Overview

Adult family homes (AFH) are regular residential homes licensed to care for up to eight residents. These homes are private businesses and provide residents with a room, meals, laundry, supervision, and personal care. The services provided to residents depend on the needs of each individual resident and the skill level of the provider. Some homes can provide nursing services or other special care and services. The cost of care varies depending on the level of care the resident requires. Residential Care Services (RCS) regulates these homes and conducts licensing visits every 9 to 18 months.

This standard operating procedure (SOP) contains information about the minimum licensing standards and other topics related to AFHs. The content is relevant to RCS staff, AFH providers, and anyone seeking to understand how AFHs are regulated.

In this document, the icon indicates information that is of specific importance to staff that may require additional attention (i.e., documentation requirements, special focus, etc.).

Note: Throughout this document, the terms Provider, Licensee, Field Manager (FM), Regional Administrator (RA), and Administrative Assistant (AA) can also refer to their designee.

AFHs must comply with the following Washington Administrative Code (WAC) and Revised Code of Washington (RCW) chapters:

- Chapter 51.51 WAC – State Building Code
- Chapter 388-76 WAC – Adult Family Home Minimum Licensing Requirements
- Chapter 388-112A WAC – Residential Long-Term Care Services
- Chapter 388-113 WAC – Disqualifying Crimes and Negative Actions
- Chapter 70.128 RCW – Adult Family Homes
- Chapter 70.129 RCW - Long-Term Care Resident Rights
- Chapter 74.34 RCW – Abuse of Vulnerable Adults
- Title 42 §441.530 - Home and Community-Based Setting

These procedures are in addition to DSHS Administrative Policies, as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years.

Contacts

- RCS Policy Unit General Contact (**internal** RCS use)
- RCSPolicy@dshs.wa.gov (**external** RCS use)
- RCS Quality Improvement General Contact

Table of Contents

Part I: AFH Inspections Standard Operating Procedures

A. General Guidelines

Purpose

The purpose of conducting AFH licensing inspections is to ensure homes are in compliance with minimum licensing standards. The primary focus should be on resident's rights and their safety and well-being.

Procedure

Inspection Frequency

1. The first inspection for a newly licensed home must occur no later than nine months after receiving their initial license.

   Note: This does not apply to a Change of Ownership (CHOW).

2. An inspection must occur by the end of the 18th month after the end of the previous inspection.
3. RCS may inspect a home every two years (24 months) if the AFH has:
   a. No citations for the past three full consecutive inspections; and
   b. No citations resulting from complaint investigations (CI) that occurred during the last three inspection cycles.
4. The Field Manager (FM)/designee must assign AFH inspections to be unpredictable. Average inspection interval is fifteen months. This is achieved by:
   a. Scheduling inspections for homes with a history of non-compliance every 9-12 months.
   b. Scheduling inspections for homes with a history of compliance every 16-18 months.
   c. Avoiding scheduling the inspection in the same month as the home's previous inspection if possible.
   d. Incorporate variance in timing.

   Note: The ultimate goal is to be **unpredictable**. This is only a guideline, and inspections may be scheduled at other times.

General Information – Licensors must:

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

   Note: Staff may use Attachment U: RCS Notes (10-563) at any time if needed. This is for additional notes and does not replace the need to document on the designated form.

2. Not disclose the date of inspection to the AFH or others, except as required by law and the procedures outlined within this SOP.
3. Clearly communicate general observations and concerns with the provider and staff throughout the inspection, as long as it does not interfere with the ability to determine failed practice.
4. Minimize the disruption of daily routines for the residents during the inspection.

Field Manager Responsibility

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

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

B. Pre-Inspection Preparation

Purpose

The purpose of pre-inspection preparation is to identify potential issues, concerns or patterns that will need to be considered during the upcoming inspection. It may also aid the licensor to determine if a specialized team member, such as a licensed nurse, needs to either join or complete the inspection.

Procedures

1. Note all the information you gather during the pre-inspection on Attachment A: Pre-Inspection Preparation (DSHS 10-548).
2. Plan to initiate the inspection when you are likely to observe staff providing care and services to residents. Ideally the inspection will allow the licensor to observe a meal.
3. Assemble needed forms for recording data during the inspection.
4. Review pertinent documentation on the provider's history since the last full inspection:
   a. Review tracking system for compliance history, number of licensed beds, current exemptions, exceptions, or waivers, any uncorrected citations and limits on the license since the last full inspection, follow-up visits, or complaint investigations.
   b. Identify any reported changes to the AFH since the last full inspection, such as change of entity representative, change of ownership (CHOW), or any other information that may impact resident care and services.
5. Review all Statement of Deficiency(ies) (SOD) and enforcement actions since the last full inspection for compliance history and identify deficiencies cited or consultations issued.
   a. Identify and note any patterns of repeated or isolated deficiencies and relevant attestations of correction.
   b. Review all complaint investigation reports, including complaint intakes assigned a Quality Review priority, since the last full inspection.
   c. Identify any open complaints yet to be investigated. Note resident and staff names and other contacts referenced in the reports.
6. Request and return of working papers to Central Files may be completed by the Unit Administrative Assistant 3 (AA3).
7. If needed, check in with the previous or current complaint investigator to clarify issues or concerns.
8. Never remove provider files from the office. Make copies of needed items (e.g., floor plans).

C. Abuse Prevention Review

Purpose

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

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

Note: For definitions of abuse, refer to Glossary.

Procedure

1. Remain alert throughout the visit for indicators of possible abuse.
2. Document information related to any suspected or actual abuse. Potential indicators may be found:
   a. During environmental observations.
   b. While conducting interviews.

   Note: See Resources for specific examples of potential abuse, a link to Key Triggers which may indicate abuse, and sample questions to consider asking during interview.
3. During provider and staff interviews, verify understanding of abuse and what to do if abuse is suspected or witnessed. This includes understanding of:
   a. Financial exploitation, physical, mental, and sexual abuse.
   b. Steps to take in the event of suspected abuse.
   c. Notification and reporting requirements as described in the home's policies and procedures.
4. Request the home's incident investigation report if you become aware of a probable or actual incident, injury, or accident since the last inspection to determine if:
   a. Mandated reports have been submitted as required by state mandated reporting laws; and
   b. The provider has taken appropriate action to protect residents' safety.
5. Verify mandated reporting postings including the department toll-free complaint number contact and long-term care ombuds.
6. If abuse is suspected or identified, the licensor's first responsibility is as a mandated reporter. Licensors will:
   a. Immediately notify the Complaint Resolution Unit (CRU) by email (cru@dshs.wa.gov), with a cc (carbon copy) to the FM.

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

D. Infection Prevention and Control (IPC)

Purpose

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

Procedure

1. Infection Prevention and Control (IPC) Inspection Tool (DSHS 13-939)
   a. Completed for all licensing inspections in Adult Family Homes (AFH).
   b. The Centers for Disease Control and Prevention (CDC) Standard Precautions and Transmission-Based Precautions are the nationally accepted standards for IPC practices in LTC settings.
   c. The tool is used to assess the LTC setting application of CDC standards during the licensing visit.
   d. The tool includes areas for documentation of IPC observations, interviews, and record reviews.
2. RCS IPC Assessment Notes (DSHS 13-944)
   a. Used in *addition* to the IPC Inspection Tool as a supplemental documentation tool when needed.
   b. Completed IPC Assessment Notes **must always** accompany supplemental documentation tool.

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

   c. Review the Resource Links listed at the bottom of IPC Inspection Tool during pre-inspection preparation.
   d. Prepare to carry sufficient PPE for any Transmission-Based Precaution events (airborne, contact, droplet).
   e. Upon entrance, determine if there is a communicable disease outbreak in the setting.
   f. If a communicable disease outbreak is present in the setting, consult the Field Manager prior to initiating full inspection, and don appropriate PPE as directed or indicated.

E. Entrance Onsite

Purpose

The purpose of the entrance onsite section is to set the tone for the rest of the inspection. This is accomplished by always being respectful and allowing time for AFH staff and providers to ask questions.

Procedure

1. Use Attachment C: Entrance Information and Observation (DSHS 10-550).
2. Upon arrival to the home begin making observations of the outside of the home and note any environmental hazards or concerns.
3. An AFH is both a business and a home. Respectfully knock on the door and wait for someone to answer.
4. If there is no answer:
   a. Wait 15 to 30 minutes and knock again.
   b. If still no answer, call the home and/or any listed alternate number in STARS.
   c. If no answer to knocking or phone calls, contact your FM for direction on next steps.
5. When someone answers the door, introduce yourself, ask who you are speaking to.
   a. If it is a resident, ask to speak to the provider or staff person.
   b. If there is no provider or staff person at the home, contact your FM.
   c. If the staff person is present but the provider is not, request the staff contact the provider, but explain that the inspection will not be delayed for the provider.
6. Provide your business card and RCS identification and explain the purpose of the visit to the staff person or provider.
7. If you are denied entrance, restate the reason for your visit. If the person is not the provider, request that they contact the provider and explain the situation.
   a. If still denied, contact your FM.
8. Give the staff member or provider Attachment B: Inspection Process and Records Request (DSHS 10-549).
9. Explain the inspection process including observations, home tour, interviews and documentation that may be needed.

10. Ask the staff member or provider:
    a. If there is currently any infections or illness in the home.
    b. If the home has any special features (i.e., private bathrooms, window views, etc.).
    c. If there are any residents not currently in the home.
    d. To describe the normal daily routine for the home.
    e. If there are any unlicensed areas of the home, explain that while those areas will not be included in the inspection, access will be needed to assess emergency preparedness requirements such as emergency evacuation plan, fire extinguishers, and smoke detectors.
11. For a place to work that will have the least interruption to the daily activities of the home, allows access to a power outlet, and provides opportunities for ongoing observation of residents.

F. Sample Selection

Procedure

1. Work collaboratively with the provider or designee to complete Attachment D: Resident List (DSHS 10-551).
2. Selecting the comprehensive residents can be done prior to or after the tour.
   a. Select two residents for comprehensive review, one with minimal care needs and one with more care needs. If possible, avoid selecting residents that were chosen as comprehensive residents during the prior inspection.
   b. If there are two or more residents living in the home, both residents selected for comprehensive review must be present. If a sampled resident needs to leave during the visit, focus on that resident first to complete the interview and observations.
   c. If there is only one resident living in the home, that resident will be selected for comprehensive review. A closed record may be reviewed if there is a concern identified that could be systemic.
   d. If the home does not have any current residents, select at least one closed record for review.
3. All residents identified as a comprehensive resident on Attachment D will require the following:
   a. Observation of Care
   b. Medication Services Review
   c. Resident and Representative Interviews
   d. Resident Record Review

> Note: The sample may be expanded at any time if an issue is identified that warrants additional review. Expanded sample residents must not be identified as comprehensive residents. It is never required to have more than two comprehensive residents.

G. Tour and Environmental Observation

Purpose

The purpose of the tour not only allows the licensor the opportunity to inspect the physical environment, but also provides opportunities to meet residents, observe care, and note quality of life or safety concerns. Informal interviews during the tour may lead the licensor to concerns that would otherwise not be identified by record review or observations.

Procedure

1. Allow the staff member/provider a reasonable amount of time to complete any task they were involved in prior to beginning the tour and ask them to accompany you during the tour.
2. Document observations of the general physical environment on Attachment F: Environmental Tour (DSHS 10-553). All categories on the form must be completed.
3. Refer to Attachment D for residents' names and a brief summary of their needs and services.
4. Document observations of resident rooms on Attachment G: Environmental Tour – Bedrooms (DSHS 10-554).
5. You may use Attachment U or available notes pages in the packet to document any of the following that occur during the tour:
   a. Informal interviews
   b. Concerns expressed by residents
   c. Residents who appear to have unmet care or service needs
6. Test the hot water to confirm the temperature is between 105º-120º F (Fahrenheit) at the main water source used by residents for each water heater in the home.

   Note: Best practice is to have the provider/staff confirm any readings outside the required range with the home's thermometer.

