Washington State Department of Social & Health Services
Transforming lives

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Quality Assurance Early Visit Working Papers

Attachment A[1]

Review and Contact Log	
DATE	**SYSTEMS, PROCESSES, AND REVIEW**
	RCPP
	FMS
	TIVA
	TIVA 2

DATE	NOTES	INITIALS

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AFH Quality Assurance Visit

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Review of Resident Key

Attachment B[1]

The Licensor uses the "resident and caregiver list" form as a tool to identify everyone living and working in the adult family home. The form is also used when selecting the sample for the inspection. The Licensor typically fills out the form during the entrance onsite phase of the inspection, with the assistance of the adult family home provider.

If an area does not apply to the resident, place a dash in the space.

This instruction / key sheet will help you to determine what may need to go in a specific area.

State / Private pay............."S" = State (when Medicaid is the payment source) or "P" = Private

Able to interview................"Y" = Yes or "N" = No (You may not be able to interview the resident for a number of reasons ranging from cognitive impairment to overt refusal.)

Out of home ...."Y" = Yes or "N" = No (Identify whether or not the resident is literally in the home.)

Medication level ...."1" = Independent or "2" = Assistance required or "3" = Administration required

Evacuation level................"I" = Independent or "2" = Assistance required (See WAC 388-76-10870 for definitions.)

Diabetic ...."I" = Insulin dependent diabetic; "N" = Non-insulin dependent diabetic

Incontinent ...."Y" = Yes (A person is considered incontinent if they require partial or total assistance including presence of an indwelling catheter.)

Skin care issues................"P" = Pressure sore; "O" = Other (Some examples of other skin care issues are wounds and stasis ulcers.)

Nutrition issues.................."Y" = Yes (The resident requires a nutrient concentrate, supplements, or modified diet.)

Weight loss / gain............."L" = Loss; "G" = Gain

Mobility issue....................."I" = Independent or "A" = Assistance required or "T" = Total assistance

Nurse Delegation ...."Y" = Yes (Skilled services in the home such as home health or hospice.)

Outside agency ...."Y" = Yes (Skilled series in the home such as home health or hospice.)

Other ...."Y" = Yes or "N" = No (This category is intended to help identify other notable issues like example recent hospitalizations, admissions, or other changes that could impact residents.)

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ON-SITE VISIT DATE(S)		

Entrance: Provider onsite? ☐ Yes ☐ No; Arrived later? ☐ Yes ☐ No; Availability:

Attachment B[2]

RESIDENT NUMBER	RESIDENT KEY: RESIDENT NAME	DATE OF ADMISSION	BIRTHDATE	STATE / PRIVATE CARE	INTERVIEWABLE	OUT OF HOME	MEDICATION LEVEL	EVACUATION LEVEL	DIABETIC	INCONTINENT	SKIN CARE ISSUES	NUTRITION ISSUES	WEIGHT LOSS / GAIN	MOBILITY ISSUES	NURSE DELEGATION	OUTSIDE AGENCY (HOME, HEALTH, MH)	OTHER (SPECIFY BELOW)
1.																	
2.																	
3.																	
4.																	
5.																	
6.																	

OTHERS (NON-RESIDENTS IN HOME	ROLE / PURPOSE	BGI (IF APPLICABLE)
A.		
B.		
C.		
D.		

NOTES (INCLUDE INDOOR / OUTDOOR ENVIRONMENTAL CHANGES)

*M = Meets requirements N – Does not meet requirements N/A = Not applicable

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LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Provider / Resident Manager Interview Attachment B[3]

The questions below should be used as a guide and should not prevent the interviewer from asking more questions or obtaining more date if concerns are identified.

