Overview

The state has facilities designated to participate in the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) federal Medicaid program. These facilities are required to meet federal Conditions of Participation (COP) when providing services to individuals with intellectual disabilities. There are nine COPs. Residential Care Services (RCS) regulates eight COPs, and the State Fire Marshal (SFM) regulates one COP: Emergency Preparedness. The RCS regulated COPs are identified under 42 CFR § 483.420-460 and federal citation tags:

- Governing Body,
- Client Protections,
- Facility Staffing,
- Active Treatment,
- Client Behavior and Facility Practices,
- Health Care Services,
- Physical Environment, and
- Dietetic Services.

All ICF/IID clients must qualify for Medicaid assistance financially. Washington has state funded Residential Habilitation Centers (RHCs) that house numerous clients. These facilities provide Interdisciplinary Teams (IDTs) of professionals that support, identify, and develop behavior modification techniques to address behavioral difficulties and train those who qualify for extensive training services to gain independent living skills. This support gives those clients opportunities to transition into less restrictive type settings.

The Center for Medicare and Medicaid Services (CMS) uses the term “clients” and “individuals” interchangeably in the State Operations Manual (SOM). Throughout this Standard Operating Procedure (SOP), the term “client” is used.

ICFs must comply with the following the electronic Code of Federal Regulations (eCFRs) Revised Codes of Washington (RCWs), and Washington Administrative Codes (WACs). These chapters give RCS the authority to certify and investigate reports of abandonment, abuse, exploitation, and neglect of vulnerable adults.

- Social Security Act Title 19 § 1902 – State Plans for Medical Assistance
- 42 CFR § 438.66 – State Monitoring Requirements
- 42 CFR § 442.100-119 – Certification of ICF/IIDs
- 42 CFR § 483.400-480 – Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Chapter 70.129 RCW – Long-term Care Resident Rights
- Chapter 74.34 RCW – Abuse of Vulnerable Adults

- WAC 388-97-2020 – Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Chapter 388-111 WAC – Residential Habilitation Centers - Compliance Standards
- State Operations Manual (SOM):
  Appendix J – Intermediate Care Facilities for Individuals with Intellectual Disabilities
  Appendix Q – Determining Immediate Jeopardy

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

Contacts

- RCS Policy Unit General Contact, RCSPolicy@dshs.wa.gov
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Part VI: Appendices

Part I: Survey Overview

Overview

The Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Appendix J provides guidelines for observation of client outcomes. Attention is directed to what actually happens to clients, including:

- Whether the facility provides needed services and interventions;
- Whether the facility ensures clients are free from abuse, neglect, or exploitation;
- Whether clients, families and guardians participate in identifying and selecting services;
- Whether the facility promotes greater independence, choice, integration, and productivity;
- How competently and effectively the staff interact with clients; and
- Whether all health needs are being met.

Observation is the primary method of information gathering. The procedures below explain survey types and give general procedures for surveyors to follow. Each survey type has specific tasks that surveyors must complete. Specific instructions to all tasks are located in the section labelled 'Survey Tasks.'

Task assignments

- Entrance Conference
- Task 1 – Sample selection
- Task 2 – Review of systems to prevent abuse, neglect, and exploitation
- Task 3 – Focused observations
- Task 4 – Required interviews
- Task 5 – Medication administration observation
- Task 6 – Visit all areas
- Task 7 – Record reviews
- Exit Conference

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. Determine facility coverage and appoint a Team Lead for each survey.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

Administrative Assistant (AA) Responsibility

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

1. Maintain a schedule for recertification surveys for all ICF/IID facilities according to CMS guidelines.
2. Assist the team with travel plans as needed.
3. Maintain current facility certification status in the electronic tracking tool.
4. Alert the Office of the State Fire Marshal (OSFM) of the pending recertification survey.

A. Focused Fundamental Survey (Tasks 1-3)

Overview

All ICF/IID recertification surveys utilize the focused fundamental survey. In addition to the entrance and exit, the focused fundamental survey follows the procedures outlined for tasks one through three.

The focused fundamental survey process utilizes a system centered on 27 key regulations from seven of the eight Conditions of Participation (COPs). Each of the key regulations has corresponding regulations which are reviewed ***if*** the key regulation is determined to be out of compliance (see 'Extended Survey' for more information). When the facility is determined to be in substantial compliance with the identified key standard, the corresponding standards are automatically determined to be compliant since the key standard could not be compliant otherwise.

Procedure

1. Conduct annual recertification surveys within 12 -15 months of the last survey.
2. During the focused fundamental survey, the primary method of information gathering is observation. Initially spend at least one hour of general observations of clients .
   a. Conduct interviews and record reviews to confirm or provide additional information of any concerns identified during observations. Except for the Individual Program Plan (IPP) and the Comprehensive Functional Assessment (CFA) for sample client(s), do not conduct an in-depth reviews of progress notes or historical data unless there is suspected non-compliance of a key standard. The client sample list may be expanded at any time if needed.
3. The focused fundamental survey involves review of the key standards within the COPs. If indicated during the review of key standards, any of the corresponding standards may be cited as needed. Conduct Tasks 1 - 3 and 5, in addition to the entrance conference and exit conference.
4. **All** surveys must include a medication administration observation and a meal observation.
5. Review the key standard list and if a key standard is out of compliance, review the associated corresponding standards. See Appendix J grid for more information.
   a. Review the COP and the key standard(s) under each COP. The specified W tags under each shaded key standard are the corresponding regulations associated with that key standard. If no significant concerns are identified, the survey may conclude.
6. All key standard citations and corresponding standard citations must have a Statement of Deficiency (SOD) report written.
7. Conduct consensus and the exit conference.

B. Extended Survey (Tasks 1-3)

Overview

During a focused fundamental survey, if a key standard of a COP is found to be out of compliance, then the survey team will review all corresponding standards under that key standard to determine compliance with that condition (i.e., to determine condition-level compliance). This is known as an extended survey.

If the review of the key standard and corresponding standards could result in a condition-level non-compliance finding, then the team must survey all the standards within that COP (see 'Full Survey' for additional information).

Procedure

1. During a focused fundamental survey, if a key standard of a COP is found to be out of compliance, review all corresponding standards to determine compliance with that condition. If the review of the key standard and corresponding standards could result in a condition level non-compliance finding, then all the standards within that COP must be reviewed. This review is known as an extended survey.
2. Tasks 1 – 3 will have been completed at this point.
3. The Team Lead will inform the facility of the extended status.
4. If there is evidence of non-compliant facility practice, neither the focused fundamental nor the extended survey processes preclude the survey team from review of any other standards.
5. If there are no identified COPs out of condition and depending on the Field Manager (FM) decision, conduct consensus and the exit conference. Write a SOD for all identified citations.
6. If there are COPs out of compliance per 42 CFR § 483.420-460, proceed to write a SOD for citations at the appropriate level (condition, key, standard). The survey should be expanded to a 'Full Survey' if there is non-compliance for any of the following COPs:
   a. Client Protections;
   b. Client Behavior and Facility Practices; or
   c. Health Care Services.
7. All citations must have a SOD report written.
8. Conduct consensus and the exit conference.

C. Full Survey (All 7 Tasks)

Overview

For recertification surveys, the survey must convert from the extended survey to a full survey if the review of the key standard and corresponding standards results in a COP non-compliance finding for any of the following COPs:

- Client Protections;
- Client Behavior and Facility Practices; or
- Health Care Services.

Review of all of the standards within all eight COPs is required. In addition to the entrance and exit procedure, follow the procedures outlined in all seven tasks. A full survey is the only time COP Governing Body and Management is reviewed.

Procedure

1. Determine if a full survey needs to be conducted when any one or more of the following criteria are met:
   a. An immediate jeopardy (IJ) is identified;
   b. The survey team determines from the extended survey that Condition-level deficiencies exist at one or more of the COPs listed below per 42 CFR § 483.420-460:
      i. Client Protections;
      ii. Client Behavior and Facility Practices; or
      iii. Health Care Services; or
   c. At the discretion of the FM.
2. All citations must have a SOD report written.
3. Conduct consensus and the exit conference.

D. Team Lead Roles and Responsibilities

Overview

The survey process is complex and time sensitive, requiring structure and leadership. As such, the FM assigns a Team Lead for each survey to coordinate the survey process, give survey team members direction and the facility a point person of contact. Briefly outlined below are the responsibilities of the Team Lead. Formal procedures for all survey tasks are located in the section labelled 'Survey Tasks.'

Relevant Forms

Attachment A: Recertification Survey Action Plan (DSHS 15-518)
Attachment C: Entrance Conference Attendance Record (DSHS 15-522)
Attachment D: Required Provider Survey Documents (DSHS 15-523)
Attachment E: Sample Selection (DSHS 15-521)
Attachment T: Team Lead Notes (DSHS 15-539)
Attachment U: Exit Conference Roster (DSHS 15-540)
Attachment V: Surveyor Notes (DSHS 15-541)
Attachment W: Team Lead Focused Fundamental Survey Review Checklist (DSHS 15-542)
Attachment X: Team Lead Full Survey Review Checklist (DSHS 15-543)
Attachment Y: Team Lead Summary (DSHS 15-544)
CMS-3070G ICF/IID Survey Report
CMS-3070H Survey Report

Procedure

The Team Lead will:

1. Prepare for the Survey
   a. Develop an action plan using Attachment A for the team to follow during the course of the survey.
   b. Collect the ICF/IID survey packet forms.
   c. Schedule a team meeting to discuss the survey action plan, including all survey team members and the FM. The action plan must include the following:
      i. survey type;
      ii. entrance activities;
      iii. anticipated exit date;
      iv. facility specific information; and
      v. team member assignments.
2. Conduct the entrance conference.
3. Select the client sample list and assign each surveyor an equal number of sample clients. See section labelled 'Sample Selection' for more information.

