how residents are dressed and interviewing residents about the temperature.
m. Observe general maintenance and housekeeping.
n. Observe and inquire regarding resident or facility pets (WAC 388-107-1610) if facility policy allows.
o. Observe for safe storage of housekeeping supplies, including hazardous supplies and equipment (check Resident Characteristic Roster for known behaviors).
    Example: If a resident does their own laundry, can they manage their own detergents?
p. Observe hand washing areas for staff and residents and observe whether staff are washing hands as required.
q. Conduct initial kitchen tour and observe for general cleanliness and sanitation practices.
r. 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 to ensure it was implemented as approved. The CRS approved plan can be obtained by contacting the front desk of CRS.

9. Review facility nursing services by observing for:
    a. Storage, and handling of nursing equipment and supplies.
    b. Infection control including disposal of hazardous waste, etc.
10. Observe exterior environment:
    a. Walk outside and around the property of the facility.
    b. Observe the area utilized for storage of garbage and refuse.
    c. Observe for presence of rodents or pests.
    d. Observe exterior exit.
    e. Observe for resident access to outside without staff assistance and note uneven walking areas or unsafe areas.
    f. Observe for unsafe stairs, ramps, and handrails requiring maintenance.
    g. Observe for a fence or wall at least 72" high surrounding outside recreation space (WAC 388-107-0890).
    h. Observe for adequate lighting necessary for safety and needs of residents.
11. Observe and inquire regarding the required posting of:
    a. Current facility license, including limits/conditions on the license.
    b. Complaint Resolution Unit (CRU).
    c. Ombuds Information.
    d. Appropriate Resident Advocacy Groups.
    e. Copy of the report, cover letter and plan of correction (POC) of most recent full inspection conducted by the department.
    f. Resident Rights.
    g. Emergency Evacuation Routes.
12. Communication during the tour:
    a. Communicate with the administrator throughout the tour regarding the features of the facility, clarification, and enhancement of observation and concerns. Do not communicate about an issue too soon unless it is a serious issue that the facility must deal with immediately. Do not communicate issues that may lead to failed practice until you have collected enough information to make that decision.
    b. Communicate to the residents and staff as to the purpose of the visit and engage in brief conversations.
    Example: What is your name? How long have you lived here? What are you planning to do today? (Resident) or How long have you worked here? (Staff)
    c. Introduce yourself or request the administrator introduce the licensing team to the residents and staff during the tour.
    d. Inform residents that if they have questions or concerns, they can discuss issues with the licensors during the inspection.

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13. Completion of tour:
    a. Thank the administrator for the tour.
    b. Obtain the completed Resident Characteristic Roster and Sample Selection (Attachment D: Resident Characteristic Roster and Sample Selection), the facility generated staff list, and other documentation requested during the entrance conference.
    c. Inform the administrator that the team will be meeting briefly.
    d. Inform the administrator of what step is planned next in the process.
    e. Inquire if the administrator has any questions at that time.

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F. Resident Sample

Purpose

Select a sample of residents in the ESF that best represents the resident population regarding care and service needs. The size of resident sample is based on facility census and consists of residents selected for review. The sample selection must occur as soon as possible after the tour to allow ample time for observations and interviews.

Procedures

1. Select the residents for the sample from the information gathered during the preliminary sample selection phases: pre-inspection preparation, entrance, and tour.
2. Review the completed Resident Characteristic Roster and Sample Selection (Attachment D: Resident Characteristic Roster and Sample Selection) with licensing team.
3. Choose resident sample numbers in accordance with the Resident Sample Chart below. These are the minimum required reviews for the complete resident sample. If an additional issue is not identified, then the in-depth review may not be necessary.

Resident Sample Chart			
Number of residents	Sample Selection	Complete Review of sample (*all areas*)	Single or Limited Area Review
6 or less	all	all	0
7-16	50% of residents (at least 6)	total sample selection	add 3 residents if needed

4. Refer to the Resident Characteristic Roster and Sample Selection (Attachment D: Resident Characteristic Roster and Sample Selection) and information obtained through observations and interviews to ensure the resident sample represents as many as possible of the applicable categories below:
   a. Interviewable and non-interviewable.
   b. Medically fragile (WAC 388-107-0260).
   c. State funded.
   d. Receive basic services such as help with activities of daily living.
   e. Have special dietary needs or significant weight changes.
   f. Require medication assistance.
   g. Have special or unmet needs or are potentially vulnerable for abuse.
      Example: Residents with dementia, delusional thought process, 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).

5. Make efforts to include residents who have not been in a previous inspection sample.
6. The administrator and facility staff may be an important source for obtaining additional information on the selected resident sample.
7. Sample Substitutions
   a. Adjustments can be made to the resident sample in the following situations:
   b. If the team finds it necessary to remove a resident from the sample, such as:
      i. Resident declines to be interviewed or observed.
      ii. Resident is not available during the inspection.
   c. If a specific area of concern is identified during the inspection in facilities with seven (7) or more residents, the sample must be expanded by three (3) to investigate single or limited areas of concern (refer to Resident Sample Chart). If the scope of the problem is adequately identified within the current sample, the expanded sample is not necessary.
   d. Any substitution should be with a resident who best fulfills the reason the first resident was selected.
   e. Don't assume a resident is unable to be interviewed. Verify it for yourself after various attempts.
   f. If a resident is substituted, document the reason for the substitution.
      Example: Your initial sample included a resident with diabetes who chose to decline an interview. You substituted with another resident with diabetes. Sample working paper documentation: "Resident A declined interview, substituted with Resident Q who has similar care needs."