The following questions are required during the provider / resident manager interview:
• Has the resident ever expressed concerns about the care in this home? How did you handle it?
• What would you do if you saw, suspected, or were told that a resident was being abused, neglected, or financial exploited?
• What do you do if a resident elopes or becomes assaultive to other residents or staff?
• When did you participate in an evacuation drill? In what order do you evacuate residents? Where is the meeting place?
• What do you do if a resident falls?
• Do you work alone? How do you get help? How do you contact the provider?
The following questions are guides and could be asked if specific resident issues are identified during the course of the inspection:
• What kinds of decisions / choices do you allow the resident to make?
• How do you go about making the resident's feel comfortable here?
• What kinds of care and services does this resident need?
• How do you know what kind of care and services this resident needs?

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
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ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number

Attachment C[1]

Instructions: The questions below are intended as a guide and should not prevent the interviewer from asking more questions or obtaining more data if concerns are identified. If you are concerned about the answers, please investigate further.

Introductory Questions – The Interviewer should use the following questions as a lead in to the interview:

- What is the best part about living here?
- How long have you lived here?
- Are you from around here?
- If you could change one thing here, what would it be?

Required Questions – Check "Yes," "No," or "Declined to answer"

	YES	NO	DECLINE TO ANSWER
Can you make choices about the care and services you receive here at the home?	☐	☐	☐
If you have a roommate, were you informed you would have a roommate?	☐	☐	☐
Could you change roommates if you wanted?	☐	☐	☐
Do you have the opportunity to participate in community activities?	☐	☐	☐
Can you choose who visits you and when?	☐	☐	☐
Do they pay attention to what you have to say?	☐	☐	☐
Can you choose to lock your door?	☐	☐	☐
Do you have access to food anytime?	☐	☐	☐
Do you receive services in the community?	☐	☐	☐

ADDITIONAL NOTES

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number Attachment C[2]

Instructions: Choose one or more questions from each of the following sections.

Care and Service Needs
• Can you tell me what kind of help you get from the staff here?
• How well does staff meet your needs?
Support of Personal Relationships (if the resident has family or significant others)
• Does staff give you time and space to meet / visit with friends and family who come to visit?
• Are you able to make personal phone calls without being overheard?
Reasonable House Rules
• Tell me about the rules of the house?
• What have you been told about how long you can stay up at night or how early or late you can watch TV?
Respect of Individuality, Independence, Personal Choice, Dignity
• Do staff here know about your preferences?
• How does the staff treat you? Speak to you?
• What kinds of things do you make choices about?
• Do you have any concerns about how you are treated?
Homelike Environment
• What is your room like? Are you comfortable there?
• What personal items were you allowed to bring when you came here?

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number Attachment C[3]

Instructions: Choose one or more questions from each of the following sections.

Response to Concerns
• Do you feel like you can tell someone if you don't like it here?
• Who would you talk to if you had concerns? What do you think they would do about it?
Sense of Well-Being and Safety
• Do you feel safe here?
• Does anything make you feel uncomfortable here?
Meals / Snacks / Preferences
• How is the food here?
• How often do you get the foods you like to eat?
• If you can't eat something or don't like something what kind of replacement does the home offer you?
Activities
• What kind of activities are offered to you by the home?
• What kinds of things did you do for fun and relaxation before you came here?
• Are there activities you would like to do that are not offered?
• Is there anything you wanted to do and the home helped you do it?
Notice
• Do you handle your own finances or does someone help you with that?
• What were you told about paying for our care here and the home's policy about admitting and keeping residents whose stay is paid for by the state (Medicaid)? When and how were you told about this?

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number Attachment C[4]

Instructions: The questions below are intended as a guide and should not prevent the interviewer from asking more questions or obtaining more data if concerns are identified. If you are concerned about the answers, please investigate further.

Introductory Questions – The Interviewer should use the following questions as a lead in to the interview:

- What is the best part about living here?
- How long have you lived here?
- Are you from around here?
- If you could change one thing here, what would it be?