3. Check in regularly with the FM, informing them of the progress of the survey, relaying any concerns, and asking for direction where applicable.
4. Facilitate Team Meetings daily or as needed, capturing the discussion of potential findings each day.
5. Take the lead in communicating with the facility as needed throughout the survey process.
6. Ensure all survey tasks are completed and all required documents are collected.
7. Facilitate 'Survey Consensus' discussions with the team.
   a. Once consensus is reached, compose the Survey Report (CMS-3070H).
   b. Notify the FM of the findings prior to the exit meeting.
9. At the conclusion of the consensus meeting, ensure the facility's conference room is tidy (i.e., removing all documents and/or working papers and trash) and return keys to the facility.
10. Conduct the exit conference.
11. Facilitate SOD Completion.

Part II: Survey Tasks

Overview

The Centers for Medicare and Medicaid Services (CMS) provides a methodical survey protocol to follow that focuses on the "outcome" of the facility's provision of active treatment. Observation is a key requirement of the survey process. To corroborate observations, the surveyor conducts interviews and records reviews. The survey process has seven tasks. This chapter explains protocols for each of the tasks, in addition to entrance and exit conferences.

All surveyors use these protocols to measure compliance with federal requirements. These protocols identify relevant areas and issues surveyed as specified in each regulation, and, in some cases, the methods used to survey those areas and issues. These protocols promote consistency in the survey process. The process ensures the review of the facility is thorough, efficient and in compliance with the regulations.

Included in the survey protocols are interpretive guidelines that serve to clarify standard regulations and Conditions of Participation (COPs). The guidelines define and explain the relevant eCFRs referred to as regulations.

Any identified deficiencies are based on noncompliance with the regulations. The decision of whether there is noncompliance must be based upon review of the facility's performance, practices, or conditions in the facility.

Where the surveyor believes conditions or practices are not in compliance with a regulation, the surveyor uses observation, record review and interviews to substantiate the existence of noncompliance. At the completion of the survey, the surveyor should have sufficient information to make compliance decisions.

In most cases, the ICF/IID health survey and the Life Safety Code (LSC) survey (conducted by the Office of the State Fire Marshal [OSFM]) are scheduled to occur simultaneously.

A. Entrance Conference

Relevant Forms

Attachment C: Entrance Conference Attendance Record (DSHS 15-522)
Attachment D: Required Provider Survey Documents (DSHS 15-523)

Procedure

1. The Survey Team will:
   a. Be alert and in "observation mode" before entering the facility. Once in the facility, notify the facility administration of your arrival.
   b. When leaving the facility for the night (or lunch break, etc.), ensure the room is locked.
   c. Practice confidentiality during all phases of the survey.
2. The Team Lead will conduct the Entrance Conference, including:
   a. Introductions and distribution of business cards for all survey team members.
   b. Informing the facility of the type of survey and provide an anticipated exit date.
   c. Provide the facility with an overview of the survey and explain the process to include:
      i. A physical onsite tour of the facility, inside and outside structures.
      ii. Direct observations, and interviews with the clients, families/guardians, and staff involved in the clients' care.
      iii. Review of relevant programs, treatments, and client records.
   d. Request the required documents from the facility using Attachment D.

      Note: Due to the differences in each facility, edit the attachment as needed.

      For recertification surveys, present the facility with ICF/IID Survey Report (CMS-3070G) for completion. If needed, assist the administrator and/or designee with completion of the form. The form must be completed and collected at the end of the survey.
   e. Request a room or access to a power outlet, a place to sit and work, and a means to secure belongings and/or RCS equipment.
   f. Request loaner keys for any areas that require a key for entry.
   g. Secure signatures of the staff present at the entrance conference on Attachment C.
   h. Ask the facility to identify which staff will be the point person if question arise or the team requires assistance.

B. Task 1: Sample Selection

Overview

The purpose of drawing a sample of clients from the facility is to ensure all regulatory requirements are applied to a proportionate representation of clients. The sampling methodology outlined below is not intended to create a "statistically valid" sample. The methodology allows for flexibility in the sample selection and ensures that the sample represents most of the focused fundamental tags.

Select the *core* sample of clients from a list of the facility's current client list without regard to client developmental levels or locations in the facility. At a minimum, the core sample should include clients that meet any one or more of the following criteria:

- Admission within the last six months;
- Participation in a day program;
- On a medication self-administration program; and/or
- Frequent hospitalizations or emergency room visits.

The complete sample for the facility will include a core number of clients selected at the beginning of the survey and additional clients added during the process of the survey as needed, based on observations and/or interviews.

Relevant Forms

Attachment E: Sample Selection (DSHS 15-521)
Attachment F: First Hour Observation Report (DSHS 15-525)
Attachment V: Surveyor Notes (DSHS 15-541)

Procedure

1. The Team Lead will select the sample using the following guidance to calculate the core sample size:

# of Clients residing in the facility (Census)	Core Sample size (Sample Ratio)
17-50 clients	4 clients
51-100 clients	6 clients
101-150 clients	8 clients
Over 150 clients	10 clients

2. While selecting the sample, the team members will:
   a. Begin general observations, which should occur over a period of no less than one hour. See section labelled 'Focused Observations' for more information.

b. During the initial observation, identify client names if areas of concern are identified. Examples may include, but are not limited to:
   i. Clients with significant medical concerns which may be impacting the implementation of their Individual Program Plan (IPP);
   ii. Clients with significant behaviors with lack of or inappropriate staff intervention;
   iii. Clients that are idle for extended periods of time;
   iv. Clients that appear to have strengths but are not encouraged to use those skills or are performing activities below their skill levels; and
   v. Clients who are not provided appropriate medical care.

3. After one hour, the team should reassemble to discuss observations and which core sample clients each surveyor will be assigned. Surveyors may suggest adding expanded sample clients at this time as needed.
4. Once the sample is assigned equitably among team members, record the core sample using Attachment E. Ensure the document contains:
   a. A summary listing of all client information comprising the survey sample (including any additions or substitutions to the sample).
   b. Any identifiers used as a reference to protect the client's confidentiality.
   c. A description of the representative sample selection, to include:
      i. The total number of clients in the sample.
      ii. The number, if any, of the clients added to the sample, including the reason added (e.g., complaint investigation); and
      iii. The number, if any, of the clients substituted in the sample, including the reason for withdrawing the original client (see 6 below).
5. Additional clients may be added to the sample based on observations that occur during the survey. Document the reason for adding the client(s) to the sample using Attachment E.

> Example: Add a client to the sample based solely on the fact that they are on a self - administration program for medication.

6. If it is determined that a client is on an extended leave from the facility and/or will be unavailable during the survey process, a client substitution is acceptable in the core sample. With a substitution made, surveyors must ensure that the client added to the sample meets the same requirements and criteria listed above.
7. Throughout the survey, each member of the team will share information and possible findings relative to their assigned client(s). Consult with one another on a regular basis during the survey to maximize sharing of data, knowledge, and competencies.
8. Conduct a full review (observation, interview, and record review) of all clients in the core sample list.
   a. A client added to the sample during observations due to concerns requiring further investigation does not require a full review of their program record.

C. Task 2: Review of Systems to Prevent Abuse

Overview

The focus of Task 2 is to determine if the facility has systems in place to prevent abuse, neglect, exploitation, and to resolve complaints. The complaint/incident management system has three objectives:

- Protective oversight.
- Prevention.
- Efficiency and quality of services.

Task 2 consists of two phases. In the absence of the criteria listed below, Task 2 is completed upon the conclusion of Phase One. If any one or more of the following of the criteria below are identified, the review must include Phase Two:

- Substantiated (by the facility) complaints or facility reported events in Client Protections since the last recertification survey;
- A survey history of citations at W127, W153-W157; or
- Concerns identified by the survey team that warrant a Phase Two review.