Note: Throughout the remainder of this chapter, the term "resident" will refer to the substituted resident or representative when applicable.

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G. Interview

Purpose

The purpose of interviews is to collect information about resident life in the facility by speaking with residents, administrator, facility staff, and other contacts.

Procedure

1. Interviews will include the following individuals:
   a. Residents:
      i. Sample residents.
      ii. Residents are the best point of contact when gathering data on resident quality of life and care.
      iii. If a resident has difficulty communicating, consider interviewing at another time or through alternate methods such as in writing or using an interpreter.
      iv. A resident has the right to choose not to interview. In this event, substitute with another resident as addressed in the Resident Sample.
         If a resident is substituted, document the reason for the substitution.
      vi. Throughout the inspection, the licensing team should be available for contact by any resident requesting to talk to them.
   b. Facility staff: administrator, MHPs, nursing staff, caregivers, other staff working at the facility, and volunteers.
   c. Other contacts: family members or resident representatives, outside resources or agencies including case managers, health care practitioners, home health/hospice, law enforcement, and other contacts not associated with the facility.
2. Formal Interviews
   a. Conduct formal interviews with all sampled residents.
      i. Review the person-centered service plan (PCSP) briefly prior to conducting the sample resident interview.
      ii. Address the areas in Attachment E: Resident Interview. The questions in Section A must be asked verbatim. From categories B-K, ask the sample question or your own, ensuring that each category is discussed. As much as possible, let the resident lead the interview.
3. Document the question(s) you asked in each category on Attachment E: Resident Interview.
4. Choose the best location for interviews considering:
   a. Privacy (including ensuring that monitors and intercoms are turned off).
   b. Comfort and accommodation of the persons' needs.
5. Interview a family member or resident representative when a sample resident is not interviewable, cannot give reliable or sufficient information, or their interviewing capability is limited due to issues that impair communication such as speech impairment, confusion, delusion, or dementia.

a. If a representative is substituted, document the reason for the substitution.

6. Obtain the services of an interpreter if the resident sample includes a non-English speaking resident. This may require a scheduled return visit. Notify the FM early in the process if an interpreter is required for a sampled resident.
7. Interview others involved in the resident's care and services such as parole officer, case manager, ombuds, advocacy groups, etc., to obtain information that is necessary to support a citation.
8. Document IPC interviews on the IPC forms.
9. Process:
   a. Use pre-inspection preparation information, observations and informal interviews conducted during the tour, and a brief review of the person-centered service plan to supply information and points of discussion for the interview with the sample resident, facility staff, or other contacts.
   b. Introduce yourself to the resident and briefly explain the reason for the interview and the inspection process.
   c. Let the resident know their right to choose not to be interviewed and the inspection team's need to take notes during the interview in order to be accurate.
   d. Explain to the resident their comments could be used in the future, and we cannot guarantee confidentiality if legally challenged.
   e. Obtain permission from each sample resident before sharing information with the administrator. Explain there may be circumstances when the department must share information due to mandated reporting requirements.
   f. Let the interviewee lead the interview.
   g. Use open-ended questions and active listening skills for all interviews. Speak slowly and clearly.
   h. Use quotation marks when quoting what the resident says they feel, e.g. "I feel", or "It makes me feel." Quotations can have a major impact in the SOD.
   i. Address any statements that appear unclear or need further explanation.
   j. Observe the resident and their environment during the interview.
   k. If the resident gets tired before the end of the interview, complete the interview later.
10. Interview Conclusion:
    a. Allow the interviewee to ask questions and provide any additional information.
    b. Provide a contact number.
    c. If a follow up interview is anticipated, inform the interviewee that they may be contacted again and inquire as to their availability.
    d. Complete documentation of interview. Notes must support any compliance determination.
    e. If quoting anyone, make sure it is verbatim.
11. Informal Interviews:
    a. Conduct informal interviews with residents, visitors, administrator, and staff throughout the inspection.

b. If a specific issue is identified, conduct an in-depth interview about the issue using Attachment E: Resident Interview.

12. Document the information from the interviews using attachments as a guide.
    a. Sample resident interview: Attachment E: Resident Interview
    b. Other contact interview: Attachment F: Other Contact Interview or Attachment K: Notes/Worksheets.

H. Observation of Care

Purpose

The purpose of observations is to ensure the care provided in the ESF is appropriate for the resident's needs, consistent with the PCSP, performed by qualified and trained staff, and upholds resident rights for quality of life, dignity, privacy, and choice.

Citations based upon observations form the basis of the most defensible citations. Observations of residents will occur throughout the inspection. Observation of care will provide current information regarding resident care needs, including nursing care and provision of care, behavioral health support and services, staff to resident interaction, staff training, and possible complications regarding special care needs of a resident.

Procedure

1. Conduct observations of residents at all times during the inspection and document observations and issues regarding resident outcomes (actual or potential).
2. Conduct observations targeted to care issues of residents when a specific care issue has been identified. For these observations:
   a. Observe, if possible and with resident's permission, the caregiver providing assistance with personal care.
   b. Do not touch or examine a resident or provide hands-on care. Request facility staff to provide the direct care if the resident agrees.
3. Document observations including description of observation, resident name, caregiver name, date, time, and location of observation. Documentation may be done on any of the appropriate forms (Attachment E: Resident Interview, Attachment K: Notes/Worksheets, Attachment G: Environmental Observations).
4. Document IPC observations on the IPC forms.
5. Collect additional data that may be required to support, clarify, or invalidate the observations.
   Example: A resident is observed to have long, dirty fingernails. Further data collection included an interview with caregiver who relayed the resident was refusing fingernail care.
6. RCS registered nursing staff will conduct all observations that require looking at a resident's breasts, genitalia, and buttocks.
7. Data Gathering for Observations
   Residents may be identified for potential observation of care through any part of the inspection including the pre-inspection preparation, on-going observations and interviews with residents, staff, and outside contacts:
   a. Document any care issues noted during the licensing file review and interviews in the pre-inspection preparation (e.g., a resident mentioned in a recent complaint report or identified as having care issues by the case manager).

b. Note any residents who express problems or concerns or those residents who appear to have unmet care needs.
c. Review of the resident characteristic and sample selection form (Attachment D: Resident Characteristic Roster and Sample Selection) and interviews with residents, facility staff and outside contacts may also identify care issues requiring observations.