Required Questions – Check "Yes," "No," or "Declined to answer"

	YES	NO	DECLINE TO ANSWER
Can you make choices about the care and services you receive here at the home?	☐	☐	☐
If you have a roommate, were you informed you would have a roommate?	☐	☐	☐
Could you change roommates if you wanted?	☐	☐	☐
Do you have the opportunity to participate in community activities?	☐	☐	☐
Can you choose who visits you and when?	☐	☐	☐
Do they pay attention to what you have to say?	☐	☐	☐
Can you choose to lock your door?	☐	☐	☐
Do you have access to food anytime?	☐	☐	☐
Do you receive services in the community?	☐	☐	☐

ADDITIONAL NOTES

ADULT FAMILY HOME (AFH) **AFH Quality Assurance Visit**		PROVIDER'S NAME
		AFH NAME
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number Attachment C[5]

Instructions: Choose one or more questions from each of the following sections.

Care and Service Needs
• Can you tell me what kind of help you get from the staff here?
• How well does staff meet your needs?
Support of Personal Relationships (if the resident has family or significant others)
• Does staff give you time and space to meet / visit with friends and family who come to visit?
• Are you able to make personal phone calls without being overheard?
Reasonable House Rules
• Tell me about the rules of the house?
• What have you been told about how long you can stay up at night or how early or late you can watch TV?
Respect of Individuality, Independence, Personal Choice, Dignity
• Do staff here know about your preferences?
• How does the staff treat you? Speak to you?
• What kinds of things do you make choices about?
• Do you have any concerns about how you are treated?
Homelike Environment
• What is your room like? Are you comfortable there?
• What personal items were you allowed to bring when you came here?

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Resident Interview: Resident Number Attachment C[6]

Instructions: Choose one or more questions from each of the following sections.

Response to Concerns
• Do you feel like you can tell someone if you don't like it here?
• Who would you talk to if you had concerns? What do you think they would do about it?
Sense of Well-Being and Safety
• Do you feel safe here?
• Does anything make you feel uncomfortable here?
Meals / Snacks / Preferences
• How is the food here?
• How often do you get the foods you like to eat?
• If you can't eat something or don't like something what kind of replacement does the home offer you?
Activities
• What kind of activities are offered to you by the home?
• What kinds of things did you do for fun and relaxation before you came here?
• Are there activities you would like to do that are not offered?
• Is there anything you wanted to do and the home helped you do it?
Notice
• Do you handle your own finances or does someone help you with that?
• What were you told about paying for our care here and the home's policy about admitting and keeping residents whose stay is paid for by the state (Medicaid)? When and how were you told about this?

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
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LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Assessment and Care Plan Analysis: Resident Number ☐ Private ☐ Medicaid Attachment D[1]

Charting by Exception		
TOPIC	**ASSESSMENT AND PRELIMINARY SERVICE PLAN WAC 10330 – 10350**	**NEGOTIATED CARE PLAN (SERVICES, WHO, WHEN, AND HOW) WAC 10355 - 10385**
General Information	Date:	Date:
Admission date: **Hx**, Med list, diagnosis, allergies, cognitive status	Prior to admission	Completed within 30 days? ☐ Yes ☐ No Signatures? ☐ Yes ☐ No
Medication Management: Level(s) of Assistance Injections Nurse Delegations		
Treatments, Special Care, Programs, Hospice		
Communication		
Evacuation Capability WAC 10870	**Independent** **Needs Assistance**	**Independent** **Needs Assistance**
ADLs Eating		
Toileting		
Mobility		
Transferring		
Positioning		
Personal Hygiene		
Dressing		
Bathing		
Preferences: Sleep, Food, Routine, etc.		
Medical Devices WAC 10650		
Behavior / Crisis Plan		
Activities and Preferences		
Other		
Revision / Significant Change / Annual		

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Assessment and Care Plan Analysis: Resident Number ☐ Private ☐ Medicaid Attachment D[2]