Relevant Forms

Attachment G: Task 2 Phase One (DSHS 15-526).
Attachment H: Task 2 Phase Two (DSHS 15-527)
Attachment I: Sample Client Interview and Observation Worksheet (DSHS 15-528)
Attachment V: Surveyor Notes (DSHS 15-541)

1. Phase One Procedures

a. The assigned staff will begin Task 2 observations, following the process outlined on Attachment G. Observations should be documented on Attachment V.
b. If Phase One observations identify any concerns, targeted interviews must be conducted, in the following order (when possible):
    i. Interview the client first. Do not exclude clients who use alternate means of communication, such as communication boards or gestures. Most clients are able to communicate in some manner.
    ii. Interview the family, legal guardian, advocates (if applicable) and close friends (if identified) of each client for whom a concern was identified either during observations or client interviews. Interviews may be conducted at the facility or by telephone.
    iii. Interview facility staff as needed. This includes direct care staff (DCS) from more than one shift, the applicable Qualified Intellectual Disability Professional (QIDP) or medical personnel.

c. Interviews are conducted to determine:
   - How often injuries/mistreatment are occurring;
   - What process the facility is using to report such instances;
   - The timeliness of notifications;
   - Whether clients are protected from harm during investigations; and
   - Whether the facility implemented process changes to prevent future injuries and/or mistreatment.

d. Carefully document interviews on Attachment V, capturing names, job titles, the date, time and locations of interviews, and the summary of the content discussed.

e. Request reporting or investigation records after the observations and interviews have been completed based on the areas of concern identified.

f. For any specific injury noted during observations (regardless of whether the client is in the sample or not), request the documentation associated with the injury (i.e., reporting record, investigation report, etc.). The goal of this documentation review is to verify the information provided by the staff and to ensure the prompt reporting, investigation, and protection of clients with injuries and allegations of abuse, neglect, or exploitation.

g. Determine if the facility thoroughly investigated the incident. A thorough facility investigation must include at a minimum:
   i. The collection of all interviews, statements, physical evidence and any pertinent maps, pictures, or diagrams;
   ii. Review of all information related to the allegation;
   iii. Resolution of any discrepancies;
   iv. Summary of conclusions; and
   v. Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.

2. Phase Two Procedures

a. If it is determined during Phase One that there is insufficient evidence to find that the facility is in compliance with the COP for Client Protections per 42 CFR § 483.420, an extensive review is required following the process outlined on Attachment H.

b. Request the facility log of client incidents and reports from the last three months.

c. Select a sample of five percent of the incidents from the total client incidents occurring the requested timeframe. A minimum of 10 must be reviewed. If fewer than 10 are reviewed, the reason why must be documented in the working papers.

d. Request the investigative reports for these incidents. Determine whether each incident was:
   - Reported promptly;
   - Investigated thoroughly;
   - Had safeguards put into place to protect the client during the investigation;
   - Corrective measures taken in order to prevent recurrences.

e. Review the facility's policy and procedure documents on incident management, restraints, seclusion, and time out interventions. The policy must contain information about management and safety interventions and the facility's procedures regarding all the requirements of the COP.
f. If unable to determine compliance with the COP for Client Protections after review of the requested records, or the surveyor identifies any patterns of possible abuse, neglect, or exploitation (or the incident report logs for the past three months indicate an extremely high incident rate), proceed to a full review of the total number of incidents and reports for the past three months to determine if there is noncompliance by the facility.
g. If issues exist that rise to the level of Immediate Jeopardy (IJ), notify the FM immediately and follow the procedures outlined in Appendix Q – Determining Immediate Jeopardy. Refer to section labelled 'Immediate Jeopardy (IJ)' for more information.
h. If the facility has systems in place to prevent abuse, neglect, and exploitation, resolve complaints, and take appropriate corrective measures, then Phase Two is complete.

D. Task 3: Focused Observations

Overview

It is critical that observations occur over a sufficient span of time across the entire survey at varying times (i.e., early morning, afternoon, and evening) and occur across the client's various environments (e.g., home, recreation, and day program).

The purpose of observations is to determine the existence of effective therapeutic relationships between staff and clients. Staff must respect the rights of the clients and interact with them in a productive manner. Observe whether staff are able to effectively manage the environment and can effectively de-escalate and manage behavioral concerns.

Observations of mealtimes, client's communication with staff and others, behavior interventions, and routine activities should reflect a consistent pattern of interactions. Based upon the overall initial observations, the team may be able to determine if an extended or full survey rather than a focused fundamental survey will be required.

Relevant Forms

Attachment F: First Hour Observation Report (DSHS 15-525)
Attachment I: Sample Client Interview and Observation Worksheet (DSHS 15-528)
Attachment V: Surveyor Notes (DSHS 15-541)

Procedure

1. Surveyors Will:
   a. Initially note and record the first general impressions of each area where the client(s) reside (i.e., the environment). Conduct these observations, without intruding (unless it is necessary to alert a staff member to a possible risk to a client) for at least an hour in each initial location.
   b. Schedule time to observe special training programs that are critical to the client's development. Never request the facility to alter a client's schedule in order to observe the client during the survey.
   c. Observe each sampled client in as many treatment settings as possible, including off campus (i.e., therapy groups, activities, treatment team meetings, etc.).
   d. All clients in the core sample must be observed. Keep the following in mind while conducting observations:
      i. Introduce yourself to clients and staff.
      ii. Remain as non-obtrusive as possible.
      iii. Do not stand in doorways or sit where the client usually sits.

iv. Do not assist direct care staff (DCS) in activities (i.e., do not assist a client in a wheelchair to an activity at staff request).
v. Always attempt to be out of the way of client activities, while ensuring you are able to observe.
vi. Do not accept gifts or snacks.
vii. Do not interfere in the activities of the clients unless they are clearly in danger.

> Examples may include:
> - A client has fallen and needs immediate first aid and no staff are available. (Help the client, call 911)
> - You witness an assault between staff and a client. (Call for help and remain present until help arrives to protect the client)
> - A client is about to touch a hot stove unattended. (Attempt to block the area so the client is protected)

e. Observations should include the following:
- **Active Treatment:** Each Individual Program Plan (IPP) must be appropriate for the client based upon their Comprehensive Functional Assessment (CFA) and revised with changes in client program needs. The IPP must correspond to what treatments, programs, or services the client is actually receiving.

  The goal of the observations is to determine that the current objectives of the IPP match the strengths and needs of the client, staff are familiar with the methodology of accomplishing these programs, and staff apply them as written in the IPP. If confirmed, there is no need to conduct formal staff interviews. Staff interviews are not conducted routinely, unless there are discrepancies with the IPP programs identified after observing the client in several environments.

- **Staffing levels:** During observations, note how the on-duty staffing ratios either promote or prevent a safe and productive active treatment environment. Signs of inadequate staffing include:
  - Chaotic environment;
  - Client-to-client abuse or self-abuse by clients;
  - Clients sitting unengaged for long periods of time with little or no staff presence;
  - Clients not given the opportunity to assist in their daily routines due to the need to "get things done" (such as assisting with meal preparation); or
  - Active treatment programs not being carried out due to inadequate on-duty staffing.

- **Qualified Intellectual Disability Professional (QIDP):** The increased time devoted to observations during the survey provides more of an opportunity to observe the QIDP in action. If, after completing observations, the surveyor has unresolved concerns, interview the QIDP in an effort to resolve those concerns.

- **Health Care Services:** Observations will support the determination of whether or not the sampled clients are receiving medical care as indicated. If during observation there is concern about the health of a client, the nurse surveyor (if one is present) should talk with the client and/or the nurse about the issues observed. In the event that there is not a nurse surveyor, the non-clinical surveyor will need to consult with licensed clinical staff (i.e., licensed nurse). See SOP Chapter 18-Across All Settings for more information.

- **Physical Environment:** During observations, the surveyor should observe the facility for cleanliness, comfortable temperature, and any safety hazards (i.e., obstructed walkways, resilient, nonabrasive, and slip-resistant floors).

E. Task 4: Required Interviews

Overview

Clients living in the facility, their families, guardians, and advocates, and DCS are important sources of information about active treatment services, as well as the care and services provided on a daily basis. Interviews are conducted for two purposes:

- To determine how the client and/or their representative perceives the services delivered by the facility; and
- To clarify information gathered during observations.

Surveyors must attempt to interview all sample clients individually. However, clients have the right to decline to participate. Other factors that may prevent an interview from taking place include behavioral difficulties, or the client's current condition. If the interview does not occur, the rationale for not interviewing the client should be documented in the surveyor's working papers. If the reason the interview did not proceed is for any reason other than client refusal (i.e., behaviors, medical condition, etc.), the documentation must be supported by information included in the medical record and information from staff.

While conducting interviews and observations of the sample clients in their routine environments, the behavior and interactions of all other clients and staff that contribute to the surroundings can be documented as needed.

Use the following hierarchy of sources in the order shown:

- Client
- Families, Legal Guardian, or Advocate
- DCS
- QIDP and/or Professional Staff
- Managers, Administrators, or Department Heads

Client questions should focus on the following areas:

- Choice and Community Participation
- Personal Finances and Possessions
- Personal Relationships and Privacy
- Client's and Family's Participation in the IPP process
- Service Delivery
- Client Rights and Protections
- Health Status
- Wrap-up Questions

During the course of observations and interviews, consider the following:

- Are staff competent to carry out the client's choices and skill development activity?
- Is there evidence that programs are in fact being carried out throughout the client's waking hours?
- Are interventions revised based on changes in the client's progress toward goals?
- If staff cannot demonstrate the skills necessary to implement the individual's programs and choices, if interventions are not being carried out consistently, or if revisions to interventions do not occur, is active treatment delivered?

Relevant Forms

Attachment DD: Dignity and Respect during Observation, Interview, and Record Review (DSHS 15-524)
Attachment F: First Hour Observation Report (DSHS 15-525)
Attachment I: Sample Client Interview and Observation Worksheet (DSHS 15-528)
Attachment V: Surveyor Notes (DSHS 15-541).