7. For smoke alarms, request the provider test the alarm in the presence of the licensor. Homes that serve residents who are not able to hear the fire alarm warning must install visual fire alarms in addition to auditory alarms.
   a. If the alarms are interconnected, request the provider test one alarm and confirm each alarm can be heard.
   b. If the alarms are not interconnected, request the provider test each alarm and confirm each alarm can be heard.
   c. If visual alarms are installed, observe they work when tested.
   d. Alarms must be heard in the following areas:

1) Every resident bedroom;
2) In the immediate vicinity of resident bedroom(s), and if applicable, the sleeping areas used by the home's staff; and
3) On every level of a multi-level home.

> Note: Homes licensed prior to 07/01/2010 are not required to have smoke alarms interconnected. CHOW homes that have been continuously licensed prior to 07/01/2010 are grandfathered and do not require interconnection.

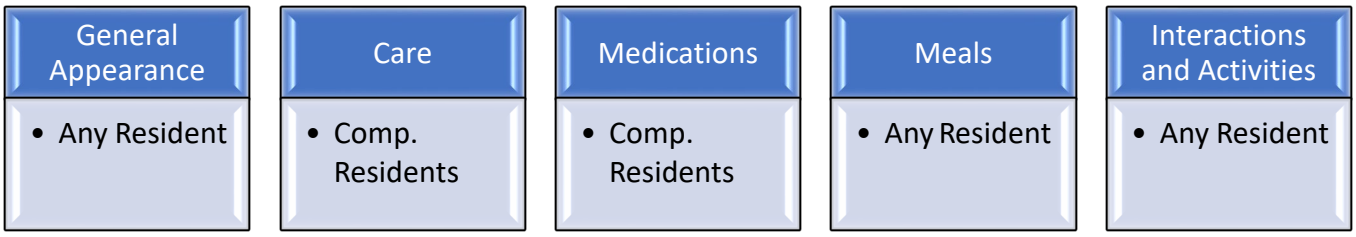
8. Conclude the tour, thank the staff member/provider for their time and move on to the next part of the inspection.
9. If the comprehensive residents have not yet been selected, select the sample.

H. Observation and Documentation of Care

Purpose

The purpose of observation and documentation is to assess how well care and services are being provided and determine if the residents' physical and emotional needs are being met. Observation should focus on ensuring the care provided reflects appropriate training, is consistent with the needs of the residents, and upholds the resident rights for quality of life, dignity, privacy, and choice.

Observations should be focused on the comprehensive residents but should include all observations the licensor determines demonstrate the care and services in the home. Below is a visual representation of the observation categories:



Procedure

1. Document observations on Attachment H: Resident Observations (DSHS 10-555), ensuring residents' health and dignity are always addressed.
2. Observations should occur throughout the inspection. Always respect a resident's right to refuse to allow you to observe care.
3. Care observations should focus on the comprehensive residents and their activities of daily living.
   a. If the residents chosen for comprehensive review do not receive care in an identified area, it is appropriate to observe care for another resident.
      1) If care of the comprehensive residents cannot be observed, document the reason why.

> Note: ADLs include those activities related to personal care (e.g., bathing or showering, dressing, getting in and out of bed or a chair, walking, toileting, and eating). See glossary for full definition.

   b. When possible, obtain permission from the resident to observe staff providing personal care. All observations of the residents' breasts, buttocks, and genitalia must be conducted by a licensed nurse.
   c. Observation of care along with review of the resident records will help the licensor determine if the care and services in the home meets the needs of the residents.

4. Document any issues or concerns observed that require follow up. Examples of areas that may require additional review include:
   a. Personal hygiene including oral hygiene, grooming, body odors, nail care, clean clothing, and hair care.
      1) Clothing should be appropriate for the season, while maintaining the resident's dignity and comfort.
   b. Functional risk factors such as positioning, vision deficits, or the use of any restraints, including medical equipment (e.g., bed rails).
      1) All physical care provided should follow safe practices and appropriate handling according to the resident's negotiated care plan (NCP).
      2) Observe the resident's response to the care being provided.
   c. Be mindful of any visible skin conditions such as dryness, bruising, wounds, or skin breakdown.
   d. Observe the residents' level of comfort, identifying any residents who may be demonstrating signs of pain.
   e. Observe resident's mobility in the home, ensuring compliance with the NCP.

   > Example: If the NCP indicates the resident is independent with walking, but the licensor observes the resident utilizing a walker, further review may be needed.

5. Always be mindful of the residents' level of cognition. Note any observed behavioral concerns.
6. Note the residents' level of involvement in care and daily activities.
7. Observe for appropriate infection control practices (i.e., handwashing, use of gloves, etc.).
8. Note any residents who express problems or concerns or those who appear to have unmet care needs.
9. Note any caregivers who do not appear to know the residents' needs or have the knowledge, skills, or abilities to meet those needs.

I. Medication Services Review

Purpose

The purpose of the medication services review is to determine if the home has an effective system to ensure resident medications are provided according to their physician's orders and the level of medication assistance needed based on the resident's NCP. This also includes addressing resident refusals of medication, appropriate storage of medications, disposal of unneeded or expired medications, and management of psychopharmacologic medications.

Procedure

1. Complete a comprehensive review of the two selected residents', including a reconciliation of the resident's medications. Document the review on Attachment L: Medication Review (DSHS 10-557). Reconciliation should include:
   a. List of all prescribed and over the counter (OTC) medications, including the name of the medication, dose and frequency, and the name and phone number of the prescribing practitioner.
   b. Compare medications on hand for the resident against the list, looking for any discrepancies in the medication, dose, and/or frequency.
   c. Confirm all medications have an appropriate verification source. Appropriate sources include any of the following:
      1) Pharmacy produced medication administration record (MAR) (includes both electronic and hard-copy MARs)

      > Note: AFH providers may use their own MAR, but an AFH provider MAR cannot be accepted as the only verification source. If the home uses their own MAR, one of the approved verification sources must also be included in the record.

      2) Pharmacy produced medication label
      3) Physician's order
      4) Written prescription
   d. Ensure all medications are unexpired.
   e. If concerns arise that may necessitate the counting of medications, request the provider count the medications while RCS staff observe the process.

   > Note: RCS staff should never touch medications directly. All handling of medications must be completed by the provider or their staff. RCS staff may handle medication container(s).

2. Observe medication services/assistance. Obtain the permission of residents if needed (e.g., a resident receives insulin injections in their bedroom or other private setting. Permission to observe is not needed if provided in the home's common areas, such as during mealtime).

a. Observe to determine if the correct medication is given to the correct resident at the correct time through the correct delivery method.
b. Determine if the level of medication assistance and administration observed is appropriate for the resident's needs.
c. Observe the resident's ability to take medications safely and appropriately.
d. Observe the resident and staff interaction and make sure that staff are communicating appropriately with residents.
e. If a resident is assessed as being independent with their medication, observe them to see if they can properly manage their medications.
f. If the resident keeps medications in their room, observe whether their medications are in locked storage.

3. Gather data from other sources to support any concerns with medication services. An observation alone does not necessarily confirm deficient practice.
4. If a licensed nurse is not present for the inspection, contact the FM or their designee if a discrepancy is found and a nurse is needed to complete the medication review.

Psychopharmacologic Medications

Special attention should be paid to any psychopharmacologic medications prescribed to residents. Any resident receiving a psychopharmacologic medication must have strategies and modifications defined in their NCP per WAC 388-76-10463. This includes psychopharmacologic medications prescribed for off-label use (non-mental health diagnoses).

WAC 388-76-10000 defines psychopharmacologic medications to include:

- Antipsychotics
- Antianxiety (anxiolytics)
- Antidepressants

RCS has also determined mood stabilizers will be an included classification for review. Hypnotics (sedatives) are optional to include (meaning it is not required to be added to the review of psychopharmacologic medications but are not prohibited from being included). Do ***not*** include medications that do not fall into these classifications in the designated section of Attachment L, even when used for mental health diagnoses.

If concerns arise related to the use of a specific medication prescribed to a resident, discuss the concerns with the FM or designee to determine if non-compliance needs to be addressed. Refer to Resources for links to determine medication classifications.

Note: If licensors or investigators become concerned about chemical restraints related to the use of *any* medication, follow SOP guidance and mandatory reporting requirements contained in Chapter 74.34 RCW by making a report to the Complaint Resolution Unit (CRU).

J. Observation and Documentation of Meals

Purpose

The purpose of observing meals is to determine if the home has an effective system to ensure resident meals are provided in a manner that shows safe food handling practices, provides residents a choice based on preferences as well as dignity, and meets the requirements under WAC 388-112A.

1. Conduct meal observations at eye level with residents. Do not stand over them.
2. Document observations on Attachment H. Ensure documentation contains the date and time of the observation, as well as the identity of the individuals observed. Observations should determine if:
   a. A minimum of three meals a day are being served at regular times.
   b. Mealtimes support resident activities and choice.
   c. Food is being handled and stored properly.
      1) If residents assist with food prep, observe whether they also follow proper food handling techniques.
   d. Kitchen equipment is clean and in good condition.
3. Identify residents who may need special assistance (i.e., those with swallowing problems, visual deficits, tremors, loss of motor skills, etc.).
4. Make note of residents who appear to be isolated in their room during mealtime.
5. Identify residents who have a specialized or mechanically altered diet.
6. Make note of any residents who appear to have difficulty with eating. Observe how the provider/staff interact and offer assistance to residents, verifying each resident receives the necessary supports according to their NCP.
   a. Observe the meal for the following, noting any observed concerns that require follow-up:
      1) General appearance of the meal
      2) Nutritious content
      3) Liquids provided per resident choice
      4) Physician prescribed supplements or special diets are followed
      5) Timeliness of service according to mealtimes noted
   b. Note the following observed for residents, if applicable:
      1) Dentures are in place, fit well and there are no obvious care issues or pain.
      2) Eyeglasses are on
      3) Staff assist residents with repositioning at the table
      4) Resident's preferences are considered
   c. Note any concerns expressed by the residents about food temperature, taste, variety, quality, or quantity.
7. Gather data from other sources to support any concerns with meal services. An observation alone does not necessarily confirm deficient practice.

K. Resident and Representative Interview

Purpose

The purpose of the resident and representative interviews is to clarify concerns identified during the inspection process. Ask the interviewee about life in the AFH and given them an opportunity to discuss any concerns they may have related to the home. The interviews should focus on resident quality of life, safety, freedom of choice, and care and services.

Types of Interviews

1. Comprehensive interview: Document the interview with the comprehensive residents on Attachment J: Comprehensive Resident/Representative Interview (DSHS 10-558) according to the form's instructions.
2. Condensed interview: Document condensed interviews on Attachment K: Condensed Resident/Representative Interview (DSHS 10-558a) according to the form's instructions.
3. Focused interview: A focused interview occurs when a specific concern has come up during the inspection and one or more resident or representative interviews are needed to gain insight.

Note: For the purposes of this section, resident representatives may include any of the following:
- Durable Power of Attorney (DPOA), guardian, or other person designated as the surrogate decision-maker in the resident's file
- The resident's spouse or state registered domestic partner, children, parents, or adult siblings
- A person identified by the resident as their representative when asked

Procedure

1. Interview Scenarios:
   a. If both sampled residents can be interviewed: Complete a comprehensive interview with both sampled residents and a condensed interview with one representative.
   b. If one sampled resident can be interviewed and the other is unable to be interviewed: Complete a comprehensive interview with the sampled resident that can be interviewed and a comprehensive interview with the other resident's representative.
   c. If one sampled resident can be interviewed and the other resident refuses: Complete a comprehensive interview with the resident that can be interviewed and a condensed interview with the representative of the resident that refused to be interviewed.
   d. If both residents are unable to be interviewed: Complete a comprehensive interview with both resident representatives.
   e. If both residents refuse to be interviewed: Complete a condensed interview with one resident representative.
   f. If there are no residents in the home: An interview is not required.