8. Make observations of residents throughout various times and locations of the inspection to provide a more complete perspective of the resident's engagement in services and activities at the facility. Consider hourly rounds to support a compliance condition that needs a longer observation period for documenting an apparent issue that may impact the resident consistently throughout the day. Example: residents who have fall histories could be observed at several time throughout the day to see if they have mobility assistive devices nearby.
9. A resident has the right to choose not to be observed. In this event, substitute with another resident as addressed in the Resident Sample Selection Process.
10. Observations of the resident's general appearance can occur at any time during the inspection. Consider:
    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 or hearing deficit, side rail use, 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.
11. Observations specific to a resident or care issue may require a more structured and planned setting for the observation. Observe for the following:
    a. Resident response to the care provided:
        i. Resident behavior.
        ii. Resident level of comfort.
    b. Observe staff interacting with resident(s).
    c. Observations of the MHP may include:
        i. Providing and documenting direct service to residents.
        ii. Utilizing de-escalation techniques if needed.
        iii. Discussing and implementing behavioral support plans.
        iv. Providing education and assistance to caregiving staff regarding behavioral interventions.
    d. Observations of caregiver or nursing staff performing care may include:
        i. Staff to resident interaction.
        ii. Appropriate infection control practices.
        Example: when using "Point-of-Care" devices such as finger-stick devices and blood glucose meters.

iii. Assistance provided as identified in the PCSP.
iv. Physical care provided using safe and appropriate techniques.
v. Inclusion of resident's participation in care tasks to the maximum of their ability as identified in the PCSP.

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I. Abuse Prevention Review

Purpose

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

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

Field staff will:

1. Remain alert throughout the visit for indicators of possible abuse. Document information on any suspected or actual abuse. Potential indicators may be found:
   a. During environment observations.
   b. While conducting interviews.
      Note: See Resources for specific examples of potential abuse, link to Key Triggers which may indicate abuse, and sample questions to ask during interview.
2. During administrator and staff interviews, verify understanding of abuse and what to do if abuse is suspected or witnessed. This includes staff understanding of:
   a. Financial exploitation, physical, mental, and sexual abuse.
   b. Steps to take in the event of suspected abuse.
   c. Notification and reporting requirements as described in the ESF's policies and procedures.
3. Request the facilities incident investigation report if you become aware of a probable or actual incident, injury, or accident since the last inspection to determine if:
   a. Mandated reports have been submitted as required by state abuse reporting law; and
   b. The provider has taken appropriate action to protect residents' safety.
4. Verify mandated reporting postings including the department toll-free complaint number contact and long-term care ombuds.
5. If abuse is suspected or identified, the field staff's first responsibility is as a mandated reporter. Field staff will:
   a. Immediately notify the CRU by email (cru@dshs.wa.gov), with a cc to the FM.
   b. Contact the FM if any of the following situations occur:
      i. If possible resident abuse or neglect is occurring during the visit.
      ii. If the investigation will extend the timeframe of the licensing visit.
      iii. If unsure how to proceed.
      iv. If investigation should be conducted immediately.
      v. If immediate enforcement may be needed.

vi. If a nurse is needed and a nurse is not on the team.
vii. If law enforcement (LE), Adult Protective Services (APS), or both should be notified for purpose of conducting a joint investigation.

c. Immediately notify LE if:
   i. There is reason to suspect sexual assault has occurred.
   ii. There is reason to suspect physical assault has occurred.
   iii. There is reasonable cause to believe that an act has caused fear of imminent harm.
d. LE does not need to be notified for an incident of physical assault between two (2) residents that causes minor bodily injury and does not require more than basic first aid unless:
   i. Requested by the injured resident/legal representative or family member.
   ii. The injury appears on the back, face, head, neck, chest, groin, inner thigh, buttock, genital or anal area.
   iii. There is a fracture.
   iv. There is a pattern of physical assault between the same residents.
   v. There is an attempt to strangle a resident.
e. Verify resident(s) safety before conclusion of the on-site visit.
   i. FM Responsibility: 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.

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J. Medication Services

Purpose

The purpose of medication services is to provide field staff with an overview of the ESF's medication service system. The medication service task incorporates observations, interviews, and record review to ensure the facility has developed and implemented a medication system that promotes the safe delivery of medications for all residents. Observations and data collection include medication storage, medication delivery system, and respect for resident rights.