Procedure

Surveyors will:

1. Conduct interviews in private locations.
2. Ensure the client's name, name and role of person being interviewed (if different from the client), date and time of interview, the method of interview (face-to-face or telephone contact), location of interview (if face-to-face) and summary of the interview are clearly documented using Attachment V.
   a. If attempting to interview the client or guardian, a minimum of three attempts must be made. Each attempt must be documented.
3. Ask at least one question related to each topic area. The wording to the questions may be modified, based on the client being interviewed and on the communication skills of that client.
   a. Staff should be easily available and may be present in the room but should not be able to overhear conversation unless the client makes a request for staff to remain in close proximity.
4. For clients who use a specialized communication method, attempt to begin the interview on a one-to-one basis. If you find you are unable to communicate with the client, ask someone familiar with the person to assist you (e.g., a family member or a staff person).
5. Be sensitive to signs that the client is tiring or becoming uncomfortable and either end the interview or continue it at a later time.
6. At the end of the interview, if you think you may need to discuss or confirm personal information with staff or family, ask the client if it is OK to share that information. Honor the client's request when possible.
7. Interviews with family members, legal guardians, or advocates can be conducted at the facility, at a location convenient to both the surveyor and the interviewee, or by telephone. The interviews should be scheduled at mutually agreed upon times in order to minimize disruptions to family members', legal guardians', or advocates' activities.

8. Interviews with staff are not done routinely. There is no need to conduct formal staff interviews if:
   a. The current objectives of the IPP match the strengths and needs of the client;
   b. DCS are familiar with how to implement these programs effectively; and
   c. Objectives in the IPP are being carried out as written.
9. If interviews with staff are needed, document staff names, positions/job titles, dates, times, reason for the interview and a summary of the details.
10. Conduct interviews with DCS to determine what the facility does to provide individualized services and supports, if needed. Ask questions that elicit information about how staff learn what to do with clients across the spectrum of support and programming activities they are expected to perform.
11. It is often necessary to ask impromptu questions during observations for clarification. Ask open-ended questions in order to confirm observations, obtain additional information, or corroborate information (e.g., accidents, odors, apparent inappropriate dress, adequacy, and appropriateness of training activities).

    Example: if you have just observed Client A engaging in stereotypical behaviors, ask: "Can you tell me what, if anything, you do when he rocks back and forth?"

12. Interview Interdisciplinary Team (IDT) Members who have assigned active treatment responsibilities for each sample client if concerns arise. Conduct these interviews near the end of the survey and base the interviews on information that was gathered during observations and direct interviews with clients and direct care staff.

In the absence of finding interaction between staff and clients during observations, it may be necessary to determine whether or not staff are knowledgeable about client objectives and techniques for implementation of programs.

F. Task 5: Medication Administration Observation

Overview

Observe and record the administration of medications (also called a "pass"). The purpose of the medication review is to direct the facility's attention to ensuring an error free medication distribution system, and away from the paper, processes that often do not represent actual errors in medication administration. Observations and interviews with the client and staff focus on the medication administration. A medication error is an observed discrepancy during the medication pass between what is ordered by the physician and what is administered to the client.

If there are clients on a medication self-administration program, the evaluation of the program should be part of the active treatment observations. The medication administration pass observed during the observations may or may not be for clients in the survey sample.

The medication administration observation will encompass a total of 12 medication doses. The observations should be split between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). The record of observation should be reconciled (with the most current signed physician's orders), soon after the observation to allow for interviewing the administrating nurse if questions arise.

Relevant Forms

Attachment L: Medication Pass Observation Worksheet (DSHS 15-531)
Attachment V: Surveyor Notes (DSHS 15-541)

Procedure

Surveyors Will:

1. **Medication Preparation**
   a. Record on Attachment L the client's name (or confidential identifier), the name of the medication, dose, route, expiration date, and time to be administered.
   b. This is often done by requesting to read either the medication bottle or package and/or medication "Punch card". Alert the nurse that you will be observing the medication pass and will need to document the information.
2. **Observation**
   a. Remain non-obtrusive as possible. Observe the preparation and administration of medications to clients. Findings at this juncture should be focused on what the surveyor observes, not what the medication administration record (MAR) states.

b. If there are clients at the facility who self-administer medications, attempt to observe the self-administration.
c. Respect the client's right to privacy by verbally asking the client for permission to observe.
d. Document if medications are crushed prior to administration.
e. Observe infection prevention practices by staff administering the medications. If the staff administering medications fail to use infection prevention, this would lead to a deficiency.

3. **Documentation**
   a. Record your observations on Attachment L, and any additional comments on Attachment V, if needed. If applicable, document administrative actions. Did the nurse shake the liquid, pour at eye level, or offer water? Follow the person administering medications and observe the clients receiving the medications.
   b. When observing staff administering medications to a client, plan to watch the entire process to include all doses.
   c. Complete Attachment L for each dose given for each client observed.
   d. Note every detail about medication administration in your notes.

> Example: "eye drops administered to both eyes" or "nurse took pulse" or "all medications crushed and administered in applesauce."

4. **Reconcile**
   a. Record review may help identify possible errors, however detection of blank spaces on the MAR does not alone constitute the occurrence of actual medication errors. The surveyor(s) conducting medication observation will need to follow-up on any observed concerns through additional record review and interviews.
   b. Reconcile the record of observation with the prescriber's medication orders to determine whether or not medication errors have occurred. It is best practice to review the MAR *and* the most current physician orders to ensure accuracy. For each medication on Attachment L determine if the medication was administered:
      - According to a valid prescriber's order(s)
      - To the correct client
      - At the correct time
      - In the correct dose
      - By the correct route
      - According to correct accepted standards of practice and manufacturer's specifications
   c. For medications not on the surveyor's list, examine the record for medication orders that were not administered and should have been. Such circumstances may represent omitted doses, one of the most frequent types of errors.

d. Before concluding that an error has occurred, discuss the apparent error, if possible, with the person who administered the medications, as there may be a logical explanation for an apparent error. Document the interview.
e. The surveyor should now have a complete record of what was observed and what should have occurred according to the prescribers' orders.
f. At the exit conference, describe to facility staff examples of the errors detected. Do not analyze the errors and come to any conclusions on how the facility can correct them. Do not attempt to categorize errors into various classifications (e.g., wrong dose, wrong client). Stress that an error occurred and that future errors must be avoided.

5. Intervening During Medication Administration

a. There may be times when the surveyor should intervene before the person administering the medication makes a critical suspected medication error. This would only occur when there is a situation involving the likelihood of life-threatening risk to a client.
b. When the surveyor encounters such a situation, bring it to the attention of the person about to administer the medication. The timing of this would take place at the point in which that person has committed to administering the medication, such as upon entering the client's room or approaching the client. The surveyor should question the person away from the client, such as at the medication cart or in the medication room, in a way that is respectful of the person administering medication and will not bring unnecessary alarm to the client. The intent is to confirm whether a significant medication error was or was not about to occur.

G. Task 6: Visit All Areas

Overview

By the end of the survey, each area of the facility serving certified clients must be visited in order to:

- Ensure that all areas of the facility (including those that are not represented by clients in the sample) are providing services in the manner required by the regulations.
- Assess the physical safety of the environment.
- Assess that individual rights are proactively asserted and protected.

Relevant Forms

- Attachment N: Physical Environment Checklist for Rainier School PAT E RHC (DSHS 15-533)
- Attachment Q: Physical Environment Checklist for Lakeland Village RHC (DSHS 15-536)
- Attachment R: Physical Environment Checklist for Fircrest RHC (DSHS 15-537)

Procedure

Surveyors Will:

1. After individuals in the sample have been assigned to team members, review the facility's map or building layout. The Team Lead will assign members to visit each remaining residential and on-campus day program site prior to completing the survey.
2. Ensure that each area of the facility that is utilized by clients has been visited. This visit may be done with or without facility staff accompanying you, based on surveyor preference, and subject to staff availability.
3. Each ICF/IID facility type has a specific form to be used for Task 6 (see relevant forms listed above). Document all areas inspected on the specific form for the specific facility. Comments can also be documented on the form.
4. Converse with clients, family members/significant others (if present), and staff. Observe staff interactions with other staff members as well as with clients for insight into matters such as individual rights and staff responsibilities.

H. Task 7: Record Review

Overview

Review of the client record during the Focused Fundamental Survey is kept to a minimum for all sample clients. Should the survey become a full survey, records are reviewed in more detail. During Task 1, sample selection, each sampled client's Individual Program Plan (IPP) was requested and reviewed. Each IPP will be utilized during observations to determine if:

- The client's skills match the IPP.
- The IPP is being followed.
- Staff understand the IPP.
- Staff and client interactions during the programs reveal no concerns.
- There are no health concerns interfering with the IPP.

Do not spend an excessive amount of time looking at fine details in the record review of the selected sample. The purpose for record reviews is to:

- Help the surveyor focus observations on the client's plan.
- Verify the applicable information obtained from your observations and interviews.
- Review revisions that have been made to the objectives.
- Verify that needed health and safety supports are in place.

If there are no identified concerns, then the record review is complete.