Scenarios with 1 resident living in the home:

g. If the sampled resident can be interviewed: Complete a comprehensive interview and a condensed interview with one representative.
h. If the sampled resident in unable to be interviewed: Complete a comprehensive interview with the resident's representative.
i. If the sampled resident refused to be interviewed: Complete a condensed interview with one resident representative.

Interview Scenario	Resident 1	Resident 2	Representative 1	Representative 2
a.	Comprehensive interview	Comprehensive interview	Condensed interview (or 3 attempts) with 1 Representative	
b.	Comprehensive interview	Unable to interview	Nothing required	Comprehensive interview (or 3 attempts)
c.	Comprehensive interview	Refused interview	Nothing required	Condensed interview (or 3 attempts)
d.	Unable to interview	Unable to interview	Comprehensive interview (or 3 attempts)	Comprehensive interview (or 3 attempts)
e.	Refused interview	Refused interview	Condensed interview (or 3 attempts) with 1 Representative	
f.	If there are no residents in the home, an interview is not required.			
g.	Comprehensive Interview	No second resident	Condensed interview (or 3 attempts)	No second rep
h.	Unable to interview	No second resident	Comprehensive interview (or 3 attempts)	No second rep
i.	Refused interview	No second resident	Condensed interview (or 3 attempts)	No second rep

2. If an interpreter is required to conduct the resident or representative interview, obtain an interpreter through interpreter services or the language line. This may require a return visit.
3. If you are conducting the interview in the home, relocate to an area in which the interview can be performed with a reasonable amount of privacy.
4. Inform the resident or representative that information given may be included in the final written report.

5. Inform the interviewee that they have the right to refuse to answer any question.
   a. If the resident refuses, respect their right to do so and document this on Attachment J.
6. Unless a representative is in the home at the time of inspection and available for interview, attempt to contact them by phone.
   a. You must make at least three attempts to contact the representative. Each attempt must be documented in the working papers, including the date and time.
7. If a specific concern is identified, you may conduct focused interviews with other residents to assess the situation.
8. Attempt to individually engage all residents in conversation regarding the care they receive and if their rights are being respected.
   b. For any type of interview, if the interviewee expresses a specific concern, you should ask increasingly detailed questions and document their concerns.

L. Resident Record Review

Purpose

The purpose of resident record review ensures information contained in the resident's records are consistent with the resident's care and service needs. Completing a resident record review of the two comprehensive residents, since the last inspection, will help determine if the information is accurate, current and appropriately supports the quality of life, safety and provision of care and services for the resident. All concerns that arise from a record review should be followed-up on with interviews and observations to determine if failed practice is identified.

Procedure

1. Document the review on Attachment I: Resident Record Review (DSHS 10-556).
   a. If the home does not have any current residents at the time of inspection, review at least one closed resident record.
2. During the record review process, be alert at all times to the residents' environment and activities around you.
3. Evaluation of records should include:
   a. Resident assessment
   b. Preliminary Service Plan and Negotiated Care Plan
   c. Staff notes included in the resident record
4. If concerns are identified, expand the review as needed to determine if failed provider practice is identified.
5. During the inspection, it may become evident that more information is needed to determine provider compliance, such as:
   a. Healthcare practitioner records.
   b. Hospital records.
   c. Home health records.
   d. Police or law enforcement records.

Note: Do not delay necessary collateral record review (written request, onsite visits, fax, or phone call). All contacts must be made within 20 working days of exit from the home, unless an extension is approved by the FM.

M. Provider and Staff Interview

Purpose

The purpose of provider and staff interviews is to determine if the AFH staff and the provider or resident manager are knowledgeable and have a clear understanding of the care and services each resident in the home require, including their safety and quality of life. Information gathered during the pre-inspection prep work or during the inspection may drive the interview questions. Otherwise use the questions on the staff/provider interview forms.

Procedure

1. General conversations regarding resident care and services and the operation of the home should occur throughout the inspection.
2. Use Attachment P: Provider / Resident Manager Interview (DSHS 10-560) to interview the provider or resident manager (attempt to interview a different individual than the prior inspection when possible).
3. Use Attachment Q: Staff Interview (DSHS 10-561) to interview one staff member.
   a. If the staff member or provider refuse to be interviewed, clarify the reason and remind them that a failure to cooperate with the inspection is a violation of WAC 388-76-10915.
4. Ask open ended questions and be careful not to ask leading questions.
5. Allow the staff member/provider time to clarify information during interviews.

N. Administrative Record Review

Purpose

The purpose of staff record review is to determine if the provider has developed a system to keep track of all the necessary qualifications for their staff. This ensures that all staff are competent and qualified for their positions.

The review consists of three parts. The first is a ***full*** review of one current caregiver hired since the last inspection and one of the following: provider, resident manager or entity representative. If no caregivers have been hired since the last inspection, attempt to review a caregiver not reviewed in the previous inspection.

The second part is a ***targeted*** (*focused*) review of background checks for all persons age 12 and older who may have unsupervised access to residents.

The third part is a review of the home's administrative records (e.g., liability insurance, succession plans, evacuation logs, etc.)

Relevant forms:

- Attachment M: Administrative Records Review (DSHS 10-559) – used to complete the full staff reviews and/or expanded sample staff. Targeted reviews of background checks may also be completed on this form.
- Attachment N: Administrative Records Review Continuation (DSHS 10-559a) – used to complete additional background check reviews and review of the home's administrative records.
- Attachment O: Administrative Records Review – Former Staff and Others with Unsupervised Access (DSHS 10-559b) – used for review of former staff (staff no longer employed by the home since the last inspection) and others with unsupervised access (e.g., household members, volunteers, etc.).

Procedure

Full review of two staff

1. Request to review the entire staff record for the two staff identified for the full review.
   a. If the home does not currently employ any staff, review only the provider record.
2. When reviewing continuing education credits for the chosen two full staff reviews, record the number of hours the person received in the time period between their last two birthdays.

> Example: A review conducted on December 1, 2023 of a person born on Jan 1 would need to have all hours between Jan 1, 2022 and Jan 1, 2023 reviewed.

> Note: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Advanced Registered Nurse Practitioners (ARNPs), and Nursing Assistants - Certified are exempt from this requirement, unless voluntarily certified as home care aids. Refer to WAC 246-980-025 for more information.

a. The licensor may use the number of credits found at the last inspection only if:
   1) less than one year has passed since the last inspection;
   2) the staff member being reviewed was also reviewed during the last inspection; and
   3) the staff member has not had a birthday since the last inspection.
b. Only DSHS-approved courses may be used to meet the continuing education requirements. Licensors must verify that continuing education courses were DSHS-approved. Verification may be done by logging into the Instructor and Curriculum Tracking System (ICTS).
   1) If the licensor does not have access to ICTS at the inspection site, they may contact their FM with the course number and the FM will verify the courses for them.
   2) If the FM is unavailable or unable to verify the data prior to the end of the inspection or if there are concerns about the certificate, the licensor may also make a copy of the certificate and verify the courses when they return to their workstation.
c. If records appear incomplete or dates are not current from certifications or trainings, communicate the findings to the provider or caregiver to ensure there are not more recent documents available.

Review All staff based on the Staff Sample Selection table below:

3. Request to review copies of the background check results for the following:
   a. Employees between the prior inspection and the current inspection but no further back than the last two years, even if the employee no longer works in the home. This includes non-caregiving staff (e.g., housekeeping, maintenance, etc.)
   b. The provider (including each co-provider) or the entity representative if the provider is an entity
   c. A resident manager who is not also the provider/entity representative
   d. All staff who may have unsupervised access to residents
   e. All volunteers and students
   f. Household members who 12 years of age or older (this includes all individuals who use the home as their primary address and who is not a resident, per WAC 388-76-10000).

   Note: Never take copies of the background check results from the home. If non-compliance is found, note your observations and interviews with the provider. All copies of background checks are maintained by the Background Check Central Unit (BCCU).

   g. If the home employs more than 8 current staff, review a sample using the following grid as guidance:

Staff Sample Selection	
Total # of employed staff	# of staff in sample
9-16	5
17-30	6
31-50	7
51-75	8
76+	At least 15% of total staff

h. If the home has more than 8 former staff, review a sample using the same grid as guidance.

4. Review the home's administrative records. Verify the following, if applicable:
   a. Liability insurance, including professional liability insurance
   b. Medical Test Site Waiver (MTSW)
   c. Pet records
   d. Evacuation logs

> Note: Licensors must always consult with their FM prior to requesting the home complete an evacuation drill.

O. Exit Preparation

Purpose

The purpose of exit preparation is to determine AFH compliance based on the data gathered during the inspection.

Procedure

1. Well organized data will help facilitate the communication between the licensor and the provider during the exit as well as provide the licensor with a useful tool while writing the Statement of Deficiencies (SOD).
2. Review all forms and documentation to ensure all inspection requirements are completed.
3. Identify concerns and specific issues related to any requirements the AFH potentially failed to meet. Document identified areas on Attachment R: Exit Preparation Worksheet (DSHS 10-562).
   a. Any potential failed provider practice must be supported by at least two sources of evidence (see SOP Chapter 18 - Across All Settings and the Principles of Documentation [POD] for more information)
   b. Note any examples that can be provided to assist the provider with understanding the non-compliance issues.
   c. Note any potential deficiency which may require further information or data collection.
4. Review the information to determine if the failure to meet a requirement has resulted in a negative resident outcome or has the potential for a negative outcome.

P. Exit Conference

Purpose

The purpose of the exit conference is for the licensor to clearly explain the findings during the inspection and to explain the preliminary decision(s) regarding identified failed provider practice.

Procedure

1. Briefly discuss each resident included in the sample and summarize:
   a. Observations of the resident.
   b. Observations of the environment.
   c. Any expressed concerns or unmet needs. Be sure to ask the resident for permission to share any information they disclosed to you.
2. Based on regulations, describe the preliminary deficiency finding(s) and other issues and or concerns (if any) you have that will require further information after leaving the home.
3. Allow the provider/representative the opportunity to discuss and supply additional information that they believe is pertinent to the findings.
4. If unsure of all deficiencies at the time of the exit conference, provide a status update to the provider/representative and inform them that the deficiencies discussed may be amended upon completion of the data collection or consultation with the FM.
5. Inform the provider prior to leaving the home that a written report will be sent within 10 working days of the last date of data collection.
6. Discuss the concept of immediately beginning the correction of deficient practice with the provider.
7. A written plan of correction or safety plan may be required prior to leaving the home if:
   a. Issues found are serious and impact the resident's immediate health, safety, and welfare; and
   b. With approval of the FM and Compliance Specialist (CS).
8. Ensure there are no surprises for the provider and that all information about deficient practice was discussed prior to the provider receiving their SOD.
9. Ensure all citations are based on facts supported by evidence and current WACs or RCWs.
10. Do not provide feedback that reflects personal preference, opinions, or views.

> Note: Do not argue with a provider about identified failed facility practice. Explain their appeal rights and that an Informal Dispute Resolution (IDR).

Q. Off-site Activities

Purpose

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

Procedure

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

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

   1) All contact attempts should be completed within 20 working days from exit, unless FM approval to extend this time frame is received and documented.
   2) Document the date and time of attempts on Attachment K.

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

b. Review and analyze all data collected after exit to make final determination of failed practice.
   1) If failed practice is identified, the findings will be documented in detail within the SOD based on identified rules and regulations.
c. Coordinate any enforcement recommendations with the FM according to SOP Chapter 7: Enforcement.
d. Create the Confidential Identifier List (DSHS 27-235) and include a copy when sending the SOD.
e. Complete data entry in Secure Tracking and Reporting System (STARS).
f. Use the standards outlined in SOP Chapter 18: Across All Settings when writing the SOD if applicable.
g. Notify the provider if:
   1) Information in the SOD is different from what was communicated during the exit conference (including additions, deletions, or changes).
   2) There are delays in completion of the SOD.
      a) Document the pertinent details of the call including the date, time, who the meeting was with, and what information relayed to the provider.