TOPIC	ASSESSMENT AND PRELIMINARY SERVICE PLAN WAC 10330 – 10350	NEGOTIATED CARE PLAN (SERVICES, WHO, WHEN, AND HOW) WAC 10355 - 10385
Charting by Exception		
General Information	Date:	Date:
Admission date: **Hx**, Med list, diagnosis, allergies, cognitive status	Prior to admission	Completed within 30 days? ☐ Yes ☐ No Signatures? ☐ Yes ☐ No
Medication Management:		
Level(s) of Assistance		
Injections		
Nurse Delegations		
Treatments, Special Care, Programs, Hospice		
Communication		
Evacuation Capability WAC 10870	**Independent** **Needs Assistance**	**Independent** **Needs Assistance**
ADLs Eating		
Toileting		
Mobility		
Transferring		
Positioning		
Personal Hygiene		
Dressing		
Bathing		
Preferences: Sleep, Food, Routine, etc.		
Medical Devices WAC 10650		
Behavior / Crisis Plan		
Activities and Preferences		
Other		
Revision / Significant Change / Annual		

Washington State Department of Social & Health Services
Transforming lives

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Charting by Exception Notes

Attachment D[3]

*M = Meets requirements N – Does not meet requirements N/A = Not applicable

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Medication Management

Attachment E

MEDICATION SYSTEM WAC 10430 AND 10485	M	N	N/A	NOTES
Locked meds (including refrigerated)	☐	☐	☐	
Original labeled container	☐	☐	☐	
Organized to prevent errors	☐	☐	☐	
Order / refill medications	☐	☐	☐	
NOTES				

RESIDENT NUMBER:	M	N	N/A	NOTES
Medication organizer, if applicable WAC 10480	☐	☐	☐	
Filled by licensed pharmacist, nurse, resident, or family member	☐	☐	☐	
Label: Resident name, RX and OTC medications, dosage, frequency	☐	☐	☐	
Medications are readily identifiable	☐	☐	☐	

DAILY MEDICATION LOG (MED ASSIST OR ADMIN) WAC 10475	RES. NO.			RES. NO.			NOTES
	M	N	N/A	M	N	N/A	
RX and OTC meds	☐	☐	☐	☐	☐	☐	
Dosage	☐	☐	☐	☐	☐	☐	
Frequency	☐	☐	☐	☐	☐	☐	
Scheduled time	☐	☐	☐	☐	☐	☐	
Staff initials	☐	☐	☐	☐	☐	☐	
New med / order change recorded per WAC 10475	☐	☐	☐	☐	☐	☐	
Med refusal, reason, physician notification WAC 10435	☐	☐	☐	☐	☐	☐	

ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

PROVIDER'S NAME		
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ON-SITE VISIT DATE(S)		

Nurse Delegation

Attachment F[1]

Nurse Delegation WAC 10400	M	N	N/A	NOTES
Consent	☐	☐	☐	
Initial Nurse Delegation visit	☐	☐	☐	
Caregiver qualifications reviewed by delegator	☐	☐	☐	
Insulin injection / diabetic special care certification	☐	☐	☐	
Instruction / task sheet per delegated task	☐	☐	☐	
Supervisory review / changes	☐	☐	☐	

Records and Administration

Daily Medication Log (Med Assist or Admin) WAC 10475

ITEMS	RES. NO.			RES. NO.			NOTES	ITEMS	RES. NO.			RES. NO.			NOTES
	M	N	N/A	M	N	N/A			M	N	N/A	M	N	N/A	
Notice of rights and services with signatures	☐	☐	☐	☐	☐	☐		Nurse Delegation documents	☐	☐	☐	☐	☐	☐	
Medicaid policy with signatures	☐	☐	☐	☐	☐	☐		Medication log	☐	☐	☐	☐	☐	☐	
Resident information requirements	☐	☐	☐	☐	☐	☐		Management of medical professional orders	☐	☐	☐	☐	☐	☐	
Assessment / Prelim Service Plan	☐	☐	☐	☐	☐	☐		Disclosure of charges	☐	☐	☐	☐	☐	☐	
Negotiated care plan with signatures	☐	☐	☐	☐	☐	☐		Type of system	☐	☐	☐	☐	☐	☐	
Legal documents	☐	☐	☐	☐	☐	☐		Useful format	☐	☐	☐	☐	☐	☐	
Personal belongings inventory								Confidential	☐	☐	☐	☐	☐	☐	
Financial recordkeeping								Availability	☐	☐	☐	☐	☐	☐	