Procedure

1. Review the medications for the sampled residents during the resident record review.
2. Contact the FM to determine if a Registered Nurse (RN) needs to join the team to complete the medication review, observe the medication pass, or if an issue is identified.
3. Medication review includes:
   a. Medication storage: safety, labeling, organizers.
   b. Medication delivery system: documentation, assistance/administration, alterations, suitability for resident needs.
   c. Medication prescriptions received timely.
   d. Respect of resident rights: right to refuse, individual choice and preference.
   e. Disposal of medications.
4. Make observations of medication services throughout the inspection.
5. Document findings.
6. Observe medication storage area throughout the inspection for the following:
   a. Medications are secure for residents not capable of self-storage.
   b. Medications are properly labeled.
   c. Medications for a specific resident are stored together and are kept separate from other resident medications, food, and toxic chemicals.
   d. Storage area is locked and accessible only to designated staff.
   e. Medications are stored according to medication label recommendations.
      Example: "keep refrigerated."
7. Observe staff during medication assistance and administration throughout the inspection for the following:
   a. Staff knowledge and technique.
   b. Staff-to-resident interaction and communication.
   c. Appropriate level of medication assistance and administration.
8. Complete record review of general medication system
9. Interview residents regarding medication services.
10. Interview staff regarding medication storage, including:

a. System for controlling and securing medications for residents assessed to be capable of self-administration or self-administration with assistance.
b. Use of medication organizers.

11. Observe resident room during interview for medication issues such as medications on floor or inappropriately stored.
12. Review medication records noting any documentation of refusal or no availability of medications, if the physician was notified of a refusal, and if appropriate action was taken if there was a pattern of refusal (for pattern of refusal see WAC 388-107-0350).
13. Conduct resident record review noting if the PCSP addresses medication.
14. Medication Pass: If medication issues are identified, a RN will conduct observations of a medication pass including:
    a. Compare observations with the prescriber's orders.
    b. Review the medication records for accuracy and completeness.
    c. Review if the facility reconciles and secures controlled medications.
    d. Observe whether staff confirmed the resident's identity prior to giving medications.
    e. Record procedures staff use to handle and administer medications.
    Example: flushing gastric tubes, crushing medications, injecting diabetic insulin.
    f. Identify medications not being given in a timely manner.
    Example: antibiotics and pain medications.
    g. Review how emergency medication issues are handled.
    Example: allergic reaction, incorrect medications given, overdose.
    h. Review what the facility does to obtain medication in a timely manner.
    i. Document medication pass observation on ESF Medication Pass Worksheet (Attachment N: Medication Pass Worksheet).
    j. If issues or outcomes are identified regarding medication services during interviews and observations, reconcile medications with the logs for documentation of residents receiving medications and supplements as ordered and note findings.
    k. If an issue is identified, expand the sample to include supplemental residents per guidance in Resident Sample.

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K. Environmental Observation

Purpose

The purpose of environmental observation is to observe the physical environment of the ESF that affects resident care, health, quality of life and safety.

Procedures

1. Conduct observations regarding the appearance of the facility throughout the inspection.
2. Conduct observations of an open resident room, if resident permits, during the tour and during a resident interview.
3. Share observations with the licensor responsible for conducting and coordinating the environmental observations.
4. Conduct observations in the common areas.
5. Document findings of environmental observations using Attachment G: Environmental Observations. If additional space is needed, use the notes page (Attachment K: Notes/Worksheets).
6. Check water temperature in resident utilized bathrooms (WAC 388-107-0970).
7. Conduct observations of common areas and resident rooms including the following:
   a. Information posted: contact for department hotline and Ombuds hotline.
   b. Interior environment homelike and clutter free.
      i. Homelike refers to avoiding an institutional setting appearance and can include furniture, decor, and recreational materials.
   c. Access to secure, covered outdoor area.
   d. Maintenance and Housekeeping – Interior.
   e. Quality of life.
   f. Safety issues.
   g. Safety and disaster preparedness.
   h. Exterior environment.
   i. Sufficient space to accommodate residents in common areas.
8. Review license for exemptions related to facility construction prior to observations.
9. Consult with the administrator and staff if you need any clarification of observations of the environment.
10. If smoking is permitted for residents, check that the facility has identified a safe area 25 feet from the building per Chapter 70.160 RCW.
    Note: per care plan, smoking supervision may be required.
11. If electronic monitoring (audio or video) is used, ensure they adhere to WAC 388-107-0780 and WAC 388-107-0790.
12. Discuss with other members of the team if you identify clinical or nursing care issues during the environmental observations to ensure that issues are not systemic.
    Examples: wound care, incontinence care, pressure sore, injury.

13. Notify the FM and contact the CRU to report to the SFM if information gathered during environmental observations identifies a fire safety issue.
14. Contact the FM to determine if a RN needs to join the team to complete an identified nursing care issue.

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L. Food Services

Purpose

The purpose of food services is to provide the licensor with an overview of the ESF food service operation to include risk-based inspection criteria which consists of 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.

Chapter 246-215 WAC Food Code provides the safety standards for food served or sold to the public in Washington State. Washington adopted the 2009 Food and Drug Administration (FDA) Food Code, with some modifications. The Food Code serves as the basis for food service inspections providing rules that are more consistent with the national food safety standards incorporating the latest knowledge of food science and technology. General observations and data collection regarding food services occurs throughout the inspection. Dining observation is a part of the food service task and will be conducted at one (1) or more meals.

Procedure

1. 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.
2. For all residents in the sample with diet related concerns:
   a. Interview and observe the residents regarding meals and food services, individual nutritional needs, preferences, and reasonable accommodations including, but not limited to, modified or therapeutic diets or feeding tubes.
   b. Review resident records for prescribed or non-prescribed nutrient supplements or modified or therapeutic diets.
3. Conduct interviews and observations regarding food services with residents in the sample.
4. Conduct record reviews specific to food services for these residents only if an issue has been identified.
5. Document on Attachment I: Staff and Administrative Record Review the food handler cards for sample staff. If a resident is routinely involved in the preparation of food to be served to other residents, or as part of an employment-training program through Supportive Employment with Home and Community Services, request a food handler card.
6. Conduct observation of food services for high risk factors to ensure a risk-based inspection is conducted and proper control measures are in place.
7. Complete Attachment M: Food Service Observations and Interviews in accordance with WAC 246-215-08430.
8. Wear a hair restraint if applicable throughout the kitchen inspection in accordance with WAC 246-215-02410.