The FM will:

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

R. Follow-up Visits

Purpose

The purpose of follow-up visits is to determine if the home is back in compliance with the state licensing laws and rules cited in any previous inspection or complaint investigation. The follow-up visit is focused on the areas of deficient practice previously cited. The FM will determine the type of follow up visit based on the criteria listed below. They may delegate to or consult with the licensor as needed.

Timelines:

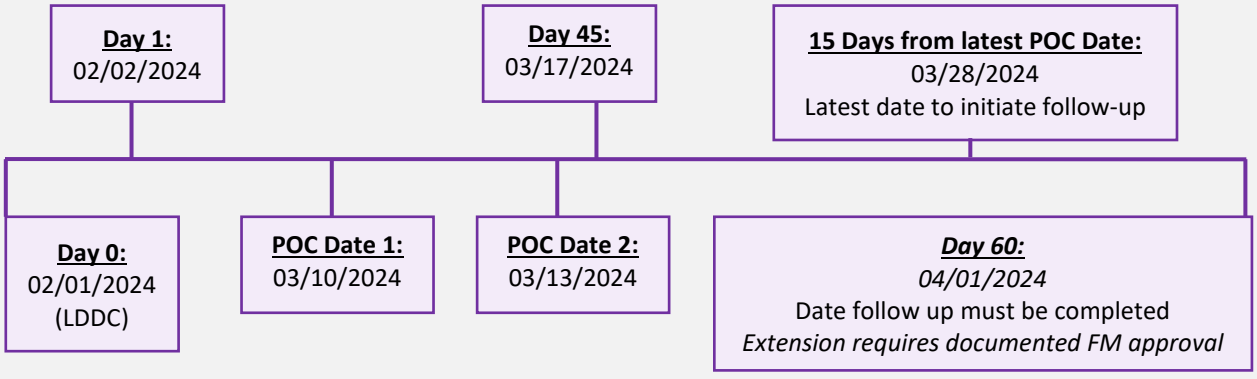
- Date of alleged compliance (45 day): Date of alleged compliance must not exceed 45 calendar days from the last date of data collection, unless approved by the FM.
- Follow up due date – requirement 1 (15 day): Follow up must be initiated within 15 calendar days from the latest date the AFH has listed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

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

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

Example

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



Off-Site Verification

Telephone verification

1. Correction of the deficiencies may be verified by telephone when all three of the following criteria are met:
   a. The deficiencies do not have a direct, adverse impact on resident care, (i.e., citations are not associated with a negative or potentially negative resident outcome);
   b. The deficient practice issue is such that there are clear, objective criteria for determining compliance; and
   c. The provider has a good history of compliance with the provision of care and services to residents.
2. The licensor will:
   a. Review documentation and call the provider to discuss the issues to determine if sufficient documentation is present to justify reporting the deficiency as corrected or to recommend to the FM that an on-site follow-up visit be conducted.
   b. Document pertinent details of the call in either EWP or using Attachment T. Documentation must include:
      1) Whether the deficiency was corrected or uncorrected; and
      2) Date and time the provider was notified of the outcome of the visit.

Documentation/letter verification

1. Correction of deficiencies may be verified by letter or documentation submitted by the provider when:
   a. The deficiencies do not have a direct, adverse impact on resident care, (i.e., citations are not associated with a negative or potentially negative resident outcome);
   b. The home sends a letter that fully addresses the necessary actions taken by the home to implement the correction, whether their plan(s) worked and how and when correction was achieved; and
   c. The home sends copies of documents as verification (i.e., cardiopulmonary resuscitation/first aid cards, TB test results, orientation checklists).

   Note: If the deficiency was related to background checks, it is appropriate to verify documentation remotely via video call. Do not have the provider submit copies to the department, as copies are not to be maintained in the working papers.
2. The licensor will:
   a. Review provided documents to ensure that all areas of deficient practice are addressed. Documentation should be filed with the visit working papers.
   b. Document pertinent details of the verification in either EWP or using Attachment T. Documentation must include:

1) Whether the deficiency was corrected or uncorrected; and
2) Date and time the provider was notified of the outcome of the visit.
3) Store the documents sent by the home to demonstrate compliance with the working papers.

On-site verification

Corrections of deficiencies must be verified by an on-site visit when:
1. Deficiencies exist with a negative or potentially negative resident outcome;
2. The documentation submitted by the provider does not adequately support the conclusion that correction has been achieved; or
3. At the FM's discretion.

Procedure

1. The FM will:
   a. Work with the licensor to schedule the follow-up visit within the defined time frame (see below).
   b. Ensure the licensor has completed the follow-up documentation using either EWP or Attachment T. Documentation must include:
      1) Whether the deficiency was corrected or uncorrected at the time of follow up; and
      2) Date and time the provider was notified of the outcome of the visit.
   c. Schedule and track any additional visits and citations once the home is initially out of compliance. Remember that attestation timeframes are at the Department's discretion. While a home may have up to 45 calendar days to implement corrective actions, the FM can require a shortened timeframe for correction based on other compliance issues or the health and welfare of the residents in the home.
   d. Include the licensor who did the original inspection or complaint investigation in the follow-up visit, whenever possible.
   e. Investigating new complaints during follow-up visits should not occur unless directed by the FM. When possible, the follow-up visit should be completed before writing new citations.
   f. If the home continued to be out of compliance after the second follow-up visit, notify the Compliance Specialist (CS) to strategize further enforcement action steps (see SOP Chapter 7 – Enforcement for more information).
   g. Only schedule a third follow-up visit after consultation with the CS.
2. The Licensor will:
   a. Consider the following prior to the follow up:
      1) Current deficient practice issues, including nature, scope (number of residents impacted or potentially impacted) and severity (seriousness or extent of the impact or potential seriousness or extent of the impact on residents) of each cited deficiency.
      2) The enforcement remedies imposed as a result of the inspection.

b. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.
c. Focus the sample selection on residents who are most likely to be at risk of problems/conditions/needs resulting from the deficient practice cited in the original report.
d. Only review evidence obtained between the AFH's last date on the attestation and the date of the follow up to make compliance decisions.
e. Document the follow-up visit in either EWP or using Attachment T. Documentation must include:
    1) Whether the deficiency was corrected or uncorrected at the time of follow up; and
    2) Date and time the provider was notified of the outcome of the visit.
f. If the first follow-up visit results in continued non-compliance, a second follow-up visit must be completed within 45 calendar days from the last date of data collection of the first follow-up visit.

Upon completion of all follow ups:

1. Record corrected and new or uncorrected deficiencies in STARS.
2. Follow SOD writing processes for any new or uncorrected deficiencies (see SOP Chapter 18 – Across All Settings for more information).

General:

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

> Note: Per RCW 70.128.167 request for an IDR does not delay the effective date of any enforcement remedy except payment of civil monetary fines.

S. Monitoring Visits

Purpose

The purpose of monitoring visits is to gather information related to the safety and welfare of residents in the home and to determine if the home is able to provide necessary care and services to residents. These visits are conducted at the discretion of the Field Manager (FM) in consultation with the Compliance Specialist (CS). Monitoring visits typically occur after the completion of the investigation and after issuing the Statement of Deficiency (SOD) with enforcement.

Procedure

There are three avenues for monitoring visits to occur:

1. Monitoring visit(s) MUST be conducted when the home is under the following enforcement actions, until the action is completed:
   a. Summary Suspension and Revocation of a License, including a Stop Placement Order Prohibiting Admissions; and/or
   b. Revocation of a License and Stop Placement Order Prohibiting Admissions.
2. Monitoring visit(s) MAY be conducted when there is a:
   a. Stop Placement Order; or
   b. Condition(s) on License Order.
3. Monitoring visits MAY be conducted after issuing a SOD with citations when there is no enforcement for findings and residents are at high risk while correction is pending. For example:
   a. Finding made due to a serious lack of judgment on the part of the provider, but no resident harm resulted.
   b. RCS requested a safety plan due to risks present in the home.
4. The decision to conduct a monitoring visit for a citation without enforcement will be made in consultation with the Regional Administrator (RA) and the FM.

Operational Requirements

1. Monitoring visits will be:
   a. Unannounced;
   b. Brief in duration;
   c. Focused on the residents' safety and welfare.
2. During the monitoring visit, the Licensor will:
   a. Note how many residents are in the home and conduct both focused observations and informal interviews of residents and staff. Conduct interviews with others not associated with the home only if necessary.
   b. Review resident records only if there is a need to seek additional information related to potential or actual resident welfare and safety issues.
   c. Consult with the FM if there are new or unresolved safety or welfare concerns.
   d. Communicate with the provider as needed about regulatory matters.
   e. Complete the Monitoring Visit (DSHS 10-684) form.

3. The Licensor will record the dates of monitoring visits in STARS.
4. The Licensor will retain monitoring visit forms according to retention rules and use as needed to verify that visits were made.

Procedure

1. The FM will:
   a. Consult with the CS (Field Services Administrator [FSA] when not related to enforcement) to determine:
      1) If monitoring visits are needed;
      2) If needed, the frequency the visits should occur; and
      3) The duration or number of monitoring visits to be made (most monitoring visits will be for a limited time period).
   b. Create a task in STARS and assign staff to conduct the monitoring visit(s). The FM may delegate this task to the AA3. Include in the task:
      1) The name of resident(s) allowed by the FM to return to the home under a Stop Placement Order, if any.
      2) Information regarding special issues, such as residents or family members who should or should not be reviewed.
   c. Assign new complaint intakes to the investigator conducting monitoring visit. Complaints may be addressed during the monitoring visit.
2. The Licensor will:
   a. Review and understand the:
      1) Purpose of the monitoring visit(s);
      2) Recent history of enforcement actions in effect and any previous monitoring visit(s);
      3) Resident lists from current or previous monitoring visits;
      4) Most appropriate time of visit related to the issues, such as evenings or weekends; and
      5) Status of on-going complaints, if any.
   b. Conduct the Monitoring Visit following the guidance in this procedure.

Follow Up Activities

1.The Licensor will:
   a. Consult with the FM about any new concerns found during the monitoring visit.
   b. Report to the CRU any new concerns or new information related to the open investigation.
2. The FM will:
   a. Assign any new intakes to the Licensor doing the monitoring visit. The FM may assign to a different Licensor at their discretion.
   b. Notify the CS (or FSA if visit is not related to enforcement) of the new investigation or new concerns or both.
3. The CS, when involved, will:
   a. Inform the Compliance and Enforcement UM about additional findings related to the home's noncompliance and risks related to safety and welfare.

T. Capacity Increase

Purpose

An AFH may request an increase in their bed capacity at any time by submitting a completed Change in Licensed Bed Capacity – Increase form (DSHS 06-168). This form is submitted to the Business Operations and Analysis Unit (BOAU), and it will be passed to the field from this unit. There are specific requirements when a home is requesting a bed capacity increase to seven or eight beds that are addressed below. This procedure outlines the process for conducting an inspection after any bed capacity increase request, as well as specific instructions for conducting an inspection after a bed capacity increase to seven or eight beds.