Review the written training programs that are developed for each client's objective to ensure they meet the regulatory requirements and to familiarize yourself with the strategy to help focus your observations. Review those parts of the record most relevant to your purposes as described below. If there are noted concerns, the record review will focus on obtaining additional information to clarify areas of question or concern identified during the observation.

The records for clients added to the core sample (expanded sample clients), should only be reviewed for the observed areas of concern.

Example: In the case of a client observed to be doing work that appears to be for the benefit of the facility, the record should be reviewed to determine whether:

- the work is included in the client's IPP;
- whether fair compensation is provided; and
- whether the client's needs are being addressed by the facility.

The client and the staff should be interviewed, and the information compared to the program records.

Relevant Forms

Attachment L: Medication Pass Observation Worksheet (DSHS 15-531)
Attachment M: Annual Fire Drill Review (DSHS 15-532)
Attachment V: Surveyor Notes (DSHS 15-541)

Procedure

The surveyor should ask the DCS carrying out the program(s) for program documentation. If the client is making steady progress, the program data will reflect this. However, if there is no progress made or if there has been a regression, there should be evidence that the QIDP/IDT is aware of the issue and is addressing it. In this case or in situations where actual programs do not match IPP programs or do not seem appropriate for the client based upon the client's identified skills, surveyors must interview appropriate staff.

Surveyors Will:

1. **Review the IPP:** Identify the developmental, behavioral, and health objectives to accomplish during the current IPP period. Identify what, if any, behavioral strategies (e.g., behavior modification programs, use of psychotropics) are being used with clients in your sample. Determine if health or other problems might interfere with participation in program services.
2. **Review program monitoring and changes:** Review the most recent IDT notes to identify what revisions were made to the IPP. Determine whether revisions were based on objective measures of the individual's progress, regression, or lack of progress toward their objectives.
3. **Review the health and safety supports to verify:**
   - That the client has received follow-up services for any health or dental needs identified in the IPP.
   - Check the client's current medication regimen.
   - For clients with whom restrictive or intrusive techniques are used, verify that the necessary consents and approvals have been obtained.
4. For those clients observed during administration of medications, reconcile observations from Attachment L with the MAR and Physicians' orders. clients on self-administration medication programs will require an additional review of their training objective to verify the correct implementation of the program.
5. During full surveys, review of staff qualifications is required. Use Attachment V to record information.
6. Fire drill reviews are also required during full surveys. Use Attachment M to record all information.
7. For all other records reviewed that are relevant to findings, document on Attachment V.
8. Only make copies of the client's record that are needed to verify each deficient practice. Once copies are made, return all records to the client chart. Ensure all original documents (i.e., those with ink signatures on them) remain in the client file.

9. At this stage of the survey, you should have a good idea of the client's active treatment program and whether or not deficiencies are identified. If not, further observations and interviews may be needed to determine if deficient practices exist as well as further record reviews.
10. Share all areas of concern during team meetings to identify trends and to confirm deficient practices.

I. Survey Consensus

Relevant Forms

Attachment W: Team Lead Focused Fundamental Survey Review Checklist (DSHS 15-542)
Attachment X: Team Lead Survey Review Checklist (DSHS 15-543)
Attachment Y: Team Lead Summary (DSHS 15-544)

Procedure

1. Once all interviews and records reviews are completed, begin consensus. This activity is facilitated by the Team Lead (see section labelled 'Team Lead Roles and Responsibilities' for more information). Refer to Exhibit 355 Probes and Procedures for Appendix J as needed.
2. The Team Lead or designee will alert the facility of the pending exit date and secure a meeting place and time. All team members contribute to the findings of their sampled clients. The team is to discuss each finding and associated tag, coming to an agreement on the deficient practices.
3. It is imperative that structure and guidelines for the consensus process are followed. If the process is not followed, the facility will notice discord among team members and the process will be delayed, causing difficulties in unforeseeable areas. (Refer to section labelled 'Team Lead Roles and Responsibilities' as needed.)
4. The Team Lead will compose preliminary findings on the ICF/IID Deficiencies Report (CMS-3070H) for those requirements that are determined to be deficient and the findings that support a deficiency practice with "not met." Write the deficiency statement in terms specific enough to allow staff to understand the aspect of the requirement that is not met. Indicate on the ICF/IID Deficiencies Report (CMS-3070H) the data prefix tag, followed by a summary of the deficient facility practice(s). Briefly identify the supporting findings for each deficiency (i.e., transfer to the CMS-3070H the identifiers of all clients to whom the deficient practice applies). For specific instructions on properly completing the form, see CMS instructions on the back of the form.
5. It is not necessary to write a full description of the findings on the CMS-3070H since they will be described in more detail on the completed SOD (CMS-2567). It is necessary to complete the CMS-3070H for each survey because the CMS-3070H is the only document in which the survey team's recommendations for deficiencies are recorded (which may be changed later on the final CMS-2567 as a result of FM review) and because not all client examples may be used on the CMS-2567. If the FM is not on survey with the team, notify the FM of the findings at the conclusion of the consensus meeting.
6. All team members sign the CMS-3070H page 3.
7. Prepare a confidential client identifier list for the facility to reference during the exit conference.
8. Conclude the consensus meeting by determining how the team will conduct the exit process if there are particular concerns. The Team Lead or designee will notify the facility when consensus is completed.

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J. Exit Conference

Overview

The purpose of the exit conference is to describe to the facility the requirements that are not in compliance with the regulations. The Team Lead, along with the survey team, meets with the facility at the end of the survey to present the team's preliminary findings. The team's findings are presented by sharing information from the CMS-3070H with the facility. Each issue is explained in enough detail, so the facility knows the deficient practices and is able to begin working on a Plan of Correction (POC). A copy of the client identifier list is given to the administrative staff for reference during the conference. The facility determines who will join in the exit conference.

The exit conference during the onsite survey is both a courtesy to the facility and a way to expedite the facility's planning ahead of the formal receipt of the survey findings in the SOD CMS-2567. An exit conference is not guaranteed, as noted in SOM Chapter 2 section 2724.

Relevant Forms

Attachment U: Exit Conference Roster (DSHS 15-540)

Procedure

Surveyors Will:

1. It is expected that the entire survey team attend the exit conference. Should concerns arise, notify the FM. The Team Lead and the survey team enter the exit conference room at the same time.
2. The Team Lead will ensure at least one team member brings Appendix J to the meeting for reference if needed. Limit the amount of documentation brought into the meeting.
3. Determine if there will be telephone conferencing to join the meeting and determine the best place to sit that allows all staff to hear.
4. The Team Lead will ensure the survey team is introduced.
5. Distribute Attachment U to facility staff for signature and ensure the administrator has a copy of the confidential client list for reference.
6. Briefly explain the type of survey and why it was conducted.
7. Express appreciation to facility staff for facilitating the survey.
8. Inform the facility that the findings are preliminary and official findings will be communicated via the CMS-2567. Explain the timeline for the CMS-2567 and the POC:
   a. The CMS-2567 will be provided to the facility within 10 working days (WD).
   b. The facility will have 10 calendar days after the receipt of the CMS-2567 to submit a POC.
9. Explain how the exit conference will be conducted and how the findings will be presented. (Team members may be asked to present portions of the survey findings with examples).

10. Inform the facility that if they believe any survey findings are based on inadequate or inaccurate information, they should provide the survey team with the information they believe would change the decision of the team within two WDs. Inform the facility that they may also dispute any findings through the RCS Informal Dispute Resolution (IDR) process. See SOP Chapter 22-Informal Dispute Resolution for more information.

Presentation of Preliminary Findings

1. Provide information about the survey team's preliminary findings in a manner that is understandable to those present (e.g., say the deficiency "relates to the absence of a post discharge plan of care", not to "Tag W205"). Provide examples as necessary and allow the facility to provide additional information if it chooses. Avoid using jargon or acronyms.
2. Explain why the findings are a violation of Medicaid requirements, or state requirements. Provide enough detail to assist the provider in expediting correction of the deficiency.
3. If a facility asks for a specific regulatory reference, it should be given with a disclaimer that the code reference is preliminary. If a facility does not specifically ask for the regulatory basis, the survey team will use its own judgment in determining whether this information would provide additional insight.
4. If the team is still deliberating about which tag is most pertinent, do not speculate. Describe the general area of non-compliance without specifying a regulatory code.
5. The survey team may describe the general seriousness (e.g., harm) or urgency the deficiency may pose to clients. With this in mind, if there were IJ finding(s), these should be discussed first. If the facility asks if the noncompliance is isolated, patterned, or widespread, respond with the facts, such as, "The noncompliance was found to affect "X" number of clients."
6. Use factual statements, such as "the team will recommend this condition be considered out of compliance." Do not make declaratory statements such as "Overall, this facility is very good" or "This condition was not met."
7. Do not discuss survey results in a manner that reveals the identity of an individual client.
8. During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.

Closure

1. Collect Attachment U and the completed CMS-3070G (if a recertification survey).
2. Offer additional explanation to the facility administrator or designee about the process of submitting the POC, pertinent due dates and options for disputes through IDR.
3. Ensure the facility administrator or designee has contact information for the survey team and the FM.