9. Observe food safety to include personal hygiene, employee health, time and temperature control, and potential cross contamination during food preparation and service.
10. If concerns are identified, conduct further observations and interviews, and consider requesting a food sample to evaluate temperature and palatability.
11. The licensor responsible for the food service task will make introductions to food service staff, conduct informal interviews, establish which staff is the contact, and briefly explain the food service task to facility staff.
12. Other members of the team will share general observations with the licensor responsible for conducting the food service task.
13. Food services will include the consideration, through the sample residents, of individual resident needs such as:
    a. Preferences.
    b. Alternate choices.
    c. A system for residents to express their comments on food services.
    d. Prescribed diets.
    e. Prescribed nutrient supplements and concentrates.
    f. A variety of daily food choices.
    g. Temperature of food.
    h. Assistance with eating if applicable.
14. There is no need to routinely check the temperature of food. However, if a resident complains about food temperature or if you see prepared food sitting for long enough to impact the appropriate temperature of the food being served, check the temperature just before it is served to residents.
15. Interviews with residents, administrator, caregiver staff, collateral contacts, and food service staff are important sources of information.
16. Observation of a meal may require an adjustment in the inspection schedule to allow time for the observation.
    a. If a meal is occurring at time of entrance or tour, field staff will conduct general observations if more opportunities will not occur later in the inspection.
    b. If no other meal observations will occur or many residents will be out of the facility during other meals, the team leader will inform the administrator that the entrance conference or tour will be postponed in order to conduct a meal observation at that time.
17. Dining Observation:
    a. Conduct meal observation while sitting, if possible, to avoid standing over the residents. Be aware that documenting during observation can impact resident comfort.
    b. Observe dining area for adequate seating capacity (75% or more residents per meal setting).
    c. Observe for timeliness of meal service.
    d. Observe for sufficient time and staff to meet resident needs.
    e. Observe meal for attractively served meals that are nourishing and palatable.
    f. Observe any sample residents who require eating assistance.

18. Identify sample residents who are currently receiving meals in their room, noting the reason and if the meals are assisted per care needs.

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M. Resident Record Review

Purpose

The purpose of resident record review is to collect and review documented data in the ESF 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

1. Conduct a complete resident record review for residents in the sample.
2. Use Attachment H: Resident Record Review to document information including:
   a. Resident assessment.
   b. Monitoring of resident's well-being.
   c. PCSP.
   d. Medication record and other information.
   e. Crisis Behavioral Support Plan (this document may be incorporated with care plan).
3. For all sample residents, gather information from the record review to support or validate issues identified during observations and interviews.
4. Determine if information obtained from record review will require further interviews and observations.
5. Observations and ongoing communication with the facility staff continue throughout the record review process. However, 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 or residents.
6. If information regarding assessment issues has been identified, the licensor should review the qualified assessor qualifications.
7. Expanding record review:
   a. If necessary, conduct a *single or limited area* record review of expanded sample residents in the selected sample (see Resident Sample). A record review for expanded sample residents is not a routine process and should only be done if necessary to make a compliance decision. It is driven by a specific issue or concern identified during observations, interviews, and record reviews of in-depth sample residents.
   b. Expand the documentation review beyond six (6) months only when an actual or potential outcome requires further history.
8. When to review a facility record:
   a. Review of additional documentation kept by the facility may be required to complete data collection regarding a specific issue.
   Example: review of investigation outcome for a resident with recent falls.
   Facility documentation that may need to be reviewed if further information is needed to determine compliance include:

i. Incident/accident documentation.
ii. Policies and procedures.
iii. Financial records only as they are related to resident care or services not being met.
iv. Quality Improvement (QI) Committee notes (only for the information necessary to determine the existence of a QI committee and that it is operating in compliance with the regulations, or if the licensee offers the QI committee records as evidence of compliance) (WAC 388-107-0220).

9. When to review a closed resident record:
   a. Review a closed resident record when an issue is identified that directly relates to a specific resident no longer in the facility, if no current residents reside in the facility, or if there is a concern regarding discharge or transfers.
   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 closed record; therefore, selection of the closed record may occur later in the process.
   d. Review record for identified concern and document using Attachment H: Resident Record Review or Attachment K: Notes/Worksheets.
   e. Obtain a name and contact phone number for legal representative if necessary to determine facility compliance.
   f. Obtain a name and contact phone number for the healthcare practitioner, case manager, and other supports if necessary to determine facility compliance.
10. When to review other records:
   a. Review of outside records, such as hospital records, police records, agency records, and other records not associated with the facility will rarely be done and only when necessary to determine failed practice.
      i. Document a contact name and number or address regarding outside record (Attachment F: Other Contact Interview).
      ii. Interview resident or facility staff to ensure the contact information is accurate.
      iii. Initiate the review of outside records (written request, onsite visits, fax, or phone) as soon as possible. The inspection is not complete until the last date of data collection.

N. Facility Staff Sample and Record Review

Purpose

The purpose of facility staff sample and record review is to select a staff sample and to determine whether the ESF has a systematic and consistent way to ensure 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 facility.