Procedure – Capacity Increase to Six Beds or Fewer

1. The BOAU will:
   a. Ensure the application is filled out completely and there are no errors. Once verified, forward the application to the appropriate field office for inspection.
2. The FM/designee will:
   a. Receive the application and assigns the inspection to a licensor.
   b. An inspection to increase capacity is scheduled and should not be conducted at the same time as an unannounced full inspection. Any planned licensing inspection of a home should continue as scheduled and not be adjusted to accommodate an expected request to increase capacity.
3. The Licensor will:
   a. Review the floor plan on file for the home, the capacity increase application, and any other documents received from BOAU.
   b. Check the file for any previous documentation from the local building official or previous changes to the floor plan.
   c. Review the home's provider summary and visit log in STARS.
   d. Contact the home to determine if the additional residents will be living in a bedroom that has previously been inspected or one that has been added or modified. Request an updated floor plan if a previously unlicensed bedroom will be added.
      1) If the home had previously had the bedrooms that will be used by the additional residents inspected and approved by both the local building official and RCS, verify that RCS files reflect that the requested rooms have been approved.
         a) If the requested capacity is six or fewer, an onsite visit may not be required. Work with the FM to determine if this will be necessary.
      2) If RCS records do not show evidence that the bedrooms had previously been inspected and approved by the local building official, request that the provider submit an AFH Building Inspection Checklist for the additional bedrooms.
         a) The checklist must be marked "passed" and signed by the building official in order to be accepted.
         b) An onsite visit is required, even if the bedrooms had been previously inspected and approved by RCS, to review any changes that may have been made.

e. Review the proposed floor plan with the provider to determine if the home has sufficient toilets to meet the one toilet to five people living in the home ratio required per WAC 388-76-10780.
f. If the home is on a septic system, review documentation from the local health jurisdiction to verify the septic system is approved for the total number of people who will be living in the home (e.g., if a provider intends to live in the home with their spouse and six residents, the septic system should be approved for eight or more).

> Note: If the documentation from the local health jurisdictions lists the number of bedrooms rather than the number of people, ask the applicant to contact the local health jurisdiction to get the approval changed to the number of people the system can support.

g. Once all the documentation is gathered, schedule a time for the inspection with the provider if an onsite visit is required.
    1) If the licensor has all of the necessary information, they may schedule the inspection during their first contact with the provider.
    2) When scheduling the inspection, inform the provider that a staff member who is not the provider or entity representative will need to be available for interview. They can be available over the phone, but they need to be able to complete the interview.
h. Prepare for the onsite visit if required by completing any pre-inspection work and compiling the following documents:
    1) Two copies of the proposed floor plan.
    2) One copy of the working papers, which include two copies of the floor plan key. Make extra copies of the bedroom inspection pages as necessary.
i. Assemble necessary supplies, such as measurement equipment, thermometer, etc.
j. Conduct the onsite visit. Fill out the working papers completely.
k. Observe the bedrooms that will be used by the additional residents. Document any of the following:
    1) Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
    2) Any toxic or other unsafe substances or items that need to be removed or fixed.
    3) Any aspect of the physical space that does not meet the WAC requirements (e.g., door or window size or ability of resident to use them to exit in any emergency, nonfunctioning smoke detector, non-approved heat source, etc.).
    4) Any concerns about the lighting or available storage space.
l. Measure the room to determine the resident capacity. Do not include the space used by a door swing, vestibule, closet, armoire or wardrobe, or bathroom in the calculated useable floor space
m. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.

n. Review the data collected throughout the inspection process to determine if the applicant meets the AFH minimum licensing requirements. Further analysis and data collection may be needed. Discuss any issues or concerns related to the requested capacity increase with the FM.
o. Before leaving the home, let the provider know one of the following:
    1) A recommendation will be made to approve the capacity increase and someone from BOAU will contact them about paying their additional bed fee;
    2) A recommendation cannot be made to approve the capacity increase, the reason why, and how the provider can follow up with the licensor to schedule a follow up visit if they are able to correct the reason the recommendation cannot be made.
p. If all or part the requested capacity increase is approved, fill out both copies of the new floor plan and new floor plan key. Sign and date and ask the provider to sign and date. Leave one copy with the provider and keep one copy for the home's file.
    1) If only part of the requested capacity increase is approved, discuss with the provider if they are able to and wish to make changes that will allow the full capacity increase to be recommended. If so, let the provider know how to follow up with the licensor to schedule a follow up visit.
q. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation with the CS, RA, Office Chief, or RCS Director.

<u>If the capacity increase request will be approved:</u>

1. The FM or their designee will notify the BOAU that the new rooms have been approved and the capacity of the home can be updated in STARS.

<u>If the capacity increase request will not be approved:</u>

1. If the capacity will not be increased, the FM or their designee will notify the BOAU of the decision and the reason why and all supporting documentation.
2. The FM will work with the licensor to determine if the application needs further consultation from a CS, RA, Office Chief, or RCS Director.
    a. Applications that are not approved that do not need further consultation are clear and indisputable violations of the WAC. Examples are a bedroom that does not meet the size requirements or does not have an outside window.

> Note: These are examples only. It is up to the licensor and the FM to determine if they believe a recommendation from a resident or indications of lack of financial solvency are sufficient to not approve the application. The licensor and FM may make this decision without consultation, but consultation can be used if another opinion or further guidance is needed.

    b. Applications that are not approved that may need further consultation are those that are not clear and indisputable violations of the WAC. Examples are residents who do not believe the home has the capacity to care for two additional residents or doubts about financial solvency.

3. Allow the provider 60 calendar days from the date of the inspection to contact the licensor regarding any corrections to the deficiencies that may allow the home to increase their capacity.
   a. Once 60 days have passed, if the home has not made the necessary corrections, send the file back to BOAU with the notification that the application is not approved.
4. The BOAU will create the notice to the applicant that the application is not approved.

Procedure – Capacity Increase to Seven or Eight Beds

1. The BOAU will:
   a. Process the application fee;
   b. Ensure the form is filled out correctly.
   c. Verify all of the required documentation is included.
   d. Conduct a credit check on the applicant, and spouse if applicable to determine financial solvency.
2. The BOAU reviews the entire application packet to ensure the applicant meets the following qualifications required by the statute:
   a. Home has no outstanding bed fees.
   b. Home has been licensed for 24 months or more.
   c. Home has been licensed for a capacity of six for 12 months or more.
   d. Home has received two full inspections or more.

      Note: **Between June 6, 2024 and January 1, 2026**, homes meeting all criteria except two full inspections may submit a capacity increase application and have their inspections completed upon receipt of the application.

   e. Home has not had any enforcement actions taken on the license for the period of the last two full inspections.
   f. Home has given residents a 60-day notice.
3. If the BOAU finds that the home does not meet these criteria, they will send a notification to the applicant that the application is void and cannot be accepted.
4. If the BOAU can verify that the applicant meets all of these criteria, they will send the application packet to the appropriate field office for inspection.
5. The FM will:
   a. Receive the form and assign the inspection to a licensor.
   b. When a home needs one or two full inspections, assign full inspection onsite within 90 days of receiving application packet from BOAU.
   c. Assign a second inspection at least six months after the first inspection when two inspections are needed. When a home is out of compliance as a result of the first inspection the second inspection will be completed at least six months after the home is back in compliance.
   d. Determine whether the seven or eight bed capacity inspection will be completed during the same visit as the second full inspection.

6. The Licensor will:
   a. Review the floor plan on file for the home, the capacity increase form, and any other documents received from BOAU.
   b. Check the file for any previous documentation from the local building official or previous changes to the floor plan.
   c. Review the home's Provider Summary in STARS. Check for complaints or citations indicating a lack of financial solvency or insufficient staffing.
   d. When one or two full inspections are needed
      1) complete the full (unannounced) inspection before completing the remaining steps in this procedure, unless the FM determines the capacity increase visit will occur during the full inspection.
      2) when approved by the FM, complete the capacity increase visit during the full inspection. Complete the remaining steps in this procedure prior to the full inspection *with the exception of contacting the provider or the local building jurisdiction*. This is to ensure the full inspection is unannounced, in compliance with WAC 388-76-10910.
   e. Contact the home to determine if the additional residents will be living in a bedroom that has previously been inspected or one that has been added or modified. Request an updated floor plan if a previously unlicensed bedroom will be added.
      1) If the bedrooms that will be used by the additional residents were previously inspected and approved by both the local building official and RCS, verify that RCS files reflect that the requested rooms have been approved.
      2) If RCS records do not show evidence that the bedrooms had previously been inspected and approved by the local building official, request that the provider submit an AFH Building Inspection Checklist for the additional bedrooms. The checklist must be marked "passed" and signed by the building official in order to be accepted. An onsite visit is required, even if the bedrooms had been previously inspected and approved by RCS, to review any changes that may have been made.
   f. Review the proposed floor plan with the provider to determine if the home has sufficient toilets to meet the one toilet to five people living in the home ratio required per WAC 388-76-10780.
   g. If the home is on a septic system, review documentation from the local health jurisdiction to verify the septic system is approved for the total number of people who will be living in the home (e.g., if a provider intends to live in the home with their spouse and six residents, the septic system should be approved for eight or more).

      Note: If the documentation from the local health jurisdictions lists the number of bedrooms rather than the number of people, ask the applicant to contact the local health jurisdiction to get the approval changed to the number of people the system can support.

   h. Once all of the documentation is gathered, schedule a time for the inspection with the provider.

1) Inform the provider that the local planning office needs to be contacted by RCS, following the process in the next section.
2) Once the local planning office has been contacted, contact the provider again to schedule the inspection.
3) When scheduling the inspection, inform the provider that a staff member who is not the provider or entity representative will need to be available for interview. They can be available over the phone, but they need to be able to complete the interview.

i. Prepare for the onsite visit by completing any pre-inspection work and compiling the following documents:
   1) Two copies of the proposed floor plan.
   2) One copy of the working papers, which include two copies of the floor plan key. Make extra copies of the bedroom inspection pages as necessary.
j. Assemble necessary supplies, such as measurement equipment, thermometer, etc.
k. Conduct the onsite visit. Fill out the working papers completely.
l. Observe the bedrooms that will be used by the additional residents. Document any of the following:
   1) Lack of cleanliness and/or any damage that could affect resident health or cause the room to not be homelike.
   2) Any toxic or other unsafe substances or items that need to be removed or fixed.
   3) Any aspect of the physical space that does not meet the WAC requirements (e.g., door or window size or ability of resident to use them to exit in any emergency, nonfunctioning smoke detector, non-approved heat source, etc.).
   4) Any concerns about the lighting or available storage space.
m. Measure the room to determine the resident capacity. Do not include the space used by a door, vestibule, swing, closet, armoire or wardrobe, or bathroom in the calculated useable floor space.
n. If the bedroom has an attached bathroom, inspect the bathroom, and document any deficiencies on the working papers.
o. Review the data collected throughout the inspection process to determine if the applicant meets the AFH minimum licensing requirements. Further analysis and data collection may be needed. Discuss any issues or concerns related to the requested capacity increase with the FM.
p. Before leaving the home, let the provider know one of the following:
   1) A recommendation will be made to approve the capacity increase and someone from BOAU will contact them about paying their additional bed fee;
   2) A recommendation cannot be made to approve the capacity increase, the reason why, and how the provider can follow up with the licensor to schedule a follow up visit if they are able to correct the reason the recommendation cannot be made.
q. If all or part the requested capacity increase is approved, fill out both copies of the new floor plan and new floor plan key. Sign and date and ask the provider to sign and date. Leave one copy with the provider and keep one copy for the home's file.

1) If only part of the requested capacity increase is approved, discuss with the provider if they are able to and wish to make changes that will allow the full capacity increase to be recommended. If so, let the provider know how to follow up with the licensor to schedule a follow up visit.

r. Work with their FM on any questions regarding whether or not a home's request should be approved, not approved, or needs further consultation with the CS, RA, Office Chief, or RCS Director.