Part III: Additional Guidance

A. Immediate Jeopardy (IJ)

Overview

The Centers for Medicare and Medicaid Services (CMS) interprets IJ to mean a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more Condition of Participation (COP) has caused, or is likely to cause, serious injury, harm, impairment, or death to a client receiving care in the facility. See Appendix Q – Determining Immediate Jeopardy for CMS guidance related to this process.

The facility must accurately identify the situation, thoroughly investigate, and resolve it as quickly as possible. In addition, noncompliance cited at IJ is the most serious deficiency type and carries the most serious sanctions for facilities.

There are identified triggers that can assist in considering IJ. The listed Appendix Q Triggers do not automatically equal IJ. The team must investigate to determine if the situation has caused or is likely to cause serious harm, injury, impairment, or death.

3 Core Components of IJ

1. Noncompliance:
   An entity has failed to meet one or more federal health, safety, and/or quality regulations; the survey team should also identify, to the best of their ability, when the IJ began. This means determining at what point the entity's noncompliance made serious injury, harm, impairment, or death occur or likely to occur. Duration of IJ is dependent on the nature and extent of noncompliance and the recipients at risk. Often, a serious adverse outcome is identified in an event or incident. However, the survey team's investigation should seek to determine how long the IJ has existed, which may be prior to the event or incident.

   The duration of the IJ does not automatically end, even if the client is no longer in danger by the noncompliance (e.g., client is no longer in the facility or has expired). The survey team must determine if the noncompliance continues to create a likelihood for serious injury, harm, impairment, or death for any other clients.

2. Serious Adverse Outcome or Likely Serious Adverse Outcome:
   As a result of the identified noncompliance, serious injury, harm, impairment, or death has occurred, is occurring, or is likely to occur to one or more identified clients at risk; this serious adverse outcome may be physical, mental, and/or psychosocial in nature. The surveyor will use evidence gathered during observations, interviews and/or record reviews to support the assertion that the client has suffered a serious adverse outcome as a result of the identified noncompliance.

   Only one client needs to have suffered or be likely to suffer a serious adverse outcome for IJ to exist. Consider a serious adverse outcome when the noncompliance has caused death, loss of a limb, or permanent disfigurement.

   Consider IJ when noncompliance causes a client to experience avoidable pain that is excruciating, and more than transient in nature. Consider pain avoidable when there is a failure to assess, reassess, and/or take steps to manage the client's pain. Consider if one could reasonably expect a serious adverse outcome if there is no immediate action taken**.**

   Psychosocial/Mental Harm and using the Reasonable Person Concept:
   Serious adverse outcomes may not always affect physical functioning. Noncompliance rising to the level of IJ may also affect the client's mental or psychosocial well-being. In some situations, it may be difficult to determine psychosocial outcome for the client. In those situations, consider if a reasonable person in a similar situation could expect to experience a serious adverse outcome because of the same noncompliance.

3. Need for Immediate Action:
   When noncompliance causes a serious adverse outcome or creates the likelihood that a serious adverse outcome will occur, the facility must take immediate corrective action to prevent the serious injury, harm, impairment, or death from occurring or recurring. Even if the client has been removed from the situation (e.g., transferred to acute care, discharged, or has died) immediate action must be taken to remove the systemic problems which contributed to, caused, or were a factor in causing the serious adverse outcome, or making such an outcome likely.

Relevant Forms

IJ Template
Attachment CC: Survey and Complaint Investigation Tracking Cover (DSHS 15-546)
Attachment V: Surveyor Notes (DSHS 15-541)
Vulnerable Adult Statement Of Rights [VASOR] (DSHS 16-234A)

Procedure

Surveyors Will:

1. Document activities on Attachment V and provide a copy of the VASOR when interviewing clients for abuse, neglect, or exploitation. Documentation of interviews should include the person's full name, date, and time of the interview, if any witnesses were present, and if the VASOR was provided, as well as the reason why. If the VASOR was not given, the reason should be clearly documented in the working papers.
    a. If unable to discern the client's response to a facility's noncompliance, attempt to interview the client's family, or other individuals involved in the client's life to determine how the client reacted or would have reacted to the noncompliance.
    b. If unable to conduct interviews with the family or representative, apply a reasonable person approach.
2. If the case involves a potential criminal action, law enforcement must be notified. The facility should begin immediate removal of the risk to clients, and immediately implement corrective measures to prevent recurrence.
3. Determine the specific Federal regulation for the situation. Use one IJ Template for each tag considered at IJ level, referring to Appendix Q guidelines as needed.
4. Use evidence gathered from observations, interviews, and record reviews to carefully consider each component of the IJ outlined in the left-hand column of this IJ Template.
5. In order for IJ to exist, the survey team must answer "Yes" to all three core components and provide a preliminary fact analysis in the right-hand column if the IJ Template to support their determination.
6. Identification of an IJ situation will be made while onsite. The survey team must immediately notify the FM when a possible IJ situation is identified.
7. Once the FM confirms an IJ situation exists, the team must proceed to validate by gathering information from facility staff. Consider the facility's response to any harm or potential harm that meets the definition of IJ.
8. Identify and clarify any inconsistencies or contradictions between observations, interviews, and record reviews.
9. Use the IJ Template to document evidence of each component of the IJ. The IJ Template conveys information to the facility. Any information presented on this template is subject to change and does not reflect an official finding. CMS-2567 is the only form that contains official survey findings of the IJ (Refer to SOM Chapter 2, Section 2724).
10. Notify the facility administration of the IJ as soon as possible, with a clear and concise finding written on the IJ Template. Note the date and time that the facility received the form at the top of page two. In most cases, this will be before the exit conference, but must be delivered to the facility no later than two working days (WD) following the end of the survey.

a. If official notification of all deficiencies (i.e., CMS-2567) was not given on the second day along with the IJ information, a completed CMS-2567 must be sent to the facility within 10 WD.
b. In the rare instance an IJ is identified after the survey team has exited, the survey team must return to the facility to validate the finding using the IJ Template.

Approval of the Removal Plan

The removal plan, if implemented appropriately, must remove the likelihood that serious harm will occur, or recur. Approving the written removal plan does not mean the IJ is removed. The facility's removal plan must:

a. Identify those clients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
b. Specify the action the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

IJ Removal

Once the facility's removal plan is approved and the facility reports it has been successfully implemented, confirmation of IJ removal is verified onsite. Removal of the IJ does not mean that substantial compliance has been achieved – only that the immediate risk to clients has been abated. During onsite revisit surveys, the survey team will verify through observations, interviews, and/or record reviews that all elements of the removal plan have been implemented successfully.

Note: Even if the facility implements the removal plan prior to the exit conference of the original survey in which the IJ was cited, the IJ continues until an onsite revisit verifies the date that IJ was removed.

Procedure

With confirmation of the removal of the IJ, issue a completed CMS-2567 and request a POC that achieves substantial compliance.

1. The Survey Team will:
   a. Ensure the core components of IJ and the actions taken by the entity to remove the IJ are documented on the CMS-2567. The documentation must identify and describe the following information:
      i. The date the IJ began (the date facility's noncompliance caused a serious adverse outcome, *or* made a serious adverse outcome likely), if known;
      ii. The date the facility was notified;

iii. The specific requirement violated, including a description of the noncompliance and the serious adverse outcome that occurred, or was likely to occur;
iv. Identification of client(s) affected or identified at risk of serious injury, harm, impairment, or death within the DPS;
v. Date when the IJ was removed, as confirmed by an onsite verification.
vi. A statement of the seriousness of the remaining noncompliance, if any (i.e., Condition/Standard level).

b. Issuing an IJ begins the 23-Day termination procedure (See SOP Chapter 7 – Enforcement for more information).

2. The FM Will:
   a. Notify the Regional Administrator and CMS and/or HCA immediately when there is any situation involving the likelihood of life-threatening risk to a client (imminent risk, imminent harm).
   b. Ensure staff understand the IJ procedures and correct documentation on the IJ Template and CMS-2567 procedures.
   c. Evaluate and approve the facility's removal plan.
   d. Initiate recommendation for enforcement action when the facility is unable to comply with the POC requirements for the COP (See SOP Chapter 7 – Enforcement for more information).
3. AA3 Will:
   a. Document survey activities on the electronic tracking tool.
   b. Deliver the written notice describing the IJ to the facility no later than **2 WD** of the survey exit. If the official notification of all deficiencies (CMS-2567) was not given on the second day, send a completed SOD on the CMS-2567 to the facility by the tenth WD.
   c. Upon request, forward all supporting documentation to CMS and/or HCA within **3 WD** of the survey exit. Forward the information by overnight mail to ensure that CMS and/or HCA receives it. Upon receipt of the survey information, CMS and/or HCA reviews the documents and makes its determination of noncompliance.
   d. If notification of only the IJ deficiencies was sent to the facility and CMS/HCA, and there are other, non-IJ deficiencies found during the same survey or investigation (i.e., standard/key level), send the composed CMS-2567 with those deficiencies to the facility and forward copies to CMS and/or HCA within ten WD.
   e. Complete Attachment CC. Retain a copy for records.