The ESF is responsible for orientation of each staff and ensuring all staff meet the training requirements specified in Chapters 388-112A WAC and 388-107 WAC. The ESF is responsible for developing a system to ensure that documents related to staff's qualifications, training, and other requirements are obtained and maintained on the ESF premises and easily accessible to department staff. The staff sample is selected after the tour.

Procedure

1. Request a staff list at the entrance conference (Attachment B: Request for Documentation).
2. Select the staff sample at the team meeting (see Selection Criteria below).
3. Provide the list of required staff records to the administrator. Request the staff records within a reasonable time on the day of the review.
4. Review staff records for required training, credentials, screenings, and other qualifications as it pertains to their job requirements.
5. Document on Attachment I: Staff and Administration Record Review.
6. Document IPC record review on the IPC forms.
7. Refer to Training Requirement grid WAC 388-112A-0070 for additional information regarding ESF training requirements.
8. Review the facility emergency disaster plans including annual staff training (WAC 388-107-1600).
9. Expand the staff sample only if you have determined that there may be issues or concerns regarding the ESFs ability to ensure that the administrator and staff meet the training and other requirements. The expanded sample can help determine if the issue is isolated or widespread.
10. Use interviews and observations to identify possible or actual negative outcomes to residents related to staff training or qualifications.
11. If issues related to quality of life or provision of care and services were identified during the observations and interviews that may indicate the employee's lack of training or qualifications, review records for pertinent information.
12. Selection criteria for facility staff sample:
    a. If the ESF has changed administrators since the last inspection, review the administrator's records to ensure they meet the appropriate qualification and training requirements.
    b. Review staff list for hire dates and titles:

i. Select three (3) employees 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 (3) were hired, review records for all new employees.
ii. If there have been no new hires since the last inspection, select three (3) staff who were not reviewed during the previous inspection.
iii. In addition, conduct a targeted review of one (1) to two (2) employees (this could include the administrator) with a work history of over two (2) years at the facility to ensure a system is in place to conduct background re-checks and continuing education requirements.
iv. A minimum of four (4) staff should be reviewed.

13. Communicate findings of incomplete or outdated information to the administrator to provide the opportunity for them to submit any outstanding documentation.
14. A record review alone may not provide enough information to confirm or disprove a deficient practice. Further data collection from interview or observation may be necessary.

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O. Facility Staff Schedule and Staffing Levels Review

Purpose

The purpose of the facility staff schedule and staffing levels review is to determine whether the ESF has enough appropriately qualified and trained staff who are available to safely provide necessary care and services consistent with residents' PCSP under routine conditions as well as during emergency and disaster situations.

The ESF is responsible for maintaining staffing levels as outlined in WAC 388-107-0230 and WAC 388-107-0240.

Procedure

1. During the entrance, request working schedule of care staff, nursing staff, MHPs, and on-call RNs and MHPs for prior two (2) weeks (Attachment B: Request for Documentation).
2. Conduct a complete review of working schedule.
3. Discuss with administrator any gaps in coverage and, if needed, request additional proof of staffing coverage such as timecards.
4. If staffing issues are identified, request one (1) or two (2) additional staff working schedules from the past 90 days and conduct a complete review of working schedule.
5. Document information on Staff Schedule Worksheet (Attachment O: Staff Schedule Worksheet).
6. A record review alone may not provide enough information to confirm or disprove a deficient practice. Further data collection from interview or observation may be necessary.

P. Exit Preparation

Purpose

The purpose of exit preparation is to prepare for the exit conference by reviewing and analyzing all information gathered during the ESF inspection, identifying deficiencies based on the regulations and statutes (WAC, RCW), and determining if further action is required.

The exit preparation occurs at the end of the on-site inspection prior to the exit.

Procedure

1. Communicate with the administrator and facility staff throughout the inspection to facilitate complete data collection and to ensure no "surprises" at the exit conference.
2. Notify the administrator when the on-site inspection has been completed and the RCS team is meeting for the exit preparation.
3. Schedule the exit conference with the administrator and invite the Ombuds and interested residents to attend. Contact the Ombuds as early as possible to let them know when the exit is scheduled.
4. Schedule a team meeting to review identified concerns based on observations, interviews, and record reviews and to determine deficient practice.
5. Facilitate the exit preparation and organize the information to be presented using the Exit Preparation Worksheet (Attachment L: Exit Preparation Worksheet) in a manner that can be clearly understood by the administrator and the Ombuds. List the issues in order of severity with most serious issues presented first and consultations last.
6. Review information and deficiencies and identify any negative resident outcomes or the potential for a negative outcome using specific residents from the sample when possible. If residents will be present for the exit or have requested that their issues be kept confidential, ensure confidentiality is maintained.
7. Conduct the exit preparation in a setting that is on-site and confidential.
8. 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.
9. Decide if further information will be required after the exit and identify the licensor responsible for that data collection.

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Q. Exit

Purpose

The purpose of the exit is to provide the ESF with information on the results of the inspection, the identified deficiencies, and findings, and to provide the administrator an opportunity to present additional information.

The exit conference occurs at the end of the inspection. The exit conference is conducted with the RCS licensing team and the administrator. Other participants may include other ESF staff, the Ombuds, residents, and resident's representatives.

Deficiencies identified by field staff at the exit must be regulatory based. Because the licensors have communicated with the administrator throughout the inspection, the identified deficient practices should not be a surprise. The exit conference is held in a private setting in the facility, observing confidentiality and encouraging dialogue. If, after the exit, licensors make changes or additions to the information presented at the exit, a licensor will contact the administrator with information about the changes prior to sending the SOD.