Additional steps for homes requesting a capacity increase to seven or eight beds, the licensor must:

1. Contact the local jurisdiction where the home is located. The passed legislation requires the department to notify the local jurisdiction of the home's request to increase their capacity to seven or eight and allow the jurisdiction to provide a recommendation to the department. In order to fulfill this requirement, contact the local jurisdiction via email using the template linked here prior to scheduling the inspection to notify them of the request to increase bed capacity and to allow them to provide recommendations on whether to approve the request. For the purpose of fulfilling this requirement, the planning office of the city in which the AFH is located will be the local jurisdiction you must contact.
   a. If the city or town does not have a planning office, contact the operator, and ask for direction on who to contact.
   b. If the home is located outside of city limits, contact the county in which the home is located.
   c. Use the information on the local building official's inspection form to determine what jurisdiction is appropriate.
   d. If the local jurisdiction has not responded after five working days (WD) inclusive of the day the email was sent, send a follow-up email on the sixth WD. If they have not responded by the 10th WD, contact the provider on the 11th WD to schedule the inspection. Document your attempts to contact the local jurisdiction on the working papers.
   e. If you receive a recommendation from a different office within the local jurisdiction other than the planning office, this should still be considered when determining whether to recommend approval or denial of the request. Document who contacted you and what their response was on the working papers. If you do not also receive a response from the planning office, you do not need to follow up but can consider this recommendation in place of a recommendation from the planning office.
2. Review the additional documents received from BOAU:
   a. Review the notification given to residents/representatives of the capacity increase.
      1) If new residents have moved in since the capacity increase application was submitted, the licensor will request from the provider a copy of the 60-day notice to the new resident(s).
   b. Review the traffic mitigation plan.
   c. Review the documentation of the sprinkler system. The home must either provide a signed permit from the local fire authority or an inspection document from a licensed sprinkler provider showing that the inspection was passed (look for words like 'passed', 'compliant', etc. within the report).

1) The inspection must have been conducted on the entire sprinkler system. There are separate requirements for testing the backflow, but this is not sufficient. We need documentation that the entire system was inspected.
2) A signature is not required. Licensors are not required to contact the company to verify the report if it is not signed. However, if a licensor feels a report may be fraudulent for any reason, they may work with their FM to determine if they need to contact the company to verify the report.
3) Some homes may not have a sprinkler because their license is limited to serving only residents who are independent with evacuation. The home will check the box noting this on the capacity increase request form. The home must have a limit placed on their license noting that the home may only admit and care for residents who are independent with evacuation. This may already be in place or can be added when you approve the increase.

3. Choose at least one resident to interview and complete the resident interview section. If no resident can be interviewed, choose a resident's representative to interview. Document the reason for interviewing a resident representative.
4. Choose at least one staff member who is not the provider or entity representative to interview and complete the caregiver interview section. If the home does not have a caregiver who is not the provider or entity representative, document this in the working papers. Also state how this affects your decision to recommend approval or denial of the request to increase capacity.

<u>If the capacity increase request will be approved:</u>

1. If the capacity increase will be approved, the FM or their designee will notify the BOAU that the new rooms have been approved and the capacity of the home can be updated in STARS.
2. For homes that do not have a sprinkler system because they only care for residents independent with evacuation, notify BOAU that a limit needs to be placed on the license.

<u>If the capacity increase request will not be approved:</u>

1. If the capacity will not be increased, the FM or their designee will notify the BOAU of the decision and the reason why and all supporting documentation.
2. The FM will work with the licensor to determine if the application needs further consultation with the CS, RA, Office Chief, or RCS Director.

U. Licensing Additional Bedrooms or Bathrooms

Procedure

When a provider requests that an additional bedroom and/or bathroom be licensed, the licensor will:

1. Ask the provider to send in a copy of the Building Inspection Report showing that the bedrooms in question have been inspected and approved by the local building inspector.
2. If this room has been added to the home or modified, request copies of all applicable building inspections.
3. Determine if the home's capacity will increase once the rooms have been inspected and approved. If so, the provider should have already sent in a capacity increase request to BOAU. If the provider has not yet sent in this request, they must submit a request for capacity increase and the associated fee prior to proceeding with the onsite inspection. Once the BOAU receives the increase form, they will contact the assigned Field Manager to let them know that the home is ready for onsite inspection.
4. Determine the number of toilets available to staff, household members, and residents. The AFH must have at least one toilet per five people in the home. For example, if the home only has one toilet, the home will be limited to four residents and one caregiver.
5. Obtain a current, accurate floor plan of the home. Have an electronic copy of the floor plan and floor plan key ready for use at the onsite inspection. Also bring two copies of the floor plan key to update at the end of the visit.
6. Discuss whether these additional rooms will affect the provider's current Medicaid Policy. The Medicaid Policy may need to be updated if the home plans to take more or less Medicaid residents, plans to designate new Medicaid bedrooms, or plans to charge supplemental fees for the newly licensed rooms. If so, plan to review the policy during your onsite visit.
7. Discuss with provider the condition the rooms should be in for licensing. The room must be clean, and all doors, windows, blinds, etc. must be in good working order.
8. Have an electronic copy of the initial licensing working papers, "Resident Bedroom/ Bathroom Worksheet", and/or, "Resident Bathroom Worksheet," as necessary, as well as "Notes and Drawings," "Exit Summary Worksheet," and, "Adult Family Home Floor Plan Key". These are the documents that you will use during the onsite inspection.

Onsite Inspection

Bedrooms

The licensor will:

1. Observe the room for any significant damage that may affect a resident's health or cause the room to not be homelike. For instance: chipped paint/exposed drywall, marred doors or doorways, damaged paneling, holes in walls, etc.
2. Observe the room for cleanliness. For instance: stains in carpets, dirty walls, fingerprints on doors, cobwebs, dust, etc.
3. Check all drawers and closets for unsafe items, and toxins which should be removed.
4. Windows:
    a. Measure the rooms windowsill height to ensure it does not exceed 44 inches from the floor.
    b. Measure the bedrooms window to ensure it has a minimum of 5.7 square feet opening unless it is a ground level floor window opening, which may have a minimum clear window opening of 5.0 square feet.
    c. In addition to the above minimum square footage, the egress window must have a minimum window opening height of 24 inches, and a minimum opening width of 20 inches.
    d. Check inside and outside of windows for any obstructions located above the windowsill like headboards or footboards, tall dressers, plants, or trees, etc. If there is more than one window in the room, at least one must be available for emergency egress.
    e. Check window coverings to ensure they open and close easily and allow for residents' privacy.
    f. Check window to ensure that it opens and closes easily and requires no key or tool to open. The window should be in good working order and should open without difficulty or getting stuck.
    g. Inspect screen to ensure it is securely installed and prevents the entry of insects.
    h. Check the window, track, and sill for cleanliness.
5. Lighting:
    a. Check to ensure lighting is adequate for the space.
    b. Check to ensure the fixture and bulbs are in good working order.
    c. All light sockets should have a light bulb.
6. Doors:
    a. Open and close doors to ensure they open and close easily and latch properly when shut.
    b. For existing door locks, ensure that the provider has an unlocking device nearby and is able to gain rapid access to the room when locked. Make sure the bedroom door handle does not have a lock on the outside where one could be locked in the bedroom.
    c. If the door does not have a lock, discuss with the provider the plan to ensure privacy.

7. Closets/Armoire:
    a. Inspect inside of closet for safety hazards.
    b. Make sure you are able to open the closet door(s) from the inside. For sliding closet doors this may mean having handles on the inside, or a stopper to prevent the doors from closing all the way.
    c. For sliding closet doors, ensure there are floor guides installed securely.
    d. Bi-folding doors do not require an inside door handle as you can just push the door open from the inside.
8. Smoke detector:
    a. Inspect the detector for damage and ensure that it is securely installed.
    b. Have the provider set off the smoke alarm to ensure it works properly and can be heard from the farthest point in the home. Smoke detectors must be interconnected.
9. Heat Source:
    a. Identify that the room has a heater in good working order.
    b. If there is an electric wall heater and/or cadet heater, check for a manufacturer's label which should identify how much distance must be left between the heater and flammable items such as the bed, nightstand, curtains, clothes, etc. Typically, the recommendation is a 3-foot allowance away from the heater. If the heating element is hot to the touch, a fire-resistant barrier must be installed to prevent access to the hot heating surface.
10. Utility Access in Bedrooms
    a. If there is an electrical panel, water shut off valve, access to a crawl space or attic through the bedroom in question, the provider must provide written notice to residents that these utilities are located in the bedroom and may need to be accessed.
    b. If there is utility access in the bedroom, the provider must ensure the resident(s) living in the room are unable to gain access to the utility to ensure their safety.
11. Measuring the room:
    a. First, using a measuring tape or laser, measure the length and the width of the room, from baseboard to baseboard, excluding built in closets. Calculate the subtotal square footage of the room and record this information on the working papers.
    b. Second, determine if there is an armoire (used in lieu of a closet), door swing, vestibule or other unusable area in the room that must be subtracted. Measure this area, calculate the square footage and record on the working papers.
    c. Subtract the unusable square footage (calculated in B) from the room subtotal (calculated in A) to determine the usable square footage of this room.

> Note: Length in inches × Width in inches ÷ 144 = Square footage

Calculations: For 'Door Swings'			
Door Width in Inches = Sq Ft for ¼ of Circle Swing			
Dr Width"	Sq Ft ¼ Swing	Dr Width "	Sq Ft ¼ Swing
25"	3.41 Sq Ft	33"	5.94 Sq Ft
26"	3.69 Sq Ft	34"	6.30 Sq Ft
27"	3.98 Sq Ft	35"	6.68 Sq Ft
28"	4.28 Sq Ft	36"	7.07 Sq Ft
29"	4.59 Sq Ft	37"	7.47 Sq Ft
30"	4.91 Sq Ft	38"	7.88 Sq Ft
31"	5.24 Sq Ft	39"	8.30 Sq Ft
32"	5.59 Sq Ft	40"	8.73 Sq Ft

Triangular Area (calculate sq ft)
A=1/2(**bh**)
Measure the base **(b)** of the triangle
Measure the height **(h)** of the triangle
Multiply the base by the height **(b x h)**
Divide this amount by two (**2**)

12. Room Capacity, Configuration and Limitations:
    a. If the usable square footage of the room is 80 - 120 sq. ft. the room may be licensed for one resident as long as the configuration of the room allows for the placement of one bed.

> Note: The Furniture must be able to be placed in safe locations in the room (i.e., beds may not be near electric heaters, dressers may not obstruct window openings, there must be adequate space to access the closet.)

    b. If the usable square footage of the room is 120 and above, the room may be licensed for two residents as long as the configuration of the room allows for the placement of two beds.
    c. Some residents who utilize mobility aids for ambulation are unable to safely navigate through narrow doorways and walkways. If you identify a bedroom with a narrow doorway (less than 27" wide) or that can only be accessed through a narrow hallway (less than 27" wide) this bedroom will need to be limited to independent residents only.

Bathrooms

The licensor will:

1. Inspect the configuration and size of the bathroom to determine the accessibility for those using mobility aids or needing standby assistance. If the bathroom is small and does not allow for unrestricted use by those residents using mobility aids or needing standby assistance, contact the FM to determine if the bathroom will be licensed for Independent residents only. The FM may contact the Initial Licensing Manager to review such scenarios.
2. Inspect the bathroom for cleanliness and safety hazards, like toxins, area rugs, etc.
3. Doors:
   a. Open and close doors to ensure they open and close easily and latch properly when shut.
   b. For existing door locks, ensure that the provider has an unlocking device nearby and is able to gain rapid access to the room when locked.
   c. Check to ensure that nothing obstructs the provider's ability to open the door from the outside, such as vanity drawers that pull out in front of the door.
4. Water:
   a. Ensure that water measures between 105- and 120-degrees Fahrenheit.
   b. Ensure that the water runs clear/clean and is not rusty or dirty.
   c. Ensure that the aerator is in good working condition and does not spray water out of the sink.
   d. Make sure the sink drains properly.
5. Shower/Tub:
   a. Ensure that at least one grab bar is available in the bath, shower, or toilet.
   b. Check the floor of the shower/tub for a non-slip surface. A shower mat on the floor that rolls or moves easily underfoot is not safe and should not be accepted.
   c. If shower doesn't have a shower curtain have a conversation regarding how they will prevent water from getting on the floor and causing a slip/fall hazard.
6. Toilets:
   a. Check to see that there is a toilet paper holder within arm's reach of the toilet.