B. Facility Revisit Surveys

Overview

When a facility has been found to be out of compliance and submits an acceptable POC, a revisit determines if the facility has regained compliance. The revisit survey will focus on the regulations cited as non-compliant. The revisit survey purpose is to determine compliance with the cited regulations.

Appropriate POCs received for all standard level citations may not require a revisit survey. The FM will make the determination.

Failure of a facility to comply with one or more COP requires a revisit. Any facility that does not comply with all of the COPs is considered limited in its capacity to furnish services at an adequate level or quality. Compliance with all COPs is required for certification.

When the facility has a revisit survey and they have failed to implement the POC or credible letter of compliance, adverse actions continue, based on findings of the first survey and the findings of the revisit. If at the time of the revisit the facility complies with the requirements forming the basis for the original termination but has new deficiencies that are also grounds for termination, a new termination process commences with the revisit.

Relevant Forms

Attachment A: Recertification Survey Action Plan (DSHS 15-518)
Attachment C: Complaint Survey Action Plan (DSHS 15-545)
Attachment CC: Survey and Complaint Investigation Tracking Cover (DSHS 15-546)

Procedure

1. Surveyors Will:
   a. Review the POC with the FM and determine the need for a revisit survey or if compliance can be determined without a revisit.
   b. If the POC is acceptable for standard level citations and no revisit is necessary per FM, complete the post-certification revisit report, CMS-2567B in ASPEN.
   c. If a revisit survey is needed, the Team Lead from the original survey (or the complaint investigator) will write a revisit plan using Attachment A, or Attachment C and select a team (if necessary) to include members from the original survey and brief the team on the action plan.
   d. Conduct the revisit survey (see 'Survey Tasks' for more information) and determine if the facility is in compliance with the cited regulations and the POC.

e. If conducting a revisit survey, use the POC to determine if the facility is back in compliance by reviewing an appropriate sample (see 'Sample Selection' for more information. Explore each step of the facility's POC by observing practices and/or collecting the needed documentation. Since the deficient practice relates directly to the POC, by determining if the POC is implemented and working correctly, the deficiency can be considered corrected, and the citation can be closed.
f. Upon completion of the survey, the Team Lead determines if the facility is in compliance with federal regulations and conducts the Exit Conference.
g. If regulations are not in compliance, develop a new SOD with a CMS-2567. If regulations are back in compliance, a post-certification revisit report, CMS-2567B is completed.

2. FM Will:
   a. Review the facility's POC and determine if a revisit is necessary.
   b. Consult with the Team Lead regarding the revisit survey action plan and team formation.
3. AA3 Will:
   a. Complete documentation in the electronic tracking tool.
   b. Issue via eFax (preferred method) or certified mail all letters/documents as determined from ASPEN.

REVISIT / DATE OF COMPLIANCE GRID			
REVISIT NUMBER	STANDARD/KEY LEVEL CITATIONS	COP LEVEL CITATIONS	IMMEDIATE JEOPARDY
1ST	SOM Chapter 2 section 2732 A, B	SOM Chapter 3 section 3016A, 3038B	SOM Chapter 3 section 3010B, Appendix Q
	No revisit necessary, unless FM determines revisit is needed to verify compliance. Compliance is certified as of the latest correction date on the approved POC. If not back in compliance after 1st revisit, proceed to 2nd revisit.	Onsite revisit is required to verify compliance. An acceptable credible allegation of compliance letter is required within 45 calendar days of exit. Compliance is certified as of the date of the revisit unless the facility is able to provide evidence of compliance at an earlier date. If not back in compliance after 1st revisit, proceed to 2nd revisit.	Onsite revisit is required to verify compliance. An acceptable credible allegation of compliance letter is required within 45 calendar days of exit. Compliance is certified as of the date of the revisit unless the facility is able to provide evidence of compliance at an earlier date. Continues on termination track if compliance not achieved.
2ND	SOM Chapter 3 section 3016A	SOM Chapter 3 section 3020A2	
	Onsite revisit is required to verify compliance. Compliance is certified as of the date of the 2nd revisit. If not back in compliance, a remedy must be imposed if not already imposed.	**Visit must be pre-approved by CMS** Compliance is certified as of the date of the revisit unless the facility is able to provide evidence of compliance at an earlier date. 55th calendar day of noncompliance, submit documentation to CMS. 60th calendar day of noncompliance, Denial of Payment letter is sent.	**Visit must be pre-approved by CMS** Compliance is certified as of the date of the 2nd onsite revisit or the date confirmed by the acceptable evidence, whichever is sooner. Continues on termination track if compliance not achieved.
A 3RD REVISIT IS NOT ASSURED AND ***MUST*** BE PRE-APPROVED BY CMS AND/OR HCA			
3RD	SOM Chapter 3 section 3018 Compliance is certified as of the date of the 3rd onsite revisit. If not back in compliance, proceed to termination.		

EXAMPLES OF ACCEPTABLE EVIDENCE MAY INCLUDE, BUT ARE NOT LIMITED TO:	GIVENS:
• An invoice or receipt verifying purchases, repairs, etc.	• An approved POC is required whenever there is noncompliance;
• Sign-in sheets verifying attendance of staff at in-services training.	• Remedies can be imposed anytime for any level of noncompliance;
• Interviews with more than 1 training participant about training	• Onsite revisits can be conducted anytime for any level of noncompliance.

C. Required Timelines

Overview

ICF/IID certification/recertification/complaint deficiencies have several levels:

- Standard level citations
- COP level citations
- IJ level of citations

There are federal requirements and timelines for each level and specific revisit schedules. Standard level citations may not require a revisit with an acceptable POC (unless directed by the FM).

The day the team exits the facility is considered the date of the survey. The following day begins day one of the 10 working day (WD) tracking, as required by CMS. Below are described timelines and procedures.

Abbreviated Condition of Participation (COP) Timeline Grid

COP Unmet Diagram

Date of Survey SOM Chapter 3 section 3010B	Date the entire survey is completed (exit date), regardless of when the exit conference is held
IJ – 2nd Working Day Appendix Q – Determining Immediate Jeopardy, SOM Chapter 3 section 3010B	IJ SOD delivery no later than 2 WD following date of survey
10th Working Day	send SOD with COP cover letter
IJ – 23rd Calendar Day Appendix Q – Determining Immediate Jeopardy, SOM Chapter 3 section 3010B	Termination takes effect unless IJ removed prior to 23rd day
45th Calendar Day	If Credible Allegation received, conduct 1st revisit survey
46th to 90th Calendar Days	2nd opportunity for revisit survey if approved by CMS
55th Calendar Day	If compliance not achieved, forward documentation to CMS/HCA. Notify facility termination is recommended.
60th Calendar Day SOM Chapter 3 section 3006C	Denial of Payment for New Admissions (DPNA) Letter and opportunity for informal hearing.

Abbreviated Immediate Jeopardy (IJ) Timeline Grid

Immediate Jeopardy Scenario Diagram

Date of Survey SOM Chapter 3 section 3010B	Date the entire survey is completed (exit date), regardless of when the exit conference is held
IJ – 2nd Working Day Appendix Q – Determining Immediate Jeopardy, SOM Chapter 3 section 3010B	IJ SOD delivery no later than 2 WD following date of survey
3rd Working Day	FM will forward all supporting documentation to CMS / HCA (e.g., SOD, correspondence, contact reports)
5th Working Day	CMS / HCA notify the facility and the public of the proposed termination action
10th Working Day	send SOD with COP cover letter
IJ – 23rd Calendar Day Appendix Q – Determining Immediate Jeopardy, SOM Chapter 3 section 3010B	Termination takes effect unless IJ removed prior to 23rd day
45th Calendar Day	If Credible Allegation received, conduct 1st revisit survey
46th to 90th Calendar Days	2nd opportunity for revisit survey if approved by CMS
55th Calendar Day	If compliance not achieved, forward documentation to CMS / HCA. Notify facility termination is recommended.
60th Calendar Day SOM Chapter 3 section 3006C	Denial of Payment for New Admissions (DPNA) Letter and opportunity for informal hearing.

Note: These dates are maximum timeframes.

Considerations

If CMS and/or HCA disagrees with the survey findings, based upon its review of the documentation, CMS and/or HCA discusses the results of the review with the survey team and solicits further evidence to support the survey team's recommendation. CMS and/or HCA confers with the survey team as to the appropriate action to take.

Should CMS and/or HCA and the survey team fail to agree that an IJ exists, CMS and/or HCA conducts a revisit with the survey team and together they ascertain if the IJ to the Client's health and safety exists or has been removed. If CMS and/or HCA and the survey team agree that an IJ exists, no revisit is necessary by CMS and/or HCA. Federal surveyors base the determination of IJ on an onsite determination. Under no circumstances should CMS and/or HCA reverse a survey team recommendation that an IJ has been removed or not removed.