Procedure

1. The RCS team coordinator will facilitate the exit.
2. Notify the FM prior to the exit if a deficient practice is identified that requires an immediate plan of correction and obtain FM approval to request the POC prior to leaving the facility.
3. Utilize Attachment L: Exit Preparation Worksheet to ensure all issues are addressed at the exit.
4. Identify deficient practices with the appropriate regulation or statute (WAC/RCW).
5. Provide examples when appropriate, identifying specific resident issues without violating a resident's request for confidentiality.
6. Communicate the issues and findings in an organized, clear manner using language and examples that are easily understood by those attending the exit.
7. Provide the administrator an opportunity to discuss, ask questions and present related additional information.
8. Inform the administrator of the process following the exit and what to expect, including further data collection, the SOD, and the Informal Dispute Resolution (IDR) process. Clarify that if further information is obtained after the exit, the administrator will be contacted by telephone with any additions or significant changes to the deficiencies discussed at the exit, and that the administrator will be notified if there are any delays in their receipt of the SOD.
9. Ensure the administrator has a business card and contact phone number for the field staff and the appropriate FM.
10. Thank the administrator for their cooperation with the inspection.

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R. Follow Up

Purpose

The purpose of the follow up is to determine if the ESF is back in compliance with the state laws and rules cited in any previous inspection or complaint investigation.

Follow up inspections will be brief, focused, and purposeful reviews.

Procedure

1. The FM will:
   a. Consult with the licensor to determine if the follow up will be done by:
      i. Telephone verification
      ii. Documentation/letter verification
      iii. On-site verification
   b. Track any additional visits or citations once the ESF is initially out of compliance.
   c. Include at least one (1) person who did the original inspection or complaint investigation in the follow up whenever possible.
   d. Generally, limit the practice of investigating new complaints during follow ups. When possible, the follow up is completed before writing new citations.
      Note: Additional citations cannot be added to a follow up. New concerns must be submitted to CRU and consulted with FM.
   e. Notify the Compliance Specialist (CS) and Regional Administrator (RA) to strategize further enforcement action steps if the ESF continues to be out of compliance at the second follow up.
   f. Consult with the CS and RA before scheduling a third follow up.
2. Timelines:
   a. POC dates must not exceed 45 calendar days from the last date of data collection unless approved by the FM.
   b. Follow up occurs within 15 calendar days after the last date the ESF has listed on the POC as field staff schedules allow.
   c. Follow up occurs no later than 60 calendar days from the last date of data collection.
      Note: if the POC dates were approved by the FM to exceed 45 calendar days, this 60-calendar day deadline will be extended by the same amount.
   d. If the first follow up results in a deficiency, a second follow up occurs within 60 calendar days from last date of data collection from first follow up.
   e. When planning the date for the follow up visit, the field staff should consider how much time they need to allow for the provider to be able to demonstrate compliance.
3. The Licensor will:
   a. Only review information from the time period between the last date on the POC and the date of the follow up to determine if the deficient practice has been corrected and the ESF is back in compliance.

b. Consider the following prior to the follow up:
   i. Current deficient practice issues, including the nature, scope (number of residents impacted or potentially impacted), and severity (seriousness or extent of the impact or potential impact on resident)of the deficient practice of each cited deficiency.
   ii. The enforcement remedies imposed as a result of the inspection.
c. Conduct the onsite follow up:
   i. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.
   ii. Focus the sample selection on residents who are most likely to be at risk of issues resulting from the deficient practice cited in the original report.
d. Upon completion of all follow ups:
   i. Follow the STARS processes necessary to schedule and complete the follow up.
   ii. Record corrected and/or uncorrected deficiencies in STARS.
   iii. Write a new SOD for any uncorrected deficiencies.
e. For off-site follow ups:
   i. Process document review follow ups in the same manner as an on-site follow up.
   ii. After the off-site review, the licensor will determine if there is enough information to correct deficiencies or if they will recommend to the FM that an on-site follow up be conducted.
f. General:
   i. Citing additional issues not cited in the original visit should be rare and cited only following consultation with the FM.
   ii. Base the sample size on the deficient practice cited and the number of residents necessary to review to determine compliance. Typically, more than one (1) resident will be included in the sample to have enough information to determine compliance.

4. Telephone only verification:
   a. Correction of the deficiencies may be verified by telephone only under the following situations:
      i. The deficiencies are not associated with a negative or potentially negative resident outcome.
      ii. The deficient practice issue is such that there are clear, objective criteria for determining compliance.
      iii. The ESF has a good history of compliance with the provision of care and services to residents.
   b. The licensor must document pertinent details of the call and a statement indicating if the facility was found back in compliance.
5. Documentation verification:
   a. The licensor will call the ESF when it is appropriate to do compliance verification. The licensor can specify what documentation may be acceptable to submit as evidence.

b. The ESF must submit documentation for each deficiency to show they are back in compliance. This documentation verification must be submitted on or before the attested plan of correction date and fully address each deficiency cited:
   i. The actions the provider has taken to implement the correction.
   ii. Whether the plan worked.
   iii. When the correction was achieved.
   iv. How correction will be maintained.

c. Correction of the deficiencies may be verified by documentation submitted by the ESF when:
   i. The deficiencies are not associated with a negative or potentially negative resident outcome. The deficient practice issue is such that there are clear, objective criteria for determining compliance.
   ii. The ESF has a good history of compliance with the provision of care and services to residents.
   iii. The ESF sends evidence of compliance, fully addressing necessary actions taken by the facility to correct deficiencies; including how and when the correction was achieved. Examples: CPR/first aid cards, tuberculosis test results, orientation checklists, or criminal background check results.

d. The inspection team reviews the documentation and calls the administrator to discuss the issues and determine if sufficient documentation is present to justify reporting the deficiency as corrected, or to recommend to the FM that an onsite revisit inspection be conducted.

e. The inspection team documents pertinent details of the call to the ESF and a statement indicating if the ESF was found back in compliance and places the information in the facility file along with documents sent by the facility.