<u>Procedure-After the Onsite Inspection</u>

1. If the bedrooms or bathrooms meet licensing requirements, the licensor will:
   a. Update the floor plan and floor plan key to reflect the rooms previously and newly licensed. Include the room designation (A, B, C, etc.), the number of residents that can be in each room, and the assigned evacuation level of each room (Independent [I] or Independent/Needing Assistance[I/A]). Always be sure the floor plan and the key match.
   b. Review and have the applicant sign the Floor Plan Key contained in the AFH Electronic Working Papers. Email a copy of the Floor Plan Key to the applicant and keep a copy in the electronic licensing file folder.
   c. If the home's capacity has changed, note the home's new capacity on the floor plan and the key.

d. If the newly licensed bedrooms will affect the provider's Medicaid Policy you should have reviewed the policy to ensure that no residents' rights are infringed upon, and the policy is in compliance with licensing requirements. If the policy did not meet requirements at the onsite visit, have the provider send in an acceptable policy before recommending that the additional rooms be licensed.
e. If the home's capacity will change, either the licensor or the FM, based on your unit's protocol, will contact the BOAU to let them know that the new rooms have been licensed and the capacity of the home can be updated in STARS.
f. If the AFH's capacity cannot be increased, the FM will notify the BOAU. The BOAU will send the AFH provider a denial letter and the Home and Community Living Administration (HCLA) Finance and Accounting Unit will send a refund in 4- 6 weeks.
g. The provider cannot exceed their current licensed capacity until the BOAU has formally changed the home's licensed capacity. The BOAU will send the home a new license reflecting the change in capacity.

2. If the bedrooms/bathrooms do not meet minimum licensing requirements, document the items that do not meet requirements on the "Exit Summary Worksheet." Keep a copy of this form in the licensing file and give a copy to the provider. The provider will need to contact the licensor for another onsite inspection once the identified issues have been addressed.

Part II: Additional AFH Procedures

A. Change of Ownership (CHOW)

Purpose

The purpose of the change of ownership (CHOW) section is to provide direction on how to handle a CHOW as it relates to the inspection process in the field. A CHOW of an AFH can occur for many reasons, such as:

- The provider may be selling their home
- The provider may be changing their business structure; or
- The provider may be adding or removing someone from their license.

Procedure

1. No inspections are done prior to licensure for any CHOW.
2. If the CHOW consists of changes to the administrative structure of the home, the previous inspections schedule should be maintained.
3. A full inspection must be completed within 30 days if the home is under a POC for outstanding violations at the time of the CHOW.
4. If the home is under a POC for outstanding violations:
   a. A Full inspection must be completed within 30 days if the person or entity is not licensed for another home at the time of the CHOW.
   b. A full inspection must be completed within six months if the person or entity is licensed for another home at the time of the CHOW.
5. The FM may call for an inspection at any time if the problems are identified in the home.
6. All inspections will be unannounced and done according to the inspection procedure.

Application Receipt

The Business Analysis and Applications Unit (BAAU) receives CHOW applications through the AFH web application portal.

1. The BAAU AA will:
   a. Create an electronic file folder for the application.
   b. Log-in into the Admin Page and upload the application with supporting documents into the created file folder.
   c. Create the application record in the Secure Tracking and Reporting System (STARS) and enter relevant payment information.
   d. Document the CHOW number and prospective AFH name under the current license in STARS.

2. The BAAU Program Specialist 3 (PS3) will:
   a. Review the application for completeness and accuracy.
   b. Complete the Financial Assessment.
   c. Complete background and fingerprint checks, if applicable.
   d. Enter the application information in STARS such as Facility Features, Ownership (Applicant/License, Management Company, & Landlord Information) and Managerial Staff.
   e. Complete various checks as determined by RCS.
   f. Draft an 'incomplete' letter to the applicant if corrections to the application are required or items are missing.
   g. Send the 'incomplete' letter to the applicant via email.
   h. Document all correspondence with the applicant in STARS.

Forwarding a Complete Application to the Field Manager (FM) for Review

1. Once it is determined the application is 100% complete, BAAU PS3 will:
   a. Upload the documents to RCS' record management tool (RMT) (i.e., Perceptive Content) except for the Disclosure of Services and the Checklist.
   b. Move the electronic file folder into the 'Uploaded' folder on the secure shared drive.
   c. Forward the application record to the Field Manager (FM) in STARS.
   d. Notify the FM and Regional Administrator (RA) via email that the application is ready for their review and recommendation.
      1) Notify the applicant via email that the application is under review by the FM.
   e. Upload sent emails to Perceptive Content.
      1) Add a copy of the sent emails to the application file folder.
2. The FM will:
   a. Review:
      1) Any unresolved complaint intakes;
      2) Most recent inspection information, including any deficiencies not yet noted as corrected;
      3) Enforcement history; and
      4) Any other information it would be important for the department to consider.
   b. Make a recommendation to approve or not approve the CHOW application.

   > Note: A recommendation to not approve a CHOW application requires RA approval.

3. The Business Operations and Analysis Unit (BOAU) will:
   a. Approve and issue the license in STARS.
   b. Notify BAAU of the approval.

New License Notification

Once BOAU issues license and notifies BAAU, the BAAU Administrative Assistant will:

1. Notify the new provider of the license issuance via email, with a cc to the FM.
2. Notify the outgoing provider/licensee of the new license approval via email.
3. Mail a copy of the license letter, license, background and fingerprint check results (if applicable) and the Character, Competency & Stability (CCS) Determination (DSHS 03-506) form (if applicable) to the new provider.
4. Update the Disclosure of Services to include the new license number and initial license date.
   a. Forward the form to be posted on the AFH Locator.
5. Upload the sent emails, license, and the Disclosure of Services to the RMT.

Application Void, Deny or Withdraw

1. The department will void an application if the applicant:
   a. Does not return requested information to the department within 60 calendar days of the department's first request for additional information for an incomplete application; or
   b. Has not obtained an AFH license within 12 months of first submitting the application to the department; or
   c. Does not meet the WAC 388-76-10037 requirement.
2. The department may deny an AFH application based on WAC 388-76-10120 and WAC 388-76-10125.
3. Applicants may voluntarily withdraw their application at any time.

B. Inspection After Revocation or Suspension

Purpose

RCW 70.128.070 states that the department shall conduct inspections at least every 18 months on licensed AFHs. When a home's license is under summary suspension or revocation, but they are appealing that enforcement action, the decision when to conduct an inspection within this timeline should be made on a case-by-case basis. Some of the determining factors are:

- The type of enforcement remedy imposed;
- If residents reside in the home; and
- If health and safety risks persist.

Homes are expected to be in compliance with Chapter 388-76 WAC until the appeals process is complete and the decision to revoke the license is final. This section gives guidance on how to determine an inspection schedule in this situation. Further information about enforcement actions can be found in SOP Chapter 7: Enforcement.

Procedure

1. If an AFH license has a summary suspension:
   a. Summary suspension orders are effective immediately, which also suspends the requirement to continue inspections.
2. If an AFH license is revoked without summary suspension:
   a. Revocation orders are not effective until the enforcement action is final, which includes the timeline for filing an appeal. The department must continue inspections, starting within six months of the date of the written notice of enforcement.
   b. The FM may decide to discontinue inspections if there are no residents living in the home.
3. The enforcement action is considered complete according to the following timeline:
   a. On the 29th calendar day after the enforcement action, if the AFH does not appeal the enforcement action.
   b. On the 22nd calendar day after the initial order by the Office of Administrative Hearings (OAH), if the AFH appeals the enforcement action but does not request review of the initial order; or
   c. On the 10th calendar day after the final order by the Board of Appeals, if the AFH requests a review of the initial order.

> Note: More information about calculating timelines can be found in WAC 388-02-0035. Providers may have additional appeal options. Consult with the CS if questions arise on how to proceed.

Field Manager Responsibility

1. While an AFH is appealing revocation with or without a summary suspension, the department must conduct monitoring visits according to the FM's discretion. The FM must work with the CS, the RA, and the Compliance and Enforcement UM to make these determinations. Refer to 'Monitoring Visits' for more information.
2. Full inspections must be conducted starting within six months of the date of the written notice of enforcement, or sooner at the discretion of the FM. The FM will work with the CS to make these determinations.
3. If the department receives a complaint about a home that is under summary suspension, or revocation, or both; staff must follow normal complaint investigation procedures found in SOP Chapter 20 – Complaint Investigations.

Part III: Appendices

A. Resources and Forms

1. Resources

a. Professional Page for Providers
b. Drugs.com
c. Frequently Asked Questions

2. Inspection Forms

a. AFH Inspection Packet (DSHS 10-575)
b. Attachment A: Pre-Inspection Packet (DSHS 10-548)
c. Attachment B: Inspection Process & Records Request (DSHS 10-549)
d. Attachment C: Entrance Information & Observation (DSHS 10-550)
e. Attachment D: Resident List (DSHS 10-551)
f. Attachment E: Staff List (DSHS 10-552)
g. Attachment F: Environmental Tour (DSHS 10-553)
h. Attachment G: Environmental Tour – Bedrooms (DSHS 10-554)
i. Attachment H: Resident Observations (DSHS 10-555)
j. Attachment I: Resident Record Review (DSHS 10-556)
k. Attachment J: Comprehensive Resident/Representative Interview (DSHS 10-558)
l. Attachment K: Condensed Resident/Representative Interview (DSHS 10-558A)
m. Attachment L: Resident Medication Review (DSHS 10-557)
n. Attachment M: Administrative Records Review (DSHS 10-559)
o. Attachment N: Administrative Records Review Continuation (DSHS 10-559A)
p. Attachment O: Administrative Records Review-Former Staff (DSHS 10-559B)
q. Attachment P: Provider/Resident Manager Interview (DSHS 10-560)
r. Attachment Q: Staff Interview (DSHS 10-561)
s. Attachment R: Exit Preparation Worksheet (DSHS 10-562)
t. Attachment S: Floor Plan Key (DSHS 10-564)
u. Attachment T: Follow-Up Visits (DSHS 10-568)
v. Attachment U: Notes (DSHS 10-563)
w. Monitoring Visit (DSHS 10-684)
x. AFH Confidential Identifier List (DSHS 27-235)

3. Community Engagement Partner Forms

a. Disclosure of Services Form (DSHS 10-508)
b. Disclosure of Charges Form (DSHS 15-449)
c. AFH Information Change Form
d. Change in Licensed Bed Capacity Increase (DSHS 06-168)
e. Change in Licensed Bed Capacity Decrease (DSHS 06-169)
f. Adult Family Home Notice of Transfer or Discharge (DSHS 15-456)

B. Glossary of Terms

Abandonment – as defined in RCW 74.34.020.

Abuse – as defined in RCW 74.34.020.

Activities of daily living (ADL) – Those activities related to personal care, such as: bathing or showering, dressing, getting in and out of bed or a chair, walking, toileting, and eating.

Adult Family Home (AFH) – State licensed residential homes to care for two to eight vulnerable adults who may have mental health, dementia, and/or developmental disability/special needs. The homes are private businesses providing each person with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services.

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

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

Background Check Central Unit (BCCU) – means a division within the department that processes background checks for department authorized service providers and department programs who serve vulnerable individuals across Washington State. WAC 388-113-0010.

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

Chemical restraint – as defined in RCW 74.34.020.

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

Completed – means that a final decision from the IDR or IIDR process is determined, a written record generated, and the State survey agency has sent written notice of this decision to the facility; ***or*** a facility does not request the IDR/IIDR timely; ***or*** chooses not to participate in the IIDR process.

Compliance – The state of an organization that meets prescribed specifications, contract terms, regulations, or standards.

Consultation in AFH – Documentation of a first-time violation of statute or regulation with minimal or no harm to residents identified in an adult family home. Documentation of a consultation includes an entry made on the cover letter that consists of:

- a regulatory reference to the Washington Administrative Code (WAC) requirement and/or Revised Code of Washington (RCW); and
- a brief (2 – 4 sentences) statement summarizing the deficient practice.

Corrected – means the cited deficiency has been corrected and is now in compliance with regulatory compliance.

> Note: A single deficiency may be corrected while others remain out of compliance.

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).

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

eFax – is the use of the internet and email to send a fax (facsimile), rather than using a standard telephone connection and a fax machine.