ITEMS	M	N	N/A	NOTES
Evacuation drill	☐	☐	☐	
Pet: Rabies records	☐	☐	☐	
Accident / injury	☐	☐	☐	
Liability insurance	☐	☐	☐	

NOTES

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ADULT FAMILY HOME (AFH)

AFH Quality Assurance Visit

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ON-SITE VISIT DATE(S)		

Records and Administration

Attachment F[2]

Please answer the following:	Staff 1	Staff 2	Staff 3	Staff 4	Non-Exempt Staff	
Name and date of hire					Name of Non-Exempt Staff	
Why exempt?					Name	HCA Expiration Date
DOH expiration date						
Fundamentals date completed						
CPR expiration date						
First Aid expiration date						
Food Safety expiration date						
Nurse Delegation: Basic						
Insulin						
BGI expiration date					COMMENTS	
Fingerprint date						
TB test results: Step 1						
Step 2						
Outcome	☐ + / ☐ -	☐ + / ☐ -	☐ + / ☐ -	☐ + / ☐ -		
TB x-ray, blood, sign / symptoms						
Date						
Outcome	☐ + / ☐ -	☐ + / ☐ -	☐ + / ☐ -	☐ + / ☐ -		
Specialties: Mental health						
Developmental disabilities						
Dementia						
In-home orientation checklist						

Exempt LTC Workers: LPN, RN, CNA, or persons in an approved CAN training program, or Medicare Certified Home Health aide, person with special education training and an endorsement granted by the Superintendent of Public Instruction and LTC worker employment in LTC setting between 1/11/11 to 1/6/21 AND met educational requirements at the time.

Non-Exempt LTC Workers: Staff must have direct supervision until he/she has completed Core Basic Training within 120 days.

Caregiver Specialty: HCA - Need certificate within 120 days of hire. HCA exempt – Need certificate within 90 days of hire. No unsupervised access without specialty certificate.

Washington State Department of Social & Health Services
Transforming lives

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AFH Quality Assurance Visit

PROVIDER'S NAME		
AFH NAME		
LICENSOR'S NAME	LICENSE NUMBER	AFH ADDRESS
ON-SITE VISIT DATE(S)		

Summary Worksheet

Attachment G

TOPIC		FOLLOW UP REQUIRED (IF YES, CHECK BOX)	DATE RECEIVED
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

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AFH Quality Assurance Visit

PROVIDER'S NAME	
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ON-SITE VISIT DATE(S)		

Summary Worksheet Attachment H

Education Provided in the Following Categories:

CATEGORY	COMMENTS	CATEGORY	COMMENTS
☐ Resident Assessment		☐ Nurse Delegation	
☐ Resident Assessment Update		☐ Resident Records	
☐ Preliminary Service Plan		☐ Administrative Records	
☐ Negotiated Care Plan		☐ Staff Qualifications	
☐ Negotiated Care Plan Update		☐ Medical Devices	
☐ Medication System		☐ Resident Rights	
☐ Medication Storage		☐ Other:	
☐ Medication Log		☐ Other:	
No Visit Made		**Due to "0" residents within 90 days of becoming licensed.**	

Notes

DEPARTMENT USE ONLY	C.R.U Referral (if applicable)	Last date of data collection:
TYPE OF FOLLOW UP NEEDED	CONTROL NUMBER ☐ Field notification of C.R.U. referral	CASE CLOSED DATE