Part VI: Appendices

A. Resources

1. Adult Protective Services
   Phone: 1-877-734-6277
2. ALTSA Headquarters Phone Numbers
3. Appendix Q-Triggers
4. Complaint Resolution Unit
   Phone: 1-800-562-6078
5. DDA Ombuds
6. ICF/IID Deficiencies Report (CMS-3070H)
7. ICF/IID Survey Report (CMS-3070G)
8. Immediate Jeopardy Scenario Diagram
9. Post-Certification Revisit Report (CMS-2567B)
10. Principles of Documentation (POD)
11. Reporting Grid
12. Statement of Deficiencies and Plan of Correction (CMS-2567)
13. Survey Team Composition and Workload Report (CMS-670)
14. Vulnerable Adult Statement of Rights [VASOR] (DSHS 16-234A)

B. Forms

Survey Forms:

1. Attachment A: Recertification Survey Action Plan (DSHS 15-518)
2. Attachment AA: Complaint Allegation (Client to Client) (DSHS 15-519)
3. Attachment B: Survey Hour Tracking (DSHS 15-520)
4. Attachment C: Entrance Conference Attendance Record (DSHS 15-522)
5. Attachment CC: Survey and Complaint Investigation Tracking Cover (DSHS 15-546)
6. Attachment D: Required Provider Survey Documents (DSHS 15-523)
7. Attachment DD: Dignity and Respect during Observation, Interview, and Record Review (DSHS 15-524)
8. Attachment E: Sample Selection (DSHS 15-521)
9. Attachment F: First Hour Observation Report (DSHS 15-525)
10. Attachment G: Task 2 Phase One (DSHS 15-526)
11. Attachment H: Task 2 Phase Two (DSHS 15-527)
12. Attachment I: Sample Client Interview and Observation Worksheet (DSHS 15-528)
13. Attachment J: Meal Observation (DSHS 15-531)
14. Attachment K: Human Resources Background Check and File Review (DSHS 15-530)
15. Attachment L: Medication Pass Observation Worksheet (DSHS 15-531)
16. Attachment M: Annual Fire Drill Review (DSHS 15-532)
17. Attachment N: Physical Environment Checklist for Rainier School PAT E RHC (DSHS 15-533)
18. Attachment Q: Physical Environment Checklist for Lakeland Village RHC (DSHS 15-536)
19. Attachment R: Physical Environment Checklist for Fircrest RHC (DSHS 15-537)
20. Attachment T: Team Lead notes (DSHS 15-539)
21. Attachment U: Exit Conference Roster (DSHS 15-540)
22. Attachment V: Surveyor Notes (DSHS 15-541)
23. Attachment W: Team Lead Focused Fundamental Survey Review Checklist (DSHS 15-542)
24. Attachment X: Team Lead Full Survey Review Checklist (DSHS 15-543)
25. Attachment Y: Team Lead Summary (DSHS 15-544)
26. Attachment Z: Complaint Survey Action Plan (DSHS 15-545)

Other Related Forms:

1. Complaint Checklist (for ISR)
2. COP Unmet Diagram
3. Immediate Jeopardy Template
4. Monthly Workload Report

C. Glossary of Terms

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

Agency – State agency.

Aspen (Automated Survey Process Environment) – a suite of software applications designed to help State Agencies collect and manage healthcare provider data.

Aspen Central Office (ACO) – refers to Centers for Medicaid and Medicare Services (CMS).

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

Certification – The process used by the department to determine if an applicant or service provider complies with federal health, safety, and program standards and is eligible to provide certified community residential services and support to clients.

CMS State Operations Manual, Appendix J – Federal Guidance to Surveyors for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

CMS State Operations Manual, Appendix PP – Federal Guidance to Surveyors for Long Term Care Facilities.

CMS State Operations Manual, Appendix Q – Federal Core Guidelines for Determining Immediate Jeopardy.

Code of Federal Regulation (CFR) – The Departments and Agencies of the Federal Government providing codification of the general and permanent rules published in the Federal Register.

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

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

Community Protection Program – Specialized supports within a supported living model which are designed to assist those individuals that have been identified as a potential risk to the safety of the community. Eligibility for the program is determined by:

- Regional Committees and is based on a client's history;
- A formal Risk Assessment which is completed by a qualified professional contracted with DDA; and
- The client's voluntary agreement to participate.

Conditions of Participation (COP) [ICF/IID only] – Refers to a “condition for coverage” relevant to suppliers. The COP are requirements with which an entity must comply in order to participate in the programs. The COP are categorized into three requirements:

- Structure
- Process

- Outcome

Credible allegation of compliance – means a statement, letter, or documentation that:

- Is realistic in terms of the possibility of corrective action being accomplished between the exit and the date of the alleged compliance; and
- Indicates resolution of the deficiencies.

Crisis diversion – Crisis diversion services are provided by trained specialists and are available to individuals determined by DDA to be at risk of institutionalization. Crisis diversion support services are provided in the client's own home. Crisis diversion bed services are provided in a residence maintained by the service provider.

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

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

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

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

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

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

Extent of deficient practice – The number of deficient cases relative to the total number of sampled cases. This is shown in a numerical format with identifying the number of deficient cases within the universe (e.g., 1 of 3). Please refer to definitions of scope and severity.

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

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."

Federal programs – This includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Homes (NH).

Forms CMS-2567, CMS 2567B, CMS-2567L Statement of Deficiencies – The official document(s) communicating the determination of compliance or noncompliance with the Federal requirements. In addition, they are the form(s) an entity uses to submit a plan to achieve compliance. Each form is an official, legal record that is available to the public on request.

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

Immediate jeopardy (IJ) – means a situation in which immediate corrective action is necessary because the non-compliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a vulnerable adult receiving care in a facility.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The Social Security Act created this optional Medicaid benefit to fund "institutions" (four or more beds) for individuals with intellectual disabilities. The Secretary defines this as providing "active treatment."

Medicaid Fraud Control Division (MFCD) – This statewide division is based in Olympia and includes a branch of four staff in Spokane to focus on Eastern Washington. MFCD investigates and prosecutes the criminal abuse and neglect of vulnerable adults in Medicaid-funded facilities and fraud perpetrated by health care providers against the Medicaid system.

Medication administration pass (ICF/IID) – One observation of medication administration on a particular shift that captures half (six) of the required drug dose observations (12) during a recertification survey.

Medication dose – Multiple tablets or capsules required to deliver a dose of a single medication count as one dose.

Medication pass – The process through which medication is administered to patients.

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.

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

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

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

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

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

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

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

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

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.

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

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

D. Acronym List

AA	Administrative Assistant
ALTSA	Aging and Long-Term Support Administration
ASPEN	Automated Survey Processing Environment System
CFA	Comprehensive Functional Assessment
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COP	Conditions of Participation
DCS	Direct Care Staff
DDA	Developmental Disabilities Administration / Administrator
DPNA	Denial of Payment for New Admissions
DPS	Deficiency Practice Statement
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
FM	Field Manager
HCA	Health Care Authority
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IDR	Informal Dispute Resolution
IDT	Interdisciplinary Team
IJ	Immediate Jeopardy
IPP	Individual Program Plan
LSC	Life Safety Code
MAR	Medication Administration Records
OSFM	Office of State Fire Marshal
PAT	Program Area Team
POC	Plan of Correction
QIDP	Qualified Intellectual Disability Professional
RCS	Residential Care Services
RCW	Revised Code of Washington
RHC	Residential Habilitation Centers
SA	State Agency
SFM	State Fire Marshal
SOD	Statement of Deficiency
SOM	State Operations Manual
SOP	Standard Operating Procedures
VASOR	Vulnerable Adult Statement of Rights
WAC	Washington Administrative Code
WD	Working Day

E. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/01/2024	Full Chapter	Chapter reformatted	Provide for easier navigation within the SOP	MB R24-041
05/01/2024	Full Chapter	Processes updated to capture current systems	Provide current guidance to staff	MB R24-041
05/01/2024	Section A.4 Surveyor Conduct	Section removed	Staff will refer to administrative policies for guidance	MB R24-041
05/01/2024	Section C Documentation Overview	Section renamed Additional Guidance	To better align with systemic SOP updates	MB R24-041
05/01/2024	Section D Alternative Sanctions	Section removed.	Staff will refer to Chapter 7-Enforcement	MB R24-041
05/01/2024	Section E Employee Development	Section removed	Staff will refer to Chapter 19-Staff Training	MB R24-041
05/01/2024	Section F Privately owned ICF/IID	Section removed	There are no privately owned ICF/IIDs in WA State. Section will be readded if this changes.	MB R24-041
05/01/2024	Section C. 8 Informal Dispute Resolution (IDR)	Section removed	Staff will refer to Chapter - IDR	MB R24-041
05/01/2024	Section C.5 Complaints and Investigations	Section removed	Staff will refer to Chapter 20 – Complaint Investigations	MB R24-041
05/01/2024	Sections C. 1-3, 6 SOD, POC, and required timelines	Section removed	Staff will refer to Chapter 18 – Across All Settings	MB R24-041
06/12/2020	Section 16F	Deevelopment of Chapter 16F	Establish new section in the SOP	MB/SOP R20-071

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
	Privately owned ICF/IID		for additional procedures	
9/20/2019	16B Survey Tasks	Development of subchapter 16B and 16D	Subsection B and D added to ICF/IID SOP Chapter	MB/SOP R19-070
7/12/2019	16C Documentation	Development of subchapter 16C	Subsection C added to ICF/IID SOP Chapter	MB/SOP R19-049
4/19/2019	16A Survey Overview	Development of Chapter 16A	Establish new ICF/IID SOP Chapter	MB/SOP R19-034