Electronic medical record (EMR) or Electronic health record (EHR) – a digital version of a chart with resident medical/health information stored in a computer.

Electronically stored information – DSHS records stored in an electronic format. Requires hardware and software to be accessed and read (e.g., spreadsheets, databases, images, video recordings). Also known as electronic records.

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.

Exemption/Exception – means a temporary situation granted by the RCS Director in which an entity is exempt or has an approved exception to the requirement to comply with a specific regulatory requirement.

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 universe.

Failed provider practice – Describes the action(s), error(s), or inaction(s) on the part of the licensee relative to statute(s) or regulation(s) and, to the extent possible, the resulting negative outcome(s) to vulnerable adult(s). Term includes deficient practice, which is defined as "lacking an essential quality or element, and inadequate in amount or degree."

Financial exploitation – as defined in RCW 74.34.020.

Finding – A term used to describe each item of information found during the regulatory process about entity's practices relative to a specific requirement cited as being not met.

Fingerprint check – means a fingerprint check is considered a positive identification check. The fingerprints of an applicant are reviewed to match fingerprints taken at the time of an arrest or conviction of a crime.

Focused interview, record review or observation – A focused review or interview involves a specific issue rather than a comprehensive review. You may look at it like the focused review is in response to an identified issue or potential issue. A comprehensive interview or record review covers many areas that are pre-determined.

Folder – A type of aggregation or container within a file system used to store related records and folders.

Food service worker – means according to Chapter 246-217 WAC, an individual who works (or intends to work) with or without pay in a food service establishment and handles unwrapped or unpackaged food or who may contribute to the transmission of infectious diseases through the nature of the individual's contact with food products or equipment and facilities. This does not include persons who simply assist residents with meals.

Formal interviews – structured interviews with sample residents, the service provider, staff, family members or representatives, or other collateral contacts.

Gender neutral language – Use of terms to increase the confidentially and be inclusive of the vulnerable adult(s) in the specific setting. This includes pronouns, which do not associate a gender with the vulnerable adult in order to protect the identity, such as, they, them, or theirs. Emphasize attempts to avoid using gender specific pronouns such as he, him, his or she, her, hers.

Home – A generic term used to describe an adult family home in the State of Washington.

Homelike – means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to decorate one's living area and arrange furnishings to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.

Household member – means a person who uses the address of the adult family home as their primary address and who is not a resident.

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 the 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.

Imminent danger or **Immediate threat** – means serious physical harm to or death of a resident has occurred, or there is a serious threat to the resident's life, health, or safety.

Improper use of restraint – as defined in RCW 74.34.020.

Informal interviews – general conversations or information gathering which may occur during any part of the inspection process.

Inspection – A generic term used to describe the process by which RCS staff evaluates a licensee's compliance with statutes and regulations. Complaint/incident investigations are only one type of on-site inspection/survey done to determine the health and safety of vulnerable adults in licensed or certified long-term care residential settings.

Isolate or **Isolation** – means to restrict a vulnerable adult's ability to communicate, visit, interact, or otherwise associate with persons of his or her choosing. Isolation may be evidenced by acts including but not limited to:

- Acts that prevent a vulnerable adult from sending, making, or receiving his or her personal mail, electronic communications, or telephone calls; or
- Acts that prevent or obstruct the vulnerable adult from meeting with others, such as telling a prospective visitor or caller that a vulnerable adult is not present, or does not wish contact, where the statement is contrary to the express wishes of the vulnerable adult.

The term "isolate" or "isolation" may not be construed in a manner that prevents a guardian or limited guardian from performing his or her fiduciary obligations under Chapter 11.130 RCW or prevents a hospital or facility from providing treatment consistent with the standard of care for delivery of health services

Last Date of Data Collection (LDDC) – The final date data was collected for the Compliance Determination (CD).

Legal representative—A generic term which includes the resident representatives who act on behalf of the resident concerning care and services provided by the facility, home, or entity. This would include power of attorney, surrogate decision-maker, guardian, or any other person authorized by law to act for another person.

Licensee – A generic term to describe individuals or entities licensed or certified to provide services as an adult family home, assisted living facility, enhanced services facility, and/or nursing home care in the state of Washington.

Likely/likelihood – means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.

Mandated reporter –this is an employee of the Department or the Department of Children, Youth and Families (DCYF); law enforcement officer; social worker; professional school personnel; individual provider; an operator of a facility or a certified residential services and supports agency under Chapter 71A.12 RCW; an employee of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, hospice or certified residential services and supports agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to Chapter 18.130 RCW.

Mechanical restraint – as defined in RCW 74.34.020.

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 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.

Mental abuse – as defined in RCW 74.34.020.

Minimal harm – means violations that result in little to no negative outcome or little or no potential harm for a resident.

Misappropriation of resident property – means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money.

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

Modified off-site visit – means conducting the facility CMAR visit off-site, or partially off-site, including electronic health record (EHR) review, interviews, entrance, and exit. The Modified off-site visit is done during times of Natural disaster, pandemic or other events that make on-site visits untenable.

Modify - Allows users to read, write, and delete files and subfolders.

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

Neglect – as defined in RCW 74.34.020.

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

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

Personal exploitation – as defined in RCW 74.34.020.

Physical abuse – as defined in RCW 74.34.020.

Physical restraint – as defined in RCW 74.34.020.

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

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

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

Protective services – means any services provided by the department to a vulnerable adult with the consent of the vulnerable adult, or the legal representative of the vulnerable adult, who has been abandoned, abused, financially exploited, neglected, or in a state of self-neglect. These services may include, but are not limited to case management, social casework, home care, placement, arranging for medical evaluations, psychological evaluations, day care, or referral for legal assistance.

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

Psychopharmacologic medications – the class of prescription medications, which includes but it not limited to antipsychotics, antianxiety medications, and antidepressants, capable of affecting the mind, emotions, and behavior.

Recurring/Repeated –

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

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

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

Scope – The prevalence or frequency of deficient cases (scope) relative to the total number of actual and potential cases (universe). The extent is expressed in a numerical format. The scope is used as the numerator when determining the extent of deficient practice.

Self-neglect – as defined in RCW 74.34.020.

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

Sexual abuse – as defined in RCW 74.34.020.

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

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

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

Universe – The prevalence or frequency of deficient cases (scope) relative to the total number of actual and potential cases (universe). The extent is expressed in a numerical format. The universe is used as the denominator when determining the extent of deficient practice.

Unsupervised access – means not in the presence of:

- Another employee or volunteer from the same business or organization; or

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

Volunteer – an individual who interacts with residents without reimbursement.

Vulnerable adult – as defined in RCW 74.34.020.

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.

Willful – as defined in RCW 74.34.020 (related to abuse, neglect, or exploitation).

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

C. Acronym List

AA	Administrative Assistant
ADL	Activities of Daily Living
AFH	Adult Family Home
ALTSA	Aging and Long-Term Support Administration (now HCLA)
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
BAAU	Business Applications and Analysis Unit
BCCU	Background Check Central Unit
BOAU	Business Operations and Analysis Unit
CC	Carbon Copy (in emails)
CCS	Character, Competency and Suitability
CD	Compliance Determination
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CHOW	Change in Ownership
CI	Complaint Investigations
CLIA	Certified Laboratory Improvement Amendment
COVID	Coronavirus Disease
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DCYF	Department of Children, Youth, and Families (formerly Child Protective Services or CPS)
DDA	Developmental Disabilities Administration
DOB	Date of Birth
DOH	Department of Health
DOL	Department of Licensing
DPOA	Durable Power of Attorney
DSHS	Department of Social and Health Services
eFax	Electronic Facsimile
EWP	Electronic Working Papers
F	Fahrenheit
FM	Field Manager
FSA	Field Services Administrator
HCBS	Home and Community-Based Services
HCLA	Home and Community Living Administration (formerly ALTSA)
HCS	Home and Community Services
HH	Household Members
I	Independent
I/A	Independent or Needs Assistance
ICTS	Instructor and Curriculum Tracking System
ID	Identification

IDR	Informal Dispute Resolution
IPC	Infection Prevention and Control
LDDC	Last Date of Data Collection
LE	Law Enforcement
LN	Licensed Nurse (includes both RNs and LPNs)
LPN	Licensed Practical Nurse
LTC	Long-Term Care
MAR	Medication Administration Records
MFCD	Medicaid Fraud Control Division
MH	Mental Health
MTSW	Medical Test Site Waiver
NA	Nurse's Aide/Nurse's Assistant
NA-C	Nursing Assistant Certified
NA-R	Nursing Assistant Registered
NCP	Negotiated Care Plan
ND	Nursing Delegation
OAH	Office of Administrative Hearings
OTC	Over the Counter
PC	Perceptive Content
PHE	Public Health Emergency
POA	Power of Attorney
POC	Plan of Correction
POD	Principles of Documentation
QR	Quality Review
RA	Regional Administrator
RAP	Records of Arrests and Prosecutions
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
RPP	Respiratory Protection Program
SBC	State Building Code
SOD	Statement of Deficiency
SOP	Standard Operating Procedures
STARS	Secure Tracking and Reporting System
TB	Tuberculosis/Tuberculin
WAC	Washington Administrative Code
WD	Working Day
WNDOB	Washington State Name and Date of Birth

D. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/06/2025	• Entire Chapter	Form link updates	Forms now available on the internet	• N/A
01/17/2025	• Entire Chapter	Formatting updates	Comply with new DSHS branding	• N/A
01/17/2025	• II.D AFH Licensing Fees	Removed from Chapter	This topic will be captured in Chapter 20	• MB R25-011 • 02/2025 Support Call
01/17/2025	• I.Q. Off-Site Activities	Section added	Provide consistent guidance for staff following an inspection	• MB R25-011 • 02/2025 Support Call
01/17/2025	• Entire Chapter – Sunset Review	SOP updated to align with current procedures and systems	To provide current and accurate staff guidance	• MB R25-011 • 02/2025 Support Call
05/2024	• II.J. Capacity Increase 7 or 8 beds	Added expedited timeframes for capacity increases	To provide guidance to staff on the expedited process criteria	• MB R24-045
05/2024	• I.A. Pre-Occupancy	Section removed (moved to Chapter 11 in 02/2019)	Removed placeholder in chapter	• MB R24-045
05/2024	• FAQs	Section removed	To avoid confusion among staff by including potentially outdated guidance	• MB R24-045
09/2023	• Monitoring Visits	Section added	To provide staff guidance for this process	• MB R23-070
08/2023	• Licensing Additional Bedrooms /Bathrooms	Section added	To provide staff guidance for this process	• MB R23-061
03/2023	• Full Chapter	Chapter reformatted.	Provide a more user-friendly document.	• MB R23-026

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
		Clarification for POCs when IDR is being requested. Requirement for sprinkler systems to be inspected annually removed.	Provide current and accurate guidance.	
11/2020	• 12C8 Capacity increase • 12C7 Information changes	A new section was added to outline the process for a capacity increase. The previous procedure for capacity increase was removed from 12C7.	Passed legislation allows some adult family homes to increase their capacity to 8. These homes have additional requirements and must be inspected. This new section	• MB R20-136 • A staff training was conducted as part of the Statewide Community Call on 6/22/2020. • Staff were asked to use a draft for practice and provide feedback prior to final implementation.
10/2020	• 12B1 General guidelines	Added a requirement to fill out the working papers completely.	To ensure staff are reviewing every aspect required by the working papers, the working papers must be completely filled out.	• MB issued
7/2020	• 12B8 Observation of Care	Document which observations are required, and which can be done as needed Document which residents must be observed, and which can be observed as needed Reorganize information for clarity	To improve standardized practice across the state and to ensure essential observations are completed	• MB R20-086
4/2020	• 12B17 Inspection After	Includes information about timelines for inspections when a	To advise staff how to meet statutorily required timelines	• MB R20-051

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
	Revocation or Suspension	home is appealing an order for suspension or revocation	when under revocation or suspension order	