6. On-site verification must be conducted:
   a. If documentation verification of correction was not received.
   b. For deficiencies with a negative or potentially negative resident outcome.
   c. When the documentation submitted by the ESF does not adequately support the conclusion that correction has been achieved.
   d. After a finding of a violation for which a stop placement has been imposed, within 15 working days from the request for follow up.
   e. For violations that are serious, recurring, or uncorrected following a previous citation.
   f. At the FM's discretion.

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Part II: Resources and Forms

A. Resources

1. Additional Guidance: Abuse Prevention Review
    a. Observations for indicators of possible abuse:
        - Client-to-client interaction for possible unsafe behavior of one client toward another.
        - 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.
        - 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 PBSP and follow 388-107-0420.
        - Uncommon or numerous skin tears.
        - Bruising with injuries with unknown cause.
    b. Key Triggers
    c. Sample Interview Questions (see Appendix E of SOP Chapter 20)

B. Forms

1. Attachment A: Pre-Inspection Preparation (DSHS 15-571)
2. Attachment B: Request for Documentation (DSHS 15-572)
3. Attachment C: Resident List (DSHS 15-573)
4. Attachment D: Resident Characteristic Roster and Sample Selection (DSHS 15-574)
5. Attachment E: Resident Interview (DSHS 15-575)
6. Attachment F: Other Contact Interview (DSHS 15-576)
7. Attachment G: Environmental Observations (DSHS 15-577)
8. Attachment H: Resident Record Review (DSHS 15-578)
9. Attachment I: Staff and Administrative Record Review (DSHS 15-579)
10. Attachment K: Notes/Worksheets (DSHS 15-581)
11. Attachment L: Exit Preparation Worksheet (DSHS 15-582)
12. Attachment M: Food Service Observations and Interviews (DSHS 15-583)
13. Attachment N: Medication Pass Worksheet (DSHS 15-584)
14. Attachment O: Staff Schedule Worksheet (DSHS 15-585)
15. Attachment 02: Staff Schedule Worksheet – 8 Hour Shift (DSHS 15-585A)
16. Attachment 03: Staff Schedule Worksheet – 12 Hour Shift (DSHS 15-585B)
17. Attachment P: Revisit Form (DSHS 10-683)

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Part III: Appendices

A. Glossary of Terms

Administrator or designee – 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.

Agency – State agency

Background check – A review of an individual's criminal history and a review of any civil adjudication proceedings.

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

- A regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and
- A brief (3 – 4 sentences) statement summarizing the deficient practice.

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

- 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).

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

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

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."
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.
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.
Formal interviews – structured interviews with sample residents, the service provider, staff, family members or representatives, or other collateral contacts.
Health care – The care, services or supplies related to the health of a vulnerable adult, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling for a physical or mental condition, a prescribed drug, device, or equipment.
Informal interviews – general conversations or information gathering which may occur during any part of the inspection process.
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.
Licensee or designee – A generic term to describe individuals/entities/providers licensed or certified to provide 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.
Mental Health Professional – any person qualified and licensed to provide assessments, diagnosis, and therapy for mental health conditions.
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.
Provider – a) any individual or entity that provides services to DSHS, OR b) a person, group, or facility that provides services. RCS providers include Adult Family Homes, Assisted Living Facilities, Certified Supported Living providers, Enhanced Services Facilities, ICF/IID facilities and Nursing Homes.
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.

- 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.

Reporter – 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, Law Enforcement or Anonymous*.

- **Public** – are generally residents or clients, family of residents or clients, DSHS staff, DDA staff, 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.

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

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 – 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.

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

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

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

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.

Vulnerable adult – Comprehensively defined in RCW 74.34.020, includes a person:

a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
b) Subject to a guardianship under RCW 11.130.265 or adult subject to conservatorship under RCW 11.130.360; or
c) Who has a developmental disability as defined under RCW 71A.10.020; or
d) Admitted to any facility; or
e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under Chapter 70.127 RCW; or
f) Receiving services from an individual provider; or
g) Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.

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

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

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B. Acronyms

APS	Adult Protective Services
CHOW	Change in Ownership
CPR	Cardiopulmonary Resuscitation
CRS	Construction Review Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DOH	Department of Health
DSHS	Department of Social and Health Services
ESF	Enhanced Services Facilities
ESH	Eastern State Hospital
FBI	Food Borne Illness
FDA	Food and Drug Administration
FM	Field Manager
HCS	Home and Community Services
ID	Identification
IDR	Informal Dispute Resolution
IPC	Infection Prevention and Control
LE	Law Enforcement
LTCOP	Long-Term Care Ombuds Program
MHP	Mental Health Professional
OSFM	Office of State Fire Marshal
PCSP	Person-Centered Service Plan
POC	Plan of Correction
PPE	Personal Protective Equipment
QI	Quality Improvement
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
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
WSH	Western State Hospital
WSP	Washington State Patrol

C. Change Log

Eff. Date	Chapter/ Section #	Brief Description of the Change	Communication and Training Plan
10/01/2023	Entire Chapter	Finalization of draft, chapter establishment	MB R23-078 Training provided through 9/5/2023 Support Call

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